Humanitarian psychological support as an organized field is relatively young. Pioneers in the field were involved primarily in providing psychological support to refugees and internally displaced persons in conflict and nonconflict situations. This article describes basic principles for the design of psychological support programs and interventions. The International Federation of Red Cross and Red Crescent Societies (IFRC) began a psychological support program in 1991. The IFRC chose psychological first aid as its model for implementation in developing countries. Psychological first aid fits all the principles for psychological support program design and is adapted to individual communities. The first generation of psychological support programs differed dramatically depending on the countries in which they were developed. A second generation of psychological support programs evolved in response to the earthquake/tsunami of December 26, 2004. The Inter-Agency Standing Committee international guidelines consolidated the advances of second-generation programs and provided a clear indication of the wide acceptance of the importance of psychological support. A glimpse is provided of the third generation of psychological support programs, and an admonition is made for a more empirical evaluation of the effectiveness of interventions.

Editor’s Note
Gerard A. Jacobs received the International Humanitarian Award. Award winners are invited to deliver an award address at the APA’s annual convention. A version of this award address was delivered at the 115th annual meeting, held August 17–20, 2007, in San Francisco, California. Articles based on award addresses are reviewed, but they differ from unsolicited articles in that they are expressions of the winners’ reflections on their work and their views of the field.

Keywords: disaster mental health, humanitarian assistance, international psychology, psychological support, psychological first aid

The Flight 232 aviation disaster in Sioux City, Iowa, on July 19, 1989, was the first of a series of events that led to the development of a national plan for disaster mental health services (Jacobs, 1995). As a result of our work in that disaster relief operation, Randy Quevillon and I proposed to both the American Psychological Association (APA) and the American Red Cross the development of a national plan for providing psychological support in the aftermath of disasters. Similar ideas were fielded from other psychologists in the months that followed as a consequence of Hurricane Hugo in the Southeast United States and the Loma Prieta earthquake in Northern California. After two years of preparation, APA and the Red Cross announced in October 1991 that they had reached an agreement to have APA support the Red Cross in routinely providing psychological support in disaster relief operations both for those directly affected by the event and for the humanitarian relief workers who respond.

In 1992, I visited the International Red Cross and Red Crescent Museum in Geneva. I was very impressed with the Wall of Time, a display listing each of the disasters and conflicts that had resulted in more than 1,000 deaths since the founding of the Red Cross in 1859, all of which were arrayed around the circular outer wall of the museum. It was striking that out of the many hundreds of events chronicled on the wall, only a few had occurred in the United States. It became clear to me that as disaster psychology developed, it would need to look beyond the borders of the United States to include an international humanitarian perspective and to serve a much broader world audience.

Essentially, the term psychological support refers to strategies for helping meet the psychological needs of ordinary people who have experienced extraordinary events. It focuses on helping people deal with the emotional, cognitive, physiological, and behavioral reactions to traumatic events. Traditional mental health services, in contrast, focus on responding to psychopathology or on long-term self-improvement. Over the past 15 years, concepts of psychological support have evolved and matured. Terminology in the field can still be somewhat confusing, and terms are often used with contradicting definitions. In many cases, however, psychological support has been categorized into (a) disaster mental health or disaster psychology, which involves services provided by mental health professionals, and (b) psychological first aid, which involves support provided by family, friends, and neighbors but not by mental health professionals (Jacobs & Meyer, 2005).

I have served as an American Red Cross Disaster Services volunteer since the crash of Flight 232. I was one of

two psychologists who represented both APA and the American Red Cross on the committee that developed the Disaster Mental Health Services model, providing commentary from South Dakota on each generation of proposals. I served for eight years as a national consultant for Disaster Mental Health Services in the American Red Cross and as one of the initial members of the APA Advisory Board for the Disaster Response Network, APA’s national network of disaster response volunteers. Within my first few years in those various roles, I met a number of Red Cross paid or volunteer staff who had served as international humanitarian delegates with the American Red Cross, the International Federation of Red Cross and Red Crescent Societies (IFRC; the part of the Red Cross movement that deals with nonconflict situations), or the International Committee of the Red Cross (the part of the Red Cross movement that deals with conflict and acts of war). The delegates told harrowing tales of their experiences serving refugees and internally displaced persons in conflict and nonconflict situations. I was surprised to learn that these delegates had not been offered any assistance in coping with the experiences they had directly experienced, with the scenes they had witnessed, with re-entering their comparatively plush Western lives after working for months or even years in portions of the world experiencing intense hardship, or with rejoining a family constellation that had continued to grow and develop despite the delegate’s absence.

