



# Contextualization of Psychological First Aid: An Integrative Literature Review

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## Key words

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## Abstract

**Purpose:** Contextualization of psychological first aid (PFA) in different cultural, political, and socioeconomic contexts and in different population groups is essential. This review analyzes the efforts that have been made to contextualize PFA in different parts of the world for different disasters and emergencies.

**Design:** Integrative literature review.

**Methods:** The major databases that were searched for related literature published until August 2019 included JBI, MEDLINE, Embase, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), BIOSIS, ISI Web of Knowledge, Scopus, EBSCOhost, and PsycINFO. A total of 17 studies published in peer-reviewed journals were included. The review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) model, and the 6W3H tool was applied to synthesize the results.

**Findings:** PFA has been adapted to various disasters and populations in different countries and regions. The organizations that administer PFA range from community level to national level. Professional or “outside helpers” who enter disaster-affected locations include psychologists, fire fighters, social workers, and nurses. “Inside helpers,” who live and work in the disaster-affected areas, include HR staff, teachers, and peer emergency personnel. Only a few studies have reported the exact number of first responders who administered PFA. Some studies revised PFA as group based, and a few reported the classification of groups of victims. Notably, all adaptations adhered to the basic principles of PFA, and the time at which PFA was administered ranged from a few days to months after an incident. PFA was conducted on site in all studies. The selection of the location depended on the type of disaster and local situation with due consideration of safety. Only a few studies specified the rationale for revising the PFA. None of these 17 studies reported the cost, cost-benefit, or cost-effectiveness of PFA.

**Conclusions:** Population-focused, context-specific, and group-based PFA is emerging worldwide. Nurses are actively playing a role in providing PFA. Research gaps exist in differentiating between the roles played by “outside” and “inside” responders, considering vulnerable age groups other than children, incorporating the major PFA concepts such as resilience, and evaluating the cost-effectiveness of PFA.

**Clinical Relevance:** It is imperative that nurses and other emergency staff consider the intersection of age, gender, cultural, political, social economic, and spiritual contexts when developing a context appropriate PFA.

Every year, millions of people are affected by natural and human-induced disasters that lead to loss of lives and homes and physical injuries (Hechanova, Manaois, & Masuda, 2019). After identifying a safe place, providing immediate psychosocial support is an integrated part of disaster assistance (Jacobs, 2007) that is considered to facilitate the resilience of individuals, families, and communities in recovery (Dieljtens, Moonens, Van Praet, De Buck, & Vandekerckhove, 2014). A wide range of programs have been developed to provide acute psychosocial support (Kılıç & Şimşek, 2018), and one such intervention is psychological first aid (PFA).

The World Health Organization (WHO) defines PFA as a humane and supportive response to a fellow human being who is suffering and may need support (Dieljtens et al., 2014). The National Child Traumatic Stress Network (NCTSN) defines it as “an evidence-informed intervention designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping” (Brymer et al., 2006, p. 391). There is a consensus about the five key elements of PFA: safety, calming, connectedness, self-efficacy, and hope (Hobfoll et al., 2007). Brymer et al. (2006) elucidated eight core actions of PFA: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection, information on coping, and linkage. PFA was rated as a class III–IV clinical guideline, which indicates that it is widely supported by expert opinion and rational conjecture as an acceptable option for an intervention provided by trained staff (Fox et al., 2012) and is now considered to be an essential element in the preliminary care of disaster victims (Dieljtens et al., 2014; Shultz & Forbes, 2014). Psychologists, nurses, social workers, fire fighters, and rescue professionals often act as the first responders (Field, Wehrman, & Yoo, 2017). However, PFA is particularly salient for nurses since many PFA elements are often integrated into their usual scope of care, comfort, and support to survivors immediately after a disaster (Giarratano, Bernard, & Orlando, 2019). The WHO and NCTSN have promoted the most widespread PFA field operation guides, which have been translated into various languages (Brymer et al., 2006).

In addition to the WHO and NCTSN field operation guides, different PFA adaptations have been developed and tailored to various target populations and contexts (Shultz & Forbes, 2014). Because the local conditions differ for different contexts, guidelines for local needs and cultures are critical for PFA to be effective (Kılıç & Şimşek, 2018). Since it is essential to identify which practices in psychosocial support might be more

effective in particular situations (Dieljtens et al., 2014), this article's focus is on contextualization.

