

## Psychological First Aid (PFA) To Expand Mental Health Support and Foster Resiliency in Underserved and Access-Compromised Areas

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**Abstract:** *Psychological first aid (PFA) has been universally endorsed as an important addition to the corpus of mental health-related support services. As support grows for its utilization, consideration should be made of using PFA beyond its initial formulated applications. PFA may be considered a psychological crisis intervention designed to foster human resilience. This paper argues it may prove of value in fostering resiliency in underserved and access-compromised areas. In doing so, PFA may be seen as a way to extend mental health-related services to areas and situations where there are shortages of those services either by situational interference or longstanding under development. In the final analysis, consonant with World Health Organization (2019) goals and recommendations, PFA may even be used as an intervention to foster the achievement of universal mental health coverage delivered not only in non-specialized health settings, but via non-traditional community-based mechanisms, as well.*

**Keywords:** *Psychological first aid; PFA; psychological crisis; resilience*

### Introduction

In the wake of adversity (disaster, war, disease, violence), it is a truism that there will be more psychological “casualties” than physical casualties (Institute of Medicine, 2003; Bass et al., 2005; Lating, 2005). Simply said, the mental health surge (increased need for mental health services) will often be greater than the physical health surge. Pioneer disaster psychiatrist Beverley Raphael estimated that about 25% of a population affected by disaster would suffer from psychological distress and dysfunction she referred to as the “disaster syndrome” (Raphael, 1986). Norris et al. (2002) subsequent to a review of 160 studies covering 60,000 survivors concluded that roughly 25-60% of those impacted by disaster (including mass violence) would suffer severe to very severe impairment with the adverse impact being most significant in developing nations. Compounding the public health burden is responding to the mental health surge: 1) in areas wherein access to formal mental services has been compromised or 2) in otherwise underserved areas (rural areas, developing nations, geographically isolated areas). This reality has been a daunting challenge for public health planners even under the best of circumstances in otherwise resource-rich environments such as in most of North America. There is no debate on the need to enhance mental health capacity for the underserved or post adversity (disaster). The only challenge is how to best do so.

### A New Model for Expanding Mental Health Services

Reliance upon traditional mental health services is simply not an option in the wake of community adversity or large-scale human suffering. Access to trained mental health providers is limited in the wake of adversity and disaster, even more so in geographically isolated areas or developing nations. To remedy this problem, recommendations from the Johns Hopkins Center for Public Health Preparedness have included the training of local indigenous human resources to provide “micro-counseling” and crisis-oriented psychological intervention to enhance community resilience (Everly & Lating, 2017; McCabe et al., 2014).

Civilian paraprofessionals, educators, faith-based leaders, and emergency services personnel have been successfully trained to deliver brief counseling and psychological crisis intervention services since the 1960s (Jain, 2010; Hattie et al., 1984; Brown, 1974; Noullet et al., 2018; Everly, McCabe, et al., 2014; Everly & Kennedy, 2019). In an early yet compelling review, Durlak (1979) reviewed all published studies that had compared the clinical outcomes of licensed mental health professionals (such as psychologists, psychiatrists, and social workers) with those of peer/paraprofessionals. The results of his analysis of 42 research studies revealed the effectiveness of volunteer peer/ paraprofessionals was overall comparable to trained mental health professionals and, in some studies, actually superior to the professionals. Cherie Castellano at Rutgers University received the

## PSYCHOLOGICAL FIRST AID (PFA)

2018 Silver Medal from the American Psychiatric Association in recognition of her success in implementing “peer-based” crisis intervention programs (Castellano, 2012). The interventionists who staffed her programs were community-based civilians and uniformed emergency services personnel (police, firefighters, etc.) specifically trained in the provision of psychological crisis intervention using highly structured intervention protocols. Durlak concluded, “Moreover, professional mental health education training and experience are not necessary prerequisites for an effective helping person.” (Durlak, 1979, p. 6). Consistent with Stapleton, et al. (2006) and Everly (2002), he concluded the evidence suggests effectiveness seemed associated with following well-structured intervention protocols.

### Psychological First Aid (PFA)

The Inter-Agency Standing Committee (IASC, 2007), in its guidelines for mental health response, specifically mentions a variation of psychological crisis intervention referred to as psychological first aid (PFA) as a means of addressing large-scale mental health demands:

“Most individuals experiencing acute mental distress following exposure to extremely stressful events are best supported without medication. All aid workers, and especially health workers, should be able to provide very basic psychological first aid (PFA). PFA is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support” (pp. 118-119).

According to the Institute of Medicine (2003),

“Psychological first aid is a group of skills identified to limit distress and negative health behaviors...PFA generally includes education about normal psychological responses to stressful and traumatic events; skills in active listening; understanding the importance of maintaining physical health and normal sleep, nutrition, and rest; and understanding when to seek help from professional caregivers” (IOM, 2003, p.7).