In 1994, I began to advocate for better care for international humanitarian workers within the IFRC. In 1991, the IFRC had begun to explore the idea of developing a worldwide Psychological Support Program. I wanted to ensure that the IFRC was considering the needs of the international humanitarian delegates, not simply the needs of those directly affected. I had an emerging vision even then of developing psychological support programs that could improve the resilience and coping capacity of people throughout the world, in different continents, cultures, and circumstances. However, I felt that the first step was to take care of the humanitarian relief workers who were voluntarily putting themselves on the front lines to try to serve those in need. I did not see myself participating in the development of those models, but rather saw myself encouraging the experts in the field to move in that direction.

I don’t think I could have imagined then the way my career would develop. To my dismay, I learned that there were relatively few experts in the field at that time. Many of these early pioneers had made their marks in related fields and routinely put themselves at significant risk for the sake of serving those in need. They were and continue to be an inspiration to me.

Pioneers: The Care of Refugees and Internally Displaced Persons

Mary Petevi had worked for years within the Office of the United Nations High Commissioner for Refugees and the World Health Organization. (She recently retired after more than 30 years in the field.) Much of her time was spent in the field in difficult circumstances, trying to protect and support those affected by conflict and disaster. Her focus on the protection of refugees and internally displaced persons included an understanding of the psychological and social impact of being a refugee and an understanding of the need for basic psychological and psychosocial support. She also understood the problems of applying Western developed-nation concepts of diagnoses, treatment, and psychopharmacology to persons in severe distress in developing countries. She brought to this work her own experience of being a refugee since 1974. She empowered local professionals, associations, and the refugees and displaced persons themselves in the development of policies and practices. She supported their efforts toward improved individual and collective psychosocial functioning and recovery. She spearheaded the development of the World Health Organization’s Tool for the Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations: A Community-Oriented Assessment (Jacobs, Revel, Reyes, & Quevillon, 2006; Petevi, Revel, & Jacobs, 2001), and their Declaration of Cooperation: Mental Health of Refugees, Displaced, and Other Populations Affected by Conflict and Post-Conflict Situations (Petevi, 2001).

Jean-Pierre Revel had served for many years as a physician field delegate with various nongovernmental organizations before joining the IFRC. He assisted those who found themselves in some of the most difficult circumstances and locations in the world. He was chosen to be the first coordinator of the IFRC Psychological Support Program. Although not a mental health professional, he had a sense, firmly rooted in years of fieldwork, of the need for effective basic psychological support. He developed a model that explained that individuals affected by traumatic events were most likely to seek psychological support from their friends and family, and he suggested that the community was the best level for intervention (International Federation of Red Cross and Red Crescent Societies, 1998).

Michael Wessells has spent much of his career protecting children and families in conflict and postconflict situations, working both with the Christian Children’s Fund and as a professor teaching a new generation about these issues. He received an APA Presidential Citation for his humanitarian work at the annual APA convention in Hawaii in 2004. His development of effective community-based models and his development of theory have touched count-
less lives (e.g., Wessells, 1998, 2006; Wessells & Monteiro, 2004).

Jon Hubbard has served for many years as a psychotherapist and field-based researcher for the Center for Victims of Torture in Minneapolis. He has served in many conflict situations. Among other psychosocial projects, Hubbard has worked to develop culturally appropriate community-based research models that can be implemented quickly in diverse communities (e.g., Hubbard & Miller, 2004). He continues to remind psychologists that even in complex crisis situations, intervention decisions are best based on valid empirical data and on program evaluation that is supported by and actively involves the target communities themselves. He is part of the Center for Victims of Torture team that received the APA International Humanitarian Award in 2006 (Stepakoff et al., 2006).

