POCKET GUIDE

To Early EMDR Intervention Protocols

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Contents

This Pocket Guide is included in the EMDR Foundation's
EMDR Early Intervention and Crisis Response: Researcher's Toolkit.
To access the entire Toolkit, go to http://www.emdrfoundation.org/toolkit/

4-2018

ERP—Emergency Response Procedure [Quinn; 2004]	
For Use With	Victims of trauma within hours of incident. Patients that present with "silent terror" shaking, inability to speak, or if verbal in a highly agitated state. Can also be used for acute abreactions during any phase of the EMDR process.
Phase 1 **Client History**	1. Get brief history from ambulance, hospital staff, or whoever has information (if patient can't tell you, focus on immediate trauma only). 2. Establish present time orientation and safety. 3. If client is verbal get history on immediate trauma (right before trauma to present moment).
Phase 2 **Preparation**	1. Normalize patient's behavior and physical reactions. 2. Explain what acute stress reactions are. 3. Give brief explanation of EMDR 4. Establish a calm and present orientation 5. Client does not have to be speaking in order to begin.
Phase 3 **Assessment**	1. Assume that patient is in a highly agitated, acute stress reaction state. 2. Patient is already accessing image because they are already in them internally. 3. Assume NC (I am in danger). 4. Assume initial PC (I am safe now from that event). 5. Assume emotion as high fear or terror. 6. Assume a SUD close to 10. 7. Therapist notices body sensations. 8. Do not encourage free associations.
Phase 4 **Desensitization**	1. Utilize dual attention to help patient gain external focus (in the ER or safe area, away from event). 2. Use bilateral stimulation and use cognitive interweaves to establish current safety and present time orientation.
Phase 5 **Installation**	1. Standard installation is not done. 2. Current safety is reinforced instead using breathing techniques. 3. Patients must say that they are safe and recognize that the event is over to move to closure. 4. Or, if client wants to give you a narrative of what is experienced, do a narrative and shift to EMD protocol or R-TEP.
Phase 6 **Body Scan**	1. Not done formally. 2. Acknowledge cessation of shaking, calming of body, and ability to connect.
Phase 7 **Closure**	1. Provide education script about what can happen after a trauma experience. 2. Give referrals for if symptoms continue to be acute and are not subsiding. 3. Client is given handout on common physiological and emotional symptoms that occur in the first 48-72 hours.
Phase 8 **Reevaluation**	1. In emergency situations, reevaluation doesn't always happen. 2. Whenever possible, contact patients within a week via phone to assess situation and provide support.

EMDR-ER—EMDR Emergency Room [Guedalia and Yoeli; 2000]	
For Use With	Used when patients are unable to move onto the ambulatory staging area. Patient is frozen, laying, unable to resume motor functioning, dazed stupor or dorsal vagal state.
Phase 1 **Client History**	1. Medical and physical stabilization and safety • Basic level of physical relatedness, can respond to questions, breathing cadence slows down • Can focus eyes, looks around, shows interest at some level of surroundings 2. Mirror: Breathe in same cadence and hold patient's hand 3. You must establish trust and safety in the moment. 4. Establish present time orientation and say short comforting statements.
Phase 2 **Preparation**	1. Make them comfortable so they can interact with environment and you. 2. Introduce yourself, make contact and ask for permission to tap; if no, go to explanation of EMDR 3. If client can't respond verbally, touch two places and stand in their line of vision as you touch them. 4. Foster sense of calm and safety; educate about normal acute stress disorder reactions.
Phase 3 **Assessment**	1. Present affirmation of patient being alive and safe in present moment. 2. Assist client to move from internal focus to external focus. 3. Have client do a narrative of the event (note affect, NC, sensations) 4. Have client focus on IMAGE (target) of event. 5. Clinician gives PC to client; affirm safety, control, recovery; get a VOC and then an NC if prudent 6. Encourage authentic empathy, crying, and sighing—EMOTION. 7. You do not have to get a SUD, as it is probably obvious (ex 15 out of 10) 8. Do NOT ask about body if client is injured.
Phase 4 **Desensitization**	1. Use distancing techniques, video, reversed binoculars, television. 2. Suggest tapping on hands, shoulders, and knees. 3. Have client begin narrative of target experience; Do NOT have client close their eyes. 4. Continue to infuse current safety and present orientation.
Phase 5 **Installation**	1. Therapist repeats narrative of what happened to client, building a more rich story 2. Check patient's physical and emotional state, using BLS if possible 3. Help incorporate sequences, such as time and place, into narrative 4. Subtly use patient's own language to repeat the story to get cohesive picture/narrative 5. Goal: the world isn't such a bad place, it's worth it to continue living 6. Focus is on installation of control, self-determination, power/competence and humanity 7. Narrative created will hopefully be crystallized for future reference 8. Repeat until the patient has reprocessed the event and demonstrated that he/she is able to verbalize sensory experiences
Phase 6 **Body Scan**	1. Acknowledge changes in patient's emotional tone and physical reactions. 2. Check for any residual, unprocessed information.
Phase 7 **Closure**	1. Have patient repeat narrative in presence of physician. 2. Provide handout about the normalization of symptoms and what to expect in the next 48-72 hours.
Phase 8 **Reevaluation**	1. Patient is given information for follow-up with; let patient know they are eligible for group and other therapeutic services. 2. Have patient verbally commit to follow-up with appropriate physicians and clinicians. 3. Patient is discharged.

