This manual is for the sole purpose of supporting the work of Trauma Recovery, EMDR Humanitarian Assistance Programs (Trauma Recovery/HAP) TRN volunteers. This manual may not be used in part or in whole for any training purposes without the express approval of Trauma Recovery/HAP. Accordingly, this manual may not be reproduced in part or in whole by any process without the written permission from Trauma Recovery/HAP.
Hello,

It is with great enthusiasm and respect for our work with the volunteers of Trauma Recovery, EMDR Humanitarian Assistance Programs that we present this manual. Trauma Recovery/HAP was born out of the ambitious efforts of a group of EMDR clinicians who responded to the Oklahoma City Bombing.

This legacy of providing hope and healing has continued for nearly 20 years. Our work internationally as well as nationally has been a rich experience. The wisdom gained by this experience has taught us two important lessons:

“We need to be prepared to heal and trained to help”

This manual builds a framework for developing a local chapter of the Trauma Recovery Network.

It was developed as part of a collective effort by many of the emerging TRNs. We are most grateful for the time and energy all these volunteers put into its creation.

Thank you to the Western Massachusetts TRN for forging the way and sharing the How To Start a TRN binder that acted as our foundation. The Arizona TRN co-created the 2nd edition of the TRN Manual, providing us with updated clinical forms and a wealth of psychoeducation material. The Arizona TRN is also leading the way in website development for the TRNs.

The Long Island TRN developed a manual template and a power point for developing a local TRN. Their power point is included in the TRN introduction material.

The San Diego TRN created the template for our new brochure.

We are also grateful to the community of First Responders and Emergency Management Teams who taught us how to be a part of a disaster response team and opened their offices, fire stations, and places of worship in order to receive the trauma education and clinical expertise of our Trauma Recovery Network volunteers.

Sincerely,

Carol R. Martin
Executive Director
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I. INTRODUCTION
I. Introduction

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TRAUMA RECOVERY NETWORK (TRN)--VOLUNTEER CRITERIA

A Clinician who wants to volunteer for their local TRN must meet the following criteria:

1. Completion of EMDR Basic Training. It is strongly suggested that all TRN members be Certified EMDR clinicians do to the nature of the trauma work administered by TRN volunteers. If a clinician is not certified, but would like to provide clinical services as part of their volunteer responsibilities to the TRN then it is advised that the TRN Consultant assess the skill level of the clinician prior to approving this clinician for clinical services to the team.

2. Registration as a Trauma Recovery/HAP Volunteer

3. Current Clinical License (submit copy of proof of licensure to your TRN Coordinator)

4. Maintenance of current Malpractice Insurance (submit copy of cover page to TRN coordinator). For clinicians who work for an agency who do not carry their own malpractice insurance, the clinician must clarify if the agency will authorize the clinician to provide such services under their agency’s malpractice insurance. A statement from the agency to this effect must be provided and kept on file with the TRN coordinator.
JOB RESPONSIBILITIES OF A TRN COORDINATOR

- Lead efforts to ensure that TRN clinicians are recruited and oriented to Trauma Recovery/HAP
  - TRN policies and procedures.
- Serve as liaison with the TRAUMA RECOVERY office and local emergency management,
  - Community service and media organizations.
- Sign the Group Affiliate Agreement Form
- Maintaining the following records:
  - Volunteer Agreement Form
  - Current Malpractice Form
  - Current License Verification
  - Contact information for all TRN group members
  - Meeting Minutes
  - Research data including IES data for all pro bono sessions
- Provide Trauma Recovery/HAP’s Clinical Director with a year end statement that includes a synopsis of
  TRN involvement for the year
- Providing Trauma Recovery/HAP’s Clinical Director with any research data collected including IES
  data
- Ensuring that all new TRN volunteers have reviewed the TRN manual and signed all necessary
  documents.
- Coordinate efforts for relevant trainings for TRN members
- Coordinate TRN referrals in a timely manner
- Coordinate fiscal issues with Trauma Recovery/HAP
The Clinical Director will add your name and contact information to the national list of Trauma Recovery/HAP affiliated TRN coordinators.

Job Responsibilities of the TRN Consultant:

The role of the TRN consultant is to provide consultation to TRN clinicians for pro bono services. This may be done in person, by phone or by Skype. TRN Consultants must be EMDRIA-Approved Consultants or have completed at least 10 hours of training if they are a Consultant–In-Training.
Volunteer Clinician
Statement of Affirmation and Agreement

WHEREAS, _______________ (the “Clinician”) wishes to provide pro bono therapeutic services as a volunteer with the __________ affiliate of Trauma Recovery/HAP’s Trauma Recovery Network (TRN) in response to extraordinary community needs in the event of disasters that cause traumatization.

NOW THEREFORE, The Clinician hereby affirms and agrees as follows:

1. The Clinician affirms:
   
a) That s/he is a licensed mental health professional, who has completed an EMDRIA-approved Level II EMDR training program and is knowledgeable by training and experience in providing mental health trauma services; and

   b) That s/he has registered on the Trauma Recovery/HAP website (www.trauma-recovery.org) as a volunteer.

2. The Clinician agrees
   
a) To update his/her volunteer clinician registration information as his/her circumstances change;

   b) To maintain professional malpractice/liability insurance ($1 million/3 million) throughout the time of service as a TRN volunteer clinician;

   c) To provide written evidence of said insurance to the TRN Coordinator, as well as notice of any change in said insurance coverage; and

   d) To provide written evidence of professional licensure within his/her state to the TRN Coordinator.

3. The Clinician affirms and agrees
   
a) That all therapeutic services s/he provides will be his/her responsibility and will be covered under his/her insurance;

   b) That s/he will perform such therapeutic services in a manner consistent with the attached Best Practice Recommendations for Pro Bono Clinical Treatment;

   c) That the Clinician may accept or refuse to provide services as a TRN volunteer clinician at any time, provided that commitments already undertaken are completed in accordance with their terms;
d) That the Clinician may also provide services as a visiting pro bono clinician in other communities when the need is great and Trauma Recovery or another local or regional TRN affiliate requests their assistance, provided the law of the visited state permits and the Clinician’s insurance will apply to such assistance;

e) That Trauma Recovery does not oversee or supervise the provision of services and in no way assumes any liability in connection with their delivery or effect; and

f) That the Clinician may terminate his/her status as a TRN volunteer clinician by thirty (30) days written notice to Trauma Recovery to the TRN Coordinator.

In consideration of the Clinician’s compliance with these affirmations and agreements, Trauma Recovery will recognize the Clinician as a TRN volunteer clinician unless and until the Clinician gives written notice to terminate the relationship.

______________________________________________________________________________          _______________
Clinician Signature                                                  Date

______________________________________________________________________________
Clinician’s Name (printed)

______________________________________________________________________________
(Street Address)

______________________________________________________________________________
(City)

(State) _____ (Zip) ___________

(Telephone numbers)________________________________________________________________

(E-mail address) __________________________________________________________________

I. Introduction
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Attachment to Volunteer Clinician Statement of Affirmation and Agreement

Best Practice Recommendations for Pro Bono Clinical Treatment

Volunteer clinicians shall accept cases as TRN volunteer clinicians in a timely manner after the TRN Coordinator has been informed of the circumstances and has agreed that a TRN response is appropriate to meet a community need.

The service provided will be a specific therapeutic intervention for the post-traumatic disturbance resulting from the recognized circumstance and related events. The focus for each client will be on resolving the unprocessed disturbance from these specific events, not on providing a full and comprehensive course of individual psychotherapy. The model will be the type of service generally characterized as brief treatment or Emergency Early Intervention Treatment. It can be expected that, in most cases, the particular distress from these events will be resolved within 5 sessions: 1 intake session and 4 sessions of EMDR psychotherapy.

If additional psychotherapy is needed, volunteer clinicians may need to refer to a list of other providers. A volunteer clinician should consult his/her state’s laws on referring clients post pro bono treatment. Payment for those additional services will be the responsibility of the client.

For some clients, it will be clear from the first session that more than five sessions will be necessary. In these cases, a volunteer clinician should refer the client. Emergency Early Intervention Treatment should not be started.

A volunteer clinician is responsible for providing therapy in a manner consistent with the Ethical Code of his/her professional discipline, in a manner responsive to the client’s needs, and in a manner consistent with the reasonable expectations of the client based on the terms of the informed consent form. Clients referred by a TRN Coordinator to a volunteer clinician will generally be expecting to receive EMDR therapy; therefore, it is expected that volunteer clinicians will be using EMDR as the primary therapy modality for post-traumatic disturbance.

SUD and VOC scores will be obtained from each client at the beginning of each session, and the Impact of Events Scale (IES) will be given to each client just prior to the beginning of the first session, and after the final session and at 3 months follow up, to assess the possible need for referral and ongoing treatment, and to determine the effectiveness of this intervention. Results of this testing will be coded for anonymity, and returned to Trauma Recovery for analysis. Any client who does not wish to give permission for scores to be used (see Client Informed Consent Form) will still be eligible for receiving volunteer clinician services.

Clients will be expected to read and sign the Informed Consent form in duplicate, and will be given one copy. If a volunteer clinician’s state requires an additional disclosure/informed consent form, it is up to each volunteer clinician to comply with all of his/her state laws. Volunteer clinicians will retain a copy of the signed, informed consent form.
Trauma Recovery, EMDR Humanitarian Assistance Programs

Affiliation Agreement

WHEREAS, Trauma Recovery, EMDR Humanitarian Assistance Program has established a network consisting of groups of EMDR clinicians who agree to provide EMDR therapy on a pro bono basis to clients who have experienced trauma due to a significant event that has occurred in their community and to share within and across such groups best practices in providing such services (the “Trauma Recovery Network”); and

WHEREAS, volunteer clinicians in _____ have formed such a group and would like to affiliate with Trauma Recovery as part of its Trauma Recovery Network (“TRN”) (the “Affiliate”);

WHEREAS, ___________ and _________________ have agreed to serve as the coordinators of the Affiliate; and

WHEREAS, Trauma Recovery/HAP would like to have the group as an affiliate which shall be known as the ____________ TRN.

NOW THEREFORE, Trauma Recovery/HAP and ________________, on behalf of the group hereby agree as follows:

1. Trauma Recovery/HAP will:

   (a) Provide recommended standards and practice guidelines based on accumulated expertise in the use of EMDR for disaster response.

   (b) Collect and disseminate relevant information on questions raised by volunteers and other affiliates when these questions are of general interest within the TRN.

   (c) Assist the Affiliate to network with emergency management officials in its locality so that effective mental health intervention is adequately provided for in emergency planning.