Foundation Principles in Humanitarian Psychological Support

In participating in the development of models for international disaster psychology and psychological support, I consulted with colleagues in community psychology, community theory, and cognitive–behavioral psychology. I expected to find dramatic differences in the ways different cultures experience traumatic stress, but as I worked in more and more countries and on various continents, I was struck much more by the similarities of traumatic stress reactions than by the differences. Spielberger (1966) presented a model of individual reactions to stress. Although the key to his model was the individual’s cognitive appraisal of the stressor, he also suggested that individuals have a limited supply of coping resources, and once those resources are expended, the individual will experience a stress reaction. Hobfoll (1989) has extensively elaborated these concepts in his conservation of resources theory.

I have come to define traumatic stress as stress that is of such magnitude that it can overwhelm anyone’s coping resources, no matter how strong they are, how well-prepared, or how extensive their coping skills. I have developed a hypothesis over the years that it is the overwhelming nature of the stress that leads to the similarity of reactions in such disparate cultures. Nevertheless, with Spielberger as a mentor, I was strongly aware of the importance of culture in helping people prepare for and respond to stress in their lives (see, e.g., Spielberger & Diaz-Guerrero, 1976). That is, culture in all its aspects has the potential to influence both resilience and the ability to recover from traumatic stress—to affect them positively or negatively.

The seven basic principles that I teach for designing an appropriate psychological support program have essentially been the same from the beginning, but my understanding of those principles has matured over time. First, do no harm. That cautionary statement is not merely a trite tru-
need. The Inter-Agency Standing Committee’s (2007) guidelines share this point of view repeatedly throughout the document.

Similarly, I have endorsed principles to guide the actual interventions of providers. Again, these have remained much the same from very early in the development of disaster psychology (Quevillon & Jacobs, 1992), but my understanding of them has matured. First, providers need to be flexible. Whether in disaster psychology or psychological first aid, situations in crises change rapidly, and the needs of those affected change quickly as well. Meeting people’s needs in such situations requires frequent changes in strategies and may mean that, at times, the provider will most effectively offer psychological support by helping meet primary needs (e.g., distributing food, water, and blankets). Second, be supportive. Third, be soothing. Fourth, use some direct guidance. Fifth, be an advocate. Although therapists may need to be cautious and concerned about these issues in a therapeutic alliance, psychological support is not therapy, but is short-term crisis intervention. The focus is to help the client work through this difficult experience in life. It is important to understand traumatic stress reactions and their potential to affect cognitive processing, memory, and problem solving. It is often particularly helpful, for example, to help clients understand their range of options in choosing a strategy to cope with an immediate decision. Sixth, educate. Recent research supports historic clinical intuition that understanding the overwhelming nature of traumatic stress may be the most important protection against long-term traumatic stress reactions (Ehlers & Clark, 2006). Seventh, make referrals as needed. Neither disaster psychology nor psychological first aid are intended to deal with psychopathology. Clients with psychopathology need to be referred to the traditional mental health system. In some developing countries, it may be necessary to help build or augment a mental health infrastructure to serve these needs. Eighth, be present to clients! I have come to believe over the years that this is one of the most important roles a provider can have in psychological support. Essentially, this concept proposes that providers need to be ready to serve those affected by traumatic events when they are ready to be served, not according to the schedule of the providers. Sharing the experience of those in crisis can be a significant source of support to them. In Thailand, one of the most traditional interventions is to simply sit in silence with those who have experienced a traumatic event. I have found the same strategy very useful in many mass-casualty events in the United States.

