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Logistic and Structural Considerations for the Use of Psychological First Aid in Humanitarian Emergencies

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Logistic and Structural Considerations for the Use of Psychological First
Aid in Humanitarian Emergencies

Taylor Johnson

Fall 2019

SIT Global Health and Development Policy

Dr. Alexandre Lambert

Johns Hopkins University

Public Health

Recommended Citation:

Johnson, Taylor. (2019). Logistic and Structural Considerations for the Use of Psychological First Aid in Humanitarian Emergencies (Unpublished undergraduate independent study project). School for International Training, Nyon, Switzerland.

Abstract

Following the IASC recommendations for implementation of psychological first aid (PFA) in 2007, providing PFA in humanitarian emergencies as a method of psychosocial support has become one of the standard interventions in the wake of crises. However, the impact of PFA on future mental health outcomes remains largely unstudied and many structural and logistic factors (e.g. training of PFA providers, reviewing evidence to inform practice, and policy considerations) must be managed in order to ensure appropriate, high-quality PFA in humanitarian emergencies. This research aims to synthesize both primary interview data and the existing literature surrounding PFA in humanitarian emergencies to develop practical training, policy, and research recommendations for the global mental health community moving forward.

Acknowledgments

Many people made this paper possible with their generous support throughout the research process. I would like to extend a sincere thanks to the experts who participated in the interviews for this research: Alison Schafer, Caroline Schlar, and Donatella Paioro. Your insight into social support during humanitarian crises is enlightening, and your willingness to support my academic efforts and development was inspiring.

Secondly, the support and guidance of the SIT Global Health and Development Policy staff were essential throughout these past few months. Thank you for consistently providing advice and guidance on how to reach my goals for this project.

And finally, I would like to thank the other SIT Global Health and Development Policy students for their unfailing support throughout this semester. Their selfless efforts to create a supportive academic environment for all its members were admirable and crucial to the success of this paper.

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Introduction

Global mental health is a relatively new field with an increasing number of obstacles. One of the main challenges is the increasing number of humanitarian emergencies and the increasing duration of these crises, with children, internally displaced persons, refugees, and women and girls continuing to be especially vulnerable populations (UN Office for the Coordination of Humanitarian Affairs, 2018). Because rates of mental health disorders like depression, anxiety, and post-traumatic stress disorder can double in emergency situations, it is crucial that mental health and social support are addressed comprehensively and appropriately during humanitarian emergencies (World Health Organization [WHO], 2019). Prior to 2002, the standard intervention to address trauma-related stress in the immediate aftermath of a crisis was debriefing, during which a group or individual survivors of a traumatic event are encouraged to talk about the emotional, physical, and social difficulties they have been facing in the wake of the traumatic event. However, in response to several systematic reviews concluding that debriefing in the first 2 weeks after a crisis may negatively impact survivors, the World Health Organization Department of Mental Health and Substance abuse no longer recommends the use of debriefing as an immediate mental health and social support intervention (WHO, 2012).

Since the decline in using debriefing after crises, psychological first aid (PFA) has become the standard tool for providing immediate psychosocial support in humanitarian emergencies. PFA is defined as a humane, supportive response to suffering, including listening carefully, addressing basic needs, encouraging social support, and protecting survivors from further harm (Sphere Association, 2011). This approach differs from debriefing in multiple aspects: there is less of an emphasis on telling the traumatic story to the provider, and more of an emphasis on meeting people where they stand, emotionally and physically. As outlined by

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Psychological First Aid: Guide for field workers (2011), there are three action principles within PFA: look, listen, and link. In this way, when PFA providers are in the field during a humanitarian emergency, they are prepared to look for and identify people who may be distressed (including assessing physical symptoms of distress), engage in meaningful conversation with them in order to assess their needs, and then guide them towards other resources to meet those needs, whether they require services for further mental health care, social support, or addressing other basic needs. These principles are straightforward and adaptable, meaning that PFA can be used in a wide variety of situations and by people who are not mental health professionals, which makes PFA a promising tool for use in humanitarian situations because of the multitude of settings they encompass and the potential lack of mental health professionals in the area.

However, ensuring that responders utilize PFA as effectively as possible in humanitarian emergencies and implement it appropriately for the populations served is crucial to ensuring proper social support services during these crises. However, there is little quantitative research available on the effectiveness of PFA, except for a recently conducted randomized control trial that found it significantly decreased symptoms of anxiety and negative affect while also promoting positive affect scores (Despeaux, Lating, Everly, Sherman, & Kirkhart, 2019), let alone research conducted on facilitating factors and barriers to PFA in emergency settings (Fox et al., 2012). This leaves a gap in the literature that a comprehensive, qualitative analysis of the logistic and structural considerations for the usage of PFA in humanitarian emergencies could address. This qualitative analysis will address this gap by incorporating both primary qualitative data from formal interviews with PFA experts and reviewing the current literature on these aspects of PFA.

