EMDR, Community Psychology, and Innovative Applications of a Trauma Recovery Network as a Tool for Social Change

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This article discusses the need for and ways to implement novel applications of early eye movement desensitization and reprocessing (EMDR) interventions (EEIs) at the community level for marginalized groups. Trauma Recovery Networks (locally based groups of licensed EMDR clinicians volunteering to provide pro bono disaster services, also known as *TRNs*) are an underused and insufficiently tapped tool when it comes to addressing the sequelae of disasters in our communities. We propose expanding our concept of and work with disasters beyond the traditional, legally recognized definition of Disaster (big D) to include ongoing stressful and traumatic community events or “little d” disasters. By serving those affected by little d disasters, the field of disaster response can be broadened in powerful ways. Marginalized communities typically suffer more and receive fewer services in the wake of traditional Disasters, threatening their civil rights and increasing the allostatic load on their collective health. Attending to the ongoing little d disasters, in these communities can be an important tool for social change, and various proposals for local TRNs are discussed.

Keywords: early EMDR intervention (EEI); community psychology; underserved; public mental health; civil rights; disaster response

Eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2001) typically focuses on helping individuals, couples, families, or small groups heal from the impact of trauma. This article shines a light on how we might apply EMDR interventions to help affect broad social change *particularly* for underserved communities which suffer trauma related to discrimination and marginalization. Members of disenfranchised groups cope with multiple traumas, in higher doses and from broader sources, all while being considered the “other” by segments of the societies in which they call home.

The impetus for this piece is the work the Boston Area Trauma Recovery Network (TRN) has been doing in collaboration with governmental and non-governmental organization (NGO) partners since responding to the needs of the 2012 Hurricane Sandy survivors on New York’s Staten Island and to the 2013

Boston Marathon bombing survivors locally. Because of witnessing problems in disaster response inequities, the Boston Area TRN has been working with local community leaders, the Boston Public Health Commission (BPHC), and with the Boston Mayor’s Office of Resilience and Racial Equity to develop creative new initiatives for ameliorating chronic traumas in under-resourced segments of the community. Our collaboration with the BPHC and the Boston Mayor’s Office of Resilience and Racial Equity have particular emphases on gender bias, racial inequity, poverty, and marginalized, underserved populations.

We propose trauma reprocessing through disaster intervention in traditional and nontraditional ways as an avenue for social change. We briefly introduce the tools of early EMDR interventions (EEIs), protocols and research, and the history and structure of TRNs. We review the relationship between civil rights,

disaster response, and the need to attend to those who are more socially vulnerable, and the physical health consequences they face. We introduce the concepts of big D and little d disasters as a way of organizing ongoing community response that draws from the principles of community psychology. Last, we address how we might apply these tools to interrupt cycles of violence and tension in communities under chronic stress, address vicarious trauma of community workers, increase resilience in vulnerable and marginalized populations, and in so doing improve traditional disaster response.

Historical Context

When posttraumatic stress disorder (PTSD) debuted in 1980 as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., *DSM-III*; American Psychiatric Association [APA], 1980), it continued a history of diagnoses that primarily referenced publicly visible experiences of men at war (“hysterical disorders of warfare,” Yealland, 1918, and “shell shock,” Myers, 1940). Private traumas that affect people, especially women and children, in their day-to-day lives, were not part of the concept. Concurrently, women’s movements around the world were raising consciousness about private traumas such as rape, domestic violence, incest, and other forms of child abuse and developing theories regarding the history and manifestations of gendered dominance. The seminal political piece by Hanisch (1969), “The Personal Is Political,” set the stage for later work by establishing the notion that personal, private trauma was overlooked and minimized by those with power, and that it was crucial to contextualize experience and not blame the victim. Groundbreaking academic research on sexual violence (Russell, 1984) and on domestic violence (Walker, 1979) linked abuse of women to the symptoms of trauma and shifted the field’s focus to include private domains and everyday life. At the same time, Herman’s (1992) seminal work, *Trauma and Recovery*, proposed examining the true scope and consequences of private trauma, asserting “the most common post-traumatic disorders are those not of men in war but of women in civilian life” (p. 28).