Planning for Humanitarian Psychological Support

The disaster mental health model developed collaboratively by APA, the American Red Cross, and other mental health professions (Jacobs, 1995) relies on the direct provision of crisis intervention services by licensed mental health professionals. This model has seemed to be an effective support strategy in disasters ranging from house fires to the terrorist attacks of September 11, 2001, but it remains to be effectively empirically tested. Disaster mental health’s reliance on mental health professionals, however, makes it impractical for most of the world (and for potential catastrophic events in the United States). The World Health Organization (2005) reported that wealthy nations have 770.5 mental health professionals per million residents, whereas impoverished nations have only 3.2 mental health professionals per million residents. Thus, in impoverished nations, reliance on mental health professionals is simply impractical. It may also be unrealistic in very large-scale events in wealthy nations. There is always a finite number of mental health professionals. However, if psychologists teach members of the general population how to more effectively support one another, there is almost always a provider nearby.

When the IFRC chose a model to use in helping nations develop psychological support programs, it settled on psychological first aid. This approach was developed primarily in Scandinavia (Jacobs & Meyer, 2005). When I first visited Denmark in 1994, Vinni Smed, who was then the director of the IFRC Reference Centre for Psychological Support, told me that the Danish Red Cross had already trained more than 10,000 residents to provide psychological first aid, and she felt that it had become well-integrated into their culture.

Psychological first aid refers to the provision of basic psychological support by members of the general population, not by mental health professionals. It is community based and is adapted to the culture and practices of whatever community the program is developed by and for. Because the program is developed with the community and the support is provided by members of the community, the support is likely to be culturally responsive. Psychological first aid is low cost, having few expenses other than developing the training and public education materials for the targeted communities. Psychological first aid is community based and low cost, which significantly contributed to its being a sustainable strategy. Additionally, the core skill in psychological first aid is active listening, which is at the heart of many therapeutic techniques. Participants report that active listening is useful not only in their psychological first aid support, but also in their personal and professional communications and relationships. This versatility contributes to its popularity and therefore to its sustainability. Psychological first aid also incorporates the traditional coping strategies of the society, building on the strengths of the culture. Furthermore, it builds the response capacity of families and friends, and these are the people to whom individuals most often turn for psychological support.
There is a saying that seems to be understood throughout the world: “When you have a hammer, everything looks like a nail.” If you have only one tool for providing psychological support, you may tend to do the same thing for everyone, everywhere, every time. Given the breadth of individual differences, this is unlikely to be effective. The saving grace of psychological first aid is that it is adapted and shaped for each community in which it is implemented, so that the tool takes on many different shapes in different cultures. The IFRC’s model called for an initial assessment of the needs of the country. This was to be followed by months of adaptation of the model through the collaboration of the IFRC consultants assigned to assist the country and the organizing committee within the Red Cross or Red Crescent national society that had requested assistance in developing a program. I was asked to participate in the first implementation of the model in Bulgaria in 1996, and it has been developed in various forms in countries throughout Europe, much of Asia, and portions of Africa and South America.

The Inter-Agency Standing Committee’s (2007) recently released guidelines, developed by United Nations agencies and most major international humanitarian organizations, reiterate the long-standing recommendation that expatriate providers (those who are residents of another country) should not provide direct services. Rather, they should consult with and train local providers to enhance their skills in serving their people (Inter-Agency Standing Committee, 2007, pp. 48–49). This is because providing psychological support in a community in which one does not know the culture, the language, the history, the religious beliefs, or the worldview is likely to cause problems and may cause harm. The first principle of providing psychological support, of course, is to do no harm.

Therefore, psychological support programs are generally the product of consultants familiar with such programs (consultants who may be expatriates), leaders of the psychological support program in the country or community developing the program (including representatives of the community who are not professionals), and frontline providers. This is an amazingly rich mixture of human experience. One of the most powerful and rewarding features of this work is the incredible group of colleagues with whom I have the opportunity and privilege to work.

Many outstanding psychological support programs now serve those in need in many parts of the world, and many impressive colleagues direct and manage those programs and serve as frontline providers. I spend much of the rest of this article highlighting a few of these colleagues and their programs to illustrate the development of the field. The limitations of space prohibit paying individual tribute to everyone who has made a significant contribution. However, I feel that it is critically important to highlight a few of the works of these colleagues, because as an expatriate, I would be unable to do more than write empty theoretical treatises if my colleagues around the world did not invite me to consult with them and provide training for their programs. In many ways, it is genuinely their work that this International Humanitarian Award honors.

