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# EMDR Emergency Room and Wards Protocol (EMDR-ER)

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The EMDR-Emergency Room and Wards Protocol (EMDR-ER©) was developed by Dr. Judith Guedalia, after being present at more than 26 Mass Casualty Events (MCEs). She and the other members of Shaare Zedek Medical Center's Trauma Team attended to more than 38% of the 1,623 patients injured in Jerusalem terror attacks during the "Second Intifada." The Second Intifada spanned nearly 4 years, lasting from November 2000 until September 2004.

## EMDR Emergency Room and Wards Protocol (EMDR-ER) Script

### Phase 1: History Taking

#### *Screening*

The EMDR-ER Protocol is used with patients who do not seem able to move on to the ambulatory staging area (i.e., are still on gurneys, frozen on a chair, or on a hospital bed), and who display difficulty in being able to reassume normal appropriate affect, physical, psychological, or behavioral functions at an adequate level given the situation.

Since patients are usually in the emergency room (ER) for many, many hours (5 to 8 hours), there are numerous opportunities to assess the patient's ability to communicate by various means, including just being nearby, standing or sitting next to the patient—whether the patient is on a chair, gurney, bed, and so forth, or doing a more formal type of assessment. Once the patient reaches a basic level of safety, the therapist then can begin communicating safety phrases to the patient. The criteria for the patient reaching a basic level of safety are the following: shows a basic level of physical relatedness, can focus eyes, can respond to questions, looks around the gurney or chair, shows interest at some level of the surroundings, breathing cadence slows down to normal.

When the patient shows the basic level of safety, the therapist can nod, hold the patient's hand, breathe in the same cadence as the patient. At this point of the patient's recovery, it is not necessary to respond to questions asked by the patient with verbal answers. This is because verbal areas of the brain may have shut down and the acutely stressed patient many not hear answers but can sense presence and holding. Very often patients in this situation have not been able to relate to language as evidenced by repeating the same questions despite the answers given. Often, they are in a dissociative-like state that is more of a biological response to acute stress. This state need not be labelled or medicated immediately.

The next step is for the therapist to begin to say short, comforting, and grounding phrases such as the following:

*"You are alive";*
*"You are safe now";*
*"You are in the hospital;"*
*"I am here for you."*

When this level of trust and safety is achieved, the work begins to move forward. Installing a sense of safety, trust, and the realization that they are among the living, is facilitated by the presence of a trained EMDR clinician. Once the sense of immediate safety is established, the introduction of the EMDR-ER protocol is possible and recommended. This protocol can be used with good results even with patients who speak a different language than the therapist; however, an interpreter might be helpful.

When the patient is showing dissociative responses to the trauma such as: hysterical paralysis or a fugue-like state, do not attempt any EMDR. Also, EMDR is not used in the ER with patients who seem to have below borderline intelligence as assessed by clinically administered (bedside) tests such as the Mini Mental State Examination (MMSE). The needs of these patients are different. Repetition in a quiet environment—without a lot of stimulation of the ER—may be better for them. EMDR may be too stimulating for them.

Receiving permission to engage the patient, in some form of bilateral stimulation (BLS), is frequently not possible during the initial stages of hospitalization. When a patient cannot provide permission—and BLS might still be appropriate—only a physician or nurse is allowed to touch the patient. Once the clinician has received an okay to touch the patient from the patient himself, BLS in the form of tapping is possible.

## Phase 2: Preparation

### *Safe Contact—With Dual Attention Elements*

The patients are generally prone on a gurney (possibly compounding the drawing of attention inward to their recent trauma). With medical permission, check if the patient can be raised or somewhat raised to a sitting position and then say the following:

Say, *"Hello, my name is* _____ (state name)."
Then say, *"You are in the hospital now and you are safe. Is it okay for me to touch you here?"*

_____

_____

If the client nods his head, it is taken as an agreement that permits touch. If the patient does not agree, go into the cognitive explanation before conducting bilateral stimulation with touch.

Point to where you will touch the patient.

With those who cannot respond verbally at this time, either touch in two places, or stand in their line of vision as well as touching them. This draws their attention outward to the safe present; this is the ER type of "Dual Attention" that keeps the patient in the *present* and provides a reality check to the fact that they are now *safe*. The external attention created by the touch, the calm tone of voice, and the safe presence of the therapist in the patient's line of vision is particularly important for the hyper-aroused patient who requires grounding.

### *Introduce the EMDR-ER Protocol or Intervention With a Cognitive Neuropsychological Lesson*

Say, "*When we experience trauma, our brain takes in many sounds, feelings, images, smells, and even tastes, all at the same time. This avalanche of sensations coupled with the very real fear of dying, gets encoded or locked in our brain. The area of the brain that is generally activated in such situations is called the Limbic System. This is the area that stores and processes emotion in our brain. This area experiences memories and is not generally seen as accessible by speech.*"

We use this further explanation to encourage the patient's recovery and cooperation.