Context is a situation or environment that is external to a given phenomenon (Welter, 2011). Contextualization is the incorporation of contextual details in practice, giving due consideration to the economic, cultural, political, and multifaceted aspects of a situation (Salet & de Vries, 2019). The optimal goal of PFA is to facilitate resilience, which is closely related to the local organizational, cultural, and societal background (Hechanova, Ramos, & Waelde, 2015; Kc, Gan, & Dwirahmadi, 2019). Some studies have reported the application of PFA in different disaster scenarios, but little is known about the application of PFA in the contexts of different disasters, cultures, political systems, and timing (Shultz & Forbes, 2014). To fill this knowledge gap, we conducted an integrative literature review (ILR).

The ILR method aims to produce a convergent synthesis of qualitative, quantitative, and mixed-methods studies (Whittemore & Knafl, 2005). Because the contextualization of PFA programs is reported in multiple types of studies published in peer-reviewed journals (e.g., case reports, field reports, experimental studies, and reviews), using ILR to synthesize the contextualization of PFA was considered to be the most suitable approach. The aim of this ILR was to systematically review existing efforts to contextualize PFA to provide insights to aid further contextualization of PFA in the future.

## Methods

We followed Whittemore and Knafl's theoretical framework for ILR, which includes five stages: problem identification, literature search, data evaluation, data analysis, and data presentation (Whittemore & Knafl, 2005). The review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.

### Problem Identification

An initial literature search via the Cochrane Library revealed no prior systematic literature reviews on this topic. Hence, our ILR was guided by the following research question: What efforts have been made to contextualize PFA?

### Literature Search

An extensive literature search was conducted in several related major databases, including JBI, MEDLINE, Embase, the Cumulative Index to Nursing and Allied

Health Literature (CINAHL), BIOSIS, ISI Web of Knowledge, Scopus, EBSCOhost, and PsycINFO. When the key word “contextualization” was added to the search strategies, few studies were found. Therefore, to obtain as many potentially eligible references as possible, we conducted a search using “psychological first aid OR PFA” as the only key word. The following specific search terms were applied: (“psychological first aid” OR PFA [Title/Abstract]) OR (“psychological first aid” OR PFA [MeSH Terms]) OR (“psychological first aid” OR PFA [Topic]) OR (“psychological first aid” OR PFA [Keyword]).

The search was conducted in August 2019. Two independent researchers reviewed the obtained studies based on the inclusion and exclusion criteria presented in Table S1. Discussion with a third researcher was used to resolve disagreements between the first two researchers. A total of 17 peer-reviewed articles met the inclusion criteria. The literature search process is illustrated in Figure S1.

## Data Evaluation, Data Analysis, and Synthesis

According to Whittemore and Knafl (2005), there is no gold standard for critical appraisal in ILRs. Because most studies found on this topic were descriptive, the JBI Critical Appraisal Checklist for Text and Opinion Papers (McArthur, Klugárová, Yan, & Florescu, 2015) was used to critically appraise the included studies (Table S2). Two independent researchers then conducted data analysis and synthesis. The primary findings of the 17 studies were extracted and are summarized in Table S3. The 6W3H administrative tool (i.e., “Who, for Whom, What, When, Where, Why, How, How many, How much”) is widely used to create a strategic action plan in many fields, including healthcare services (de Carvalho, Silva, & dos Santos, 2018). Because PFA entails specific actions and plans for psychosocial support, the 6W3H administrative tool was applied to describe and synthesize the results (Table S4).

## Results

### Study Characteristics

The 17 peer-reviewed articles were published between 1988 and 2019. They included field reports ( $n = 8$ ), quantitative quasi-experimental studies ( $n = 5$ ), and ILRs ( $n = 4$ ). The target groups to which PFA was administered included children or adolescents ( $n = 5$ ), disaster survivors ( $n = 7$ ), employees or staff ( $n = 2$ ), responders or disaster workers ( $n = 2$ ), perinatal women ( $n = 1$ ), and nursing home residents ( $n = 1$ ). The

countries where the studies were based included the United States ( $n = 7$ ), the Philippines ( $n = 2$ ), Southern Lebanon ( $n = 1$ ), Kenya ( $n = 1$ ), Haiti ( $n = 1$ ), Norway ( $n = 1$ ), and unspecified locations ( $n = 3$ ). The disasters reported in these studies were human-induced trauma or critical incidents ( $n = 11$ ) and natural disasters ( $n = 6$ ). More detailed information on the characteristics of the 17 studies is provided in Table S3.

