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Integrated Community-Based Psychological First Aid (CBPFA) to Improve Community Resilience for Community Volunteer Member (*Kaders*) at Disaster Prone Area

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Table of Contents

Introduction 1

Background & Significance of the Problem 1

Statement of the Problem 4

Statement of the Purpose 5

Literature Review 6

Review of Theoritical Literature 6

Disaster Mental Health & Mental Health Psychosocial Support 6

Resilience 9

Community Resilience 12

Indonesia Community Health System 15

Kader 17

Psychological First Aid (PFA) 17

Response-team PFA model 18

The Red Cross movement and the IFRC model 19

The WHO and War Trauma Foundation and World Vision International (2011) Model. 20

Community-Based Psychological First Aid (CBPFA). 20

Review of Relevant Research 22

Community-Based Psychological First Aid (CBPFA) 22

The Mental Health Kaders and Disaster Community Mental Health Nursing (CMHN) in Indonesia 25

Religious Spiritual Belief and Disaster 27

Research Framework 34

Development of Framework 34

Formulation of Hypothesis 37

Operational Definition of Research Variables 37

Independent Variable 37

Dependent Variables 37

Method and Procedures 38

Description of Research Design 38

Intervention 39

Development of Intervention 39

Consultation 46

Collaboration. 47

Setting 48

Participants 49

Recruit of Participants 49

Data Collection 52

Ethical Consideration 52

Measurement Method 55

Data Analysis 58

Result 59

Demographic Characteristics 59

Normality Test 60

Homogeny Test 62

Hypothesis 1 65

Hypothesis 2 67

The Multivariate Analysis 69

***The Linear Regression*.** 69

***The Mancova Test*.** 73

The Two Way MANOVA. 74

Discussion 76

Summary of the Results 76

CBPFA and Culture 78

CBPFA and Resilience 80

Limitations 82

Implications 82

Implications for practice 82

Implications for research. 83

Conclusions 85

Acknowledments 87

References 89

Appendix 1. Knowledge of PFA Questionnaire i

Appendix 2. Psychological First Aid Percevied usefulness Questionnaire v

Appendix 4. The Connor-Davidson Resilience Scale（CD-RISC） ix

Appendix 5. Communities Advancing Resilience Toolkit (CART) Survey xi

Appendix 6. Demographic Sheet... xiv

Appendix 7. Cover Letter of Consent Participants xv

Appendix 9. Permission Letter to Public Health Center xxiv

Appendix 10. Indonesia Version Explanatory Form.. xxvi

Appendix 11. Indonesia Version Inform Consent.. xxviii

Appendix 12. Indonesia Version Demographic.. xxx

Appendix 13. Indonesia Version Knowledge of PFA Questionnaire......................... xxxi

Appendix 14. Indonesia Version the General Self-Efficacy Scale (GSF)................ xxxiv

Appendix 15. Indonesia Version Communities Advancing Resilience Toolkit (CART) Survey.. xxxv

Appendix 16. Indonesia Version Psychological First Aid Percevied usefulness Questionnaire.. xxxvii

Appendix 17. Indonesia Version CBPFA Handbook for Control Group................. xxxix

Appendix 18. Indonesia Version CBPFA Handbook for Case Group xl

List of Figure

Figure 1. IASC Intervention Pyramid for MHPSS in emergencies (IASC, 2007) 9

Figure 2. The societies-to-cells framework (Szanton and Gill, 2010) 15

Figure 3. Indonesia Health System 16

Figure 4. Research Framework, modification from the societies-to-cells framework (Szanton and Gill, 2010) 36

Figure 5. Research Design 39

Figure 6. Pandeglang City Map (https://bpbd.bantenprov.go.id/read/peta.html) 48

Figure 7. Flowchart of Participants Recruitment 51

List of Table

Table 1. Research on CBPFA 23

Table 2. Kaders role in Disaster Mental Health (DMH) 27

Table 3. Religious Spiritual Belief and Disaster 30

Table 4. Content of CBPFA Training 38

Table 5 Demographic Characteristics 60

Table 6 The Normality Test of Variables 61

Table 7. Comparison of Pre-Training Outcomes for Control and Case Group (N=98) . 63

Table 8. Comparison of Percevied Usefulness of CBPFA Training for Control and Case Group 64

Table 9. Participant's Response of the Overall Percevied usefulness of CBPFA 65

Table 10 Comparison of Pre- and Post-Training Outcomes of Participants in Control Group 66

Table 11 Comparison of Pre- and Post-Training Outcomes of Participants in Case Group 67

Table 12 Comparison of Outcomes for Control and Case Groups after Training 68

Table 13 Comparison of Mean Difference Outcomes for Control and Case Groups 69

Table 14 Multivariate Linear Regression Analysis of Predicting the Knowledge of CBPFA 70

Table 15 Multivariate Linear Regression Analysis of Predicting Individual Resilience Score 71

Table 16 Multivariate Linear Regression Analysis of Predicting Self Efficacy Score .. 72

Table 17 Multivariate Linear Regression Analysis of Predicting Community Resilience Score 73

Table 18 Multivariate Analysis of MANCOVA 74

Table 19 Multivariate Analysis for Two-Way MANOVA... 75

Abstract

Disaster is brought an impact not only on the physical state but also on the mental health state. Building a local assistance program has been growing attention to improving community resilience as well as reducing the community reliance on mental health professionals in addressing mental health needs. Indonesia has a potential community based-disaster preparedness strategy by utilizing the existing community empowerment program, which named *Kaders*. One of the well-known community-based mental health programs on disaster is Community-Based Psychological First Aid (CBPFA) which was first developed by Jacobs and Mayers (2006). CBPFA builds community resilience by strengthening the community resources. Because CBPFA works on community based, it requires the cultural adaptation to be accepted by the community member. The cultural adaptation employed in this study was integrated the religious value into CBPFA training.

Therefore, the aim of the study was to improve community resilience by developing integrated CBPFA for non-professional community workers (*Kaders*) and to evaluate the effectiveness of the training program on *Kaders'* knowledge, confidence, and resilience. The research design was a quasi-experimental non-equivalent (pre-test, post-test) control group model. A total of 98 *Kaders* participated in this study, 52 with integrated CBPFA training as a case group and 46 with original CBPFA training as a control group. Before and after training, CBPFA knowledge and skills, individual resilience (CD-RISC) and community resilience (CART), and self-efficacy (GSE scale) were measured, and the perceived usefulness of CBPFA training was measured only after training.

Whether there are significant differences between variables by both parametric

test and non-parametric test were examined for testing the two hypotheses, 1) the CBPFA training increase *Kaders'* knowledge and skill of CBPFA, individual and community resilience, and 2) the integrated CBPFA group shows higher scores on the post- training test compare to the CBPFA group, including knowledge & skill of CBPFA, their perceived self-efficacy, Self-Perceived resilience, and community resilience. The findings of the study supported the first hypothesis that CBPFA training improved the all expected outcomes in both groups ($p<.05$) by using dependent T Test and Wilcoxon test. However, there was no statistically significant difference among the groups ($p > .05$) on the pre- and post-score difference which made the second hypothesis was not supported in the study by using both of Independent T Test and Mann Whitney. Nevertheless, in terms of the perceived usefulness of CBPFA for *Kaders*, the case group perceived overall perceived usefulness more than the control group ($\chi2$ (2, N = 98) = 11.589, $p <. 05$). In addition, they scored significantly higher in their perception of perceived usefulness of the program in reducing stress on themselves (t (96) = -4.450, p=.000), and others (t (96) = -3.982, p= .000) and identifying resources that exist in the community (t (96) = -2.048, p= .045). This is because of the religious value that unified in this study. *Kaders* as participants in this study were nonprofessional in mental health. Therefore, by adding religious values start from the first lesson of the CBPFA training, it helps the *Kaders* to easily understand how to overcome their stress and to support each other in the perspective of religion. This study is the first CBPFA study that integrated religious value as the cultural adaptation strategy. The findings from this study add the feasibility of implementing community-based disaster mental health preparedness such as CBPFA in the future.

Keywords: Community-based, disaster, *Kaders*, PFA, resilience

Introduction

Background & Significance of the Problem

Disaster has deeply impacted the population who live in the affected area in Indonesia. Loss of life, serious injuries, destruction of homes and other property, displacement, and family separation create serious disruption in people's lives, and can affect their mental health and psychosocial well-being. Some people develop new mental disorders after crisis events such as General Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), depression and other psychotic diseases (Goldman & Galea, 2014), while others appear to have very minor psychological impact and recover naturally with little or no intervention. People who recover naturally draw on a number of factors including personal resilience, family and community support, and local assistance programs. There is a growing recognition for the development of local assistance programs to help improve individual and community resilience as well as addressing the psychological needs.

Previous studies have shown local assistance programs can improve community resilience (Macy, et al 2004; Wade et al 2013; McCabe, et al 2013). These studies state that community resilience encourages growth and recovery after adversity and are associated with better mental health outcomes among survivors of disasters. Community resilience is seen as a strategy to support and foster disaster preparedness and community recovery from catastrophic events. However, Indonesia as disaster prone country, faces several challenges in disaster mental health preparedness. The Indonesian government has only recently started to develop (2005) the community mental health system by upscaling Aceh Public Health Nurses (PHN) with mental health training and psychosocial programs renaming it as the Community Mental Health Nursing Program

(CMHNP). Currently the program is not intended to build community resilience as part of a disaster preparedness action plan, but rather to respond to the severe shortages in the mental health system in the aftermath of the 2004 Tsunami.

As previously mentioned, although the CMHNP does not reflect the mental health promotion activities to promote community resilience, it could provide a suitable pathway for community resilience programs to be implemented. Currently the overarching problem is the absence of any community involvement in disaster preparedness activities. If we want to create greater community resilience, we must include the people within those communities.

The Inter Agency Standing Committee (IASC) and the Sphere Project have released the guidelines of Mental Health and Psychosocial Support (MHPSS) support suitable for disaster situations (IASC, 2010). Furthermore, the guidelines strength the importance of community involvement and recommends that volunteers and primary health care staff should be trained in providing early psychological support to people experiencing acute distress. The MHPSS guide, also recognizes the importance of and the long history in the Indonesia community health system of the *Kader* program. *Kaders* are community member volunteer who work for community health services and live in the village they serve. Originally, the *Kader* program was developed to overcome mother and child issue which was a greatest threat in the 1970s. Nowadays, *Kader* serve on health-related issues including community mental health care in the community and are supervised by a village committee. Previous studies related to the role of *Kader*s in post disaster community mental health care have been conducted after the Tsunami 2004 (Prasetyawan, et al 2006; Keliat, et al 2011) and showed the 79 trained *Kader*s in community mental health care along with general practitioners and Public Health

Nurses (PHN) were able to identify 2062 mental illness cases in the community.

The role of community members actively engaging in disaster situations has been recognized as important by experts and researchers in disaster management. Recently several community disaster mental health care models which actively involve community member participation and aim to build community resilience have been introduced examples include: Community-Based Psychological First Aid (CBPFA), psychosocial intervention, and the Community Support Training Program (Jacobs & Meyer, 2005; Simonsen & Reyes, 2003; Wade, et al 2013). However, only the CBPFA model is well recommended by World Health Organization (WHO) and the International Federation of Red Cross and Red Crescent Societies (IFRC). CBPFA aims to train members of the community (not mental health professionals) to provide basic psychological support to their families, friends, neighbors, and coworkers as a means of managing their own stress (Jacobs & Meyer). CBPFA builds on the strengths within the community by incorporating effective local traditions and values. This psychosocial support is critical for countries such as Indonesia where tradition and local value is strongly attached with religious and spiritual values. For the majority of Indonesians Islamic religious and spiritual beliefs are central to individual identity and sustained by the culture. In disaster situation, these beliefs provide Indonesian Muslims ways to cope with the disaster by providing them with spiritual answers and hope. Scientific literature supports the importance of religiosity / spirituality in the mental health and wellbeing of communities in disaster situations (Koenig, et al 2012). Religious and spiritual beliefs act as protective factors and cultural factors contribute to posttraumatic growth and resilience in survivors. Hence, religious and spiritual beliefs help survivors to shape positive thoughts, feelings and behaviors in the post disaster and recovery period.

Given that Islam is the majority religion in Indonesia it is imperative that the development of any community based psychosocial intervention integrates Islamic values throughout the program. Although the CBPFA is a proven and effective means of increasing the resilience of those who affected by disaster, to date there has not been any training or practice which integrates spiritual and religious values in the delivery. As this inclusion is critical to Indonesian communities there is a recognized need to develop a community-based disaster mental health program that can be delivered by the *Kader*s that includes education and skills which include religious and spiritual approaches. By doing so it will not only be a beneficial to healing and but also be culturally acceptable.

Statement of the Problem

Indonesia with numbers of disaster in the last decades need to shift the paradigm of community-based disaster mental health care not only in response phase but also start from preparedness phase. As we knew already disasters can become uncontrollable, once the event has got underway. Therefore, preventive steps need to be taken before, during and after the disaster events. If each individual in the community is familiar with ways of coping and precautionary measures, then the disruption by a disaster can be reduced (Sampath, 2001). The gap between the limited available mental health resources and the overwhelming mental health need following disaster should be responded by involving community member in early psychosocial support.

Building resilient community as the preventive strategy to overcome the disaster mental health issue can be started from individual resilient. The IASC, The Sphere Project and IFRC have produced guidance on the provision of MHPSS support during emergencies, based on research evidence and expert consensus. Both sets of guidance emphasize the importance of strengthening community-based support and self-help in

humanitarian contexts, recommending that volunteers and primary health care staff be trained in providing Psychological First Aid (PFA). One of well-known PFA for community is CBPFA. The purpose of CBPFA not only to alleviate disaster mental distress but also to increase the resiliency. CBPFA serves as the method of choice to assist developing countries in beginning psychological support programs (Jacobs & Meyer, 2005; Simonsen & Reyes, 2003). However, Indonesia has specific culture which religious and spiritual beliefs are central to individual identity and sustained by the Indonesia culture with the predominant religion is Islam. The need to implement sustainable community based disaster mental health program should be incorporated with the religious value that existed already as part of cultural sensitivity strategy.

Statement of the Purpose

The purpose of this study is to develop integrated CBPFA for community member (*Kader*s) that improve the community resilience and to evaluate the effectiveness of the training program on *Kaders*' knowledge, confidence, and resilience.

Literature Review

Review of Theoritical Literature

Disaster Mental Health & Mental Health Psychosocial Support

Disaster with various type may cause psychological distress and disorder to affected populations. Disaster is a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts (UNISDR, 2009). More over according to Indonesia Disaster Management Law (2007), the disaster is defined as an event or series of events that threatens and disrupts live and livelihoods, caused either by natural or non-natural and man-made factors, which produce death, environmental damage, loss of assets, and psychological impact. Events associated with disaster can cause traumatic stress when they cause or threaten death, serious injury, or the physical integrity of individuals. According to World Health Organization (WHO, 2017), the following stressors can precipitate psychological distress state after disaster including severity of disaster, life threats, prior traumatic, lack of social support, injury, loss of loved ones and community life, and dislocation from home, family and community. The impact of disaster on psychological and social aspects may take acute phase in the short term, still they can persist for the long-term mental health and psychosocial well-being of the survivors.

WHO & UNHCR (2012) stated that the prevalence of mild and moderate common mental disorders in the general population is 10% and that this can increase to 20% after a disaster, severe mental health problems, such as psychosis or severe depression, typically affect 2–3% of any given population but can increase to 3–4%

after a disaster. Moreover international investigations has been revealed the evidence related to the effect of disaster on psychological distress and disorder, such as GAD (Bravo, et al 1990; Goenjian, 1993; Norris et al, 2001; Goldman & Galea, 2014), depression (Chan, et al 2012; Bonde, et al 2016), and PTSD (Neri, et al 2008; Utzon-Frank et al, 2014; Aslam et al 2010). It was clearly recognized in the aftermath of the disaster that any neglect psychological support could impair effort at physical rehabilitation, therefore providing psychosocial support to communities affected disaster is key component of WHO strategy (WHO, 2013). According to IASC guidelines psychosocial and mental health on disaster (2010), Interventions should be delivered within a four-layered pyramid of complementary levels of support. The first layer is basic services and security, secondly community and family support the third and fourth are focused, non-specialized support and specialized services. The first to third layers should be delivered by community health workers in primary health setting and the fourth layer should be provided by mental health professionals. Therefore, WHO (2006) highlighted that appropriately trained community-level workers who understood the nuance of the local community were effectively used to render psychological support.

Mental health and psychosocial support (MHPSS). The basic term of MHPSS is refer to any type both local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. In term of mental health support, the variety support is easily to define, support like an interventions in health or education, support in community-based intervention. Any 'MHPSS' issues including social problems, emotional distress, mild to moderate mental disorders (such as depression and posttraumatic stress disorder), severe mental disorders (such as

psychosis), alcohol and substance abuse, and intellectual disability.

The IASC and The Sphere Project have produced manual of MHPSS service during emergencies. The guidelines emphasize the importance of strengthening community-based support and self-help in humanitarian contexts, recommending that volunteers and primary health care staff be trained in providing Psychological First Aid (PFA) to people experiencing acute distress (Inter-Agency Standing Committee, 2010). The guidance also recommends developing a coordinated network of support services offering different levels of specialization to meet different levels of need. The IASC (2010) describe the community mental health service as pyramid Intervention (Figure 1), with the basic services and community supports towards the base of the pyramid and more focused, specialized services towards the top.

1) Layer 1: Ensure that security is achieved and basic needs and essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) are met in a manner that protects the dignity of all people, including those with special vulnerabilities. To avoid discrimination, stigma and further distress, do not target groups at risk exclusively. Apply the same principles to advocacy. Always inform persons of concern how, where and when they can access humanitarian services, to reduce distress.
2) Layer 2: Strengthen community and family support. Promote activities that foster social cohesion. Support the restoration or development of community-based structures that represent the population in terms of age, gender and diversity. Promote community mechanisms that protect and support individuals using participatory approaches. Ensure that play and recreation spaces and activities are available, especially for children. Layer 3: Provide focused

psychosocial support. Promote individual, family or group interventions to provide emotional and practical support to those who find it difficult to cope alone or with their own support network. Non-specialized workers in health, education or community services usually deliver such support, after training and with ongoing supervision.

3) Layer 4: Clinical services. Make clinical mental health services available to those with severe symptoms or whose intolerable suffering renders them unable to carry out basic daily functions. The problems of such persons are usually induced by the emergency, or pre-existed it. They include (but are not limited to): psychosis, drug abuse, severe depression, or disabling anxiety symptoms; some may be at risk of harming themselves or others. Interventions are usually led by mental health professionals

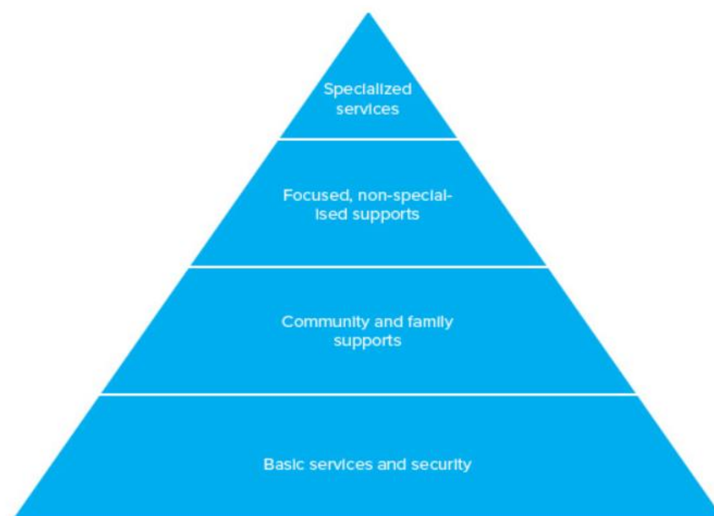

Figure 1. IASC Intervention Pyramid for MHPSS in emergencies (IASC, 2007)

Resilience

Resilience has become center of attention to understand how a human being

response in their adversity. Among the scientific literature, there is no universally accepted definition to define the meaning of resilience. Researchers viewed and defined a resilience as a trait, a process, or an outcome (Luthar, 2006; Masten, Best, Garmezy, 1990; Boss et al al 2017; De Haan et la, 2013; Masten 1999; Masten & Cicchetti, 2016). According to those literatures there are two common definitions which has been emerging: (1) resilience as a personal trait; (2) resilience as a process.

1) Resilience as a Personal Trait

Researchers who assume that resilience may be a personal trait or a group of trait defining resilience because the human ability or capacity to recover from and successfully adapt to life adversities or major critical events (Grotberg, 2003; Minnard, 2002; Norman, 2000). Based on this definition, resilience is more stable and fixed because it comes from individual trait, yet it still can grow from the experience of daily hassles. Later on, those that have resilience would be expected to possess a way greater chance of thriving when life circumstances are difficult (Lopez, Prosser, & Edwards, 2002).

The interesting part is the perspective of this group who no longer view individual as a victim; rather individual is viewed as a survivor. Once a person is seen a survivor, it means that the person has an ability to overcome the life adversities and gain positive adaptations. Hence, resilience is require human strength and growth. Speaking about positive adaptation, Post Traumatic Growth also refer to positive adaptation, however resilience is different from Post Traumatic Growth. The Post Traumatic Growth require a stressful event to precipitate positive adaptation ability, moreover the positive adaptation ability is growing more than their ability before the stressful event occurred, while resilience considers as a psychological growth that may or may not

occur after adversity (Miller, 2003). In other words, supported the attitude of this group, people that resilient show their ability to returns rapidly to a previous state following trauma or negative life events (Bolig & Weddle, 1988, in Holaday & McPhearson, 1997).

2) Resilience as a Process

The researchers who defined resilience as a process state that resilience as a dynamic process of positive or successful adaptation despite the experience of adversity, trauma, threats, or stressful life events (Luthar et al., 2000; Luthar & Ziegler, 1991; Masten, Best, & Garmezy, 1990; Rutter, 1990). According to Fonagy, et al (1994), resilience is not a set of individual attributes born or acquired during development, but resilience 1s a set of social and intrapsychic processes which consist of combination of individual, family, social and cultural environments, its interact one to another.