The First Generation of Psychological Support Programs

In 2004, I was invited to organize a symposium at the 28th International Congress of Psychology in Beijing. I chose to highlight four programs in countries in different parts of the world with whom I had been privileged to consult, sometimes as an IFRC representative and other times representing the Disaster Mental Health Institute.

Sirry Thormar gave a presentation on her pioneering work in Iceland. She directed the development of one of the first national psychological support programs in the world, integrating disaster mental health and psychological first aid models in a program that has become part of the culture of that small island nation. From its inception, Thormar has been a member of the IFRC’s International Roster for Psychological Support, a team of international consultants who contribute their knowledge and expertise to Red Cross and Red Crescent national societies around the world. The Icelandic Red Cross maintains an active continuing education program for professionals, bringing world leaders in the field to Reykjavik to provide training.

Burcu Aydin described the Turkish Red Crescent psychological support program, undertaken with the collaboration of the Turkish Psychological Association. She helped develop the program following the 1999 earthquake that resulted in widespread devastation and loss of life in western Turkey. The program evolved into a model in which psychological support is based in community centers. These traditional Turkish centers include mental health professionals among their staff. They host wedding receptions and similar events, give courses on sewing and cooking, and generally serve as community gathering sites. Psychological first aid has been added to that traditional mix of courses and activities, and in some centers, more traditional mental health services have been made available. The Turkish Psychological Association has also worked with the Turkish Red Crescent Society to implement a disaster mental health program.

Rose Kasina was instrumental in the development of a psychological support program to serve Kenyan residents affected by the 1998 bombing of the U.S. embassy in Nairobi. She described the adaptation of that program to serve HIV/AIDS patients, after the disaster-caused needs of those affected by the bombing had been largely met.

Jun Maeda, an associate professor of psychology at the Muroran Institute of Technology in Hokkaido, was a core member of the team that developed the psychological support program in the Japan Red Cross Society. The Japanese
program has been based in medical teams, because the medical setting is one place in which cultural restrictions on emotional expression and asking for help do not seem so strong. In addition, the Japanese Red Cross Society has 92 hospitals in Japan and fields medical teams in disaster response. They hope to move toward adding a psychological first aid component as Japanese society becomes more accepting of psychological support concepts.

These four programs were designed and implemented by some of the best and brightest in the field of psychological support. I would consider these, together with the American Red Cross disaster mental health program and the Danish Red Cross psychological first aid program, to be first-generation programs, which continue to evolve and change based on changes in the profession and in the cultures they serve.

Developments in Asia: A Second Generation of Psychological Support Programs

The tsunami of December 26, 2004, was among the largest disasters in recorded history, particularly with regard to the loss of human life. The state of Aceh in Indonesia was rocked by the second most powerful earthquake ever recorded (United States Geological Survey, 2007). Minutes later, the coast was struck by a wall of water that reached nearly 100 feet in height in areas of Aceh and wreaked havoc more than two miles inland (Canadian Association for Earthquake Engineering, 2005). The shock wave from the earthquake also raised tsunami waves 65 to 100 feet in height that caused extensive destruction and loss of life in India, Sri Lanka, and Thailand and caused less devastating damage in a number of other countries, most notably the islands nation of the Maldives. Many populated islands there were swept completely underwater by the tsunami. This event also triggered a need for psychological support of historic proportions. Fortunately, a new generation of professionals was ready to support those countries in developing a new generation of programs, building on the psychological support program in India developed jointly by the Indian Red Cross Society and the American Red Cross.

In January 2001, the state of Gujarat in India was struck by an earthquake centered in the Kutch district near the city of Bhuj. It was the second most deadly earthquake in India’s history, a country with a very active seismic history (Cooperative Institute for Research in Environmental Sciences, n.d.). I was asked by the American Red Cross to serve as a humanitarian delegate, implementing a psychological support program that could serve the people affected by the earthquake. Working together with local colleagues and the local Red Cross branches and national staff, we developed a program specific to the Gujarati culture.

