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The Application and Adaptation of Psychological First Aid: The Filipino Psychologists' Experience After Typhoon Haiyan

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This study examined the experiences, adaptations, observations, and insights on the use of Psychological First Aid (PFA) in the Philippines. Nineteen PFA providers who were trained in the basics of PFA from three major cities in the Philippines took part in this study. Respondents' knowledge about PFA was consistent with the core principles of promoting a sense of safety, calm, self- and community efficacy, connectedness, and instilling a sense of hope. The delivery of PFA was adapted to the Filipino culture through the use of local counseling models, a group-based set-up, and the use of mindfulness and relaxation techniques. The respondents highlight the perceived efficacy in using and adapting PFA to support Filipino survivors after a disaster like Typhoon Haiyan.

Keywords: psychological first aid, group intervention

The past decades have seen a growing regularity of disasters as well as an increase in research on the appropriate psychosocial support interventions for disaster survivors. The Intervention

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Pyramid for Mental Health and Psychosocial Support for Emergencies proposed by the Inter-Agency Standing Committee (IASC; 2007) suggests that the most basic intervention for all survivors is ensuring their well-being and safety. Once basic needs are ensured, there may be a need to provide interventions that will help survivors who have mild to moderate psychological reactions to the disasters they have experienced. These interventions may include community and family response services such as family tracing and reunification, community healing ceremonies, mass communication on constructive coping methods, supportive parenting programs, formal and non-formal education activities, provision of livelihood, and activation of social networks (i.e., women's groups and youth clubs). Beyond these interventions, the pyramid describes a third layer of interventions that provide individual, family, or group interventions (focused but non-specialized care) to a smaller number of survivors who may still be experiencing mild to moderate health disorders. This may include psychological first aid (PFA) or basic mental health care. At the top of the pyramid are specialized services (i.e., psychological or psychiatric support) that are provided by psychologists and/or psychiatrists to survivors experiencing significant difficulties in daily functioning.

Psychological first aid or PFA is a practical support process for survivors that includes assessing their needs and concerns and helping them address these by connecting them to the right information, relevant services, and applicable social support. As a psychosocial support intervention, it involves comforting people, helping them feel calm, and boosting their self-efficacy (World Health Organization [WHO], War Trauma Foundation, & World Vision International, 2011). It is humane and non-intrusive as providers listen to people but do not pressure them to talk. Unlike professional counseling or psychological debriefing, PFA does not ask survivors to analyze what happened to them and put time and events in order. Given the increasing evidence that psychological debriefing is counterproductive and slows down the natural recovery of disaster survivors, and the literature on the positive impact of PFA, it is now the preferred psychosocial intervention during the post-disaster emergency phase (WHO et al., 2011).

Although there is some research on the use and impact of PFA in the West, there has been no study thus far on the use of PFA in