Research Methodology

This analysis of the logistic and structural considerations for PFA in humanitarian contexts uses a qualitative methodology, integrating primary data from individual, formal interviews with experts in the field and secondary data from academic and organizational resources relevant to the topic.

The interviews conducted for this analysis were formal, semi-structured interviews. The interviewees were selected based on their previous contribution to research evaluating PFA, experience in training PFA providers, developing PFA guidelines, or providing PFA in humanitarian emergencies themselves. The questions aim to gather information on the interviewee's professional experience with PFA and how their experiences relate to PFA's effectiveness, especially regarding impacts on self-efficacy among providers, improving training efforts, the development of the research, the use of PFA at a policy level, and perceptions of PFA among providers and recipients.

The interviewees included were Alison Schafer, Donatella Paioro, and Caroline Schlar. Alison Schafer is currently a technical officer at the WHO and has contributed to multiple academic papers and technical guidelines regarding PFA, including the development of *Psychological First Aid: Guide for field workers*, a guidebook developed by the WHO, War Trauma Foundation, and World Vision (WHO et al., 2011). Donatella Paioro and Caroline Schlar are staff psychologists at Médecins Sans Frontiers (MSF) Geneva, both of whom have experience with PFA training for work in humanitarian emergencies.

The literature review component of this analysis includes both academic and organizational sources. The academic secondary sources were identified through searching

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academic databases for academic articles regarding the structural and logistic factors impacting the use of psychological first aid in humanitarian emergencies. Nine sources were identified in this manner to be included in the literature review section (Allen et al., 2010; Fox et al., 2012; Dieltjens, Moonens, Praet, De Buck, & Vanderckhove, 2014; Schafer, Snider, & Sammour 2016; Lee, You, Choi, Youn, & Shin, 2017; Birkhead & Vermeulen, 2018; Akasaka & Kawashima, 2019; Horn et al., 2019; Despeaux, Lating, Everly, Sherman, & Kirkhart, 2019). The organizational resources were identified by searching prominent humanitarian aid organizations engaged in mental health and psychosocial support in humanitarian emergencies and identifying their PFA guidelines and reports. Two sources were identified in this way and included in the literature review (International Medical Corps, 2010; World Health Organization, War Trauma Foundation, & World Vision International, 2011).

Ethical Considerations

In order to ensure that the methodology of this analysis was ethically sound, the interviewees were only asked to speak in a professional capacity, verbal consent was obtained to reference all conversations included in the analysis, and no members of vulnerable populations were recruited to participate. Because of this, the School for International Training's local review board reviewed an expedited human subjects review application and approved it without modifications. Additionally, none of the interviews were recorded, and all interviewees are aware that they can withdraw their participation at any time. All participants have received copies of the final draft to confirm the accuracy of the responses represented in the analysis.

Limitations

This analysis has several limitations, including a small sample size regarding the formal interviews, a brief period between the interviews and the submission of the final draft, and the difficulty in recruiting experts to participate. These limitations potentially hinder the generalizability of the results and the depth of the analysis.

Literature Review

To better understand the current strengths and challenges facing the implementation and effectiveness of PFA in humanitarian emergencies, it is crucial to analyze the relevant literature within the greater context of the growth and development of PFA. Therefore, this section of the paper analyzes both academic and organizational sources surrounding multiple themes, including evidence surrounding PFA effectiveness, PFA guidelines, perceptions of PFA among providers, training structure, and the impact of recipient characteristics. However, to best represent the progression of the literature, the analysis of these sources is in chronological order.

In 2008, PFA had already gained traction internationally and disaster relief organizations in the United States were beginning to utilize it in crises. To assess provider perceptions of this newly implemented intervention, Allen et al. (2010) conducted the first quantitative evaluation of provider perceptions of PFA after Hurricanes Gustav and Ike. Their results indicated that provider perception was overall positive, with providers reporting that PFA is beneficial in their response activities; however, differences arose depending on whether the recipient was a child or adult, with providers reporting more confidence in providing PFA to adults than children (Allen et al., 2010), suggesting that this could be an area of improvement in future PFA training initiatives.