Moreover Masten (2015) assumes that resilience will be dynamic because human individuals and their contexts are always changing. This group highlighted a dynamic term to describe that resilience creates possibility. The possibility that resilience can be fostered and developed which means there is another factor beyond personal trait or individual characteristic such as the influence of families, schools, peers, communities that can help to increase resiliency so that people can successfully overcome the adversity. Moreover, opposite with the first group who state resilience is personal trait, yet this group assumes resilience require an experience or situation that high risk for precipitating of psychopathology (Luthar et al., 2000a).

Masten and Cicchetti (2016) revealed a system framework of resilience into eight principles. The following core ideas as follow:

a) Many interacting systems at multiple levels shape the function and development

of living systems.

b) The capacity for adaptation of a systems and its development are always changing

c) Change can occur spread all across domain and level of function, since interconnections and interactions influence to living systems.

d) Systems are interdependent.

In the detail explanation of this interactive systems describe that individual are embedded in families and other systems (peer groups, schools), and families successively are embedded in other systems (culture, community and society). Interaction of people, families, and bigger contexts affect all of the interacting systems, although some systems may have greater direction influence (parents have greater influence for the care of children). From the systems perspective, resilience may be a system at one level will depend upon the opposite systems that directly support that individual's resilience, like parent or family.

Community Resilience

The concept of resilience may be defined in many ways therefore to date there is no universal definition of community resilience. Lee (2017) define community resilience as the ability of a community to be back to the pre disaster state after the disturbance. While, Windle (2011) see the community resilience as the collective ability of certain area based on their geographic location to resolve the catastrophic effect of disaster by working together so that immediately they can return to their daily function (Windle, 2011). While. Yet, the definition of community resilience has grown by assuming that community resilience is the community adaptation after a disruption along with a process that encourage the growth and development of community even no

disaster occur. The community resilience is a process of ongoing preparedness efforts leading to redundant systems, collaboration, equity, flexibility, and self-sufficiency of the community members, which allows the community to withstand and recover from a disaster with minimal loss of life and function. Szanton and Gill (2010) proposed the framework in resilience in order to explain how individual and community resilience can be interfering each other (Figure 2).

Society-to-Cells framework (Szanton and Gill, 2010). The society to cells framework by Szanton and Gill (2010) proposed the holistic view of resilience from micro level to macro level and the essential of nursing practice is to foster resilience trough action that affecting one or more factors, this action can increase possibility of affecting comprehensive change. Moreover, they state that nursing plays as pivotal role to improve the resilience trough the intervention which can enable recovery, résistance and rebound of the individuals as well as their families, communities, and societies.

The society to cells by Szanton and Gill (2010) is based on 6 fundamental tenets:

1) Each person is born with resilient potential, however as human being who can change over the time, the change is depending on in interactions between society, community, and family, and individual psychological, physiologic, and cellular factors and how each factor reacts to a challenge.
2) Resilience includes 3 aspects: (1) resistance to a (2) recovery from a challenge, or (3) rebounding from a challenge.
3) Nurses can foster resilience through action affecting 1 or more factors, and this action has increased possibility of affecting comprehensive change if it addresses multiple factors.
4) Each factor may interact with all the other factors.

5) Just as there may be particularly vulnerable periods of risk so there are times where an individual, community, or society may be particularly resilient in meeting a challenge.
6) Resilience is both a process and a capacity.

Individual resilience is necessary for a community to overcome adversity because of the connection and influence individuals have on their community. There is a clear relationship between the well-being of an individual and the well-being of a community. Community resilience requires people to come together and volunteer. Individuals need to know how to bounce back from their problems so they can have a positive influence on their community. If a person has a strong sense of resilience, they will be able to make a strong commitment to their community and actively contribute. A person must be able to recover from their own setbacks. People bring key resources to the community, this include their specific knowledge and expertise

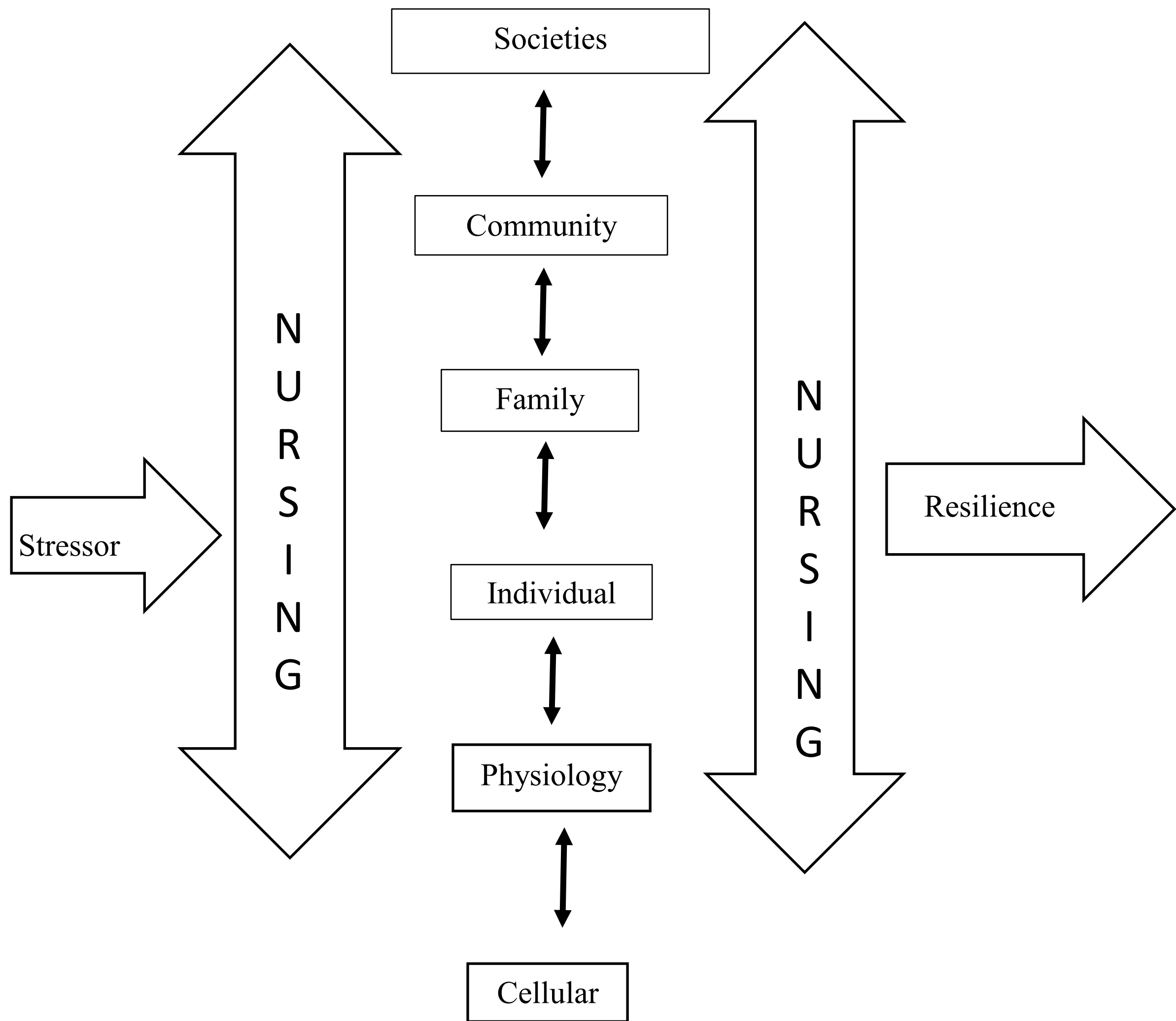

Figure 2. The societies-to-cells framework (Szanton and Gill, 2010)

Indonesia Community Health System

Indonesia health system is divided in to several level of authority and facility, start from the central level, provincial, district, sub-district and village level. Indonesia has decentralized system since 1999 especially in public health system. The distinction of each level role is vivid when managing the health section. The central and provincial level are mostly responsible in setting up the norm and guidelines of public health system, while the operational function and finance/budget issue are managed by the

district level.

Regarding the health facilities, the referral hospitals are divided in two type, the national hospital run by central government and provincial hospital run by provincial government. Commonly the referral hospitals are located in the capital city or large city in the province. According to Ministry of Health (2018) of the 2925 hospitals in Indonesia, 810 hospitals are both provincial and district hospital. The primary health care named by *Puskesmas* (PHC) are located in sub district level and cover a catchment of approximately 30,000 people. For some sub districts, due to the large coverage area, at the village area, there is *PUSTU* (sub-health centers), *POLINDES* (village midwife clinics), and *Posyandu* (Integrated health posts) (see Figure 3). Posyandu run the community health activities which managed by the *Kaders*.

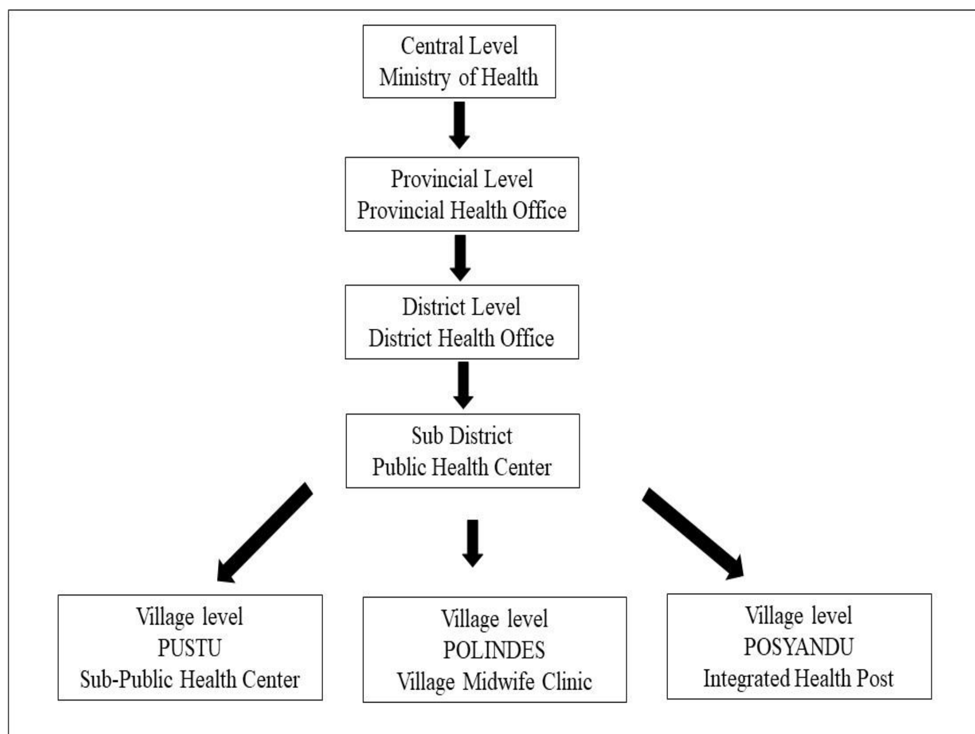

Figure 3. Indonesia Health System

Kader

Kader is a volunteer primary health care worker who lives and works in the villages he/she serves. Originally, the *Kader* program was developed to address the mother and child issue which was being the greatest threat in Indonesia around 1970. *Kaders* are selected by the head of the village or a village committee with involvement of the PHC.

*Kader*s work at *Posyandu* whereas bridges people at the village level to get the access to the *Puskesmas* and hospitals and each *Kader* responsible for every 10-20 families. By 2018, there were 283.370 *Posyandu,* ideally each *Posyandu* serves approximately 100 under five children or approximately 700 persons in the community (Ministry of Health, 2018). According to the total number of Posyandu by 2018, so there are an estimated more than one million *Kaders* in Indonesia, because each Posyandu has four to five *Kaders.* There are various types of community health *Kaders* include: the gizi *Kaders* (who works in nutrition); the kesehatan *Kaders* (who works in health); the KB *Kaders* (who works in FP); the first aid *Kaders*; the non-communicable/ chronic disease *Kaders*; and the mental health *Kaders*. Especially mental health *kaders,* the program was developed in 2005 following the Tsunami 2004 and Aceh was the pilot project in that time.

Psychological First Aid (PFA)

Psychological First Aid (PFA) refers to the immediate psychological support that is offered after a disaster or other psychological stressor that impacts individuals and communities (Tait, 2006). In the historical development of PFA, the first emerged term was around 1940's when the World War II just begun and over the times there were numerous types existed (Jacobs and Meyer, 2005). They go on wrote that the variation

forms of PFA on that period were still unclear and cluttered in the time of disaster, moreover these models were not yet solidified. Nevertheless, addressing the similarity of PFA models, the researchers who concern in the psychological effect of traumatic event realized, it is important that individual need to be connected to their social support as soon as possible aftermath a traumatic event (Walker, 1990).

In the section below, there are three major of PFA will be discussed, especially in the community-based Intervention.

Response-team PFA model. There is two models of the response-team PFA. The first one was developed by Brymer and colleagues in 2006 named as The Child Traumatic Stress Network (NCTSN) and the National Center for Posttraumatic Stress Disorder (NCPTSD) model. This model was well known and implemented in the United State, furthermore it extensively utilize in all over the world as well. This model dispatch a team consist of mental health professional to deliver mental health service at the affected area. The principles action of this model are contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping, and connection with collaborative services (Brymer et al., 2006).

The second model was developed by the Bloomberg School of Public Health and the Preparedness and Emergency Response Research Center of Johns Hopkins University and named RAPID PFA (Everly et al, 2014). The RAPID PFA was slightly different compare to the first one. The RAPID PFA model employ the non-professional mental health or lay person in giving mental health support by dispatching them at the affected area. The core principles are include reflective listening, assessment, prioritization; Intervention using cognitive-behavioral techniques, and disposition,

which involves an assessment of whether the person has gained functional capacity to return to a prior, functional state of living (Tait, 2006). Without regard to the community-based approach, the response-team model is not designed to community based Intervention.

*The Red Cross movement and the IFRC model***.** The International Federation of Red Cross (IFRC) developed a model of psychological support which is intended for the developing country in 1996 (Barbanel & Sternberg, 2005). The model is designed to be effective and culturally responsive so it can widely use in throughout the world. The program was conceptualized as preventive action with main principles of the service were divided into three layers. These main principles are described as Interventional pyramid with the basic layer, PFA is intended to provide safety and basic needs for the survivors. The second layer is intended for the survivors whose well-being would be improved if they connected to their family and community as soon as possible. The top layer is intended for survivors with mental illness and support is provided by mental health professionals.

The Red Cross movement and the IFRC model was implemented in Bulgaria and soon after the first launching, many countries participated in PFA training from 1998 up to 2000 (Barbanel & Sternberg, 2005). This model propose six manual guidelines such as introduction to psychological support, psychoeducation on traumatic stress and crisis intervention, guidelines for community involvement, support for helpers and special populations, and guidelines for community involvement.

The model has been modified so it can be cultural acceptable in 2003, as the initial goal was to be built on the strengths of the culture. The Red Cross movement and the IFRC require local representative involvement who were able to modify the program

based on local cultural practices. By doing so this model use the community-based approach for techniques of psychological support. Involving not only local government but also Non-Government Organization to run the program.

The WHO and War Trauma Foundation and World Vision International (2011) Model. The latest and most ultimate well known up to present is the WHO and War Trauma Foundation and World Vision International (2011) model with their three main actions: Look, Listen and Link which are easily to remember. First action is Look, helper should assess the immediate basic needs of survivor such as food and clothes, their surrounding and physical danger, and emotional sign for distress response. Second action is Listen, helper is require to ask survivor if they need help to feel calm or their concerns. Listen to people and help them to feel calm. In the Listen action, helper requires to use active listening skill and if the survivor express their psychological distress, the helper should use grounding technic to promote their feeling of reconnect. The last one is Link, helper should help survivor connect with their loved ones and social support network, address their basic needs, and provide coping strategy. The most important is the WHO model is not intended for professional, moreover it is strongly recommend to be used by the lay person or humanitarian workers in times of crisis.

Community-Based Psychological First Aid (CBPFA).

The CBPFA is a psychological and psychosocial support method, provided by community members who are not professionally trained in mental health services, to care for family, friends, neighbors, and coworkers during stressful life periods (Jacobs & Meyers, 2006). The model developed based on the adaptation of the 1990's Red Cross and Red Crescent Societies for mental health professionals. The original aim of CBPFA is to develop the community psychological support which build up the natural

support systems and strengths of communities (Larson & Stoa, 2014) because as their name is community based approach, the CBPFA not only mobilize the individual, but also the community itself.

The CBPFA trains community such as active listening skill, traumatic stress reactions, coping strategy, being a helper, self-care, how to solve the problem and the mental health referral process (Brymer et al, 2006; Jacobs & Meyer, 2006; Jacobs, 2008; Reyes, 2006; Vernberg et al, 2008). By doing so, CBPFA is not only increasing mental health awareness, promoting self and community-efficacy, but also enhance individual resilience and build up community resources by developing existing psychological resources (Brymer et al, 2006; Jacobs & Meyers, 2006; Reyes, 2006; Vernberg et al, 2008).

The CBPFA research on the effectiveness is important to establish CBPFA not only as an evidence-based support method, but also as safe and efficacious psychological method (Brymer et al., 2006). Process of CBPFA to be culturally acceptable is started from the consultation with community and group representatives, cultural and religious leaders, and local authorities. Those step are carefully taken in order to be well adapted for each of uniqness of population (Jacobs & Meyer, 2006; Jacobs; 2008; Reyes, 2006). Ideally, the adaptability of CBPFA creates a support method sensitive to the needs of the community, further promotes openness to psychological assistance, and constructs a sustainable psychological support system within the community (Tait, 2006).

Review of Relevant Research

Community-Based Psychological First Aid (CBPFA)

Several previous studies showed the effectiveness of CBPFA trough community participatory research method for various population, such as Native youth, tribal community, Emergency Medical Technicians (EMTs) and paramedics, and Peer Community Advisors (Trait, 2011; Fisher & Ball, 2003; Bordeaux-Rank 2015; Reed, 2016; Garigipati, 2017) (see Table 1). Those study showed that CBPFA is a flexible and practical psychological support system appropriate for the care of individual and community affected by traumatic events. The CPFA training is intended to bolster the community and individual resilience by educating the community (non-mental health professional) about the traumatic stress reactions, how to cope, how to be an effective helper, and how to enhance existing support system within the community. Moreover, the CBPFA model builds on the strengths of the community, by encouraging community member to support each other by using their effective local traditions and value.

Table 1.

Research on CBPFA

Author	Subjects	Method & Measurements	Findings
Tait, 2011	Native youth (16-19 years old) N= 96 students	- Participatory Action Research PFA Test and evaluation measure, - the Multi group Ethnic Identity Measure-Revised (MEIM-R), -The State Trait Personality Inventory (STPI), - The Social Provision Scale (SPS). FGD	CBPFA training was evaluated in a group of mostly Native college-bound students. PosT-test and follow-up results indicated that the program was well received and perceived as culturally appropriate, applicable, and potentially useful
Fisher & Ball, 2003.	Tribal community. N=13	Participatory Action Research Collected from individual interviews and a focus group	Tribal participatory research (TPR) model. An equal-plane partnership with the community as consultants and bridges between community needs with the research goals and employ community members as project staff. It is imperative to use culturally specific interventions and assessments in the research
Bordeaux-Rank, 2015.	Tribal Community. 5 Individual	Data was collected from individual interviews and a focus group with the training participants following the CBPFA ToT at 30-, 60-, and 90-days	Acommunity-participatory research model and extensive ToT (follow up study from Fisher & Ball Project). TPR model (Fisher & Ball, 2003) and qualitative analysis. The results of this study yielded high levels of effectiveness, percevied usefulness, and cultural appropriateness of CBPFA on the Rosebud Sioux Indian Reservation.

Table 1 (continued)

Author	Subjects	Method & Measurements	Findings
Reed , 2016	Emergency Medical Technicians (EMTs) and paramedics. N= 55	- The Connor-Davidson Resilience Scale (CD-RISC), - “Knowledge of Psychological First Aid” questionnaire (pre and post) - Multidimensional Scale of Perceived Social Support (MSPSS), - PTSD Checklist – Stressor Specific Version (PCL-S), - a “Psychological First Aid Percevied usefulness” questionnaire, - Self-Stigma of Seeking Help (SSOSH), - State-Trait Personality Inventory (STPI), - Stressful Life Events Screening Questionnaire (SLESQ).	CBPFA was useful both for helping others and for managing stress.
Larson-Stoa (2014)	Oncology medical staff. N= 45	Knowledge of CBPFA - CBPFA percevied usefulness questionnaire - Empathy Questionnaire (EQ-40) The State Trait Personality Inventory (STPI). Pre-Post and 1 month follow up	CBPFA was useful in T2 & T3 examination
Garigipati, R (2017)	Mental Health Professional, NGO, and Faculty member (N=27)	-Knowledge of CBPFA - CBPFA percevied usefulness questionnaire - Empathy Questionnaire (EQ-40) - Secondary Traumatic Stress (Pre QoL) Pre-Post and 1 month after	The post-test score of those questionnaire were increased, except the STS score was decreased after TOT

The Mental Health Kaders and Disaster Community Mental Health Nursing (CMHN) in Indonesia

Before the tsunami hit Aceh in 2004, there was no systematic training provided for community health workers related to mental health and psychosocial support in disaster. After then, the Indonesian government, working with national and international organizations, launched a national disaster preparedness policy, including the management of mental health and psychosocial problems in tsunami-affected Aceh communities. The CMHN program built in 2006 aimed to (1) provide psychosocial and mental health services for affected community by disasters and conflicts (2) enhance community empowerment in mental health issue aftermath disaster and conflict (3) increase disaster preparation and preparedness of community and support adequate mental health issue at the affected area (Prasetyawan, et al, 2006). Moreover Ng C, et al (2009) state that CMHN encourage the medical doctors, nursing staff and community health workers provide mobile outreach services in rural areas, which include treatment, education, and support, targeted at patients, their families and community members. However, back then, the CMHN program especially in disaster was just a pilot project at two provinces Aceh and Yogyakarta. Currently, the CMHN program focused only treating mental illness patients in community. The lack of financial support from government makes the original aim of CMHN difficult to be achieved.

The Ministry of Health (MoH) of the Republic of Indonesia issued a new decree providing general guidelines on the development of Active Alert Villages (in Bahasa: *Desa Siaga Aktif*)', a program defined as villages capable of providing basic health care services and using community empowerment to respond to health emergencies and natural disasters (Ministry of Health 2010). Later on, the Ministry of Health (2010) set a target of 75. 4210 villages, 80% achieving 'Desa Siaga Aktif' status by 2015.

