EMDR Humanitarian Assistance Programs: 20 Years and Counting

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EMDR Humanitarian Assistance Programs (HAP) was created in 1995 by EMDR clinicians who had offered pro bono care and training for therapists in Oklahoma City after a terrorist attack. HAP set its mission to bring evidence-based trauma therapy to communities that were underserved or that had suffered disasters. HAP's training programs, which are low-cost, are provided by volunteers and target clinicians in public or nonprofit agencies. HAP currently reaches about 2,000 trainees annually. Similar HAP training programs in developing countries reach about 200 clinicians annually and aim to build local communities of practice that are sustainable. HAP has responded to disasters worldwide, with both training and treatment, but increasingly directs most disaster aid to the United States as new sister organizations appear and respond to disasters in other regions of the world. In recent years, HAP has aimed to promote emergence of its Trauma Recovery Network (TRN)—local voluntary teams of clinicians who stress preparedness as a key component of disaster response. Three TRN chapters in 2010 had grown to 20 in 2013 and will soon double, providing new options for service to HAP's more than 1,500 registered clinician volunteers.

Keywords: EMDR HAP; Trauma Recovery Network; EMDR training; capacity building; disaster response; volunteers

This article, a reflective look back at the educational and disaster response work of EMDR Humanitarian Assistance Programs (HAP), is offered as an "after action report" in the hope that lessons learned will help extend the use and expand the scale of the work done by EMDR clinician volunteers in the future, working through HAP. Since 2000, several similar humanitarian response organizations, using EMDR therapy, have developed in many countries of Europe, Latin America, and more recently in Asia. Many of these sister organizations can trace their roots to the involvement of their founders in earlier international humanitarian projects of HAP. Hopefully, this retrospective look, together with reports in this volume from other EMDR-based humanitarian organizations, will be of some use to a wider audience now paying closer attention to the efficacy and effectiveness of EMDR in postdisaster environments and in enlarging the mental health resources of developing countries.

Humanitarian Interventions

Like all mental health clinicians, EMDR therapists are engaged in a caring profession. They cross a line into humanitarian action, as understood in this article, when they offer their services pro bono to an individual or community that is in great need for basic human resources but lacks the means to provide such resources for itself. The bombing of the Federal Building in Oklahoma City in 1995 was a local disaster that emerged suddenly and constituted a humanitarian crisis. It became the incident that also generated the EMDR HAP. Although that disaster was localized and evoked a swift response, it shared with all disasters the fact that it profoundly disrupted the normal means by which a community commonly managed to cope and to thrive. As the leaders and volunteers of HAP were to experience in the following years, not all disasters, with their attendant humanitarian needs, arise suddenly or recede rapidly. In many

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societies, traumatizing conditions, whether natural or man-made, are long-standing and block human communities from coping or thriving with the means they have at hand. These conditions may be found in developing countries but also in large subsections of affluent societies, such as the United States. As we will show, HAP ultimately directed its humanitarian efforts at all of these types of human disaster.

Eye Movement Desensitization and Reprocessing

In 1995, eye movement desensitization and reprocessing (EMDR) was a relatively new psychotherapy. EMDR therapy follows a protocol and has given rise to specialized protocols that support early interventions for psychological trauma patients (Luber, 2009, 2013; Shapiro, 1995). These formulations made EMDR therapy relatively easy to teach to experienced clinicians and also supported the first generation of researchers to study it. Randomized controlled trials would accumulate in later years, confirming effectiveness and efficacy of EMDR therapy for treatment of posttraumatic stress disorder. But there were few systematic studies at that time. Clinical reports were favorable to EMDR therapy as a trauma therapy, however, as was personal clinical experience among HAP volunteers.

EMDR Therapy as a Humanitarian Intervention

From its beginning, EMDR HAP approached humanitarian aid on a dual track. In the first instance, HAP volunteers went to the scene of a disaster to offer training in EMDR therapy to local clinicians who would remain to deliver care during the recovery period of months or years that follows major disasters. On the other track, the same volunteers provided direct clinical services to individuals and groups experiencing acute stress or posttraumatic stress disorder. Frequently, direct treatment was a briefly shared activity with the newly trained local clinicians to help them consolidate their new skills.