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Shortly thereafter, the WHO, War Trauma Foundation, and World Vision International published a guidebook for field workers that introduces the concept of PFA, explains how to provide PFA using the action principles of “look, listen and link”, emphasizes the importance of self-care, and practice scenarios to help workers envision how they will use PFA in the future and some of the challenges they may face. This marks a major development for PFA, further building from the mhGAP Guidelines Development Group’s assessment that organizations should offer PFA in place of psychological debriefing, solidifying the use of PFA as a standard within the field.

Beginning as early as 2012, non-governmental organizations (NGOs) began to evaluate the effectiveness of their PFA training, and the International Medical Corps did this using a training needs questionnaire, pre-post test, and a training evaluation after a two-day training session with field workers who were responding to the needs of displaced Syrians in Lebanon in 2011 (IMC, 2012). During the training evaluation, providers reported that the two-day training was informative because of its incorporation of the PFA principles of “look, listen, and link” and that case-studies, role-playing, videos, and concrete examples were especially helpful (IMC, 2012).

During this same period, systematic reviews began to evaluate the effectiveness of PFA to inform treatment standards and guidelines (Fox et al., 2012; Dieltjens, Moonens, Praet, De Buck, & Vanderckhove, 2014). Both systematic literature reviews had similar findings: there is not enough evidence evaluating the effectiveness of PFA and its various practice guidelines, with outcomes-oriented research lacking and no groups conducting controlled trials at the time. However, as Fox et al. (2012) explain, this is not surprising because providers use PFA in such sensitive and dangerous settings which are not conducive to extensive analysis, making direct

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evidence for PFA effectiveness difficult to attain. However, although PFA is not evidence-based, experts classify it as “evidence-informed” because of “available objective observations of measurements of effectiveness and expert opinion” (Fox et al., 2012). Although these reviews potentially call into question the utility of PFA, there have been qualitative papers published since that support the effectiveness of PFA. For example, Schafer, Snider, and Sammour (2016) found during focus group discussions with PFA providers and recipients in Gaza after the conflict in 2014 that PFA promoted safety, calming strategies, a greater sense of control, and hope in spite of adversity. Additionally, there was no evidence that PFA caused harm to its recipients, which is a concern when speaking with people who have recently experienced trauma, as recalling the recent trauma can cause emotional distress. Additionally, this study found that PFA delivered in a “whole-of-family” approach might be more effective and able to reach a broader population. Additionally, the authors comment that although PFA lacks evidence suggesting improved clinical mental health outcomes, “as PFA is not a clinical intervention, PFA research utilizing clinical outcomes (e.g., reduced longer-term prevalence of mental disorders) may not be a suitable research goal” (Schafer et al., 2016). This quote highlights the shift from demanding the justification and substantiation of PFA by clinical outcome research to a more holistic understanding of PFA and the potential benefits it may bring recipients.

More recently, the trend of qualitatively evaluating the effectiveness of PFA and assessing the barriers and facilitatory factors for PFA have continued. For example, in regard to training styles, Lee et al. (2017) found that a one day training composed of a three hour didactic portion and a three hour simulation-based practice showed an increase in PFA knowledge and perceived confidence for student participants and school counselor participants, and perceived preparedness, and confidence in providing PFA in future disaster relief efforts among school

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counselor participants (Lee, You, Choi, Youn, & Shin, 2017). However, this study did not find an increase in willingness to provide psychological support during a future disaster. However, this didactic and simulation model may address the barrier of time restraints during training since the training program evaluated lasted only one day. However, Horn et al. (2019) conducted a qualitative study using semi-structured interviews in order to assess PFA trainers, individuals who received training, and key informants to assess the effectiveness of short PFA training periods during the Ebola outbreak in 2014. This study indicated that training of trainers sessions were of an inadequate length, causing variability in the quality of PFA training. The newly trained providers showed a strong understanding of the active listening component, but the actual responses to people in distress did were less consistent with the protocols presented in training. In light of results such as these, Birkhead and Vermeulen (2018) argue in an editorial published by the American Journal of Public Health that for future PFA training to be sustainable, it must be flexible, modular, and multi-faceted, citing the successes of the Centers for Disease Control and Prevention's Center for Public Health Preparedness with their training guides, materials, and sessions. As PFA becomes more omnipresent within humanitarian responses, providers and humanitarian organizations must be aware of these considerations for training sustainability, effectiveness, and efficiency.

Additionally, there will need to considerations for certain vulnerable populations receiving PFA, with a special focus on children. As previously mentioned, Allen et al. (2010) found that while providers feel confident when responding to emergencies after PFA training, they are less confident when they are working with children. Fortunately, according to Akasaka and Kawashima (2019), the PFA for Child Practitioners manual successfully boosted PFA providers' confidence and competence while working with children after the Kumamoto

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earthquake in Japan. This shows a promising solution to the providers' lack of confidence when working with children found by Allen et al. (2010) and introduces the potential for specialization within generalized PFA training.