The decree reflects more than a decade of evolution of the concept of 'siaga'- 'alert',

emerging originally from an information, education and communication campaign targeting husbands' roles in safe motherhood (Shefner-Rogers and Sood 2004), until this most recent expression as a national mandate for village community mobilization. Especially in community mental system, 'the Active Alert Village' was named 'Village of Mental Health Alert'.

The 'Village of Mental Health Alert' is a program that enable community member to actively participate in community mental health system. The 'Village of Mental Health Alert' is a village which promote collaboration between PHC, PHN, and *Kaders* in delivering community mental health system. The previous studies related to the role of *Kaders* in post disaster community mental health care have been conducted (see Table 2) such as identifying mental illness case in the community (Prasetyawan, et al 2006; Keliat, et al 2011), providing mental health care after volcano eruption (Rosiana, et al, 2016; Kurniawan et, al, 2017). Indonesia government took the momentum of the Tsunami 2004 to reform community mental health system and trained of community mental health care. The CMHN has been developed and tested in the District of Bireuen. Fourteen community mental health nurses trained in the Basic Course were involved and 78 *Kader*s have been trained. As part of the course, the 'Village of Mental Health Alert' was piloted in four villages. *Kaders* along with general practitioners and PHN were being able to identify 2602 mental illness cases in the community (Prasetyawan, et al 2006; Keliat, et al 2011). Therefore, *Kaders'* role is being important in the disaster preparedness.

Table 2.

Kaders role in Disaster Mental Health (DMH)

Author	Subjects	Findings
Prasetiyawan, et al (2006)	Reports of CMH care in Aceh	78 Cadres have been training about community mental health care
Keliat, et al (2011)	Report of DMH care of Aceh	*Kader*s found 2602 mental illness cases in community
Rosiana, et. Al (2016)	25 *Kadres*	Community Mental health training for *kadres* showed significant different in *Kadre's* knowledge and perception about mental health issues
Kurniawan et, al (2017)	Qualitative study of 6 *Kadres*	High Sense of responsibility of the *Kadre* is the key in delivering community mental care
Surjaningrum, et al (2018)	Qualitative studies of 62 *Kadres*	Participation of informal workforce (*kadres*) might help to deliver information on perinatal mental health

Religious Spiritual Belief and Disaster

In the healthcare literature, religious belief and spiritual are most of the times used interchangeably, although they have different meanings (Adam & Leverlands, 1986). Spiritual derives from the Latin word *spirae* which means, to breath. The definition of spirituality or spiritual implies that there is a deeper dimension to human life, an inner world of the soul (Rumun, 2014). On the other hand, the religious or religion derives from *religio* which means to bind back or tie. Matthews (1996), define religious as an organized system of beliefs, practices, and symbols designed to facilitate closeness to God. The slight difference of spiritual and religious come from the perspective of the subject, spiritual is defined in individual terms, characterized by experiences involving meaning, connectedness, and transience, whereas religious is defined in communal terms, characterized by institutionalized practice and beliefs, membership and modes of organization. It is spiritual incarnated at the

social and cultural level. Religious takes the boundless and binds it into the limitation of language and culture, even as it may also transform as a culture.

As the largest Muslim population nation in the world, Indonesia views religion as important matter in shape the behavior of society and way of life. In Indonesia, religious belief helped the society to raise positive re-evaluation whenever facing life hardship and strengthened the social connection within and between the communities.

Religious and culture are not separable, it is unity and it is giving the identity to each person in Indonesia. The role of religious belief is critically important in times of disaster, religious is seen as one of the vital resources to mobilize participant in responding the disaster, by help seeking the meaning and positive value of disaster. Disaster in Islamic society is seen as God's will, and it is beyond of human authority.

These beliefs gave the Indonesia Muslims way to cope with the disaster by providing them with answers and hope (Adisaputri, 2016).

Praying helped to cope the psychological distress due to disaster by giving the reassurance that God has prepared the good plan for every person and there is always a silver lining in every life hardships. This belief gave Indonesia society a strength to face the crisis by rising a hope. This is in line with different studies showing that religious beliefs provide people with a sense of power, intrinsic self-worth, optimism, low level of depression and a feeling of control and safety (Ai et al., 2013; Fujiwara, 2013; Bradshaw and Ellison, 2010). For centuries, religion has been used to interpret the meaning of uncontrollable and stressful events such as disasters (Grandjean et al., 2008). From a religious perspective, disasters are often considered an act of God, caused by human failures or the power of nature (Merli, 2010).

Based on Islamic perspective, disasters are viewed as divine action and retribution (Paradise, 2005) and as collective punishment (Adiyoso and Kanagae, 2013; Merli, 2010).

For example, Acehnese believe that disaster is an act of God and after the tsunami in 2004 they needed to be prepared for the next disaster since it is part of Islamic teaching to do the best that you can (Adiyoso and Kanagae, 2013). Increasingly, it is acknowledged that Disaster Risk Reduction (DRR) and Disaster Management (DM) should be socially and culturally compatible with local communities (Delica-Willison and Gaillard, 2012). Religious or faith-based organizations can play an invaluable role in DRR and DM, since they form part of the social and cultural life of local communities (Reale, 2010). The role of religious leaders in supporting people affected by disasters and helping to shape public attitude toward disasters was emphasized in Indonesia (Adiyoso and Kanagae, 2013; Gianisa and Loic LeDe, 2018). Since religious value is shape Indonesia individual identity and is embedded by the Indonesia culture with the dominant religion is Islam, therefore creating religious psychosocial support can be a beneficial to be both healing and culturally acceptable.

Previous studies have investigated the correlations or associations between religious aspects and mental health evidence through controlled clinical trials (Table 3). These investigations stated the stimulation of religious/spiritual beliefs could result in better clinical outcomes (Azhar, et al., 1994; Razali, et al., 1998; Koszycki et al. 2010; Ka'opua et al. 2011). Moreover, related to the disaster settings, a few interventions have used spiritual resources and these have shown promise for reducing psychological consequences post disaster in Sri Lanka (Hoeberichts, 2010); reducing PTSD by using Meditation (Borman, et al, 2008), Mindfulness Meditation and Building Spiritual Strengths (Kearney, et al., 2012).

Table 3.

Religious Spiritual Belief and Disaster

Authors	Study Design	Measurement	Type of therapy	Effect of the therapy
Ebrahimi, et al (2014)	RCT: N= 51 depressed patients	Case group: 27 Control group: 24 Demographic Beck Suicide Scale Ideation	10 sessions Cognitive Therapy, each session is 1 hour. Reading Quran and praying are in the 2nd session	No difference of suicidal idea between 2 groups but there was different
Roghayeh, et.al (2015)	Quasi Experimental. N=60 women with marital conflict	Case group: 30 Control group: 30 Demographic Connor Davidson Resiliency	12 Session spiritual group therapy CT, but it doesn't clear which part does the spiritual therapy	The resiliency score of Spiritual group therapy increase significantly
Abdullah, et al (2013)	Case study with mix method 1 female General Anxiety Disorder patients	Hamilton Anxiety Rating Scales (HARS)	5 session of psychotherapies which refer to the Five Pillars of Faith (Iman) such as believing in Allah SWT, an individual should perform the prayers, do 'tafakkur', practice the Zikr (remembrance of Allah) and also believe in Allah SWT fate.	There is significant difference on HARS score after treatment
Azhar, et al (1994)	Pre post with 3- and 6-months follow-up. 62 Muslim Anxiety patients, Case group: 31 Control group: 31	23 questions on the patient's beliefs in God, the Holy Koran and the Prophet. Hamilton Anxiety Rating Scales (HARS)	Reducing the anxiety by meditation relaxation technique (using Zikr)	The case group, showed lower mean score 3 months after treatment and no significant difference 6 month after

Table 3. (continued)

Authors	Study Design	Measurement	Type of therapy	Effect of the therapy
Razali et al (1998)	Pre-post intervention case control group, with 1, 3 and 6 months follow up. 103 Muslim anxiety outpatients. Case group: 54 Control group: 49	Hamilton Anxiety Rating Scales (HARS)	Religious supportive therapy	Significant difference after 1 and 3 months but no difference after 6 months
Borman, 2008	A two group (Case vs. control) by two time (pre- and post- Intervention) experimental design. Case group: 14 Control group: 15	- The Clinician-Administered PTSD Scale The Brief Symptom Inventory-18 The State-Trait Anger Expression Inventory-2 (STAXI-2)	The 6-week (90 min/week) mantra intervention consisted of education on PTSD symptoms and skills on how to choose and silently repeat a mantra	Large effect sizes were found for reducing PTSD symptom severity (d = −.72), psychological distress (d = −.73) and increasing quality of life (d = .70).
Somasundaram, (2010)	Qualitative research of 75 PTSD refugee	Intervention notes and qualitative methods using in-depth intervention studies, participation observation and key informant interviews were used	Using cultural relaxation technique (multi religions)	Twenty-eight (88%) of those whose outcome was assessed reported that the method had been helpful
Hoeberichts, 2010	Report Study	No evaluation	incorporated meditation, mindfulness and culturally congruent spiritual ritual at group process	Integrated the spiritual ritual to group therapy was acceptable to the tsunami survivors

Table 3. (continued)

Authors	Study Design	Measurement	Type of therapy	Effect of the therapy
Yusuf, et al (2012)	pre post-test control group design. 26 family member of mental illness patient	Family Coping scale test (constructed by the researchers itself)	8 sessions spiritual approach of family therapy, consist of direction, obedience, and acceptance	significant change in total of family coping (p = 0.040)
Kearney, et al. (2012).	A prospective, longitudinal follow-up study of 92 veterans. 2 months & 6 months	The PTSD Checklist–Civilian version (PCL-C) The Patient Health Questionnaire-9 (PHQ-9) The Behavioral Activation for Depression Scale (BADS) The Short Form-8 The Acceptance and Action Questionnaire (AAQ) The Five Facet Mindfulness Questionnaire (FFMQ)	Participants met once per week (2.5 hours per session) for 8 weeks. During each meeting, participants practiced mindfulness meditation and yoga,	At 6 months, there were significant improve in PTSD symptoms, depression, behavioral activation, mental component summary score of the Short Form-8, acceptance and mindfulness,
Ulfah, E et al. (2013)	pretest post-test control group design Case group: 11 Control group: 11	Impact Event Scale	Spiritual Emotion Freedom Technique (spirituality, like prayer and acceptance and energy psychology) with three technique, set-up, tune-in and tapping.	The results showed spiritual emotional freedom technique intervention can reduce PTSD of adolescent survivors of volcanic eruption.

Table 3. (continued)

Authors	Study Design	Measurement	Type of therapy	Effect of the therapy
Koszycki et al (2014)	RCT-pilot study. 23 GAD patients. Case group: 11 Control group: 12	Hamilton Anxiety Rating Scales (HARS) Beck Depression Clinical Global Impression Severity (CGI-S)	Spiritually Based intervention (SBI) is 12 session individual therapy including discussion of spiritual framework and themes, spiritual practices such as prayer, relaxation meditation and other spiritual practice (Multi religion)	Significance difference after treatment
Rahmati, et al (2017)	a quasi-experiment. 34 family member of ICU patients	Connor Davidson Resiliency	8 group session of spiritual religious cognitive therapy. Meditation relaxation was put in the 4 and 5 session.	There was significant mean score after the intervention

Research Framework

Development of Framework

Adaptation from the societies-to-cells framework will be applied as my conceptual research framework (see Figure 4). As it is the nature of nursing to view variables in individuals, families, communities, and societies integrative and to design collaborative interventions, therefore religious integrated CBPFA intervention will be appropriate. By providing community member (*Kader*s) with knowledge and skill, it is expected the integrated CBPFA can promote community resilience. Based on the 6 factors of societies-to-cell framework, these are the following levels:

1. In Individual level, *Kader*s play a role as well as individual, family and community member with their demographic characteristics and self-efficacy awareness.
2. In the community level, the institution such as public health center (*Puskesmas*) provides Community Mental Health Program at village level, named by Mental Health Alert Village. The Mental Health Alert Village is community mental health program which empowering community involvement to increase mental health awareness as well as community level resilience. The community involvement Mental Health Alert Village can be seen in the existence of *Kader*s supporting mental health activities in community such as mental illness outreach program, assisting family/care giver of mental illness patient. In term of disaster mental health program at community level, it is necessary to empower *Kader*s by providing them with education and training to increase their knowledge and skill about psychosocial issue in post disaster.
3. In society level, providing disaster mental health education and training in collaborating with PHC, community leaders, and religious figure. The collaboration will promote sustainable and equitable resilience.

Moreover, religious belief plays as mediating factor for individual and society to raise positive re-evaluation whenever facing life hardship and strengthened the social connection within and between the communities. Religious belief gives the individual way to cope with the disaster by providing them with answers and hope, and giving them the reassurance that every event is caused by God (Adisaputri, 2016).

The integrated CBPFA model which incorporating effective local traditions and values in this study will be integrated with the religious values. Religious values integrated in CBPFA of this study is intended to complete the basic psychological support to their families, neighbors and manage their own stress with the contents of CBPFA such as are How to be a Helper; Traumatic Stress; Active Listening; Problem Solving; Instrumental (practical) Assistance; When and How to Make a Referral for Professional Assistance; Grief and Bereavement; Self-Care; and Ethics. Religious relaxation technique will be added as integration of religious and spiritual value in CBPFA. This integration will provide *Kader*s with psychosocial skill not only to overcome their daily stress such as anxiety or overwhelming due to become a helper but also to provide additional self-care technique.

According to societies-to-cell framework, religious value integrated in CBPFA training which is intended to *Kader*s, is not limited to individual change of *Kader*s but also can incorporate changes at multiple level and result *Kader*s resilience as well as family and community resilience. This change can be determined by scale such as the change of knowledge and skill of CBPFA, The General Self-Efficacy Scale, and The self-perception of individual's ability to cope with traumatic stress (Connor Davidson-Resilience Scale/ CD-RISC) and their perception of community resilience (CART).

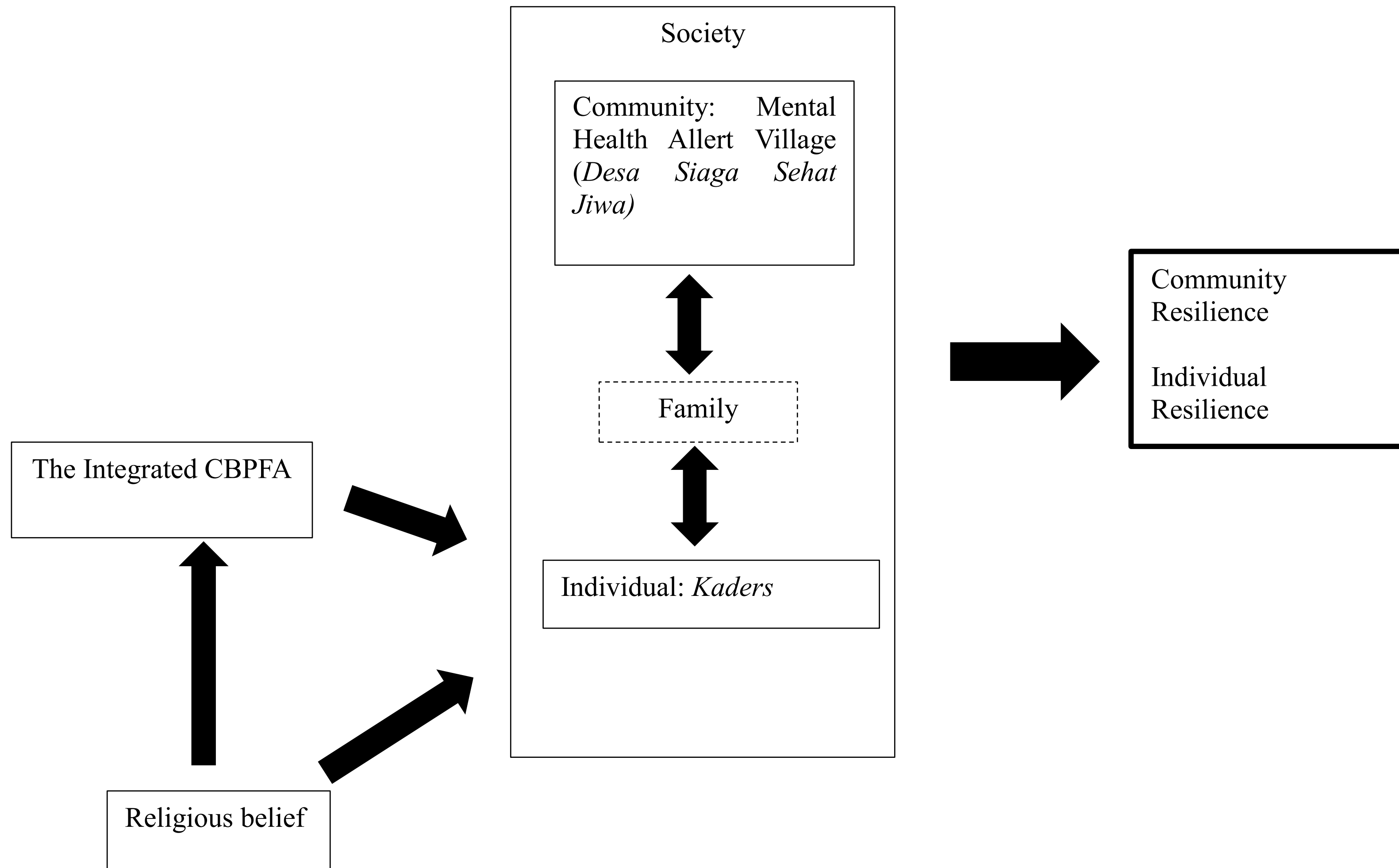

Figure 4. Research Framework, modification from the societies-to-cells framework (Szanton and Gill, 2010)

Formulation of Hypothesis

1) The CBPFA training increase *Kaders* knowledge and skill of CBPFA, the perceived self-efficacy, self-perceived resilience, and community resilience
2) Integrated CBPFA group will show higher score on the post training test compare to CBPFA group, including knowledge & skill of CBPFA, their perceived self-efficacy, Self-Perceived resilience, and community resilience

Operational Definition of Research Variables

Independent Variable

Integrated CBPFA is a psychological and psychosocial support method, provided by *Kader*s to care for self, family, friends, and neighbors during stressful life periods which integrated with religious/spiritual practice, consist of educating community members three Session of Integrated CBPFA: First Session: Being a Helper, Traumatic Stress, and Grief and Bereavement; Second Session: Active Listening and Getting Help & Safety; Third Session: Self Care, Problem Solving, and Religious/Spiritual Relaxation technique

Dependent Variables

1) The Knowledge and skill of CBPFA is participant knowledge of basic and skill CBPFA principle.

2) Individual resilience is self-perception about the ability to cope with difficult situation and participant self-efficacy.

3) Community resilience is the ability of the community in preparing the disaster including (1) connection and caring, (2) resources, (3) transformative potential, (4) disaster management, and (5) information and communication.

4) Perceived usefulness of CBPFA is participant perception about the applicability of the CBPFA training in participants' personal and professional lives.

Method and Procedures

Description of Research Design

This quantitative research study by comparing pre-test, post-test was a quasi-experimental non-equivalent control group model (Creswell, 2009), or otherwise referred to as a controlled before-and-after study (Grimshaw, et al, 2000). In this type of study, a control group with comparable characteristics and functioning to the experimental group was selected. The quasi experiment is the appropriate study design when the researcher has limitation to control the control and manipulation as well as the true experiment requirement. Therefore, a quasi-experiment is an appropriate alternative for making inferences about the groups. In addition, quasi-experiments prove very useful "where there are practical and ethical barriers to conducting randomized control trials" (Grimshaw et al., 2000).

Another alternative study to evaluate the efficacy or effectiveness of intervention is randomized control. That study is viewed as the gold standard for many types of research, yet there are some sort of limitation the conditions of this type of design cannot be met, and a quasi-experimental design is appropriate alternative (Panko, Curtis, Gorrall, & Little, 2015).

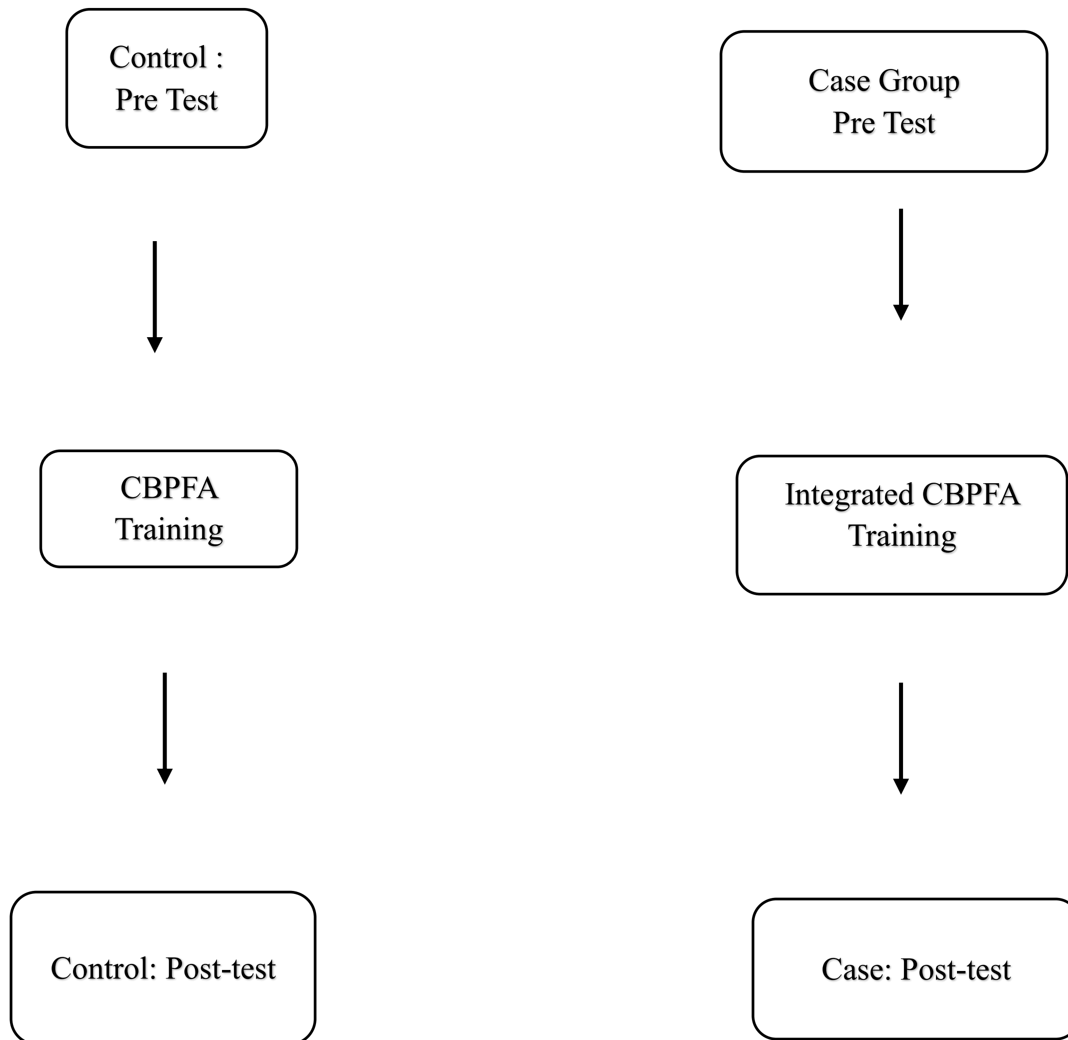

Figure 5. Research Design

Intervention

Development of Intervention

The CBPFA contents was created based on the original training curriculum from Jacobs and Meyer's (2006) Community- Based Psychological First Aid (CBPFA) includes seven lessons: 1) Being a Helper, 2) Traumatic Stress, 3) Grief and bereavement, 4) Active Listening, 5) Getting Help & Safety Planning, and 6) Self-Care 7) Problem solving. The content of CBPFA was modified in term of language from English into Indonesia and adjust some terminologies in Indonesia.