Joseph O. Prewitt Diaz, a psychologist and psychiatrist, made significant adaptations to the program on the basis of his extensive experience in Hurricane Mitch in Central America, and he began the implementation of a program in the earthquake-affected area in Bhuuj and the riot-torn camps in Gujarat. The program began with a core psychological first aid program and then moved to community mapping and collective problem solving. It was truly a community-based program. Part of Prewitt Diaz’s adaptation was to build a detailed career ladder of advanced training, enabling paid and volunteer local staff to build their knowledge and expertise over time in a well-structured process. This program has been incorporated by the Indian Red Cross Society and currently operates in Orissa and Gujarat, as well as in Kumbakonam, Tamil Nadu, without outside funding.

Prewitt Diaz’s design was genuinely psychosocial. I had the opportunity to consult with the program in 2005, and it was amazing to see how accepted it was in the communities in which it had been implemented. The program began with community committees to decide the priorities of the community and to decide how best to meet those needs with technical assistance from the program staff. One of the priorities identified by the communities was finding a way for the large number of widows to support themselves and their children. The program invested small amounts of money in community groups. The loans were sufficient to buy needed tools and were to be repaid through volunteer work with the program, rather than in currency. One group of women said they were good at sewing. The program bought them sewing machines and arranged for a place for them to work. Their group now produces school uniforms for much of the region. Another group said they were skilled in embroidery and traditional artwork. They were given the necessary tools to produce high-quality artwork for the tourist industry. These widows now support their families.

Volunteers with the IFRC Psychological Support Program organize many community-wide activities, building the cohesion of the community. Schools had local artists paint large murals representing the cycle of psychological support on the end walls of their buildings. One group of school children asked to develop a response team to support children whose families were involved in disaster, playing with them and talking with them while their parents were occupied with the recovery. Teenagers who volunteer with the program are seen as community heroes and are literally cheered by the community when they earn the right to advance to the next level of training.

The Asian Disaster Preparedness Center (ADPC) in 2002 invited the Disaster Mental Health Institute to work with them in developing psychological support programs in Asia. The ADPC and the Disaster Mental Health Institute developed a statement of understanding, with the Disaster Mental Health Institute serving as ADPC’s partner for psychological support. The Disaster Mental Health Institute...
helped develop psychological support components for a number of regular ADPC training programs, including health/hospital courses and general disaster management courses. Dozens of emergency managers throughout Asia learned the basics of psychological support in the fall of 2004, only weeks before the tsunami struck.

By the time the 2004 earthquake/tsunami occurred, the India Psychological Support Program had begun to spread into other areas of the country, and the program had generated a team of highly trained young professionals under Prewitt Diaz’s guidance. Immediately after the earthquake/tsunami event, the American Red Cross offered some of those leaders to Sri Lanka, the Maldives, and Indonesia to assist in developing programs. All three countries accepted the offer, albeit some countries more quickly than others. These programs have become some of the most impressive I have seen, and two of them were led by young professionals the age of most psychology doctoral students in the United States.

In the Maldives, Satyabrata Dash, a psychiatrist, found that the concepts espoused by psychological first aid were little known in the culture but were quickly accepted by the residents. One major complication there has been that the Maldivian language did not have words to describe many of the ideas, and the federal government closely regulates the addition of new words to the language. Therefore, to avoid having words the public would not understand and to avoid the lengthy bureaucracy of adding new words, concepts are described in phrases, sentences, or even paragraphs using the existing language, rather than with a single new word. This is somewhat cumbersome but is more effective for the time being. Additionally, the Maldives was one of the few nations in the world without a Red Cross or Red Crescent national society, so there was no pre-existing structure within which the program could naturally reside.

