Post-Disaster Social Justice Group Work and Group Supervision

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PRACTICE

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This article discusses post-disaster group counseling and group supervision using a social justice orientation for working with post-disaster survivors from underserved populations. The Disaster Cross-Cultural Counseling model is a culturally responsive group counseling model that infuses social justice into post-disaster group counseling and group supervision. The importance and the methodology for incorporating ongoing intensive group supervision to support group counseling social justice interventions and related countertransference issues that emerge in traumatic situations will be presented.

In recent years the world has faced frequent natural disasters that include hurricanes, earthquakes, floods, fires, and cyclones. These disasters can create significant social, political, and economic upheaval that disrupts people's lives and displaces them from their homes. Disasters may result in death, disease and health concerns, shortages of shelter, food, water and sanitation, human trafficking, rape, murder, physical and sexual abuse, robbery, violence, and property destruction. Further complicating post-disaster situations, there may be a lack of a civil service system (e.g., law enforcement) that typically protects and provides order for individuals and communities (Saunders, 2007). One major outcome of these situations is

the significant psychological distress and trauma that comes in the wake of disasters. Although some people are able to positively cope during post-disasters, for others, research has found considerable post-traumatic stress disorder, anxiety, depression, and a diminishing sense of purpose or will to live (Dudley-Grant, Mendez, & Zinn, 2000; Norris, Perilla, & Murphy, 2001).

Traditionally psychological post-disaster work has been based on Western principles emphasizing individual counseling (Hobfoll, Briggs-Phillips, & Stines, 2003), while ignoring the larger social justice issues that accompany disasters (Bemak & Chung, 2008; Hobfoll et al., 2007), despite the collectivistic orientation of many of the affected communities. This was evident in the aftermath of Hurricane Katrina where people of color from poor areas received minimal or no support services, consistent with a history of sociopolitical racism, discrimination, and social injustices (Chen, Keith, Airriess, Li, & Leong, 2007), that are often more pronounced after a disasters. An important consequence of traditional post-disaster mental health interventions is that disenfranchised communities remain unserved or underserved (Chen et al., 2007; San Diego Immigrant Rights Consortium, 2007).

This article presents the Disaster Cross-Cultural Counseling (DCCC) model that focuses on providing group counseling to marginalized communities from a social justice perspective. Examples of the implementation of the DCCC Model in the United States (Hurricane Katrina and the San Diego Wildfires) and internationally (the earthquakes in Haiti and Costa Rica, Cyclone Nargis in Burma, and the Tsunami in Thailand) are presented, followed by a discussion on group supervision in post-disaster work. The article begins with a brief discussion on post-disaster psychological interventions followed by a discussion, and the implementation of the DCCC Model. It is important to note that since this article is a first step in linking group counseling and group supervision to post-disaster counseling and social justice work, there is limited empirical research in this area (Hobfoll et al., 2007).

DIMENSIONS OF PSYCHOLOGICAL INTERVENTIONS FOLLOWING DISASTERS

There are several key concepts that underscore post-disaster mental health work that have been identified by the U.S. Department of Health and Human Services (U.S. DHHS, 2003), which clearly differentiate post-disaster counseling from traditional psychological services. These concepts have been validated and are universal for all survivors, regardless of cultural background or

geographical location, and provide a distinction from traditional mental health counseling. The DHHS (2003) also offers a set of guidelines for culturally competent post-disaster counseling. The nine guidelines described below provide an important basis for post-disaster mental health counseling and the DCCC model. First, no one who sees a disaster is untouched by it. Second, the great majority of people is resilient and adequately handles the post-disaster experience, even though most people's effectiveness is reduced as a result of the disaster. Third, stress and grief are normal reactions to the unusual situation of a disaster and fourth, a great deal of the emotional response for survivors originates with the problems of everyday life that were caused by the disaster. Fifth, the majority of people do not see themselves as needing mental health support following a disaster and subsequently do not seek out counseling. Sixth, mental health support following a disaster does not follow traditional psychological practices and is oftentimes more practical than psychological in nature. Seventh, mental health practitioners must alter their interventions to adequately respond within the cultural context of communities where they are working, and eighth, mental health practitioners must actively do outreach in the communities in which they are working, setting aside traditional counseling methodology and avoiding mental health labels. Ninth, a critical element in recovery is the social support system.

Others also support the notion that group interventions offer the strongest means of protection against trauma and despair following a disaster (Herman, 1997) and that psychological interventions following disasters are fundamentally different from traditional clinical interventions (Phillips, 2009). This requires a redefinition of group counseling to include short term, and even one session, interventions. Conventional counseling does not adequately address the immediacy and critical need to manage post-disaster trauma and stress, nor does it focus on raising questions about the meaning and purpose of one's life. Following a disaster psychological defenses are disrupted, normal social support networks are frequently in chaos, and normally helpful connections to stabilizing life markers are severed. Furthermore, the sense of psychological and physical safety is shattered leaving one to reconstruct meaning, purpose, and relationships while taking care of basic survival needs. Thus, rather than psychotherapy objectives that aim toward changing personality and behavior, the goals of trauma work are to create psychological safety, stabilize, grieve, reconnect with oneself and others (Herman, 1997), generate hope and create a sense of future (Bemak, 1989; Bemak, Chung, & Pedersen, 2003), provide an opportunity to share the trauma with others, normalize the experience, and validate the trauma experience (Foy, Eriksson,

& Trice, 2001). Consequently, the emphasis in post-disaster counseling is on facilitating broader community-based interventions (deJong, 2002) focused on helping the survivors gradually understand and accept their situations, and cope with uncertainty, chaos, and the new realities of the disaster aftermath.