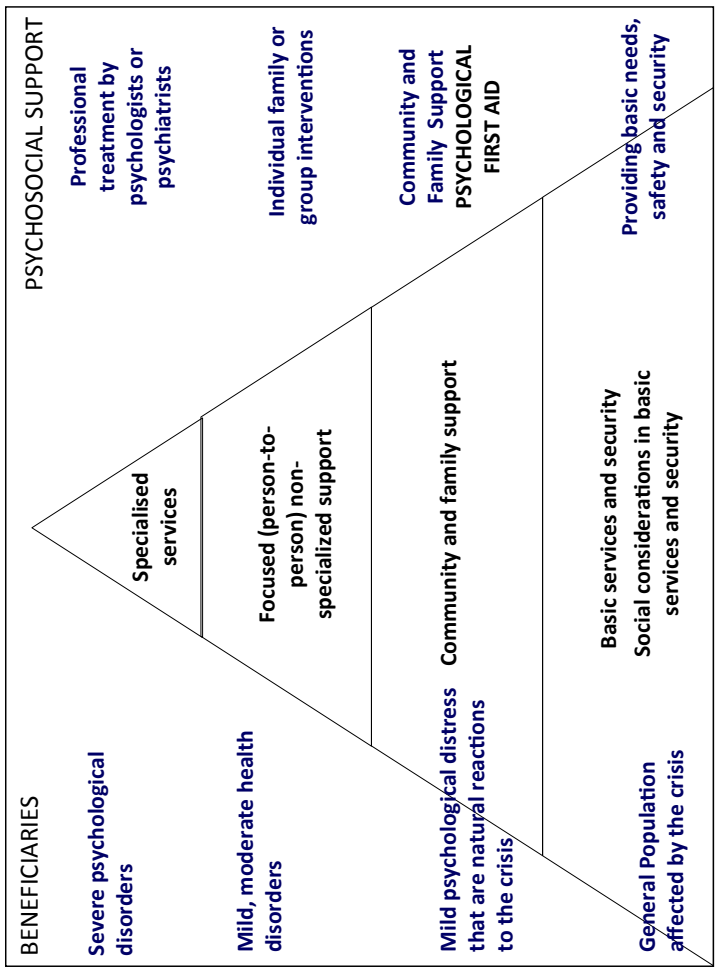

Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies.

the Philippines. Therefore, this current study seeks to fill in the gap by looking at how PFA is used in the country. Moreover, given the growing consensus on the importance of utilizing culturally sensitive and evidence-based interventions in emergency situations (IASC; 2007), we describe how Filipino PFA providers have contextualized the delivery of PFA in the aftermath of Super Typhoon Haiyan. Finally, we also present these providers' perceived utility and benefits of PFA.

Review of Related Literature

Natural Disasters in the Philippines

The issue of disaster response is very important in the Philippines because of its vulnerability to calamities. From the 1980s to the year 2010, it has experienced over 380 calamities. Located in the Pacific Ring of Fire, the country has 300 volcanoes, 22 of which are active (Conde, 2004). The Philippine Fault Zone, which is 1,200 kilometers long, is one of the longest in the world and a potential source of earthquakes (Verzosa, 2011). More so, the 36,389 kilometers of coastline make the country vulnerable to tsunamis (Laverinto, 2010).

The Philippines is also located along the typhoon belt of the North Pacific Basin in the Pacific Ocean where 75% of typhoons originate. An average of 22 typhoons visit the country each year, five to seven of which can be destructive. These trigger related disasters such as massive flooding and landslides, and cause economic and social damage. Between the years 1970 and 2009, for instance, the annual average direct damage to disasters ranged from 5 to 15 billion pesos (Laverinto, 2010).

This study was made in the wake of Super Typhoon Haiyan that hit the country on November 8, 2013. With wind gusts of 315kph, Typhoon Haiyan is the strongest tropical cyclone ever recorded. It killed 6,300 people, affected over 16 million Filipinos, and resulted in the displacement of 4,095,280 children and adults (National Disaster Risk Reduction and Management Center [NDRRMC], 2014).

Disaster Response and Coping in the Philippines

Aside from being naturally vulnerable to disasters, the country is also faced with scarcity of resources that are related to disaster response and coping. The country's budget for health care is only 2-3% of its national budget—far below what is recommended by the World Health Organization (WHO) for developing countries (Conde, 2004). Beyond the lack of financial resources, there is a dearth in human resources. The WHO-Assessment Instrument for Mental Health Systems Report on Mental Health Systems in the Philippines (2006) indicates that there are only 3.47 mental health practitioners for every 100,000 Filipinos.

Perhaps due to this scarcity of institutional resources, Filipinos rely on other resources for postdisaster help. Social connections are an important source of resilience among Filipinos and it is common to see family and friends reach out to each other after a disaster (Adviento & de Guzman, 2010; Verzosa, 2011). Another such resource for Filipinos is spirituality. Studies have suggested that spiritual coping is the most common coping mechanism of Filipino survivors (Carandang, 1996; Ladrido-Ignacio, 2011).

Given the collectivist culture and the limited number of mental health professionals, it is also not surprising that group interventions such as counseling or psychosocial processing are commonly used in the Philippines (Carandang, 1996; Ladrido-Ignacio, 2011). In addition to these, De Castro and Bautista (2015) found that postdisaster psychosocial efforts in the country include the use of PFA or psychological first aid.