Based on the aim of the study whereas to develop the Integrated of CBPFA which improve the community resilience, therefore the contents of Integrated CBPFA was modified from the original training curriculum Jacobs and Meyer's (2006). The significant modification is in adding religious/spiritual value in selected lessons. The selected lessons were the first lesson 'Being a helper', the second lesson 'Traumatic Stress', the third lesson 'grief and bereavement', the seventh lesson 'Self Care' and added the eighth lesson, 'religious relaxation technique'. Therefore, from the original seven lessons of CBPFA, it was expanded into eight lessons.

The modification of each lesson will be explained in detail as follows:

(1) The first lesson 'Being a Helper' gives a brief explanation about disaster and Islamic perspective about disaster, historical overview regarding the development of PFA, identifying helpers within your community, and it was not only describe the characteristic of a helper in general perspective, but also the importance of being a helper in Islamic perspective.

(2) The second lesson, the 'Traumatic Stress' lesson covers the definition of trauma, emotional reactions to trauma, effects of trauma on behavior, the body, and the spirit; ways to help those struggling with reactions to trauma and the Islamic perspective how to respond the disaster.

(3) The third lesson, 'grief and bereavement' covers the stages of grieving and what should we say. Moreover, how Islamic perspective seen grieving and as a Moslem what should we say and do.

(4) The fourth lesson 'Active Listening' teaches individuals skills and attitudes to help support someone by listening very effectively. This lesson also emphasizes the importance verbal and non-verbal cues to be aware of when helping someone in need.

(5) The fifth lesson, 'Getting Help & Safety Planning' focuses on teaching individuals when to recognize when additional help is needed. This is done by highlighting warning signs and teaching participants how to do a safety risk assessment and safety planning with the person they are helping.

(6) The Sixth lesson, "problem solving" emphasizes to identify available resources in their community.

(7) The seventh lesson "Self-Care" emphasizes the importance of taking care of oneself when they are in a helping role and how to manage stress in both of perspectives, in general and Islamic perspective.

(8) Lastly, the eighth lesson "religious spiritual relaxation technique" was provided in the Integrated CBPFA training. After literature review conducted, eventually religious/spiritual relaxation technique was chosen in this study. The religious spiritual relaxation technique consist such as deep breathing inhale and exhale for 3 times, then the end of exhale whispering the God Forgiveness word in Islamic tenets (*Astagfirullah*).

Selecting religious approach in this study was based on consideration that the original contents of CBPFA did not teach the participant the specific skill to overcome anxiety or overthinking response. Therefore, it is necessary to provide the participants with the specific and simple relaxation technique whenever that response appear. The relaxation technique should be close to the participant's daily practice, so it can be easy to be applied in daily life. Moreover, religious practice is part of participants' culture and life, so selecting religious approach seems fit into participant's daily life. After then, the researcher created the draft of content integrated CBPFA (see table 4).

In the draft content and at the end was being the final content, both original and integrated CBPFA consist of 4 sessions based on the time arrangement.

Table 4.

Content of CBPFA Training

CBPFA Training	Integrated CBPFA
Session 1 (09.00-12.00) Lesson 1 Being a Helper (55') **Power point presentation & Small group discussions** A. What is disaster and Psychological First Aid (PFA)? B. Being a helper • Characteristic of effective helper • Questioning the ability of being a helper • Concerning Issue of being a helper • The 3 action principles of PFA Lesson 2. Traumatic Stress (55') **Power point presentation & Small group discussions:** A. What is Traumatic Stress and how does it affect to us? B. Distress responses to crisis	**Session 1 (09.00-12.00)** **Lesson 1 Being a Helper (55')** Power point presentation & Small group discussions A. What is disaster and Psychological First Aid (PFA)? B. Being a helper • Characteristic of effective helper • Questioning the ability of being a helper • Concerning Issue of being a helper • The 3 action principles of PFA C. Islam perspective of disaster and being a helper **Lesson 2. Traumatic Stress (55')** Power point presentation & Small group discussions **A.** What is Traumatic Stress and how does it affect to us? **B.** Distress responses to crisis C. Islamic Perspective on the Distress Response (30')

Table 4. (continued)

CBPFA Training	Integrated CBPFA
Assignment **PFA Session 1: "Being a Helper" and "What is Traumatic Stress"** Lesson 3: Grief and Bereavement **(55')** **Power Point Presentation & Small group** A. The five stages of grief B. What to say **Role Play -** Demonstration of what should we say to grieving person Refer to Professional	***Assignment*** PFA Session 1: "Being a Helper" and "What is Traumatic Stress"helper in disaster (30')
Session 2 (13.00-14.00) **Lesson 4 : Active Listening (60')** Power point presentation & Role Play A. Verbal strategy B. Active Listening Skills C. The Art of Questioning Assignment PFA Session 2: "Active Listening" Session Interactive Components Demonstration of Active Listening Skills Paired Group Activity: Each pair is given a scenario to role play. One individual will role play a helper and the other will be the person in need. Training facilitators will	**Session 2 (13.00-15.20)** **Lesson 3: Grief and Bereavement (55')** Power Point Presentation & Small group A. The five stages of grief B. What to say Role Play - Demonstration of what should we say to grieving person C. Refer to Professional **D.** Grieving in Islamic Perspective (20') **Lesson 4: Active Listening (55')** Power point presentation & Role Play A. Verbal strategy B. Active Listening Skills C. The Art of Questioning Assignment

Table 4. (continued)

CBPFA Training	Integrated CBPFA
walk around the room to observe and answer questions as the training participants are completing this activity	**Demonstration of Active Listening Skills** Paired Group Activity: Each pair is given a scenario to role play. One individual will role play a helper and the other will be the person in need.
Session 3 (09.00-11.30)	**Session 3 (09.00-12.00)**
Recap yesterday's lesson (30')	**Recap yesterday's lesson (30')**
Lesson 5: Getting Help and Safety Planning	**Lesson 5: Getting Help and Safety Planning (60')**
Power point presentation A. Getting Help When Listening is not enough B. How do you know when you need extra help? C. When to worry	Power point presentation A. Getting Help When Listening is not enough B. How do you know when you need extra help? C. When to worry
Training facilitators demonstrate Safety Planning	**Training facilitators demonstrate Safety Planning**
Volunteer is requested to demonstrate safety planning with one of the facilitators being a person in need.	Volunteer is requested to demonstrate safety planning with one of the facilitators being a person in need.

Table 4. (contined)

CBPFA Training	Integrated CBPFA
The other training facilitator points out each step of a safety plan while keeping the audience engaged	The other training facilitator points out each step of a safety plan while keeping the audience engaged
	Lesson 6: Problem Solving. (55')
	Group Discussion:
	A. A plan for problem solving, S.O.D. A: Stop, Opinion, Decide, Act
	B. Where does social support come from?
	Prompt for each type of support.
Session 4 (13.00-15.00)	**Session 4 (13.00-15.00)**
Lesson 6: Problem Solving (55')	**Lesson 7: Self-Care and Compassion**
Group Discussion:	Fatigue **(45')**
A. A plan for problem solving, S.O.D. A: Stop, Opinion, Decide, Act	Power point presentation
B. Where does social support come from?	A. Possible Symptoms
C. Prompt for each type of support	B. Risk Factors
Lesson 7: Self-Care and Compassion	C. Who can help you to manage your stress?
Fatigue (45')	D. Manage your stress
Power point presentation	E. Individual Stress management
A. Possible Symptoms	F. Coping with stress
B. Risk Factors	**Islamic Perspective of Stress (20')**

Table 4. (continued)

CBPFA Training	Integrated CBPFA
C. Who can help you to manage your stress? D. Manage your stress E. Individual Stress management F. Coping with stress Closing thoughts and feedback**.**	**Session 4 (13.00-15.00)** **Lesson 8: Quranic Reflection on Stress Management (30')** A. Prayers (Salat) and relaxation B. The Remembrance (*Dzikr*) of Allah Training facilitators demonstrate the religious spiritual relaxation technique **Closing thoughts and feedback**

Consultation

Since the Integrated CBPFA training is new training program. The researcher had consultation with the expert in CBPFA as well as an Islamic Psychologist for developing the content of Islamic perspective in each lesson. Based on the feedback, not all the content are added the Islamic perspective, only the first lesson 'Being a helper', the second lesson 'Traumatic Stress', the third lesson 'grief and bereavement', the seventh lesson 'Self Care' and added the eighth lesson, 'religious relaxation technique'. Selecting several contents in the integrated CBPFA were based on the final goal of the CBPFA training that want to increase individual and community resilience. Feedback from those was brought benefit for CBPFA training as relevant model to introduce in Indonesia. Especially in the Integrated CBPFA training model, each of the lesson was added by Islamic values. Because it is important to build an understanding that disaster and the effect to the mental health can be solved trough

integration of CBPFA and Islamic perspective.

Moreover, another feedback was received regarding the involvement of local religious leader into the integrated CBPFA. In accordance with the community adaptation especially for Integrated CBPFA curriculum, the topic of overview of disaster and being a helper in Islamic perspective was brought by local religious leader. Lastly, another component of adaptation of the CBPFA training was translated the content from English to *Bahasa* Indonesia as the determination of the language of interaction.

Collaboration.

The director of PHC and PHN were also involved in organizing the CBPFA training. Originally, the training program was planned on 3 days training, however based on consultation with the director and PHN of PHC, most of *Kaders* are housewives and have to take care of their family, and it was difficult for them to follow the whole program 3 days consecutive (5 hours every day), the training changed into 2 days training (6 hours every day). The original planning want to have ice breaking into each lesson, due to time re arrangement, the ice breaking session was omitted.

Intervention Procedure

There were 2 groups created from 2 different PHC. The first group was appointed as case group and received Integrated CBPFA training, it was on January 22-23. The second group was appointed as control group and received CBPFA only training on January 29-30. Three of trainers for this training including the main researcher itself were mental health nurses from school of nursing who had expertise in community mental health and disaster care. The handbook and manual were distributed to all trainers prior to the training session, so that all the trainers had the same competencies related to the process of training and lessons. The training led by the main researchers and co facilitate by two others trainer. All the trainers were responsible for every small group practice session.

Before the training started, both of groups received pretest including knowledge and skill, self-efficacy, self-resilience and community resilience questionnaires. Both of group received hand book of CBPFA, the case group received Integrated CBPFA handbook with addition of Islamic values in each lesson and spiritual relaxation technique as the eighth lesson. Each lessons incorporating a Microsoft PowerPoint slide-based lecture, discussion, and small group practice of CBPFA techniques. Each step of this model was gone over in great detail giving examples, role playing of potential scenarios, and suggestions for thinking.

Setting

This study was conducted at 2 PHCs located in two districts around *Sumur* area, *Pandeglang* City, *Banten* Prefecture. *Sumur* area has been chosen as the area of study because the district is prone of Tsunami. The last disaster was *Sunda* Strait Tsunami December 2018, therefore, the National Disaster Agency (*BNPB*) puts *Sumur* district as the high risk area of Tsunami due to the location of *Sumur* district that really close to Indian Ocean. *Sumur* District located in the west tip of Java Island, very close to Sea (see Figure 6). *Sumur* district can be reached for 4 hours by car and also motorcycle from *Pandeglang* city.

Figure 6. Pandeglang City Map (https://bpbd.bantenprov.go.id/read/peta.html)

Participants

The population of study was *Kader*s at integrated Health Services (*Posyandu*) Pandeglang City from 2 PHC in *Pandeglang* city, *Banten* Province. For realistic research results and because of the risk of *Kaders* affecting each other, the case and control groups were determined from two PHCs in *Pandeglang* city where the geographic region and severity degree of affected area due to Tsunami 2018 were similar. The study was conducted on January 22-30, 2020. The participant was selected through the systematical random sampling. The inclusive criteria were at least 2 years' experience as *Kaders* and the range of Age 25-55 years old. The exclusion criterion was a passive participation *Kaders* (who no longer engage in *Kaders* activity for more than 6 months). Sample size was obtained based on the formula for comparing mean score of quantitative traits between 2 groups with level of confidence 95% and test power of 90%. Other parameter of the formula are adopted based on a similar study (Rahmati et al, 2017). A total of 108 *Kaders* were assigned in the study, 54 *Kader*s for case group and 54 *Kader*s for control group.

Recruit of Participants

In order to determine the *Kaders* in the case and control group, the researcher recruited participants according to the following procedure:

1. The researcher sent a letter for asking recommendation and permission as well to conduct a research at 2 PHCs (PHC X and PHC Y) in *Pandeglang* City to a director of Provincial Health Office (Appendix 1).
2. After gained a permission letter to conduct the study from the director of provincial Health Office, the researcher proceeded to the two local PHCs, explained the detail of research verbally with a letter (appendix 2) and asked further permission and support.
3. The researcher also requested to list up *Kaders* who meet the inclusion criteria and

provided the list of ID number without mentioning individual name. Generally one PHC has 160-240 *Kaders* so the researcher took 108 *kaders* as the base data in one PHC. The determination of control group and case group in each PHC was based on random sampling by using lottery method. It means the researcher selected 1 *kaders* in every 2 *Kaders* from the total population of 108 *kaders* in one PHC the researcher. Eventually, 104 numbers in total were selected, 54 numbers for case group and 54 numbers for control group. The list of *Kader's* ID number document has been kept securely in the locked box with restricted access (locked filling cabinet in locked office) and only researcher have access to open it.

4. Later on, researcher handed in the selected list number of *Kaders* as possible participants to the directors of each PHC.
5. A couple of weeks prior to training days, the researcher sent an invitation letter (appendix 3) with a willingness of attendance form to the 104 *Kaders* on the selected number lists with the assistance of PHNs at each PHC. All selected *Kader* were agreed to participate this study by returning a signed willingness of attendance form at one week before the training. The signed willingness of attendance form was put in an envelope and dropped off to one mail box that researcher has been prepared at PHC. The mail box was put in the one room at PHC and locked it securely, only the researcher has accesses to open it
6. The control group was received training on January 22-23, 2020, while the case group a week later (January 29-30). On the first day of the training, at first the researcher explained to the both of group about the research purpose, procedure and the ethical consideration verbally about their rights, including confidentiality and withdrawal from the study at any time without any prejudice and not being reported to their supervisor/director of PHC to *Kaders* who come to the training venue. Then,

the researcher asked them to sign the consent form if they agree with the conditions and consent with their participation of research. The *Kaders* who submitted the signed consent form became the participants of this research. Although 104 *Kaders* were participated and filled the pretest questionnaires at both of group, however of the 54 *Kaders* in the case group, two *Kaders* were uncompleted of the post-test questionnaires while of the 54 *Kaders* in the control group, two *Kaders* unable to come, four *Kaders* uncompleted the post-test. Eventually, 98 *Kaders* were analyzed, see Fig. 7 for details.

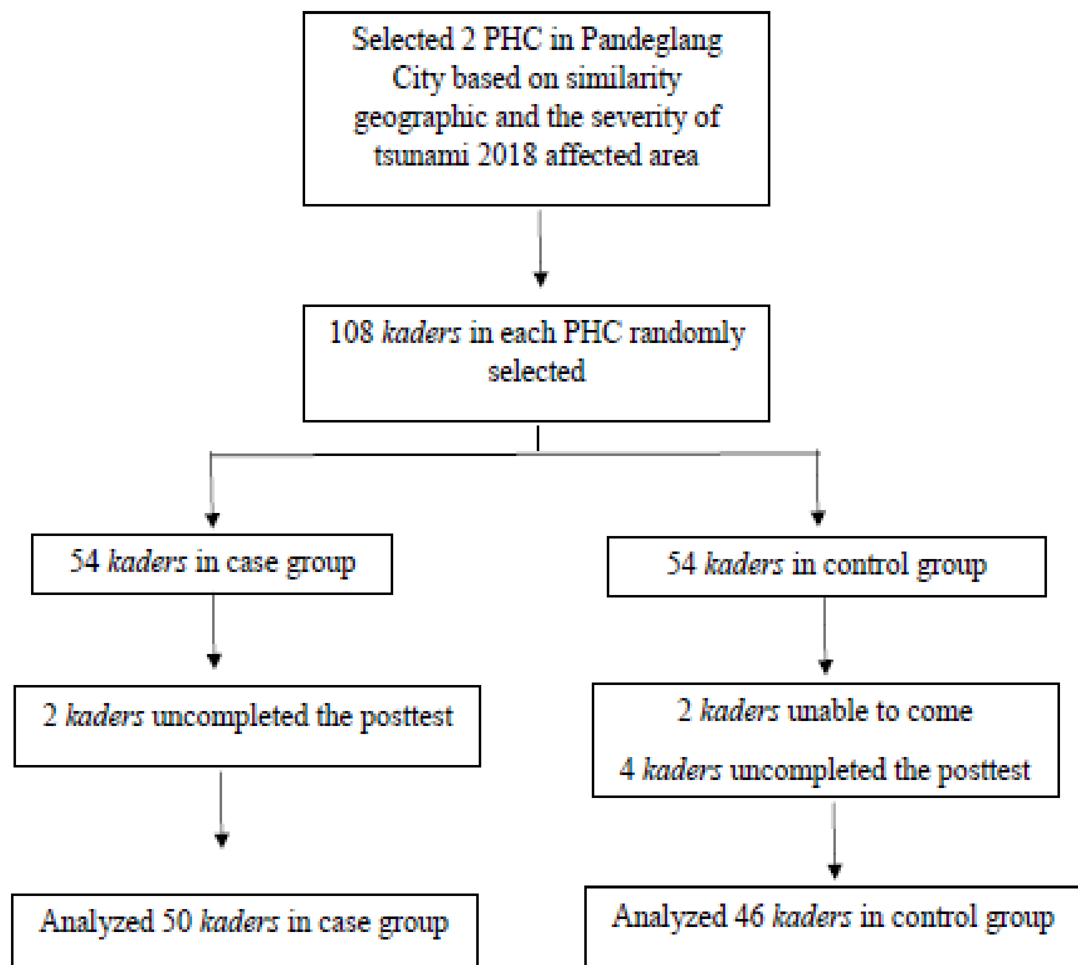

Figure 7. Flowchart of Participants Recruitment

Data Collection

The data was collected according to the following procedure:

1. Before the data collection began, the participants received 2 envelopes with a unique participant generated code, one for pre-test and the other for post-test questionnaire. They also received handbook of CBPFA in *Bahasa*.
2. At pretest, the *Kaders* of both two groups were asked to open the pretest envelope and complete pre-test survey about demographic information (gender, age, etc.) (appendix 5), the Knowledge of PFA Questionnaire (appendix 6), General Self-Efficacy (appendix 7), CART (appendix 8) and CD-RISC (appendix 9) . This took approximately 30 minutes.
3. After completed the pre-test, the case group received 2-days training with 8 lessons of CBPFA, while the control group received 2-days training with 7 lessons of CBPFA. The training was held at PHC meeting room.
4. Post-test data was collected immediately after the end of the second day of training. *Kaders* of both two groups were asked to open the post-test envelope and fill out Knowledge of PFA Questionnaire (appendix 6), the CBPFA Percevied usefulness Questionnaire (appendix 9), General Self-Efficacy (appendix 7), CART (appendix 8) and CD-RISC (appendix 9). That survey took approximately 30 minutes to complete.

Ethical Consideration

Research ethics approval has been gained from both countries, University of Hyogo, Graduate School of Nursing Art and Science (Number 2019D10) and *Syarif Hidayatullah* State Islamic University, Faculty of Health Science (Number Un.01/F.10/KP.01.1/KE.SP/10.08.008 /2020). Specifically, the following ethical considerations has been taken.

Respect for persons

An informed consent form (appendix 4) of the study are given to *Kaders* before the training was began. *Kaders* were informed of their rights, including confidentiality and the ability to withdraw from the study at any time. If they do have any questions regarding either the consent or the training, they may contact the researcher. The informed consent from *Kaders* should be sent and put into the mailbox in the PHC 2 weeks before the training began. *Kaders* participation was completely voluntary. They can decide at any time during or within 1 week after training and survey that they no longer wish to participate by contacting the researcher directly or via a phone call and mentioning their participant code so the researcher can easily identify the participant's data and delete it, they may withdraw their consent without prejudice and will not be reported to their supervisor/director. However, the researcher was not allow the participant to withdraw their participation more than one week after the training because the data analysis process has been started. Even though if they were withdraw their participation in this study, they may keep attending the training.