Given the personal, familial, and social upheaval created by disasters, there is an opportunity for flexibility and creativity in psychological interventions (Phillips, 2009). Simultaneously, there is a critical need to develop interventions that respond to the psychological realities and experiences in post-disasters, without being limited by traditional guidelines for counseling that are unrealistic in post-disaster situations, such as clearly defined times for counseling sessions, confidentiality, special private physical locations for counseling sessions, or clearly defined counselor-client boundaries. Group interventions, including single sessions, have been found to be highly beneficial in post-disaster work (Basoglu, Salcioglu, Livanou, Kalender, & Acar, 2005; de Jong, 2002; Goenjian et al., 1997; Hobfoll et al., 2007), despite the lack of uniformity of evidence-based best practices research (Gersons & Olff, 2005). Of particular note is the issue of confidentiality, which is a cornerstone and accepted standard in traditional counseling. In post-disaster situations, everything is disrupted, so that the usual standards of confidentiality may not be in place. Private space is typically difficult to find in the destruction following a disaster, so that frequently group counseling takes place in available public spaces rather than a private conference room or office. Given that the only location for group meetings is often a public one, other survivors frequently gather to listen and participate in group counseling sessions. In addition, suppositions about confidentiality are changed in collectivistic countries or cultures such as Haiti, Thailand, Costa Rica, or Burma, where there is a different value system. The dominant value is the group rather than the individual, making it an acceptable norm to speak more openly within the context of community or group. Even so, it has been suggested that the limits of confidentiality should be discussed with survivors (Myers, 1994).

Concern has been raised regarding the absence of an empirically driven set of clinical interventions for counseling in post-disaster situations (Foy, 2008), despite the significant demands and needs. As a result group therapists do not have guidelines about how to incorporate core group work principles (e.g., confidentiality, prescreening, group selection, client selection, ethics, leadership, not doing only single group sessions, etc.) into post-disaster work. Yet the power of universality, instilling hope, and altruism are strong variables in the healing process in post-disaster group counseling work. The authors

have found that even though survivors live in the same village, township, region, community, or temporary post-disaster camp site they are unaware of each other's disaster story. In the aftermath of a disaster there is total crisis, confusion, and devastation. In a desperate attempt to find family members and friends, trying to come to terms with personal loss and destruction, and concerns about survival, some of the collectivistic values becomes less prominent, resulting in a disconnect between survivors. Hence, there is often a lack of awareness of each other's disaster situations. The group process enables healing through reengagement by hearing each others' stories and realizing that others share similar experiences. Recognizing that others are having similar reactions is instrumental in normalizing survivors' responses to the disaster. This will be further discussed in the section on the DCCC Model below.

DISASTER CROSS-CULTURAL COUNSELING (DCCC) MODEL

DCCC is a model that provides culturally responsive post-disaster social justice group interventions (Bemak & Chung, 2008). The DCCC Model is consistent with the International Society for Traumatic Stress Studies and United Nations position of providing post-disaster support and services through a public health standpoint with brief targeted interventions (Yule, 2006) and the findings that show promoting social connections and contact is critical to recovery (Litz & Gray, 2002; Shalev, Tuval-Mashiach, & Hadar, 2004). The model also takes into account the vital need for understanding the historical, cultural, economic, political, and social dimensions of survivors' lives (Bemak & Chung, 2008; Goodman & West-Olatunji, 2009). The foundation of the DCCC Model is the nine DHHS guidelines that were discussed previously. The DCCC Model has five phases and offers a framework for group facilitators to assist disaster survivors to gain a sense of personal control and coping, and find psychological stability. Consistent with the U.S. position of the U.S. DHHS (2003) the model outlines how to respond and provide post-disaster counseling while being attuned and sensitive to survivors' cultural beliefs and values. It should be noted that the DCCC Model phases are not linear in nature, so that counseling may move in and out of various phases at different times in the counseling process. Figure 1 provides an illustration of the DCCC Model's five phases.