Psychological First Aid

PFA is based on five core principles that facilitate positive adaptation following trauma: (a) promoting sense of safety, (b) promoting calming, (c) promoting sense of self- and community efficacy, (d) promoting connectedness, and (e) instilling hope (Hobfoll et al., 2007; Kantor & Beckert, 2011; Vernberg et al., 2008). Brymer et al. (2006) listed how these core principles will be accomplished in eight steps: contact and engagement, safety and comfort, stabilization,

information gathering, practical assistance, connection with social support, information on coping, and linkage with collaborative services. On the other hand, WHO et al. (2011) summarized and reduced these core actions into three action principles (3Ls): look, listen, and link. Look involves checking for safety and identifying those with most basic needs and serious distress reactions. Listen involves approaching people who may need support, asking people about their needs and concerns, listening to people, and helping them feel calm. Link entails enabling people to address their basic needs and access services, helping people cope with their problems, give information, and connecting people with loved ones and social support.

There is initial evidence on the efficacy of PFA. It has been found to be a useful and empowering psychosocial support for survivors of the Haiti earthquake (Schafer, Snider, & van Ommeren, 2010). Likewise, although survivors of Hurricane Katrina showed PTSD symptoms that remained in the moderate range two years post-event, children who were provided PFA showed significant decreases in PTSD scores (Cain, Plummer, Fisher, & Bankston, 2010). The children who were given PFA also thought that the PFA given to them "helped them lots" (p. 338). Additionally, responders of Hurricane Gustave and Ike in the US revealed that they felt PFA was an appropriate intervention for responding in the aftermath of hurricanes and recommended its use in future disasters (Hambrick, Rubens, Vernberg, Jacobs, & Kanne, 2014). Among the core actions, the ones that were perceived as most helpful to survivors were safety and comfort, practical assistance, and contact and engagement (Allen et al., 2010).

The concept of PFA is fairly new in the country. Although there is literature indicating the availability of PFA in the Philippines, there is a dearth of evidence on its use and effect. The advocacy for its use in the Philippines only began in 2013 when the Psychological Association of the Philippines (PAP) called on responders to use PFA after the WHO issued a warning on the negative impact of the use of single-incident stress debriefing post-disaster (WHO, 2003). This was reinforced by observations of first responders from PAP assigned to the Villamor Airbase operations that the use of Critical Incident Stress Debriefing (CISD) appeared to agitate survivors (Aquino, 2013). The PAP adopted the IASC Guidelines on Mental Health and Psychosocial

Support (MHPSS) in Emergency Settings and began conducting training on the use of PFA. It also exhorted psychologists not to go into areas without assessment and local partners and stressed that psychosocial interventions should not be stand-alone or band-aid solutions but should instead be embedded in integrated and long-term solutions (Hechanova, 2013).

Beyond the principles under PFA, the IASC guidelines on MHPSS in Emergency Settings also recommended the need to utilize culturally-sensitive and evidence-based interventions (IASC, 2007). Litz (2008) described PFA as a flexible process and advocated the need for PFA to take into account the survivors' culture, ethnicity, religious affiliation, race, and differing languages. The WHO, World Trauma Foundation, and World Vision International (2011) guide to PFA also explains that in a crisis situation, a person's spiritual or religious beliefs and rituals may be very important in helping them overcome pain and suffering, provide meaning to their experience, and give a sense of hope and comfort.

Although PFA is typically done individually, Johnstone (2007) argued that it can be done in groups. Groups allow survivors to share their experiences thereby normalizing their reactions to a stressful situation (Johnstone, 2007). Group sharing also allows survivors to give and receive mutual social support. In fact, the delivery of psychosocial interventions in a group setting has been found to have immediate positive impact and reduce the degree of PTSD symptoms in the long run (Foy et al., 2000).

Everly, Phillips, Kane, and Feldman (2006) outlined the practice of group-PFA. Group-PFA consists of three phases: pregroup activities, six stages of group-PFA, and postgroup activities. The goal of pregroup activities is to perform an initial assessment if it is suitable to provide a group intervention and to check what basic needs are lacking. The six stages of group-PFA include (a) introduction, (b) review or briefing of what happened, (c) clarification or correction about what happened, (d) teaching by offering psycho-educational information stress reactions, trauma, and coping, (e) supporting the natural cohesion and resiliency of the group, and (f) assisting in connecting with informal and formal support systems. The goals of postgroup activities include establishing availability for future support and identifying future

needs of higher level of care, volunteers' closure and self-care, and evaluation.