Feminism has long applied this public/private distinction as a tool for analyzing social dynamics by bringing into the public sphere private, hidden, problematic situations in institutions and societies that serve the dominant group’s interests (Warner, 2014). Applying this device to the experiences of marginalized communities reveals parallels. These communities are often either invisible to the mainstream, distorted by the lens of prejudice, or hobbled by government

programs that disadvantage them, such as redlining. The effect is that traumas for these groups occur in semiprivate space, “invisible” yet in full view. For example, this article has been written in the midst of events in the United States that birthed the #BlackLivesMatter movement. From the February 2012 vigilante murder of Trayvon Martin, to police killings of unarmed African American men, women, and teens, to the June 2015 massacre at a historic Black church in Charleston, the ability of the public to broadcast recordings of incidents has highlighted the experiences of one of the many marginalized groups in the United States. These events are neither new nor isolated. They can be seen in context as an extension of the brutality of slavery and a pattern of attempts to dominate, demoralize, and sometimes terrorize African Americans since the end of slavery (DeGruy, 2005). What is new is the grassroots access to and dissemination of evidence through social media which makes it harder for the White mainstream to deny these events and opens up the possibility for greater understanding.

Although some major media outlets still portray marginalized communities out of context, using derogatory and demeaning language, fomenting an us-versus-them mentality, the reality is that marginalized communities face disproportionately large stressors, are traumatized by persecution and discrimination, and have their access to resources constrained by society’s dominant groups. Intentionally or not, ongoing social and institutional structures can result in barriers to self-determination and justice. Here too, it is important to honor the context and not blame the victim.

The challenges facing marginalized communities are shaped by intergenerational and multidimensional trauma—transmitted throughout history via ongoing discrimination, maltreatment, and biological processes. The intergenerational transmission of trauma (Yehuda, 2002), which was first examined through the psychoanalysis of children and grandchildren of Holocaust survivors, is a rich area of scientific research. Posttraumatic slave syndrome captures the phenomenon as it applies to African Americans in the United States (DeGruy, 2005). The work of Danieli (1998), explores the phenomena across cultures worldwide and through many traumatic legacies. Addressing trauma in marginalized communities has the potential to end cycles that have effected generations.

EMDR, Early EMDR Interventions, and Trauma Recovery Networks

EMDR therapy, is an empirically validated form of psychotherapy that addresses and ameliorates the

symptoms stemming from the maladaptive learning that accompanies traumatic experiences, where “traumatic” is understood to encompass a spectrum from that which is chronically stressful to that which is a life-threatening trauma and everything in between. Developed by Shapiro (2001), it is a standardized form of psychotherapy with eight phases (history taking, preparation, assessment, desensitization, installation, body scan, closure, and reassessment) that addresses the presenting problem in three prongs (past events, present triggers, and future challenges). The process of EMDR therapy is understood to cause neurological shifts in memory storage, such that the way in which a given stressful/traumatic memory is experienced, perceptually, cognitively, affectively, and somatically, is encoded in a more adaptive and accurate way (Solomon & Shapiro, 2012). Complete reprocessing in EMDR therapy seeks the facilitation of trait change (an enduring shift) over state change (temporary relief; Shapiro, 2007).

