Somatic Practices
in Disaster-Based Global Supervision

Tending to Shared Trauma and Recovery

Juanita Barnett, Elizabeth Farrah Louis, Karen Roller

ABSTRACT

This review article examines the literature on global supervision in post-disaster settings. It reveals a gap around specific culturally-responsive embodiment practices that may be considered best practices for effective supervision in post-disaster settings. The authors reflect on trauma models and somatic practices employed by their team in post-disaster supervision to prevent vicarious traumatization and compassion fatigue, and offer suggestions for further research.

Keywords: Global supervision, post-disaster settings, compassion fatigue prevention

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Disasters are natural and human-made phenomena that disrupt people's lives in a catastrophic manner physically and emotionally. The United Nations Office for Disaster Risk Reduction (2009) describes disasters as disrupting the function "of a community or society involved in widespread human, material, economic, or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources" (para. 1). The widespread effect of disasters influences how people respond, cope, rely on support systems, and process individually and collectively. The role of counseling professionals provides a unique perspective that is relevant and effective for victims and survivors of disasters. The current literature provides examples of the role counseling professionals play, and the intersection of supervision within the different contexts where disasters take place. However, there are still gaps in the literature that require attention to address the implications of the practice of supervision and recommendations for future research.

Historically, mental health professionals have dictated which settings and populations are relevant to the field. There was a time when marginalized groups, such as racial and ethnic minorities, wom-

en, and the LGBTQ+ populations were not deemed as valuable communities to research and provide clinical services. The recent shift in mental health research has expanded to validate and include diverse contexts such as disaster settings. One reason why mental health practitioners should remain involved in disaster work is the fact that disasters "create psychological distress" (Jacobs et al., 2011, p. 1077).

Psychological distress manifests differently in diverse cultures. The discipline of mental health is increasingly trained to "recognize and work with distressed individuals and families" while identifying culturally appropriate approaches (Jacobs et al., 2011, p. 1077). Socially just allied mental health practice for disaster outreach places a great emphasis on multicultural components that inform its work and encourage members to reflect upon their own backgrounds as researchers, service providers, supervisees, and supervisors in disasters.

Other core values of mental health professionals such as "vocational and career endeavors, strength-based approaches, and a focus on multiple concerns to facilitate interpersonal functioning across the life span and in multiple contexts" are areas that this discipline can contribute to disaster work (Jacobs et al., 2011, p. 1078). Disasters are important to this discipline because they appear in a context that involves many levels of oppression and historical injustices that cannot be ignored. As mental health professionals, disasters provide an opportunity to implement various interventions, advocate for victims and survivors, and use a social justice framework when we interact with different systems. Also, the rich history of career and vocational counseling in counseling professionals is especially essential after a disaster when people relocate, look for jobs, and attempt to get back into a routine (Jacobs et al., 2011). Counseling professionals attend to the developmental concerns of victims and survivors while recognizing their strengths, which are imperative for their recovery process.

Moreover, disasters play a key role in how supervision is conducted within this unpredictable setting. When mental health professionals provide clinical work, supervision is necessary when working in diverse yet complex locations. Disasters are relevant contexts in the world of supervision because they involve situations where mental health providers will require the guidance of supervisors from a counselor, consultant, or teacher perspective in order to foster an optimal supervisory relationship and counseling for victims and survivors (Bernard & Goodyear, 2014). Traditional ways of conducting supervision do not apply in disaster locations because, according to Jacobs and colleagues (2011), supervision is "typically conducted informally by team leaders, some of whom may not be licensed psychologists and ...may be social workers, counselors, or nurses" (p. 1079). Also, after a disaster, order is interrupted, and the environment may exhibit physical and emotional distress. A post-disaster situation calls for more proactive direction from mental health supervisors to inform mental health professionals about important considerations when working in an environment that has been uprooted from its normal routine. Instead of viewing disasters and supervision as separate entities, they are both involved in the process of how victims, survivors, and mental health providers are affected internally and how they recover to a stabilized baseline after a disaster.