Say, "*This is especially true soon after the event has occurred* (this seems to be a neuropsychological reality). *Initially trauma is a cortical experience in the Limbic System, specifically the hippocampus. The hippocampus is an area of the brain that looks like a seahorse. It is responsible for episodic memory and spatial navigation. Unlike motor memory such as remembering how to ride a bicycle or swim or factual memory such as recalling dates of historical events, episodic memory involves day-to-day, short-term memories—what we did yesterday, or whom we met last week. It is the area that scientists now understand to be affected in traumatic experiences. What seems to occur is very visceral* (internal in the brain) *and is not neuropsychologically available for verbal encoding. The senses such as feeling, seeing, smelling, hearing, and taste are the modalities by which information is received, processed, and encoded by the brain. Research has shown* (and our clinical experience has found) *that before these images, smells, sounds, and so forth get stored, it is beneficial to talk and give words to these sensory inputs so as to allow them to be available for verbal access in the future.*"

This may be very complicated and wordy for the ER patient. But the presence of the therapist's voice and the explanation well understood or not, tends to foster a sense of calm and safety. In general, we begin this after the patient is somewhat stabilized. Also, it gives family members something to hang onto once we begin. They may be afraid of responses that we understand to be normal for Acute Stress Disorder (ASD) patients. Also, some aspects of the cognitive intervention may be understood and begin to help the patient formulate a frame of reference and then build on it in a logical scaffolding sort of way.

## Phase 3: Assessment

It is important for the therapist to be there with acceptance and the safety of her physical presence. This seems to act as an affirmation of the patient's existence. The clinician's presence creates a dual attention; the therapist assists the patient

to move from an internal focus to an external focus as he is now safe and becomes more aware of that safety in the present with the therapist. You might whisper, again to reinforce the reality of the situation.

Say, *"You are alive," "You are safe now,"* or *"You did get away from there."*

## LISTEN TO THE PATIENT'S NARRATIVE OR STORY OF THE EVENT

Attend to body language during the recitation of the story. Note, if there is agitation in the patient's vocabulary, specific to individual or cultural background as it punctuates the narrative, for example, "Time stopped," "I can't move (speak or hear)," "I am dead," and use this to reflect or suggest negative cognitions (NCs) "I am helpless," "I am out of control," "I am going to die (am dying)." Take notes without interrupting or asking for clarifications.

Say, *"Please tell me what happened."*

### *Target, Memory, or Image of the Actual Traumatic Event*

Say, *"Please allow yourself to focus on an image, picture, or sound of the event."*

### *Image*

Say, *"What do you see now?"*

### *Positive Cognition (PC)*

The NC and PC are reversed in order to further affirm, enforce, enhance, and embed the issues of safety, control, and recovery. It is TOO early for the patient to say, "I am in control" or that "I will be ok," safe and alive are the most positive we can get.

Say, *"When you bring up that image, can you now feel that you are alive and safe?"*

_____

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Note: Some humor may be appropriate here.

Say, *"I am alive and speaking to you, which proves to me that you are also alive."*

Clinical experience has demonstrated that when patients respond with a smile, it is diagnostic of available resources. They may not truly believe that they *are* alive.

### *Validity of Cognition (VoC)*

Say, *"When you think of the incident* (or picture), *how true do those words* _____ (clinician repeats the positive cognition) *feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7
(completely false) (completely true)

### *Negative Cognition (NC)*

Say, *"What words go best with that picture and expresses your negative thinking and belief about yourself now?"*

_____

_____

_____

### *Emotions*

Say, *"When you bring up that picture or incident and those words* _____ (repeat the NC), *what emotion(s) do you feel now?"*

_____

_____

_____

Note: Connect the patient's words to the emotion in order to narrow the distance between the words and feelings or the cognitive and the visceral. Don't be afraid to show your own emotions—by crying or sighing—as it can help the patient emote and expresses your own genuineness and empathy.

### *Subjective Units of Disturbance (SUD)*

Say, *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10
(no disturbance) (highest disturbance)

Note: This question can evoke an abreaction and therefore it is not necessary to insist on a SUD at this point.

### *Location of Body Sensation*

Say, *"Where do you feel it in your body?"*

_____

_____

Note: This question can be problematic when the patients are physically injured. In such cases, this question should not be asked.

## Phase 4: Desensitization

Ask the patient to repeat the narrative and pay close attention to what the patient is saying and to your notes from previous visits to this patient. Be aware of what can be used from the narrative as a metaphor that can distance them from the scene such as video, reversed binoculars, television, or other nonreminders of the situation that brought him to the ER. Be attuned to the use of words in the past tense, "I saw," "The sounds were," "He was," and so forth, as opposed to using the present tense.

Say, *"Please tell me again what happened. Sometimes, it is helpful to think about it as if it were on television or that you are looking at it with reversed binoculars* (or any other relevant metaphors)."

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As time in the ER goes on, and the patients are off the gurneys and onto chairs, it is sometimes feasible to do bilateral stimulation (BLS). However, there is usually no private space that is quiet or secluded enough to comfortably carry this out. Subtle tapping on hands, shoulders, or knees may be more suitable as active cooperation is not required here.

Say, *"I am going to touch you gently on your* _____ (hands, shoulders, knees—wherever is appropriate or accessible); *this may help you to feel more comfortable."*

In a Mass Casualty Event (MCE), there is generally a low patient-to-staff ratio (more injured than available staff members). This may be particularly true of the psychology and social-work staff members, as each patient may bring twice as many family members in need of assistance and guidance. With this fact in mind, the therapist keeps going around and coming back to each patient. Using notes to keep track of what time the therapist was last with the client is helpful, as well as the specifics and sequence of the patient's narrative. During some MCEs, there may be tens of patients per therapist.

The therapist continues to return to the patient and restarts the processing. The time lapses tend to reduce or dilute the emotion of the narrative (a form of