Under the research consent, researcher explained that their answers will be anonymous and confidential, and personally identifiable information was not collected. Regarding the confidentially, there was no identifying information collected. Researcher used pseudonyms such as using alphabet or code number to protect their privacy and confidentiality, such as in the first day of the training, the participants was given 2 envelopes with a unique participant generated code, one for pretest and the other for post-test questionnaire. Answering questionnaires took approximately 30 minutes in each time.

For all surveys, if they don't understand with any questions, participants are welcomed to ask and researcher will explain it carefully. Moreover, they do not have to respond to any items that they are uncomfortable with answering.

Beneficence

Researcher provided further explanation in the consent letter that there is possibility while completing the surveys, or after their participation is complete, they may have negative reactions from memories of events in and since the tsunami. If at any time during or after their participation they experience a negative reaction or have trouble coping, they are strongly recommend to contact the researcher team member, who are mental health nurses and lecturers at School of Nursing, *Syarif Hidayatullah* State Islamic University, Indonesia to receive further free psychological support. There are no direct benefits for participating in this study. However, their participation will improve their knowledge and skill to cope with daily stress. Hence, it can help the researchers understand how this CBPFA training may be improved for future participants.

There were no costs associated with completing the surveys, nevertheless the researcher provided lunch during the training and transportation fee based on the participant's transportation expense in order to prevent physically exhausted.

Justice

All records of participation are kept strictly confidential, such that only I and my supervisor have access to the information. Regarding the data security, the records of this study is stored securely including the list of *Kader's* ID number document or any other paper documents (hardcopy) are kept securely in the locked box with restricted access (locked filling cabinet in locked office at the School of Nursing, *Syarif Hidayatullah* State Islamic University, Indonesia) and only the researcher have accessed to open it, and the softcopy of document at University of Hyogo Graduate School of Nursing Art and Science, Japan and will be kept 5 years after completion of the study. In any report about this study that might be produced such as my dissertation report or published either in International Journal or conference was only be presented as group data and as the name of place, city or person has

changed by alphabet to protect participant's privacy and confidentiality, and participants was not be identified in any way. All the documents were stored in the USB such as questionnaire result and SPPS analysis result and papers such as the list of *Kaders* ID number and questionnaire will be omitted by deleting permanently by using file shredder software, destroying by paper shredder machine, and not be recycled/re produced. The researcher acknowledges in consents letter, since there is no research funding support on this study, therefore no financial conflict of interest to declare.

Measurement Method

1. Demographic Information.

Demographic information is a questionnaire consist of question about age, gender, current marital status, level of education, and disaster experience.

2. Knowledge of CBPFA Questionnaire.

The Knowledge of CBPFA questionnaire is a 12-item survey of participant knowledge and skill of basic CBPFA principles. This measure was developed by Dr. Jacobs (American Red Cross, 2010). The questionnaire is presented in a multiple-choice format. Correct answers equal to 1 and incorrect answer equal to 0. The responses were then summed to produce a total score out of 12. The validity and reliability of the CBPFA knowledge in this study was 9.65. Especially question number 12 ("If someone is threatening to harm him/herself or someone else…") was modified to reflect the available emergency resources in Indonesia.

The original questionnaire directed individuals to call "9-1-1 or any other appropriate emergency contact in the area". In Indonesia, 9-1-1 is not the emergency contact number, so answer choices were updated based on existed emergency resources in Indonesia (*Kaders* or community leaders). Internal consistency for the questionnaire in the present study was good (Cronbach's alpha = 0.965).

3. Self-Efficacy Scale: The General Self-Efficacy Scale (Schwarzer, & Jerusalem, 1995)

The self-administered 10 items scale to assess a general sense of perceived self-efficacy and to predict their confidence to overcome with daily hassles as well as adaptation after experiencing stressful life events. It requires 4 minutes on average to complete the questionnaire. Scoring are made on a 4-point scale. Sum up the responses to all 10 items to the final composite score with a range from 10 to 40. In samples from 23 nations, Cronbach's alphas ranged from .76 to .90, with the majority in the high .80s. It is open access scale and doesn't need explicit permission to utilize the scale (Schwarzer, & Jerusalem, 2012). The scale is available in 27 languages including *bahasa* Indonesia (Putra, et al 2019).

4. The Connor-Davidson Resilience scale (CD-RISC) (Davidson & Coonor, 2017)

The CD-RISC was developed to assess self-perceived of individual resilience and the ability to cope the traumatic stress. It contains 25 items by responding a 5-point Likert scale response ranging from 0 ('not true at all') to 4 ('true nearly all of the time'). It is rated based on how often individual felt over the past month with the total score ranges from 0 to 100, higher scores reflecting greater resilience (Davidson & Coonor, 2017). Cronbach's alpha of this scale in the present study was 0.87. The scale also available in *bahasa* Indonesia. The researcher has gained the permission to use the scale by following specific procedure at Connor Davidson official website http://www.connordavidson-resiliencescale.com).

5. The Communities Advancing Resilience Toolkit (CART). (Pfefferbaum, et al, 2013)

The 24-item CART was designed to measure community resilience to disaster and it contains 24 items. The 24 items are included as follow: (1) connection and caring (5 items), (2) resources (5 items), (3) transformative potential (6 items), (4) disaster management (4 items), and (5) information and communication (4 items). Scoring are made on a 5-point scale. Sum

up the responses to all items to yield the final composite score with a range from 0 to 120. It is rated based on how often individual felt over the past month and higher scores reflecting greater community resilience. The Cronbach's alphas were 0.86 for connection and caring, 0.84 for resources, 0.90 for transformative potential, 0.85 for disaster management, and 0.79 for information and communication (Pfefferbaum, et al, 2013).

6. The perceived usefulness of CBFA Training

The perceived usefulness of CBPFA questionnaire is a 19-item measure designed to assess the applicability of the CBPFA training in participants' personal and professional lives. This questionnaire was developed by Jacobs (2010) for use in a multi-state prospective examination of the PFA course, coping in Today's World. The original resources from the study of Garigapati (2017) was 21 items, yet the questionnaire was modified in this study into 19 items, items number 20 and 21 were eliminated due to have the same meaning with question no. 19 itself. The questionnaire was divided into three subscales as follows, items 1-7 on the questionnaire, named perceived usefulness for self, are represented to obtain the total score for the perceived usefulness of PFA for managing personal stress over time, item 8-12 on the questionnaire, named perceived usefulness for others, are represented to perceived usefulness of CBPFA for helping others manage their stress, lastly items 13-18 on the questionnaire, named perceived usefulness for community, are represented the perceived usefulness of the CBPFA training for the community (Garigapati, 2017). Especially question number 19 asks the overall perceived usefulness of the CBPFA training. Participants rated their responses on a 6-point Likert scale (1 = Strongly Disagree to 6 = Strongly Agree). Each of subscales were summed to obtain the total score. Internal consistency for each subscales were good (Cronbach's alpha = 0.90, 0.838, 0.826, respectively).

Data Analysis

Data analysis was performed using SPSS version 25. Descriptive analyses were used to describe the study variables. Mean and standard deviations were calculated for continuous variables (age and years of services) and for each scale (CBPFA knowledge, CD-RISC, CART, GSE and Perceived usefulness of CBPFA). Prior to further statistical analyses, the normality of the data for each variable was examined. Skewness ranged from 0.00 to 0.20, and kurtosis ranged from 0.00 to 0.70. P-P plots, Kolmogorov-Smirnov and Shapiro-Wilk test displayed no normal distribution. However since the sample size of each group was ≤ 50, therefore the Shapro-Wilk test chosen.

As such, Chi-square and independent T test were employed to examine the demographic characteristics, paired samples tests were performed for CBPFA knowledge, CD-RISC, CART and GSE pre-post score in both groups. Independent T-test was also performed to compare the means pre-post score between two groups on the same dependent variables. Statistical significance was determined by p values of $< .05$.

Result

Demographic Characteristics

Total 98 *Kaders* were participated in this study, trained in CBPFA, 52 participants were assigned in case group, while 46 participants were in Control group. The demographic characteristics of the participants are presented in Table 5. There were no significant differences in gender, marital status, education level, and years in *Kadres* service score between participants in the study, except age variable (P < 0.05). The control group has higher average age (p=0.018). The majority of participants from the case group and the control group were female, married, and had a senior high school education.

In the control group, mean age of the participant was 42.13 years (*SD*=±7.57) with ages ranging from 24 to 55 years-of-age. Years of *Kader's* service ranged from two years to 25 years with a mean of 12.65 years. Thirty two participant were female (69.6%), 14 (30.4%) were male. Almost all of the participants were married (91.3%), one participant was single (2.2%), and three participants were widowed (6.5%). A variety of educational backgrounds were represented in the participants with half of participants (50%) earning a senior high school, 16 participants (34.8%) earning from a junior high school degree, and seven participants earning Diploma degree(15.2%).

In the case group, mean age of the participant was younger than in the control group 33 years (*SD*=±9.9) with ages ranging from 20 to 55 years-of-age. Years of *Kader's* service in the case group has same ranged with control group, from two years to 25 years with a mean of years of service 6.38 years. Forty two participant were female (80.8%), 10 (19.24%) were male. Forty five participants were married (86.5%), six participants were single (11.5%), and only one was widowed (1.9%).

Table 5

Demographic Characteristics

Variables	Control Group n=46		Case Group n=52		Total n=98		P
	Mean (Years)	*SD*	*Mean* (Years)	*SD*	*Mean* (Years)	*SD*	
Age	42.13	7.57	33.00	9.99	37.29	10.00	.018[a]
Years in Kader Service	12.65	6.86	6.38	6.26	9.33	7.24	.173[a]
	N	*%*	*N*	*%*	*N*	*%*	
Gender							
Male	14	30.4	10	19.2	24	24.5	.293[b]
Female	32	69.6	42	88.8	74	75.5	
Marital Status							
Single	1	2.2	6	11.5	7	7.1	.115[b]
Married	42	91.3	45	86.5	87	88.8	
Widowed	3	6.5	1	1.9	4	4.1	
Education							
Junior High School	16	34.8	14	26.9	30	30.6	.174[b]
Senior High School	23	50.0	26	50.0	49	50.0	
Diploma	7	15.2	7	13.5	14	14.3	
Bachelor	0	0	5	9.6	5	5.1	

Note. [a]Independet T-test p-values
[b] Chi-square p-value

More variety of educational backgrounds were represented in the case group rather than in the control group with half of participants (50%) earning a senior high school, 14 participants (34.8%) earning from a junior high school degree, seven participants earning Diploma degree (13.5%), and five participants earning bachelor degree.

Normality Test

Prior to statistical analyses, the normality of the data for each variable was examined. Skewness ranged from 0.00 to 0.20, and kurtosis ranged from 0.00 to 0.70. P-P plots. However since the sample size of each group was ≤ 50, therefore the Shapro-Wilk test chosen. Shapiro-Wilk test displayed non normal distribution (Table 6).

Table 6

The Normality Test of Variables

Variables	Groups	n	*Mean*	*SD*	*CI 95%*	SW
Age	Control	46	42.13	7.57	39.88 -44.38	.560
	Case	52	33.00	9.99	30.22 – 35.78	.001
	Total	98	37.29	10.00	35.28 – 39.29	.001
Years of Service	Control	46	12.65	6.86	10.61- 14.69	.030
	Case	52	6.38	6.26	4.64 – 8.13	.001
	Total	98	9.33	7.24	7.88 – 10.78	.000
Pre-Knowledge of CBPFA	Control	46	5.33	1.37	4.92 – 5.73	.007
	Case	52	6.55	1.33	6.28 – 7.02	.001
	Total	98	6.03	1.50	5.73 – 6.33	.000
Post- Knowledge of CBPFA	Control	46	8.20	1.36	7.79 – 8.60	.017
	Case	52	9.62	1.05	9.32 – 9.91	.000
	Total	98	8.95	1.40	8.67 – 9.23	.000
Pre-CD-RISC	Control	46	68.85	8.32	66.38 – 71.32	.664
	Case	52	73.02	6.59	71.19 – 74.85	.002
	Total	98	71.06	7.70	69.52 – 72.60	.061
Post-CD-RISC	Control	46	78.26	8.62	75.70 – 80.82	.043
	Case	52	82.83	7.81	80.65 – 85.00	.003
	Total	98	80.68	8.47	78.99 – 82.38	.003
Pre-CART	Control	46	80.89	7.11	78.78 – 83.00	.199
	Case	52	89.71	4.96	88.33 – 91.09	.260
	Total	98	85.57	7.48	84.07 – 87.07	.023
Post-CART	Control	46	89.13	7.97	86.76 – 91.50	.428
	Case	52	98.77	6.53	96.95 – 100.59	.705
	Total	98	94.24	8.67	92.51 – 95.98	.139
Pre-GSEF	Control	46	23.96	1.92	23.39 – 24.53	.049
	Case	52	23.92	1.59	23.48 – 24.37	.006
	Total	98	23.94	1.75	23.59 – 24.29	.001
Post-GSEF	Control	46	32.74	1.39	32.33 – 33.15	.000
	Case	52	33.29	1.66	32.83 – 33.75	.002
	Total	98	33.03	1.56	32.72 – 33.34	.000

Note. SW: Shapiro-Wilk; CBPFA (Community Based Pschological First Aid); CD-RISC (Connor-Davidson Resilience scale); CART (Communities Advancing Resilience Toolkit); GSEF (General Self-Efficacy Scale).

To analyses all the bivariate analyses, the parametric tests were conducted. There are some considerations to use the parametric test instead of non-parametric test in this study.

The consideration as follows:

1. Parametric tests assume that the data are continuous and follow a normal distribution. However with a moderate large enough sample, parametric tests are valid with non normal data.
2. Nonparametric tests are accurate with ordinal data and do not assume a normal distribution. However, there is a concern that nonparametric tests have a lower probability of detecting an effect that actually exists, therefore in order to prevent those things, the parametric test still employed in the study.
3. Normality tests should not be used to automatically decide whether or not to use a nonparametric test. But they can help to make the decision

However, in the next section, the parametric test showed there was no significant difference among the two groups after the training. For this reason, the non-parametric tests were also employed in this study.

Homogeny Test

Based on the result of *Levene's* test Equality of variance on all the dependent variables show significant based on mean ($p > 0.05$), which it means these dependent variables before training were equal (Table 7). Furthermore, analysis of different in the all pre-training outcomes among both of group shows there are significant different on the knowledge of CBPFA, CD-RISC, and CART mean score ($p < 0.05$). Nevertheless, there is no significant different among both of group on the GSEF mean score in the pre training ($p > 0.05$).

Table 7

Comparison of Pre-Training Outcomes for Control and Case Group (N=98)

Variables	Groups	n	*Mean* ± *SD*	*levene's test P value*	*P Value**
Knowledge of CBPFA	Control	46	5,33 ± 1.37	.935	.00
	Case	52	6,55 ± 1.33		
CD-RISC	Control	46	68,85 ± 8.32	.112	.07
	Case	52	73,02 ± 6.59		
GSEF	Control	46	23,96 ± 1.92	.126	.925
	Case	52	23,92 ± 1.59		
CART	Control	46	80,89 ± 7.11	.168	.00
	Case	52	89,71 ± 4.96		

*Note:*P value:* Independent T Test, CBPFA (Community Based Pschological First Aid); CD-RISC (Connor-Davidson Resilience scale); CART (Communities Advancing Resilience Toolkit); GSEF (General Self-Efficacy Scale).

The Percevied usefulness of CBPFA training was evaluated at the post-training session indicated the participants overall, endorsed the training as useful for their skill and knowledge with respect to the following considerations: appropriate for their life, consistent with cultural ways of helping, useful to manage stress, enabling provision of support to community members. Participants rated their responses on a 6-point Likert scale (1 = Strongly Disagree to 6 = Strongly Agree). Each of subscales were summed to obtain the total score and analyzed by Independent T-test.

The response of subscale 1, question number 1-7 in the questionnaire were summed to analyze that the CBPFA training was indicated useful to manage their own stress or life hardship. The average CBPFA Percevied usefulness score for the "Self" subscale was 34.28 (SD = 2.32) for control group and 36.08 (SD=1.64) for case group. The response of subscale 2, question number 8-12 in the questionnaire were summed to analyze that the CBPFA

training was indicated useful to manage the stress or life hardship of others. The average CBPFA Percevied usefulness score for the "Others" subscale was 24.17 (SD = 2.19) and 25.67 (SD=1.50) for case group. The response of subscale 2, question number 13-18 in the questionnaire were summed to analyze that the CBPFA training was indicated useful to identify and activate resources from community. The average CBPFA Percevied usefulness score for the "community" subscale was 30.50 (SD = 2.18) for control group and 31.31 (SD 1.71) for case group (Table 8). The Independent T-test analyses was employed to determine whether there is a statistically significant difference between the means in two unrelated groups. The result of the analysis shows that the Percevied usefulness CBPFA for self (t (96) = -4.450, p=.000), other (t (96) = -3.982, p= .000) and community (t (96) = -2.048, p= .045) were statistically significant difference. It means that case group participant showed that the integrated CBPFA training more beneficial than the control group participants.

Table 8.

Comparison of Percevied Usefulness of CBPFA Training for Control and Case group (n=98)

Variables	Groups	n	*Mean* ± *SD*	P value
Percevied usefulness subscale 1 for self	Control	46	34.28 ± 2.32	.00
	Case	52	36.08 ± 1.64	
Percevied usefulness subscale 2 for others	Control	46	24.17 ± 2.19	.00
	Case	52	25.67 ± 1.50	
Percevied usefulness subscale 3 for community	Control	46	30.50 ± 2.18	.045
	Case	52	31.31 ± 1.71	

The last question of the Percevied usefulness questionnaire, question number 19 asked the overall percevied usefulness CBPFA training by rating their responses. The response of question number 19 were summed and analyzed by Chi-square statistical analysis. The Chi-square was employed in order to examine whether or not there is a statistically significant difference between categorical variables in the same population. Response from both groups

rated by somewhat agree, agree, and strongly agree. Of the 52 participants in case group who completed the last item of percevied usefulness questionnaire (question no. 19), 37 participants (71.2%) reported strongly agree that the overall CBPFA training was useful, while in the control group of the 46 participants only 24 participants (52.2%) reported strongly agree that the overall CBPFA training was useful. Statistical analysis Chi-square was employed to discover if there is a relationship between two categorical variables, the groups and participant's responses (see Table 9). The relation between the groups of interventon and participant's response showed significant, χ^2 (2, N=98) = 11.589, $p < .05$. It means that the case group was likely to show the Integrated CBPFA training more beneficial than was control group.

Table 9

Participant's Response of the Overall Percevied usefulness of CBPFA

	Strongly agree		Agree		Somewhat agree	
	N	%	N	%	N	%
Total (n=98)	61	62.2	28	28.6	9	9.2
Control Group (n=46)	24	52.2	13	28.3	9	19.6
Case Group (n=52)	37	71.2	15	28.8	0	0

Note. $\chi 2$=11.589 ; P= .003

Hypothesis 1

Hypothesis 1 stated that The CBPFA training will increase *Kaders* knowledge and skill of early psychosocial support. To analyses all the bivariate analyses, the parametric test was conducted. Analysis of change in the knowledge of CBPFA, CD-RISC, CART and GSE among both of group were conducted by using paired T-test. Table 10 shows all the dependent variables mean score were increased after training in control group. The knowledge of CBPFA mean score increased from 5.33 to 8.20 ($p < 0.05$) with large intervention effect (d= 1.487). The CD-RISC mean score also increased from 68.85 to 78.26

(p< 0.05, d= 1.785). In addition the CART mean score (p< 0.05, d=1.428) increased after training as well as GSEF mean score (p < 0.05, d= 4.201). In order to confirm the result because the normality test shows non normal distribution, therefore the non-parametric test was conducted. The Wilcoxon Test results of comparison the pre- and post-training in the control group showed that the participants mean score of knowledge of CBPFA, CD-RISC, CART and GSEF increased after training, (p < 0.05) with the Z score were reported Z= -5.870, -5.082, -5.925, -5.494 respectively. Both paired T-test and Wilcoxon test show the same result, which mean all the expected outcomes are significant increase after the training (p< 0.05).

Table 10

Comparison of Pre- and Post-Training Outcomes of Participants in Control Group (n= 46)

Variable	Pre -Training (*mean ± SD)*	Post-Training (*mean ± SD)*	*P Values*	d *score*
Knowledge of CBPFA	5.33 ± 1.37	8.20 ± 1.36	.0001	1.487
CD-RISC	68.85 ± 8.32	78.26 ± 8.62	.0001	0.785
GSEF	23.96 ± 1.92	32.74 ± 1.39	.0001	4.201
CART	80.89 ± 7.11	89.13 ± 7.97	.0001	1.428

Note: CBPFA (Community Based Pschological First Aid); CD-RISC (Connor-Davidson Resilience scale); CART (Communities Advancing Resilience Toolkit); GSEF (General Self-Efficacy Scale).

Furthermore, results of comparison the pre- and post-training in the case group showed that the participants mean score in the all dependent variables increased after training such as knowledge of CBPFA, CD-RISC, CART and GSE (p < 0.05) (see Table 11). Again, the Wilcoxon Test was conducted, it showed that the participants mean score in case group increased after training such as knowledge of CBPFA, CD-RISC, CART and GSEF (p < 0.05) with the Z score were reported Z= -6.229, -6.148, -6.279, -6.298 respectively. Both paired T-test and Wilcoxon test show the same result, which mean all the expected outcomes are

significant increase after the training ($p < 0.05$).

Table 11

Comparison of Pre- and Post-Training Outcomes of Participants in Case Group (n= 52)

Variable	Pre-Training (*mean ± SD)*	Post-Training (*mean ± SD)*	*P Values*	*d score*
Knowledge of CBPFA	6.65± 1.33	9.62 ± 1.05	.0001	2.53
CD-RISC	73.02 ± 6.58	82.83 ± 7.81	.0001	1.680
GSEF	23.92 ± 1.60	32.29 ± 1.66	.0001	4.639
CART	89.71 ± 4.97	98.77 ± 6.53	.0001	2.157

Note: CBPFA (Community Based Pschological First Aid); CD-RISC (Connor-Davidson Resilience scale); CART (Communities Advancing Resilience Toolkit); GSEF (General Self-Efficacy Scale).