   (d) Provide fundraising guidance and networking and fiscal management of funds collected by Trauma Recovery/HAP on behalf of the Affiliate.

2. The Affiliate shall

   (a) Maintain a roster of at least three clinicians who have executed the volunteer clinician Statement of Affirmation and Agreement one whom shall function as the coordinator of the Affiliate and the point of contact for community agencies and others seeking to contact the Affiliate.

   (b) Develop a plan for receiving and referring cases within the Affiliate, for screening referrals as to their suitability, and for establishing a wait list if necessary for cases that are deemed appropriate.
(c) Identify an EMDRIA certified consultant who agrees to provide case consultation without fee to volunteer clinicians for their TRN clients. The consultant may be an Affiliate clinician and may be active as a TRN volunteer clinician.

(d) Submit a brief annual report to Trauma Recovery/HAP at the end of December each year that Trauma Recovery/HAP will compile and share with all TRN affiliates. The report shall note:
- The current state of membership and changes during the preceding 12 months
- The occasions on which the Affiliate provided pro bono services locally or in other communities
- Significant achievements and/or difficulties facing the Affiliate during the previous year in its clinical work
- Significant achievements and/or difficulties in educating the community and key leaders about the need for trauma treatment services as a component of emergency planning
- Recommendations from Affiliate volunteers for ways to improve the TRN program.

3. The Affiliate will strive to

   (a) Engage in ongoing education of emergency planning officials and the general public in their locality, prior to any disaster if possible, about the need for, and forms of, effective treatment of post traumatic stress and related disorders.

   (b) Collaborate with local emergency management officials to establish reasonable mutual expectations of how the Affiliate can contribute to addressing the psychological effects of emergencies as part of community-wide preparation, mitigation, immediate response, and long-term recovery.

IN WITNESS WHEREOF, Trauma Recovery/HAP and the TRN Coordinator, on behalf of the Affiliate, have signed this Agreement effective as of _______________________.

Affiliate
Name: ________________________________
Address: ____________________________
City/State/Zip: _______________________
Tel: ________________________________
Email: ______________________________

Trauma Recovery, EMDR Humanitarian Assistance Programs
Name: ______________________________
Title: _______________________________

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Chapter 5a: EMDR Humanitarian Assistance Program (EMDRHAP) and the Trauma Recovery Network (TRN) Summary Sheet

Carol Martin and Nancy Simon Summary Sheet by Marilyn Luber

Name: ___________________________ Diagnosis: ___________________________

☑ Check when task is completed, response has changed or to indicate symptoms.

Note: This material is meant as a checklist for your response. Please keep in mind that it is only a reminder of different tasks that may or may not apply to your incident.

HAP Mission: To serve the underserved by building mental health capacity in areas that most need the support of trauma trained clinicians.

Concepts underlying emergency management in the US:

- Preparation: potential threats and what will be needed
- Mitigation: steps to reduce certain possible harms
- Rescue: rescue those in harm’s way
- Recovery: short and long-term recovery of the community’s disrupted order
- Adaptation: effective adaptation to new circumstances if full recovery not possible

Trauma Recovery Network = a response to a community wide disaster.

Steps to Starting a TRN:

Step 1: EMDR clinicians decide to provide trauma recovery within their own community in response to a disaster. ☑ Completed

Step 2: Contact Clinical Director at the HAP office about interest.
- Register on the HAP website www.emdrhap.org ☑ Completed
- Log in to the volunteer database and designate an interest in starting a TRN. ☑ Completed

Step 3: Join LINKEDIN to become part of a discussion forum for TRN members ☑ Completed

Step 4: With HAP staff other area clinicians interested in TRN building. ☑ Completed
- Check the following:
  - Contact with your EMDRIA Regional Coordinator
  - Advertise for a local/regional TRN through access to their listserv
  - Names of clinicians in the HAP database interested in forming a regional TRN.

Step 5: HAP sends a list of TRN Coordinators around the country to help with starting a TRN ☑ Completed

Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols and Summary Sheets
Marilyn Luber, PhD – Editor
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ISBN: 9780826199218

I. Introduction
Step 6: The Clinical Director at HAP is responsible for the overall development and coordination of local/regional TRN’s. Communication with this staff person is vital. □ Completed

Start Up Package
☐ Sign up forms
☐ Volunteer and agreement forms
☐ Brochure
☐ TRN Manual

Agenda for the Initial TRN Business Meeting

1. Establish a name for your TRN. Include your region’s name, such as Western MA HAP TRN. □ Completed

2. Identify Coordinator/s for your TRN. There can be more than 1. □ Completed

The role of the TRN Coordinator/s includes the following:
☐ Lead efforts to ensure that TRN clinicians are recruited and oriented to HAP’s
☐ TRN policies and procedures
☐ Serve as liaison with the HAP office and local emergency management,
☐ community service and media organizations
☐ Sign the Group Affiliate Agreement Form
☐ Maintain the following records:
❑ Volunteer Agreement Form
❑ Contact information for all TRN group members
❑ Meeting Minutes
❑ Research data including IES data for all pro bono sessions
☐ Providing HAP’s Clinical Director with a year end statement that includes a synopsis of TRN involvement for the year
☐ Providing HAP’s Clinical Director with any research data collected including IES data
☐ Ensuring that all new TRN volunteers have reviewed the TRN manual and signed all necessary documents.
☐ Clinical Director adds your name and contact information to the national list of HAP affiliated TRN coordinators.

3. Identify which of the six focus areas your TRN will support.

The six areas of focus for a local/regional TRN:

☐ Local Disaster
❑ Education
❑ Networking
❑ Pro bono treatment
❑ TRN Consultant engaged to consult with TRN clinicians

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I. Introduction
- Treatment outside of the stipulated pro bono work is the TRN member’s OWN responsibility
- TRN volunteer maintains own liability insurance for all clinical involvement
- TRN Coordinator keeps on file a copy of this liability insurance
- TRN Coordinator reviews TRN manual guidelines with all members
- Check HAP office archives for day-to-day minutes on other TRNs’ recovery efforts

- Disaster Everywhere
  - TRN decides to respond to a disaster
  - TRN helps another local TRN chapter to support clinical services

- Professional Development
  Recommendations for training for chapter members and members of community:
  - All Emergency Early Intervention Protocols
    - R-TEP (Shapiro & Laub)
    - Protocol for Recent Traumatic Events (F. Shapiro)
    - EMDR Integrative Group Treatment Protocol (IGTP)
    - Imma EMDR Group Protocol (Laub & Bar-Sade)
  - Traumatology and Stabilization
  - Specialty trainings for homicide survivors, military personnel and their families and children

- Local Networking
  Work with local organizations/institutions to educate them about your TRN’s services
  - Chamber of Commerce
  - Superintendent of Schools
  - All First Responders including Fire and Police
  - Emergency Management Organizations
  - Hospitals
  - Local Newspapers and Radio Stations
  - Local Clubs, i.e., The Kiwanis Club, etc.
  - Other

Agenda item for TRN membership meeting to find organizations in community that would benefit from your TRN

Communicating with First Responders
  - Establish links with First Responders in your area
  - Check TRN Manual for working with First Responders
  - Check with other TRNs about their practices

Work locally
  - Organizations know your reputation and you have established relationships
  - More cost-effective as volunteers can reach those in need more quickly in the wake of tragedy

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I. Introduction
☐ Public Education
  ☐ Educate community on signs and symptoms for trauma and effective treatment strategies
  ☐ Consult TRN Manual for training/education purposes
  ☐ Offer Traumatology and Stabilization Training for your TRN and others

☐ TRN Networking
  ☐ LinkedIn: discussion forum
  ☐ Listing of TRN's nationwide
  ☐ National Meeting, at the EMDRIA conference, to network with other TRN members and discuss best practices, training opportunities and policy updates.

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I. Introduction
This document is a sample of a Welcome Letter that was created by the Boston Area TRN. Feel free to use it if it seems useful to your team, adjusting the language to reflect your local group. A lot of the information can be attained in other forms if you do not want to use this form.

The Boston Area TRN
Boston Marathon Bombing Response - 2013
Welcome and Basic Guidelines

Our goal is to provide a timely and measured response to the tragedy that took place on April 15, 2013. The TRN provides EMDR to people affected by the Boston Marathon bombing at no charge. Our therapists are trained and licensed clinicians who are volunteering their time and expertise to help get people back to adaptive functioning. This work will extend over the next year. EMDR is endorsed by the American Psychiatric Association, Department of Veteran Affairs, Department of Defense, and the World Health Organization. Thank you for volunteering! Below are some guidelines for the Boston Area TRN.

1. All clinicians working for the Boston Area TRN must be registered with EMDR HAP. If you are not registered, please go to emdrhap.org, go to the volunteers tab and register.

2. Pro bono counseling can be done at your office or at centers that the TRN designates. If you can do pro bono work at your office, we will refer clients to you and you can set up the appointment. If you work at a designated center, we will book appointments at the center and you will be asked to be there at certain times. We will generally ask ahead of time for your availability for certain days at the center before we book clients. Pro bono work will be limited to three sessions. If there is good reason, you may go to five sessions. Beyond that you must refer out to a choice of three other EMDR clinicians for the client. It is unethical to see someone for free and then charge them ("ambulance chasing"). Violators will be reported to the licensing board.

3. It is crucial to do a good assessment using the Impact of Events Scale, Beck Depression Inventory and Self-Care and Life Balance Inventory. These assessments tell us where we are starting and will allow us to measure our success during follow up. This is also important for the future of establishing EMDR as an effective intervention, as we have an unprecedented opportunity to show how effective our work is.

4. All clinicians will need to use an EMDR protocol for recent trauma – such as R-TEP, PRECI or the Recent Events Protocol that was included in EMDR I or II. These protocols narrow the focus of EMDR to the event. When completing your intake, please indicate the protocol you feel ready to use. There is a chapter on R-TEP available in a prepublication release by the publisher on the emdrhap.org website. Look under the picture on the home page and click on resources.

5. If any of you have grant writing skills, please let us know.

Please answer the following questions and get the information back to us:
(you can edit here and resend it in the body of the email, or download, complete, and send it back as an attachment)

25. Languages (other than English) in which you can provide treatment

IF YOU ARE NOT LOCAL AND WILLING TO FLY/DRIVE IN FROM OUT OF TOWN PLEASE FILL OUT THE FOLLOWING:

26. I can Drive in regularly _____ (indicate # of trips, days of the week) ______________________

27. I can fly in for a one-time stay _____ lasting (indicate days etc) ______________________

28. I will need housing ______ I can find my own housing ______

We sincerely want to thank you for volunteering and wish you well on this journey with us.