EMDR HAP has never been funded for the purpose of research, and research has rarely been an objective of a HAP humanitarian project. The studies that have been done include the largely unfunded efforts of volunteers who contributed their time and skill here as well. Several of these studies document the actions taken in early projects and attempt to measure their clinical impact in New York after 9/11 (Colelli & Patterson, 2008; Silver, Rogers, Knipe, & Colelli, 2005) and internationally in India (Matthess & Mehrotra, 2008), Turkey (Konuk et al., 2006), and Mexico (Jarero, Artigas, & Luber, 2011).

Very soon after its founding, the scope of humanitarian effort by EMDR HAP expanded. Incidence and impact of psychological trauma after highly publicized disasters were often matched or exceeded by levels of untreated trauma in various disadvantaged but less publicized settings and communities. This led HAP volunteers to begin training clinicians at public and nonprofit clinics in the United States that serve populations with low incomes and high levels of untreated trauma. Such training became the primary ongoing service of EMDR HAP in the United States. Closely related was ongoing training of clinicians in the U.S. Department of Defense and Veterans Affairs, who were struggling to cope with massive incidence of combat-related trauma among military personnel and veterans. Early studies had begun to document efficacy of EMDR for combat trauma (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998), but official promotion of EMDR treatment was slow to develop (Department of Veterans Affairs & Department of Defense, 2010; Russell, 2008).

Transferring clinical skills to developing countries was not as simple as offering continuing education workshops in EMDR to clinicians working in U.S. nonprofit clinics. Many countries had long-standing traumatic histories already "baked in," and disasters were both more frequent and more devastating, given low levels of resilience. World Health Organization (WHO) and development economists were increasingly aware of the association between mental health and rapid socioeconomic development (Carriere, 2013; WHO, 2010). Trauma and trauma-related mental health diagnoses were high on the WHO list of problems needing solutions. EMDR is a highly promising treatment choice, given its relatively low cost and rapid efficacy. But mental health service systems were underdeveloped, if not missing, in these countries. HAP projects would be short-lived unless they were sustained and integrated with larger indigenous efforts to build mental health service systems, as HAP has been striving to do in the West Bank, Kenya, and Ethiopia.

In the Beginning . . .

The bombing of the federal building in Oklahoma City in 1995 led to the first large-scale mobilization of EMDR clinicians to assist a community in crisis and, thereafter, to the founding of EMDR HAP as a nonprofit charity that continues to this day. For 6 months following the bombing, 186 HAP volunteers rotated into the city to treat the survivors and train clinicians.

Their free clinic treated more than 250 blast survivors, firefighters, and rescue personnel who had trauma symptoms. They also trained 300 clinicians, giving them the tools they needed to continue treatment.

1996–2006

Between 1996 and 2006, HAP clinician-volunteers from many nations responded to several domestic and international emergencies. The biggest projects were for flooding in Bangladesh and Indonesia in the early years, the 9/11/2001 attacks on Washington and New York, Hurricanes Katrina and Rita in 2005, and the tsunami in Southeast Asia in 2005–2006 (see Table 1). Many of the volunteers were facilitators or trainers for the EMDR Institute, and HAP began to train new facilitators and trainers to expand its capabilities. Training was based on the model of the EMDR Institute and conformed to the standards endorsed by the EMDR International Association. Clinicians who were trained in these early international projects learned basic EMDR but usually had limited opportunity to get further training in specialty areas or to meet with consultants.

Beyond disaster response, HAP domestic training events in basic EMDR therapy were growing in number during this period, from 7 or 8 events in 1996 to about 40 events in 2006, with an average of 20–25 participants in each (participants must complete two workshops to finish basic EMDR training). Training for Department of Veterans Affairs (VA) and military clinicians was a part of this total, with most of those events conducted by HAP volunteers who were themselves military or VA clinicians.