When counseling survivors it is critical to quickly engender a sense of safety and trust so that a warm, empathetic, and open approach is always used. To begin the group process, open questions such as "How
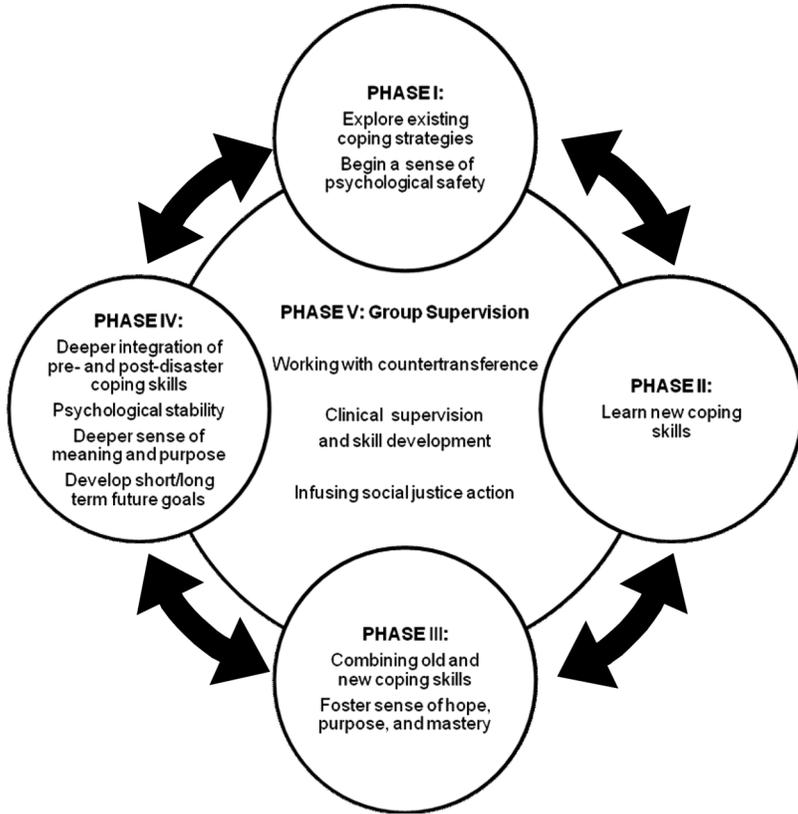
Figure 1   Disaster Cross-Cultural Counseling (DCCC) model.

is everyone doing?" consistently lead to an outpouring of feelings and a description of events and difficulties. In Phase I, survivors explore using existing coping skills to adapt and manage the post-disaster situation while beginning to feel psychologically safe. Therefore, it is important in this phase to create a comfortable and safe environment, stabilize the situation, acknowledge the crisis, and normalize survivors' reactions. Simultaneously, one must facilitate an understanding of the crisis, define the problem from a pragmatic and psychological standpoint, and encourage the utilization of previously established adaptive coping skills to generate feelings of control over one's life that will restore autonomous functioning. During this first phase critical counseling and communication skills, some of them unique to post-disaster counseling, are emphasized. In the authors' experience these skills include: active listening, problem definition, problem solution, establishing a post-disaster therapeutic partnership, active

comforting, heightened compassion, discussions about the limits of confidentiality, and follow-up survivor action steps.

During Phase II, new skills to handle the post-disaster realities are developed. The usual coping strategies may be ineffective after the disaster, necessitating that group workers explore new and alternative coping methods with survivors. An example of developing new skills is the formation of surrogate families and new communities as one way to cope with the loss of family members, as well as generating new social support networks and social connections conducive to healing. Another example is creating new healing rituals in collaboration with religious and spiritual leaders to address unique problems that emerge as a result of the disaster. For example, the authors helped promote the idea of developing new cultural mourning rituals when bodies of families and friends could not be located after the Tsunami and Cyclone Nargis, and traditional burials could not take place. Religious leaders agreed to create special healing ceremonies and practices to help survivors grieve their losses. It is important to note that in the authors' experience, religious and spiritual leaders have consistently been responsive to healing partnerships during times of post-disaster crisis.

Phase III involves combining the newly developed skills with prior coping strategies used in pre-disaster situations. This phase helps create a sense of hope, purpose, and mastery for the survivors with an integration of new and old coping skills. Through group counseling, the amalgamation of new and old coping skills helps promote psychological healing, a sense of universality, enhanced feelings of emotional stability and security, and the instillation of hope, all of which are crucial for successful adaptation to the new situation.

Phase IV involves a deeper integration of pre and post-disaster coping skills accompanied by psychological stabilization, acceptance of one's new circumstances and loses, understanding post-disaster realities, and an increasing sense of hope. Hope can be generated by "joining with rather than doing for," which promotes true empowerment and re-motivates survivors to build upon their strengths and cope with the post-disaster conditions (Hobfoll et al., 2007; Saltzman, Layne, Steinberg, & Paynoos, 2006). Simultaneously, the celebration of successes that contribute to physical security, psychological safety, and life events is an important part of the Phase IV. In this phase there is a combination of gaining a greater sense of meaning and purpose about oneself and the world, and clarity about rebuilding one's life, along with clearer ideas about managing the post-disaster situation. Short and long term future directions begin to come into focus during this phase. Thus, working in Phase IV the group worker must always offer and support a realistic sense of hope and future for

survivors, helping them to develop a clear sense of their own future and how to handle those realities.

The overarching dimension and foundation in the DCCC Model is Phase V, Group Supervision. Group supervision is critical throughout all phases of the DCCC model. Group supervision ensures group workers utilize appropriate clinical skills and interventions, and also is critical in addressing the impact of the disaster and post-disaster counseling on group counselors. Phase V will be discussed in detail in the next section on the implementation of the DCCC.

