CHAPTER

Counseling Disaster Survivors

Implications for Cross-Cultural Mental Health

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Primary Objective

- To assist mental health practitioners in understanding and providing cross-culturally responsive counseling in disaster situations by providing an intervention model (the Disaster Cross-Cultural Counseling Model)

Secondary Objectives

- To provide an overview of emergency relief disaster counseling
- To examine cross-cultural considerations in providing counseling to disaster survivors
- To become familiar with guidelines for implementing the Disaster Cross-Cultural Counseling Model

IN RECENT YEARS, THE WORLD HAS FACED NUMEROUS NATURAL AND HUMAN-INDUCED DISASTERS THAT have caused serious disruption and displacement of hundreds of thousands of people. These events consisted of the attacks on September 11, 2001; the tsunami in South Asia; hurricanes such as Katrina and Rita in the United States and the Caribbean; earthquakes in China, Japan, Afghanistan, and Pakistan; and conflict in Darfur. For example, there has been an ongoing conflict in the Darfur region of western Sudan since February 2003 where approximately 300,000 have lost their lives. There has

been systemic and wide-scale ethnic cleansing, murder, rape, torture, and enslavement (Amnesty International, 2006), resulting in significant death, destruction, family disruption, and migration. These and other disasters have displaced and dislodged people from multiple cultures, races, ethnicities, and socioeconomic classes, requiring an immediate humanitarian aid in the form of basic shelter, food, housing, sanitation, water, security, and medical services.

In addition to meeting the core basic needs, there are significant psychological issues encountered by survivors of disasters as they attempt to rebuild and reconstruct their lives, demanding a critical mental health response. These mental health issues can be far-reaching and may be needed even years after the disaster had occurred. The scale, magnitude, and quantity of the global disasters across different cultures necessitate a different type of response for different times that is culturally sensitive and responsive, particularly given the voluminous need for mental health assistance from diverse cultural groups and the reality of limited resources.

This chapter examines the growing contemporary need for culturally responsive mental health interventions with disaster survivors. The chapter begins with a brief overview of emergency relief counseling, followed by a presentation of the Disaster Cross-Cultural Counseling Model (DCCC). The DCCC is a cross-cultural model that incorporates a holistic approach examining issues within an ecological, sociological, cultural, economic, political, and psychological context of social justice and equity as a core aspect of disaster counseling. Sixteen key issues in culturally responsive disaster counseling that are applicable using the DCCC model in different types of disasters will be presented. The chapter concludes with a description of five case study critical incidents exploring the implementation of the DCCC and the impact of race, ethnicity, and class on mental health disaster counseling. The term *survivors* will be used throughout the chapter rather than *victims.*

OVERVIEW OF EMERGENCY RELIEF DISASTER COUNSELING

Given the degree of devastation that results from a disaster, it is evident that survivors will experience a multitude of psychological problems, including posttraumatic stress disorder (PTSD), anxiety, and depressive symptoms, such as sadness, hopelessness, feelings of being overwhelmed, and the lack of emotional and physical energy (Dudley-Grant, Mendez, & Zinn, 2000; Norris, Perilla, & Murphy, 2001). Symptoms may vary for each individual and manifest in different ways. Some also experience sleep disturbances that are oftentimes accompanied by nightmares that are fraught with the images of the disaster; anxiety about relocating and one's current living circumstances, which are often temporary and crowded; a need to talk about one's personal experience related to the disaster; concerns about feeling part of the community and its recovery; fear and anxiety about personal and physical safety and those of loved ones; grief over loss of loved ones and pets; and profound losses of valued and meaningful possessions. Disasters, such as hurricanes, can provoke anxiety in individuals that may be triggered by changes in the weather and the recurring fear of being vulnerable to environmental forces beyond one's control. There may also be difficulties in concentrating and completing tasks and dealing with demands of being self-reliant and strong (Dudley-Grant et al., 2000), with a heightened sense of guardedness and anxiety about whether one's life could return to a normal routine. Some may feel that they have been overlooked or ignored by media and federal agencies, such as the case in the Mississippi Gulf Coast after Hurricane Katrina where survivors felt that the media concentrated primarily on New Orleans during and after the hurricane.

Studies (e.g., Jones, Frary, Cunningham, Weddle, & Kaiser, 2001; Pfefferbaum, 1997) have found that the degree of PTSD experienced by disaster survivors is influenced by multiple variables. These

variables are divided into three general categories: (1) individual characteristics, such as age, gender, race/ethnic, trait anxiety, history of mental illness, developmental level, family characteristics, cultural factors, attribution style, and coping strategies; (2) the emotional experience and response during and after the event (e.g., positive vs. negative); and (3) the severity of physical damage to property, injury to or death of loved ones and/or friends, and the level of exposure of the individual to the event.

Ethnic, racial, and cultural differences in PTSD have also been found. One of the first studies that compared two communities after a disaster from two different countries (California, USA, and Chile) found that the Chileans reported more PTSD symptoms than their Californian counterparts (Durkin, 1993). Other studies found that African Americans and White females were more likely to exhibit PTSD and comorbid symptoms when compared to White males (March, Amaya-Jackson, Terry, & Constanzo, 1997). Results differ when comparing children across ethnic and racial groups, with White children more susceptible to distress than African Americans (Jones et al., 2001). It was suggested that these results were attributed to factors such as acculturation, socioeconomic status, and coping strategies.