### Contextualization of PFA

The 6W3H tool contains nine topics, and the following paragraphs elaborate on these nine topics separately, with “For whom” deliberately placed after “Who” for a more coherent discussion. Brief details of the 17 studies are summarized in Table S4.

**Who.** This refers to who sets up or leads the PFA program and who directly delivers PFA. In most of the studies, the organization responsible for setting up PFA was the government ( $n = 9$ ). The government set up a particular department, team, or center (Schafer, Snider, & van Ommeren, 2010; Weisæth, 2004); a department affiliated with the existing Health Ministry or police department (Law, 2010; Macy et al., 2004); or a department that cooperated with other disaster mental health teams to provide PFA (Homish, Frazer, McCartan, & Billittier, 2010). The organization was either community level (Cain, Plummer, Fisher, & Bankston, 2010; Pynoos & Nader, 1988), city level (Macy et al., 2004), provincial level (Castellano & Plionis, 2006), national level (Weisæth, 2004), or even cross-national level (Bancken, 2014). The persistence of the PFA team after a disaster also varied. In cross-national level programs, such as that for the conflict in southern Lebanon, the psychological team in a field hospital was usually dismissed once the conflict ended (Bancken, 2014). Some research-based PFA teams were formed by the researchers themselves (Brown et al., 2009; Hechanova et al., 2015, 2019; Ramirez et al., 2013). Whether the teams would continue to work or exist after the research was generally not reported. In some cases, the psychosocial team was moved to other departments, such as the municipal medical emergency ward in a case in Norway (Weisæth, 2004).

First responders included psychologists ( $n = 5$ ), nurses ( $n = 3$ ), social workers ( $n = 3$ ), teachers ( $n = 2$ ), fire fighters or rescue professionals ( $n = 2$ ), HR staff ( $n = 1$ ), and peer emergency personnel ( $n = 1$ ). The psychologists, nurses, social workers, fire fighters, and rescue professionals were “outside” of the disaster-affected local areas, whereas the teachers, HR staff, and peer emergency personnel (providing peer support) were “inside”

the areas. Who acted as the first responders depended on the situation; for instance, teachers were the best candidates for children at school (Field et al., 2017); nurses, for perinatal populations (Giarratano et al., 2019); and HR staff, for employees (Hechanova et al., 2019). For large-scale disasters, using organized support teams was likely to be more efficient (Atwoli, 2010).

**How many.** This refers to how many responders or workers participated in the PFA program. Among the 17 studies, only a few reported the exact number of first responders. In larger-scale assistance actions, one study reported numbers of counsellors ranging from 60 to 120 who served a total of 80,772 survivors (Atwoli, 2010), and another study reported the number of staff ( $n = 119$ ) but not survivors (Schafer et al., 2010). In a group-based PFA, a total of 35 professional facilitators provided help to 153 victims, where each group had two facilitators (Law, 2010).

**For whom.** This refers to the recipients of PFA. PFA was initially developed for individuals, but some PFA interventions are administered to groups, such as for children exposed to trauma and for employees after a fire (Cain et al., 2010; Castellano & Plionis, 2006; Hechanova et al., 2015, 2019). A few PFA programs differentiated between the survivors served. For example, after an airplane crash accident in the United States, the assistance response team developed different actions for first responders (emergency medical services, fire, and police), disaster workers (staff at the county emergency operations center), community members not directly involved, and families of crash victims (Homish et al., 2010). In another study, Norway's National Information and Support Centre classified survivors more specifically, such as next of kin, injured survivors and their close ones, uninjured survivors, and other groups such as helpless onlookers, rescue teams that had failed in their efforts, nonprofessional personnel handling bodies, and health personnel facing difficult choices when prioritizing (Weisæth, 2004).