Several EMDR protocols have been designed to address the sequelae of relatively recent stressful or traumatic experiences which have generally taken place less than 6 months (although sometimes up to 12 months), prior to presentation for treatment. After a San Francisco area earthquake, Shapiro (2001) observed that traumatic memory and EMDR treatment behaved differently with a recent traumatic event. She made alterations to her standard protocol birthing the Recent Events Protocol, the first “early EMDR intervention” (EEI). Since then, various EEI protocols, for use with individuals or groups, and for starting within minutes, days, weeks, or months after an event, have been developed, published, and researched. Because of space limitations, an in depth review of the protocols and research using them is beyond the scope of this article. For those interested, many of the protocols are found in the text by Lubert (2013) on EEI and disaster interventions and a graphic comparing the protocols may be found at <http://emdrresearchfoundation.org/emdr-early-intervention-researchers-toolkit>. In addition, there is a body of articles spanning 20 years which includes diverse disaster situations and populations. Although disaster research is saddled with particular challenges (Norris, Galea, Friedman, & Watson, 2006), there is published research on EEIs and disasters which includes randomized clinical trials (RCTs), various field studies, a randomized controlled field study, and various case reports and series. A review by Natha and Daiches (2014) looks at efficacy across a subset of eight of these studies which demonstrate the effectiveness and cost-efficiency of EEI.

Although we cannot control exposure to traumatic events, we can mitigate the consequences

(Abkowitz, 2008). The EMDR Humanitarian Assistance Programs (HAP, now also known as *Trauma Recovery*) have a 20-year history of volunteerism providing EMDR therapy, educating the public, and training clinicians near disaster sites to provide ongoing aid (Alter-Reid, Colelli, & Simons, 2014; Gelbach, 2014; Maxfield, 2014). During this time, the concept of TRNs was developed and implemented for more sustainable treatment delivery postdisaster (Alter-Reid et al., 2014; Gelbach, 2014). TRNs are locally run groups of EMDR-trained clinicians who volunteer their time to provide EEI services in the wake of disasters—either for locally occurring events or elsewhere by invitation. Because of the all-volunteer nature of the TRN structure, they only exist where EMDR clinicians have decided to come together to volunteer to create, staff, and run a TRN.

The type of work TRNs do currently takes place in various locations in the United States and also throughout the world via invitation of U.S.-based groups. Similar EMDR-based, disaster response and recovery projects have happened throughout Europe (Cervera, 2013; Fernandez, Callera, Maslovic, & Wheeler, 2014; Mattheß & Sodemann, 2014), Asia (Farrell, 2014; Mehrotra, 2014), Israel (Cohen & Lahad, 2013), Turkey (Konuk & Zat, 2013), the Arab world (Zaghrou-Hodali, 2014), Africa (Zimmermann, 2014), and Latin America (Jarero, Artigas, Uribe, & Miranda, 2014). In addition, there are numerous TRN-type groups of EMDR clinicians that have responded during violent political crises (Acatürk et al., 2015; Konuk & Zat, 2015; ter Heide, Mooren, Knipscheer, & Kleber, 2014; Zaghrou-Hodali, 2014).

Community Psychology

The responses of TRNs to disasters are ideal illustrations of community psychology at work. In community psychology the community, not the individual or family, is the client, and psychological research and clinical practice target problems at the level of systems and societies (Dalton, Elias, & Wandersman, 2006; Rappaport, 1987). Community psychology is akin to public mental health with strong emphases on prevention, social justice, and positive social change (Rappaport, 1987). Rather than focusing on clinical diagnosis and medical model treatment, the focus is on prevention, wellness, supporting resilience, and the belief that all communities, even marginalized ones, have adaptive systems that can help their communities thrive when supported (Dalton et al., 2006). When TRNs do pro bono disaster response and recovery, they diffuse the traumatic impact of the disaster and prevent it from taking root in the systems of

people and communities, shielding them from deeper symptoms and dysfunction down the road. But EEI goes beyond trauma management as it contributes to increased resilience for those who continue to be exposed to traumatic circumstances (Jarero & Uribe, 2012; Zaghrouh-Hodali, Alissa, & Dodgson, 2008).

Types of Disasters

The EMDR community distinguishes between big T Trauma (unusual experiences that embody the threat criterion for PTSD) and little t trauma (developmental traumas or ongoing injuries that are the fabric of an everyday life), understanding that both lay the ground for pathology (Shapiro, 2012) by overwhelming “the ordinary human adaptations to life” (Herman, 1992, p. 33). Similarly, disasters can be conceptualized as big D Disasters and little d disasters. In traditional disaster response and recovery, the main types of disasters (natural disasters, industrial/technological accidents, and acts of mass violence) can be termed *big D Disasters* because of their unusual and often life threatening natures. Within big D Disaster response, marginalized populations which are typically more vulnerable to stress, are often overlooked in treatment and outreach efforts (children, those who do not speak the dominant language, single parents, those with physical challenges, etc.). A culturally competent disaster intervention will consider these factors, and adjust accordingly.