THE DISASTER CROSS-CULTURAL COUNSELING (DCCC) MODEL

In the days, weeks, months, and sometimes years after a disaster, the common types of problems encountered by survivors are related to day-to-day living. Issues such as transportation; not being able to locate a missing loved one; the loss or death of family, friends, and pets; unemployment; loss of child care; inadequate temporary housing accommodations; filling prescriptions; and loss of medicine, eyeglasses, hearing aids, and so on all contribute to psychological problems. These problems are exacerbated by the loss of legal papers and important documents, including birth certificates and medical, school, and employment records, thus impeding the following: applying for medical, health, and financial benefits; proving citizenship; applying for housing; securing loans; and accessing social services and other types of assistance.

Mental health professionals must emphasize daily challenges in disaster work rather than immediately delving into deeper psychological issues. We would suggest a three-phase DCCC model, based on Bemak's (1989) psychosocial adjustment developmental model for refugees. For each phase of the DCCC, culturally responsive interventions are employed. In Phase I, counselors and psychologists assist disaster survivors to use existing skills to master the new environment and feel psychologically safe. During Phase II, there is an integration of formerly used skills with newly developed skills to handle the postdisaster situation, followed by Phase III, where there is stabilization and mastery over the postdisaster circumstances that are accompanied by increasingly successful adaptation. During Phase III, there is a growing sense of hope about the future and the ability for the disaster survivors to examine future goals and directions for themselves and their loved ones. It is important that mental health professionals are clear about the continuum of postdisaster adjustment within the culturally responsive framework of the DCCC. In summary, the DCCC begins with an initial priority of basic survival, life, and safety needs that facilitates stabilization and an equilibrium that allows coping and adaptation. This, in turn, leads to the ability to integrate past and present and build toward future goals and directions.

Given the degree of devastation, survivors often become disorganized in their planning and thinking. They are overwhelmed and may become unproductively overactive. Mental health professionals can assist survivors in the DCCC Phrase II by guiding survivors through problem solving and assist with prioritizing and focusing on specific goals and action, keeping in mind the cultural context. Identifying and selecting one immediate problem that is relatively solvable provides a beginning step that assists in bringing back a sense of control and confidence in survivors. It is also important to

assess survivors' functioning and coping and identify issues such as PTSD and suicidal ideation, while at the same time evaluating available resources and social support networks.

Implementing the DCCC

Cross-cultural disaster counseling requires culturally sensitive interventions that involve cross-cultural empathy (Chung & Bemak, 2002), guiding and encouraging clients to tell their stories and share their feelings, and active listening whereby the mental health professional is open and receptive to clients' painful stories and disaster experiences. This can be done in relief centers, shelters, schools, mental health facilities, or other private or public facilities. It is important to skillfully coalesce active listening without judgment, intervention, or interpretation (Dudley-Grant et al., 2000). This allows for silence and interventions that facilitate the telling of one's story. Concurrently, it is important to attend to nonverbal cues that may elicit deeper feelings and be able to unobtrusively reflect on feelings, thereby encouraging emotional expression, consistent with prior research that links catharsis to healing (Bemak & Young, 1998). This is of utmost importance in cross-cultural communication where there may exist inherent distrust by clients to self-disclose to a mental health professional from a different racial or ethnic background.

Some examples of helpful interventions include the following: "these are normal reactions to a disaster," "it is understandable that you feel this way," "you are not going crazy," "it wasn't your fault," "you did the best you could," and "things may never be the same, but they will get better and you'll feel better" (Substance Abuse Mental Health Services Administration [SAMHSA], 2006), which normalize reactions to the disaster. It is critical to note that the impulse by mental health professionals to try to "fix" the survivors' painful situation or "make" survivors feel better may in fact backfire and result in feelings of being discounted, misunderstood, or further alienated. Common errors in disaster counseling include interventions such as the following: "it could have been worse," "you can always get another pet/car/home," "it's best if you just stay busy," "I know just how you feel," or "you need to get on with your life" (SAMHSA, 2006). When statements such as these are made in cross-cultural counseling situations, they may be construed as patronizing or insensitive.

Disaster survivors may experience PTSD. The American Counseling Association (2005) has suggested 10 ways to recognize PTSD: reexperiencing the event through vivid memories or flashbacks; feeling "emotionally numb"; feeling overwhelmed by what would normally be considered everyday situations and diminished interest in performing normal tasks or pursuing usual interests; crying uncontrollably; isolating oneself from family and friends and avoiding social situations; relying increasingly on alcohol or drugs to get through the day; feeling extremely moody, irritable, angry, suspicious, or frightened; having difficulty falling or staying asleep, sleeping too much, and experiencing nightmares; feeling guilty about surviving the event or being unable to solve the problem, change the event, or prevent disaster; and feeling fear and a sense of doom about the future. In disasters, the depth of these reactions has the potential to create highly charged interpersonal dynamics in cross-cultural settings. In our experience, given the heightened sensitivity during a disaster and associated feelings and high levels of vulnerability, interventions create the strong possibility to promote a significant cross-cultural interpersonal connection based on a shared humanity, or they may promote a greater divide between mental health professionals and clients when differences are accentuated. It is a moment of intervention that requires maximal cross-cultural sensitivity and awareness, especially in times of acute distress, fear, and anxiety.