David Dockstader and Dr. Rebecca Rosenblum, co-coordinators
e-mail – BostonareaTRN@emdrhap.org

I. Introduction
Information for Boston Area TRN Clinical Volunteers

1. I am registered with HAP Yes _____ No _____
2. I would like to help with organizational and networking tasks Yes_____ No_____ 
3. I have students or connections to other volunteers who can help Yes _____ No _____
4. I am able to do pro bono work at my office Yes_____ No_____ 
5. My office is accessible to people using wheelchairs etc Yes _____ No _____
6. My office can accommodate groups of people No _____ 5-10_____ 10-20_____ 
7. I would like to work at a designated TRN center Yes_____ No_____ 
8. My level of EMDR training is Parts 1 & 2 ____ Certified ____ Consultant ____ Other (specify):
9. I already know and use a recent events protocol EMD ____ R-TEP ____ PREC1 ____
10. I would like to take the R-TEP training when it is offered Yes_____ No_____ 
11. I would like to refresh/retake the Basic (Level I and II) EMDR training Yes_____ No _____
12. I would be willing to work in NY for the NYC TRN for Super Storm Sandy Yes_____ No_____ 
13. Your name _____________________________________________________________
14. Your license type/discipline______________________________________________
15. Your license number ____________________________________________________
16. Areas of expertise ______________________________________________________
17. Your e-mail address _____________________________________________________
18. Phone numbers ________________________________________________________
19. City/ Town where you live ______________________________________________
20. City/ Town where you work ______________________________________________
21. Agencies where you work (none__) _______________________________________
22. Agencies where you supervise (none__) ____________________________________
23. Do you have experience working with 1st responders? Yes _____ No _____

I. Introduction
NETWORK RESPONSE POLICIES & PROCEDURES

The designated coordinator for the area will call the volunteer clinician to activate the emergency response. The designated area coordinators are (to be filled in by area coordinators):

If the volunteer is available:

1. The designated area coordinator will provide details of the referral, including contact information for the client.

2. The volunteer will contact the client within 24 hours to arrange the initial appointment within a week or less at the therapist’s office unless another designated location has been determined.

3. At the first appointment, the volunteer clinician will:
   a. Complete informed consent
   b. Provide notice of privacy practices utilized in your practice
   c. Take client history
   d. Make assessment of appropriateness of EMDR treatment
   e. If client requires a higher level of care (i.e., if client is not psychiatrically stable), the clinician will make appropriate referrals
   f. If client is assessed as appropriate for EMDR treatment, arrange up to five (5) additional pro bono sessions. The clinician will provide a written statement outlining what the clinician will provide in the way of pro bono sessions as part of the AETR2N for brief single incident treatment for recent traumatic incident, victims only, and the options available at the end of that treatment. See #7 below.
   g. Begin a confidential file for the client, to include:
      i. Intake summary, pre-test, and assessment notes started in first session
      ii. On-going progress notes
      iii. Treatment Summary (upon completion of treatment)
iv. Client records will be maintained by the clinician consistent with the clinician’s licensing board’s requirements. Within that time frame, data can be utilized for research, if client granted permission for use of data in research.

4. Within two weeks of the disaster, the volunteer clinician will:
   a. Attend a debriefing with their designated area coordinator to address self-care and secondary traumatization, or meet with an Approved Consultant or other network providers in the community (telephonic or in person) for debriefing.
   b. Clinicians from other State or local TRNs may be available to offer support for local clinicians.
   c. Provide feedback to the designated area coordinator about the process

5. After one-month and six-month periods following treatment, if the client has agreed, the volunteer clinician will make follow-up contact with the client to check in and complete post-testing

6. Consultation is available to each volunteer clinician throughout the process.
Disaster Mental Health Interventions for First Responders/Protective Service Workers

Mental Health Disaster Response Checklist

Robbie Adler-Tapia, Ph.D.

Basic Information for the Mental Health Practitioner

Treating Trauma Exposure for First Responders

Trauma = anything that negative impacts the psyche and changes the course of healthy development.

First Responder Trauma

Targets of Professional Exposure = targets of professional exposure include death notifications, personal exposure, when professional colleagues are hurt or killed in the line of duty, unique sensory flashbacks, and the residual impact of habitual stoicism, depersonalization and derealization.

O Line of Duty Traumas = those experienced during work that include witnessing death or near death experiences of individuals in the community, other professionals, or risk to self.

O Line of Duty Death (LODD) = deaths that occur when professionals die in the line of duty. Can be more stressful for other professionals as trying to rescue and treat a comrade.

O Post-shooting Trauma in Law Enforcement (PSTLE) = traumas post professional event. The Official process that professionals must endure following a shooting from investigations, criminal proceedings, civil proceedings, and possible on-going litigation. This on-going stress further complicates the treatment process.

O Betrayal Trauma – the experience that some professionals face when not feeling supported by department and/or command, media, public, and family.

Information About Treating Trauma Exposure for First Responders

1. Similarities and Differences with First Responders

   o Emergency Services Dispatchers or 911 operators in the U.S. dispatch other professionals to the scene of a disaster when help is needed, but rarely go to the scene. These professionals may later struggle with resolving the traumatic calls that the professional only heard over the radio or telephone.

   o Law Enforcement Professionals are more likely to work alone,

   o Other First Responders are rarely alone.

2. Culture of Stoicism, Depersonalization and Derealization

   o Stoicism is a cultural expectation in that first responders are expected to not be impacted by the events to which they respond.

   o Depersonalization is experiencing an event, but feeling like it is happening to someone else.

   o Derealization is experiencing an event, but feeling like it isn’t real.

Copyright 2013 Robbie Adler-Tapia, Ph.D.  This material is meant as a checklist for your response. Please keep in mind that it is only a reminder of different tasks that may or may not apply to your incident.

I. Introduction
Mental Health Disaster Response Checklist  Clinician ________________ Date __________

3. The Families of First Responders
   o The Traditional Family—parents, significant others, children, extended family
   o The Professional Family—squad and department

Service needs for the department may include:
   o Pre-incident training
   o CISM
   o On-scene support services
   o Command/Department Consultation
   o Family Crisis Intervention
   o Anniversary Meetings
   o Post-incident services
   o Individual treatment for duty
   o Workman's Compensation services

Note: Earning individual and group trust is the biggest hurdle to efficacy in responding to critical incidents with first responders.

Elements of a Mental Health Disaster Response

1. Who contacted the mental health professional? ________________ When? __________
2. Who will be the department contact? __________________________
3. To what type of incident are you responding?
   o Natural disaster (wildland and/or forest fires, earthquakes, a tsunami, hurricane, flood, epidemic, structural collapse)?
   o Man-made event (torture, acts of terrorism, war, drug cartel wars, school shootings, gang warfare, robbery, arson, bombs, etc.)?
4. Where did the incident occur? _________________________________
5. What is the size of the incident?
   o How many professionals are estimated to have been impacted? _____
   o How many civilians are estimated to have been impacted? _____
6. Location - Where will you implement the response? ______________
7. Demobilization – Will the professionals remain on duty or be given time off for interventions? ______ Yes ______ No
   o Time off post incident before back to work
   o No time off—first responders expected to respond to call
8. Participation
   o Who needs help? ________________________________
   o Who are team of responders? _______________________
   o What are the needs of the group to be helped? ____________
9. Professional Response
   o How many professionals are needed? ______________________
   o Are there enough? ______ Yes ______ No
   o If not, effect on organization: ____________________________

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Mental Health Disaster Response Checklist  Clinician ________________ Date __________

10. Logistics
   o Duration of intervention?
   o Where will the intervention be help?
   o Who organizes environment - food and drink for group?
   o What other basic needs are needed for participants?
   o How much time will be available for the response?
     o Hours? ________ Days? __________

11. Confidentiality?
   o Will confidentiality and privacy be honored?
   o How will confidentiality and privacy be maintained?
   o Will records be maintained for services?
   o Are there differences between professional and civilian interventions?
   o How will referrals be addressed?

12. Costs/Payment
   o What are the costs/budget?
   o Is this a voluntary response or paid?
   o How will billing and payment be handled?

Post Incident Services

Who contacted the mental health provider?
   o Individual referral?
   o Department referral?

Type of service requested?
   o Individual services ________ Yes ________ No
   o Group services ________ Yes ________ No

EAP available
   o EAP internal/external to department? ________ Internal ________ External
   o Concerns about EAP referral: ________ Yes ________ No
   o EAP providers knowledgeable about first responders? ________ Yes ________ No
   o Option to go to private practitioner ________ Yes ________ No
   o Will there be any on-going civil or criminal investigations/litigation? ________ Yes ________ No

   o Confidentiality of therapist’s records if legal proceedings ________ Yes ________ No

What will be expected from the mental health provider?
   Will the department expect reports about the group? ________ Yes ________ No
   Will the department expect reports about the individual? ________ Yes ________ No

How will information be shared?
   With whom? ________________
   o How? In writing? ________ Yes ________ No
   o Verbal report? ________ Yes ________ No

Contact Information:
   Will there be internal affairs investigations or external investigations of any kind? ________ Yes ________ No

What records will be maintained, if any? ________ Yes ________ No

By whom? ________________

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Mental Health Disaster Response Checklist  
Clinician ________________ Date _______________

**Mental Health Services for First Responders**

1. **Psychological Component of the After Action Review (AAR)** - Therapists may add a psychological component to the AAR:
   - How did it impact me?
   - What do I need to do to care for myself?
   - How do I get closure?
   - Who else is struggling?
   - What if anything do I need/want to do for my brothers and sisters who also experienced this exposure?
   - How does this impact our next call? Our next shift?

2. **Critical Incident Stress Debriefing (CISD) as part of Critical Incident Stress Management (CISM)** Focus is to provide "Psychological First Aid" as an immediate debriefing in order to minimize the harmful affects of job stress, specifically in crisis or emergency situations.
   - **Yes**  **No**
     - CISM services include seven steps (adapted from Everly & Mitchell, 1997):
       - *Pre-crisis Preparation*: pre-incident stress management training, education, and skill building.
       - *Disaster or Large-Scale*, as well as, school and community support programs that include demobilizations, informational briefings, "town meetings" and staff advisement.
       - *Defusing* is a 3-phased, structured group activity that is after or soon after the event for assessment, triaging, and acute symptom mitigation.
       - *Critical Incident Stress Debriefing (CISD)* refers to the "Mitchell Model" (Mitchell and Everly, 1996) This is a 7-phase, structured group discussion, usually provided 1 to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up, and if possible provide a sense of post-crisis psychological closure.
       - *One-On-One Crisis Intervention/Counseling or Psychological Support* throughout the full range of the crisis spectrum.
       - *Crisis Intervention and Organizational Consultation.*
       - *Follow-up and Referrals for Assessment and Treatment*, if necessary.