The DCCC model is underscored by an emphasis on social justice and an integration of these principles. Disenfranchised communities in post-disasters often experience a continuation of systematic oppression and discrimination. These communities are unable to meet basic social justice needs, receive services, access resources, or gain a sense of psychological and physical safety (Hobfoll et al., 2003). To address post-disaster injustices the DCCC emphasizes that group workers advocate for services that promote access and equity of resources and services (Bemak & Chung, 2008). By integrating social justice principles into post-disaster group counseling interventions, counselors can support survivors to become their own advocates, which is particularly important for populations with a history of disempowerment and marginalization. The right to protection and services can be proactively addressed within group counseling milieu. Hence, the DCCC is an ideal intervention for post-disaster situations providing interconnectedness and healing in difficult and severe situations.

IMPLEMENTATION OF THE DCCC

DCCC: Planning and Training

Preparation and planning are essential before entering a post-disaster situation. Given that post-disaster environments are always chaotic, it is crucial that there is a cooperative link with on-site organizations and agencies that can organize and plan the logistics of a counseling team visit prior to deployment. Prior invitations from on-site local organizations that plan the trip and establish up-front credibility are critical in reducing further chaos and confusion in post-disaster situations. Since there has been agreement that preparation and cultural competence are indispensable in post-disaster counseling (Halpern & Tramontin, 2007) it is important to carefully choose a mixed gender and inter-ethnic or inter-racial team with solid training and experience in group, multicultural, and social justice

counseling, who can adequately respond to the multiples needs and diversity within the post-disaster community. Team selection should also be based on flexibility, adaptability, openness, self-reliance, cooperativeness, and ethnic and gender diversity. Team members with multiple language abilities are a benefit to the team. For each of the disaster sites in which this model was applied by the authors (i.e., Hurricane Katrina, San Diego wildfires, and the Haiti earthquake) team selection was done by the authors. To supplement the teams' existing background, knowledge, and skills, there was an intensive training orientation that included: An overview of the DCCC model; a review of trauma symptoms and counseling; an overview about the disaster communities (e.g., legal and undocumented migrants, Native American, and Haitian communities); social justice issues (e.g., issues of mistrust based on years of discrimination, sociopolitical disempowerment, and neglect); cultural information; and appropriate culturally responsive counseling methodologies (e.g., the role and respect given to Native American elders, the importance of silence, and the speed and tone in speaking). In part and where applicable the training is based on the critical need for disaster group workers to have an understanding and awareness of issues related to biculturalism, and the conflict and ambivalence this may cause as it related to identity and functioning (Hernandez & Isaacs, 1998). This was evident in work with the Latina/o migrants in San Diego and the Gulf Coast, or the Native Americans in San Diego, who have roots in their cultures of origin, but must also negotiate how to survive in a different dominant culture. These issues may become exacerbated in a post-disaster situation.

Furthermore, in the training, as well as in working with survivors, it is important to emphasize that group workers always remember that they are the guests of the disaster communities or countries in which they are working. Therefore, group workers must be open and fully respectful of traditional cultural healing practices, such as Voodoo in Haiti, and not perpetuate what we have called *psychological colonialism* by imposing Western values and practices that are culturally insensitive.

Comparatively, working in developing countries, such as Burma, Haiti, and Thailand, there are typically no trained mental health professionals, but rather locally based staff working in international organizations. Given the lack of formal training in these situations, an intensive 2 week culturally appropriate counseling skills training program emphasizing group work, trauma symptoms, intervention strategies, social justice principles, and the DCCC Model was developed and presented through carefully selected regional bilingual and bicultural translators.

DCCC Group Counseling Interventions

Since post-disaster situations are not "normal," group counseling and interventions are done differently to adapt to these circumstances. Both the international and national post-disaster settings required innovative interventions that are rooted in community-based on-site group work. These interventions require group workers to be proactive without defined times to conduct groups and to sometimes hold groups in available public spaces. Hence, the DCCC necessitates that group counselors are flexible and creative regarding how and where group counseling is done. For example, after Katrina, the Disaster Relief Center (DRC) sites were housed in school gyms or empty Kmart stores, where the survivors waited in line for resources, such as food, water, trailers, housing, medicine, etc. Some waited for hours and even days. At times, survivors were invited to join in group discussions while waiting in line, or their children were invited, with parental permission, to join the children's support group in another area of the DRC. A typical opening was to approach individuals or families who were standing or sitting in the post-disaster reconstruction area and ask how they were doing, and if they would like to join the group discussion. Once the group worker established rapport, they would slowly engage others who were also waiting by asking and encouraging them to join in and share their experiences. This approach is consistent with the outreach work mentioned in the U.S. DHHS (2003) guidelines, and resulted in numerous small group counseling sessions being formed.

Similarly in Haiti, group counseling was done in make-shift tent camps where survivors were housed. When depressed survivors refused to leave their cots, group work was done around the depressed survivor's cot with numerous other camp residents coming around to watch, and oftentimes joining in the conversation, thus becoming members of the group. In other instances, there was nowhere to meet in the tent camps, so group workers would find empty cots and begin group counseling with survivors sitting on several cots. Unlike traditional group counseling methods, where group members may be preselected and screened, groups were oftentimes formed spontaneously in tent camps, on lines waiting for food, or in open spaces. Even so, participants were always asked for their permission and agreement to talk and share about their experiences. Survivors were not forced or coerced to participate in group counseling, but rather invited to join in the group sessions, participating only by choice.