In addition, mental health professionals need to know the suicide warning signs. If a client is threatening or hinting at hurting or killing himself or herself; looking for or seeking access to firearms, pills,

or other items that could be harmful; talking or writing about death, dying, or suicide; expressing feelings of hopelessness; or sharing feelings of rage or uncontrolled anger, all of these could be signs of suicide or potential violence. Other indications may include seeking revenge, acting reckless or engaging in unseemly risks, expressing feelings of being trapped with no escape, increasing the use of alcohol or drugs, withdrawing from friends and family, feeling overly anxious and agitated, sleeping too much or too little, having dramatic mood changes, and losing a sense of purpose to live (SAMHSA, 2006). Again, during a time of susceptibility and defenselessness, cross-cultural issues have the potential to become accentuated and require the mental health professional to be culturally competent.

Group work is also an ideal intervention for disaster survivors and must be facilitated within a multicultural framework (Bemak & Chung, 2004). Groups provide a commonly felt bond of universality. Sharing their disaster story with others who have encountered the same or similar experiences can be reassuring for those who believe that their experience was unusual or unique (Ehntholt, Smith, & Yule, 2005). This format provides opportunities to explore loss and reminisce about "before," to observe a variety of coping strategies, to view others at various stages in the resolution of trauma, and to gain satisfaction (altruism) by helping others. Thus, groups can serve as a forum for survivors to vent their feelings and problem-solve issues related to the disaster experience (Peuler, 1998) and offer a forum for people to quickly identify those with greater psychological need (Gillis, 1993).

Brief psychotherapy with youth, focusing on trauma and grief, up to 3 years after a disaster event has also been found to be effective (Goenjian, Karayan, & Pynoos, 1997). Since avoidance is a common reaction to a major disaster for children, behavioral techniques have been found to be effective. Play therapy, anxiety management techniques, and projective techniques, such as play, art, drawing, relaxation, storytelling, educating children about common posttrauma symptoms, desensitization, and other behavioral techniques, have all been found helpful with this population (Deblinger, McLeer, & Henry, 1990; Pfefferbaum, 1997). Workshops have also been found to be beneficial in helping survivors understand postdisaster stress management and develop coping strategies. Interventions should reflect developmental capabilities of survivors (Pynoos & Nader, 1993). In addition, it is important that survivors of all ages are educated about the possibility of retraumatization and the possible need for additional mental health support. Given that the DCCC is a culturally responsive model, it can be implemented in school- and community-based prevention and intervention programs that have the potential to promote normalcy and reduce stigma for children and parents.

Cultural Considerations

It is essential that mental health professionals doing postdisaster work using the DCCC have an understanding and sensitivity to the relevant cultural norms and expectations of the cultural groups with whom they are working (Marsella, Friedman, & Gerrity, 1996). Since disasters affect a great number of ethnically and racially diverse individuals and communities, different interventions may be required to address their unique ways of coping with postdisaster stress. Their desires may also consist of the need for and pursuit of more formalized mental health support. Simultaneously, a cultural sense of honor and pride, religious and spiritual orientation and belief systems, and ways of handling and dealing with grief and loss are significantly different across cultures. Similarly, communication across cultures also presents the challenge to go beyond language and respond to nuances of specific words, phrases, slogans, proverbs, and colloquialisms, which take on particular importance at times of high levels of stress. Well-intentioned attempts to help without considering cultural factors may create misunderstanding and be interpreted as meddling or interference or even as political attempts to exert influence and/or control. Related to these needs for cross-cultural

sensitivity, mental health professionals must also be aware of, understand, and acknowledge the historical and sociopolitical background of survivors from ethnic, racial, and oppressed populations that may contribute to cultural mistrust.

According to Doherty (1999), a major goal in counseling and psychotherapy has historically been to bring about a degree of conformity to the norms of the dominant majority group. When doing cross-cultural disaster work, the aim to link stability with the dominant group raises serious questions about respect for the norms and culture of diverse groups. Working from a framework of the dominant culture has the potential to alienate and further traumatize the survivors, with the potential to convert survivors to victims. In the DCCC model, mental health professionals must take into account the normative lifestyle and culture of the various affected groups when helping individuals accommodate and stabilize during postdisaster.

Given the lack of resources and services, another factor that we witnessed during our recent trip to the Mississippi Gulf Coast to work with Katrina survivors was anger and resentment directed at other racial and ethnic groups. We observed numerous displays of anger and resentment between Black, Latino, White, and Vietnamese survivors that flared up in parking lots, supermarket lines, rental car agencies, and disaster relief centers. The racial tensions manifested in direct ways through verbal encounters and sometimes physical assault. Tensions were high, and racism was more overtly expressed than usual. Although the values and attitudes themselves may already have been present, the actual expression was more open with the potential for greater and more direct hostilities. We would suggest that mental health professionals using the DCCC model must be aware and openly and constructively address racial and ethnic tensions in disaster situations where there may be potential conflicts over access to resources and services.

Another factor that is important to consider when working with the DCCC model is how a counselor or psychotherapist enters a disaster site. Mental health teams dispatched to disaster sites can at times be an overwhelming presence. Carrying the assumption that "you need us" without being sensitive to the cultural values regarding Western-based counseling brings with it the danger that the mental health professionals may quickly become unwelcome. The openness of the community to disaster counseling may coincide with the usage of culturally appropriate rituals in responding to grief and loss and making sense of the disaster experience. For example, in Mississippi, many people spoke about God and the Devil as the forces behind the disaster and the postdisaster healing. To negate this framework for understanding Katrina and the future would have challenged a cultural belief system and diminished trust and credibility with clients. Thus, it is important to not impose on clients a "one-size-fits-all" rationale for what happened or inflict a belief system for how they should grieve or mourn, which, however well intentioned, may cause more harm than good. Using the DCCC, it is imperative to harbor respect and understanding for the cultural beliefs and rituals of those affected by the disaster.

