After Utøya – EMDR and recent trauma.

Bjørn Aksel Aasen  
Specialist in Clinical Psychology, NPF  
EMDR Europe Accredited Trainer

This presentation is based on elements from three relatively similar EMDR protocols for recent disasters, Francine Shapiro (2009): *Recent Traumatic Event Protocol*; Elan Shapiro and Bruit Laub (2008): *R-TEP* and Jarrero, Artiga & Luber (2011): *EMDR Protocol for Recent Critical Incidents*. The aim has been to synthesize these into the most simple and pragmatic version that mirrors what experienced EMDR clinicians in this field use in practice.

What is described below is not interventions immediately following the event. For early EMDR intervention soon after the traumatic event, see Gary Quinn: *Emergency Response Procedure*. What is described below are interventions that are appropriate after the dust has settled and one is in a therapeutic setting. See also Artigas, L., & Jarero, I. (2009): *The butterfly hug*.

### Overview

1. Less detailed overview of the event.
2. Narrative of the events with BLS (optional).
3. Focus on the worst part of the incident with as much of the EMDR protocol as possible.
4. Go to the next part of the event that stands out, reprocess this and continue in this way until you are through the whole incident.
5. Run an internal video of the whole event and reprocess the distressing elements until the client can go through the entire event without distress.
6. Check and process present triggers.
7. Future Template - possible triggers and worries.
**Phase 1**
Obtain an overview of the event as a series of fragments, moments and experiences. Level of detail depending on the client's level of activation. Float Back to investigate any similar maladaptive reaction pattern, if needed.

**Phase 2**
Safe Place and possibly other safety and grounding strategies. Link to experiences of coping and confidence and maybe strengthen this with BLS.

**Phase 3**
Go through the entire event in detail.

Identify worst Partial Target. It may be desirable to go through the event while doing continuous BLS, using hand taps or pulsars. This may dampen activation somewhat and make it easier to identify Partial Targets.

Identify worst Partial Target. Set up standard protocol (NC, PC, VoK, E, SUD and Location). Allow flexibility where needed.

**Phase 4**
Processing the worst Partial Target.
Consider the appropriateness of EMD vs EMDR. This involves an assessment of the extent to which one must follow longer channels or go back to the worst moment again and again. Consider the process, duration of events, time remaining of the session and level of activation. Be flexible in emphasis in the direction of EMD or EMDR.

In most cases one does not go directly to phase 5, unless one sees that something near a closure could be achievable and beneficial.

**Phase 3**
Back to Phase 3 and Assessment for other Partial Targets / disturbing moments. Each of these are processed as separate Targets with accompanying NC, PC, etc. The sequence may be chronological, but one can also follow the patient in a search for which Partial Target is most distressing now, or which moment or situation is coming to the fore now.

**Phase 4**
Processing of each of these Partial Targets.
Phase 5
Installation of PC when all Partial Targets is processed. Video of the entire sequence of events along with PC.

Phase 6
Body Scan. Video of the entire sequence of events along with PC. Processing of any discomfort that may come up.

Phase 7
Security and grounding strategies needed when processing of events is incomplete. TS, positive cognitions with BLS, Butterfly Hug, Light Stream Technique mm.

Phase 8
Check and process present triggers. Future Template - possible triggers and concerns.

References