Hypothesis 2

Hypothesis 2 indicated that Integrated CBPFA group will show higher score on the post training test performance compare to CBPFA group, including knowledge & skill of CBPFA, their perceived self-efficacy, Self-Perceived resilience, and community resilience. Data were obtained from the four questionnaires as follows Knowledge of CBPFA, GSE, CD-RISC and CART. Analysis of change in the all questionnaires among both of group were conducted by using Independent T-test.

Table 12 shows that there is a significant difference in the mean score of knowledge of CBPFA, CD-RISC and CART after training between the control group and case group (*p-value* = 0.00). It means that there is a significant effect of Integrated CBPFA training for the participant's knowledge of CBPFA, self-perceived resilience, and community resilience among case group. On the other side, there is no significant different on the self-efficacy (GSE) mean score ($p > 0.05$) among two groups.

Table 12

Comparison of Outcomes for Control and Case Groups after Training

Variable	Control (n=46) *(mean ± SD)*	Case (n=52) (*mean ± SD*)	*P Value*	*d score*
Knowledge of CBPFA	8.20 ± 1.36	9.62 ± 1.05	.0001	1.178
CD-RISC	78.26 ± 8.62	82.83 ± 7.81	.007	0.557
GSE	32.74 ± 1.39	33.29 ± 1.66	.081	0.357
CART	89.13 ± 7.97	98.77 ± 6.53	.000	1.331

Note*:* CBPFA (Community Based Pschological First Aid); CD-RISC (Connor-Davidson Resilience scale); CART (Communities Advancing Resilience Toolkit); GSEF (General Self-Efficacy Scale).

After all, when comparing the mean score difference of pre- and post-training among both groups, there are no significant different on all of outcomes (p > 0.05) with the effect size medium to large on the knowledge of CBPFA, self-perceived resilience, and community resilience (see Table 13). It means there is no different effect of CBPFA training method between two groups on their knowledge of CBPFA, self-efficacy, self-perceived resilience, and community resilience.

The non-parametric was conducted as well, to confirm the comparison mean difference of pre-post training among both groups. The Mann Whitney result shows no significant different among all of outcomes (p > 0.05) with the U score of knowledge of CBPFA, CD-RISC, GSEF, and CART are reported U= 1114.000, 1125.000, 973.000, 1091.000 respectively. It means both Independent T-test and Mann Whitney test show the same result, all the expected outcomes are not significant difference in both of groups (p> 0.05).

Table 13

Comparison of Mean Difference Outcomes for Control and Case Groups

Variable	Control Group (n=46)		Case Group (n=52)		*P Value*	*d score*
	Mean	*SD*	*Mean*	*SD*		
Knowledge of CBPFA	2.87	1.62	2.96	1.17	.752	1.178
CD-RISC	9.41	9.41	9.81	5.84	.807	.557
GSEF	8.78	2.09	9.37	2.02	.164	.357
CART	8.24	5.77	9.06	4.20	.421	1.331

Note: CBPFA (Community Based Pschological First Aid); CD-RISC (Connor-Davidson Resilience scale); CART (Communities Advancing Resilience Toolkit); GSEF (General Self-Efficacy Scale).

The Multivariate Analysis

This study conducted further data analysis, the multivariate analysis such as linear regression, Manova test, and Mancova test. Especially for the age variables, it assumes that age variable showed non -normal distribution, it may contribute the meaning of significance of the intervention effect for both groups (see Table 6). Therefore, the researcher conducted further data analysis, such as linear regression, the multivariate analysis Manova and Mancova by controlling age variable.

The Linear Regression.

The Multiple linear regression used in this study in order to predict the value of all dependent variables based on the value of all the demographic characteristics. The first linear regression is to predict the knowledge of CBPFA based on all the demographic attributes, such as groups, age, gender, marital status, education level, and years of service. Table 14 shows the impact of all demographic characteristics on the knowledge of CBPFA. The R^2

value of .18 revealed that the predictors explained 18% variance in the outcome variable with F (6, 91) = 3.26, $p < .05$. The Findings revealed that age (β= -.47, p<.05) and gender (β= -.27, p<.05) predicted the knowledge of CBPFA, whereas groups marital status, education level, and years of service have no significant effect on the knowledge of CBPFA (p >.05).

Table 14

Multivariate Linear Regression Analysis of Predicting the Knowledge of CBPFA (n=98; p<.05)

Variable	*Unstandardized β*	*SE*	*t*	*p*	*95%CI*
(Constant)	5.688	.812	7.005	.000	[4.08, 7.30]
Groups	-.139	.311	-.446	.657	[-.76, .48]
Age	-.066	.020	-3.210	.002	[-.11, -.03]
Gender	-.875	.343	-2.548	.013	[-1.56, -.19]
Marital Status	.025	.444	.057	.955	[-.86, .91]
Education Level	-.007	.191	-.034	.973	[-.39, .37]
Years of Service	.042	.029	1.487	.140	[-.01, .10]

*CI=Confidence Interval

The second multiple regression was run to predict CD-RISC mean difference from groups, age, gender, marital status, education level, and years of service. Table 15 shows the impact of all demographic characteristics on the Individual Resilience (CD-RISC). The R^2 value of .05 revealed that the predictors explained 5% variance in the outcome variable with F (6, 91) = .75, $p > .05$. The findings revealed that all the demographic characteristics do not show significant effect on the individual resilience (p >.05).

Table 15

Multivariate Linear Regression Analysis of Predicting Individual Resilience Score [a] *(n=98; p<.05)*

Variable	*Unstandardized β*	*SE*	*t*	*p*	*95%CI*
(Constant)	12.163	4.804	2.532	.013	[2.62, 21.71]
Groups	.336	1.842	.182	.856	[-3.32, 3.4]
Age	-.116	.121	-.955	.342	[-.36, .13]
Gender	-2.507	2.031	-1.234	.220	[-6.54, 1.53]
Marital Status	4.386	2.625	1.671	.098	[-.83, 9.60]
Education Level	-.699	1.130	-.619	.538	[-2.94, 1.55]
Years of Service	-.012	.169	-.069	.945	[-.35, .32]

Note: [a] Connor Davidson-Resilience Inventory Scale (CD-RISC); *CI=Confidence Interval

The next multiple regression was run to predict GSEF mean difference from groups, age, gender, marital status, education level, and years of service. Table 16 shows the impact of all demographic characteristics on the Self Efficacy (GSE). The R^2 value of .06 revealed that the predictors explained 6% variance in the outcome variable with $F(6, 91) = .98$, $p > .05$. The findings revealed that all the demographic characteristics' have no significant effect on the self-efficacy ($p > .05$).

Table 16

Multivariate Linear Regression Analysis of Predicting Self Efficacy Score [a] (n=98; p<.05)

Variable	*Unstandardized β*	*SE*	*t*	*p*	*95%CI**
(Constant)	8.31	1.28	6.49	.000	[5.76, 10.85]
Groups	.83	.49	1.68	.096	[-.15, 1.8]
Age	.02	.03	.55	.582	[-.046, .08]
Gender	-.24	.54	-.45	.654	[-1.32, .83]
Marital Status	.49	.70	.70	.488	[-.91, 1.88]
Education Level	-.45	.30	-1.49	.140	[-1.05, .15]
Years of Service	-.02	.05	-.46	.649	[-.11, .07]

Note: [a] General Self Efficacy (GSEF); *CI=Confidence Interval

The last multiple regression was run to predict CART mean difference from groups, age, gender, marital status, education level, and years of service. Table 17 shows the impact of all demographic characteristics on the Community Resilience (CART). The R^2 value of .04 revealed that the predictors explained 4% variance in the outcome variable with F (6, 91) = .66, $p > .05$. The findings revealed that all the demographic characteristics' have no significant effect on the community resilience ($p > .05$).

Table 17

Multivariate Linear Regression Analysis of Predicting Community Resilience Score[a] *(n=98; p<.05)*

Variable	***Unstandardized β***	***SE***	***t***	***p***	***95%CI***
(Constant)	11.20	3.13	3.60	.001	[4.99, 17.42]
Groups	.72	1.20	.60	.551	[-1.67, 3.10]
Age	-.10	.079	-1.24	.220	[-.25, .06]
Gender	-1.33	1.32	-1.01	.317	[-3.96, 1.3]
Marital Status	2.07	1.71	1.21	.230	[-1.33, 5.46]
Education Level	-.61	.74	-.82	.412	[-2.07, .855]
Years of Service	.03	.11	.29	.775	[-.19, .25]

Note: [a] Community Advanced Resilience Tool (CART); *CI=Confidence Interval

The Mancova Test.

The Mancova test uses to determine whether there are any statistically significant differences between the adjusted means of three or more independent (unrelated) groups, having controlled for a continuous covariate. It should meet three assumptions, the first, two or more dependent variables should be measured at the interval; or ratio level (continuous variables). In my study, the mean difference of all the dependent variables (CBPFA knowledge, CD-RISC, GSEF, CART) met the first assumption. The second assumption is one independent variable should consist of two or more categorical, independent groups (a nominal variable or an ordinal variable), whereas in my study group variable met the second assumption. The third assumption is one or more covariates are all continuous variables, so the age variable was met the third assumption. Result from MANCOVA analysis showed there was no statistically

significant difference between CBPFA group on the combined dependent variables after controlling for age, $F(4, 92) = 1.153$, $p > .05$, Wilks' $\Lambda = .952$, partial $\eta 2 = .048$ (see Table 18).

Table 18

Multivariate Analysis of MANCOVA

Effect	Value	*F*	*P*	*Partial Eta Squared*
Intercept	.346	43.491	.000	.654
Age	.871	3.392	.012	.129
Group	.952	1.153	.337	.042

Note: $F(4, 92) = 1.153$, $p = .337$, Wilks' $\Lambda = .952$, partial $\eta 2 = .048$

The Two Way MANOVA.

The two-way MANOVA was conducted to understand if there is an interaction between two independent variables on the two or more dependent variables. Two major assumptions should be fulfilled. The first assumption is two or more variables should be measured at the interval or ratio level (continuous data) while in my study the mean difference of all dependent variables are met the first assumption. The second assumption, two independent variables should consist of two or more categorical, independent groups, for instance in this study, the group of CBPFA intervention and group of age variables. The researcher divided the age variables into two group, the first group was the participant's range of age 20-39 years old, and the second group was the participant's range of age more than 39 years old.

The result of the two-way MANOVA showed there was no statistically significant interaction effect between CBPFA group and age on the combined dependent variables, $F(4, 91) = .577$, $p > .05$, Wilks' $\Lambda = .975$, partial $\eta 2 = .025$. (see Table. 19). It means that those

multivariate analysis by controlling the age variable showed there was no significant difference in both groups on the dependent variables by controlling the age variable.

Table 19

Multivariate Analysis for Two-Way MANOVA

Effect	Value	*F*	*P*	*Partial Eta Squared*
Group Case	.975	.577	.680	0.25
Age Group	.968	.749	.561	0.32
Group*Age	.929	1.725	.146	0.71

Note: $F(4, 91) = .577$, $p = .680$, Wilks' $\Lambda = .975$, partial $\eta 2 = .025$

Discussion

In this chapter, the summary of the results is defined at first. Then, the researcher will discuss interpretation and support to add clarity to the findings. At first, the researcher will discuss the findings from the perspective of CBPFA and Culture. Later, the section will end with the discussion of CBPFA and Resilience.

Summary of the Results

The first aim of the study is to develop Integrated CBPFA training for community volunteer members (*Kaders)* in Indonesia which expected to improve the community resilience. The development of the Integrated CBPFA ensure the contents of the training can be beneficial to improve the community resilience and be culturally acceptable. Selecting the religious value is one of cultural sensitivity approach of community-based program in order to increase the resilience. According to Garigapati (2017), it is commonplace to include a representative of the community in which PFA training is taking place to ensure cultural responsiveness, therefore the integrated CBPFA program has taken several strategies.

One of the strategies was consulting the contents of Islamic value in the Integrated CBPFA with an Islamic psychologist in Indonesia, then involving the religious figure and community leader in the day of the training. The consultation period attempted to formulate the Integrated CBPFA as a community-based mental health intervention with Islamic values as the standpoint and psychosocial approach as the intervention. The Integrated CBPFA training in this study supports communities by helping them identify and develop their psychosocial by using resources in their community, including their religious and cultural

values. As Flora and Flora (2007) stated, religiosity may lead to higher bonding social capital. The social capital itself is one of the important aspects in community resilience and this is congruent with the initial aim of the study.

The second purpose of the study is to evaluate the effectiveness of the integrated CBPFA. This study compared the expected outcomes of individual resilience as well as community resilience from two groups, the Integrated CBPFA group and original CBPFA group, by measuring the CDRISC and GSEF mean score as the indicator for individual resilience, and CART mean scores as the measurement of community resilience.

Both of parametric and non-parametric test were employed in this study. According to both of test, the results of the study highlighted that CBPFA training has caused a statistically significant increase on the expected outcomes of both groups. The expected outcomes which statistically significant increase were knowledge and skill of CBPFA of *Kaders* as well as on individual and community resilience which has been indicated by the CDRISC, CART, and GESF of both groups ($p < .05$). These results are congruous with the previous studies, such as mental health training for Cadres (Marastuti, et al, 2020; Istiani, et al, 2015) and CBPFA Training (Reed, 2016; Bordeaux-Rank, 2017; Garigapati, 2017).

On the other hand, the study did not support the second hypothesis. There was no statistically significant difference between the groups in the pre-post training score ($p > .05$) although this study run the non-parametric test, eventually the findings showed same result with the parametric test's finding. Furthermore, the multivariate analyses were conducted to determine whether any contributed factors such as demographic factors to all dependent variables. The first multivariate analysis was linear regression. The findings showed that only the knowledge of CBPFA was being predicted by the variable age and genders, whereas the CDRISC, GSEF, and CART were not significance different by all the demographic characteristics. Because of an assumption was emerged that the age variable may influence

the result because two groups were not identical in age. Therefore, the other multivariate analyses were also employed such as Manova test and Mancova test. Those tests were employed to determine the age variables effect on the mean difference score of all dependent variables. Unfortunately, both multivariate analysis results showed after controlling the age variable, there were no statistically significant interaction effect between CBPFA group and the dependent variables.

However, when comparing the perceived usefulness CBPFA training between case and control group, the scores on perceived usefulness of CBPFA training for self, others, and community in the case group were significantly higher than those of the control group ($p = .000$). Even more, the overall of the perceived usefulness of CBPFA training showed the Integrated CBPFA training was more beneficial than was the original one.

CBPFA and Culture

In Indonesia, religious aspects play as part of cultural aspects in responding to disaster. Although this study did not prove that the CBPFA training added religious interpretation (the integrated CBPFA) was more effective in improving participant knowledge and resilience than the original CBPFA program, still the perceived usefulness of the integrated CBPFA for *Kaders* was demonstrated that integrated CBPFA was more beneficial for them. The possible reason for this finding is the contents of the integrated CBPFA training itself. Several contents of integrated CBPFA are added the Islamic perspective, moreover the contents using the examples reflecting their religious daily life because the *Kaders* are not professional health workers. For instance, the concept of disaster, the Integrated CBPFA training explain what the meaning of disaster is based on Islamic perspective, what we should say when expressing the condolence in Islamic way. Those examples make them feel familiar and ease to accept new concepts. Moreover, the integrated CBPFA training did not only offer the psychoeducation about disaster, traumatic stress, and coping in general point of view, but

it also offered further explanation about alternative: how great it is to be a helper in the Islamic perspective, as well as how to cope with the problem by referring to God. That is, believing that God is in control, that nothing happens beyond God's control, and that we, as human, should just accept whatever happens, especially when unexpected events without any warning happen. By doing so, adapting CBPFA by acknowledging cultural values such as religiosity was effective for developing coping among disaster responders.

This is particularly beneficial for countries where religion is prominent, like Indonesia, which is the country with the highest number of Muslims in the world with approximately 86% Muslims. Religion is not merely a set of private beliefs in the minds of individual believers, but the basis of dynamic social interactions that influence decisions at all levels of society (Deneulin & Rakodi, 2011). Moreover, Call (2012) stated the influence of religion in Indonesia is reflected in the values and attitudes of societies and individuals, which in turn shapes the behavior of individuals and peoples (their social interactions) on natural disaster adaptation strategies in community. Hence, it can be concluded that the efficacy of CBPFA in this study is partly attributed to their strong commitment to religion. Unfortunately, this study did not assess the religiosity of the participants. The effect of incorporating religious-cultural themes into CBPFA should be clarified when its efficacy is compared with the control group who received original CBPFA.

However, there were no statistically significant difference among the groups in the mean difference of pre-post training score. The possible explanation for this finding is the relation of the principal of CBPFA with the sociocultural perspective. Indonesians have been described as a collectivist culture. People view themselves as part of a community rather than as individuals and show a strong preference for adhering to group to which they belong (Gupta and Sukamto, 2020). A well-known collectivist culture is *Gotong Royong* tradition. Based on this point of view, the original CBPFA was perceived culturally relevant and useful

with *Gotong Royong* tradition. *Gotong Royong* is the traditional spirit which becomes a key cultural operator where labor is accomplished through reciprocal exchange and the villagers are motivated by a general ethos of selfishness and concern for the common good (Mardiasmo and Barnes, 2015). *Gotong Royong* emphasizes the positive notions of mutual family and community support. The spirit of *Gotong Royong* is congruent with the aim of CBPFA; that is, to strengthen community resources by further developing existing psychological assets (e.g., support systems, natural strengths) which increasing mental health awareness, promoting self and community-efficacy, and encouraging self-care (Jacobs & Meyers, 2006; Reyes, 2006) (Creamer & Liddle, 2005). The significant result in both groups explained that CBPFA is culturally adaptive for Indonesian society and it can help to diminish the psychological adversity of disaster.

CBPFA and Resilience

This study provides a preliminary evidence that the CBPFA training has significantly increased the *Kaders* resilience which has been indicated by the CD-RISC, GESF, and CART. Previous research suggests that resilience can be learned, developed and enhanced through cognitive transformational practices, education, and environmental support (Grafton et al., 2010). This study proved that trough the CBPFA training, *Kaders* can foster individual and community resilience. This result is supported the Ehlers and Clark (2000) statement that teaching individual with the understanding of traumatic stress and coping skills may be the best strategy for building resilience to traumatic stress. The present integrated CBPFA training provides *Kaders* with knowledge and skill on how to be an effective helper by identifying their effective helper in their own community, how Islamic values view the importance of being a helper and to encourage mutual help in community based on Islamic perspective.

Providing coping skill has been part of CBPFA lesson which derived from the concept

of PFA, it is to promote sense of self- efficacy by providing information on coping (Vernberget al., 2008). In the literature, there are research results showing the benefit of the CBPFA that increases self-efficacy and self-confidence (Chandra et al., 2014; Everly et al., 2014; Farchi et al, 2018; Kantaris et al, 2020). The results of this study point at the effectiveness of CBPFA training in terms of increasing individual resiliency as well as community resiliency and improving self-efficacy in non-professionals trained to respond to various situations, from daily pressure to traumatic events. Furthermore, CBPFA program can have extensive benefits. The CBPFA is not only promoting natural strengths and enhancing existing support systems, but also reducing community reliance on professionals by shifting the helping role to the community members.

Reducing the community reliance on the professional's service is most needed for developing countries such as Indonesia, where community-based disaster-related mental health services do not have adequate resources to respond to mental health needs. Besides, in *Sumur* district, a remote and rural area located in *Pandeglang* City, community prevention efforts tended to be worn down and depleted over time. This gradual depletion of resources is most evident in *Sumur* district due to the risk factors, such as: limited accessibility to mental health services due to geographical isolation, inadequate number of mental health clinicians needed to fulfill the needs of community and disparities in mental and medical health service. The CBPFA is efficient and effective for reasons as it is adaptable to be community-specific (i.e., language, training modules specific to community needs, and can be delivered using a variety of methods), increases accessibility to psychological support, can be sustained by communities at little to no cost, and provides individuals with the support and care that is culturally responsive and appropriate (Jacobs, 2016). Back again that the aim of CBPFA is to strengthen community resources by further developing existing psychological assets (e.g., support systems, natural strengths) by increasing mental health awareness, promoting self and

community-efficacy, and encouraging self-care (Creamer & Liddle, 2005; Jacobs & Meyers, 2005; Reyes, 2006;). It is likely, even though in the case group the participants received integrated CBPFA with additional religious adaptation, the original CBPFA itself was designed to bolster individual resilience, so it can help to increase the resilience of both groups.

Limitations

The current study was limited to the context of the CBPFA training with generally similar religion and did not assess further application of the module in diverse Indonesian religions. Studies on further adaptation of this training for specific communities would be an important focus for further work. It would also have been of interest to have conducted follow-up studies to assess long-term knowledge retention and the impacts of applying this training in immediately disaster affected contexts.

Regarding the examination of religious and spiritual value, it is recommended to examine the religious and spiritual level when using the religious approach of the study. It will be more sophisticated if the future study would be able to evaluate the effect of incorporating religious-cultural into the specific intervention or program.

Implications

Implications for practice

Findings from the study provided evidence that incorporating religious value which is considered as part as culturally sensitive strategy in CBPFA program is beneficial and feasible for community based-support program. This is important thing in order to make a sustainable program, a community-based support program should be feasible and pragmatic with the ongoing follow up and evaluation process.

The effectiveness of community-based support program adapting the local values has been proved by a number of previous studies. For instance, Garigipati (2017) conducted a

study which involved traditional healers who are significant figures in which CPFA training is taking place to ensure cultural responsiveness based on consideration that the Nepali communities are reliant on faith-based healing, which is an important part of community recovery in Nepal. Another previous study showing the effectiveness of CBPFA for the cultural strategy approach was conducted by Bordeaux-Rank (2017). In Bordeaux study, CBPFA was developed for the Rosebud Sioux Tribe, India. The results of his study were positive and yielded high levels of the perceived usefulness, and cultural appropriateness of CBPFA on the Rosebud Sioux Indian Reservation.

In the present study, the researcher integrated the religious aspect as part of cultural aspects in the community based-support, CBPFA training program, particularly Indonesian communities who emphasize religious aspects and attempt to realize religious values in everyday life. Gaduh (2011) stated that religion and traditional value are not easily separable in Indonesia, a country considered to be both multiethnic and multi religious. In relation to nursing practice context, according to Rochmawati, Waechula, and Camero (2018), religious involvement in daily nursing practice appears culturally appropriate and is encouraged. Therefore, the influence of religion on natural disaster adaptation strategies in communities is of great importance in Indonesia. Even more, nowadays in Indonesia, basic mental health services have been integrated into general health services in PHC and their networks, which makes the development of CBPFA more feasible to be applied in the *Kader* as part of community mental health service.