Cultural Differences in Dealing With Loss and Grief

Different cultures have dissimilar beliefs and understanding about the origin and nature of life and death. This is manifested in rituals and practices associated with honoring major life transitions and events, culturally sanctioned manners in which to express one's feelings during major life transitions, the perceived social implications and appropriateness of those feelings, techniques for dealing with feelings that cannot be directly expressed, and expectations from family and community (Rosenblatt, 1993). Historical studies have shown how individuals in Western culture have mourned differently over time (Kohn & Levav, 1990; Newnes, 1991). Cross-cultural studies show variety in cultural responses to death, manner of mourning, and nature of internalization of loss. Rather than being

process oriented, mourning is seen as an adaptive response to specific tasks required by the losses that must be dealt with, regardless of the individual or historical backgrounds (Hagman, 1995), and must be addressed with cultural sensitivity.

For example, White Americans report thinking significantly more about grief, religious feelings, and death than the Japanese (Asai & Barnlund, 1998). In Japan, ancestor worship is ritualized and supported by the belief that the living maintain their bonds with the dead. This approach provides a resolution by survivors that is linked with the journey of rebirth for the deceased, providing emotional benefits and an ongoing relationship based on continued balance and harmony with the deceased (Goss & Klass, 1997). Rubin (1990) compared mourning behaviors in the United States with those in an Israeli kibbutz. The finding suggested that in a dense social network such as a small- or medium-sized kibbutz, mourning is part of a wider circle of family, friends, neighbors, and coworkers and that the funerals in the United States may force loose social networks to generate an image of social support.

GUIDELINES FOR IMPLEMENTING THE DISASTER CROSS-CULTURAL COUNSELING MODEL

Using the DCCC requires cross-cultural sensitivity, awareness, knowledge, and skills, as defined by the American Psychological Association's (2003) multicultural guidelines. Along the lines of the multicultural frameworks that define the general field of counseling and psychology, specific recommendations are applicable to disaster recovery. The following are 16 guidelines for effectively implementing the DCCC in postdisaster counseling.

1. Understand the context of the disaster event within a culturally relevant framework. Is the disaster considered a work of nature, a spiritual or religious occurrence, the wrath of God, a message from a higher being, punishment from ancestors, and so on? Understanding, appreciating, and accepting the meaning of the event for survivors helps to effectively shape culturally responsive interventions that are embedded in the inherent cultural and individual worldviews.

2. Mental health professionals must be highly sensitive to language barriers and make sure not to neglect survivors because of language differences (Bemak, Chung, & Pedersen, 2003). It is essential that psychologists and counselors consult with members of the local community to assist with translation as needed (Hobfoll et al., 1991). Simultaneously, it is important to carefully discuss confidentiality and mutually define with bilingual translators their comfort and ability to maintain privacy regarding other survivors within their ethnic community who may be clients.

3. The focus of initial contact with survivors is on fundamental survival needs within a cultural context. It is essential to begin by helping survivors deal with meeting the basic needs for food, water, clothing, physical health, safe, and shelter. To discuss psychological health is premature when there are fears and anxiety about these basic needs. Basic survival must also be considered within the framework of the larger culture. For example, many Hurricane Katrina survivors of color felt marginalized and believed that those with greater socioeconomic status and those who were White had better access to resources and service systems. This type of reaction by minority groups within majority cultures creates important dynamics that are essential to address within the therapeutic context and may elicit feelings and subsequent expressions of anger, rage, depression, sadness, hopelessness, and despair.

4. As mental health professionals engage in cross-cultural counseling with diverse populations, it is important to be aware of perceived issues of cultural mistrust (Coleman, Wampold, & Casali, 1995).

Distrust of the counselor or therapist may create barriers in the therapeutic relationship that hinder openness and discussion about the deep-rooted pain and anguish caused by a disaster. Along with knowing about cultural mistrust, one must also maintain an awareness of feelings of racism, prejudice, and discrimination that may be experienced by the survivor group and become apparent in transference reactions during the therapeutic encounter.

5. Mental health professionals must incorporate advocacy into their work when they witness unfair or unequal treatment related to services and resources (Bemak & Chung, 2005). This oftentimes is related to cultural diversity and covert discrimination or inattention to basic needs and rights. Collaboration with survivors is particularly important since they may feel vulnerable and helpless and lack the skills and ability to challenge inept or unresponsive systems, particularly after a disaster. Forming these partnerships requires bonding and alliances to co-advocate along with survivors to get basic services. Needless to say, this type of alliance and co-advocacy are not typically part of traditional psychotherapy.

6. Mental health professionals must move out of traditional roles and be proactive in establishing linkages with other service providers, agencies, and officials. This is critical in fostering credibility and trustworthiness as mental health providers. Furthermore, having contacts with individuals who provide support services such as housing, clothing, food, and so on is a key to meeting basic needs. For example, working in the Gulf Coast following Hurricane Katrina, it was critical that we linked with physicians who were providing medical treatment, federal government officials who were distributing housing vouchers, food and clothing distributors, insurance company agents, religious leaders, and established community leaders from various ethnic groups.