In recent research and practice, group PFA has become of more focus as well. As mentioned earlier, the “whole-of-family” approach showed promising results according to Schafer et al. (2016), providing qualitative evidence that this approach has promising potential for implementation in future practice. Furthermore, in the only randomized control trial to date evaluating PFA, Despeaux, Lating, Everly, Sherman, and Kirkhart (2019) found that group PFA significantly increased positive affect and lowered negative affect and state anxiety 30 minutes after the PFA intervention when compared with a group conversation condition. This not only provides compelling quantitative evidence that PFA itself is effective, but also that group PFA has promising potential as an effective and efficient response in humanitarian emergencies.

The literature surrounding PFA has greatly evolved over the past 15 years, which reflects the urgency of implementing PFA in order to address mental health and psychosocial support needs in the wake of a disaster and the efforts of the field to assure that provision of and training for PFA is of the utmost quality and efficiency. From perceptions to barriers and efficacy, there remain many questions on how to best utilize and implement PFA in humanitarian emergencies. To best answer these questions, research will need to continue evaluating and adapting to practice, incorporating provider and recipient experiences while incorporating quantitative evidence whenever possible. To further this goal, the remainder of this paper will be dedicated to synthesizing the literature review and the primary qualitative data from interviews with PFA experts and providers in an effort to appropriately capture the effectiveness of, facilitating factors for, and barriers to PFA in humanitarian settings.

Analysis

When evaluating the logistic and structural factors impacting PFA, three major themes emerged: training factors, evidence for effectiveness, and policy. Thus, the structure of the analysis will follow these themes, synthesizing the existing literature on the subject with the findings from the formal interviews.

Training Factors

To ensure that the quality of PFA delivered is appropriate for the humanitarian context, there are multiple factors to consider and adapt to each individual training situation. The five factors that frequently emerged were ensuring appropriate training content for people without psychological support backgrounds, appropriate length of training, training techniques utilized, cultural adaptability for training role-plays and examples, preparing providers for group PFA settings, and introducing specific strategies to approach working with children.

Since PFA is designed to be accessible to people without a psychological support background, training content needs to be both thorough, understandable for people from varied professional backgrounds, but also adequately equip them with the tools necessary to provide PFA of high quality that does not harm the recipient. Thus, the fact that providers often do not come from a psychological support background can be a barrier to address; this requires training that clearly defines the purpose of PFA and the role of PFA providers, and also what it is not, while also remaining engaging and effective. Regarding the need to clearly define PFA, training needs to convey that PFA providers are therapists and that there are limits to the support they can give PFA recipients. During the interview, Alison Schafer reinforced this idea and commented that understanding the limit of the support they can provide through PFA can be especially

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frustrating for providers when they are faced with situations that require further training and experience, such as being unequipped to help a recipient who is a victim of intimate partner violence (A. Schafer, personal communication, November 18, 2019). However, having training content that clearly defines the purpose and limitations of PFA can help providers better understand their role and limit the risk of the providers inadvertently harming the recipient by stepping outside the realm of what they are properly trained to do.

However, even if the content is appropriately adapted for the professional background of the trainee, the length of the training can have a crucial impact on the quality of PFA provided in the future. As mentioned in the literature review, Horn et al. (2019) have criticized the usage of short training programs for non-specialists, which they found resulted in variable PFA quality during the response to the Ebola outbreak in 2014. However, the fact that the intended environment for using PFA is in emergency settings, time and resources may be scarce regarding training. Thus, it may be more feasible to improve the engagement and modify the content within the training procedures instead of increasing the length of the training. Alison Schafer stated during the interview that her preferred length of training is one full day and that it does not need to be longer; however, she also believes the implementation of half-day training sessions of only a few hours is concerning (A. Schafer, personal communication, November 18, 2019). Therefore, evaluating the length of training will continue to be essential to ensure the quality of PFA.

In addition to the length and content of PFA training, another factor to consider are the training techniques utilized. Specifically, the utilization of role-playing and simulation activities during training can increase the quality of the training and eventually the PFA provided. As mentioned in the literature review, Lee et al. (2017) found that following a one-day PFA training session with students and school counselors consisting of a three-hour lecture and a three-hour

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simulation-based practice was effective in increasing PFA knowledge and perceived confidence providing PFA. This shows the utility of role-playing and simulation activities within a PFA training context and reinforces the evidence that one day PFA training is effective, especially when the training incorporates simulation components. Alison Schafer also recommends role-play and simulation-based training techniques within PFA training, and she finds the increase in online, PowerPoint-based presentations concerning (A. Schafer, personal communication, November 18, 2019). Therefore, in the future, to ensure that short, one-day PFA training sessions are effective and appropriate, the training sessions should incorporate role-playing and simulation elements.