Many survivors welcomed the opportunity to talk with others, disclosing that this was the first time they had an opportunity to share their experiences in a safe environment. Given the nature of post-disaster situations, confidentiality issues become secondary,

since last names were never used, and group counseling was initiated within the context of the emergency situation, rather than in a formal setting. Sessions ranged from 20 to 90 min depending on the need and time survivors were available and usually involved only one session. In the Haitian tent camps, individuals with more serious mental health problems were identified by camp leaders, and groups gathered around the cot of the individual with their permission. Rapport was established within minutes and group members opened up very quickly, which is fairly common in these situations. As survivors began to tell their stories, it became clear to the group participants that their reactions to the disaster were normal and shared by many others. The nine key universal concepts described earlier were evident, e.g., everyone was affected, most people were resilient in handling the aftermath of the earthquake, group counseling helped normalize stress and grief reactions, strong emotions were evident, individuals did not seek out counseling (but welcomed it), group interventions were designed to fit the circumstances, culture provided an important context for responsive group counseling interventions, and social support was critical in the groups and recommendations for follow-up. Combined with these concepts were curative factors which quickly surfaced. Universality, altruism, cohesion, catharsis, interpersonal learning, existential factors, love, and the instillation of hope became rapidly evident within the groups, with groups very quickly going through the initial stage (getting acquainted and establishing trust), and almost immediately entering the working stage (generating cohesion and being productive).

After survivors shared their stories, group discussions evolved into talking about pre-existing coping strategies (DCCC – Phase I), and explored new ways to handle the disaster situation with survivors sharing new ideas for coping (DCCC – Phase II). This resulted in helping each other with suggestions, information, advice, social justice issues, and building hope (DCCC – Phases II to IV). An example of operationalizing the different DCCC phases was illustrated in the Gulf Coast after Katrina, when a group facilitator approached a White man and his mother sitting in line for housing. As they were sharing their struggles an African American woman sat down next to them. The group facilitator asked the African American woman how she was doing and invited her to join in the conversation with the man and his mother. Shortly after, a Vietnamese woman sat down and was invited to share her story. The group talked about their post-disaster fears, concerns, losses, the racial tensions in the community, and shared with each other their strategies for coping, all the while giving each other hope and support (Bemak & Chung, 2008).

DCCC Social Justice Group Interventions

Making connections with disenfranchised and marginalized populations is challenging under any circumstances, but especially difficult in post-disaster work. Group workers must address a lifetime of social justice issues, such as, distrust, discrimination, poverty, and skepticism, to make a connection with survivors. Survivors already know why counselors are there—the stranger who shows up uninvited, expecting to help them deal with their devastation and pain. Following a disaster it is essential that group workers do not promulgate "mental health colonialism" and interventions that lead to "sustained dependency" in vulnerable communities. Rather the DCCC Model emphasizes "joining not doing," so that authentic empowerment through individual and community rebuilding can take place through the powerful mechanism of culturally responsive group counseling. The DCCC intervention becomes a partnership in survival and healing that leads to self and community reliance.

Often, school and community counselors living and working in the disaster region are also severely impacted by the disaster, causing high levels of personal distress. Furthermore, they often lack cultural competencies to provide post-disaster counseling (Mollica et al., 2004), as well as skills and training specific to these situations. Given the high demand for counseling, school and community mental health professionals from other regions are frequently deployed to provide services. Even so, they are not always prepared to work in post-disaster situations, or be culturally responsive. For example, after Katrina, FEMA (Federal Emergency Management Agency) established a counseling booth in the DRCs and erected a big sign with the words "*Crisis Counseling.*" No one came. This issue was discussed during the DCCC group supervision pointing out the cultural stigma towards "crisis counseling." The next day the DCCC counselors took down the FEMA sign and replaced it with "*Stress Support.*" With the new sign being culturally acceptable the stigma was removed and many survivors came to the booth for help. The lack of cultural responsiveness and sensitivity in this instance was evident. Partnerships were further cultivated when one of the DCCC group supervisors attended daily meetings with state officials to advocate for mental health services for survivors (Bemak & Chung, 2008).

It is essential that group facilitators are aware of their clients' life experiences, since some survivors wanted to share their stories about the years of historical sociopolitical injustices that were reignited by post-disaster survival. In Haiti, for example, survivors constantly referred to their frustration and anger with the historical injustices of the government, while in the Gulf Coast there was tremendous

anger at the lack of response by the federal government. It is critical in the DCCC Model to acknowledge the entire experience of the survivors, including their past. Group workers must truly demonstrate active listening and be present on a deeply personal level, to care in ways that others have not cared, to be genuine and authentic, and most of all to be aware, understand, accept, and acknowledge the depth and roots of frustration, anger, and pain that are linked to a cultural, historical, economic, and sociopolitical context (Bemak & Chung, 2008; Goodman & West-Olatunji, 2009).