In the Philippines, the use of group-based PFA among government worker-survivors has been found to significantly increase participants' pre- and posttest scores on self-efficacy and coping skills (Hechanova, Ramos, & Waelde, 2015). The PFA process, psychoeducation and practice of mindfulness, and the use of group sharing were the most useful components of the intervention. Participants cited that group sharing allowed them to share their stories with others who went through the same experience.

The preceding study focused on the benefits of PFA to survivors. However, the utility of PFA for disaster survivors from the perspective of Filipino providers has not been recorded thus far. Therefore, this study seeks to contribute to the literature by providing information on the knowledge, experience, adaptations made by providers of PFA, and their observations of survivors' reactions. Specifically, we asked:

1) What were the providers' knowledge of PFA and how did responders receive this knowledge?
2) What were their experiences in the conduct of PFA?
3) What adaptations/additions were made in the conduct of the PFA and why?
4) What were survivors' reactions to PFA?

METHOD

This qualitative study involved interviews/open ended surveys conducted with providers of PFA.

Respondents

Using convenience sampling, 19 PFA providers (14 females and 5 males) participated in this study. Providers reported having undergone basic training on PFA given either by representatives of the World Health Organization, by faculty members of the University of Santo Tomas, or by members of the Psychological Association of the Philippines. Eight came from Metro Manila, six from Cebu, and five from Iloilo. Responders' age ranged from 22 to 51 years old.

All of them had a background in psychology with majority (n = 13) having postgraduate training in clinical/counseling psychology. After undergoing training, all of them were tasked to deliver PFA immediately to the areas where interventions were most needed. These areas were identified based on reports provided directly by social workers from the Department of Social Welfare and Development in different regions of the Philippines. Their clients included adult survivors from the affected communities, government employees, and workers of humanitarian organizations who responded in the crises situations. Each of the participants handled more than two groups of survivors with some handling as much as six to eight during the entire emergency period (defined by IASC as between 0-3 months right after an emergency).

Procedures

After getting their consent, face-to-face interviews were conducted with PFA providers in the first half of 2014. The interview consisted of open-ended questions that looked into responders' knowledge of and experience in the delivery of PFA. Sample questions included: (a) What do you know about PFA? (b) What was the process you followed and why? (c) How did you find the use of PFA? (d) What were the participants' reactions before and after you did PFA? (e) How did you feel about using PFA over other means of interventions?

In the event that the respondents were not available for a face-to-face interview, they were asked to email their answers to interview questions to the researchers. The questions were asked in English and the responses were also given in English. Audio recordings of the interviews were transcribed.

Data-Analysis

Thematic analysis was conducted on the qualitative data using three-step coding (Ezzy, 2002). One member of the research team initially performed open coding to explore the data. The codes were then sent to two other team members. Additional open codes were set up and the three members came to an agreement with regards

to which codes to retain. Once open codes were finalized, the second step, known as axial coding, was done by the three members in order to examine the relationship between the codes. A fourth member of the research team finally did selective coding in order to identify the core code and to compare the codes with the existing body of literature on PFA. During selective coding, snippets were likewise chosen to represent the main code or theme. The final codes were arrived at by all the members of the research team.

RESULTS AND DISCUSSION

This paper provides information on the knowledge of PFA, experiences in conducting PFA, adaptations made to the PFA process, challenges in conducting PFA, and providers' observations regarding the perceived benefits of PFA to the recipients.

Knowledge of PFA

When asked about their knowledge of PFA, all respondents articulated PFA's purpose and processes or steps undertaken to deliver it.

Purpose of PFA. According to the respondents, PFA is the "most appropriate immediate intervention after a disaster" because it identifies the basic needs of survivors, provides safety and security, focuses on coping, and links survivors to people and agencies. One respondent described PFA's purposes as "to provide for basic needs, safety and security, and to check for trauma." One respondent added that PFA is letting survivors have that "sense of safety, direction, and stability." Another said that PFA is "designed to reduce initial distress caused by traumatic events by fostering long- and short-term adaptive functioning and coping." Finally, another provider said that PFA allows survivors to "feel safe and reconnect with people and agencies."

The respondents' knowledge of PFA's purpose is consistent with the core principles of PFA (Hobfoll et al., 2007; Vernberg et al., 2008). The PFA Guide of WHO et al. (2011) describes that the goal of PFA is to help survivors recover from a distressing event by making them feel safe and calm, connected to other people, identifying survivors who

might need more advanced support and helping them obtain access to information (WHO et al., 2011).