Regardless of the type of disaster, mental health issues can develop from the aftermath of that traumatic exposure. Reactions to disasters can manifest in the form of trauma, posttraumatic stress disorder, depression, anxiety, substance abuse, and relationship problems (Aten et al., 2008; Bickbell-Hentges & Lynch, 2009; Dominey-Howes, 2015). For mental health providers who choose to respond to the aftermath of a disaster, there is the risk for vicarious trauma. According to Dominey-Howes (2015), vicarious trauma is "the response of those persons who have witnessed, been subject to explicit knowledge of or, had the responsibility to intervene in a seriously distressing or tragic event." (p. 2). Mental health responders listen to survivors' stories, witness their challenges, and experience their distress as they try to manage their own emotions. Factors that may influence the onset of vicarious trauma can include the length of exposure to a particular disaster, previous exposure to traumatic situations, gender, age, and the lack of support (Dominey-Howes, 2015). Also, mental health professionals in post-disaster environments may experience compassion fatigue. Symptoms of compassion fatigue resemble the psychological, physiological, and cognitive symptoms of victims (i.e., PTSD for work) and are developed through exposure and

empathy (Lahad, 2000). These responses warrant the effective presence and therapeutic support of a trauma-competent supervisor during this difficult moment.

Haiti's history of natural disaster

Haiti is the poorest country in the Western hemisphere (World Bank, 2021). The vast majority of residents have very low socioeconomic statuses and live in poverty. Residents experience great difficulties and burdens in simply meeting the basic needs of life. According to Zanotti (2010), 76 percent of Haitians learned to survive earning less than $2 per day, and 56 percent with less than $1 per day. Following the recent coup and invasion by Columbian mercenaries resulting in widespread gang activity, Haitians are living in terror (Gamba, 2022). With the citizens of this country in such an impoverished state, yielding revenue or income for the state through taxation is not plausible. A country with such extreme poverty typically lacks the resources required to assist with disaster relief and recovery. According to Benjamin and colleagues (2011), natural, technological, or human-made disasters can pose even more extreme outcomes in poor countries.

Haiti has a great deficiency of infrastructure, economic opportunities, and services. In 2008, Haiti experienced four hurricanes that further exacerbated and impacted the country's poverty conditions, economic situation and resources, and building infrastructure. Thus, Haiti became very dependent on foreign and international support. Nongovernmental organizations and many other international support agencies provided aid to Haiti to help them circumvent the hardship of meeting basic needs for daily living.

In January of 2010, Haiti suffered a natural disaster in the form of a 7.0 magnitude earthquake that resulted in mass fatalities. Today, it is still unclear exactly how many lives were lost. It is estimated that there are approximately 200,000–300,000 casualties, about 200,000 injured, and nearly 2,000,000 who are displaced and/or homeless as a result of the earthquake (McKersie, 2010). Considering the lack of infrastructure in Haiti's buildings and facilities, an earthquake of that magnitude would naturally cause many homes to be destroyed, even to the point of crumbling. According to Zanotti (2010), the earthquake "destroyed over 80 percent of Port au Prince, but also delivered a serious blow to the thin layer of state administrative structures that were in place in the country" (p. 756).

Mental health response

There is great disparity in health services in Haiti, especially mental health services. Improving mental health services in Haiti with such poor resources can be even more challenging. While many national, international, and other organizations jump in to respond to emergency disasters by providing financial support, medical services, and basic necessities such as food, shelter, clothing, and many other services, many residents also deal with the reverberating trauma of natural disasters – particularly earthquakes, and this trauma is not well-tended. Raviola and colleagues (2012) clarified that Haiti does not have its own tiered formal mental health system. While most Haitians are forced by circumstance to focus more on meeting their basic survival needs before attending to their mental health needs, there is great correlation between both areas. Mental health treatment is necessarily secondary to other needs, especially medical conditions. Haitians and Americans typically collaborate together on stabilizing these needs through Partners in Health (PIH) after natural disasters (Raviola et al., 2012).

After the 2010 earthquake, many Haitians demonstrated psychological distress, such as fear, anxiety, depression, sleep disturbances, etc. Phobias were quite prevalent, as many people would not take refuge in safe and intact structures and elected to sleep outdoors, and in unsafe environments (Benjamin et al., 2011). Seeing the dead and management of the dead also had a great impact on the community's mental health. Even today, many people have not heard from or seen their relatives, and must assume they are dead. It is imperative for crisis management teams to be cognizant of this tragic reality, and also include a plan for disposing of mass numbers of bodies. One strategy implemented by PIH was to arrange many memorial ceremonies in honor of the dead to facilitate collective grieving, provide comfort, and begin emotional healing (Raviola et al., 2012). PIH was very instrumental in engaging in research to assess the needs of Haiti, and understand the culture's view of mental health within that population. It became

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involved with training and education, utilizing local professionals to interpret and incorporate the language into the training. PIH also advocated by organizing mass events that increased mental health awareness, and reduced stigmas associated with trauma responses (Raviola et al,, 2012). Incorporating Haiti's cultural practice, coordinating the services with local health agencies, and implementing these strategies in a collective dynamic fostered a sense of belonging and altruism amongst the citizens. It helped build resilience and strength, knowing that although Haitians were in a state of despair with limited to no resources, they were still able to help one another.