Tables adapted from Marilyn Luber's Scripted Protocols (2009, 2013) and original theorists' publications. ©2013, 2018 Beverlee Laidlaw Chasse

	EMDR PRECI—Protocol for Recent Critical Incidents [Jarero and Artigas; 2011]
For Use With	Used with disaster survivors more than two days after a traumatic event up to six months post event (or as long as there is still ongoing trauma). Appropriate for events where clients are still living in areas with ongoing trauma and violence.
Phase 1 **Client History**	1. Do not do any early history—focus only on narrative. 2. Ask client to describe the traumatic event in narrative form from right before the event occurred until the present moment. 3. If there is great distress (can't speak, crying) do not push for narrative and get a brief description of what happened. 4. Identify fragments of the event that stand out for them. 5. Do not use bilaterals. 6. Give diagnostic psychometrics of IES and SPRINT, if possible.
Phase 2 **Preparation**	1. Screen for appropriateness for EMDR PRECI • Life threatening substance abuse, serious suicide attempts, self-mutilation • Serious assaultive behavior, signs of dissociative disorder 2. Educate about EMDR-AIP 3. Explain mechanics of train "stop" signal and "keep going" signal. 4. Teach butterfly hug and have them do it. 5. Teach self-soothing strategies (1) abdominal breathing (2) concentration exercise and (3) pleasant memory technique.
Phase 3 **Assessment** **&** **Phase 4** **Desensitization**	1. Have client run a movie of the event from right before the beginning until today. 2. Do not use bilaterals. 3. At the end have them tell you the worst fragment. 4. Assess fragments individually. • Worst fragment • Elicit other fragments • Desensitize all fragments using standard procedures until SUD at "0" or ecologically sound. 5. Processing sequence includes image, NC, emotion, SUD, location of physical sensation—no PC or VOC. 6. Only offer NC if clients are unable to come up with their own. 7. Use butterfly hug or eye movements for desensitization. 8. To elicit other fragments ask the client to visualize the entire sequence of the event again with eyes closed and reprocess only the fragments with disturbance.
Phase 5 **Installation**	1. Develop a PC for the entire event. 2. Get a VOC. 3. Install PC using butterfly hug when client no longer identifies further disturbance when visualizing event with eyes open. 4. Shapiro suggests reviewing whole sequence holding PC.
Phase 6 **Body Scan**	1. Run a body scan using standard procedures. 2. Reprocess any disturbance.
Phase 7 **Closure**	1. Standard procedure. 2. Use Jarero and Artigas' self-soothing strategies learned at the beginning if necessary. 3. Remind client to use one of the self-control techniques as needed.
Phase 8 **Reevaluation**	1. Make sure past memories are reprocessed. 2. Reprocess any present triggers. 3. A future template is done for each trigger.