   In additional, mental health professionals may provide assessment of individuals and case management for individuals with on-going needs.

3. **Psychological First Aide (PFA)**
   - **Yes**  **No**
     - PFA Field Operations Manual available online
     - PFA apps for smart phones available

4. **Mental Health First Aid (MHFA)**
   - **Yes**  **No**
     - [http://www.mentalhealthfirstaid.org](http://www.mentalhealthfirstaid.org)

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I. Introduction
5. Assessment and Case Management

Safety Planning – questions to assess safety
- How to intervene if first responder is still on the job?
- What documentation, if any, will the department request?
- Risk to the public, the individual, and/or other first responders, i.e., first responder is armed
- Are mental health services a requirement for return to duty?
- What assessment will the mental health provider be asked to provide to the department, if any?

Fitness for Duty Process = to make case management and clinical decisions with first responders. (Only if the mental health professional is qualified to conduct fitness for duty assessment).
- Is a safety plan necessary?
- If so, who needs to know?
- How do you protect a career?
- Is a DTO assessment necessary?
- Is a DTS assessment necessary?
- How will this occur?

5. Assessment of Individual First Responders

Modified SAD PERSONAS Scale Revised (Pearls)
'SAD PERSONAS' helps assess suicide risk:
- Sex
- Age
- Depression
- Previous attempt
- Ethanol
- Rational thinking loss
- Social supports lacking
- Organized plan
- No spouse
- Availability of lethal means
- Sickness

- After assessing the risk of danger to self or others, the therapist must make an appraisal of how to manage the risk. This may include immediate intervention, contact with department and staff, referral to a higher level of care, and medication management.
- Referrals for Medication Assessment and Management may be needed

6. Treatment

- Is treatment necessary?
- What will be the format? Group and/or individual?
  - Group
    - CISD within a CISM Model of Care
    - EMDR Group Protocol
  - Individual Psychotherapy
    - CBT
    - CPT
    - PE
    - EMDR
Individual EMDR With First Responders/Protective Service Workers Notes

Case conceptualization with EMDR
Important to consider if there are legal issues:
  o Any issues impacting flow of treatment? ____ Yes ____ No
  o Will notes be subpoenaed? ____ Yes ____ No
  o Is it prudent to proceed if forensic involvement? ____ Yes ____ No
  o Are your records complete and in compliance with ethical and legal standards? ____ Yes ____ No
  o If departmental referral, what are the expectations? ____ Yes ____ No

Is it appropriate to continue with treatment? ____ Yes ____ No

Comprehensive versus Work-focused
  o Comprehensive ____ Yes ____ No
  o Work-focused ____ Yes ____ No

Individual Treatment with EMDR
____ Yes ____ No

Phase 1: History Taking, Case Conceptualization & Treatment Planning Phase

1. Conduct Biopsychosocial Intake
2. Assess for trauma and dissociation. Use standardized assessments if possible for future assessment and documentation.

  Targets
  o Targets of Opportunity = most easily accessed and precipitating factor in treatment visit such as targets from recent professional event, personal event or both.
  o Targets of Professional Exposure = death notifications, personal exposure, when professional colleagues are hurt or killed in the line of duty, unique sensory flashbacks, and the residual impact of habitual stoicism, depersonalization and derealization.

Target Identification
Using Parade of Faces for First Responders Parade of Faces Script
The calls that linger include often:
  o First and worst calls
  o Child related calls and fatalities
  o Suicides
  o Calls where the professional felt personally threatened or was injured
  o Calls with intense odors and or human remains
  o Associations with professional’s personal life

Questions (Parade of Faces format):
  o Most difficult call that haunts you:
  o First call that haunts you?
  o Image the calls like a parade that you watch from the first to the most recent call. Those may include calls about suicides, children, severe bodily injuries, and/or body odors such as blood, brain matter, decomposition, and burning flesh.

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I. Introduction
Mental Health Disaster Response Checklist

Clinician ______________________ Date ______

- NC: When you think about that parade of faces of the calls that haunt you, what’s
  your negative belief about yourself now? Those might be things like, ‘I should
  have done something?’ ‘I’m powerless?’ ‘I can’t forget or get over
  it.’

- Positive belief about yourself when you think of your career:

- First call that made you proud about becoming a first responder:

  Image the parade of the calls that haunt you on a television channel and you have the
  remote. What channel would you put all of the calls that haunt you?

- Channel for Haunting Calls:

- Channel for Positive Events:

- Channels for Calls Where Feel Successful and Helpful:

Diagnostic Challenges

- How does diagnosis impact job and career?

- With specific diagnosis able to/willing to return to line of duty? Yes __ No

- Safety plan necessary? Yes __ No

- If yes, what steps will be taken?

- Who will be part of the intervention?

- It is important for mental health professionals to assess response to the
  department and/or command. This could impact the first responder’s
  career and future in the profession.

Phase Completed

Yes ___ No

Phase 2: Preparation Phase

In addition to teaching the “mechanics” of EMDR, it is imperative to assess and
develop resources for first responders, and to teach first responders about trauma and the
wear and tear of the career – physical, spiritual, and psychological.

Resources (Not all will be necessary)

- Resources you count on:

- Resources client needs in following areas:

- Diet and eating:

- Sleep hygiene:

- Physical health:

- Stress management skills:

- Spiritual needs:

- Skills already has:

- Interpersonal skills for healthier personal and professional relationships:

- Residual effects from childhood interfering in current life:

- Residual effects from personal life:

- Residual effects from professional life:

- Resilience and Hardiness Assessment of current impact of how coping with career
  and “wear and tear” of career impacts life:

- Skills and/or tools I use:

- Skills and/or tools I need:

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reminder of different tasks that may or may not apply to your incident.
Professional Grief and Loss Resources
- How can closure be constructed since only seeing middle of critical incident?
- Spiritual and religious needs?
- Appropriate/helpful to attend funeral services/practice closure/other types of closure?

Resources/Tools for First Responders to Manage the Line of Duty Exposure
- EQUIPMENT is an acronym for first responders to remind them to maintain their health while in the line of duty.
  - Engage your resources and acquire new ones.
  - Quality of Life is important each day!
  - Utilize medical and mental health services
  - Improve your longevity by participating in daily self-care – diet, exercise, and hearth health
  - Prepare for survival by practicing and learning new skills
  - Mentor others by modeling healthy professional behavior both on duty and off.
  - Educate yourself about the long-term impact of trauma exposure and keep acquiring new resources for coping
  - Never forget that you are as important as those you protect, serve, and rescue!
  - Take care of each other - at work and at home.
- Containers = way to contain intense psychological and physiological experiences from line of duty vs using stoicism, dissociation, depersonalization and/or derealization. Important to remind them that it is not to be closed indefinitely but just to hold the material that would interfere with the work in the present until the job is done

Containers
Teach containers to first responders to continue in career. Containers taught? __yes/no

Containers Script

Sometimes we have thoughts, or feelings, or body sensations that get in the way at work or at home. Do you ever have thoughts or feeling like that? I want you to know that if we need to we can put those thoughts or feelings in a container like a box or something really strong that they can’t get out. What do you think you would need to hold those thoughts or feelings?"

Next say, “I want you to be able to put all of those thoughts or feelings, or what we worked on today in that container. Sometimes we need different containers for different thoughts or feelings. Sometimes, it helps to draw pictures of the __________ (container) and make sure it’s strong enough to hold everything that you need it to hold.

Let’s imagine that everything you worked on today is put in the container and we lock it away/seal it away until we meet next time when we can take it out to work on it again. When we get together we will work to empty your container so there’s always room for new stuff if you need it. If you start thinking about things that bother you that are too hard to handle or it seems to come out before our next session, you can just imagine putting it into the container and sealing it in there until we meet again.”

Phase Completed

______ Yes ______ No
Phase 3: Assessment Phase
  o EMD  o EMDR

Complete TICES (acronym for target, image, cognition, emotion, and sensation).
  • Target=Critical Incident (see Parade of Faces): 
  • Image=worst part of specific critical incident. If multiple images, make chronological list and start with first one specific to critical incident: 
  • Cognitions:
    o NC (elicited during Parade of Faces): 
    o PC (elicited during Parade of Faces): VoC: /7
  • Emotions in relation to critical incident: SUDS: /10
  • Sensation in relation to critical incident:

Phase Completed  Yes  No

Phase 4: Desensitization (according to Standard EMDR Protocol/EMD Protocol)
With EMD, the therapist is active in helping client contain other associations and focus on specific critical incident. Document associated incidents for possible use later.
  o Note: Remember first responders may not show affect because of the culture of stoicism.

Phase Completed  Yes  No

Phase 5: Installation (according to Standard EMDR Protocol/EMD Protocol)
PC or new PC (if new one is better):
Rate VoC: /7
Pair - Incident+PC+BLS
Continue to rate VoC:
Phas completed  Yes  No

Phase 6: Body Scan
Note: First responders learn to disregard personal body sensations while in line of duty so Body Scan may be surprising/disturbing. Help them to be mindful while helping them understand what is happening.
  o Unresolved tension/tightness/unusual sensation:
  o Unresolved tension/tightness/unusual sensation + BLS
  o Decision point:
    o Continue with additional trauma work
    o EMD for one event sufficient

Phase Completed  Yes  No

Phase 7: Closure (according to Standard EMDR Protocol/EMD Protocol)
Incomplete Session
  o Use Container Exercise and/or other relaxation techniques to prepare for end of session.
  o Remind first responder to practice relaxation skills and containers to continue being successful in line of duty.
  o Remind to practice resources previously identified in order to cope with wear and tear of career.

Phase completed  Yes  No

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Phase 8: Reevaluation

**EMD**: re-evaluate incident

- SUDS of Incident: _____/10
- VoC of Incident: _____/7
- Body Sensations: Clear? __________ Yes ____ No

**EMDR**: Check Parade of Faces for new traumatic or positive events:

- Traumatic material: ______________________
- Positive Events: ______________________
- Current triggers? ______________________
- Future Template? ______________________

*Phase completed?* __________ Yes ____ No

**NOTES:**

______________________________

______________________________

______________________________
II. CLINICAL FORMS
PRO BONO CONSENT FOR TREATMENT TERMS

When you work with a therapist from the Trauma Recovery, EMDR Humanitarian Assistance Programs Trauma Recovery Network you will receive brief, single incident EMDR trauma treatment. EMDR involves recalling an event while experiencing rapid bilateral stimulation (eye movements, tones or tapping) to facilitate the process. The EMDR-related procedures will be fully explained to you prior to beginning treatment. If it is determined that you could benefit from a more comprehensive treatment program or referral for a more intensive psychiatric treatment, your therapist will discuss with you with referrals and treatment options. Working with another therapist or treatment provider will most likely involve using your health insurance or negotiating a fee.