Disaster recovery

Disaster recovery typically begins right after the initial disaster has lessened, and consists of restoring the original country or community back to its original state before the disaster. Unfortunately, countries like Haiti that lack resources will have to rely on external assistance, such as that provided by national and international organizations, which can further exacerbate hardship (Benjamin et al., 2011). In Haiti, there was great support from NGOs, national and international organizations, collaborations and partnerships, although the country continues to lack resources and sanitation, and continues to recover from the earthquake and subsequent disasters. Many people were so eager to provide support that a challenging part of that process was managing workers who lacked ade-

quate skills to meet the needs at the time, such as intensive trauma medical care. An additional issue with the Haiti recovery process was having appropriate and adequate equipment and supplies, such as medical supplies, clothing, water, etc. (Benjamin et al., 2011). Despite the generosity provided by many, there was still a great shortage and lack of appropriate supplies to match the services needed. After a disaster, a great need and emphasis is placed on security and law enforcement. After the earthquake in Haiti, there was a noticeable absence of police presence on the streets, partly because many officers were attending to their own families. Additionally, there was a scarcity of basic resources needed to enforce the law and provide security, such as ammunition for firearms and fuel for police vehicles (Zanotti, 2010).

After the 2010 earthquake in Haiti, the country was also faced with the challenge of the cholera epidemic, and a hurricane that further oppressed and deprived the residents. The greatest weaknesses resulting from this natural disaster are the lack of resources available for effective crisis management planning, and the country's dependence on external aid for recovery. Haiti does not have the adequate resources to properly implement and execute a crisis management plan. Even with international aid workers and local Haitian citizens available to help, fatalities are definitely higher when immediate local response and resources are not available. The neighboring country of the Dominican Republic is also not adequately self-sufficient to assist

Haiti in natural disasters of this magnitude that result in great casualties.

A complaint regarding the recovery process is the quick and hurried decisions that Haitian authorities made during the crisis, which was due to the magnitude of the humanitarian crisis. According to Feldman (2013), authorities made decisions to relocate, rather than revitalize and industrialize in the midst of great chaos. Rather than making comprehensive plans, they simply made minimal efforts to address immediate needs without focusing on underlying long-term issues. Haiti already lacked resources, and trusted such assistance from organizations that could not be trusted with the expertise to rid the country of its despair from the disaster. Many can now see the multiple errors or mishaps after the disaster that devastated Haiti in 2010 and continues to impact the lives of its citizens, but unfortunately today Haiti still lacks the resources to effectively recover and restore the country's infrastructure if such a disaster were to recur.

Supervision preparation

While reactions to disasters have been well documented, there is a dearth of literature regarding supervision in global outreach disaster settings. Current studies have addressed important considerations that supervisors and supervisees should be prepared to discuss and be aware of dynamics that may impact supervisees' service delivery (Aten et al., 2008; Goodman et al., 2014; Lahad, 2000; Petttifor et al., 2014). Before supervisees and supervisors arrive at a post-disaster site, they have already been exposed to information about the disaster through the media, or learned about the extent of its aftermath from an agency. Supervisors and supervisees may experience an "immediate identification with the survivors" with an "increase in empathy" (Lahad, 2000, p. 276). Although supervisors and supervisees should not refrain from having empathy, they still need to recognize their roles when providing mental health support to victims, survivors, and rescue workers. Supervisors must critically reflect upon which role (e.g., teacher, counselor, or consultant) would be appropriate within a disaster setting to foster the supervisee's professional development and ensure client welfare (Bernard & Goodyear, 2014). For supervisees, being in a disaster situation may

affect their engagement with their supervisors and clients in the form of resistance, shame, anxiety, competence concerns, and transference (Bernard & Goodyear, 2014). It is imperative that the supervisor and supervisee have a strong supervisory alliance prior to arriving at the disaster site in order to effectively serve clients and supervisees while engaging in ongoing reflection on their experiences in a chaotic condition.

Supervisors and supervisees will have to adapt to the parameters of disaster work because the situation will be different from the usual "traditional clinical practice" (Spokane et al., 2011, p. 1152). Post-disaster interventions are usually brief, with an opportunity to incorporate informal support and techniques, and acquire informal roles such as distributing supplies, food, or clothing (Spokane et al., 2011). In addition, supervisory relationship concepts such as parallel process may play out in supervision between the survivor and supervisee (Lahad, 2000). Supervisors and supervisees will need to be flexible as they work in informal environments, and participate in activities that might not be considered therapeutic. To protect the supervisory relationship from problematic ruptures, ongoing self-regulation and co-regulation of predictable trauma responses must be continually monitored and processed effectively.