PFA training efforts that include preparing providers to act in a manner that is culturally appropriate is standard, because of how crucial cultural respect is to build a connection with recipients of PFA (some of these strategies are described in table 1, taken from *Psychological First Aid: Guide for field workers* [WHO et al., 2011]). However, in order to ensure that the role-play and simulation activities within the training itself are productive, it is important that the training session materials are culturally appropriate and relevant to the trainee population and tailored to the future response activities, if possible. Alison Schafer's strategy for accomplishing this is to fit cultural practices is creating the training materials to fit the cultural norms of the population to the best of your ability based on experience, and then seeking feedback from the trainees and then incorporating their modifications, if there are any (A. Schafer, personal communication, November 18, 2019). An example she provided from her time working in Gaza illuminates this process well: the role-play situation being presented was consoling a parent whose child is missing, and Schafer's recommendation to the providers was to not provide false hope to the parent by reassuring the parent that their child would be found, because unfortunately

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there is a high probability that their child will not be found. To Schafer, providing false hope is not the role of the PFA provider and could be harmful in the long term to the recipient. However, within the Muslim religious context, some recipients would find it rude and almost offensive to not provide reassurance to the parent, because it borders on showing a lack of faith. This is just one example of how cultural norms and practices can influence the way that people experience, express, and respond to grief and trauma, and it demonstrates the need for PFA training and trainers to be aware as possible of the cultural context within which they are operating and the need for them to be flexible and open to feedback regarding this highly nuanced and sensitive aspect of PFA.

CONSIDER THE FOLLOWING QUESTIONS AS YOU PREPARE TO OFFER PFA IN DIFFERENT CULTURES:

Dress	» Do I need to dress a certain way to be respectful?
	» Will impacted people be in need of certain clothing items to keep their dignity and customs?
Language	» What is the customary way of greeting people in this culture?
	» What language do they speak?
Gender, Age and Power	» Should affected women only be approached by women helpers?
	» Who may I approach? (In other words, the head of the family or community?)
Touching and Behaviour	» What are the usual customs around touching people?
	» Is it all right to hold someone's hand or touch their shoulder?
	» Are there special things to consider in terms of behaviour around the elderly, children, women or others?
Beliefs and Religion	» Who are the different ethnic and religious groups among the affected people?
	» What beliefs or practices are important to the people affected?
	» How might they understand or explain what has happened?

Table 1: Cultural Considerations for PFA providers. (WHO et al., 2011)

Regarding the development of new PFA techniques for humanitarian response, group PFA is a promising candidate. There are multiple studies showing positive responses to group PFA in multiple settings, and logistically group PFA settings allow for a larger audience to

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receive PFA, while also increasing the potential impact of each individual provider. In a reflective learning report after the implementation of PFA in Gaza, Schafer et al. (2016) found that a “whole-of-family” approach was especially effective, promoting both familial and community relationships. Additionally, the only controlled trial evaluating PFA was assessing the impact of group PFA, showing that group PFA increased positive affect scores and lowered negative affect and state anxiety scores. Additionally, Caroline Schlar remarked during our interview that group PFA can be useful for disseminating information to an entire group or family, which is an important consideration, since this facilitates information sharing with the entire family (C. Schlar, personal communication, November 21, 2019). All these examples show the potential benefits of group PFA, but group PFA has its own issues with implementation. Specifically, Alison Schafer commented during the interview that while group PFA is very promising and has had positive results in her experience (increased social support, stronger sense of community, provides a chance to integrate mothers into psychosocial support services), there are potential cases where the group mentality may shift towards catharsis and rumination on the trauma (A. Schafer, personal communication, November 18, 2019). This is not the goal of PFA, which aims to maintain a hopeful and supportive environment. Because of these concerns, it is especially important that providers of group PFA know how to guide the conversation away from catharsis and reliving the trauma and towards more constructive conversations.