However, when allocating resources for disastrous events, the tendency—promoted by the *DSM* and traditional conceptualizations of PTSD—is to look for precipitants that are extraordinary events, big T Traumas (Shapiro, 2001, 2012), or in this case big D Disasters. This turns our gaze away from the everyday circumstances of people’s lives, the little t traumas (Shapiro, 2001, 2012), and away from what can be conceived as small d disasters. We think of terrorist bombings as disasters, but miss the chronic violence that terrorizes communities. We think of those abroad experiencing terrorism, natural, and technological disasters, but forget the impact on their loved ones within our borders. We think of hurricanes, earthquakes, and industrial accidents as environmental disasters, but miss environmental racism that puts toxin-producing industry in the neighborhoods of the poor. We think of the visible, front-line first responders (fire fighters, police officers, and emergency medical services) but miss the people behind the scenes—dispatchers, orderlies, tow truck drivers, and janitors or cleaning women who clear away glass, blood, and the evidence of horror.

If TRNs were to broaden the types of disasters to which they respond, so that they included the chronic onslaughts facing marginalized people, there would be a profound opportunity to interrupt these cycles and instigate a course change. If TRNs did so in collaboration with other governmental bodies (public health commissions and others) or NGOs such as the Red Cross, the impact could be even more powerful. These kinds of initiatives hold tremendous benefit for members of TRNs and of the community, including preparation for large-scale disasters. We propose our work as an outside-the-box model for using TRNs and EEI to redress societal challenges.

Disproportionate Health Impacts of Trauma on Marginalized Communities: Allostatic Load

The importance of EMDR therapy as a public health or community psychology intervention can be justified solely based on the need to ameliorate the impact of trauma on the physical body. Research such as the Adverse Childhood Experiences Study (Felitti et al., 1998), articles by McFarlane (2010), and others explore the relationship between trauma and health. In related research, the concept of allostatic load—the chronic accumulation of wear and tear on the body—speaks to the health impact of adversity that socially vulnerable people and communities disproportionately face in daily life (Ganzel, Morris, & Wethington, 2010; Juster, McEwen, & Lupien, 2010; Logan & Barksdale, 2008; Simandan, 2010), and is thought to be a biological link that explains group disparities in mortality and morbidity (Gustafsson et al., 2014; Pantell et al., 2013; Seeman, 1996).

Chronic stressors cumulatively reduce the physical and psychosocial resilience of vulnerable people in our communities. When an acute stressor, such as a disaster, arrives, it can deplete any physical and psychosocial resilience that remains. When the institutions that are supposed to help do not provide it, there is an immediate physical reaction that contributes to poor health (Seeman, 1996). This dynamic, termed *institutional betrayal*, occurs when the institutions we trust and depend on perpetuate wrongdoings, such as when schools do not protect children from being bullied, and thus cause additional trauma and revictimization (Goldsmith, Martin, & Smith, 2014; Smith, Gómez, & Freyd, 2014). When governmental agencies and NGOs do not consider the social conditions of communities in planning, trauma response providers unwittingly contribute to allostatic load, and unnecessarily

increase the likelihood of additional suffering and poor recovery outcomes.

Disaster Response and Recovery: Civil Rights and Social Vulnerabilities

Disaster work is a robust discipline in its own right, and a review of the field is beyond the scope of this article, but a brief introduction to some principles and issues is helpful. Disaster intervention is critical because disasters typically affect a broad slice of the community, and many affected would never seek out psychotherapy but are willing to receive short-term disaster interventions. Seeking treatment after an earthquake or bombing or train accident is less stigmatizing and does not require a formal psychiatric diagnosis. Disaster response provides an opportunity for interventions that can improve resilience in a community, mediating the impact of trauma, and preventing long-term, debilitating consequences. Disasters afford opportunities to improve things for communities as a whole, through psychoeducation, coordination of services, and systems level changes. And given that disasters are both increasing in severity and frequency worldwide (Carriere, 2014), examining how we intervene is of great concern.