While research has focused on supervisors and supervisees, there is an absence in the literature in differentiating between individual supervision and group supervision. Supervision appears to be synonymous with individual supervision unless the phrase "group supervision" is explicitly used to make the distinction between these two forms of supervision. Goodman and colleagues (2014) explored peer group supervision within a liberation psychology and critical consciousness theory framework, which encompasses a social justice perspective in disaster work. The authors explained how peer group supervision focused on "introspection and personal awareness" for counselors and psychologists to develop counseling skills in critical consciousness and liberation psychology (Goodman et al., 2014, p. 230). The results of the peer group supervision reflected upon the context of community members (e.g., culture, strengths, and sociological issues), process (e.g., practitioner role, connection and respect), and post-outreach follow-up (e.g., outgrowth of community outreach), which all reflect cultural competence, so-

cial justice, and community collaboration (Goodman et al., 2014). Additionally, this nontraditional group supervision required practitioners to advocate for clients, conduct outreach, reflect on their commitment to social justice, and shift from the traditional individual perspective to community-based "collective healing and empowerment" (Goodman et al., 2014, p. 234).

Another form of group supervision used a social justice lens to provide supervisees with interventions and address countertransference issues in post-disaster communities. Bemak and Chung (2011) used a Disaster Cross-Cultural Counseling model, a multicultural responsive group that integrates social justice into post-disaster work and group supervision within and outside the United States. Bemak and Chung (2011) argued that group interventions "offer the strongest means of protection against trauma and despair following a disaster and redefines group counseling," and that traditional counseling fails to "adequately address the immediacy and critical need to manage post-disaster trauma and stress" (p. 5).

Bemak and Chung (2014) explained how traditional counseling guidelines are unrealistic for disaster mental health outreach – in particular, "clearly defined times for counseling sessions, confidentiality, special private physical locations for counseling sessions, or clearly defined counselor-client boundaries" are not feasible most of the time (p. 6). There is currently a lack of empirically-based guidelines for group therapists to implement in disaster settings, especially when considering these nontraditional components. Socially-just group supervision can offer resiliency narratives, address the contexts, remain sensitive to clients' cultural beliefs and values, and facilitate culturally-responsive skills. Such skills include "active listening, problem definition [and] solution, establishing a post-disaster therapeutic partnership, active comforting, heightened compassion, discussions about the limits of confidentiality, and follow-up survivor actions steps" (Bemak & Chung, 2014, p. 8-9). These skills are structured and supported by the supervisor to ensure that the community's needs are being met and that the supervisee is competent in these skillsets. On the other hand, team selection for socially-just group supervision requires that the supervisee is flexible, multiculturally aware, self-reliant, has skills to digest countertransference, and proactively engages

in the debriefing process in supervision (Bemak & Chung, 2011).

However, there are exceptions when "group supervision" is not explicitly stated. Studies that involve professors and students who serve in disaster settings usually do not acknowledge the type of supervision. For example, Ball State University's counseling professionals' disaster training program is involved with the American Red Cross (ARC). In the past, Ball State master and doctoral students volunteered in Mississippi post-Hurricane Katrina under the supervision of their professor, a licensed psychologist. Dr. Bowman selected students based upon their "maturity level, counseling skills, and ability to take supervision" (Bowman & Roysircar, 2011, p. 1167). Before heading to the disaster, Dr. Bowman discussed with her students their roles, responsibilities, self-care issues, "appropriate decorum, health issues, and the importance of flexibility" (p. 1168). Dr. Bowman and her supervisees reviewed brief directive counseling approaches, crisis intervention knowledge, diversity, and cultural differences (Bowman & Roysircar, 2011). From this supervision experience, students reflected upon their interdisciplinary collaboration and "applied their training as counselors and as consultants" (p. 1168). However, details regarding group supervision process were not tracked.

Another disaster response program is Disaster Shakti of Antioch University New England. Created by Dr. Roysircar, Disaster Shakti follows ARC's psychological first aid approach, and uses a single-session framework and short basic counseling interventions (Bowman & Roysircar, 2011). Prior to arriving at a disaster site, Dr. Roysircar engages her students in discussions related to the needs of people who are globally affected by different natural disasters. Students are trained to prepare for disaster trauma through crisis management and self-care techniques, and they learn about cross-cultural adaptation and resiliency (Bowman & Roysircar, 2011). Further training is also provided in "multicultural competencies, racial identity development, disaster response competencies, social justice advocacy, community collaboration, knowledge about communities to serve, and vicarious traumatization" (Bowman & Roysircar, 2011, p. 1171). At the disaster site, supervisees incorporate skills they learned, such as trauma-focused cognitive behavior strategies, grief counseling, empowering survivors, and participating

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in self-assessment of their strengths and protective factors under the direction of their supervisor (Bowman & Roysircar, 2011).