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REP—Recent Event Protocol [Francine Shapiro; 1995, 2001, 2018]	
For Use With	Patients who have experienced a recent trauma within the past two to three months, but past the first two days. If patients are displaying Acute Stress Reactions, additional stabilization exercises in history taking/preparation (like below) should be used.
Phase 1 **Client History** **&** **Phase 2** **Preparation**	1. Develop rapport and trust—goal is to prepare client to tell story while being calm and maintaining dual attention. 2. Educate regarding ASR symptoms; normalize physiological and psychological difficulties with regard to recent experience. 3. During narrative history taking on critical event, assess for the following to determine client readiness for trauma processing: Signs of dissociative disorders (not event-related symptoms); a danger to themselves or others; active psychosis; major vegetative depression; a history of suicide attempts; loss of consciousness during event. Loss of consciousness during event; can client maintain connection with therapist and sensation during BLS 4. Gather only essential background; medical/medications/drug/alcohol use/abuse/resources/past traumatic experiences. 5. Have client demonstrate deep breathing and other activities that activate the parasympathetic system and the relaxation response, grounding techniques. 6. Do "safe place" or resource exercise—tap into positive adaptive experiences if needed 7. Prepare client for EMDR processing of recent event—teach metaphors and techniques that foster stability and a sense of mastery and control—explain mechanics, stop signal. 8. Discuss ways to distance self during narrative, if necessary, until able to fully connect to experience. 9. Obtain a narrative of the event from what they were doing before the event until they felt safe, noting segments of disturbance for potential targets, identifying the most disturbing (first target).
Phase 3 **Assessment** **&** **Phase 4** **Desensitization** **&** **Phase 5** **Installation**	1. Process the most disturbing segment "t" first (use of eye movements preferred; other methods tapping, auditory, tactile). 2. Assess: Image, NC, PC, VOC, Emotion, SUD, Location of physical sensation. 3. Can suggest a tentative NC and PC if they have difficulty. 4. Reprocess using standard EMDR protocol through to completion of installation. 5. Get SUDs down to 0 or 1, and VOC up to 6 or 7. (Ecologically sound.) 6. **Repeat phases 3-5 for all other disturbing segments "t's" of the event in chronological order.** 7. Once all targets have been processed, have client visualize the entire event from start to finish with eyes closed. If disturbance is reported, process using standard EMDR protocol. 8. Continue to process until client can visualize the event from start to finish without any emotional, cognitive or somatic distress (unless ecological). 9. Develop a PC for the entire event, have client visualize entire event with that PC in mind with eyes open and adding EM's.
Phase 6 **Body Scan**	1. Combine original incident with PC and ask client to scan the body; process any sensations client reports. 2. If disturbing material, feelings or sensations emerge, return to processing or appropriately contain material if needed.
Phase 7 **Closure**	1. Choose appropriate termination point and adequately debrief. 2. Provide support and normalize experience. 3. If material is not completely processed, utilize safe place, visual healing, or containment to close incomplete session. 4. Discuss possibility of continued processing between sessions; encourages client maintain a log; call if having difficulties.
Phase 8 **Reevaluation**	1. Check to make sure all parts of the recent past event are preprocessed. 2. Target and reprocess any present triggers activated by this event. 3. Do a future template for each present trigger.

