A DEEPER LOOK AT ASAP...

1. What inspired you to develop the Acute Stress Adaptive Protocol (ASAP)?
ASAP was born out of necessity. As a former police officer and EMDR clinician working with first responders, I saw the gap between traditional debriefings and actual trauma processing. I wanted to create something that was structured, effective, and could be peer-delivered to support responders in real time—before trauma symptoms became embedded.

2. How does ASAP differ from traditional Critical Incident Stress Debriefing (CISD)?
CISD is conversation-based and focused on emotional expression, information gathering, and group cohesion. ASAP, on the other hand, is structured around using bilateral stimulation for two reasons: resource building and reprocessing of the trauma experience—it's more neurobiologically informed. It provides an opportunity to make a more adaptive understanding of the experience through the use of the core elements of EMDR. This leads to regulation and resolution of the trauma experience.

3. How do you see ASAP fitting within or complementing existing CISM frameworks?
ASAP is not meant to replace CISD—it complements it. It gives peer teams another tool, especially when individuals are not ready to talk or when incidents require deeper regulation. It can be used alongside defusings by using Phase 1 of the ASAP form. These skills offer self-monitoring for the person, stabilization through mindfulness and offers the person a way of thinking about themselves in the future all before their first sleep cycle. The ASAP also can be offered before the CISD to help regulate and desensitize the experience which prepares them to now experience the emotional expression promoted by the CISD process.

4. What are the core principles or guiding values behind ASAP?
Accessibility, safety, stabilization and grounding, peer empowerment, and flexibility. It's built to be used by trained peers with appropriate policies, procedures, and referral mechanisms in place.

5. Can you walk us through what an ASAP session looks like from start to finish?
An ASAP session involves 8 structured steps: assessment grounding and stabilization, identifying the trauma memory, using bilateral stimulation to reduce arousal, installing adaptive beliefs, and reassessing. Sessions can be 40–60 minutes and end with a plan for follow-up or reassessment of the real-time emotional impact.

6. Who is qualified to deliver the ASAP protocol?
Trained peer support members who have completed the 32-hour ASAP training. While it's based on EMDR principles, it's structured to be safe for non-clinicians to use within peer support frameworks.

A DEEPER LOOK AT ASAP...

7. How do you ensure safety and containment during peer led ASAP sessions?
Training emphasizes screening, stabilization, and knowing when to refer out. Each session follows a structured protocol that avoids open-ended exploration and stays within the responder's window of tolerance. An additional layer of safety comes from the role of the emotional support team, whose members are trained to monitor participant well-being before, during, and after the session. They assess readiness, provide in-the-moment grounding if needed, and ensure a clear plan is in place for anyone requiring follow-up or escalation to a licensed mental health professional.

8. What makes ASAP appropriate for peer delivery, especially in high-stress, field-based environments?
It's brief, structured, and does not rely on narrative disclosure. Responders don't have to talk about the event—they only need to think about it. That makes it a perfect fit for peer support in real-world conditions and ensures a layer of confidentiality.

9. What does the research say about the effectiveness of ASAP?
We've completed three years of research, with large effect sizes showing reduction in PTSD symptoms and physiological stress. Biofeedback data shows real-time reductions in arousal during sessions. We have also designed the ASAP to treat moral injury, a dimension of trauma that is very prevalent in this population.

10. Have you found any trends in outcomes specific to certain populations (e.g., police, fire, dispatch, corrections)?
Yes. The ASAP has proven to be very effective with a diverse population of frontline workers from police, fire, and EMS to dispatchers, emergency room staff, corrections, and child protection workers. Even retired first responders who have struggled with decades old trauma experiences see large reductions in physiological stress and moral injury.

11. How is the protocol being evaluated (e.g., psychometric tools, biofeedback)?
For the research we use 11 different psychometric measures from the International Trauma Questionnaire which looks at complex PTSD and the Moral Injury Outcome Scale to name just a few. We also use real-time skin conductance response via NeuroSmart to assess both perceived and physiological outcomes.

12. Can you share some insights or stories that stand out from ASAP implementations?
One peer team in Maine ran ASAP sessions after a mass shooting. Multiple responders showed dramatic stress reductions within 30 minutes, and many opted into longer-term EMDR therapy afterward. It opened the door.

A DEEPER LOOK AT ASAP...

13. How do you see ASAP integrating into departments that already have CISM teams?
Easily. It adds depth. Peer teams can offer ASAP to individuals who don't want to speak in a CISD group or who need something more regulating. Once a person has experienced the ASAP, they show up for the CISD better regulated and more in control of their emotions... This will completely enhance the experience of the CISD. This is a powerful combination.

14. Do you view ASAP as a replacement for CISD or a complement to it?
A complement. Some situations call for group reprocessing; others require individual, quiet one-on-one trauma regulation. ASAP fills that second need.

15. What's the learning curve like for CISM-trained peers who want to get trained in ASAP?
Very manageable. Most CISM-trained peers already understand boundaries, emotional regulation, and post-incident support. ASAP training builds on that foundation of CISM with the added structure of the protocol and by diving deep into understanding the nervous system and the need for regulation. Another added feature of the ASAP training is we dispel the myth that if a person becomes dysregulated of activated it's a bad thing. No. This show of emotional arousal is where peer support does their best work. ASAP gives peers the tools for regulating this arousal and also is the screening tool for a direct referral.

16. How do you address skepticism or resistance from departments unfamiliar with EMDR-based methods?
We start with science and outcomes and then the personal stories of first responders and how they gained a profound sense of relief after experiencing the ASAP and most times the relief is related to something personal. Once leaders hear these stories and see the biofeedback data and hear testimonials from their own people, the resistance fades.

17. What barriers have you faced in implementing ASAP, and how have you overcome them?
Early on, there were clinical scope concerns. We addressed these through careful protocol design, legal review, and training emphasis on safety and referrals.

18. How do you navigate the legal or ethical considerations of peer-led interventions?
Clear guidelines, strict training, monthly consults, and constant emphasis on competency. We make sure peers understand they are not clinicians; this is not treatment and know when to refer.

19. What does the training process look like for becoming an ASAP facilitator?
A 4-day training with hands-on practice and scenario-based learning. We also offer refreshers and monthly support.

A DEEPER LOOK AT ASAP...

20. Are there refresher trainings or ongoing support for teams after initial certification?
Yes. Teams can access monthly support using zoom calls, continuing education, and direct access to the ASAP team.

21. Is there a quality assurance process or fidelity model to maintain standards?
Absolutely. We use a fidelity checklist, peer debriefing models, and encourage periodic skills reviews.

22. Where do you see ASAP evolving in the next 5–10 years?
I see it being embedded in responder academies, national peer support models, and even international aid work. The structure makes it highly adaptable.

23. Are there plans to adapt ASAP for other populations (e.g., healthcare workers, military, educators)?
Yes, and it's already started. We've trained healthcare and military peer teams, and we're beginning to look at youth-serving professionals. A youth version of the ASAP has already been created and is in the final stages before we start our research.

24. How can CISM teams collaborate with the ASAP community to strengthen responder wellness?
Through cross-training, joint program development, and open dialogue. We all want the same thing -resilient responders who recover well from trauma. ASAP is one more way to get there.