Vulnerable population

Even within a natural disaster, there are individuals who are vulnerable and at greater risk during recovery or restoration of the community. In Haiti, after the 7.0 magnitude earthquake in 2010, many small local organizations intentionally focused on providing assistance to women and children, whose safety and rights were of great concern due to the "fragile and post-catastrophe environment" that increased the likelihood of rape and violence (Bell, p. 30, 2010). Individuals with a disability are also at greater risk, and must be included in crisis management planning.

Camps designated as safe spaces for children were implemented during the Haiti earthquake recovery process to keep children safe from risks and hazards that posed a threat to their physical, emotional, and psychological well-being. In these environments, relationships were established, and screening and assessment were done to identify high-risk children who needed additional services. Education and training was provided to incorporate lifesaving skills in disastrous situations, and routines were established to foster a sense of normalcy, security and building self-esteem (Madfis et al., 2010).

Among the limitations of such camps is that there was funding to provide only short-term services. Although there are long-term consequences of disaster, and children benefit from these camps in psychosocial, mental health, and educational realms, issues arise when attempting to locate a displaced parent. Some parents intentionally forsake their children in these camps, hoping for a better life and outcome for their children due to the despair and poverty of their own living conditions.

These camps therefore inadvertently increase orphaned children in need of homes in Haiti.

Professionals' self-care

Current literature highlights the ethical implications of supervisee self-care and group supervision. Within the supervision relationship, a collaborative process where "supervisory expectations are clearly delineated; the effect of the worldviews of the supervisor, supervisee, and client are addressed" is needed for ethical standards to be integrated (Pettifor et al., 2014, p. 202). A disaster setting exacerbates the importance of upholding ethical standards where there are different cultural considerations. Power differentials between the supervisor, supervisee, and client are emphasized, and diversity factors can be introduced by both supervisors and supervisees. When operating in a new setting, an awareness of historical oppression, cultural mental health practices, previous disaster encounters, and an understanding of the limits and biases of Western psychology can prepare both supervisors and supervisees to engage in ethical supervision and community outreach.

At the same time, supervisors are responsible for modeling and practicing appropriate self-care for supervisees in the event of a disaster (Aten et al., 2008). Aten and colleagues examined how the parallel process theory is applicable for supervisors to model self-care because supervisees tend to "observe and internalize representations of their supervisors" (p. 77). Supervisors need to be mindful of how supervisees may view their actions, which can impact how supervisees respond to a disaster. Supervisors can normalize and validate supervisees' experiences while maintaining professional boundaries. During the post-disaster period, supervisors may need to provide supervisees with additional empathy and support, but not extend their role to counseling or exploiting supervisees to meet their personal needs (Aten et al., 2008).

Also, supervisors can educate supervisees about stress-management resources, common problems in providing psychological services in disaster settings, and can develop "an informational self-care packet" (Aten et al., 2008, p. 77). Studies have illustrated how supervisors can encourage supervisees to practice positive coping and monitor their process towards incorporating self-care in their lives (Aten et al., 2008; Lahad, 2000). Nevertheless, supervisors should be aware of supervisees' personal struggles, and address any challenges because they may adversely affect the client and the supervisory dyad. Supervisors must be cognizant of supervisees' behaviors because, according to Ladany and colleagues (1996), approximately 97% of supervisees withhold information in supervision. This may be due to shame, lack of confidence in their clinical skills, anxiety, and self-doubts that can affect how they experience their clients and supervisors (Aten et al., 2008; Yourman & Farber, 1996).

McKersie writes about his experience with the Haiti earthquake disaster relief as a medical professional and how it impacted his life, expressing strong emotional feelings, a sense of closeness with other professionals who also volunteered in Haiti, a sense of connectedness with current clients of Haitian or Dominican descent, an overwhelming feeling of inadequacy, and many other feelings that he did not experience prior to his time in Haiti (2010). It is imperative that professionals also seek trauma-informed counseling to process their embodied experience and the emotions and thoughts associated with such experiences. It is known that many disaster recovery workers commonly deal with post-traumatic stress disorder and many other mental health disorders because of the disasters. Working in these types of environments is quite physiologically demanding and overwhelming. Although it can be an altruistic experience, it may also have other grave impacts to the psychological wellbeing of the helping professional. As professionals are intentional about their self-care, especially in disaster response and recovery, the quality of care and services provided to those in need will improve. Lastly, engaging in reflection about the experiential learning is essential to meaningfully integrate and resolve the many lessons that cannot be learned without direct experience (Kolb, 1984; Kuk & Holst, 2018).