Process of PFA. When the respondents were asked about the process of PFA, their responses highlighted its difference from other forms of intervention like professional counseling, psychological debriefing, and CISD. They said that PFA is a "humane and supportive" response to disasters in the sense that it "protects people from harm" because PFA providers "focus on the here and now." One participant said that in giving PFA, we "don't force them to talk about what happened" and we "do not mention about the incident, [we do] not put them back at that moment, [we] focus on how to cope but not on what happened." In addition, PFA "explores on the capacity and strengths of the people and on what they can do from their end." For another respondent, "the emphasis is on hope."

There was also a general perception that, as an immediate and early postdisaster intervention, PFA is easier, simpler, and more effective than CISD. The respondents preferred PFA because "it is effective among survivors [because] it ensures that needs are addressed without exacerbating pain, suffering, or shock. It does not create harm like CISD because they do not recall the events."

These responses are in keeping with other findings that PFA is unlike psychological debriefing that focuses on exploring facts, thoughts, and reactions about the critical event (Watson, Brymer, & Bonanno, 2011). Although PFA involves being available to listen to people's stories, it does not necessarily involve discussing in detail the distressing event and pressuring people to tell their feelings and reactions about the event (WHO et al., 2011).

When respondents were asked who can give PFA and when PFA is provided, their answers were consistent with international guidelines (Brymer et al., 2006; WHO et al., 2011). According to a respondent, PFA can "be done by ordinary laymen given proper training and orientation" and someone "can give it even if you are not a mental health professional." Another respondent articulated that "PFA should be a skill of first responders and the non-psychologists." As suggested by WHO et al. (2011), PFA is not something like counseling that only licensed or certified professionals can do (WHO et al., 2011). First responder teams, primary and emergency health care, school crisis

response teams, and faith-based organizations, and other disaster relief organizations can provide PFA as long as they are trained with the principles and proper delivery. One advantage of PFA compared to other psychological interventions is that PFA is designed for delivery not only by mental health professionals but also by other disaster response workers as part of an organized disaster response effort (Brymer et al., 2006).

In terms of when PFA should be given, respondents said that it is the "appropriate immediate intervention after a disaster" and "even after a month, it is still the most appropriate method." According to the WHO et al. (2011) guidelines, PFA is given the first time one encounters a distressed person. This could be during or immediately after the critical event, sometimes days or weeks after, depending on how long the critical event and how severe it was.

Experience in Delivering PFA and Additions/Adaptations Used

Experience in Delivering PFA. When asked about how they delivered PFA, some respondents reported that although they did the eight steps of PFA, they were not necessarily done in the linear manner suggested by Brymer et al. (2006). One PFA provider enumerated the steps that their team followed: "Introduction, then build rapport, maintain calm and ensure safety, *kamustahan* (informal conversation) and listen, spot trauma symptoms, psychoeducation of the effects of disaster on well-being, spot strength, positive traits, and positive coping, plan to move on, and link." During the introduction and rapport building, providers introduce themselves, ask survivors for their names and needs, discuss the purpose of the session, and explain confidentiality. This satisfies the same goals of contact and engagement. During the entire PFA session, providers remain in calm disposition by keeping one's tone of voice soft and composed. Also, providers ensure safety by finding a quiet place to talk and even protecting the person's privacy and dignity from the media. Sometimes, when providers observe some anxiety and tension from the survivors, they teach and demonstrate to them breathing and relaxation exercises, and mindfulness. As one provider observed,

mindfulness and relaxation techniques "had an immediate effect on the disposition of the survivors. It helped them feel calm and in control while talking about their experience." These techniques satisfy the goals of stabilization of emotionally distressed survivors.

Another respondent added that the step of addressing the needs of survivors is very informal: "how-are-you-now type of *kwento* (informal talk), *may magkukuwento* (someone shares his/her story), everyone listens, [and] you end with coping and linking." A respondent explained, "when you ask a Filipino, *'Kamusta ka ngayon?'* (How are you right now?), you are inviting that person to share stories. It breaks the ice."