In the first meeting, you and your therapist will discuss treatment goals and inform you as to the number of pro-bono sessions you will have available to you.

The following has been discussed with me concerning the use of EMDR:

- As a part of preparation for this therapy you will work closely with your therapist to learn and practice specific relaxation techniques.
- Some individuals may experience a high level of emotion or physical sensation.
- Distressing or unresolved memories may surface through the use of EMDR.
- Following the counseling session, the processing of additional incidents/material may continue, or other dreams, flashbacks, memories, feelings, etc. may surface.

Before beginning EMDR treatment I have considered all of the above and have discussed this with my therapist.

Your signature below will indicate that you understand and accept the terms of this agreement.

Client Signature: ___________________________ Date: ________________

Guardian Signature: ___________________________ Date: ____________

(if Client is under 18)
Client Information

Identification

Name: ___________________________ Today’s Date: ___________________________

Date of Birth: _____________________ Age: ___________________________

Home Address: ____________________________________________ Apt: ________________

City: _____________________________ State: ________ Zip: ______________________

Home Phone Number: ___________________________ Mobile Phone Number: ________________

Calls will be discrete, but please indicate any restrictions:

____________________________________________________________________________

Other Professionals Involved in Your Treatment

Medical Provider/Clinic Name: _______________________________________________________

Address: __________________________________________ Phone: _______________________

May I have your permission to contact this person for continuity of care? Yes ______ No ______

Psychiatric Provider/Clinic Name: ___________________________________________________

Address: __________________________________________ Phone: _______________________

May I have your permission to contact this person for continuity of care? Yes _____ No _____

Emergency Contact

If there is an emergency during our work together, or I become concerned about your personal safety, I
am required by law and the rules of my profession to contact someone close to you (relative, spouse,
close friend).

Name: ___________________________ Relationship to you: ____________________________

Phone number (s): ________________________________________________________________
# Intake Assessment Summary

<table>
<thead>
<tr>
<th>Client Initials</th>
<th>Age</th>
<th>Gender</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Assessment:</td>
<td>Informed consent signed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Presenting Problem:

History reviewed?


**Diagnosis:**
- Acute Stress Disorder
- PTSD
- Other:
- Other:

Check All that Apply:

<table>
<thead>
<tr>
<th>Poor pre-morbid adjustment</th>
<th>Instability in current life circumstance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single incident trauma</td>
<td>Multiple incident trauma</td>
</tr>
<tr>
<td>Possible secondary gain (or loss)</td>
<td>Problematic drug/alcohol use or other addictions</td>
</tr>
<tr>
<td>History of addiction - well resolved</td>
<td>History of addiction - at risk for activating addiction</td>
</tr>
<tr>
<td>Prior trauma - well resolved</td>
<td>Prior trauma – unresolved</td>
</tr>
<tr>
<td>Able to access subjective feelings of safety</td>
<td>Able to use positive resources</td>
</tr>
<tr>
<td>Potential legal involvement (advise client of potential risks)</td>
<td>Potential medical issues (advise client of potential risks)</td>
</tr>
</tbody>
</table>

**Suggested protocols to proceed with EMDR:**

- Resourcing & Stabilization
- ERP
- R-TEP
- Group Protocol
- EMDR 8-Phase Treatment Approach
- Recent Events Protocol
- EMDR-PRECI
- Other:

Not appropriate to proceed with EMDR treatment *at this time* due to:

<table>
<thead>
<tr>
<th>Active psychosis</th>
<th>Danger to self/others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active addictions</td>
<td>Dissociative disorder (DID, DD-NOS)</td>
</tr>
<tr>
<td>Unable to change state/self-soothe</td>
<td>Possible neurological impairment/loss of consciousness</td>
</tr>
<tr>
<td>Major vegetative depression</td>
<td>Cannot maintain dual attention</td>
</tr>
<tr>
<td>Cannot tolerate affect (+ or -)</td>
<td>Markedly unresolved prior trauma</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

Referrals made to:

- Medical: 
- Psychotherapy:
- Psychiatric: 
- Other: 
- Records Sent to Referral?
WAIVER  To Continue Treatment

I wish to continue my treatment

with ____________________.

I do not wish to be referred to another therapist.

My current therapist and I will negotiate the

method of payment for therapy services.

Client Signature  Therapist printed Name  Therapist Signature  ___/___/200___

Date

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Research Data Reporting

Date of Report:_____________

Client Initials: _____________

Age: ____________

Gender: ____________

Incident: ______________________________________________________

Date of Incident: ________________

Total Number of Sessions:_____________

Protocol Used: ________________________

Pre-Treatment IES-R Score: __________

Post-Treatment IES-R Score: __________

30-Day Post-Treatment IES-R Score: __________

If 30-Day Post-Treatment IES-R is not completed, please explain:

______________________________________________

Therapist Signature                                                  Therapist Name

Date: ____________________________
Client Initials __________ Client DOB __________ Event ________________

Today's Date __________ Clinician ________________________________

Story Summary: ________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

Was able to complete story in 1st appointment (circle) yes no ____

**EVENT SUDS:** START _____ END _____

**POD #** Today's Date __________ Session # _____ Clinician ______________________________

Worst Picture:

Negative Cognition:

Positive Cognition:

Start VOC: End VOC:

Emotions:

Start SUDs: End SUDs:

Body Sensations:

**POD #** Today's Date __________ Session # _____ Clinician ______________________________

Worst Picture:

Negative Cognition:

Positive Cognition:

Start VOC: End VOC:

Emotions:

Start SUDs: End SUDs:

Body Sensations:

II. Clinical Forms
Today's Date

Session #

Clinician

Worst Picture:

Negative Cognition:

Positive Cognition:

Start VOC: 

End VOC:

Emotions:

Start SUDs: 

End SUDs:

Body Sensations:

Today's Date

Session #

Clinician

Worst Picture:

Negative Cognition:

Positive Cognition:

Start VOC: 

End VOC:

Emotions:

Start SUDs: 

End SUDs:

Body Sensations:

Today's Date

Session #

Clinician

Worst Picture:

Negative Cognition:

Positive Cognition:

Start VOC: 

End VOC:

Emotions:

Start SUDs: 

End SUDs:

Body Sensations:
TRAUMA RECOVERY NETWORK (TRN)

INFORMED CONSENT FOR BOSTON AREA TRAUMA RECOVERY NETWORK

QUALITY IMPROVEMENT PROJECT

Purpose of the Study: The purpose of this project is to examine the effectiveness of the interventions of the Boston Area Trauma Recovery Network following community crises and disasters. In signing this document, you are giving your consent for us to analyze and report on the data we collect as part of the Boston Area TRN services you and others receive. You will be asked to fill out or answer forms measuring various symptoms during the treatment sessions and then again 3-12 months after your last session. Demographic data will be collected with an intake form.

Potential Risks and Benefits: EMDR is an evidenced-based psychotherapy for trauma. Your TRN clinician is providing you with one of several forms of EMDR specifically focused on helping people heal from recent traumatic events. EMDR has also been found to be helpful for depression, anxiety and other mental health problems. EMDR involves recalling an event while experiencing rapid bilateral stimulation (eye movements, tones or tapping) to facilitate the healing process. The quality improvement project will help us to understand better the effectiveness of this treatment, and help us in providing these services to other people who have similar experiences. Sometimes during any psychotherapy, distressing unresolved memories surface, however, we will work with you to manage any disturbing feelings that may arise. If additional psychotherapy is requested or needed at the end of the pro-bono sessions, you can discuss options for further treatment with your clinician.

Voluntary Participation: Participation in this project is voluntary. YOU CAN STILL RECEIVE SERVICES EVEN IF YOU DECIDE YOU DO NOT WANT YOUR DATA USED IN ANY QUALITY IMPROVEMENT PROJECT. You may withdraw your permission for the use of your responses at any time without penalty or loss of benefits to which you are otherwise entitled. A signed copy of this consent will be given to you.

Confidentiality: Confidentiality will be maintained because we will give each set of questionnaires and forms a unique identification number that is not linked to your name and identity, so the research staff will not know who has received services. Only your clinician(s) and sometimes the TRN coordinators will know your identity. Please be advised that the law imposes on licensed therapists/mental health clinicians the duty (1) to report suspected abuse and neglect of children, the disabled and the elderly, (2) to intervene with clients who intend to harm themselves or others, (3) and to release court-subpoenaed records. If published, results from this project will be reported with no disclosure of your identity or identifying information.

You have been provided with a copy of the therapist’s Notice of Privacy Practices. If you have questions regarding the Privacy Notice or your privacy rights, you should speak to your therapist. You may obtain a summary of or copy of your records upon written request and payment for copying charges, if any.

Contact Person: If you have any questions, at any time, about this quality improvement project, please contact Dr. Rebecca E. Rosenblum via email at BostonAreaTRN@emdrhap.org or leave a message at her office voicemail 617-661-1422.

By signing this form, you are indicating that you understand that you agree to participate in this study according to the terms outlined in the Consent Form.

Respondent Name (printed)  
Respondent’s Signature  
Date

Witness (printed)  
Witness Signature  
Date

Rebecca E. Rosenblum, Psy.D., Principal Investigator – Boston Area TRN Quality Improvement Project

II. Clinical Forms
# Summary of Follow-Up Contact with Crisis Clients

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<th>Client Initials</th>
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<th>Summary of Contact</th>
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Therapist Signature ___________________________  Therapist Name ___________________________  Date ______________
III. ASSESSMENT TOOLS
Assessing Readiness for Early EMDR Intervention (EEI)

Francine Shapiro outlines several important steps in ascertaining if a client is ready to utilize EMDR (New Notes, 2006) to process disturbing material. The client’s signs of readiness include being able to tolerate distressing affect associated with the unprocessed material. The client must be able to just “let whatever happens happen.” The client must be able to change state and have positive networks. The client must be able maintain dual attention during processing and tolerate BLS.