Although research was not a part of HAP projects, the publication of research studies supporting EMDR therapy during this period appears to have increased interest among nonprofit and public agencies to get clinical training in EMDR therapy. Another factor, frequently noticed in the HAP office by 2006, was the influence of clinicians newly promoted to the role of clinical director at their agency, who had been trained by HAP previously and now wanted their clinicians to have the same skill set.

TABLE 1. Growth and Activity of EMDR HAP, 1995–2014

Year	No. of Training Events (United States/ Other locations)	No. of Therapists trained by HAP	New HAP Registered Volunteers	Major Disaster Responses	Comment
1995	U.S. multiple	300	186	Oklahoma City	Bombing
1997–1998	U.S. multiple/ other multiple	?	?	Bangladesh/Indonesia/ Turkey/Mexico	Floods/ earthquake
2001	?	?	?	India (Gujarat)	Earthquake
2004	21	336	?	?	?
2005	30 U.S.; 3 other	730	50	India/Thailand/Sri Lanka/ Louisiana, and Mississippi	Tsunami/ hurricane
2006	49	1,268	318	Indonesia	Tsunami
2007	63 U.S.; 7 other	1,211	147	Indonesia	Tsunami
2008	55 U.S.; 11 other	1,261	101	Chengdu, China	Earthquake
2009	54 U.S.; 17 other	1,528	131	Chengdu, China	Earthquake
2010	80 U.S.; 24 other	2,156	165	Haiti/Joplin, Missouri; and Tuscaloosa, Alabama	Earthquake/ tornados
2011	73 U.S.; 17 other	2,229	155	Sichuan, China	Earthquake
2012	100 U.S.; 5 other	2,157	222	Oklahoma	Tornado
2013	99 U.S.; 13 other	2,334	330	New York/New Jersey/ Connecticut	Hurricane
				Newtown, Connecticut	School shooting
				Yarnell, Arizona; and San Diego, California	Forest fires
2014 through June 30, 2014	55 U.S.; 7 other	1,313	149	Philippines	Typhoon

Note. ? = incomplete data.

2007 to Present

Within the United States, the major activity of HAP in recent years has continued to be basic EMDR therapy training of clinicians at public and nonprofit agencies, which are the principal source of mental health care for socioeconomically disadvantaged communities in the United States. Annual numbers of participants have grown steadily to more than 2,000. A secondary benefit of domestic training has been the preparation of new facilitators and trainers to meet the demand for training. Most of these EMDR educators remain volunteers for HAP; some go on to become independent clinical educators or to work for the EMDR Institute. Many of these continue to function as HAP volunteers as well. In every case, they add to society's resources for training clinicians in EMDR therapy.

Domestic disaster response has continued to be a major focus of HAP activity. Following the massive response to Hurricanes Katrina and Rita, however, HAP began to modify its approach to emergency response. Previously, major events, such as Oklahoma City, 9/11, and Katrina, had elicited strong support from the EMDR community in the form of donations and volunteers ready to travel to a scene of disaster. Each of these events, however, had compelled HAP to create a structure of coordination and procedure from scratch. Although earlier lessons had not been forgotten at the HAP office, they were unknown to each new crop of volunteers. Also, the cost of sending volunteers and supporting them in the field often far from their homes was prohibitive. At the same time, "lesser" disasters in local communities often failed to arouse strong interest from elsewhere in providing help.

In response to these difficulties, HAP launched a Trauma Recovery Network (TRN), consisting of local chapters whose EMDR-trained members would be prepared in advance of community need, would be networked with other local emergency responders, and would work to raise public understanding of trauma and its treatability during nonemergency times (Alter-Reid, Colelli, & Simons, 2014).

Local TRN volunteers would be ready to respond when emergency need arose, and TRN members in other communities would be available to join them if needed. Meanwhile, all TRN members would have a shared set of understandings about their role and their relationships with other emergency responders. Veteran volunteers from three locations, New York, Western Massachusetts, and St. Paul, formed the first TRN chapters after the major HAP project responding to Katrina in Louisiana. By 2014, there were 20 U.S. TRN chapters and two in Canada. Another 20 localities had TRN chapters in formation. The existing chapters have been highly motivated and responsive to emergencies in many locations where HAP previously would have been unable to mount a rapid response of adequate scope.