7. It is important to work from a larger ecological context (Bemak & Conyne, 2004) so we as mental health professionals can provide support within this larger family and community context. Waxler-Morrison, Anderson, and Richardson (1990) identified questions that help facilitate the context of health and culture, asking about how survivors reconstruct their lives and relationships, meet their community obligations, and maximize their satisfaction in relationships. It is essential to ask these types of questions and understand the relationship of social and collectivistic values combines with the larger ecology of each individual.

8. DCCC also necessitates the psychoeducational information approach when appropriate. Dissemination of relevant information can be helpful in facilitating psychological healing, especially knowing that for the first few months of postdisaster, there are significant behavioral and psychological difficulties such as sleeping or eating problems. Important information can also be given as it relates to race relations, given intensified feelings after disasters that may be displaced onto different cultural groups that may dissipate over time with psychoeducational groups and group interventions. There should be a caution here to not rely solely on education as a means for postdisaster healing but rather to integrate psychoeducational interventions as part of a broader intervention strategy that incorporates attention to culture.

9. In any disaster, it is important to designate a lead team member who can be the liaison with regional, state, national, international, and nongovernmental organization officials (Aguilera & Planchon, 1995). This is a key component of working with the DCCC model and was evident in Mississippi working with Katrina survivors when the first author was the lead contact attending meetings with state and regional mental health officials, Federal Emergency Management Agency (FEMA) and SAMHSA representatives, and regional community leaders.

10. Employing the DCCC model uses some of the training pedagogy that has been established for mental health professionals. Current disaster counseling requires licensed professionals who could commit for 2-week time periods, which, in the case of Hurricane Katrina, left many survivors without counseling support. In the DCCC model, we require a licensed professional who will provide supervision for unlicensed professionals or graduate students. In addition, the DCCC allows for 1-week intensive time commitments. This significantly expands the human resource pool and provides excellent training under supervision, similar to a practicum or internship experience. It was tragic after Hurricane Katrina when there were tremendous mental health needs, yet restrictions on licensure requirements, and 2-week minimum commitments made it difficult for mental health workers to offer their services. Subsequently, when we took 14 advanced graduate students to work on the Gulf Coast, we saw almost 600 survivors within a 1-week period. There were daily 2- to 3-hour supervision and debriefing evening sessions and constant cell phone backup contact during the workdays with all 14 students for any emergencies.

11. Implementing the DCCC model requires building disaster response capacity building among local mental health professionals to ensure long-term sustainability. A combination of training and supervising local professionals and paraprofessionals (in regions where there are few or no professionals) to provide counseling support is key to working toward longer term capacity building.

12. The focus of the DCCC is on strengths and coping strategies (Doherty, 1999), not on psychopathology. Disasters create devastating situations that generate strong and sometimes dysfunctional survival strategies. A premise for the DCCC model is to understand the context for coping strategies rather than view them as pathological.

13. The DCCC model strongly promotes the use of natural support systems in disaster relief work. It is critical that mental health workers have a clear understanding of the nuclear and extended family and community relationships within a cultural context and work with groups of survivors accordingly.

14. Using the DCCC model, there is a focus on group, family, and community work that underscores the need for human connection and belonging that is critical postdisaster. Thus, we encourage group interventions wherever possible to promote a sense of universality and common bonds. Drawing on the experiences of others has shown great benefit and is recommended for disaster counseling work (Paton, 1996).

15. Mental health professionals must approach their work with clients with a maximum level of psychological self-awareness, as well as social, cultural, and political self-awareness. The mental health professional's awareness of these different levels intersects with the survivor's sharply heightened worldviews following a disaster.

16. The 15 guidelines for using the DCCC model thus far have focused on working with survivors. It is also important to acknowledge and accept that mental health professionals working in disaster relief will also need "self-care." Our feelings as mental health professionals may be greatly accentuated working with people in postdisaster crisis. Therefore, we must be ready to deal with the strong and pronounced countertransference issues and pain associated with doing intensive work, especially when emphasizing cross-cultural counseling. It is therefore important that mental health professionals ensure that they receive support and supervision. Professionals must take time to debrief with other professionals on-site and have support networks available via cell phones and other means.

CONCLUSION

As the world experiences global warming and climate changes, it is inevitable that natural disasters will occur. Often, those who have the least help and assistance during postdisaster are impoverished and come from culturally diverse ethnic and racial groups. The DCCC proposes a model of culturally responsive postdisaster counseling and guidelines for implementation that are derived from the multicultural guidelines. The DCCC addresses culturally sensitive counseling in a postdisaster situation that requires mental health professionals to be flexible, creative, and aware of their own stereotypes, biases, and privilege when working with cross-cultural disaster survivors.

CRITICAL INCIDENT

The five critical incidents are taken from real-life situations experienced during work in Mississippi after Hurricane Katrina. The critical incidents describe the implementation of the DCCC model through a series of case studies that portray pre- and postdisaster life circumstances and the psychological well-being of various survivors. Each of the vignettes describes DCCC-based cross-cultural mental health interventions following Hurricane Katrina. The critical incidents were coauthored with 14 individuals[1] who were part of the Counselors Without Borders Project team providing counseling in Mississippi. To fully understand the context of the critical incidents, this section will begin with a brief description of the disaster relief centers, the setting where the mental health disaster counseling took place, followed by the five critical incidents. All clients' names used are fictitious to maintain confidentiality.