In Sri Lanka, the program was developed together with the Sri Lankan Red Cross Society. Anjana Dayal was the expatriate program director there until recently and worked with a local counterpart. Local committees were formed throughout the American Red Cross’s area of assigned responsibility, which included most of the devastated southern coast of the nation. An example of the program’s responsiveness to the communities can be seen in one heavily impacted village. When the community committee was asked what their highest priority was for psychological support, they asked for help in rebuilding their school. The program staff replied that such work was not part of their mandate. The committee responded that the question asked of them was how the psychological support program could most help the community recover and that rebuilding the school was their priority. So the psychological support program began by helping the community rebuild the school. Doing so gave the children a place to go during the day, restoring some degree of order and predictability to their lives. In addition, in the evenings the restored school building served as a gathering place for the community to discuss their difficulties and recovery efforts. Moreover, the committee saw that the psychological support program was serious about listening to them and about making a difference. The program in Sri Lanka has progressed to the point that a Buddhist monastery has asked that their monks be trained in psychological first aid because they can see that it is becoming a part of the Sri Lankan culture. In addition, the American Red Cross is assisting the government in developing a postgraduate diploma in disaster mental health for social workers.

In Aceh, Indonesia, the region doubly damaged (earthquake and tsunami) by one of the worst disasters in world history, the American Red Cross has teamed with the Indonesian Red Cross society to develop the psychological support program. Sujata Bordoloi, who had served as the senior national staff member in the program in India, was tapped to be the expatriate program director of the Indonesian program. This program faced the daunting task of helping more than 120 communities across the most severely impacted coastline to reconstitute themselves. In many areas, 80% of the residents were killed in either the earthquake or the tsunami. This mortality level meant that many of the people with crucial roles in the functioning of the society were gone. In many cases, entire villages were simply erased from the earth, and much of the key city of Banda was flattened by the combination of a major earthquake and the 100-foot wall of water that arrived 15 minutes later. Social reconstruction and the rebuilding of community networks through culturally responsive interventions have been a central feature of the psychological support program there. Additionally, the University of Indonesia and the American Red Cross will develop a master’s degree in disaster psychology to develop leaders for the future.

Both in Sri Lanka and in Indonesia, the psychological support programs have decided to develop their local staff even further, by having 20 of their key workers in each country complete the Disaster Mental Health Institute’s Graduate Certificate in Disaster Psychology–Asia. This certificate program involves four advanced courses individually adapted to each country and taught by Disaster Mental Health Institute faculty, as well as additional readings and projects based on the coursework.

APA’s large donation to the American Red Cross in the immediate aftermath of the tsunami was not targeted specifically at psychological support, but was given with the explicit instruction that it be used wherever it was most needed. Nevertheless, the APA membership can examine these programs with pride, both in the profession, and in APA’s role in financially supporting the American Red Cross efforts.
Another path of the development of psychological support in Asia was APA’s direct support of psychologists and other mental health professionals in the tsunami-affected countries. APA teamed with the International Union of Psychological Science in inviting psychological associations or individual psychologists (there is no national psychological association in Sri Lanka) in the four most affected countries to nominate participants for one week of training held in Singapore. As APA’s consultant on the tsunami, I was also charged with consulting with these participants and offering assistance where I could. In Tamil Nadu, India, the most affected state in India, participants in the Singapore training organized one week of training in psychological support together with the National Association of Psychologists and the Sri Ramachandra Medical College. Psychologists and psychology graduate students from a number of programs in the region were participants. In Sri Lanka, the Singapore participants returned to their disparate roles as academics and practitioners. Some consultation has been provided in Sri Lanka, but there has been no coordinated effort there by the Singapore participants. In Thailand, some of the psychologists trained in Singapore have been developing models that expand beyond the traditional Buddhist model of support. In both academic and applied roles, these psychologists are finding new culturally responsive strategies for providing assistance to enormous numbers of those directly affected by the event. The Indonesian Psychological Association has undertaken some very creative programs, particularly focusing on the needs of youth in the most affected regions. These programs were then adapted for the Yogyakarta region following the large earthquake there in May 2006. Similar to the psychological support program in India mentioned earlier, psychologists in the Indonesian Psychological Association have identified financial concerns as a major stressor in the affected areas, and they are exploring an emerging concept of psychoeconomics. They are currently trying to begin a new professional society within the Indonesian Psychological Association to build on these innovative efforts.