Steps to assess readiness for target processing:

1. Screen for dissociative disorders, utilizing DES or other appropriate means
2. Assess for active psychosis or major vegetative depression
3. If loss of consciousness occurred during the event or there is any other physical issue of concern, contact the client’s medical provider, with client’s permission
4. Determine if client is a danger to him/herself or any one else
5. Assess for current crisis, if other than any crisis being fueled by recent traumatic incident
6. Ascertain if client can change state using some method (safe place, etc.) and tolerate/regulate positive and negative affect
7. Determine if client has the ability to maintain connection to the therapist and sensation during BLS (dual attention)
8. Client has adequate internal and external resources available that they will utilize

If the client does not meet this readiness criterion, the clinician will work with the client to become more stable and extend time in Phase 2 preparation is indicated. If the client is not psychiatrically stable and cannot be assisted in becoming stable in an outpatient setting, the clinician will make the appropriate referrals for client’s safety and stabilization.
Posttraumatic Growth Inventory

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your crisis [or researcher inserts specific descriptor here], using the following scale.

**Note to investigators** — you will need to format the items so that participants have a way of responding to each one. The procedure we recommend is to place the numerical values of the scale after each item.

In addition, the Roman numeral codes for the factors should also be removed.

σ = I did not experience this change as a result of my crisis.
1 = I experienced this change to a very small degree as a result of my crisis.
2 = I experienced this change to a small degree as a result of my crisis.
3 = I experienced this change to a moderate degree as a result of my crisis.
4 = I experienced this change to a great degree as a result of my crisis.
5 = I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life. (V)
2. I have a greater appreciation for the value of my own life. (V)
3. I developed new interests. (II)
4. I have a greater feeling of self-reliance. (III)
5. I have a better understanding of spiritual matters. (IV)
6. I more clearly see that I can count on people in times of trouble. (I)
7. I established a new path for my life. (II)
8. I have a greater sense of closeness with others. (I)
9. I am more willing to express my emotions. (I)
10. I know better that I can handle difficulties. (III)
11. I am able to do better things with my life. (II)
12. I am better able to accept the way things work out. (III)
13. I can better appreciate each day. (V)
14. New opportunities are available which wouldn't have been otherwise. (II)
15. I have more compassion for others. (I)
16. I put more effort into my relationships. (I)
17. I am more likely to try to change things which need changing. (II)
18. I have a stronger religious faith. (IV)
19. I discovered that I'm stronger than I thought I was. (III)
20. I learned a great deal about how wonderful people are. (I)
21. I better accept needing others. (I)

Note: Scale is scored by adding all responses. Factors are scored by adding responses to items on each factor. Items to which factors belong are not listed on form administered to participants.
PTGI Factors
Factor I: Relating to Others
Factor II: New Possibilities
Factor III: Personal Strength
Factor IV: Spiritual Change
Factor V: Appreciation of Life

References of Potential Interest


In Reciprocation

There is no charge for the PTGI, and there is no charge for the reproduction of the scale for use in research. In reciprocation, we would like you to send us a gratis copy of any manuscripts, theses, dissertations, research reports, preprints, and publications you prepare in which our materials, or any version of them, is used. Both L. G. Calhoun and R. G. Tedeschi can be contacted at:

Department of Psychology - UNC Charlotte - Charlotte, NC 28223 USA
This manual contains two Depression scales;

The CES-D and the PHQ-9.

Clinicians are more familiar with using the BDI. Currently though, the BDI is copyrighted and there is a $2/form charge. For research purposes, individual clinicians will have to either pay this cost or use a different form.

The CES-D and the PHQ-9 are highly recommended by other EMDR Clinicians. They are both effective and brief.
Below is a list of difficulties people sometimes have after stressful life events. Please read each item and circle how distressing each difficulty has been for you during the past seven days with respect to ______________, how much were you distressed or bothered by these difficulties?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Any reminder brought back feelings about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>I had trouble staying asleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Other things kept making me think about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>I felt irritable and angry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>I avoided letting myself get upset – when I thought about it or was reminded of it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>I thought about it when I didn't mean to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>I felt as if it hadn't happened or wasn't real.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>I stayed away from reminders of it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>Pictures about it popped into my mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>I was jumpy and easily startled.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>I tried not to think about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>I was aware that I still had a lot of feelings about it, but I didn't deal with them.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>My feelings about it were kind of numb.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>I found myself acting or feeling like I was back at that time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15</td>
<td>I had trouble falling asleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16</td>
<td>I had waves of strong feelings about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17</td>
<td>I tried to remove it from my memory.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>I had trouble concentrating.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19</td>
<td>Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20</td>
<td>I had dreams about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21</td>
<td>I felt watchful and on guard.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22</td>
<td>I tried not to talk about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Impact of Event Scale (revised)

Scoring Information

**SUBSCALES**

Avoidance = Mean of (8) Items: 5, 7, 8, 11, 12, 13, 17, 22

Intrusion = Mean of (7) Items: 1, 2, 3, 6, 9, 16, 20

Hyperarousal = Mean of (7) Items: 4, 10, 14, 15, 18, 19, 21

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**Assessing Psychological Trauma and PTSD**

**A Handbook for Practitioners**

Chapter 13: The Impact of Event Scale – Revised

by Daniel S. Weiss, PhD and Charles R. Marmar, MD

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San Francisco, CA 94143-0984
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Fax: (415) 750 6921

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Adapted by:

Western Mass. EMDR Trauma Recovery Network
D.E.S.

Name ___________________ Date ___________________ Age ________ Sex ________

Directions: This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

Example:

0% 10 20 30 40 50 60 70 80 90 100% (cover)

1. Some people have the experience of driving a car and suddenly realizing that they don’t remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes they don’t remember pulling on. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

8. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

13. Some people sometimes have the experience of feeling that their body does not belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

19. Some people find that they are sometimes able to ignore pain. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were different people. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
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<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

26. Some people sometimes find wirings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

27. Some people find that they sometimes hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

28. Some people sometimes feel as if they are looking at the world through a fog so that people or objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
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<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>
DES TAXON

It is important to screen adult clients for dissociative disorders prior to processing traumatic material.

Pathological dissociation can be assessed by a subset of eight items on the DES, and is called the DES-T (Waller et al., 1996). These are numbers 3, 5, 7, 8, 12, 13, 22 and 27 on the DES.

To score the DES-T, a Microsoft Excel spreadsheet was created by Darryl Perry and is in the public domain at http://www.isst-d.org/education/des-taxon-portal.htm. Scoring the DES-T assists in determining the probability that an individual dissociates pathologically.

A conclusive diagnosis of a dissociative disorder requires a thorough assessment, with instruments such as the Dissociative Disorders Interview Schedule (DDIS) by Colin Ross, MD (1997), the Structured Clinical Interview for DSM-IV Dissociation (SCID-D) by Marlene Steinberg (1999), or the Multidimensional Inventory of Dissociation (MID) by Paul Dell.
**INSTRUCTIONS**

Enter DES item scores in column E.

Results will automatically be calculated.

<table>
<thead>
<tr>
<th>Item #</th>
<th>DES</th>
<th>DES-T</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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**Probability of taxon given X or P_{\hat{X}}** 0.99181

This spreadsheet calculates a single test-taker's score on the Dissociative Experiences Scale (DES). It also calculates the Bayesian probability that the test-taker belongs in the DES Taxon. Cell E30 computes the DES score by taking the mean of all the DES item scores. Cell F30, which is labeled as the "average DES-T," is actually the sum of the scores on the eight taxon items, divided by the DES score in Cell E30. This spreadsheet was written by Darryl Perry, who specified that it is to remain in the public domain and that its source code is to be distributed for free. The calculations in this workshop are a translation of the SAS computer program that may be found in the following article:


To score the DES-T, a Microsoft Excel spreadsheet was created by Darryl Perry and is in the public domain at [http://www.isst-d.org/education/des-taxon-portal.htm](http://www.isst-d.org/education/des-taxon-portal.htm).

Scoring the DES-T assists in determining the probability that an individual dissociates pathologically.
IV. PSYCHOEDUCATIONAL MATERIALS
SELF CARE & LIFE BALANCE INVENTORY

1. There are people who care about me that I trust to whom I can talk.
2. I do things to relax and unwind at the end of the day.
3. I listen to my body's signals and recognize when I am becoming and have the presence of mind to do something.
4. When I feel work at the end of the day, I can disengage.
5. I eat without much of a choice.
6. I practice muscle relaxation, prayer, walking, mediation or other breathing techniques.
7. I share how I am feeling with at least one friend or my partner.
8. I sleep well and get at least seven hours of sleep a night.
9. I am careful about what I eat and get a balanced diet.
10. I drink at least 1.5 liters of water (approx. 3 glasses) a day.

6. I never / seldom / sometimes / often / always
5. I do something I find fun (e.g., play a game, go to a movie, read a book etc.)
4. I work for less than ten hours a day.
3. I take some time for myself to do quiet things, meditate, write and so on.
2. I have at least once a day, or more than once a week / twice a week / once a week / twice a week / once a week / almost every week / always
1. I believe without much of a choice.

Instructions: In the last month, how often has the following been true for you? For each question, write the number that best fits your experience on the line before the question.

Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes / Yes /
TOTAL SCORE:

(2) More than once a week / (3) About once a week / (4) Once a week / (5) Less than once a week / (6) Never

23. I find it difficult to complete my daily tasks—event when I encounter difficulties
22. I become distracted or easily lose interest when I'm engaged in an activity
21. I feel good about how I spend my leisure and extra time in relation to what I want to do
20. My ability to communicate with others is...

GROUP 1: Grown Up, Working, Household, Work, College...

19. I spend time with family or friends when I feel close to them.
18. At work, I take a break at least every two hours, and switch tasks when I need to do something else.
17. I feel that I have the training and skills I need to do my job well.
16. I do something I find creative or expressive (e.g., writing, cooking,
15. I binge drink or smoke, or use other recreational drugs.
14. I take alcohol or other recreational drugs (at least once a week, or every year).
13. I feel tense or anxious; my body is consistently tense.
12. I get full from eating a full meal and lose weight and keep weight.
11. I feel tense or anxious; my body is consistently tense.
10. I get full from eating a full meal and lose weight and keep weight;

GROUP 2: Writing, Cooking...

9. I spend time with family or friends when I feel close to them.
8. At work, I take a break at least every two hours, and switch tasks when I need to do something else.
7. I feel that I have the training and skills I need to do my job well.
6. I do something I find creative or expressive (e.g., writing, cooking,
5. I binge drink or smoke, or use other recreational drugs.
4. I take alcohol or other recreational drugs (at least once a week, or every year).
3. I feel tense or anxious; my body is consistently tense.
2. I get full from eating a full meal and lose weight and keep weight.
1. I feel tense or anxious; my body is consistently tense.
76-100: A score in this range suggests that you may have good self-care skills and lifestyle balance strategies in place.

71-75: A score in this range suggests that you may have moderately good self-care skills and lifestyle balance strategies and that you could possibly benefit from developing a plan to improve your self-care.