**What.** This refers to the key contextualized content of PFA programs. Several studies formulated their own models, such as a seven-step psychological support plan (Bancken, 2014), a psychosocial intervention continuum (Macy et al., 2004), "listen protect connect" (Ramirez et al., 2013), mental health and psychosocial support with five actions (Atwoli, 2010), and the brief A<sup>A</sup>B<sup>A</sup>C<sup>A</sup>D<sup>A</sup>E (Assess, Be, Comfort, Do, End/Exit; Schafer et al., 2010). These models named and organized actions in different terms, but the actions were consistent with the eight core actions of PFA (Brymer et al., 2006). They all started from

"contact" and ended at "delivery."

Further, the content of PFA, as reported in some studies, was simplified by considering the profile of the targeted population and context. For instance, in the Psychological First Aid Field Operations Guide for Nursing Homes, "contact" and "engagement" were deleted since many of the relief workers were "insiders" working with the residents in nursing homes (Brown et al., 2009). Furthermore, some studies combined PFA programs with other interventions, such as a culturally sensitive group-based mindfulness PFA (Hechanova et al., 2015), a positive psychology-based PFA (Vernberg, Hambrick, Cho, & Hendrickson, 2016), and an organizational intervention consisting of PFA and open space technology (Hechanova et al., 2019). Notably, these models support the promotion of people's resilience and ability for post-disaster psychological growth and recovery (Hechanova et al., 2015, 2019; Vernberg et al., 2016).

**When.** This refers to when PFA is administered after a disaster and for how long. Most studies suggested that PFA should begin within 24 hr (Weisæth, 2004) or anytime when survivors are found to be facing difficulty (Brown et al., 2009). However, due to preparation delay, the beginning time frame ranged from 3 days (Hechanova et al., 2019) to 2 weeks (Law, 2010) to even 10 months after a disaster (Ramirez et al., 2013). How long a PFA program lasted depended on the scale of the disaster, the affected area, and the numbers of survivors, which varied.

**Where.** This refers to the location for PFA. The ideal place depended on the type of disaster and local situation, with due consideration of safety. Most studies set up temporary shelters that were safe near the disaster site, such as hospitals and private residences (Bancken, 2014). Locally accessible locations such as churches, schools, hotels (Cain et al., 2010; Ramirez et al., 2013), and nursing homes (Brown et al., 2009; Giarratano et al., 2019) were considered good choices. Easily accessible locations were suggested to present less psychological barriers than mental health facilities (Pynoos & Nader, 1988). However, psychotherapy offices may provide a more professional environment when structured counselling services are needed (Vernberg et al., 2016).

**Why.** This relates to the argument for contextualizing PFA. There were three main considerations. First, there was an emphasis on the planning and implementation of developmentally sensitive disaster mental health prevention and intervention efforts (Vernberg et al., 2016). Especially for children, the sensitive consideration



of age-related developmental was needed (Cain et al., 2010; Pynoos & Nader, 1988). Second, cultural issues were explored. Hechanova et al. (2015) implemented group-based and spiritual-based PFA programs in view of the collectivist cultures of the Philippines, where the self is imbedded in significant groups (e.g., family, clan, and close friends) and spirituality. Castellano and Plionis (2006) noted the unique psyche of emergency personnel, who included individuals who interpreted seeking mental health services as “weak.” The culture among emergency personnel attracts individuals who exhibit a “take charge, control-oriented style.” Hence, peer-to-peer support was developed to lend credibility to the counseling efforts. Third, contextual issues were discussed, such as the cases elaborated above in nursing home (Brown et al., 2009) and in cross-border conflict settings (Bancken, 2014). The steps or stages were revised, added, or removed to account for the diverse natures of the disasters and the unique variations in local situations.

**How.** This refers to the way researchers contextualized PFA. Most studies reported that their PFA programs were based on literature review or developed by psychosocial experts. Few studies cited existing international guidelines, such as the Inter Agency Standing Committee Guidelines (Law, 2010) and the PFA version by the NCTSN and National Center for PTSD (Cain et al., 2010). Only one program in a nursing home was reviewed by a multidisciplinary team (Brown et al., 2009). In only one study, the staff who delivered PFA was asked to give feedback (Schafer et al., 2010).