Somatic practices for socially-just group supervision in disaster outreach

With these ethical considerations in mind, the current authors posit that socially just and ethical global supervision depends upon supervisors role-modeling and facilitating a multitude of somatic relational skills to discharge trauma in real-time so the outreach team can effectively serve the target community post-disaster, while protecting themselves from vicarious trauma and compassion fatigue. Using Rothschild's (2017) autonomic nervous system precision regulation measure as a guide can help supervisors self-monitor for stress modulation in themselves, supervisees, and members of the community being served. Pendulating between private discharge of intense affect, and public facilitation to regulate movement, breath, and attuned touch can expand supervisees' self-care tools to digest vicarious trauma throughout an outreach mission. The current authors share reflections from on-the-ground outreach in Haiti over several years.

There are multiple factors in holistic, culturally-responsive, embodied supervisory preparation, implementation, and integration that lead to success with the Global Trauma Research: Haiti Trauma Project team. The executive director builds a relational container through year-round monthly meetings with the core team to reflect upon past missions and upcoming programs, documenting lessons learned and planning for anticipated needs using a framework of Strengths, Weaknesses, Opportunities, and Threats (SWOT).

- Core team members are assessed for strength-based skills, placed in roles that play to those strengths, and supported in intentional recruitment of appropriate volunteers for the multiple training and direct service projects that will unfold.

- Orientation to each mission's objective is outlined clearly, and realistic expectations are set for each component.

- Each month's global group supervision provides space for each member to share felt sensations, emotional responses, and meaning-making about past projects, as well as anticipation of upcoming projects.

- Explicit inquiry about self-care practices folx are implementing encourages diversity, creativity, and normalization of methods employed. Anxiety is embraced, and support is explicitly offered throughout the year's planning process.

These processes are modeled from the executive director to the trauma treatment team, as well as the trauma treatment team to the targeted community with whom we collaborate in on-the-ground outreach and ongoing telesupervision after each deployment.

Once on-the-ground for outreach:

- Each trauma team member is gifted a reflection journal and encouraged to write in it daily.

- Each group supervision team member is invited to take turns leading a somatic grounding technique to start each day's group supervision.

- A cohering sense of connection is prioritized through holding hands in a circle while setting intentions, so that the social nervous system of the team is a resource from which all members draw throughout the day's work.

  Group supervision members are deployed for the day in pairs intentionally matched for optimal ease, connection, support, and mutuality; this action reflects a deep relational awareness on the part of the executive director to know how to support all members effectively, and reduce overwhelm in practitioners.

- This group cohering process is then facilitated by each pair with the community group they serve; the community is supported to decide how they wish to come together to join, which often involves holding hands in a circle, singing psalms, and committing the day's service to the community and a higher power. Throughout the morning's work, community members come together in small groups to share stories of loss, overwhelm, and hope; spontaneous attuned touch is regularly employed between community members to facilitate discharge of trauma narratives and provide regulating support, while trauma treatment team members move between groups and facilitate regulated processing of overwhelm toward a coherent narrative. *Mimesis* (matching and mirroring without mocking) in intentionally employed to facilitate co-regulation of trauma narratives, and trauma team members take over as necessary to model trauma processing.

- A lunch break is protected fiercely each day. All trauma treatment team pairs are brought back to the group for a shared meal, where group members are encouraged to share both stressors and highlights of the morning. Concerns are documented for deeper processing in the evening, and the executive director prioritizes providing live supervision each afternoon to the subgroups needing more structure and support.

- The entire community is called together in one large town hall at the end of each day for members to share their experiences with the large group, and then self-selected subgroups are facilitated to discuss needs for the coming day, which are also shared back with the large group so that members are connected across groups. At the end of the work day, the trauma treatment team is recalled to rest. Group members stay in shared housing, so are encouraged to communicate directly about their needs for solitude or connection. External processors are supported with a shared living space to connect and unpack the day informally, while internal processors are supported with quiet time in their rooms before dinner.