R-TEP—Recent Traumatic Episode Protocol [Elan Shapiro & Brurit Laub; 2008, 2014]	
For Use With	Victims of RECENT trauma who may or may not be continuing to experience ongoing trauma in the aftermath of a crisis.
Phase 1 **Client History**	1. Brief intake history to assess SMS (Severity/Motivation/Strengths). 2. Current trauma-focused therapy contract. 3. Psychoeducation regarding trauma episode and AIP (Adaptive Information Processing). 4. Conceptualizes traumatic episode as a trauma continuum from before the traumatic event until the present. 5. General description of trauma. AVOID GOING INTO DETAILS No BLS.
Phase 2 **Preparation**	1. Extended preparation uses E. Shapiro's 4-element self-soothing strategies (includes grounding, deep breathing, eliciting relaxation response, and safe place) and Laub's Resource Connection Envelope.
Phase 3 **Assessment**	1. Obtains a narrative history of the trauma episode with BLS. 2. Uses Google search with BLS to identify the first PoD (Point of Disturbance) and then assesses the PoD with image, NC, PC, VOC, emotion, SUD, and body sensation location. 3. Waits for clients to respond with their own NC before offering one. Suggests a tentative NC and PC to the client if they have difficulty forming NC or PC. 4. After a PoD is reprocessed, repeat Google search using BLS to find the next PoD. Sequencing is not necessarily chronological. 5. Each identified PoD is assessed as a complete target with image, NC, PC, VOC, emotion, SUD, and body sensation location.
Phase 4 **Desensitization**	1. Uses "Focused Processing" = default EMDr strategy (containing associations to current episode only.) Or EMD Strategy (containing associations relating directly to the PoD only) when it is an intrusive fragment. EMDR free associative processing is used if trauma episode-focused processing is not sufficient. 2. Uses various forms of BLS, but recommends tapping and EM and always keeping eyes open, as well for monitoring outer attention and grounding in the present safety. 3. Each subsequent PoD is processed with Focused Processing to completion of installation phase (not necessarily chronological). No body scan yet.
Phase 5 **Installation**	1. Install PC for each target when SUD is ecological. 2. Installation of the PC uses standard EMDR procedure with frequent checking of VOC. 3. Installation for entire episode is conducted when the client identifies no further PoDs when doing a "Google search" of episode. 4. PC is developed for the whole episode. 5. Installation of the episode PC uses standard EMDR procedures, which include frequent checking of VOC.
Phase 6 **Body Scan**	1. No body scan until all the targets of the T-episode are processed. 2. Then do body scan for whole episode.
Phase 7 **Closure**	1. Use E. Shapiro's 4-element self-soothing strategies (includes safe place and Laub's resource connection envelope).
Phase 8 **Reevaluation**	1. Check for remaining PoDs using "Google Search" at next session. 2. Follow-up at the end.

***EMD strategy**: Narrow focus going only with associations relating to the PoD but returning to Target (PoD) and checking SUD when it departs from PoD. If SUD stuck (6 sets) expand naturally into EMDr strategy. Used when POD is an intrusive fragment (reoccurring image, sensation, thought, feeling.)*

***EMDr strategy**: Wider focus allowing associative chains relating to the T-Episode. If SUD stuck consider narrower*

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	EMDR IGTP—EMDR Integrative Group Treatment Protocol – Adult [Jarero and Artigas, 2000]
For Use With	Providing treatment to large groups of people (both children and adults) impacted by large-scale critical incidents.
Phase 1 Client History ***For children use toys and play during phases 1 & 2.***	• Attention to basic needs (shelter, food, security) and getting permission to treat (from hosting organization). • Establish emotional protection team (and gather history through this team: symptoms, family status, infrastructure, etc.). • Organize meeting to explain trauma from adaptive information processing perspective. • Invite people to participate in a small group process (if many people, schedule multiple sessions over many days—no more than 20-30 participants in a group). Two hours are scheduled for a group session.
Phase 2 Preparation	1. ***PART ONE***: Goal of building rapport and trust (with children—use drums, puppets, toys, storytelling, etc.). 2. Emotional protection team is introduced and placed around the circle (try to have 8-10 participants per team member). Active supportive listening is the role—do not probe for emotional responses or information. 3. Explain group process, policies and procedures. Do brief introductions. Introduce AIP (adaptive information processing). 4. Ask people for symptoms they may be exhibiting (Have any of you been experiencing nightmares? Show of hands). 5. Don't force anyone to talk, and note if there is any deterioration or dysfunction—those who are unable to attend to their basic responsibilities and activities. (Triage those who may need more personal attention.) 6. Normalize symptoms. Teach self-soothing activities (abdominal breathing, concentration exercise, pleasant memory, butterfly hug)—remind that they can use these activities anytime 7. Share coping strategies to use after a trauma (i.e., drinking water, eating healthy, exercise, self-soothing techniques, etc.). 8. Prepare for trauma work by checking and validating the signs and symptoms of PTSD (can do IES or CRTES). 9. Encourage people to verbalize traumatic memories as much as they feel comfortable doing so. 10. ***PART TWO****:* Introduce and use HAP SUD scale measure (HAP faces). 11. Give out paper and crayons and write name on top left page and then turn over the paper. 12. Divide into four squares; put letters A, B, C, D on each square.
Phase 3 Assessment	1. As a group, remember the event, and raise their hands to acknowledge that they are thinking about worst part of event. 2. Draw in square "A" a picture that represents this experience. Have them do SUD rating 0-10 and any NC. Write them down.
Phase 4 Desensitization	1. Put crayons aside and do butterfly hug for 60 seconds while looking at picture "A." 2. Observe feelings and draw whatever you want in square B related to the event. 3. Get another SUD when you look at square "B"—write it down 4. Do butterfly hug for 60 seconds again looking at picture "B" 5. Repeat steps 1-4 for pictures "C" and "D" 6. Look at drawing that disturbs you the most, and write down the SUD about how you feel about the drawing now.