International engagement by HAP has also been evolving over the past 8 years. Throughout this period, strong national and regional EMDR associations have existed or been developing in Europe, Latin America, and Asia, most of them with a HAP-like component, which was ready to take on challenges on its own turf and to assist neighbors as needed. Where in the past, U.S. HAP might organize a disaster response and welcome volunteers from many other countries to participate, it increasingly made sense for nearby EMDR groups to respond and request help from other nations as needed. One major, but brief, collaboration of this sort was among the HAP organizations from the United States, France, and Belgium in 2011 to provide training in French to Haitian psychologists after the massive earthquake in Haiti. In another brief collaboration, HAP trained clinicians in Chengdu, China, after a massive earthquake in 2008, at the request of Germany's Trauma-Aid group, which had trained clinicians in Beijing.

There remained several countries where HAP was asked by local leaders to sustain a training role over a long time frame. These engagements were typically for training EMDR therapists and sometimes for helping, as in India and the West Bank, to prepare outstanding therapists as EMDR trainers. Other countries where HAP has continued as a trainer of clinicians include Kenya, Ethiopia, Sri Lanka, Iceland, and Philippines.

Goals of EMDR HAP

Throughout its history, HAP has aimed to bring the benefits of EMDR therapy to individuals and communities that are enduring significant traumatization and that, for one reason or another, are not otherwise able to access effective care. The specific goals of EMDR HAP today derive from the reasons why effective care might be inaccessible.

First, in times of disaster, there may be an intensification of trauma coupled with a general disruption of normal pathways to treatment. For that reason, HAP has dedicated itself to responding to disasters. To increase the effectiveness of disaster response within the United States and to lower its cost so that more care can be provided, HAP has created and is working to expand a National Trauma Recovery Network of

local volunteers who are committed to prior preparation for effective emergency response.

Second, in "normal" times, many communities within the United States experience persistently high levels of untreated trauma and its sequelae. Such communities may have low-cost clinics available, but the clinicians lack training in an evidence-based trauma therapy such as EMDR. For that reason, HAP has the goal of providing low-cost high-quality training in basic EMDR. For the same reasons, HAP has undertaken international projects, unrelated to a recent disaster, that aim at building the capacity of local caregivers to address widespread untreated trauma. In the absence of highly developed systems of mental health delivery, such capacity building efforts cannot be done rapidly. Rather than spread its efforts too thinly, HAP has become selective about the countries where it will seek to build capacity and has made efforts to work in those locations that aim to expand their service capacity over a long term. Basic EMDR training is offered repeatedly, but advanced specialty topics in EMDR therapy are also provided, and when possible, efforts are made to prepare local clinicians as trainers, facilitators, and consultants. These goals have been the foci of work in the West Bank (Zaghrout-Hodali, Alissa, & Dodgson, 2008), in Kenya, in Ethiopia (Ashman, 2014), and in India (Errebo, 2010; Farrell, Keenan, & Basil, 2006).

Management of Programs and Services

Administration. EMDR HAP is overseen by a board of directors which sets basic policy and appoints an executive director to manage programs and services. Since 2003, the HAP office has been in Hamden, Connecticut. A flexible data system linked to e-mail and a website (http://www.emdrhap.org) together enable a small staff of seven full-time-equivalent personnel to manage a volunteer base of over 1,500 clinicians (including 150 from outside the United States), schedule and staff more than 100 training events each year, enroll and track more than 2,000 training participants, support a growing number of local TRN chapters (currently 20), solicit financial support, market literature on EMDR to clinicians, and provide public education on EMDR, trauma, and HAP.

Funding. Donations to HAP, a public charity under the U.S. Internal Revenue Code Section 501(c)(3), are tax deductible. Donations tend to increase at times of major emergent humanitarian need, but over the long haul, more than 80% of HAP's revenue comes from its low-fee training services. HAP pursues an active program of grant seeking as well as soliciting individual contributions.