- Dinnertime is also fiercely protected. The group comes together to celebrate healing moments and be intentional about shifting into rest-and-digest. After about an hour of informal digestion time, group supervision leaders facilitate a SWOT analysis to complete any remaining emotional charges of the day. Various embodied self-care options are then offered and facilitated between group members to wind down for sleep, to include: yin yoga, evening walk, music and dance, soccer, hair braiding, facials, journal writing, shoulder rubs, and improv games.

The cycles of this team's approach to the year and each service day are mapped onto Judith Herman's triphasic model for trauma resolution: safety and stabilization, trauma memory processing, and reconnection (1992). Using this embodied model for group supervision in disaster outreach settings minimizes the impulse for supervisees to block their physiological and/or emotional responses to the overwhelm they experience, while realizing the limits to how their service can improve the lives of the impacted community. Making space for role

modeling a variety of co-regulatory embodiment practices throughout the day strengthens the resiliency responses of each member, as they are able to choose from approaches that best suit their nervous system and needs in the moment. Normalizing the body's response to group trauma processing creates more emotional bandwidth within and between the members, who then embody that capacity for the community served. Providing psychoeducation to the community served about how they are already implementing this model, and ways to further enhance that through the group and individual practices they are learning with the trauma treatment team, helps increase their self-sustainability and maintenance of embodied gains from the outreach.

Discussion

According to Bersh (2010), Haiti could have had less destruction and fewer casualties if the government had been more vigilant in preparing for disasters and advocating for improved building standards. Benjamin and colleagues (2011) clearly express that it is the responsibility of the country to have a minimum standard of preparedness to maintain, despite receiving assistance from other organizations. Considering all that has occurred with the devastation in Haiti and the continued suffering of its residents from their lack of resources, it is imperative that governing officials and foreign/international supports assess a more effective crisis management plan to prepare for future disasters. Many have thought that Haiti should not continue to operate as a country due to its lack of resources and provision, but many people in that country believe in the slogan that "Another Haiti is Possible" (Bell, 2010). Despite the deprivation and overwhelming oppression of poverty, this population has a shared resilience and resourcefulness to one another, which has proven to foster hope, encouragement, and the continued will for life (Bell, 2010).

Whether supervision is conducted individually or within a group setting, the structure of supervision can influence supervisors' and supervisees' approach. The previously mentioned studies depict important contributions of supervision in diverse disaster environments. Yet the studies provided limited information on the implementation of supervision within a particular disaster setting, in particular operationalizing embodied practices to prevent vicarious trauma and compassion fatigue. Although hurricanes and earthquakes are recognized as types of disasters where supervision takes place, it is difficult to grasp from the literature the differences and similarities within these forms of disasters. The role of the supervisor is mentioned, but specific examples of how they deliver supervision are missing. In the current literature, the practice of supervision in disaster settings is vague, and provides surface-level terminology that fails to provide supervisors and supervisees who may be interested in disaster clinical work with a conceptualization of the hour-to-hour supervisory process. Even though the current literature effectively provides examples of the expansion of traditional roles of supervisors and supervisees in post-disaster situations, it falls short in providing examples of boundaries of nontraditional roles, and the lived experience of how to process the overwhelm while role-modeling for supervisees in real-time.

Another important implication involves mental health professionals' programs that do not have community outreach as an integral part of their program, where training in disaster clinical work must therefore occur outside the classroom, usually during school breaks. There is a limit of available opportunities to engage in this vital experiential work, and there are no job security incentives for supervisors and supervisees in traditional clinical settings to gain international supervision experience in disaster settings. Also, for supervisors and supervisees who do have experience in disaster supervision, there is a lack of evaluation of supervision, the cultural appropriateness of interventions,

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and ethical behaviors in these diverse communities. The shortage of empirical evaluations of supervision in disaster settings creates a risk for clients, supervisees, and supervisors who may be unaware of detrimental strategies or beliefs that could have long-term effects. Since disaster interventions and supervision are time-sensitive and brief, an effective evaluation system is needed to ensure that multicultural competence and social justice principles are adhered to in diverse contexts.

Future recommendations include promoting graduate training; increasing disaster supervision guidelines for supervisors and supervisees; and providing continuing education opportunities (Pettifor et al., 2014). More research is needed to address whether theoretical orientations such as trauma-focused cognitive behavior therapy, liberation psychology, and psychological first aid are effective for different types of disasters. Somatic specialists are also encouraged to center culturally-responsive disaster outreach research into the field's development. More emphasis is needed to recognize the role of supervision within these orientations to address the needs of victims and survivors. Additionally, supervisors and supervisees need to be aware of international ethical codes and mental health professionals' ethical standards in order to understand their roles and boundaries as they practice ethical guidelines in supervision (Pettifor et al., 2014).