In the United States, the most common responses to disasters do not involve trauma treatment *per se* but instead focus on addressing basic needs—safety, sustenance, communication systems to reconnect people who have been separated, establishing temporary shelters, returning people to housing, and so forth. On the psychological front, interventions most often seen and endorsed include psychological first aid (Bisson, 2007), psychoeducation about trauma and stress, trainings in coping techniques such as stress management or mindfulness, and interventions such as critical incident stress management (CISM; Everly & Mitchell, 2013) for smaller and more defined components of a community such as first responders. By and large, these responses are crisis interventions and symptom management approaches that do not set out to treat the trauma by preventing it from taking root or by addressing the neurological damage in the way that EMDR psychotherapy and EEI do.

As alluded to previously, the impact of a disaster on any community is not random; it is determined by the daily circumstances and resources of people living in the area (Klinenberg, 2002). Vulnerability load is a concept that can be calculated by tallying the particular subset categories within age, race, income, household composition, family composition, housing type, disease/illness, access to services, language and

literacy, immigrants, gender, and disability (Centers for Disease Control and Prevention, 2010; Cutter & Emrich, 2006; Kailes & Enders, 2007). The higher the number of social determinants present in a household, the higher the vulnerability (Martin, 2015) and the greater the health risk (Chandra et al., 2011), as mapped out by Martin's social determinants of vulnerability framework (Martin, 2015). Imagine a single mother who rents, is working poor, has a chronic medical illness, does not speak English well, and has no access to a vehicle. She faces significant challenges and chronic stressors in her daily life just trying to get her children to school, attend appointments, get to work, and pay her bills. Now, imagine her after a disaster, how her suffering would be multiplied, and how it is complicated by her circumstances. In the United States, civil rights legislation aims for redress of these disparities by ensuring the right to federally funded programs and activities including disaster relief (Centers for Disease Control and Prevention, 2010; Milligan & Company, 2007; Paulison, 2005).

Nonetheless, there have been documented violations of civil rights statutes after disasters (Muñiz, 2006). Hurricane Katrina provides an overabundance of pre- and postdisaster examples of disproportionate suffering in historically overlooked communities. Social factors and disenfranchisement combined in such a way that people of color, low-income households, those with disabilities, and the elderly represented most of those who were left behind, injured, or perished (Quigley, 2007). Renters in low-income neighborhoods had limited access to postdisaster services which primarily benefit homeowners; utilities and transportation infrastructure were late to reach them causing further trouble. The Boston Area TRN witnessed anecdotal examples of these phenomena on Staten Island after Hurricane Sandy. People with lower socioeconomic status (SES) tended to have homes in low-lying flood zones and appeared to suffer more property damage in addition to greater emotional terror as tsunami-height waves came ashore. This was further compounded by increased exposure to mold and its health effects, as limited financial resources complicated people's access to healthy temporary housing.

Despite these problems, socially vulnerable people also possess a baseline level of resilience and are most knowledgeable about their own needs. Trauma response efforts, which should include the range of nonclinical mental health interventions such as psychological first aid, CISM, posttraumatic stress management, and EEI, are more powerful when implemented with the guidance of community

members (Blacklock, 2012; Brymer et al., 2006; Macy et al., 2004). Mandating this would ensure the development of truly inclusive trauma response that respects the cultural and social context of the people being served, understanding that some people can assist in some situations but require assistance in others (Flanagan, Gregory, Hallisey, Heitgerd, & Lewis, 2011; Macy et al., 2004).