Respondents also found that teaching about stress reactions, spotting trauma symptoms, and highlighting adaptive coping seems natural to the PFA process. The emphasis on psychoeducation is congruent with the literature that emphasizes PFA as mainly educative. One respondent said, "there is a natural flow to it. From letting survivors express thoughts to explaining that their reactions are normal, to strengthening their positive coping strategies, to empowering them to take action."

Other respondents reported adhering to the three core action principles of look, listen, and link (WHO et al., 2011). Summarizing the basic principles in 3Ls was a good memory device. A respondent shared, "I didn't have to follow [the] steps because I followed the lead of the client via look, listen, and link." Another respondent added, "know their needs, keep them safe, you listen, reconnect." Majority of the PFA providers adhered to the principles of promoting safety, attending to practical needs, enhancing coping, stabilizing survivors, and connecting survivors with additional resources.

When respondents were asked about their experience in conducting PFA, their answers were generally positive. For one, respondents felt confident about using PFA. One of them said "I'm confident about using PFA because I believe it is an effective tool for survivors compared to CISD." Given that the respondents underwent training on the proper use of PFA before being deployed to affected areas, this confidence in the delivery of PFA may be attributed to their training and their experience. Akoury-Dirani, Sahakian, Hassan, Hajjar, and Asmar (2015) and Everly, Barnett, and Links (2012)

showed that PFA providers' knowledge, confidence, and readiness increase after training.

Also, according to respondents, PFA is brief and practical. A respondent said, "PFA is brief and it immediately responds to the needs of survivors; more practical." Another respondent added, "compared to other interventions, [PFA is] not time consuming and does not need further sessions." As suggested by the WHO, PFA is often a one-time intervention and providers may only be there to help for a short time (WHO et al., 2011).

Additionally, PFA is easy to follow and use. One respondent said, "[PFA is] easy enough, [I] can grasp each of the steps readily, [and] easy to explain to people." Another respondent added, "it's a friendlier approach, easier to conduct, and the facilitator doesn't get too stressed."

When respondents were asked about their experience in conducting PFA, they highlighted the flexibility of delivering PFA. One of them said, "I am comfortable with using PFA because I can modify it as I deem appropriate." Another added, "it can be interjected with counseling techniques." These modifications are nevertheless still consistent with the principles of PFA. For instance, one respondent said that they interchanged the steps on stabilizing the survivor and gathering of information. These responses are consistent with literature that describe PFA as flexible and is sensitive to timing, context, age, culture, and preference of the survivor (Watson et al., 2011).

Adaptations in conducting PFA. The respondents adapted different models and techniques into their practice of PFA. These include the application of a local counseling model, integration of mindfulness, relaxation techniques, and group energizers and activities, use of group-based PFA, and conduct of an open space activity.

Pagdadala model. PFA was adapted in a way that it integrates local counseling models of the story of "burden-bearing" or *pagdadala* (Decenteceo, 1999). One aspect of PFA is listening to the needs and concerns (the burden or *ang dinadala*) of the survivor (the burden bearer or *ang nagdadala*). The goal of PFA in helping survivors gain a sense of self-efficacy (Brymer et al., 2006; Hobfoll et al., 2007; WHO et al., 2011) aligns with the goal of *pagdadala* or burden-bearing. It

teaches ways of helping make people's burden easier to bear. In this way, the *pagdadala* model is also considered a community-based mental health and psychosocial support model (M. L. Verzosa, personal communication, December 8, 2015). Two PFA providers from Iloilo[1], for instance, said:

> The pagdadala model of Decenteceo, where respondents expressed their needs and the burdens they are carrying in life with a group and explored or presented ways and means in dealing with their concerns. Respondents were not categorically directed to talk about their experiences during the disaster. Some just spontaneously told the group about it.

Another respondent, who used the *pagdadala-ginhawa* model, a revised version of the pagdadala model (M. L. Verzosa, personal communication, December 8, 2015), shared that "the integration with the *pagdadala* model involves the symbolism of crossing the bridge as a representation for overcoming challenges, and of casting to the fire one's burdens as a way of moving on."