Hence, the importance of a pre-intervention orientation for group leaders regarding the historical and current cultural, socioeconomic, and political situation both locally, regionally, nationally, and sometimes even internationally cannot be overstated. For example, the wildfires destroyed large segments of the American Indian community in California. Given the knowledge about cultural sensitivity embedded in the DCCC Model, requests were made to the authors to approach the Council Tribal leaders. When the group workers approached the American Indian Tribal Council leaders in San Diego and asked permission to work on the reservation, one of the leaders commented, "We are used to devastations." This was a profound remark, rooted in centuries of history, and political and modern day sentiment at that reservation. During the meeting with the Tribal Council it became clear that there was an understanding, appreciation, and respect for Indian culture and values by the DCCC team leaders, which resulted in an invitation to work on the reservation.

A creative example of DCCC group counseling was evident at an American Indian Tribal school. Initially, teachers and students were ambivalent about counseling from outsiders, yet open since the Tribal Council had extended an invitation. This prompted discussions in supervision that focused on ways to build creative connections and establish rapport. So, instead of traditional ways of building rapport and making connections, the group workers shared earphones filled with hip hop music, played basketball, engaged in playful lunch room banter, played touch football, or fist bumps followed by "what's up?" Creating trust and relationships in these ways led to profound group discussions about social justice issues and associated issues of disaster, racism, discrimination, hurt, loss, and hope.

Another example was in a San Diego border town that had been destroyed by the fires. One African American and two Latino middle school boys came for a group counseling meeting facilitated by a White male that was being held outside under a tree in the school yard. The boys were joking and laughing with each other with clearly no intent of sharing anything serious. They wrestled with each other, ran around pushing each other, happy to be outside and out of class.

Sitting on the grass, the counselor began joking about their wrestling moves. Suddenly, one boy asked the counselor if he was here to talk about the fires. The counselor said, "Yes," then the jokes continued. During the next few minutes, each boy made a sarcastic remark about the police and the border patrol, prompting a comment from the facilitator that they sounded angry with the authorities. They froze momentarily, walked over and sat down next to the counselor with their heads down. Over the next 30 min in a heartfelt way, prompted by probing questions from the counselor, the group talked about how frightening the fires had been, what they had lost, and how they were still afraid. Quietly encouraged by the group counselor to share their stories, they spoke eloquently with humor and sadness about their respective struggles to be accepted and valued; sharing how the fires had magnified their feelings of marginalization as ethnic minorities, and the difficulty they felt as impoverished students of color. The counselor listened carefully, at times asking for clarification or more details, and encouraged the boys to find commonality and respond to each others' experiences. As the meeting drew to a close, the boys shared that they felt understood. Standing to leave, one boy commented to the counselor, "I know not all White people are bad," illustrating the importance of cultural competence in working across racial and ethnic lines. Critical social justice issues of discrimination, poverty, cultural diversity, and historical oppression, as well as coping strategies and support were all explored within the group.

Internationally, the DCCC Model was implemented in tent camps in Haiti and Costa Rica, and villages in Burma and Thailand. In group discussions similar to those in disaster settings in the United States, survivors disclosed that they had not had an opportunity to talk about their experiences. One man shared with the group that he had lost his entire family. Another woman talked about losing five of her six children. Many talked about their nightmares, and fear of bad or evil spirits. One man disclosed how he blamed himself for not holding on to his younger sister tighter before she was swept away by the waves. Another woman tearfully recounted how she wasn't able to pull her daughter from the rubble after the earthquake. These powerful experiences created a sense of shared pain and loss among survivors, and prompted both practical and psychological support through the group process. The group counselors also shared about their team's efforts to address injustices and improve conditions. This involved advocating to United Nations officials, meeting with key administrators, and submitting reports with recommendations to major organizations for providing humanitarian assistance. The efforts by group workers had tremendous significance for survivors, creating a sense of hope and appreciation. Thus, the group interventions created awareness

and action for survivors and their communities that related to personal and social justice concerns and advocacy work.

Finally, in the groups, attention had to be paid to the survivors' concerns with basic human needs, such as, physical safety, food, shelter, medicine, clothing, and protection from violence and abuse. The presence of group counseling in these marginalized communities, and addressing these critically basic needs and issues gave the message to survivors that they were not forgotten, and that their concerns were being heard, and in many instances addressed.

Three Components of DCCC Social Justice Group Supervision

Under the DCCC model post-disaster clinical group supervision must go beyond traditional clinical supervision and skill development, with special attention to issues of countertransference, especially given the survivor's intense and continuous stories of trauma, loss, pain, and anger. It is essential that group facilitators have a safe place where they can debrief and process what they have heard, witnessed, and experienced. The three components to the DCCC group supervision are: (1) Personal Healing and Working with Countertransference; (2) Group Counseling Clinical Supervision, and Skill Development; and (3) Infusing Social Justice Action.

The first component, *Personal Healing and Working with Countertransference,* creates room for psychologically safe discussion and processing. For example, in Haiti group workers saw thousands of building and homes destroyed with bodies buried in the rubble, while in Thailand and Burma, they regularly saw multiple corpses and animal carcasses after the disaster. Given the gravity of what group counselors observed, coupled with the deeply painful stories that they heard in the groups, a significant aspect of supervision was spent on processing their experiences and coming to terms with their own horror, pain, survivor's guilt, and sadness.