It is important for government agencies and NGOs alike to engage in critical internal reviews to locate and address their blind spots. As TRNs offering EEI, we can incorporate certain questions into how we manage our responses. What communities typically get served? How is “public” or the “community” defined? In the United States, do we include only those who speak English, or are adults, or have financial means, or are legally documented, or are independently mobile, or attend church, or can make Saturday appointments, or can get to private offices in the suburbs? Taking seriously a mandate to serve those who are traditionally underserved means getting out of our comfort zones. For a TRN, it might mean developing relationships with interpreters who will make treatment access possible, budgeting the extra time it takes to tell a story twice, and advocating with our partner organizations. It would also mean implementing systems to address vicarious traumatization of the interpreters, just as we advocate doing so for clinicians because attending to the well-being of the disaster workforce is paramount. Another example would be how the TRN run by clinicians who work with adults needs to make special efforts to find or collaborate with clinicians who can fill the gap and work with children and adolescents. The general principle is to cultivate mindful awareness of the gaps in the system and seek collaboration with those who can address those gaps. These issues should bear consideration during disaster response whether or not the treatment is EEI, trauma-focused cognitive behavioral therapy (CBT), psychological first aid, or CISM.

Often, disaster response systems are set up in a way that favors those with more power and more resources—either through intentionally disproportionate resource delivery or through unintentional neglect. People of color are often more vulnerable to the consequences of ecological hazards (Faber & Krieg, 2002) or environmental disasters (Fothergill, Maestas, & Darlington, 1999). To alleviate suffering, we need to take special steps to be conscious of these issues and blind spots, and how they affect people in our communities, and develop treatment and intervention resources in a manner that promotes easy access for those who are marginalized.

Early EMDR Interventions: Tools for Psychological Second and Third Aid

As mentioned previously, using EMDR for disaster work is different than using it in a psychotherapy practice or health care setting. In EMDR psychotherapy, using the standard protocol, a client engages in EMDR to address the root experiences driving their present symptoms. To use a gardening metaphor, in standard EMDR therapy, you aim to remove an undesired plant that has sprouted up above the topsoil. The plant has an entrenched root system, which will allow it to sprout again and again, so you focus on addressing the roots. With EEI, the trauma or stressor is like a new seedling, easier to remove than an established plant. As in EMDR therapy, in EEI, the present-day stressor can range from highly problematic stressor to full-blown trauma, and the person’s developmental stage influences symptom presentation. However, although a past experience often lays the ground for the current stressor to start rooting, that past experience is not the focus of the work. Because of this, EEI is more contained and can be tolerated by a broader group of clients, done with very brief preparation work, and results in less defensive looping.

Because EEI does not delve into the past, it is typically six or fewer sessions and yet it provides strong, significant, enduring, symptom reduction (Acaturk et al., 2015; Jarero & Uribe, 2011, 2012; Konuk et al., 2006). In a comprehensive disaster response model, psychological first aid (PFA) would provide the first level of mental health intervention, and in a coordinated effort, those providing PFA could work in concert with an EEI operation. As noted, there are group versions of EEI, which are particularly suited for what could be termed *psychological second aid*, with individual EEI protocols making up the third level of intervention, or psychological third aid. In this type of structured and coordinated response, delineated by Carriere, Silver, and Farrell (2015) each level acts as screening and triage, determining who should be recommended to the next and more intensive form of care.

Interrupting Cycles, Improving Neighborhoods, and Fostering Resilience

As noted earlier, the United States has a long history of tension between uniformed officers, predominantly the police but also others, and marginalized communities. This history is a complex one with problems and needs on both sides. The assumption

of the authors is that although there may be instigators on both sides—people bent on taking their frustrations out on each other, and even people who feel they need to bait others or put them “in their place”—most people on both sides want a path that will lead to fewer conflicts and fewer tragedies. In our community of Boston, various steps taken by the police administration to address these issues have garnered praise and recognition (Pattani, 2015). They include simulation exercises, community policing, and ways to help police officers manage work-related stress, including CISM, EMDR therapy, and realistic scenario training, a form of expanded role play aimed at helping officers maintain calm physiology and thinking in threatening and dangerous situations (Grossman & Christensen, 2008).