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	EMDR IGTP - CONTINUED FROM PREVIOUS PAGE
Phase 5 Future Vision (Installation)	1. Draw how they see themselves in the future (on back of paper) with a word or phrase that explains it (use this to identify adaptive and non-adaptive cognitions for possible follow-up). 2. Look at drawing and do butterfly hug for 60 seconds.
Phase 6 Body Scan	1. Do standard body scan technique (notice your body, notice anywhere that you feel anything). 2. Do butterfly hug again for 60 seconds. Have your emotional protection team going around to ensure everyone is okay. 3. Body shaking (like dog after a bath) to encourage laughing and release.
Phase 7 Closure	1. Have participant go to calm, happy, safe place (that they got at the beginning). 2. Use butterfly hug for 60 seconds. Deep breathe three times.
Phase 8 Reevaluation	1. Identify those needing further assistance and have them seen individually or in a smaller group format. 2. Give participants a post IES; one week and three month follow up is recommended.

EMDR G-TEP (EMDR Group Traumatic Episode Protocol - Elan Shapiro, 2015 ©	
For Use With	• Suitable for working with groups of people (older children and adults) impacted by large-scale critical incidents. • Also suitable for families, couples. • Offering stabilisation, stress management & an adaptive processing screening check, for all exposed. • Providing intensive current trauma episode processing when appropriate
Intake & Data Collection	• Obtain initial data for assessment information, screening & group selection: • Conduct brief individual interviews & joining when possible • Administer psychometric measures for PTSD, Depression & Resilience (e.g. PCL-5, MINI; PHQ-9, BDI; BRS / CD-RISC 10) • Repeat these measures POST treatment & at FOLLOW-UP • Work Seated around tables up to about 12 participants in a group. 2-3 hours are scheduled for a group session.
Materials & Setup	• Participants work on a G-TEP Worksheet printed on a large sheet of paper; Coloured pens or pencils; A silicon rubber wristband or a sticker; Faces scale & stickers for children or non-literate populations. • The G-TEP manual has the protocol script & all the instructions for the group leader and a worksheet with summary notes. • The setup is designed for use with this single worksheet to guide the process step by step. • The slides & worksheet of the EMDR G-TEP are colour-coded so that each step has its own colour to make it easier to follow. • The Worksheet is a meta-communication: in which the trauma event is enveloped with present/past/& future resources graphically conveying that the event is in the past- they are safe now in the present & that there is hope for the future. • Group leader should have additional support staff, to aid with logistics, monitor & support those who need assistance.
Step One Preparation	• **STEP 1 Preparation & screening:** This step can stand alone as it is helpful for all for stress management & for screening. • Ask to write down SUD before (0….10). • Teach the 4 Elements exercise (Includes Safe/calm place drawing or words). • Ask to write SUD after (0….10) ; Write the Date TODAY.
Step Two: Onset of Trauma	• Write a heading (word or words, symbol or sketch) for the Onset of Trauma Episode. • Write SUD (0…….10) now. • Write the 'Date THEN' (for when the event happened). NB: No sharing of the traumas.
Step Three: Past Resource	• Recall a memory where you felt good with yourself, felt whole. • Notice feelings and body sensations. • Strengthen connection with set of Butterfly Hugs. • Draw or write something to represent it. • Give it a name and strengthen with Butterfly Hugs. • Invite group sharing of good memories.