61-70: A score in this range suggests that your self care skills and lifestyle balance strategies may be poor to average.

41-60: A score in this range suggests that your self care skills and lifestyle balance strategies may be poor, and that you could possibly benefit from developing a plan to improve your lifestyle and improve your self-care.

0-25: A score in this range suggests that your self care skills and lifestyle balance strategies may be poor, and that you could possibly benefit from developing a plan to improve your lifestyle and improve your self-care.

SCORING GUIDELINES

Source: National Insititute

Please note that this scale is not a clinical diagnostic instrument and is provided for educational purposes. If you have any concerns about your own or someone else's emotional health, you should consult with a mental health professional.
Suggested Resourcing, Grounding & Stabilization Techniques

These are possible preparation/stabilization/resource/grounding techniques the therapist can utilize to prepare the client for trauma processing and to use during processing if necessary. Some individuals may not be able to do Safe Place, so there are many possible alternatives. The therapist will use clinical judgment in determining when the client can tolerate the affect necessary to process the trauma and is ready to proceed.

**Grounding/Breath Skills**

“Make yourself just as comfortable as you can in your chair. Notice your feet on the floor. Feel the floor beneath your feet, press your feet into the floor to feel how it supports your feet.” (Pause for a few moments.) “Allow your focus to move up your legs to where you feel your weight in the chair, and just focus on that for a moment. Feel the support of the chair under you.” (Pause for a few moments.) “Then allow your focus to move up to where you feel your back against the chair and focus on that for a few moments.” (Pause for a few moments.)

“What do you notice now?” Ct. may respond with “I feel more present,” “I feel calmer,” or something similar.

“Allow yourself to notice that for a moment, just notice what that’s like to feel _____________________________” (their words).

“What do you notice now?” If positive response from ct., you may install this with BLS by asking, “Where do you feel that in your body? Just notice that as I turn on the equipment/you follow my fingers.” Use slow, short sets to install, per standard resource development procedures.

Instruct the client to practice this skill throughout the days following the session.

**Breathing Skills**

“Make yourself as comfortable as you can in your chair. Just take a big, deep breath, all the way down into your belly and hold it for just a moment.” (Pause for a moment, but not to the point of discomfort.) “Just breathe that out.”

“What do you notice now?” Ct. may respond with something like “that feels good,” “I feel a little calmer,” etc.

“So just allow yourself to take that deep, slow breath again, and really notice what that ___________________________ (client’s words) feels like as the air goes into your lungs, holding it for just a moment, and then allowing yourself to exhale slowly, noticing what it’s like as the breath leaves your lungs.”

“What do you notice now?” If you have a positive response from ct., you may install this with BLS by asking, “Where do you feel that in your body? Just notice that as I turn on the equipment/follow my fingers.” Use slow, short sets to install, per standard resource development procedures.

Instruct the ct. to practice this skill throughout the days following the session.
Safe/Peaceful Place

The goal of this exercise is to allow the first experiences of BLS to be positive, to assess readiness, ego strength, to develop a tool to be utilized before, during and after processing, and to help create a safe place in the office for processing.

Utilize the procedures you learned in EMDR Basic Training to develop and install an imaginary place or the memory of an actual experience when the ct. feels calm, safe, peaceful, maybe the best they have ever felt. Anchor this place/ experience in the body. Develop/install a cue word. Instruct the ct. to practice this skill to make it more available for them in the future.

If the client is not able to find a safe/peaceful place, use another skill for calming and soothing.

Alternatives to Safe/Peaceful Place

The following suggestions can be developed and installed similarly to safe/peaceful place and other resources. Elicit this information from the client:

- Where is a place you feel safe?
- Who is a person you feel safe with?
- How safe do you feel here now?
- Where in your body do you feel the most calm, most comfortable?
- If you had a safe/peaceful place, what would it be like?
- What experience of strength/success/self-efficacy/coping can you recall?
- What positive body feelings do you have from a sport/music/creative activity, etc.?
- What memory do you have of a time when you felt good about yourself?

With anything positive you are able to elicit, ask “where do you feel that in your body?” and then simply say “just notice that” and add short sets of BLS to strengthen.

Containers

Using an imaginal container allows the client to modulate the amount of material they are accessing at any given time. Use of a container reduces processing between sessions when the client does not want the material readily accessible. A client will learn that they can be in charge of what they are thinking about/feeling with using and practicing a container.

“I want you to imagine a container of some kind that you could use to hold ________ (unfinished material/uncomfortable or intolerable feelings/etc.) Think of something that can be temporarily sealed up, like a box, a jar, a chest, a small room, etc. It can be as big or small as you need it to be. What comes to mind?”

Client states something like “a box” or “a barrel.”

“Okay, great. Using your imagination, just see yourself putting all that ___________ (unfinished material/uncomfortable or intolerable feelings/etc.) in that container. Take all the time you need, and get it all in there. Taking all the time you need, when it’s all in there, just seal it up.”

Check with the client to see if they need more time. If so, allow them to continue until they have the container sealed up. If they are struggling to get the material in there, ask if they need help, like a
tool or someone to help them. The client can use their imagination to bring in whatever help they need and continue to put the material in the container, taking all the time they need, and sealing it up temporarily. The client can continue until they feel complete, and just check in with them to see if they need more time.

Ask the client “What do you get?”

The client will usually state something like, “it’s all in there,” or “most of it is in there,” or “that feels better.”

Then ask, “What do you notice in your body?” With any positive client response, install.

“Notice how that feels in your body,” and add BLS for installation.

Suggest that the client practice this skill whenever anything sneaks out of the container. A client can also contain material/affect by sending it to the future (their next session, etc.) or sending it to the therapist’s office.

Resource Extending

In Roy Kiessling’s section on “Extending Resources,” in Marilyn Luber’s EMDR Scripted Protocols, Basics and Special Situations (2009, pp. 87-92, see references), the client is asked to identify a skill, strength, or resource they feel will help them deal with the trauma. After being asked to focus on that resource, add BLS, asking at the end of the set, “what do you notice and feel?” This resource can be anchored with a cue word or physical anchor (pressing a knuckle, etc.) and then should be practiced with cued and uncued distress to further install the resource. An anticipated disturbance can also be cued, with the client utilizing their resource for calming and soothing.

Four Elements “Light”

Based on the “Four Elements Exercise for Stress Management” by Elan Shapiro (in Luber, Basics and Special Situations, 2009), this shortened version is very useful for quick grounding.

Explain that the “four elements” are air, earth, water and fire. For air, ask the client to take a deep breath. Give them a moment to stay with that. For earth, ask the client to notice their feet on the ground, the chair under and behind them, and again, give them a moment to stay with that. For water, ask the client to make saliva, and give them a moment. For fire, ask the client to look around the room for something the color of fire, such as red, orange, yellow, blue, and white. Bring the client back to air, with a big deep breath, and then ask what the client notices. Most of the time, the client will say something like, “better,” “more present,” “calmer,” etc.

Future Healthy Adult Self

The therapist asks the client to describe how they want their life to be, what they want to be different, how they want to feel, when treatment is complete. They may say, “I want to be sober, happy, independent, and have a job I like.”

Read this description back to the client with BLS and ask them to see if an image of that “future healthy self” begins to show up.
They will report an image of what they will look like/feel like/act like as that future healthy adult, further develop that image by asking questions like “what are you wearing as that future healthy adult?” “How does that future healthy you feel in his/her body?”

Install further with BLS and strengthen with BLS until there is no change. Ask for a name for that future healthy self, things like “Healthy Joe,” “Happy Susan,” etc., and install with the name, possibly anchoring physically to a knuckle, etc. You can also further install with cued and uncued distress to strengthen their access to this resource. You can further install with a physical anchor with pressing a knuckle, etc.

Ask the client to practice this resource by bringing up this image/name/anchor, until they notice a shift in their body, in the days following installation of this resource.

This resource can be utilized as an interweave if processing is stuck, or if the emotions become too overwhelming for the client during processing.

**Oasis/Healthy Pleasurable Activities**

This tool can also help the client develop skills of affect regulation/self-soothing. Ask:

“What is a favorite activity that you have?” Client may say things like “needlepoint,” “watching football on TV,” “running,” “petting my dog,” etc. Keep the focus on a non-addictive/compulsive activity (i.e., not smoking, drinking alcohol, snorting cocaine, etc.).

“Bring up an image of yourself doing that. Describe the scene to me. What do you see, hear, smell, and feel?”

Keeping the client focused on the positive aspects only of this experience, further develop as necessary and install with BLS. Ask for a cue word and possibly anchor to a knuckle, etc. Suggest again that the client practice in the days after the session.

**Spiritual Beliefs**

This is another possible resource to assist the client with affect management and tolerance, self-soothing, etc. Ask:

“What spiritual beliefs do you have that are particularly helpful to you?”

Client may say things like, “I believe in God,” “I know God is there to help me,” “I really like to say the rosary,” “I believe everything happens for a reason,” etc.

“What do you notice in your body when you say that?”

Client may say things like, “My heart feels warm,” “I feel calmer,” “I feel more hopeful,” etc.

“Focus on that,” and use BLS to install. Perhaps ask for a cue word for this resource, install with a physical anchor, further install with cued/uncued distress, etc. Ask the client to practice this resource in the hours or days following the session.
Skills/Strengths Client Would LIKE to Have

“What do you feel you need inside to be able to process the trauma?” The client may say something like “courage.”

“I want you to think of a time when you felt courage, when you really faced the fear and did what you needed to do even though you were afraid.”

Client can describe the time they had that experience.

“What image represents that experience?” The therapist will ask the client to brighten/turn up the volume on that image. Strengthen with BLS until it no longer changes. Ask for a cue word and/or physically anchor in the body.

Ask the client to practice going to this resource in the days following the session.

Light Stream (Shapiro, 2001)

“Notice any upsetting sensations in your body. If it had a shape, what shape would it be?” Wait for ct’s response, and then say: “If it had a size, what size would it be?” Again, wait for ct’s response, and then say: “If it had a color, what color would it be?” Wait for response. “If it had a temperature, what temperature would it be?” Wait for response. “If it had a texture, what texture would it be?” Wait for response. “If it had a sound (high pitched, low pitched, etc.), what sound would it be?” Wait for response. “What is your favorite color that you associate with healing?” Wait for response.

“Imagine that a light of this favorite color is coming in through the top of your head and directing itself at that sensation in your body. Let’s pretend that the source of this light is the cosmos so the more you use, the more you have available. The light directs itself at the sensation and resonates, vibrates in and around it. As it does, what happens to the sensation shape, size, color, temperature texture or sound?”