Implications for research.

The design of the present study contributes to the research in the field of CBPFA. Although the effectiveness of CBPFA has been widely studied, there is a paucity of the research design of CBPFA in case control design. For instance, most of studies of CBPFA were conducted by using one group design (Wade, et al 2013; Hechanova, et al 2015; Lee, et al 2017).

Those previous studies mentioned no control group as the limitation of the study. A control group is required because it helps to strengthen the internal validity of the study and enhance generalizations. This study conducted quasi-experimental non-equivalent control group model by comparing the original CBPFA group with the integrated CBPFA group. Even this study did not show any significant different of both groups on the knowledge of CBPFA, individual and community resilience. However, this study has showed the genuine effect of CBPFA in both groups. Originally, CBPFA was designed to bolster individual resilience, the findings of the study emphasize that no matter how modification and cultural adaptation has been done to the content of CBPFA, and still the original purpose of CBPFA was to improve individual and community resilience.

Conclusions

The main purpose of this study was to develop CBPFA training which integrated the religious-traditional value in Indonesia. This integrated CBPFA training can be regarded as the first CBPFA training which combined the psychoeducation with Islamic approach. Even the CBPFA has mandated that the training should be culturally acceptable but adding religious value has never been done in the other previous studies. The religious value was chosen as one of local traditional adaptation in developing of CBPFA because Indonesia culture is strongly attached by religious value. Moreover the *Kaders* were not a mental health professional, so it is important to formulate the content of CBPFA training with something that familiar with their daily life. By doing so it is expected the integrated CBPFA which was conducted in this study, can be easily to be implemented and accepted in Indonesia society. The researcher targeted *Kaders* as the participants of study and examined their knowledge-skill of CBPFA and resilience by using the questionnaire of the Knowledge of PFA Questionnaire, the perceived usefulness of CBPFA, GESF, CART, and CD-RISC.

By comparing two CBPFA trainings approach, the researcher wants to examine which one of the training is more effective to improve not only knowledge and skill, but also the individual and community resilience. In accordance with the original aim of CBPFA itself that intended to boost the community resilience by empowering local resources, the both of CBPFA training has successfully improve the knowledge-skill of CBPFA, individual and community resilience of the participants in the study. However, the current study did not find a significant different of CBPFA training between two groups on their knowledge-skill of CBPFA and individual and community resilience. Although the study did not support the second hypothesis, yet the result of self-perceived usefulness of CBPFA demonstrated that the *Kaders* showed the integrated CBPFA more accepted for them to mitigate their stress and

others and identify the existed resources in their community. This is because of the religious value that unified in this study. By adding religious values start from the first lesson of the CBPFA training, it helps participant to recall the role of religion to overcome their stressor and identify their existing resources.

Based on the finding of this study, in the future, the study of integrated CBPFA can be developed not only for Moslem society but also other different religion society by adjusting their own religious characteristic. Moreover, using follow up study and regular supervision are needed to evaluate the retention of knowledge and the sustainability of the training program.

In term of the sustainability of the program, the integrated CBPFA can be embedded in the health care system at the community level and be integrated into health system response capacity. Findings from this study add the feasibility of implementing community-based disaster mental health preparedness such as CBPFA in the future. In addition, Indonesia already has community involvement program, named *Kaders*, by equipping the *Kader*s with the knowledge and skill in early psychosocial support, CBPFA is believed reducing the community reliance to the specialty care service and bridging the link to get mental health care in the primary health settings.

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Appendix 1. Knowledge of PFA Questionnaire

Before beginning the CBPFA Training, we would like to know how familiar you already are with the material in the course. A number of questions about psychological first aid and resilience are presented below. Please check the box in front of the best answer for each question. There is no grading involved, we just want to see what course participants already know coming into the course.

1. "Psychological resilience" refers to:

☐a person's ability to effectively handle stressful situations of all sorts

☐the confusion that occurs when confronted with a stressful situation

☐a mild stress reaction

☐a fairly serious psychological reaction

2. Psychological first aid is:

☐a way of providing traditional first aid using only your mind

☐a term for emergency assistance provided by mental health professionals

☐reserved for use in hospital emergency rooms

☐a set of actions that can offer immediate support for people in need of help

3. Stress reactions after difficult experiences:

☐are experienced by everyone exposed to the stress

☐are not experienced by everyone, but are ordinary reactions to extraordinary events

☐are a sign of personal weakness

☐require referral to a mental health professional

4. A critical component of coping is:

☐confronting each crisis head on

☐refusing to accept changing conditions

☐waiting for things to return to normal

☐connectedness with others

5. Assisting with basic needs:

☐is a job best left to disaster relief workers

☐isn't necessary in a crisis

☐can get in the way of good psychological support

☐is an essential part of psychological first aid

6. When providing psychological first aid:

☐you need to push for personal information

☐you sometimes need to make decisions for the person you're helping

☐you need to respect the person's personal boundaries

☐you never discuss religious beliefs

7. A great way to build children's ability to cope with stress is to:

☐force children to talk about the stressful events with parents or caregivers

☐help them develop good friends

☐make sure children focus their attention within the home

☐schedule enough activities so children don't have "down time”

8. For those providing psychological first aid, self-care is:

☐unimportant until things calm down

☐not advised, because support should be given to psychological first aid providers only by

professionals

☐critically important skill

☐unnecessary because psychological first aid providers have good coping skills

9. In a very stressful situation:

☐it is best to care for adults and leave children for later

☐it is important to understand the unique needs of children

☐children generally respond the same as adults

☐children usually don't need much psychological support

10. When considering whether to approach someone to offer psychological first aid:

☐it is important to observe and be aware

☐it is important to approach the person especially if they are angry

☐remember that calling law enforcement officers or emergency medical personnel is in appropriate

☐you should never tell the person you are offering psychological support

11. Maintaining a daily routine after a difficult event:

☐is especially important for children

☐is something that parents need to do to control their children

☐is impractical because of the stress and chaos of difficult events

☐puts significant additional stress on children

12. If someone is threatening to harm him/herself or someone else:

☐it is best for a psychological first aid provider to handle the situation

☐call another psychological first aid provider to back you up

☐Consult with a law enforcement official, government or health worker, or a community/religious leader

☐there is no cause for alarm, because people who talk about it usually don't do

Appendix 2. Psychological First Aid Percevied usefulness Questionnaire

Please rate your view of the PFA training for the following items.

1 Strongly Disagree	2 Disagree	3 Somewhat Disagree	4 Somewhat agree	5 Agree	6 Strongly Agree

1. Because of the PFA training, I feel better able to identify and cope with my stress.
2. Because of the PFA training, I feel better able to identify and cope with very difficult aspects of my profession.
3. Because of the PFA training, I feel better able to identify and cope with the traumatic experience of the people to whom I provide care.
4. Because of the PFA training, I feel more resilient to adversity in my personal and professional life.
5. Because of the PFA training, I feel better able to identify and avoid burnout.
6. Because of the PFA training, I feel better able to identify sources of support around me.
7. Because of the PFA training, I feel better able to seek out support from others when needed.
8. Because of the PFA training, I feel better able to support other community member volunteer and help them cope with their stress.
9. Because of the PFA training, I feel better able to identify others' stress.
10. Because of the PFA training, I feel better able to support others and help them cope with their stress.
11. Because of the PFA training, I feel better able to provide community-based care.
12. Because of the PFA training, I am able to better understand the needs of my community.

13. Because of the PFA training, I will work more with local religious leaders and healers to provide care for the community.
14. Because of the PFA training, I am more confident that I will be able to provide psychosocial support to the community, regardless of any negative perceptions or attitudes surrounding mental health.
15. Because of the PFA training, I am able to provide better care to my community, family, friends, and coworkers.
16. Because of the PFA training, I am now able to adequately identify protocols for mental health emergencies in the communities of Indonesia and provide referrals as needed.
17. PFA training would be useful for others in Indonesia
18. PFA training should be provided to others in Indonesia
19. Overall, the PFA training was useful to me.

Appendix 3. **The General Self-Efficacy Scale (GSF)**

Please rate your view of your ability for of daily living the following items.

1 Not at all true	2 Hardly True	3 Moderately true	4 Exactly true

No	Statement	Score
1	I can always manage to solve difficult problems if I try hard enough	
2	If someone opposes me, I can find the means and ways to get what I want	
3	It is easy for me to stick my aims and accomplish my goals	
4	I am confident that I could deal efficiently with unexpected events	
5	Thanks to my resourcefulness, I know how to handle unforeseen situations	
6	I can solve most problems if I invest the necessary effort	
7	I can remain calm when facing difficulties because I can rely on my coping abilities	
8	When I a, confronted with a problem, I can	

	usually find several solutions	
9	if I am in trouble, I can usually think of solutions	
10	I can usually handle whatever comes my way	

Appendix 4. The Connor-Davidson Resilience Scale（CD-RISC）

Instruction: the following table is a self-statement scale, which is used to assess resilience. According to your situation in the past month, choose one of the most suitable items for each of the following statements. There is no right and wrong point in answering these questions.

0: Not true at all

1: Rarely True

2: Sometimes true

3: Often true

4: True nearly all of the time

No	Statement	0	1	2	3	4
1	Able to adapt to change					
2	Close and secure relationships					
3	Sometimes fate or God can help					
4	Can deal with whatever comes					
5	Past success gives confidence for new challenge					
6	Tries to See the humorous side of things					
7	Coping with stress can strengthen me					
8	Tend to bounce back after illness or hardship					
9	Things happen for a reason					
10	Best effort no matter what					
11	Can achieve goals despite obstacles					

12	When things look hopeless, I don’t give up					
13	Know where to turn for help					
14	Can stay focused under pressure					
15	Prefer to take the lead in problem solving					
16	Not easily discouraged by failure					
17	Think of self as a strong person					
18	Make unpopular or difficult decisions					
19	Can handle unpleasant feelings					
20	Have to act on a hunch					
21	Strong sense of purpose					
22	In control of your life					
23	I like challenges					
24	You work to attain your goals					
25	Pride in your achievements					

Appendix 5. Communities Advancing Resilience Toolkit (CART) Survey

The following statements are possible descriptions of your community. Please circle one response for each statement.

Response Options:

1 Strongly Disagree

2 Disagree

3 Neither Disagree nor Agree

4 Agree

5 Strongly Agree

No	**Statement**	**1**	**2**	**3**	**4**	**5**
1	People in my community feel like they belong to the community.					
2	People in my community are committed to the well-being of the community.					
3	People in my community have hope about the future.					
4	People in my community help each other.					
5	My community treats people fairly no matter what their background is.					
6	My community has the resources it needs to take care of community problems (resources include money, information, technology, tools, raw materials, and services).					

No	Statement	1	2	3	4	5
7	My community has effective leaders.					
8	People in my community are able to get the services they need.					
9	People in my community know where to go to get things done.					
10	My community works with organizations and agencies outside the community to get things done.					
11	People in my community communicate with leaders who can help improve the community.					
12	People in my community are aware of community issues that they might address together.					
13	People in my community discuss issues so they can improve the community.					
14	People in my community work together to improve the community.					
15	My community looks at its successes and failures so it can learn from the past.					
16	My community develops skills and finds resources to solve its problems and reach its goals.					
17	My community has priorities and sets goals for the future.					
18	My community tries to prevent disasters.					
19	My community actively prepares for future disasters.					

No	Statement	1	2	3	4	5
20	My community can provide emergency services during a disaster.					
21	My community has services and programs to help people after a disaster					
Total Score						

Appendix 6. Demographic Sheet

Participant Code Number

Age: ____________

Sex: Male ☐ Female ☐

3. What is your current marital status?

- ☐ Single, never married
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ I choose not to answer

4. What is the highest level of education you have completed?

- ☐ Junior High School/ Islamic Boarding Junior High School
- ☐ Senior High School/Islamic Boarding Senior High School
- ☐ Some university/college
- ☐ Bachelor's degree/university or College degree

5. How long have you been working as a *Kader?*___ years_____month

6. Do you have any experience in disaster?

☐ Yes ☐ No

7. If yes, what was it?

- ☐ Flood
- ☐ Volcanoes
- ☐ Earthquake
- ☐ Drought
- ☐ Landslide
- ☐ Tidal Wave/ Tsunami

Appendix 7. Cover Letter of Consent Participants

Eni Nuraini Agustini,

Disaster Nursing Global Leader (DNGL) Student

Graduate School of Nursing Art and Science

University of Hyogo

eni.nuraini@uinjkt.ac.id

Mobile Phone: 0812-8595470

I am a doctoral student at University of Hyogo. I would like to conduct research about the Integrated Community-Based Psychological First Aid (CBPFA) for *Kaders*. The CBPFA is a type of training provided to people to help them provide better support and care to family, friends, and to help them cope with their own stress more effectively. Thus, the purpose of the research is to understand how participants in this training perceive the training and the skills provided, how they may use the skills in their personal lives, how useful the training is in addressing social and personal demands.

During this study, you will be joined 2 days training which provide participants with the necessary skill sets needed to assist individuals experiencing traumatic stress due to traumatic events, as well as disasters. Training participants will learn about active listening, how to be a helper, grief and bereavement, ethics, self-care, risk assessment, safety planning, signs of traumatic stress, and when to refer for professional assistance. Prior the training you will be asked for some demographic information (gender, age, etc) and an initial survey that contains questions regarding your knowledge of Psychological First Aid (PFA) concepts, your perception related to your personal ability responding the stressful situation as well psychological support with communities. The survey will take approximately 30 minutes to

complete. Next, you will complete a second survey online within 2 days after the training ends. The second survey will ask about your knowledge of PFA concepts and your perceptions of the training and its percevied usefulness. That survey will take approximately 15 minutes to complete.

There is no known harm associated with your participation in this research, however the psychological discomfort associated with your disaster experience might be appeared, and in which case you may take self-pace breaks or further psychological support. I would also encourage you to either speak to me since I am mental health nurse or the PHN about your feelings.

Several steps will be taken to protect your anonymity and identity. I will be creating a list of participant names and I will assign you a code number that will be placed on the questionnaire you complete. No personal identifying information will be collected on the questionnaire. But if you wish to be quoted by name on anything, I would accommodate this request. The list of participant names, code numbers, and the questionnaires will be kept in a locked filing cabinet at the University of Hyogo Graduate School of Nursing Art and Science, Japan and will be kept 5 years after completed of the study, such that only I and my supervisor will have access to the information.

Please known though that you do not have to answer any questions or discuss any topics that make you feel uncomfortable. Your participation is completely voluntary. Should you decide at any time during training or discussion that you no longer wish to participate, you may withdraw your consent without prejudice and will not be reported to your supervisor (PHN). There are no direct benefits to you. However, I hope that in the future, other people might benefit from the crisis intervention efforts that training participants will be able to offer once the CBPFA training is completed. Participants will be equipped to train others in their community, and, thus, build capacity at the local level. My final report will be presented at

various scientific forum. All records of participation will be kept strictly confidential.

You may ask more questions about the study at any time. Please feel free to contact me, Eni Nuraini Agustini at 0812-9595470 while I am in Indonesia or at the email address eni.nuraini@uinjkt.ac.id.

Or my Supervisor

Professor Sonoe Mashino, RN, PHN, Ph.D,

Graduate School of Nursing Art and Science

University of Hyogo

13-71 Kitaohji-cho, Akashi

Hyogo 673-8588 JAPAN

Tel: +81-78-925-9658

Email: sonoe_mashino@cnas.u-hyogo.ac.jp

This study has been approved by the Ethical Review Board at University of Hyogo.

*)Kindly, please keep the Call for Interview Participants and research consent form up to

Participant Sheet

RESEARCH CONSENT FORM

Name of Researcher : Eni Nuraini Agustini
Title of Study: Integrated Community-Based Psychological First Aid (CBPFA) to Improve Community Resilience for Indonesia Community Members Volunteer

Please read and complete this form carefully. If you are willing to participate in this study, ring the appropriate responses and sign and date the declaration at the end. If you do not understand anything and would like more information, please ask.

I have had the research satisfactorily explained to me in verbal and/or written form by the researcher	YES / NO
I understand that the research will involve survey and 3-days training.	YES / NO
I understand that I may withdraw from this study at any time without having to give an explanation. This will not affect my future.	YES / NO
I understand that all information will be treated in strict confidence and that I will not be named in any written work arising from this study	YES / NO
I understand that any documents material of me will be used solely for research purposes and will be destroyed on completion of your research	YES / NO

I freely give my consent to participate in this research study and have been given copy of this

form for my own information.

____, ____________________

Participant's signature Date

____, ____________________

Researcher's name and signature Date

Disaster Nursing Global Leader (DNGL) Student

Graduate School of Nursing Art and Science

University of Hyogo

eni.nuraini@uinjkt.ac.id

Mobile Phone: 0812-8595470

*)Kindly, please keep the Call for participants and research consent form up to

Researcher Sheet

RESEARCH CONSENT FORM

Name of Researcher : Eni Nuraini Agustini
Title of Study: Integrated Community-Based Psychological First Aid (CBPFA) to Improve Community Resilience for Indonesia Community Members Volunteer

Please read and complete this form carefully. If you are willing to participate in this study, ring the appropriate responses and sign and date the declaration at the end. If you do not understand anything and would like more information, please ask.

I have had the research satisfactorily explained to me in verbal and/or written form by the researcher	YES / NO
I understand that the research will involve survey and 3-days training.	YES / NO
I understand that I may withdraw from this study at any time without having to give an explanation. This will not affect my future.	YES / NO
I understand that all information will be treated in strict confidence and that I will not be named in any written work arising from this study	YES / NO
I understand that any documents material of me will be used solely for research purposes and will be destroyed on completion of your research	YES / NO

I freely give my consent to participate in this research study and have been given copy of this

form for my own information.

____, ___________________

Participant's signature Date

____, ___________________

Researcher's name and signature Date

Disaster Nursing Global Leader (DNGL) Student

Graduate School of Nursing Art and Science

University of Hyogo

eni.nuraini@uinjkt.ac.id

Mobile Phone: 0812-8595470

*)Kindly, please keep the Call for participants and research consent form up to

Appendix 8. Permission Letter to Province Health Office

Jakarta,   Desember 2019

Kepada Yth,.
Dr. H. M. Yusuf, S.Sos, M.Si
Kepala Dinas Kesehatan Propinsi Banten
di
Banten

Assalamu'alaikum Wr. Wb.
Bersama ini disampaikan bahwa Saya Eni Nuraini Agustini, MSc. Dosen PSIK-FKIK, UIN Syarif Hidayatullah Jakarta dan mahasiswa *Graduate School of Nursing Art and Science, University of Hyogo Japan*, mengajukan permohonan izin melakukan penelitian yang berjudul ***Psychological First Aid (PFA*) Terintegrasi di Komunitas untuk Meningkatkan Ketangguhan Komunitas bagi Para Kader di Area Rawan Bencana** dalam memenuhi tugas akhir studi saya. Penelitian ini bertujuan untuk mengembangkan model PFA di komunitas bagi para kader di kecamatan Sumur melalui 3 hari pelatihan agar para kader memiliki ketrampilan mencegah munculnya masalah kesehatan mental pada saat bencana dan meningkatkan ketangguhan mental bagi para kader. Sehubungan dengan itu kami mohon Saudara dapat memberikan izin kepada kami untuk melakukan penelitian di puskesmas yang sesuai dengan kondisi tersebut diatas. Keterlibatan kader ini bersifat sukarela dan saya harap tidak ada unsur paksaan dari pihak pimpinan. Terlampir lembar penjelasan penelitian.
Demikian atas perhatian dan kerjasama Saudara kami ucapkan terima kasih.
Wassalamu'alaikum Wr. Wb.

Hormat Saya,

Eni Nuraini Agustini, MSc
Doctoral Student of Disaster Nursing Global Leader (DNGL) Program
Graduate School of Nursing Art and Science, University of Hyogo
Program Studi Ilmu Keperawatan

UIN Syarif Hidayatullah

Pembimbing Akademik

Professor Sonoe Mashino, RN, PHN, Ph.D,

Graduate School of Nursing Art and Science, University of Hyogo

Appendix 9. Permission Letter to Public Health Center

Jakarta,   Desember 2019

Kepada Yth,.
Kepala UPT Puskesmas Sumur
di
Banten

Assalamu'alaikum Wr. Wb.

Bersama ini disampaikan bahwa Saya Eni Nuraini Agustini, MSc. Dosen PSIK-FKIK, UIN Syarif Hidayatullah Jakarta dan mahasiswa *Graduate School of Nursing Art and Science, University of Hyogo Japan*, mengajukan permohonan izin melakukan penelitian yang berjudul ***Psychological First Aid (PFA*) Terintegrasi di Komunitas untuk Meningkatkan Ketangguhan Komunitas bagi Para Kader di Area Rawan Bencana** dalam memenuhi tugas akhir studi saya. Penelitian berupa 3 hari pelatihan bagi para kader yang bertujuan untuk mengembangkan model PFA di komunitas bagi para kader di kecamatan Sumur agar para kader memiliki ketrampilan menolong kesehatan mental pada saat bencana dan meningkatkan ketangguhan mental bagi para kader.
Sehubungan dengan itu kami mohon Saudara dapat memberikan rekomendasi kader-kader dengan kriteria yaitu pengalaman sebagai kader selama 2 tahun dan berusia 25-55 tahun bisa berpatisipasi dalam penelitian ini . Keterlibatan kader ini bersifat sukarela dan saya harap tidak ada unsur paksaan dari pihak pimpinan. Terlampir lembar penjelasan penelitian.

Demikian atas perhatian dan kerjasama Saudara kami ucapkan terima kasih.
Wassalamu'alaikum Wr. Wb.