Responding to this situation is one example of how TRNs can create initiatives to aid with small d disasters and Flannery’s hospital-based crisis intervention service, the Assaulted Staff Action Program (Flannery, LeVitre, Rego, & Walker, 2011) provides a model TRNs can draw from in trying to address these tense situations between police and community members. The transferable concepts in his work include attending to the community as a whole by offering services to all, understanding the interactions between physiological states of both groups, valuing the importance of secure attachments between both “sides,” and acknowledgement that clashes between the two groups are often fueled by trauma, misunderstandings, history, and a sense of duty to protect. Imagine a person questioned by police, who becomes so panicked that increasing heart rate causes a loss of fine motor skills while looking for identification. This behavior may inadvertently prompt a similar cardiac response in the officer. Anticipatory stress related to anger about or fear of racism or of what one will find on patrol duty, can further increase heart rate, impacting gross motor skills, causing seemingly irrational behaviors, and overriding more positive reactions. Violence between neighborhood residents can play out in a similar fashion. Reprocessing trauma with EMDR has been found to enhance vagal tone, reduce “sympathetic predominance,” and increase the likelihood of maintaining adroit decision-making skills in stressful situations (Sack, Lempa, & Lamprecht, 2007), and providing EEI to these community groups as part of nontraditional disaster response has the potential to interrupt these cycles. EEI initiatives with youth or other neighborhood groups who have been traumatized by police–community interactions gone wrong, or fears of the same, could go a long way to diffusing tensions.

Collaborating With Government Agencies and Community Workers

In the wake of the broad response to the 2013 Boston Marathon bombing and the subsequent events in Watertown, Cambridge, and Dartmouth, various reactions surfaced. There was a wide variety of free treatment offered, such as EEI through the Boston Area TRN, acupuncture and massage from others, and eventually many different types of offerings from the Resiliency Center which was dedicated to serving those affected by the bombing. Trauma specialists often say that the acute stress reactions of people who have experienced trauma are normal responses to abnormal circumstances. But for some communities, potentially traumatic events are chronic, almost daily features, making abnormal circumstances part of normal life. Many people residing in the Greater Boston area regularly cope with chronic violence in their communities. Many are still asking questions regarding the disparities in attention to and funding for recovery between those affected by the events of the Boston Marathon bombing and those affected by ongoing community violence (Barber, 2014; Bidgood, 2013). In response to this thread of criticism, the Boston Area TRN sought out partners and relationships that would facilitate initiatives aimed at addressing the little d disasters that occur in our communities on an ongoing basis.

Projects in Discussion

The collaboration between the BPHC Network and the Boston Area TRN is a promising example of incorporating EEI, along with other tools, into local urban government’s psychological trauma response infrastructure. The Network is managed by the Office of Public Health Preparedness at the BPHC and is a collaboration of organizations that have agreed to centralized coordination based on emergency management best practices. In addition to EEI, Network partners bring skills in psychological first aid, post-traumatic stress management, and CISM attuned to diverse urban populations and environments. The primary role of the Boston Area TRN in the Network is to provide EEI and facilitate EMDR training.

There are many opportunities for collaboration with NGOs and government agencies. The Boston Area TRN has had numerous conversations to this end; however, a feature of this work is that launching a project can be difficult despite interest and enthusiasm. One application of EEI with small d disasters that we discussed with the BPHC is with community workers. In Boston, there are many NGOs doing vital work in various neighborhoods: church-based drop-in

groups for people with trauma; groups that help with the work of setting up funerals, memorials, and burials after someone has died from community violence or tragedy; a group that brings therapy dogs into community events where tensions might run high; and those working with the homeless or the opioid epidemic—and all have staff doing vital but taxing work with marginalized residents.