Volunteer Training. Training events are staffed by volunteer trainers and facilitators who have met the standards of the EMDR Institute and the EMDR International Association (EMDRIA). In domestic training projects, participants are expected to secure qualified consultation privately. In international training, when EMDR is just being introduced in a country, HAP makes flexible ad hoc provision for consultation, either by visiting consultants or via Skype and/or telephone conference. A large number of current trainers and facilitators became qualified for this work to meet HAP's need. Candidates for these roles are offered mentors (for facilitators) or special workshops (for trainers) before shadowing experienced volunteer educators at multiple training events and being observed in their initial practice as EMDR educators.

The emergence of the TRN chapters has provided expanded roles for EMDR therapists who are not facilitators or trainers. All chapters are committed to ongoing training in specialty protocols related to early treatment of trauma and special populations as well as in psychological first aid as supported by Red Cross and other emergency response organizations. All TRN chapters are committed to including an EMDRIA-certified consultant in their membership. TRN members have completed basic EMDR training at a minimum and are encouraged to become EMDRIA-certified clinicians. HAP has also provided workshops, in TRN communities and elsewhere, on Recent Traumatic Event Protocol (RTEP).

Project Logistics

Project Selection. Enrollment in domestic training events, in EMDR Part I or Part II, is limited to licensed clinicians engaged in full-time (30 or more hours per week) clinical work at a public or nonprofit agency. Typically, an agency sponsors the training and provides a venue capable of accommodating at least 25 participants who meet the criteria, although they may work at different agencies. Both low fees and the fact that the training team comes to the participants' community for the 3-day event help to make the process affordable. Specialty training is offered rarely, except for workshops such as RTEP which serve the preparedness goals of TRN chapters.

International projects are selected and defined in a more complex and ad hoc manner. If the project is focused on training, in whole or in part, HAP looks for evidence that the potential trainees are

adequately prepared as clinicians to absorb the training. If translation of the instruction is required, HAP looks for evidence that translators are available and skilled in translating in this technical domain. Because this is often difficult to ensure and because translation slows down the pace and accuracy of training, HAP today favors projects that can be conducted in the shared language of the training team and the participants without need of translators. In most cases, international training projects are paid for by grants, donations, or other third-party payers rather than by the participants.

Selection of projects focused on direct service to first responders and survivors of a disaster is affected by many considerations: funding to support transportation and maintenance of clinical teams, shared language or available clinician/translators, and sponsorship or endorsement of the project by a local governmental or health agency. Early in its history, U.S. HAP was a provider or co-provider of most international disaster relief projects involving EMDR and aimed to support EMDR clinicians from other countries to develop similar humanitarian organizations. Because such organizations have emerged, HAP's involvement in disaster response internationally has been reduced, whereas HAP's focus on capacity building in developing countries has increased. In capacity building work, as in the West Bank, Kenya, and Ethiopia, project selection is jointly designed with local partners to support their progress in expanding knowledge of EMDR and integrating EMDR therapy into their national health-care systems. Focus is typically on training and consultation, developing indigenous consultants and educators, and bringing in specialty training, always constrained by availability of third-party funding.

Supporting Volunteers in the Field. For domestic training projects, volunteers are selected with an eye to their proximity to the site, to reduce travel costs, and consideration of the match between areas of special expertise among the training team and any special focus of the sponsoring clinic (e.g., if the clinic serves mostly children or individuals with chemical dependencies). Volunteer specialties are also considered in staffing international projects. By definition, HAP volunteers serve without pay in the projects they agree to join. They typically make their own travel arrangements and are directed to lodging that is convenient to the project site. HAP reimburses travel, food, and lodging costs.

Volunteers typically work in teams and organize their activity in the field to take account of any special circumstances in their work. In training projects, the trainer is considered the "captain of the ship," authorized to take final decisions after the team has explored any problem. In TRN projects, each chapter endorses shared standards listed on the HAP website, but beyond that, each chapter is autonomous and designates its own coordinators of the voluntary work. TRN chapters are encouraged to attend to secondary stress on volunteers (Alter-Reid, Evans, & Schaefer, 2010).