In San Diego and the Gulf Coast group counselors witnessed racism, inequalities, unfair treatment, and lack of assistance to ethnic and low income communities. Furthermore, working with the migrant communities close to the Mexican border, counselors witnessed U.S. Border Patrol randomly stopping survivors (including counselors of color from the DCCC team) to check if they were undocumented. This situation created political countertransference and subsequently strong reactions by some of the counselors (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008), which were further influenced by media images of undocumented people. Group supervisors must have awareness and understanding of such post-disaster social justice

issues to efficiently provide supervision with group facilitators about how to effectively address these issues.

The second component of DCCC social justice group supervision, *Group Counseling Clinical Supervision and Skill Development,* is essential in employing advanced clinical skills specific to post-disaster work. Difficult clinical issues that were rooted in working with trauma, loss, sadness, anger, and hope constantly emerged in the groups and required careful and skilled supervision. In addition, it is important to attend to the unique dimensions of post-disaster counseling, and carefully discuss and distinguish differences with traditional group counseling, such as, establishing a post-disaster therapeutic partnership, active comforting, heightened compassion, follow-up survivor action steps, time boundaries, confidentiality, meeting in public open spaces, and boundaries around counselor-client relationships.

Simultaneously, it is important to attend to the third component of social justice supervision, *Infusing Social Justice Action,* so that group counselors can help to change and attend to social injustices experienced by clients. Discussions about what actions are being taken or can be taken to rectify post-disaster injustices help contribute to a sense of empowerment in what often feels like a hopeless situation for both the survivors and group counselors. For example, in both national and international situations group counselors were encouraged by supervisors not only to verbally share information with survivors about resources, services, and how to locate family members, but also to distribute a resource list (translated into appropriate languages) with this information. In areas with high illiteracy, social networks were tapped so that family members, friends, and neighbors were asked to help read the information packet. Given the intensity and demands of post-disaster group counseling these three components were addressed in group supervision meetings at the end of every day, 7 days a week, for 2 to 3 hr. In Haiti, an in-depth report about effectively addressing the social justice problems encountered by many of the survivors was submitted to the nongovernmental organization (NGO) who organized the trip and the funding agency. Amazingly, rather than being fatigued or tired, social justice group supervision reinvigorated group counselors and helped them feel supported, and to regain a sense of purpose and hope with an eagerness to face the next day.

CONCLUSION

In summary, we suggest that the DCCC social justice group work and supervision model is helpful in the healing that needs to take place with disenfranchised and marginalized populations following

disasters. This was evident in the continuous self reports received from survivors in both national and international settings, and the frequent requests for return visits for additional counseling of the DCCC teams. The DCCC Model offers a framework for powerful sharing on multiple levels, and provides an avenue in post-disaster situations to discuss, in groups, concerns about personal, family, community, and social justice needs. The model promotes group and community healing during a very difficult time in a culturally responsive manner. The DCCC Model also emphasizes the importance of group supervision in promoting social justice, healing, clinical skills, and development. It is recommended that evidence-based research be conducted to further evaluate the efficacy of the Model. Studies could examine the usefulness of group counseling in relationship to decreasing trauma and high levels of stress and anxiety, as well as evaluating the cultural appropriateness of the interventions. In addition future studies may look at the worth of single group sessions, as well as the impact of confidentiality or lack of confidentiality on group interventions.

REFERENCES

Basoglu, M., Salcioglu, E., Livanou, M., Kalender, D., & Acar, G. (2005). Single-session behavioral treatment of earthquake-related Posttraumatic Stress Disorder: A randomized waitlist controlled trail. *Journal of Traumatic Stress*, *18*, 1–11. doi: 10.1002/jts.20011

Bemak, F. (1989). Cross-cultural family treatment with Southeast Asian refugees. *Journal of Strategic and Systemic Therapies*, *8*, 22–27.

Bemak, F., & Chung, R. C.-Y. (2008). Counseling disaster survivors: Implications for cross-cultural mental health. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (6th ed., pp. 325–340). Thousand Oaks, CA: Sage.

Bemak, F., Chung, R. C.-Y., & Pedersen, P. B. (2003). *Counseling refugees: A psychosocial approach to innovative multicultural interventions*. Westport, CT: Greenwood Publishing.

Chen, A. C.-C., Keith, V., Airriess, C., Li, W., & Leong, K. (2007). Economic vulnerability, discrimination, and Hurricane Katrina: Health among Black Katrina survivors in Eastern New Orleans. *Journal of the American Psychiatric Nurses Association*, *13*, 257–266. doi: 10.1177/1078390307307260

Chung, R. C.-Y., Bemak, F., Ortiz, D. P., & Sandoval-Perez, P. A. (2008). Promoting the mental health of migrants: A multicultural-social justice perspective. *Journal of Counseling and Development, Multicultural and Diversity Issues in Counseling Special Issue*, *38*, 310–317.