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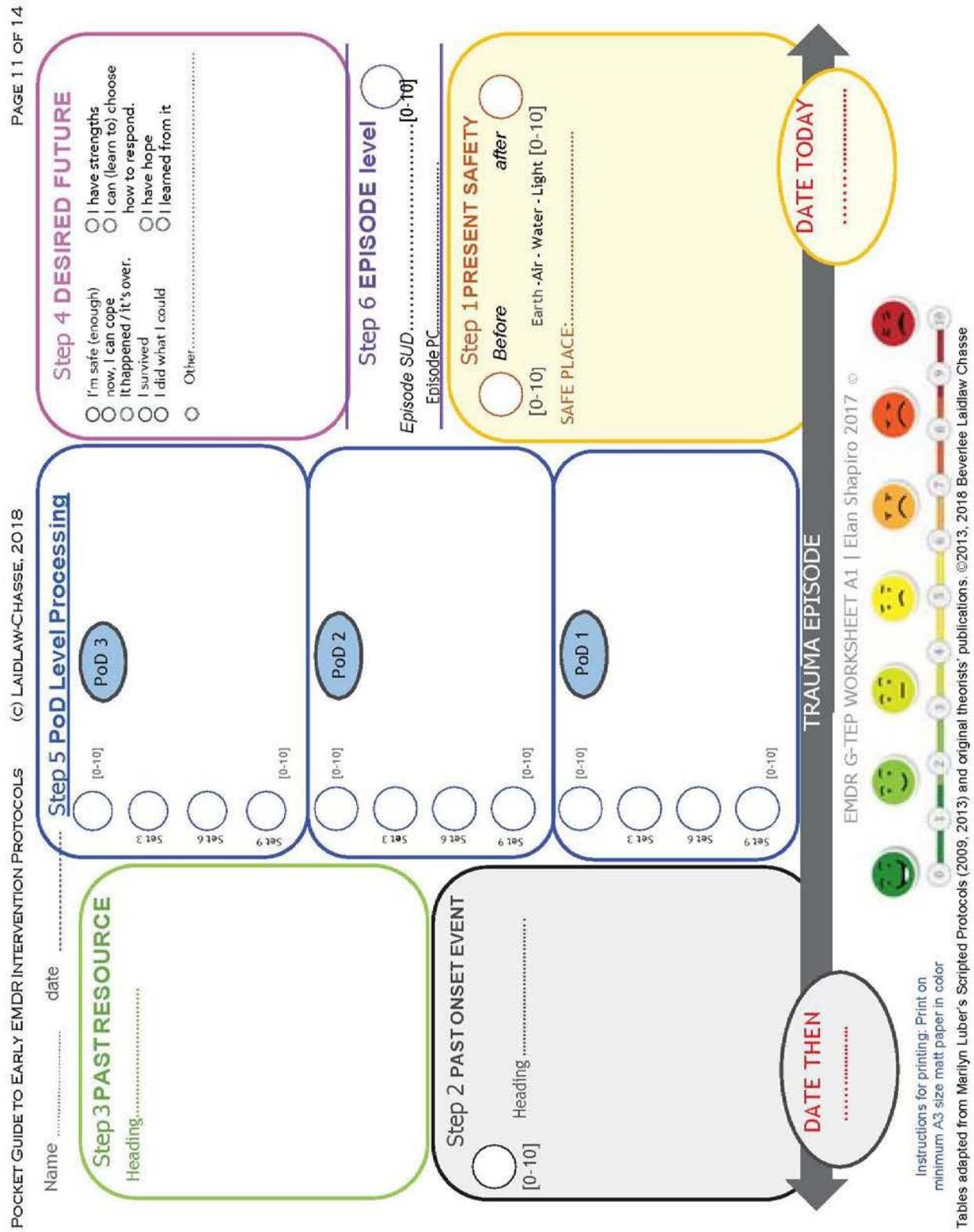
Step Four: Future Resource	***EMDR G-TEP - CONTINUED FROM PREVIOUS PAGE*** • Ask group members how they would like to think about themselves and the events that have happened. Show list for examples. • Draw or write any other thoughts or pictures of how you would like to see yourself in the future. • Invite group sharing of desired future.
Step Five: Pod Level Processing	• Scan Episode to Identify Points of Disturbance (PoDs). • Focused Processing (Desensitization) of each in turn with EMD type strategy. • Identify PoDs using 'Google Search'/Scan. • Use self-BLS by tapping in the (PRESENT) safe place DATE TODAY box and then the (PAST) disturbance DATE THEN box, i.e. with one hand. Look at your hand as you do this. • When a PoD is identified then STOP and draw/write it. Write SUD rating (0 – 10). Take some deep breaths until everyone is ready. • Focused processing. Focus on the PoD and tap on Step 1 DATE TODAY in the safe place box, and then the PoD in Step 5, tap back and forth together with the group leader who paces the group by counting &/or loud tapping. After each set of BLS, take a breath and pay attention to Images, Sensations, Feelings, and Thoughts or to whatever you notice. • Repeat for 9 sets (3 x 3 for each PoD). After every 3rd set re-focus on that PoD and write down SUD (0 – 10). • Repeat the same procedure three times (PoD level processing as in items 1 and 2 above for PoD1, PoD2, PoD3).
Step Six: Episode Level Processing	• Ask group members to think about the whole episode and check the Episode SUD (0–10) rating. If Episode SUD is above 5 consider further sessions. • Underline the sentence that feels the most true now (in box 4). How would you like to think about the whole Episode now?. What have you learned? What are you taking with you? Encourage group sharing and feedback from all participants. . • Install a PC for the Episode: Choose the words that feel the most true now. Repeat silently while using Butterfly Hugs (2 to 3 sets of about 20 seconds each).
Step 7: Closure	• Rehearse 4 Elements.
Step Eight: Follow Up	• Do additional sessions if needed. • Screen for those who need a referral for individual sessions.