And finally, the final theme regarding training factors that emerged through this analysis is the need for training to appropriately address the challenges for PFA providers when working with children. Allen et al. (2010) found that PFA providers report lower confidence when working with children than when they are working with adults, showing a potential opportunity

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for training to address provider self-efficacy by emphasizing training providers specifically on supporting children with PFA. Additionally, Akasaka and Kawashima (2019) also noted some additional challenges providers encountered when providing PFA to children after the Kumamoto earthquake in Japan, including frustration with responding to children with aggressive responses or one who clings to providers in a way that is inappropriate according to social norms. However, Akasaka and Kawashima (2019) also found that the PFA for Child Practitioners manual was successful in increasing the providers' confidence when providing PFA to children and their competency in providing that PFA. Regarding how providers can better adapt to working with children, Schafer cited two primary areas of improvement: language and behavior (A. Schafer, personal communication, November 18, 2019). In her experience, she has noticed that providers are unsure how to speak to these children, even if they have experience with children in their personal life. She emphasized the need for providers to use simple language that is more human and kinder like they would naturally when speaking to children. However, she also noted that the priority when providing PFA to a child is the "link" action principle of PFA; for protection purposes, it is often in the best interest of the child to be reunited with a parent, guardian, or close relative, making this a key priority for PFA providers when working with children. Donatella Paioro discussed in our interview that in general, they recommend limiting physical contact with people after trauma because it is not accepted in many cultures; however, this recommendation is not as applicable to children, who may need physical contact as a way to reassure them. Thus, Paioro recommends being close enough to the child for them to initiate contact, but not to pressure them to do so (D. Paioro, personal communication, November 21, 2019). Considering these recommendations and the evidence showing PFA providers' hesitation when working with children, future training efforts should aim to

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incorporate advice on communicating with children and how to best link them to the people and resources they need during a humanitarian emergency.

During the course of this analysis, there have been multiple areas of improvement within PFA training identified. In order to maximize the quality of PFA provided while maintaining feasible training expenditures, training efforts will need to clearly define the role of the provider, have a relatively short time frame (but no less than a length of one full day), incorporate role-play and simulation activities to remain informative and engaging, continuously evolve to match the cultural norms of the population, and devote special attention to the challenge of providing PFA to children in humanitarian emergencies.

Evidence Limitations

In the global mental health field, there is an imperative to ensure that the interventions used are effective, appropriate, and acceptable, and PFA is no exception to that imperative. However, there is no quantitative evidence showing any improvement in clinical mental health outcomes in humanitarian emergencies where PFA was a part of the response strategy (Fox et al., 2012; Dieltjens et al., 2014). Since these reviews, there has only been one controlled trial evaluating PFA, which was not conducted in a humanitarian setting, but the study did find decreased levels of anxiety and negative affect and increased levels of positive affect after a group PFA intervention (Despeaux et al., 2019). While this study is promising in moving PFA towards being evidence-based, not all experts believe that PFA truly needs to be evidence-based because it is so thoroughly evidence-informed. Thus, this section of the analysis aims to determine whether the fact that PFA is currently evidence-informed and not evidence-based opens the quality of PFA and its utility to criticism within a humanitarian context.

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Although the two previously mentioned systematic reviews finding direct evidence of PFA's effectiveness (Fox et al., 2012; Dieltjens et al., 2014), there are multiple qualitative studies supporting the effectiveness of PFA in a more holistic manner. The main aspects of PFA supported by evidence are positive feedback from recipients, positive perceptions among providers, and reported improved self-efficacy among providers.

When considering whether there is additional evidence needed to support the utility of PFA in humanitarian emergencies, one of the most important considerations is whether recipients themselves value the support provided through PFA. Schafer et al. (2016) evaluated this in Gaza, finding that recipients reported beneficial psychosocial effects and contributed positively to safety, reduced distress, increased ability for calming practices and providing social support, and increased hopefulness and a sense of control, all of which have shown to promote recovery in the wake of a disaster (Hobfoll et al., 2007). Thus, although there may not be clinical outcomes-based evidence to support to usage of PFA, there is compelling evidence from recipients that suggests PFA is a useful immediate response to promote recovery.

In addition to recipient perceptions, provider perceptions of PFA utility is an important consideration. Regarding whether providers believe that PFA is helpful as a psychosocial intervention for its recipients, there is considerable evidence that providers perceive PFA positively. Allen et al. (2010) found that providers found PFA to be helpful to their disaster response activities and positively rated the utility of the core actions of PFA, as defined by the National Child Traumatic Stress Network and the National Center for Posttraumatic Stress Disorder: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social support, information on coping, and linkage with collaborative services (Brymer et al., 2006). Considering that these core actions should be

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essential priorities within the humanitarian field, the fact that providers find these parameters met by PFA calls into question whether additional evidence from clinical mental health outcomes is necessary to justify the implementation of PFA in humanitarian emergencies. When discussing provider perceptions of PFA in the interview with Alison Schafer, she agreed that generally PFA perceptions are positive, with the exception of providers wishing that they could do more for the recipients, as mentioned in the training factors portion of this analysis (A. Schafer, personal communication, November 18, 2019). Thus, the positive provider perception of the utility of PFA supports its implementation in disaster response efforts.