Disaster Relief Centers

The disaster relief centers (DRCs) in the United States are set up by local and federal government officials to provide assistance for disaster survivors. All resources such as food, water, and clothing are free. In our experience with Hurricane Katrina, the DRCs located in higher socioeconomic status (SES) areas have more resources and assistance, such as medical care and clothing, as compared to the low-SES areas, where there might only be food and water. The DRCs may be housed in large buildings such as a school gymnasium, a warehouse, or a large tent. All around the DRC facilities are tables for various types of assistance—for example, debris removal, financial aid, applying for a trailer, other accommodations (i.e., shelters, hotels, etc.), medical assistance, and so on. In front of each table are rows of chairs for people to sit as they wait their turn, similar to an open-spaced waiting room. All the case studies took place at the DRC where survivors were seeking assistance.

Case Study 1

Mr. Tran is a 40-year-old Vietnamese who lost his apartment and belongings in Hurricane Katrina after living in Mississippi for 21 years. For the past 3 months, Mr. Tran and his daughters (ages 10 and 14) were living in a tent. FEMA workers had serious concerns about Mr. Tran and his children living in a tent with temperatures dropping below 30 degrees. However, Mr. Tran refused to move to a shelter. Given the concerns, a FEMA worker asked a counselor to speak with Mr. Tran. The counselor learned in an hour session that Mr. Tran was afraid to move to the shelter, believing that it was not only dangerous but that he and his children could be separated. He felt they could handle the cold with the blue FEMA tarp he had placed over the tent for warmth, safety, and protection from the rain. Mr. Tran also told the counselor about how several other Vietnamese friends in adjacent tents had created a

tent community and had become an extended family. They all shared one car to go to the DRC for food and clothing and to do errands, and they spoke daily about their predicament after the storm. He was proud of his tent home and thought it was a secure place and supportive community for both himself and his children.

As the counselor probed further, she learned about Mr. Tran's flight during the Vietnam War and his witnessing of human atrocities, as well as his 3-year refugee camp experience in Malaysia. Living in the tent with his children brought back memories of Malaysia and gave him a sense of safety, especially since he felt there was no imminent danger. In fact, his children were both attending school and had a set routine with friends and their studies, which was another reason why he resisted moving to a shelter. Also, they had all become closer as a result of their tent experience and his older daughter's new role in the family helping to prepare group meals for their tent community.

The counselor heard clearly about Mr. Tran's pride in being a hard worker and acquiring material possessions, such as a television, and his subsequent devastation when an insurance inspector, after surveying the hurricane damage, told Mr. Tran that he had nothing worthy of an insurance claim. Mr. Tran was highly distraught about the decision and kept mentally repeating the inspector's comment that he had nothing. The counselor was highly supportive of Mr. Tran, carefully listening to his story, acknowledging his history and its link to his current life in a tent community, being aware and respecting cross-cultural differences and countertransference, and showing respect for cultural values that were inherent in the Vietnamese community.

Case Study 2

Rosa, a Latina in her 30s, was at the DRC with her 8-month-old daughter. The counselor noticed them sitting alone waiting for a housing official, so she walked over to see how they were doing. When the counselor said "Hello," the response from Rosa was "No English." The counselor, being White American without Spanish language skills except for a few broken phrases, attempted to get an interpreter but was told that the interpreter would not be available for 1 hour. Rosa's eyes were wide, she seemed scared, and her speech was fast. The counselor used one of the few phrases she knew in Spanish, *bonito bambino* (beautiful baby), in an attempt to connect and make Rosa feel less afraid. Rosa smiled and repeated what was said, correcting the counselor's Spanish and causing both of them to laugh. Rosa thanked the counselor for saying her daughter was beautiful. The counselor then began playing with the child and gave nonverbal support to Rosa by smiling and making eye contact. Rosa pointed to her daughter and said, "*ocho*" (8 months old). As they waited for the interpreter, the counselor and Rosa worked on a housing application, filling out the paperwork, with the counselor using words like *nombre* and *telefono.* Rosa would smile and answer slowly, teaching the counselor the numbers in Spanish using her fingers. When the counselor was able to repeat the numbers, Rosa would become excited. Sometimes during the hour, Rosa and the counselor sat together in silence. The hour was profound, with Rosa's anxiety and fear being reduced and a human connection created that transcended language and culture. Rosa profusely thanked the counselor when she left a few hours later. This demonstrates the cross-cultural connection one can make despite language barriers and that assisting survivors with basic needs, such as filling out a form for housing, is just as important as working on deeper psychological issues.

Case Study 3

At a crowded DRC, Maggie, an elderly White woman, was trying to secure a trailer since Katrina had destroyed her house. The destruction had left behind a pile of what had once been Maggie's life, which included her furniture, pictures, walls, and the roof that had once offered shelter and protection from the rain and wind for her and her late husband. After the disaster, Maggie moved into a crowded

home with her daughter Sue, who was a heavy drinker and verbally abused Maggie; Sue's boyfriend; and three children. Their fighting and arguments escalated weekly until finally Sue ordered her mother to leave. Being kicked out of her daughter's home, Maggie found herself alone (her husband had died 6 months before of a heart attack) and pleading her case to FEMA to get a trailer.