Furthermore, greater awareness of supervision as a "distinct professional competence" and formal training in disaster-based competencies is needed (Pettifor et al., 2014). On the same note, more clarity is necessary to understand how the supervision processes would look similarly and differently among professors, psychologists, and other mental health professionals with students and early career practitioners. These unique dynamics can inform these professional relationships and increase professional development by acknowledging the different needs and important considerations of the supervisors and supervisees within disaster work. Further research can shed light on the difference between individual and group disaster supervision while recognizing effective supervision models. These are vital recommendations that need to be considered to appropriately and effectively participate in supervision in disaster settings that affect supervisors and supervisees, but more importantly, the victims and survivors, our clients.

The role of supervision continues to be transformed from a traditional to nontraditional structure that involves supervisors, supervisees, and clients in post-disasters. Current evidence can attest to the effectiveness of supervision in disaster settings, but important areas of growth remain that are needed by mental health professionals. While we understand the significant consequences of disasters, we still lag behind in fully comprehending how our unique training values can influence the lives of victims and survivors with whom we have brief encounters, but can create a lasting impact on their lives. Moving forward, let us not forget about our contributions thus far, but renew our commitment to gain competency in an area that is greatly needed in a setting that can forever change someone's life in a split second. Survivors of disasters are not concerned about our theoretical orientation or type of supervision, but what they do care about is that we are prepared to support them in a difficult time, so let us strive to exceed their expectations of what supervision can offer them.

It is incumbent on those in various roles in the helping profession to reach out and provide service to those in need, both domestically and abroad. The realization that there are people right here in the United States who don't have access to minimal mental health services due to a lack of resources pushes us to look at the necessity of community outreach in our own backyards (McKersie, 2010). Such disparities in skillful trauma resolution and general mental health services can be seen all over the world.

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Juanita Barnett, **PhD**, **LPC**, **NCC**, is an Assistant Professor of Counseling at Alabama State University. She is the faculty advisor for the Counselor Education Student Association and Chi Sigma Iota for the ASU Counselor Education programs. She received her doctorate degree in Counselor Education and Supervision from Auburn University; master's degree in Clinical Mental Health Counseling from Alabama State University; and her bachelor's degree in psychology from Florida State University. Dr. Barnett is a Licensed Professional Counselor in the state of Alabama and a National Certified Counselor with NBCC.

Dr. Barnett's research interests include mental health related issues within the Afro-Caribbean immigrant populations, global mental health, spirituality in counseling, and professional development amongst faculty and counselors-in-training. Dr. Barnett is currently a member of the Haitian Research Task Force. She is passionate about bridging the gap and eliminating the disparities in mental health services for underserved and underrepresented minority populations through research, advocacy, training, leadership, service, and outreach activities.

Dr. Elizabeth Farrah Louis is a Haitian-American psychologist at Harvard Medical School. She is engaged in clinical work and conducts global mental health research. She provides clinical work to immigrants, refugees, asylum seekers and survivors of torture from Latin America, the Caribbean, Africa, and Asia. Dr. Louis also provides therapy to children and adolescents, and supports their families.

Since 2015, Dr. Louis has been engaged in extensive community-based work in Haiti, focused on trauma, disaster relief, mental health, and training laypersons and health and mental health professionals. She is a recipient of the U.S. State Department Boren Fellowship and has worked with Zanmi Lasante/Partners in Health. She completed the National Institutes of Health – Harvard University, Boston University, Fogarty Global Health Fellowship with Partners in Health/Inshuti Mu Buzima in Rwanda (2019-2020). Dr. Louis teaches counseling skills at Boston College to masters students. She is a diversity, equity, inclusion and feminist consultant, and advocates for marginalized populations.

Karen Roller, **PhD**, **MFT**, is an Associate Professor of Counseling at Palo Alto University and Clinical Coordinator of Family Connections, a parent-involvement preschool system serving predominantly Spanish-speaking migrant families in the San Francisco Bay Area. Her doctorate from Santa Barbara Graduate Institute in Clinical Psychology with a specialization in Somatic Psychology included experiential coursework in pre-and-perinatal psychology. Karen has spent her clinical career in family therapy through community mental health for the marginalized and underserved including fostered youth, adjudicated youth, and the Latinx migrant community, as well as international trauma training outreach in Haiti. She co-authored *Lifespan Development: Cultural and Contextual Considerations for the Helping Professions* (Coker et al., 2023) where she was charged with the Infancy into Childhood chapters; she centered force migration and other social determinants of health for underserved and marginalized families.

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