Eni Nuraini Agustini, MSc
Doctoral Student of Disaster Nursing Global Leader (DNGL) Program
Graduate School of Nursing Art and Science, University of Hyogo
Program Studi Ilmu Keperawatan

UIN Syarif Hidayatullah

Pembimbing Akademik

Professor Sonoe Mashino, RN, PHN, Ph.D,

Graduate School of Nursing Art and Science, University of Hyogo

Appendix 10. Indonesia Version Explanatory Form

PENJELASAN TENTANG PENELITIAN

***Psychological First Aid (PFA)* Terintegrasi di Komunitas untuk Meningkatkan Ketangguhan Komunitas bagi Para Kader di Area Rawan Bencana**

Terima kasih telah menyetujui berpartisipasi dalam penelitian ini. *Psychological First Aid* (PFA) di komunitas ada sebuah pelatihan yang di berikan pada seseorang untuk menolong siapa pun agar mampu membantu dan merawat keluarganya, teman, tetangga dan membantu seseorang untuk mengatasi stress mereka sendiri lebih efektif. Banyak penelitian telah meneliti keefektifan PFA di komunitas, tetapi belum ada yang meneliti keefektifan PFA yang terintegerasi terlebih terintegrasi dengan nilai-nilai islami. Tujuan dari penelitian ini adalah untuk mengembangkan model PFA di komunitas bagi para kader di kecamatan Sumur melalui 3 hari pelatihan agar para kader memiliki ketrampilan mencegah munculnya masalah kesehatan mental pada saat bencana dan meningkatkan ketangguhan mental bagi para kader. Sebanyak kurang lebih 76 partisipan akan mengikuti pelatihan ini. partisipasi anda akan dilakukan sebanyak dua kali. Pertama anda akan diminta membaca dan menandatangani lembar persetujuan ini, lalu anda akan diminta menjawab beberapa pertanyaan di survey pertama ini. Survey pertama akan memerlukan waktu kurang lebih 30 menit. Selanjutnya, anda akan diminta untuk mengisi kembali survey yang kedua setelah pelatihan selama tiga hari ini berkahir. Survey yang kedua akan memerlukan waktu kurang lebih 30 menit.

Jika anda memutuskan untuk berpatisipasi dalam penelitian ini, anda akan diminta untuk mengisi lembar survey yang berisikan pertanyaan-pertanyaan mengenai pengetahuan anda tentang PFA dan kemampuan mengatasi kejadian-kejadian sulit, ketangguhan komunitas anda di kecamatan Sumur dan penilaian kepercayaan diri anda. Selanjutnya anda akan diminta untuk mengisi lembar survey kedua setelah 3 hari pelatihan berakhir. Lembar survey yang kedua berisikan pertanyaan-pertanyaan mengenai pengetahuan anda tentang PFA dan kemampuan mengatasi kejadian-kejadian sulit, ketangguhan komunitas anda di kecamatan Sumur, penilaian kepercayaan diri anda dan persepsi anda tentang pelatihan ini beserta manfaatnya. Survey ini memerlukan waktu kurang lebih 30 menit.

Jika anda tidak mengerti salah satu dari pertanyaan dalam survey, silahkan bertanya kepada kami dan kami akan menjelaskannya. Apabila anda tidak berkenan atau tidak nyaman dengan salah satu pertanyaan didalam survey, anda berhak untuk tidak menjawabnya. Segala jawaban anda akan kami rahasiakan dan tidak ada satu pun identitas personal yang akan dikumpulkan. Terkait dengan kerahasiaan identitas, tidak ada pertanyaan yang menyangkut identitas personal. Partisipasi anda didalam penelitian ini akan dirahasiakan dan identitas anda akan di berikan label dengan abjad atau kode tertentu untuk melindungi privasi dan kerahasiaan anda.

Semua data-data survey akan dijaga kerahasiaanya dan hanya saya berserta Pembimbing Akademik saya yang memiliki akses untuk membukanya. Semua data-data akan disimpan secara aman di *University of Hyogo Graduate School of Nursing Art and Science,*

Japan selama 5 tahun setelah berakhirnya masa belajar saya. Pada saat dipublikasikan, data-data ini akan disajikan dalam bentuk kelompok data dan tidak akan menyajikan identitas anda.

Partisipasi anda bersifat sukarela, anda berhak untuk mengundurkan diri kapan saja ditengah pelatihan berlangsung tanpa ada konsekuensi apa pun terhadap hubungan anda dengan pihak puskesmas atau pun kelurahan. Jika ada merasakan reaksi negative atau ketidaknyamanan akibat mengingat pengalaman tsunami, silahkan menghubungi kepala pelatihan ini, Eni Nuraini Agustini, yang merupakan perawat kesehatan jiwa dan dosen di prodi Ilmu Keperawatan UIN Syarif Hidayatullah Jakarta.

Tidak ada keuntungan langsung yang bisa anda dapatkan, tetapi keterlibatan anda dapat membantu peneliti memahami bagaimana pelatihan PFA di komunitas ini dapat ditingkatkan. Penelitian ini pula tidak dibiayai oleh pihak mana pun.

Jika ada pertanyaan lebih lanjut, silahkan menghubungi:
Eni Nuraini Agustini di 0812-9595470 atau email: eni.nuraini@uinjkt.ac.id.
atauu
Professor Sonoe Mashino, RN, PHN, Ph.D,
Graduate School of Nursing Art and Science
University of Hyogo
13-71 Kitaohji-cho, Akashi
Hyogo 673-8588 Jepang
Tel: +81-78-925-9658
Email: sonoe_mashino@cnas.u-hyogo.ac.jp

Penelitian ini telah memperoleh izin etik penilitian oleh komite etik University of Hyogo

**)Salinan Lembar persetujuan ini akan disimpan sampai 30 September, 2020*

Appendix 11. Indonesia Version Inform Consent

Lampiran 4-1
Untuk Peneliti

LEMBAR PERSETUJUAN

Nama Peneliti : Eni Nuraini Agustini
Penelitian: ***Psychological First Aid (PFA)* Terintegrasi di Komunitas untuk Meningkatkan Ketangguhan Komunitas bagi Para Kader di Area Rawan Bencana**

Silahkan baca dengan seksama dan isi lembar persetujuan ini. Jika anda bersedia berpartisipasi dalam penelitian ini, lingkari jawaban yang sesuai dan berikan tanda tangan di bawah format ini. Jika ada hal-hal yang kurang jelas, silahkan mengajukan perrtanyaan.

Saya sudah menerima dengan jelas dan lengkap penjelasan penelitian baik secara verbal maupun tertulis	YA / TIDAK
Saya mengerti bahwa penelitian ini terdiri dari pelatihan dan mengisi lembar survey berlangsung selama 30 menit	YA / TIDAK
Saya mengerti bahwa saya bisa menarik keterlibatan saya dalam penelitian ini kapan saja.	YA / TIDAK
Saya mengerti bahwa semua informasi yang saya berikan akan di jaga kerahasiaanya	YA / TIDAK
Saya menegrti bahwa segala informasi yang saya berikan hanya akan digunakan dalam rangka penelitian saja dan akan dimusnahkan setelah penelitian ini berakhir	YA / TIDAK

Dengan ini saya menyatakan setuju untuk berpartisipasi dalam penelitian ini dan saya juga diberikan salinan lembar persetujuan ini.

____, ____________________
Tanda Tangan Partisipan Tanggal

____, ____________________
Nama & Tanda Tangan Peneliti Tanggal

Dosen PSIK UIN Syarif Hidayatullah Jakarta
Graduate School of Nursing Art and Science
University of Hyogo
eni.nuraini@uinjkt.ac.id
Mobile Phone: 0812-8595470

**)Salinan Lembar persetujuan ini akan disimpan sampai 30 September, 2020*

Lampiran 4-1
Untuk Partisipan

LEMBAR PERSETUJUAN

Nama Peneliti : Eni Nuraini Agustini
Penelitian: ***Psychological First Aid (PFA*) Terintegrasi di Komunitas untuk Meningkatkan Ketangguhan Komunitas bagi Para Kader di Area Rawan Bencana**

Silahkan baca dengan seksama dan isi lembar persetujuan ini. Jika anda bersedia berpartisipasi dalam penelitian ini, lingkari jawaban yang sesuai dan berikan tanda tangan di bawah format ini. Jika ada hal-hal yang kurang jelas, silahkan mengajukan perrtanyaan.

Saya sudah menerima dengan jelas dan lengkap penjelasan penelitian baik secara verbal maupun tertulis	YA / TIDAK
Saya mengerti bahwa penelitian ini terdiri dari pelatihan dan mengisi lembar survey berlangsung selama 30 menit	YA / TIDAK
Saya mengerti bahwa saya bisa menarik keterlibatan saya dalam penelitian ini kapan saja.	YA / TIDAK
Saya mengerti bahwa semua informasi yang saya berikan akan di jaga kerahasiaanya	YA / TIDAK
Saya menegrti bahwa segala informasi yang saya berikan hanya akan digunakan dalam rangka penelitian saja dan akan dimusnahkan setelah penelitian ini berakhir	YA / TIDAK

Dengan ini saya menyatakan setuju untuk berpartisipasi dalam penelitian ini dan saya juga diberikan salinan lembar persetujuan ini.

____, ____________________
Tanda Tangan Partisipan Tanggal

____, ____________________
Nama & Tanda Tangan Peneliti Tanggal

Dosen PSIK UIN Syarif Hidayatullah Jakarta
Graduate School of Nursing Art and Science
University of Hyogo
eni.nuraini@uinjkt.ac.id
Mobile Phone: 0812-8595470

**)Salinan Lembar persetujuan ini akan disimpan sampai 30 September, 2020*

Appendix 12. Indonesia Version Demographic

Lampiran 5

Lembar Pertanyaan Demografi

Kode Partisipan

Usia: ____________

Jenis Kelamin: ☐ Male ☐ Female

3. Status Pernikahan ?

☐ Belum menikah

☐ Menikah

☐ Duda

☐ Janda

☐ Tidak ingin menjawab

4. Pendidikan terakhir?

☐ SMP/ MTsN

☐ SMU/SMK/MAN

☐ Akademi/D3

☐ Sarjana

5. Berapa tahun anda bekerja sebagai Kader? ___ tahun_____bulan

6. Apakah pernah mengalami bencana?

☐ Ya ☐ Tidak

7. Jika ya, apakah bencananya?

☐ Banjir ☐ Letusan gunung berapi
☐ Gempa bumi ☐ Kekeringan
☐ Longsor
☐ Gelombang pasang/ Tsunami

Appendix 13. Indonesia Version Knowledge of PFA Questionnaire

Sebelum memulai Pelatihan CBPFA, kami ingin mengetahui seberapa familiarnya anda dengan materi pelatihan ini. Beberapa pertanyaan tentang PFA dan ketangguhan akan disajikan berikut ini. Silankan beri tanda ceklis √ pada jawaban yang sesuai. Tidak ada peringkat yang diberikan, kami hanya ingin melihat apa yang anda ketahui sebelumnya.

1. Ketangguhan psikologi adalah:

☐ Kemampuan seseoarang untuk mengatasi situasi penuh stres secara efektif

☐ Kebingungan yang muncul saat orang menghadapi situasi penuh stres

☐ Sebuah reaksi stress ringan mild stress reaction

☐ Sebuah reaksi psikologis yang cukup stres

2. Psychological first aid adalah:

☐ Sebuah cara penanganan pertama tradisional hanya menggunakan fikiranmu

☐ Sebuah istilah untuk bantuan kegawatdaruratan yang disediakan oleh professional kesehatan jiwa.

☐ Dipergunakan hanya untuk diruang gawat darurat RS emergency rooms

☐ Seperangkat aksi yang menawarkan pertolongan segera untuk orang-orang yang membutuhkan pertolongan

3. Reaksi stress pasca pengalaman sulit:

☐ Dialami oleh setiap orang yang terpapar stres

☐ Tidak dialami oleh semua orang, tapi hanya reaksi yang luar biasa pada situasi yang luar biasa.

☐ Adalah tanda kelemahan seseorang

☐ Perlu dirujuk ke tenaga profesional kesehatan jiwa

4. Komponen kritis dari koping adalah:

☐ Mengkonfrontasi setiap krisis yang dihadapi

☐ Menolak untuk menerima kondisi yang menantang

☐ Menunggu untuk kembali ke keadaan normal

☐ Keterhubungan dengan orang-orang lain

5. Membantu dengan kebutuhan-kebutuhan dasar:

☐ Adalah pekerjaan yang diperuntukkan untuk petugas bencana

☐ tidak penting dalam krisis

☐ dapat diperoleh melalui dukungan psikologis yang baik

☐ adalah bagian yang penting dalam psychological first aid

6. Ketika memberikan psychological first aid:

☐ Kamu perlu memaksa untuk menayakan informasi personal

☐ Kamu terkadang perlu untuk mengambil keputusan bagi orang yang kamu sedang tolong

☐ Kamu perlu untuk menghargai batasan personal seseorang

☐ Kamu tidak pernah mendiskusikan keyakinan agama

7. Sebuah cara untuk membangun kemampuan anak-anak untuk mengatasi masalah adalah dengan:

☐ Memaksa anak-anak untuk membicarakan kejadian sulitnya pada orangtua atau pengasuh

☐ Menolong mereka mengembangkan teman yang baik

☐ Memastikan anak-anak memfokuskan perhatian mereka ke dalam rumah

☐schedule Jadwal aktifitas yang cukup sehingga anak-anak tidak perlu ada “masa sedih”

8. Bagi orang-orang yang menyediakan psychological first aid, perawatan diri adalah:

☐ Tidak penting sampai segala sesuatunya tenang

☐ Tidak dianjurkan, karena dukungan psychological first aid seharusnya hanya diberikan oleh tenaga professional kesehatan

☐ Ketrampilan yang sangat penting

☐ Tidak penting karena pemberi psychological first aid sudah memliki ketrampilan koping yang baik

9. Dalam situasi yang sangat stres:

☐ Sangat baik untuk merawat orang dewasa dan meninggalkan anak kecil dilain waktu

☐ Sangat penting untuk memahami keunikan kebutuhan anak-anak

☐ Anak-anak pada umumnya berespon sama dengan orang dewasa

☐Anak-anak biasanya tidak memerlukan dukungan psikologis

10. Ketika mempertimbangkan apakah akan mendekati seseorang untuk menawarkan psychological first aid:

☐ Penting untuk mengobervasi dan waspada

☐ Penting melakukan pendekatan ke seseorang khususnya jika mereka sedang marah

☐ Ingat bahwa memanggil petugas keamanan atau petugas medis adalah pada saat yang tepat

☐ Kamu seharusnya tidak pernah memberitahukan seseorang bahwa kamu sedang menawarkan dukungan psikologis

11. Mempertahankan aktifitas rutin sehari-sehari pasca situasi yang sulit:

☐ Penting khususnya untuk anak-anak

☐ Sesuatu yang orang tua perlu lakukan untuk mengontrol anak-anak mereka

☐ Tidak praktis karena stress dan kekacauan adalah situasi yang sulit

☐ Memberikan stress tambahan pada anak-anak

12. Jika seseorang sedang mengancam untuk menyakiti dirinya sendiri atau orang lain:

☐ Ini adalah hal yang tebaik bagi pemberi psychological first aid untuk mengatasi situasi

☐ Memanggil pemberi psychological first aid untuk membantu kamu

☐ Berkonsultasi dengan petugas keamanan, pemerintah atau tenaga kesehatan atau kyai/pemuka agama

☐ Tidak perlu ada alasan untuk waspada, karena orang yang bisanya membicarakan hal tersebut tidak akan melakukannya

Appendix 14. Indonesia Version the General Self-Efficacy Scale (GSF)

Silahkan berikan penilaian terhadap kemampuan anda untuk aktifitas sehari hari dibawah ini:

1 Tidak benar	2 Sangat tidak benar	3 Cukup benar	4 Sangat Benar

No	Statement	Score
1	Saya selalu dapat mengatur untuk mengatasi masalah jika saya berusaha cukup keras	
2	Jika seseorang menentang saya, saya selalu dapat menemukan makna dan cara untuk mendapatkan apa yang saya inginkan	
3	Mudah bagi saya untuk tetap pada tujuan dan menyelesaikan capaian saya	
4	Saya yakin bahwa saya mampu menangani secara efisien peristiwa yang tidak terduga	
5	Terima kasih kepada akal saya, saya tahu bagaimana menangani situasi yang tidak terduga	
6	Saya dapat memecahkan sebagian besar masalah jika saya menginvestasikan upaya yang diperlukan	
7	Saya dapat tetap tenang ketika menghadapi kesulitan karena saya bisa mengandalkan kemampuan koping saya	
8	Ketika saya dikonfrontasikan dengan sebuah masalah, saya biasanya bisa menemukan beberapa solusi.	
9	Jika saya dalam masalah, saya biasanya dapat memikirkan solusinya	
10	Saya biasanya dapat menangani apapun yang merintangi saya	

Appendix 15. Indonesia Version Communities Advancing Resilience Toolkit (CART) Survey

Pernyataan-pernyataan dibawah ini adalah gambaran yang mungkin dari lingkungan anda. Silahkan beri tanda √ pada pernyataan-pernyatan dibawah ini yang mungkin sama dengan lingkungan anda. Pilihan respon:
1 Sangat tidak setuju
2 Tidak setuju
3 Tidak setuju maupun setuju
4 Setuju
5 Sangat Setuju

No	Pernyataan	1	2	3	4	5
1	Orang-orang di komunitas saya, merasa bagian dari komunitas.					
2	Orang-orang di komunitas saya, berkomitmen akan kesejahteraan dari komunitas.					
3	Orang-orang dikomunitas saya, memiliki harapan tentang masa depan.					
4	Orang-orang di komunitas saya, saling tolong menolong.					
5	Komunitas saya memperlakukan orang secara adil apa pun latar belakangnya.					
6	Komunitas saya memiliki sumber yang dibutuhkan untuk mengatasi masalah-masalah di komunitas (sumber-sumber meliputi uang, informasi, teknologi, peralatan, bahan mentah, dan pelayanan)					
7	Komunitas saya memiliki pemimpin yang efektif.					
8	Orang-orang di komunitas saya, mampu untik mendapatkan pelayanan yang mereka butuhkan.					
9	Orang-orang di komunitas saya, tahu kemana untuk menyelesaikan masalah.					
10	Orang-orang di komunitas saya, bekerja dengan organisasi-organisasi dan badan-badan diluar komunitas untuk menyelesaikan masalah.					
11	Orang-orang dikomunitas saya, berkomunikasi dengan pemimpin yang mampu meningkatkan komunitas					
12	Orang-orang di komunitas saya, sadar akan masalah-masalah dikomunitas saya yang mungkin mereka bahas bersama.					
13	Orang-orang di komunitas saya, mendiskusikan masalah-masalah sehinga mereka bisa meningkatkan komunitas.					
14	Orang-orang di komunitas saya, bekerja bersama-sama untuk meningkatkan komunitas.					

No	Pernyataan	1	2	3	4	5
15	Komunitas saya melihat pada keberhasilannya dan kegagalannya sehingga dapat belajar dari masa lalu.					
16	Komunitas saya mengembangkan ketrampilan dan meemukan sumber untuk menyelesaian masalahnya dan mencapai tujuannya					
17	Komunitas saya memiliki prioritas dan seperangkat tujuan untuk masa depan.					
18	Komunitas saya mencoba untuk mencegah bencana.					
19	Komunitas saya secara aktif mempersiapkan bencana dimasa depan.					
20	Komunitas saya dapat menyediakan pelayanan gawat darurat selama bencana.					
21	Komunitas saya memiliki pelayanan dan program untuk membantu orang-orang setelah bencana					
Nilai Total						

Appendix 16. Indonesia Version Psychological First Aid Percevied usefulness Questionnaire

Silahkan beri nilai pandangan anda tentang pelatihan PFA dari beberapa item dibawah ini:

1 Sangat Tidak Setuju	2 Tidak setuju	3 Agak tidak setuju	4 Agak Setuju	5 Setuju	6 Sangat Setuju

1. Karena pelatihan PFA, saya merasa lebih mampu untuk mengidentifikasi dan mengatasi stress saya.
2. Karena pelatihan PFA, saya merasa lebih mampu untuk mengidentifikasi dan mengatasi bagian sulit dari pekerjaan saya.
3. Karena pelatihan PFA, Saya merasa lebih mampu untuk mengidentifikasi dan mengatasi pengalaman traumatis dari orang yang saya berikan pelayanan..
4. Karena pelatihan PFA, saya merasa lebih tangguh terhadap kesulitan dalam kehidupan pribadi dan pekerjaan.
5. Karena pelatihan PFA, Saya merasa lebih mampu untuk mengidentifikasi dan menghindari *burnout*.
6. Karena pelatihan PFA, Saya merasa lebih mampu untuk mengidentifikasi sumber pendukung disekitar saya..
7. Karena pelatihan PFA, Saya merasa lebih mampu untuk mencari bantuan dari orang lain ketika dibutuhkan.
8. Karena pelatihan PFA, Saya merasa lebih mampu untuk mendukung anggota komunitas lain dan menolong mereka mengatasi stresnya.
9. Karena pelatihan PFA, Saya merasa lebih mampu untuk mengidentifikasi stress orang lain.
10. Karena pelatihan PFA, Saya merasa lebih mampu untuk mendukung orang lain dan menolong mereka mengatasi stresnya.
11. Karena pelatihan PFA, Saya merasa lebih mampu untuk memberikan perawatan di komunitas.
12. Karena pelatihan PFA, Saya merasa mampu untuk lebih memahami kebutuhan komunitas saya.
13. Karena pelatihan PFA, Saya akan lebih banyak bekerja dengan pemuka agama disekitar saya untuk memberikan perawatan bagi komunitas.

14. Karena pelatihan PFA, Saya lebih yakikn bahwa saya mampu untuk memberikan dukungan psikososial kepada komunitas terlepas dari presepsi negative apapun atau perilaku sekitar kesehatan mental.
15. Karena pelatihan PFA, Saya mampu menyediakan perawatan yang lebih baik bagi keluarga, teman-teman, teman kerja dan komunitas saya.
16. Karena pelatihan PFA, Saya sekarang mampu untuk mengidentifiskasi secara adekuat protocol kegawatdarutan kesehatan mental di komunitas Indonesia dan memberikan rujukan yang dibutuhkan.
17. Pelatihan PFA akan sangat berguna bagi orang lain di Indonesia.
18. Pelatihan PFA sebaiknya diberikan kepada orang lain di IndonesiaPFA training should be provided to others in Indonesia
19. Secara umum pelatihan PFA berguna untuk saya.

Appendix 17. Indonesia Version CBPFA Handbook for Control Group

Penulis:
ENI NURAINI AGUSTINI, MSc

Appendix 18. Indonesia Version CBPFA Handbook for Case Group