In addition to the positive perception of utility from PFA providers, PFA improves self-efficacy among providers when responding to an emergency. In the interview, Alison Schafer remarked that PFA gives non-specialists permission to “be human”; that is, that they are allowed employ the tools they already use in their daily lives to comfort and support friends and family (e.g. empathy, connection, and compassion) with the survivors of humanitarian emergencies (A. Schafer, personal communication, November 18, 2019). Caroline Schlar also remarked during our interview that it gives words to something that is normally obvious (C. Schlar, personal communication, November 21, 2019). Additionally, it gives providers a framework to operate within, so they are more confident in using these social support skills. Schafer also mentioned that it can be empowering for local community members to feel prepared to support their communities in the face of a crisis. And finally, because PFA facilitates self-care and awareness of one’s own limitations, providers are better able to recognize their own needs for social support after receiving PFA training (A. Schafer, personal communication, November 18, 2019). In this way, PFA promotes effective response to humanitarian emergencies by improving the self-efficacy of providers.

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And finally, in addition to this qualitative and anecdotal support, there is an argument that clinical mental health outcomes are not appropriate measures for the effectiveness of PFA, which would diminish any claims that the lack of this type of evidence reflects negatively on the utility of PFA. Allison Schafer remarked in our interview that the goal of PFA is to be a small component of a larger response and that positive impacts on mental health outcomes in the long term may be possible, but that is not the role of PFA; its role is to promote humanity, and that having a supportive human being after a crisis is appropriate and important, regardless of whether it eventually results in improved mental health outcomes (A. Schafer, personal communication, November 18, 2019). PFA is not a clinical intervention nor is it designed to treat or prevent mental illness, so searching for clinical evidence of efficacy is not necessarily appropriate. Instead, the justification for utilizing PFA lies in the anecdotal and qualitative evidence provided by both recipients and providers who have experienced the benefits of PFA in humanitarian emergencies.

Policy Considerations

As discussed in the training context, trainers and providers of PFA need to thoroughly understand the limitations of PFA and the impact of culture on how to implement. In the same manner, organizations should develop policy surrounding the usage of PFA with these factors in mind. This section of the paper will analyze the policy considerations surrounding the appropriate implementation of PFA in humanitarian settings.

Firstly, there have been concerns that PFA has been depended on as a substitute for a more comprehensive, long term mental health system within humanitarian emergencies. Alison Schafer commented that this was a large concern after the introduction of PFA and that PFA does not constitute an entire system of mental health and psychosocial support services but needs

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to be a part of a larger system (A. Schafer, personal communication, November 18, 2019). She continued that it does not eliminate the need for specialists, and is not designed to prevent or treat mental illness; however, she also remarked that this attitude has waned in the last few years, although progress in this area would have ideally happened closer to the rollout of PFA.

This overdependency on PFA reflects a distinct misunderstanding of what PFA is and what its limitations are; as Schafer remarked, it is not a “panacea”, and should not be treated as such (A. Schafer, personal communication, November 18, 2019). Additionally, this distinction has been made in the guidelines for PFA since its early development: for example, within the publication *Psychological First Aid: Guide for field workers* (WHO et al., 2011), there is a specific section in the first chapter outlining what PFA is not: “It is also important to understand what PFA is not: It is not something that only professionals can do. It is not professional counseling...It is not asking someone to analyze what happened to them or to put time and events in order. Although PFA involves being available to listen to people’s stories, it is not about pressuring people to tell you their feelings and reactions to an event.” Keeping these limitations in mind, the humanitarian community should avoid overdependency on PFA when coordinating mental health and psychosocial support response to a humanitarian emergency.

Additionally, there are multiple qualitative studies that show that while recipients find PFA to be beneficial in response to a crisis, this benefit is minimal if other basic needs are unmet. For example, Schafer, Snider and van Ommeren (2010) found that while they were testing a pilot of draft PFA materials while responding to a major earthquake in Haiti in 2010 providers reported that “without basic needs, it’s not easy to comfort people” and “this guide [should] be more practical and adapted to the community and bring them water and nutrition.” This sentiment reinforces Schafer’s remark that PFA is not a “panacea,” and providers can be left

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in a frustrating situation if humanitarian relief efforts are not coordinated effectively, and ensuring that providers are aware of all resources for physical needs available to recipients and how to access them is essential to remedying this situation. The authors outline this consideration thoroughly in *Psychological First Aid: Guide for field workers* (WHO et al., 2011), with the preparation recommendations detailed in table 2.