We proposed that by treating the vicarious traumatization of community workers, TRNs could enable people who are crucial supports for their communities to build resilience, avoid burnout, and remain calm in high-stress situations. A similar proposal was discussed with an office of the Division of Children and Families (the body that investigates child abuse allegations and provides support to at-risk families). There has also been interest from youth groups in collaborating to address the trauma that results from street violence. Group EEI protocols are particularly suited to these types of initiatives because of their efficiency and capacity to help larger numbers of people than individual protocols and also because of the possibility of collaboration with paraprofessionals which further extends reach.

One of the avenues where the Boston Area TRN has started to make inroads with little d disaster work is by developing relationships with traditional African American church groups. Through relationships between our members and the African American ministers and pastors they know, the TRN has been invited in to church communities to offer “test runs” of EEI group protocols. One situation was with a small congregation that had suffered a schism, another was with the leadership of a larger congregation that had in a short window suffered losses of both a deacon and a member. Through offering retreat-style interventions with EEI, we allow a community to test out an EEI protocol in a calmer, non-Disaster context, and brainstorm other applications and collaborations we might devise for their members. Not only does this allow for the TRN to be called on for small d disasters, but when the next traditional Disaster hits, these communities have a direct connection to a TRN that can provide assistance. In terms of building the TRN workforce, initiatives like this enable clinicians to get trained and experienced in using EEI protocols in the field, putting them to good use on an ongoing basis, rather than waiting for the next big D Disaster to occur.

Additional benefits for these types of initiatives are numerous. We are currently exploring possibilities with the Boston Mayor’s Office of Resilience and Racial Equity to address the psychological trauma that

accompanies racism and how it affects those who are most vulnerable. This office was established through an international Rockefeller Foundation project to address resilience and climate change. With their recently launched blueprint (Boston Mayor’s Office of Resilience and Racial Equity, 2017), the Boston city government is focusing on addressing racism and how racism affects those most vulnerable to the impacts of climate change. A TRN, through treating small d disasters, simultaneously builds collaborative relationships with community workers and gatekeepers who really know their neighborhoods. Some of these people are mental health professionals and others are paraprofessionals. The former group includes some who will inevitably want to pursue EMDR training, thus diversifying the ranks of clinicians. The latter group is often trained in psychological first aid and can step into roles as emotional support personnel for group protocols. Both groups will be able to call on the TRN to address ongoing smaller scale community incidents and the TRN can call on them for large-scale disasters when the time comes. Expanding the toolboxes of community workers and natural gatekeepers (Macy et al., 2004) provides more flexibility in their work and can help them prepare residents for EEI or EMDR therapy, should they need that level of service. From an EMDR perspective, the work of EEI to treat those suffering from big D Disasters can be applied to ongoing incidents, or small d disasters, that affect a community caught in dynamics involving violence, trauma, and fear. The freedom from fear that can come with receiving EEI can help break the cycle of violence, build resilience, and establish a calmer homeostasis within neighborhoods.

Although most areas of the United States do not have an entity such as the BPHC’s Network in their public health departments—nor are they part of the 100 Resilient Cities project—creative thinking can birth similar, smaller scale interventions. A TRN could develop initiatives with a local domestic violence shelter, rape crisis unit, groups for the homeless, or refugee placement agencies. There are limitless possibilities for applying these principles with underserved populations and in so doing maintaining skills at the ready for the next disaster.

There is eagerness in marginalized communities for the tools that EMDR therapy and EEI offer; people are motivated to heal. And there is great satisfaction in working to improve access for diverse and marginalized populations and rectify the civil rights disparities. Many of the clinicians working with these populations understand the constant adversity of their day-to-day experiences. They have first-hand

experience with discrimination, threat, or fear of violence, being treated as “other” and “less than.” They know these are all traumas, that they take their toll, and that they are worthy of addressing as EMDR therapy targets. In building capacity for disaster work by training more clinicians who already work with marginalized communities, we build the capacity with clinicians who treat the everyday traumatic burdens of these communities and also have more clinicians ready for the next big D Disaster. The opportunity to make a difference in our own back yards is profound; we can build long-term collaborations with neighbors who want what we have to offer.

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