Maggie was distraught, and the FEMA worker was at a loss about what to do or say as Maggie, deeply sobbing, poured out her fears of being totally alone. The FEMA worker hurriedly found a counselor to help out. The counselor, Djimie, a Sudanese woman of Moslem faith wearing a traditional *hijab,* readily agreed to help. Djimie approached Maggie and introduced herself. Maggie was visibly surprised by Djimie's appearance and dress, yet as Djimie sat down and asked Maggie what was causing the tears, Maggie looked Djimie in the eyes and started sharing about the destruction of her home and loss of family and very quickly took out a stack of photos, pointing tearfully to family members, her deceased husband, and her abusive daughter. Djimie reached out and took Maggie's hand as she talked. Although recounting the details was very painful for Maggie, she was deeply concerned about her daughter, explaining to Djimie about her strong Christian beliefs in the importance for a child to respect and care for one's parents. Maggie tearfully reflected on the vicious cycle that might be perpetuated, with her granddaughter eventually abusing her own mother, and was deeply pained by the thought. She held tightly to Djimie's hand, crying.

The African counselor of Moslem faith and the devout Christian White woman continued to hold hands, talking about family, neighbors, current friends, loss, and faith. Sharing deep spiritual beliefs and the value of family loyalty and respect, Djimie could identify and relate to Maggie. As they talked, Maggie's voice became lighter, and her face brightened, remembering her kind neighbors. "They gave up a bed in their home for me and gave me gifts to cheer me up." Djimie chimed in, "So you're not alone?" Maggie responded thoughtfully, "No, I'm not alone." This seemed to be a turning point in their encounter as Maggie talked about a nephew in Atlanta and other friends who had supported her. Djimie reflected her identification with the loss of family, friends, and community as they spoke. Soon the FEMA worker returned and helped Maggie fill out the housing application. Upon completing the form, Maggie smiled and hugged Djimie, profusely thanking her, and walked out of the DRC. Finding the threads of commonality and transcending the cultural, religious, and ethnic differences was essential in the encounter. Although these two individuals came from dramatically different backgrounds, there was a core of cross-cultural counseling skills that created a human experience in a time of great crisis for the client.

Case Study 4

Pearlington, Mississippi, is a rural community with residents who are either on fixed incomes or living below the poverty level, and although it was located in the eye of the hurricane, it was one of the last areas to have a DRC, leaving many residents without basic necessities such as food and clothing for more than 2 months. Community residents attempted to help one another as best they could, but patience wore thin. Thus, even as people came together to help each other, tensions mounted, and racial tensions began to creep back into the everyday occurrences. When asked about the increased racial tensions in Pearlington, one man said, "Yep—things are finally getting back to normal around here."

A situation occurred that illustrated this dynamic. In an effort to support each other and survive, an older Black couple (PJ and Natasha) and a White man (Dave) were neighbors who helped one another in the aftermath of the hurricane. PJ and Natasha lost their home, so in an effort to be helpful, Dave signed the papers to his van over to the couple so they could use the van as shelter until they were able to secure a trailer from FEMA. One morning, PJ and Natasha's 32-year-old daughter, Kelicia, drove the van to the DRC's food supply center. Everything was free, and the rule was to take only what you needed. Dave became angry seeing Kelicia put many items into the van and accused her of abusing the honor code policy to only take needed supplies. Kelicia became defensive and made a comment about Dave being White. This enraged Dave, who grabbed an axe from his bag and ran toward the

van, proceeding to smash the van's windows and doors, sending shattered glass everywhere. Kelicia stood next to the van screaming, crying, and ranting, saying, "White people always done me wrong," "I can't trust White people," "My Mama is gonna blame me for what he done," and "Jesus is the only one who never cheats me!" Security officers and the military quickly apprehended Dave and removed him from the site. Having heard the glass shatter and seeing groups clustering, counselors came over to see what had happened. Many White people had gathered together in a group and were defending Dave and confronting Kelicia about taking too many goods at the center and not leaving enough for other people. Similarly, African Americans were also standing in a group and talking about how it was fine what Kelicia took and that Whites always got special treatment.

Seeing this volatile situation, a White male counselor (Pete) in his late 40s walked over to Kelicia to see if he could help. In front of the gathering crowds, he reached out his hand and encouraged her to sit down. At first she ignored him and continued screaming, crying, yelling, and pacing. Pete remained by her, talking and attempting to engage her until Kelicia finally slumped down onto a nearby bench, tearfully repeating, "White people always done me wrong," and "I can't trust White people." Seeing an opportunity to get closer, Pete sat down next to her, picked up her cap and handed it to her, and calmly assured her that it was not her fault and she did not cause the incident. Sitting next to her, he listened to her, allowed her to vent, and spoke to her in a calm, soothing voice, validating her feelings and brushing off the racial comments she made that were directed at people "like him." Kelicia continued to assert that she mistrusted White people, while Pete continued to quietly talk with her. Eventually, she was able to calm down enough to talk with Pete, who by then invited one of the local Black clergy who knew Kelicia to join them. The three of them developed a plan to tell Kelicia's parents about what happened and to find alternative shelter for the family. As Kelicia continued to make plans, Pete cleaned out the broken glass from the van.