These tsunami-related developments, both through the American Red Cross and through the nations’ psychological associations, have been the foundation of a virtual quantum leap in psychological support in the South Asia region and have produced a second generation of psychological support programs. Dedicated professionals, including Prewitt, Dash, Dayal, Bordoloi, and many others, have literally given years of their lives in our stead to serve the psychological support needs of those impacted by the tsunami, as have many of their local paid and volunteer staff. These expatriates, and many national staff of the psychological support programs who moved from other parts of their countries, have separated themselves from their families and from their home cultures, often living in difficult circumstances, to serve those in need and to build the capacity of the host nations. The local staff have invested their energy in serving their community’s recovery, in many cases delaying their own families’ recovery for the sake of the greater common good. They have done so with an impressive level of professional expertise.

Perhaps the most exciting development in this second generation of international humanitarian psychological support is the release of the Inter-Agency Standing Committee’s (2007) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, which I alluded to earlier. These detailed guidelines and practical field guides were developed through a lengthy process with representatives of most United Nations agencies and international nongovernmental organizations, led by the World Health Organization’s Mark Van Ommeren and the Christian Children Fund’s Michael Wessells, and with the input of hundreds of professionals around the world. These guidelines reflect an acknowledgement of the importance of psychological support by the humanitarian community and a commitment to meet the psychological support needs of those affected by conflict and disasters around the world. They consolidate the advances made to date in the second-generation humanitarian psychological support programs.

Third Generation: Looking to the Future

Even as these second-generation psychological support programs are maturing and evolving, a third generation is being designed. New professionals and experienced psychologists new to the humanitarian assistance field are able to see with new eyes. Justin Curry, psychosocial advisor to International Services for the American Red Cross, is one of those trying to shape a new vision for the field, focusing on long-term perspectives and developing new ways of integrating the community-based models of psychological support into other sectors of humanitarian relief. Professionals working on such components as water and sanitation and health have recognized that the community psychological first aid committees are a powerful resource for activating and educating community residents. In addition, Curry has recognized the need for more systematic and validated assessment, monitoring, and evaluation of psychological support programs. Most of the existing IFRC and American Red Cross programs have been evaluated with moderately loose qualitative methods, which makes comparison of different strategies in different events difficult. Curry has encouraged an international dialogue on strategies and techniques for effectively and scientifically evaluating programs that adapt uniquely to each culture and community. These are difficult issues in community-based programs, and they have been discussed for decades in the United States (e.g., Iscoe & Spielberger, 1970). The issues become even more complex within an international context. Valid program evaluation is particularly important.
in humanitarian efforts, in which donors need to be shown the effectiveness of their investments. It is easier to demonstrate the impact of a pound of food than a measure of psychological support, but the latter may be no less important to the recovery of an affected community.

In a separate initiative, APA has been spearheading the development of ethical guidelines and/or a code of conduct for American psychologists working internationally. Merry Bullock in the Office of International Affairs and Stephen Behnke in the Ethics Office teamed to host an international gathering of some of the world leaders in the field in December 2006 to begin to frame the necessary concepts for subsequent amplification and review by other colleagues.

In summary, international psychological support in the humanitarian community was founded by a group of pioneering professionals. These programs developed and matured. By the time of the earthquake and tsunami of December 26, 2004, the field was poised to serve those affected by this unprecedented catastrophe with a series of psychological support programs that evolved from the first generation and built on the foundation of the knowledge constructed by the pioneers in the field. The establishment of the Inter-Agency Standing Committee’s (2007) internationally agreed on guidelines is a clear sign that psychological support has come of age in humanitarian service. Although this second generation of programs thrives, leaders in the field look forward to and prepare for the next generation of innovations, particularly with respect to the scientific evaluation of those programs. I sincerely hope that you and I can contribute to that next generation.

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