Services That HAP Provides

Disaster Response. Because HAP projects are time-limited, volunteer teams away from home are usually eager to train local clinicians in EMDR. When the team leaves, they aim to leave behind local clinicians who can continue to provide effective treatment for trauma. For this reason, EMDR training is often a component and by-product of disaster response projects. In other cases, and where a domestic TRN chapter is responding in its own community, there are six principal functions (discussed later) that constitute the services expected of TRNs.

Conditions at a disaster site require flexibility. Group treatment has been used in post-tsunami projects in India (Farrell et al., 2006), Thailand, Sri Lanka, (Errebo, Knipe, Forte, Karlin, & Altayli, 2008), and other settings. Group psychoeducation followed by brief individual counseling was provided to 600 first responders and additional local caregivers in Louisiana after Katrina. When it has been feasible to train local clinicians in EMDR as part of a project, HAP teams have then supported them in their initial field use of what they had learned, as in Haiti, India, Sri Lanka, and Turkey.

Training for Military Clinicians and United Nation Therapists. The military and United Nation use their clinical staffs to support the mission of their field personnel. In the case of the U.S. military and VA, HAP has trained nearly 1,000 clinicians over many years. However, there are tens of thousands of clinicians in these services. Research has supported use of EMDR for combat trauma (Carlson et al., 1998). EMDR is now recognized officially by the VA as a recommended therapy, but decisions to train clinicians and to use EMDR are made by local commanders and administrators. Local military commanders shift every few years, and support for EMDR may decline or increase based on who is in charge. Russell (2008) has analyzed traditions of resistance to treating combat trauma. It is the perception of HAP that support for EMDR from higher echelons has grown slowly, and in some services, there is now support for developing their own EMDR trainers with expertise in combat trauma.

WHO (2013) has endorsed EMDR as an effective therapy in disaster mental health. HAP has trained WHO clinicians in the course of its project in Haiti after the earthquake of 2010, and WHO continues to seek HAP's services to train their therapists in disaster settings.

Capacity Building as a Goal. Although HAP's first humanitarian ventures involved teaching EMDR to local therapists who would be seeing traumatized people after a disaster, it was soon apparent that the early aftermath of a disaster is not the best time frame for introducing caregivers to intensive training events and trying out new skills. Both at home and internationally, HAP has developed improved approaches that focus on building clinical capacity during ordinary times instead of trying to revise skill sets in the midst of emergencies. At home in the United States, the growth of HAP's regular training program for nonprofit and public agencies was the single greatest mode of capacity building. The next step in domestic projects was the emergence of local TRNs, discussed later.

As for countries where there are major disasters, these occur disproportionately where mental health service and other sources of resilience are generally underdeveloped (Gelbach, 2008). Teaching of EMDR is therefore a valuable support to these countries, but trying to teach it in the immediate wake of disaster is inefficient. Realizing this, HAP has attempted to develop model training projects in a small number of countries where clinicians are motivated and not in crisis mode, where training includes specialty topics, and where HAP encourages the emergence of local trainers and consultants to sustain capacity once it is attained.

Capacity Building in Action. In the West Bank, collaboration with two Palestinian clinics—the East Jerusalem YMCA in Beit Sahour and the Treatment and Rehabilitation Center in Ramallah—led to training of more than 200 Palestinian EMDR clinicians in a 6-year period. Several Palestinians became consultants and facilitators, and 4 became trainers, eliminating the need for translators thereafter. Many of the new clinicians work in teams to address periodic intensifications of traumatic events. One of the trainers has already conducted EMDR training in Arabic in four other countries and is currently training Arab clinicians in Beirut serving Syrian refugees. In Ethiopia and Kenya, multiyear HAP projects have expanded the number of clinicians with both basic EMDR and advanced specialty workshops. National EMDR associations are in formation in each country.