Repercussions from this confrontation resounded through the rest of the day at Pearlington. Pete spoke with many people upset by the scene from both the Black and White communities and listened to strong opinions from both sides, largely divided along racial lines, with Whites supporting Dave's confrontation with Kelicia and expressing their belief that the Blacks are *always taking all the goods,* while Blacks believed that Whites *always got special treatment.* This situation demonstrates multiple and complex issues that emerge in the aftermath of a disaster (e.g., high levels of stress facing residents; the associated anger, mistrust, and fear; potential volatility in race relations in a disaster situation; socioeconomic issues in an impoverished community; and use of the DCCC interventions in the midst of a racially charged event). The counselor's reaction in this situation was helpful in addressing the immediate needs and feelings of the woman, validating her feelings, and maintaining his support for her despite her racially charged comments that were also directed at him. Throughout the crisis, the counselor did not personalize Kelicia's statements and remained calm and grounded, helping her to feel heard and thus de-escalate the situation. He quickly expanded her support system by connecting her with a leading clergyman in the Black community, respecting her distrust of Whites yet maintaining a role in supporting her. He followed through after the situation and calmed down Kelicia by personally cleaning out the glass from the van, going far beyond the traditional counseling-by-talking-only role; he then continued to speak with and listen to both African American and White perspectives about the incident, helping to further diffuse the situation.

Case Study 5

Disaster survivors frequently do not have contact with individuals from cultural and ethnic backgrounds other than their own. This was also true after Hurricane Katrina. This case study describes a unique opportunity to facilitate counseling between different racial and ethnic groups who have a shared experience of a disaster. In the DRC situated in a low-SES area, a White middle-aged man (John) and his mother (Judith), in her 70s, were waiting for clothes and food. Sandy, a White female counselor in her

30s, sat next to John and Judith, and they immediately began talking. John and his mother were animatedly describing the hurricane and how they lost their home and all of their possessions. They explained how they were living in temporary hotel accommodations and would be forced to leave in 2 weeks. As they spoke, a clear sense of hope and optimism was increasingly apparent, and Sandy was struck by their resilience.

As they were taking, an African American woman (Jamila) in her 40s sat down on the empty seat next to Sandy. As everyone shifted one seat closer to the food and clothing room, Sandy kneeled down in front of John and Judith and told Jamila that she was welcome to take the vacant seat. Sandy asked Jamila in an empathetic way how she was doing. As Jamila began to tell her hurricane story, John and Judith were intensely listening. Noticing their interest, Sandy asked John and Judith if they could relate to Jamila's feelings of loss. "Yes, of course, we had the exact same thing," Judith replied. A look of understanding and compassion emanated from Jamila's eyes, and the three of them noticed and acknowledged each other for the first time. They started sharing with each other their experiences, losses, and pain as Sandy facilitated the exchange. The commonality of experiences between individuals from two distinct cultures had been facilitated for people who had no contact with "other folks," as they each explained.

As the three individuals were talking, an Asian woman (Anh) in her 30s was walking close by, looking confused and lost. Anh needed to see a doctor, but in the place where the doctor typically sat was a sign saying "Doctor Not Here." Anh was being ignored and dismissed as she asked people around her in broken English what to do. Sandy asked Anh if she could help. Anh looking highly distressed and responded in broken English, "Need doctor... where go?" Sandy turned to the threesome who were continuing to commiserate with each other and asked, "Can you help this woman? She's looking for a doctor and he's not here right now. Do you know of another doctor in the area that could help?" John told Anh about a doctor in the area, and with the help of his mother and Jamila, they described the office location. As they were helping Anh, her voice became animated, her eyes showed gratitude, and the threesome offering help leaned forward, trying to explain the directions to the doctor's office. Clearly, this was an act of kindness in a difficult moment. Anh, with great appreciation, hugged each of them very tightly, saying, "Thank you" and walked away, leaving John, Judith, and Jamila to continue a lively conversation about the hurricane and their respective predicaments.

Sandy helped bring three different cultures together that would not likely meet or interact with each other. The ability of the counselor to facilitate a cross-cultural interaction required a clear sense of historical and current racial issues specific to the region, an awareness of her own biases and prejudices, and communication skills that would be received across racial and ethnic lines. The intervention was further enhanced by promoting an act of altruism in providing assistance to Anh, who, without language skills, found three helpful people coming to her rescue. Each person walked away with a feeling of comfort and connection that transcended traditional cultural barriers.

DISCUSSION QUESTIONS

1. What are some of the psychological problems that may occur as a result of a disaster?

2. Many disaster survivors experience posttraumatic stress disorder (PTSD). What variables contribute to the degree of PTSD that is faced by disaster survivors?

3. Discuss how acculturation, socioeconomic status, and coping strategies may contribute to cross-cultural issues in disaster counseling.

4. Describe the three phases of the Disaster Cross-Cultural Counseling Model (DCCC).

5. What are five ways to recognize PTSD?

6. Discuss three key cultural considerations when using the DCCC model.
7. How might a mental health professional working with disaster survivors handle language barriers?
8. How can one deal with cultural mistrust in a disaster counseling situation?
9. Discuss the benefits of group counseling in disaster interventions.

NOTE

1. The contributing authors on the critical incidents case studies are as follows: Kelly Badger, Lori Birmingham, Stacy Hurley, Delia Cordero, Karen Croushorn, Sarah Evans, Melissa Keylor, Sue Manchen, Fatima Mekki, Kerry McNamara, Neva Ortuno, Adam Shane, Nikki Zawakzki, and Marla Zometsky.

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