**How much.** This refers to the cost of running a PFA program. None of the 17 studies reported the cost, cost-benefit, or cost-effectiveness of the PFA program.

## Discussion

This ILR adopted a 6W3H structure to analyze the attempts of contextualizing PFA worldwide using the 17 identified articles. From 1988 to 2010, the studies were more population based and context specific as per the characteristics and needs of different groups. It was not until the administration of a 1-day group psychosocial processing program in 2010 (Law, 2010) that researchers turned their attention to particular culture-related issues, formulated their own PFA models, and combined PFA with other interventions. This made the contextualization of PFA more thorough, with due consideration given to the economic, cultural, and multifacet aspects.

## Who, How Many, When, and Where

Researchers have arrived at a consensus that governmental departments should be committed to organizing PFA (Kc et al., 2019). Our review revealed that both governmental and nongovernmental organizations are involved, which will have both advantages and disadvantages, depending on the political and civic society situation. In smaller states, such as Norway, it may be easier to set up a national-level organization (Weisæth, 2004). However, in the case of expansive federal states, such as the United States, it may be more practical to set organizations at a city or state level (Castellano & Plionis, 2006; Macy et al., 2004).

Whether the level of PFA organization may influence the speed of a response to the disaster is not clear. However, this aspect might influence the first core action of selecting a “safe and comfortable” site as soon as possible. Often, the selection and availability of the site may depend on the collaborating institutions, the location of the targeted population, and the financial resources to which the PFA teams have access. Although all PFA programs advocate immediate action, the wait has been as long as 10 months (Ramirez et al., 2013). Future contextualization of PFA should first pay special attention to the political structures and the nature of disaster to guarantee a timely and a stable program.

We classified the first responders as “insiders” and “outsiders” from the perspective of disaster survivors. The outsiders may be more efficient, especially for a large disaster (Atwoli, 2010). Among the various types of outsiders, nurses were highlighted because they can be easily trained, and the PFA guidelines can be easily integrated into their usual scope of care in providing comfort and support immediately after a disaster (Giarratano et al., 2019); thus, nurses could play a key role in providing PFA (Kılıç & Şimşek, 2018). However, it should be noted that the practice of PFA should not be restricted to health professionals and could also be delivered by lay people (Dijlts et al., 2014). Recently, there has been a call for indigenous psychological support teams as a viable addition to current disaster relief efforts (Edwards-Stewart et al., 2012). This development is particularly valuable if the PFA team members are “insiders” who are familiar with the local cultural norms and mores (Everly, Phillips, Kane, & Feldman, 2006). However, none of the studies reported a combination of insiders and outsiders. Moreover, little is known about the composition and size of PFA teams, representing research gaps that need to be filled urgently in the future.

## For Whom, What, and Why

As demonstrated by the results, the researchers adapted PFA to increase the developmental, cultural, and contextual sensitivity. Furthermore, some studies combined PFA programs with other interventions. Each adaptation led to a different form of PFA for a different targeted population.

Regarding the developmental characteristics of different age groups, extant research has focused mainly on children, who may more easily develop radical views about the disaster (Vernberg et al., 2016). This aspect requires special techniques and strategies according to age (Field et al., 2017). Little is known about other age groups, such as elderly individuals who are also vulnerable and have their own age-related responses. These research gaps need to be filled in the future.

Regarding cultural issues, one obvious feature was the transformation from individual-based to group-based approaches, which has yielded favorable results (Cain et al., 2010; Hechanova et al., 2015). Group cohesion fosters a supportive environment and promotes individual resilience (Castellano & Plionis, 2006). There are 12 therapeutic factors in group psychotherapy (Yalom & Leszcz, 2005), and most of these factors, especially group sharing and learning, could be included in group-based PFA programs (Everly et al., 2006; Kc et al., 2019). This is commonly observed in areas with collectivist cultures or a strong spiritual religion, such as a study based in the Philippines, where the collectivist cultures make people willing to gather (Hechanova et al., 2015). Future possible trends include the development of family- and community-based PFA in regions where the family or community is the cultural centerpiece. Another feature is the addition of cultural and religious conventions, such as prayer. Researchers must consider the precise cultural, political, and religious contexts when designing PFA interventions because all these aspects may affect how people perceive safety and cope with adversity in idiosyncratic manners (Hechanova et al., 2015).