If the client reports any change, continue to repeat the direction in the paragraph above (underlined) and ask for feedback until the shape is completely gone. This may correlate with the disappearance of the upsetting body sensation. After reducing this sensation, bring the light into every portion of the person’s body, ask for a positive statement for peace and calm until the next session. Ask the client to bring themselves back into the room.
Western Mass. EMDR   Trauma Recovery Network
Common Responses to Trauma

After a trauma, people may go through a wide range of normal responses. Such reactions may be experienced not only by people who experienced the trauma first-hand, but by those who have witnessed or heard about the trauma, or been involved with those immediately affected by it. Many reactions can be triggered by persons, places, or things associated with the trauma. Some reactions may appear totally unrelated, but that doesn’t mean they aren’t valid.

Here is a list of common physical and emotional reactions to trauma, as well as a list of helpful coping strategies. These are NORMAL reactions to ABNORMAL events.

**PHYSICAL REACTIONS**
- aches and pains like headaches, backaches, stomach aches
- sudden sweating and/or heart palpitations (fluttering)
- changes in sleep patterns, appetite, interest in sex
- constipation or diarrhea
- easily startled by noises or unexpected touch
- more susceptible to colds and illnesses
- increased use of alcohol or drugs, overeating, or other addictive behaviors

**EMOTIONAL REACTIONS**
- shock and disbelief
- fear and/or anxiety
- grief, disorientation, denial
- hyper-alertness or hyper-vigilance
- irritability, restlessness, outbursts of anger or rage
- emotional swings – like crying and then laughing
- worrying or ruminating – intrusive thoughts of the trauma
- nightmares
- flashbacks – feeling like the trauma is happening now
- feelings of helplessness, panic, feeling out of control
- increased need to control everyday experiences
- minimizing the experience
- attempts to avoid anything associated with trauma
- tendency to isolate oneself
- feeling of detachment
- concern over burdening others with problems
- emotional numbing or restricted range of feelings
- difficulty trusting and/or feelings of betrayal
- difficulty concentrating or remembering
- feelings of self-blame and/or survivor guilt
- shame
- diminished interest in everyday activities or depression
- unpleasant past memories resurfacing
- loss of a sense of order or fairness in the world; expectation of doom and fear of the future
HELPFUL COPING STRATEGIES

- mobilize a support system – reach out and connect with others
- if it is a recent event, connect with others who may have shared the stressful event
- talk about the traumatic experience with empathic listeners
- cry
- hard exercise like jogging, aerobics, bicycling, walking
- relaxation exercises like yoga, stretching, massage
- humor
- listening to relaxing guided imagery; progressive deep muscle relaxation
- hot baths
- music and art
- maintain balanced diet and sleep cycle as much as possible
- avoid over-using stimulants like caffeine, sugar or nicotine
- commitment to something personally meaningful and important every day
- hug those you love, pets included
- eat warm turkey, boiled onions, baked potatoes, cream-based soups – these are tryptophan activators, which help you feel tired, but good (like after Thanksgiving dinner)
- proactive responses toward personal and community safety – organize or do something socially active
- write about your experience – in detail, just for yourself or to share with others
- imagine yourself releasing all aspects of the traumatic experience from within yourself
- imagine being in the company of an animal or very wise person who would completely and totally understand what the experience was like for you – and – who will comfort you

People are usually surprised that reactions to trauma can last longer than they expected. It may take weeks, months and in some cases, many years to fully regain equilibrium. Many people will get through this period with the help and support of family and friends. But sometimes friends and family may push people to “get over it” before they are ready. Let them know that such responses are not helpful for you right now, though you appreciate that they are trying to help. Many people find that individual, group, or family counseling is helpful. In particular, EMDR (Eye Movement Desensitization and Reprocessing) is a useful therapeutic method that helps healing from trauma.

Adapted from:
Patti Levin, LICSW, PsyD (plevin@createforthecure.org) as found at David Baldwin’s Trauma Information Pages (http://www.trauma-pages.com)
The Firefighter Personality

Created by Dave Dockstader
Boston Area TRN Volunteer

- Many firefighters are extraverts. They are friendly and willing to do anything for their “brothers.”

- They love to build things and solve problems. While they are locking in tradition, they would rather find practical solutions. There is skepticism about new ideas or products.

- Firefighters are hands on people and become easily bored with instruction that is all lecture.

- If something is done wrong, it could cost a life. There is a real need to be in control. If a new probationary firefighter is not living up to snuff, they will tease mercilessly until the “probie” shapes up.

- There is a gallows humor that makes light of serious calls. It’s a way of coping nasty stuff.

- Firefighters live for the “big one” and are upset when they are off shift when it happens. There is a sense of adventure. They get a great adrenalin rush that feels great.

- If they have had too many bad runs and the adrenalin gets depleted and the body starts using serotonin to make the adrenalin, that they get run down and feeling depressed or cranky.

- They keep conflicts in the firehouse. Each firefighter must feel that the others will be there for that firefighter in a crisis situation, and that firefighter will have the others backs. The members of the department become another family.

- In working with firefighters after a critical incident they often measure themselves on how well they contributed or not to the team effort.

- If firefighters let others down or even just feel that they did, it produces a sense of guilt. Guilt over things that they really couldn’t change becomes a grasp for a sense of control.
• Firefighters are quick to blame themselves. Conversely, there is pride in handling very difficult situations with expertise and being of service to others. Firefighters hope that when all is said and done that they can say that they “did their job.”

**Tips on Introducing Clinical Services**

You can appeal to the firefighter’s loyalty to the others and their ability to do the job. You are bucking the tradition of “elbow therapy” in the bar room, to handle the stress. Newer firefighters will be more willing to try something else, but you need to do it right the first time because you won’t get another chance. Use a Fire Chaplain to get you in the station to start with. They are highly respected by firefighters. What are they going to get out of working with you? Be to the point. Above all, be honest. How will this be a benefit to the “job?” Emphasize that they are helping their brothers by helping themselves. Ask about how the firefighter’s reactions are showing up at home. What would their significant other say about how they are doing? When firefighters feel the relief, they will sell others, so you only need to find a few that will try it to start.


This is an extremely important article for all TRN Members to read prior to working with First Responders.
V. REFERENCES
REFERENCES

Abbasnejad, M., Mahani, K. N., & Zamyad, A. (2007). Efficacy of "eye movement desensitization and reprocessing" in reducing anxiety and unpleasant feelings due to earthquake experience. *Psychological Research, 9*, 104-117. EMDR is effective in reducing earthquake anxiety and negative emotions (e.g. PTSD, grief, fear, intrusive thoughts, depression, etc) resulting from earthquake experience. Furthermore, results show that, improvement due to EMDR was maintained at a one month follow up.


American Counseling Association Disaster Mental Health Resources - Fact Sheets. www.counseling.org.


de Roos, C. (2011). A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster exposed children. *European Journal of Psychotraumatology, 2*, 5694 - DOI: 10.3402/ejpt.v2i0.5694. Children (n=52, aged 4-18) were randomly allocated to either CBT (n=26) or EMDR (n=26) in a disaster mental health after-care setting after an explosion of a fireworks factory. Both treatment approaches produced significant reductions on all measures and results were maintained at follow-up. Treatment gains of EMDR were reached in fewer sessions.


survivors found significant differences on the Impact of Event Scale and subjective distress in a comparison of EMDR and non-treatment condition.

Hensel, T. (2009). EMDR with children and adolescents after single-incident trauma an intervention study. *Journal of EMDR Practice and Research, 3*, 2-9. 36 children and adolescents ranging in age from 1 year 9 months to 18 years 1 month were assessed at intake, post-waitlist/pretreatment, and at follow up. EMDR treatment resulted in significant improvement, demonstrating that children younger than 4 years of age showed the same benefit as the school-age children.

Jarero, I., & Artigas, L. (2010). The EMDR integrative group treatment protocol: Application with adults during ongoing geopolitical crisis. *Journal of EMDR Practice and Research, 4*, 148-155. In this study, the EMDR-IGTP was applied during three consecutive days to a group of 20 adults during ongoing geopolitical crisis in a Central American country in 2009. Changes on the IES were maintained at 14 weeks follow-up even though participants were still exposed to ongoing crisis.

Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR integrative group treatment protocol: A post-disaster trauma intervention for children and adults. *Traumatology, 12*, 121-129. A study of 200 children treated with a group protocol after a flood in Mexico indicates that one session of treatment reduced trauma symptoms from the severe range to low (subclinical) levels of distress. Data from successful treatment at other disaster sites are also reported.

Jarero, I., Artigas, L., Lopez-Lena, M. (2008). The EMDR integrative group treatment protocol: Application with child victims of mass disaster. *Journal of EMDR Practice and Research, 2*, 97-105. In this study the EMDR-IGTP was used with 16 bereaved children after a human provoked disaster in the Mexican State of Coahuila in 2006. Results showed a significant decrease in scores on the Child's Reaction to Traumatic Events Scale that was maintained at 3-month follow-up.

Kemp M., Drummond P., & McDermott B. (2009). A wait-list controlled pilot study of eye movement desensitization and reprocessing (EMDR) for children with post-traumatic stress disorder (PTSD) symptoms from motor vehicle accidents. *Clinical Child Psychology and Psychiatry, 15*, 5-25. An effect for EMDR was identified on primary outcome and process measures including the Child Post-Traumatic Stress – Reaction Index, clinician rated diagnostic criteria for PTSD, Subjective Units of Disturbance and Validity of Cognition scales. All participants initially met two or more PTSD criteria. After EMDR treatment, this decreased to 25% in the EMDR group but remained at 100% in the wait-list group.


Silver, S.M., Rogers, S., Knipe, J., & Colelli, G. (2005). EMDR therapy following the 9/11 terrorist attacks: A community-based intervention project in New York City. *International Journal of Stress Management*, 12, 29-42. Clients made highly significant positive gains on a range of outcome variables, including validated psychometrics and self-report scales. Analyses of the data indicate that EMDR is a useful treatment intervention both in the immediate aftermath of disaster as well as later.

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- Trauma Recovery Network (TRN) Chapters provide on-the-ground response and recovery to disasters within their own community. The volunteers who make up each TRN chapter provide hundreds of pro bono sessions to victims of disaster around the country.
- Trauma Recovery Network Chapters provide trauma education and pro bono treatment to First Responders within their own community.
- Trauma Recovery Network Chapters are available to respond to the mental health needs of a community following a disaster.
- You can learn more about the efforts of our national network of TRN Chapters on our website at trauma-recovery.org
- Get involved by volunteering for your local TRN chapter or starting your own!
  Contact Nancy Simons (nsimons@trauma-recovery.org) with questions.

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