Trauma Recovery Network. To ensure readiness for response to disasters in the United States, to expand the reach of emergency mental health services, and to reduce the costs of reinventing response projects and reconnecting with local emergency management systems, HAP has been building the TRN, a coalition of local/regional chapters linked to a National Trauma Recovery Network office at HAP and sharing a common vision and mission. At the local level, TRN chapters consist of EMDR clinicians, including a qualified clinical consultant and one or more locally chosen coordinators, who maintain a level of preparation and of liaison with other elements of their local emergency preparedness system, such as the public health department; police, fire, and emergency systems; hospitals; Red Cross chapters; and others. At the national level, HAP develops liaison with national governmental and nongovernmental agencies that define and support emerging standards of preparedness, response, and recovery. HAP also assists local TRN chapters to meet these standards and connect with local, regional, and national sources of support.

Six key functions define the optimum to which local TRN's aspire:

1. *Professional development*, comprising advanced clinical training in standard psychological forms of first aid that can precede or combine with EMDR early treatment protocols; mastery of EMDR applications designed for response and recovery phases of emergency care, including group treatment and care of special populations such as children (many relevant protocols are found in Luber, 2013)
2. *Local networking* between the TRN chapter and other components of the local emergency planning and management system, with all parties aware of the TRN's capabilities and how to use them in an agreed on manner when needed
3. *Community education* before emergencies to inform mental health agencies, community leaders, and the public about the nature of trauma, how it can be treated, and how individuals can promote resilience in themselves and their family
4. *TRN networking* to maintain ongoing dialogue among TRN chapters and with the National Trauma Recovery Network to share news, concerns, and lessons learned and to ensure that all chapters embrace a common set of standards and policies
5. *Local emergency response* wherein the TRN chapter undertakes the actions it has practiced and prepared, in coordination with other local actors
6. *Nonlocal response* wherein a TRN chapter calls on sister chapters for additional volunteers when the scale of a local emergency merits reinforcements

Trauma Recovery Networks in Action. In 2012–2013, Hurricane Sandy dealt a devastating blow to the

New York/New Jersey/Connecticut shoreline. TRN chapters in three states went into action immediately. Each TRN was composed of clinicians who had prepared for such an eventuality. A few months later, a lone gunman entered Sandy Hook Elementary School in Newtown, Connecticut, and killed 20 children and six educators. For the surviving children and teachers, the families, and first responders, the traumatic consequences were massive. A TRN chapter developing in the county went immediately to work, providing psychoeducation and brief therapy over the following months. Across the country, devastating forest fires in California and Arizona had traumatic effects on residents and first responders. Two local TRN groups went into action. A TRN chapter negotiated a model memorandum of understanding with a local Red Cross chapter, and another responded to bombing of the Boston marathon. Twenty established TRN chapters will soon be joined by 20 more in other cities. The advantages of informed local initiative when disaster strikes are substantial. HAP is increasingly able to concentrate on seeking outside resources to sustain these networks and on enabling the chapters to communicate quickly and learn from each other.

Looking Forward . . .

The original impulse to form EMDR HAP in 1995 has led to remarkable works around the globe. There are now many sister HAPs in other countries. EMDR has been brought to bear in many disaster situations. EMDR training has reached clinicians and agencies serving communities with high levels of need. These needs are far from met, but research has brought growing recognition of EMDR's efficacy and effectiveness for an expanding array of conditions. And the motivation of therapists who have been empowered by EMDR to "pay it forward" in volunteerism has only grown. The challenges facing HAP today are (a) to ensure that EMDR clinicians serving the most vulnerable populations are adequately supported to develop mastery and apply it where most needed and (b) to use the scarce resources available for disaster response in the most efficient and collaborative way, with expanded attention to preparedness as the key to success.

These challenges pertain both in the United States and in developing nations abroad. The common vision is to build and strengthen through collaboration a worldwide TRN.

A Final Note. In 2013, the board of directors changed the name of their organization to make its focus more immediately apparent to the general public. The new name is Trauma Recovery/EMDR Humanitarian Assistance Programs.

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