Mindfulness, relaxation techniques, and group dynamics. Mindfulness, relaxation techniques, and group energizers and activities were also integrated into the delivery of PFA, particularly in the stabilization stage. A PFA provider said, "mindfulness and relaxation had an immediate effect on the disposition of the survivors. It helped them feel calm and in control while talking about their experience." Another participant shared "PFA was interspersed with energizers, relaxation and mindfulness exercises, and some positive affirmation rituals." The participant added that these modifications were not a departure from the principles that are being espoused by the PFA but rather an "enhancement to make its delivery more interesting and comfortable for the survivors." The use of meditation and relaxation techniques, in particular, has scientific bases. For instance, Waelde et al. (2008) suggested that meditation may be a feasible and acceptable post-disaster intervention after the method has been tried on mental health workers 10 weeks after Typhoon Katrina.

Group-based PFA. Another adaptation made by PFA providers

[1] An orientation on the *pagdadala* model was given by Ms. Lyra Verzosa to the coordinator of PFA providers in Iloilo in December 2013

was to run PFA in groups. This was done not only because of the lack of facilitators but also because it is believed that Filipinos enjoy being in groups. A local study showed that Filipino participants in group-based PFA found sharing their experiences with others a useful component of the intervention because it made them feel a sense of solidarity with other survivors who had undergone the same experience (Hechanova et al., 2015) As one respondent said, "the spirit of PFA is, if you really think about it, is *bayanihan*[2]."

Filipino PFA providers were able to follow the different phases of group-PFA (Everly et al., 2006). Pregroup activities were conducted during meetings with the psychosocial support organizers and a needs assessment survey was distributed while waiting for participants to arrive. Asking and setting of expectations were usually the beginning of conducting group-PFA. During *kamustahan,* participants were usually divided into small groups of six to 10 members but during the psychoeducation stage, participants were gathered in one big group. Also, as part of postgroup activities, PFA included discussions on future care and the support these survivors need.

Open-space activity and PFA. The PFA providers also mentioned that they use open-space activity when they see that participants are not ready to individually talk about their concerns. In particular, one PFA provider said:

> We used an open-space activity where individuals go around and write solutions to the problems they identified on manila papers posted on the walls. A person (or administrator) was there to provide answers. They had so many basic needs that were unmet so the open space activity along with linkages to authority was crucial.

Challenges in Conducting PFA

However, respondents also cited the challenges in the delivery of PFA and these were: (a) lack of protocols for serious cases and for follow up, (b) lack of conducive venues, (c) linking with services, (d) lack of disaster response systems, and (e) the limited number of trained individuals who can deliver PFA.

[2]Bayanihan is a Filipino term which means the spirit of communal unity.

Respondents also recognized that PFA might not be sufficient for people who have been identified or diagnosed with mental health disorders or are severely distressed, which is in keeping with international guidelines (Cain et al., 2010). As mentioned, the respondents cited the lack of protocol on what to do for people who need more specialized help as another challenge. They acknowledged that other than providing PFA, they also needed to refer survivors, particularly those who are vulnerable or at-risk, to other services. Despite the need for these, there were no mechanisms for referral, documentation, or follow up.

The respondents also cited the lack of conducive venues as another challenge in the delivery of PFA in the Philippines. They reported difficulty in facilitating relaxation techniques in some areas because of the noise.

Aside from these, the respondents acknowledged that PFA needs to be delivered with partners or a network, otherwise there will not be any follow through. They also emphasized the value of linking people with practical support and social support like family and the appropriate agencies, which WHO describes as a major part of PFA (WHO et al., 2011). However, they reported difficulty in linking the survivors with agencies due to "poor networking in government agencies." The respondents also said that the lack of a systematic disaster response system in the Philippines limits the support that they can provide to the survivors. One PFA provider said, "you cannot give practical assistance yourself because you are there to give social support and other kinds of help. How can you be running around?"

Finally, because there was only a small number of people who could deliver PFA, respondents had to shift to group-based PFA because of the need to assist as many survivors as possible.

Perceived Survivors' Reactions to PFA

When respondents were asked what reactions they observed among the survivors after conducting PFA, their answers can be summarized into three: physical and behavioral, cognitive, and emotional.

Responders reported physical and behavioral reactions such as

a change in facial expression, smiling, and expressing their gratitude among the survivors after the PFA session. One PFA provider shared that:

> At first you can really see how burdened they are through their facial expression and then after, they feel relieved, their faces light up. Some are hesitant to trust you at first and, then in the end, their smiles become genuine and they are thankful.