Local contextual issues are mainly reflected in the embedded characteristics of the targeted populations and situations. The psychosocial needs vary between different groups after a disaster, and PFA practitioners need to pay special attention to each case (Weisæth, 2004). Therefore, some PFA actions have been excluded, adapted, and added. For example, “contact and engagement” was deleted and “safety and comfort” was adapted based on the physical conditions in a nursing home (Brown et al., 2009), while “listen” was added

to accommodate trauma-exposed students (Ramirez et al., 2013).

In addition, some approaches have integrated other modalities and concepts into the eight core actions of PFA, including positive psychology, mindfulness, and open space technology (Kc et al., 2019). These are in tandem with the common goal of psychosocial support in disaster management, which is to facilitate the resilience of individuals, families, and communities in recovery (Jacobs, 2007). The incorporation of major PFA concepts with other techniques or theories is another research gap that should be addressed in future. When contextualizing PFA, the sociological concept of intersectionality may provide a useful lens that stresses “the interconnected nature of social categorizations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage; a theoretical approach based on such a premise” (Syed, 2010, p. 61). In other words, the intersections of age, gender, cultural, political, social, economic, and spiritual contexts should be duly considered when adapting PFA.

## How and How Much

Only two studies provided specific approaches to achieve cultural sensitivity. One established a multidisciplinary team to develop a program and then sought comments from a panel of national experts (Brown et al., 2009). The other study involved feedback from experienced staff on site who were familiar with the local culture (Schafer et al., 2010). Embracing diversity and local stakeholders is thus essential in a contextually sensitive adaptation of PFA programs in the future. The eight key principles and steps of community-based participatory research that meet the indigenous research context (Laveaux & Christopher, 2009) may be highly relevant and instructive in the contextualization of PFA.

The cost-benefit and cost-effectiveness of PFA programs were not evaluated in any of the included studies. However, to realistically design a PFA intervention and to ensure its sustainability, it is crucial to consider and estimate the economic cost, especially in developing economies that often have to contend with the shortage of adequately trained staff, an underdeveloped disaster response organization system, and weak community infrastructure (Harris, Wurie, Baingana, Sevalie, & Beynon, 2018; Hughes, 2015). Future research may consider the cost of training and delivery of PFA, as well as the immediate and long-term cost-benefit of PFA.

## Limitations and Future Directions

This review is limited by including only English-language peer-reviewed publications. This may contribute to bias, since studies in other languages and grey literature (e.g., books, government reports, and authoritative websites of international organizations) were excluded. However, instead of grey literature, the use of “black literature,” which is defined as work that is formally described and published in peer-reviewed journals (Reupert et al., 2013), generates an authoritative preliminary overview of this topic.

Further, no controlled studies were found, and the scientific literature available to date does not provide any evidence about the effectiveness of PFA interventions (Dieltjens et al., 2014). Thus, more sound empirical research to evaluate the cost-benefit of PFA and suggest treatment guidelines is needed (Giarratano et al., 2019).

## Conclusion and Clinical Relevance

Population-based, context-specific, and group-based PFA interventions are the new trend in the contextualization of PFA worldwide. Nurses are the key PFA providers. Research gaps exist in differentiating between the roles played by “outside” and “inside” responders, incorporating the major PFA concepts such as resilience, considering vulnerable age groups other than children, and evaluating the cost-effectiveness of PFA. It is imperative that nurses and other emergency staff consider the intersection of age, gender, cultural, political, social, economic, and spiritual contexts when developing a context appropriate PFA.