POCKET GUIDE TO EARLY EMDR INTERVENTION PROTOCOLS (C) LAIDLAW-CHASSE, 2018
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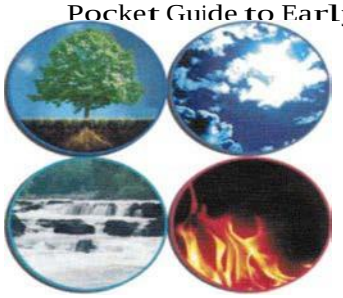
Name ..... date .....
Step 4 DESIRED FUTURE
I'm safe (enough) now, I can cope
It happened / it's over.
I survived
I did what I could
I have strengths
I can (learn to) choose how to respond.
I have hope
I learned from it
Other.....
Step 6 EPISODE level
Episode SUD.....[0-10]
Episode PC.....
Step 1 PRESENT SAFETY
Before
after
[0-10]
Earth - Air - Water - Light [0-10]
SAFE PLACE:.....
Step 5 PoD Level Processing
PoD 3
PoD 2
PoD 1
[0-10]
Set 3
Set 6
Set 9
Step 3 PAST RESOURCE
Heading.....
Step 2 PAST ONSET EVENT
Heading .....
[0-10]
TRAUMA EPISODE
DATE THEN .....
DATE TODAY .....
EMDR G-TEP WORKSHEET A1 | Elan Shapiro 2017 ©
Instructions for printing: Print on minimum A3 size matt paper in color
Tables adapted from Marilyn Luber's Scripted Protocols (2009, 2013) and original theorists' publications. ©2013, 2018 Beverlee Laidlaw Chasse



4 Elements Exercise for Stress Reduction

EARTH-AIR-WATER-FIRE

(Adapted from Elan Shapiro, 2012 by Beverlee Laidlaw Chasse)

Earth: GROUNDING, REALITY OF SAFETY IN THE PRESENT MOMENT

Take a minute to "land", be here, now. Feel both feet on the ground, feel the support of the chair. Look around and notice 3 things. What do you see? What do you hear? Imagine you are a tree, roots coming down through your feet connecting with the healing energy and strength of the Earth.

Air: BREATHING FOR CENTERING

Imagine you have a balloon in your belly. When you INHALE fill the balloon. When you EXHALE deflate the balloon completely and squeeze out any emotional distress you are experiencing. Option: Breath in through your nose as you count 4 seconds, then hold for 2 sec and then breath out for 4 sec. and hold for 2 sec. Take about a dozen deeper, slower breaths like this.

Water: CALM AND CONTROLLED. MORE IN CONTROL, SWITCHING ON THE RELAXATION RESPONSE

Make Saliva, Get moisture in your mouth. When you are anxious or in fight, flight or freeze your Sympathetic Nervous System shuts down your digestive system and your mouth goes dry. So when you start making saliva you switch on the digestive system again and the Parasympathetic Nervous System activates the relaxation response allowing you to feel calmer, focused and more in control.

Fire: LIGHT UP THE PATH OF YOUR IMAGINATION

Bring up an image of SAFE PLACE or an experience when you felt comfortable or good about yourself.