According to the respondents, survivors were smiling after the session and were expressing their gratitude immensely. "They [said] thank you for listening, for giving them a chance to express especially since it's within a group setting" and "Thankful [that] they got someone who cared for them and that their needs and concerns were heard and that they got to become more positive."

Another observation was the gradual cognitive change among the survivors. In particular, the recipients were able to reframe the way they see themselves, from being victims to survivors. They also understood that their stress reactions were because of the event, and recognized that these reactions are normal. According to the respondents, the survivors acknowledged that they were not prepared for the calamity but at the same time believed that they will be okay. A respondent shared, "At first, the survivors were confused because they were not aware what PFA was all about, and then, through the psychoeducation part, they began to understand and appreciate it." Another respondent shared the insights of some survivors saying, "They never realized that they were so stressed because they kept on working. They thought they were okay" and "[they] acknowledge that, although not all needs will be met just yet, but on a psychological level, they have this, 'mas kaya ko na ngayon' (I can do this) mentality."

Responders also reported changes in emotions, such as emotions of relief, gratitude, and hope, among survivors as a result of PFA. The respondents shared that the survivors felt relieved from the stress and they felt the burden was lessened. One respondent said: "From negative feelings, having trauma and flashbacks, to already having hope when you begin to link them and when they already know who they can approach to ask for help."

The respondents attributed this feeling of hope among the survivors to the knowledge that help is available when they need it and

the realization that there are people who will care for them.

Limitations and Implications for Future Research

As this study is exploratory in nature, there remains a great need for further field research to evaluate the delivery and effectiveness of PFA in a variety of postdisaster contexts here in the Philippines. For one, the study focused only on the providers of PFA who were trained in such intervention and might have a favorable response bias. Hence, research that looks at PFA from the point of view of survivors is also important.

It is also very relevant to note that the results reflect the perceived utility of PFA from PFA providers' perspectives as opposed to a more objective measure of the actual utility of PFA in the field. This could be addressed by conducting more research on PFA's effectiveness in a number of contexts and methods (Forbes et al., 2011). An example of this is a field experiment comparing survivors who received PFA and those who did not. This is imperative to establish the impact of PFA.

Another limitation of the study is that majority of the respondents of the study have a background in psychology and/or received postgraduate training in counseling/clinical psychology. Comparison studies between perception of professionals and non-professionals on the implementation of PFA can also be explored to see whether the reactions and insights on the use of PFA will be the same.

Implications and Conclusion

Despite its limitations, the results of this exploratory study show that over and above the additions and adaptations done, the knowledge of PFA among Filipino psychologists is consistent with its purpose and nature as outlined by current guidelines and literature (Brymer, 2006; WHO et al., 2011). The providers were able to retain what they have learned in the trainings that they received and applied these in the field. Providers of PFA were confident of its value and were satisfied with their experience of conducting PFA because of the reactions and changes of the survivors that they observed and because of its ease of use as opposed to the commonly practiced CISD. Although,

additions and adaptations were made to the steps, the nature of PFA's flexibility—individual versus group, timing, context, preference of survivor, and culture—is its strength. This is line with the assertion of Watson et al. (2011) that evaluating PFA's effectiveness is contingent on it being tailored to the specific needs of each disaster survivor. Similar to the experiences of PFA providers during the aftermath of Hurricane Gustav and Ike, PFA was well-received by survivors because of its flexible, tailored approach to addressing current concerns, and helping solve practical needs (Allen et al., 2010).

Because skills in disaster response is very important in the Philippines, education and training on PFA is a must, not only to psychologists, but also to first responder teams, primary and emergency health care, school crisis response teams, and faith-based organizations, and other disaster relief organizations.

This study also saw that PFA was commonly delivered using a group format. Because social connections are an important source of resilience and communities are a source of safety, support, and recovery, it is important to build competence in facilitating PFA in groups. Moreover, such training should be delivered to mental health professionals in communities (e.g., teachers, nurses, social workers, religious, etc.) who can utilize group-PFA in promoting community efficacy and connectedness.

Finally, the inclusion of culturally sensitive approaches suggests the importance of being able to integrate PFA principles with an understanding of the needs, context, and culture of survivors. Using culturally-nuanced metaphors and local language in delivering PFA are important to provide appropriate psychosocial support to Filipino survivors.

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