BEFORE ENTERING A CRISIS SITE, LEARN ABOUT THE FOLLOWING:

Important questions

<i>The crisis event</i>	<ul style="list-style-type: none">» What happened?» When and where did it take place?» How many people are likely to be affected and who are they?
<i>Available services and supports</i>	<ul style="list-style-type: none">» Who is providing for basic needs like emergency medical care, food, water, shelter or tracing family members?» Where and how can people access those services?» Who else is helping? Are community members involved in responding?
<i>Safety and security concerns</i>	<ul style="list-style-type: none">» Is the crisis event over or continuing, such as an aftershock from an earthquake or continuing conflict?» What dangers may be in the environment, such as rebels, landmines or damaged infrastructure?» Are there areas to avoid entering because they are not secure (for example, obvious physical dangers) or because you are not allowed to be there?

Table 2: Preparation for responding to a crisis. (WHO et al., 2011)

Recommendations

Based on the findings of this analysis, there are multiple areas the global mental health field will need to focus on regarding the implementation of high-quality PFA. These areas, as covered in this paper, are training, surrounding evidence, and policy considerations.

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PFA training plays a major role in emergency preparedness, and the humanitarian community should strive to implement the most effective, engaging, and culturally appropriate training as possible for its PFA providers. In order to achieve this, the best practices that emerged were: clearly defining the role of the provider, setting training session lengths at one full day, including simulation and role-play techniques, incorporating provider feedback on culturally appropriate training practices, and preparing providers to work with children and in group PFA settings. Taking these steps will better prepare providers to confidently and competently provide PFA in humanitarian settings.

Regarding how the field should approach the issue of finding evidence to support the effectiveness of PFA, the global mental health field should avoid relying on clinical mental health outcomes to justify the use of PFA. Although striving towards evidence-based interventions and policies is often appropriate, because of the nonclinical nature of PFA and the chaotic situations it is often implemented in, there are barriers to studying the clinical effectiveness of PFA that outweigh the potential benefits. This is especially true considering the large body of positive findings supporting the utility and perceptions of PFA from providers and recipients, making clinical effectiveness much less relevant. However, future research on how to improve PFA training, techniques, and perceptions in various humanitarian settings will be beneficial to the field and better inform protocol moving forward.

When considering the policy surrounding PFA, it is essential that PFA is only implemented in a manner that recognizes its limitations. Overdependency on PFA in place of a comprehensive mental health plan is a disservice to the populations served and places an undue burden on PFA providers by requiring them to operate outside the role they were trained to fulfill. Additionally, proper humanitarian coordination and communication are essential to make

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sure basic physical needs are met so PFA providers are better able to provide impactful social support.

By implementing these recommendations, the field as a whole will be better prepared to respond to humanitarian emergencies and the psychosocial support needs that arise while also maximizing the impact of each provider. In this way, the humanitarian community will set a standard for humane, appropriate, and meaningful relief for people who deserve to have a supportive presence while they cope with a traumatic event.

Conclusion

The provision of social support is crucial to the well-being of survivors in humanitarian emergencies, requiring humanitarian organizations to actively implement and evaluate their strategies for meeting this need during crises. With the rising frequency and popularity of PFA as a psychosocial support intervention in the past 15 years, there is an imperative to ensure that PFA is implemented as effectively as possible, while also limiting the potential risk for harm to recipients and operating well within the broader system of humanitarian aid.

To achieve this, organizations must teach PFA properly, giving the tools and competencies to providers to limit potential harm, increase benefits, and improve the self-efficacy of providers during the response. Additionally, the continuous evaluation of evidence surrounding PFA is crucial; however, the field must accomplish this in a holistic manner, not focusing solely on clinical mental health outcomes, which would misconstrue the purpose of PFA. And finally, policy surrounding PFA must remain faithful to the purpose and limitations of PFA, because overestimating the impact of PFA is a dangerous misconception that can create gaps in humanitarian responses. All of these factors must be monitored in all aspects of PFA

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implementation in order to ensure that it can continue to evolve and meet the needs of those impacted by crises since the nature of people's needs will continue to evolve as well.

PFA will continue to impact thousands of people's lives in the coming years, and there is no shortage of challenges facing the global mental health community. Because of this, falling into stagnancy regarding PFA protocol, training, and policy would be a disservice to those affected by trauma during humanitarian emergencies globally.

Abbreviation List

PFA: Psychological First Aid

WHO: World Health Organization

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