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### Clinical Resources

- Federal Emergency Management Agency. Crisis counseling—Psychological first-aid. <https://www.fema.gov/blog/crisis-counseling-psychological-first-aid>
- World Health Organization. Psychological first aid: Guide for field workers. [https://www.who.int/mental\\_health/publications/guide\\_field\\_workers/en/](https://www.who.int/mental_health/publications/guide_field_workers/en/)

## References

- Atwoli, L. (2010). Emergency mental health and psychosocial support for survivors of post-election violence in Eldoret, Kenya. *East African Medical Journal, 87*(11), 465–468.
- Bancken, J. (2014). The modus operandi of the Module Battle Stress Recovery Unit (Mod BSRU) deployed to UNIFIL from October 2006 until March 2009. *International Review of the Armed Forces Medical Services, 87*(1), 37–40, 42–45.
- Brown, L. M., Bruce, M. L., Hyer, K., Mills, W. L., Vongxaiburana, E., & Polivka-West, L. (2009). A pilot study evaluating the feasibility of psychological first aid for nursing home residents. *Clinical Gerontologist, 32*(3), 293–308.
- Brymer, M., Layne, C., Jacobs, A., Pynoos, R., Ruzek, J., Steinberg, A., ... Watson, P. (2006). *Psychological first aid field operations guide* (2nd ed., Vol. 33, pp. 391–395). Los Angeles, CA: National Child Traumatic Stress Network.
- Cain, D. S., Plummer, C. A., Fisher, R. M., & Bankston, T. Q. (2010). Weathering the storm: Persistent effects and psychological first aid with children displaced by Hurricane Katrina. *Journal of Child and Adolescent Trauma, 3*(4), 330–343.
- Castellano, C., & Plionis, E. (2006). Comparative analysis of three crisis intervention models applied to law enforcement first responders during 9/11 and Hurricane Katrina. *Brief Treatment and Crisis Intervention, 6*(4), 326–336.
- de Carvalho, E. M., Silva, F., & dos Santos, P. R. (2018). Planning and administration of environmental security and care in health services. *Revista de Pesquisa: Cuidado é Fundamental Online, 10*(1), 224–232.
- Dieltjens, T., Moonens, I., Van Praet, K., De Buck, E., & Vandekerckhove, P. (2014). A systematic literature search on psychological first aid: Lack of evidence to develop guidelines. *PLoS One, 9*(12), e114714.
- Edwards-Stewart, A., Ahmad, Z. S., Thoburn, J. W., Furman, R., Lambert, A. J., Shelly, L., & Gunn, G. (2012). Introducing embedded indigenous psychological support teams: A suggested addition to psychological first aid in an international context. *International Journal of Emergency Mental Health, 14*(4), 289–296.
- Everly, G. S. Jr., Phillips, S. B., Kane, D., & Feldman, D. (2006). Introduction to and overview of group psychological first aid. *Brief Treatment and Crisis Intervention, 6*(2), 130–136.
- Field, J. E., Wehrman, J. D., & Yoo, M. S. (2017). Helping the weeping, worried, and willful:

- Psychological first aid for primary and secondary students. *Journal of Asia Pacific Counseling*, 7(2), 169–180.
- Fox, J. H., Burkle, F. M., Jr., Bass, J., Pia, F. A., Epstein, J. L., & Markenson, D. (2012). The effectiveness of psychological first aid as a disaster intervention tool: Research analysis of peer-reviewed literature from 1990–2010. *Disaster Medicine and Public Health Preparedness*, 6(3), 247–252.
- Giarratano, G., Bernard, M. L., & Orlando, S. (2019). Psychological first aid: A model for disaster psychosocial support for the perinatal population. *Journal of Perinatal & Neonatal Nursing*, 33(3), 219–228.
- Harris, D., Wurie, A., Baingana, F., Sevalie, S., & Beynon, F. (2018). Mental health nurses and disaster response in Sierra Leone. *Lancet Global Health*, 6(2), e146–e147.
- Hechanova, R., Manaois, J., & Masuda, H. (2019). Evaluation of an organization-based psychological first aid intervention. *Disaster Prevention and Management*, 28(3), 401–411.
- Hechanova, R., Ramos, P., & Waelde, L. (2015). Group-based mindfulness-informed psychological first aid after Typhoon Haiyan. *Disaster Prevention and Management*, 24(5), 610–618.
- Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., ... Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry-interpersonal & Biological Processes*, 70(4), 283–315.
- Homish, G. G., Frazer, B. S., McCartan, D. P., & Billittier, A. J. 4th. (2010). Emergency mental health: Lessons learned from flight 3407. *Disaster Medicine and Public Health Preparedness*, 4(4), 326–331.
- Hughes, P. (2015). Mental illness and health in Sierra Leone affected by Ebola: Lessons for health workers. *Intervention: International Journal of Mental Health, Psychosocial Work, and Counselling in Areas of Armed Conflict*, 13(1), 60–69.
- Jacobs, G. A. (2007). The development and maturation of humanitarian psychology. *American Psychologist*, 62(8), 932–941.
- Kc, A., Gan, C. C. R., & Dwirahmadi, F. (2019). Breaking through barriers and building disaster mental resilience: A case study in the aftermath of the 2015 Nepal earthquakes. *International Journal of Environmental Research and Public Health*, 16(16), 2964.
- Kılıç, N., & Şimşek, N. (2018). Psychological first aid and nursing. *Journal of Psychiatric Nursing/Psikiyatri Hemsireleri Derneği*, 9(3), 212–218.
- Laveaux, D., & Christopher, S. (2009). Contextualizing CBPR: Key principles of CBPR meet the indigenous research context. *Pimatisiwin*, 7(1), 1.
- Law, R. (2010). The Department of Health response to the Maguindanao massacre in the Philippines. *Intervention*, 8(3), 263–267.
- Macy, R., Behar, L., Paulson, R., Delman, J., Schmid, L., & Smith, S. (2004). Community-based, acute posttraumatic stress management: A description and evaluation of a psychosocial-intervention continuum. *Harvard Review of Psychiatry*, 12(4), 217–228.
- McArthur, A., Klugárová, J., Yan, H., & Florescu, S. (2015). Innovations in the systematic review of text and opinion. *International Journal of Evidence-Based Healthcare*, 13(3), 188.
- Pynoos, R. S., & Nader, K. (1988). Psychological first aid and treatment approach to children exposed to community violence: Research Implications. *Journal of Traumatic Stress*, 1(4), 445–473.
- Ramirez, M., Harland, K., Frederick, M., Shepherd, R., Wong, M., & Cavanaugh, J. E. (2013). Listen protect connect for traumatized schoolchildren: A pilot study of psychological first aid. *BMC Psychology*, 1(1), 26–34.
- Reupert, A. E., Cuff, R., Drost, L., Foster, K., van Doesum, K. T., & van Santvoort, F. (2013). Intervention programs for children whose parents have a mental illness: A review. *Medical Journal of Australia*, 199(3 Suppl.), S18–S22.
- Salet, W., & de Vries, J. (2019). Contextualisation of policy and law in sustainable urban development. *Journal of Environmental Planning and Management*, 62(2), 189–204.
- Schafer, A., Snider, L., & van Ommeren, M. (2010). Psychological first aid pilot: Haiti emergency response. *Intervention*, 8(3), 245–254.
- Shultz, J. M., & Forbes, D. (2014). Psychological first aid: Rapid proliferation and the search for evidence. *Disaster Health*, 2(1), 3–12.
- Syed, M. (2010). Disciplinarity and methodology in intersectionality theory and research. *American Psychologist*, 65(1), 61–62.
- Vernberg, E., Hambrick, E., Cho, B., & Hendrickson, M. (2016). Positive psychology and disaster mental health: Strategies for working with children and adolescents. *Journal of Clinical Psychology*, 72(12), 1333–1347.



- Weisæth, L. (2004). Preventing after-effects of disaster trauma: The information and support centre. *Prehospital and Disaster Medicine, 19*(1), 86–89.
- Welter, F. (2011). Contextualizing entrepreneurship: Conceptual challenges and ways forward. *Entrepreneurship Theory & Practice, 35*(1), 165–184.
- Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing, 52*(5), 546–553.
- Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. Journal of Mental Health (5th ed., Vol. 29, pp. 24–25). New York, NY: Basic Books.

## Supporting Information

Additional supporting information may be found in the online version of this article at the publisher's web site:

**Table S1.** Inclusion and Exclusion Criteria.

**Table S2.** JBI Critical Appraisal Checklist for Text and Opinion Papers.

**Table S3.** Overview of the Included Studies Chronologic Order.

**Table S4.** Contextualization of PFA Using the 6W3H Structure.

**Figure S1.** Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram of literature search and review process.

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