de Jong, J. T. V. M. (2002). Public mental health, traumatic stress and human rights violations in low-income countries. In J. T. V. M. de Jong (Ed.), *Trauma, war and violence: Public mental health in sociocultural context* (pp. 1–91). New York, NY: Plenum-Kluwer.doi: 10.1007/b109606

Dudley-Grant, G. R., Mendez, G. I., & Zinn, J. (2000). Strategies for anticipating and preventing psychological trauma of hurricanes through community education. *Professional Psychology Research & Practice*, *31*, 387–392. doi: 10.1037/0735-7028.31.4.387

Foy, D. W. (2008). On the development of practice guidelines for evidence-based group approaches following disaster. *International Journal of Group Psychotherapy*, *58*, 567–574. doi: 10.1521/ijgp.2008.58.4.567

Foy, D. W., Eriksson, C. B., & Trice, G. A. (2001). Introduction to group interventions for trauma survivors. *Group Dynamics: Theory, Research and Practice*, *5*, 246–251. doi: 10.1037/1089-2699.5.4.246

Gersons, B. P., & Olff, M. (2005). Coping with the aftermath of trauma. *British Medical Journal*, *330*, 1038–1039. doi:10.1136/bmj.330.7499.1038

Goenjian, A. K., Karayan, I., Pynoos, R. S., Minassian, D., Najarian, L. M., Steinberg, A. M., & Fairbanks, L. A. (1997). Outcome of psychotherapy among early adolescents after traima. *American Journal of Psychiatry*, *154*, 536–542.

Goodman, R. D., & West-Olatunji, C. A. (2009). Applying critical consciousness: Culturally competent disaster response outcomes. *Journal of Counseling & Development*, *87*, 4584–465.

Halpern, J., & Tramontin, M. (2007). *Disaster mental health: Theory and practice*. Belmont, CA: Thompson Brooks/Cole.

Herman, J. (1997). *Trauma and recovery*. New York, NY: Basic Books.

Hernandez, M., & Isaacs, M. (1998). *Promoting cultural competence in children's mental health services*. Baltimore, MD: Paul H Brookes Publishing.

Hobfoll, S. E., Briggs-Phillips, M., & Stines, L. R. (2003). Fact or artifact: The relationship of hope to a caravan of resources. In R. Jacoby & G. Keinan (Eds.), *Between stress and hope: From a disease-centered to a health-centered perspective* (pp. 81–104). Westport, CT: Praeger.

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J. . . . Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry*, *70*, 283–315. doi: 10.1521/psyc.2007.70.4.283

Litz, B. T., & Gray, M. J. (2002). Early intervention for mass violence: What is the evidence? What should be done? *Cognitive and Behavioral Practice*, *9*, 266–272. doi: 10.1016/S1077-7229(02)80019-0

Mollica, R. F., Lopes Cardozo, B., Osofsky, H. J., Raphael B., Ager, A., & Salama, P. (2004). Mental health in complex emergencies. *The Lancet*, *364*, 2058–2067.

Myers, D. (1994). *Disaster response and recovery: A handbook for mental health professionals*. DHHS Pub. No. (SMA) 94-3010. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health & Human Services.

Norris, F. H., Perilla, J. L., & Murphy, A. D. (2001). Post disaster stress in the United States and Mexico: A cross-cultural test of the multicriterion conceptual model of posttraumatic stress disorder. *Journal of Abnormal Psychology*, *110*, 53–63. doi: 10.1037/0021-843X.110.4.553

Phillips, S. B. (2009). The synergy of group and individual treatment modalities in the aftermath of disaster and unfolding trauma. *International Journal of Group Psychotherapy*, *59*, 85–104. doi: 10.1521/ijgp.2009.59.1.85

Saltzman, W. R., Layne, C. M., Steinberg, A. M., & Pynoos, R. S. (2006). Trauma/grief focused group psychotherapy with adolescents. In L. A. Schein, H. I. Spitz, G. M. Burlingame & P. R. Mushkin (Eds.), *Psychological effects of catastrophic disasters: Group approaches to treatment* (pp. 669–730). New York, NY: Haworth.

San Diego Immigrants Rights Consortium, Justice Overcoming Boundaries of San Diego County & ACLU of San Diego & Imperial Counties. (2007). *Firestorm: Treatment of vulnerable populations during the San Diego fires*. Retrieved from http://www.immigrantsandiego.org/Fire.html

Saunders, J. (2007). Vulnerable populations in an American Red Cross shelter after Hurricane Katrina. *Perspectives in Psychiatric Care*, *43*(1), 30–37. doi: 10.1111/j.1744-6163.2007.00103.x

Shalev, A. Y., Tuval-Mashiach, R., & Hadar, H. (2004). Posttraumatic Stress Disorder as a result of mass trauma. *Journal of Clinical Psychiatry*, *65*, 4–10.

U.S. Department of Health and Human Services. (2003). *Developing cultural competence in disaster mental health programs: Guiding principles and recommendations*. DHHS Pub. No. (SMA) 3828. Rockville, MD: Center for Mental Health Services and Substance Abuse and Mental Health Service Administration.

Yule, W. (2006). Theory, training, and timing: Psychosocial interventions in complex emergency situations. *International Review of Psychiatry*, *18*, 259–264. doi: 10.1080/09540260600656134