Let yourself be there. What can you see, hear, smell. What does it feel like outside your body? Inside your body. Activate this experience by doing the BUTTERFLY HUG. Cross your arms across your chest so that your thumbs ore intertwined and your other fingers are spread under both collarbones. (See diagram below) Slowly tap bilaterally, on each side of your chest, to enhance the feelings of SAFETY and CALM in your body. Wear a 4 Elements Bracelet on your wrist and use it as a reminder that you now know how to immediately reduce your stress levels by performing the 4 Elements Exercise.

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Abbreviated: Resource Connection Envelope

During Preparation:

"Before we work on…… (*current traumatic experience*), we would like for you to recall a moment in time when you felt good about yourself, a time or situation in which you felt whole, or well **(Note- This does not have to be a resource directly related to the issue at hand like RDI).** You may close your eyes while beginning to tap using Butterfly Hug Bilateral (BHBs)…. Allow yourself to stay with the memory, and be there; notice what you see, hear, smell, and allow your feelings and body sensations to emerge."

Get a cue word or phrase to anchor it and provide an entrance door (Do BHB).

or

Posture Cue – Choose posture that fits their resource experience to enhance the resource (Do BHB).

During Desensitization:

Note Adaptive Responses, Positive Thoughts and Emotions, Body Sensations, and Positive Resource Experiences.

During Closing:

1) Connection to Closing Resource:

- Therapist reviews any resource noted during processing including first resource and invites the client to choose one of these; or develop another one.
- Have them connect to the resource, notice feeling, body sensations, and do BHB's.
- Get cue word or posture associated with resource (if new enhance it with BHB).

2) (*If Appropriate*) Develop a Future Resource Connection:

- How client would like to see themselves in the future. Enhance with BHB.

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Adapted from: Laub, Brurit and Shapiro, Elan. 2012, May. RTEP Training. Scottsdale, AZ

Trauma Response Information Sheet

Adapted from Lerner, M. D. and Shelton, R. D. (2005). *Comprehensive Acute Traumatic Stress Management: CATSM*. The American Academy of Experts in Traumatic Stress: Commack, NY.

The following acute stress reactions are experienced by people during a traumatic event and are normal responses to an abnormal event. The problem is when the following reactions are experienced weeks, months and years after the event and are joined by other symptoms like recurrent disturbing dreams, flashbacks, avoidance behaviors and dissociations.

Emotional Responses

- Shock
- Highly anxious; hyper-active
- Stunned; emotionally numb
- In a fog; apathetic
- Denial, dissociation, amnesia
- Feeling of unreality
- Panic
- Fear
- Intense feeling of aloneness
- Hopelessness
- Helplessness
- Emptiness
- Uncertainty
- Horror
- Terror
- Anger
- Hostility
- Irritability
- Depression
- Grief
- Feelings of guilt

Cognitive Responses

- Impaired concentration
- Confusion
- Disorientation
- Difficulty making decisions
- Short attention span
- Suggestibility
- Vulnerability
- Forgetfulness
- Self-blame
- Blaming others
- Lowered self-efficacy
- Thoughts of losing control
- Hyper vigilance
- Continually thinking about incident; playing tape over and over again

Physiological Responses

- Rapid heart beat
- Elevated blood pressure
- Difficulty breathing*****
- Shock symptoms*****
- Chest pains*****
- Cardiac palpitations*
- Muscle tension and pains
- Fatigue
- Fainting
- Flushed face
- Pale appearance
- Chills
- Cold, clammy skin
- Increased sweating
- Thirst
- Dizziness
- Vertigo
- Hyperventilation
- Headaches
- Grinding teeth
- Gastrointestinal upset
- Freeze

*** Requires immediate medical attention**

Behavioral Responses

- Withdrawal, spacing out
- No communication
- Changes in speech patterns
- Regressive behaviors
- Erratic movements
- Impulsivity
- Reluctance to abandon property
- Aimlessly walking, pacing
- Inability to sit still
- Exaggerated startle response
- Anti-social behaviors
- Amnesia, partial or complete

Spiritual Responses

- Anger and distance from God
- Withdrawal from attending services; anger at clergy
- Sudden turn towards God
- Increased involvement in religious community
- Praying, saying scripture, hymns
- Praying doesn't comfort like it used to
- Life empty without meaning
- God is powerless; individual feels unprotected and abandoned
- Question beliefs previously held
- Happened to me because I'm being punished

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