PFA enjoys virtually universal recommendation for implementation in the wake of trauma and disaster. However, there is currently limited research to support such a recommendation. In 2009 a report published by the World Health Organization (Bisson & Lewis, 2009) identified 74 published papers purporting to discuss PFA. In their search, the authors were unable to find compelling data supporting the use of PFA post disaster or trauma. The authors note:

“In summary, there is an absence of direct evidence for the effectiveness of PFA, but indirect evidence supports the delivery of services based on the principles of PFA in the first few weeks after a traumatic event. We agree that when delivered PFA should be consistent with research evidence on risk and resilience following trauma; applicable and practical in field settings; appropriate for developmental levels across the lifespan; and culturally informed and delivered in a flexible manner” (p. 15).

At the request of the Advisory Council of the American Red Cross Disaster Services, Fox et al. (2013) performed an independent comprehensive review of the effectiveness of PFA from 1990 through 2010. The goal was to assess the extant literature to determine whether PFA could be effectively provided by those without professional mental health training in the wake of disasters and potentially traumatic events. The authors identified 58 sources. After a thorough review of existing evidence, the authors concluded, “Sufficient evidence for psychological first aid is widely supported by available objective observations and expert opinion and best fits the category of “evidence informed” but without proof of effectiveness” (p. 247).

### “Listen and Refer” Models

Although evidence-informed, PFA lacks adequate evidence of efficacy. A review of the popular models of PFA (American Red Cross, International Red Cross, Mental Health First Aid™) reveals them to be largely “listen and refer” to higher levels of care intervention models. Their primary psychological mechanisms of action appear to presence, cathartic ventilation, encouragement, and screening which are largely passive. The advantage of such models is they are easy to teach. From a public health perspective, however, these models offer little to deployments wherein there is a paucity of mental health resources to which to refer. There is little value to screening, beyond acute protection, if there is no mechanism by which to continue advanced intervention. This is especially true in developing nations.

### Active Mechanism Models

The need to provide structured PFA interventions more robust in acute “clinical impact” is evident. Thorne (1952) described the need to employ more active mechanisms in the PFA paradigm. Her mechanisms of action include:

- 1) providing reassurance (regarding fears and problems);

## PSYCHOLOGICAL FIRST AID (PFA)

- 2) providing suggestions for action (to deal with psychological symptoms in need of urgent attention);
- 3) allowing catharsis (involving reflection and clarification of feelings); and
- 4) 4)using persuasion, giving advice, and other supportive methods (to deal with acute situational challenges beyond the person's resources).

A prescriptive paper in the *American Journal of Psychiatry* stated that "... after a traumatic event, it is important that those affected be provided, in an empathic manner, *practical, pragmatic psychological support*" *without significant reliance upon traditional mental health follow up* (italics added; Bisson et al., 2007, p. 1017).

Employing more robust mechanisms of action may have added benefits. Based upon longitudinal research conducted by Zahava Solomon and her colleagues, it would be reasonable to assume that a robust, albeit acute, PFA could indeed have positive effects lasting, not only acutely but, years (Solomon & Benbenishty, 1986; Solomon, Shklar, et al., 2005). The effects of psychological crisis intervention were seen to last at least 20 years when applied to military members. Somewhat similar lasting effects were observed by Boscarino et al., (2011). While this may seem surprising in response to an intervention acutely administered and originally designed to exert acute mitigating effects, closer analysis reveals that even such acute interventions may alter the long-term trajectory of adverse psychological reactions and further reduce the likelihood of the utilization of maladaptive coping mechanisms (alcohol, drug use, violence, withdrawal from social support) by altering the adverse impact of sentinel events or reshaping critical milestones.

Everly (1996) initially developed the SAFER-R model of PFA (although not labelled as PFA at the time) using mechanisms of action including explanatory guidance, anticipatory guidance, stress management, and cognitive reframing, in addition to cathartic ventilation, presence, reassurance, and encouragement. Supportive of the notion of developing and fielding a robust structured PFA intervention, Raphael (1986) argued PFA is warranted in the wake of disaster. Furthermore, as noted, Fox et al. (2013), on the basis of a Red Cross commissioned review of psychological first aid, concluded, "An intervention provided by volunteers without professional mental health training for people who have experienced a traumatic event offers an acceptable option. Further outcome research is recommended" (p. 247).

The Johns Hopkins RAPID model of PFA (Everly & Lating, 2017) emerged as a result of efforts from the Center for Public Health Preparedness in the Johns Hopkins Bloomberg School of Public Health and funded by the United States Centers for Disease Control and Prevention to develop a model of PFA whose clinical effectiveness would not be wholly dependent upon mere presence or referrals to higher levels of care and could be employed in large scale applications. Although other applications are warranted. Creation of the model began with a review of the historical and theoretical antecedents of PFA. Subsequent to the foundational reviews, structural modeling research was enlisted to identify key mechanisms of action (Smith, Everly, & Haight, 2012). Active listening, a compassionate presence, normalization, stress management, and simple cognitive-behavioral tactics were included. The componential infrastructure was refined using factor analysis and repeated structural equation modeling. It was revealed that cognitive appraisal played a critical deterministic role in adverse psychological and physical reactions in the wake of adverse situations (Smith, Everly, & Johns, 1992, 1993). This finding underscores the importance of a cognitively focused intervention (Smith, Everly, & Haight, 2012; Everly, Davey, et al., 2011). Emphasis upon such explanatory variables is what differentiates more active models of PFA from the "listen and refer" models.

The next step involved conducting content validation studies. Using more than 1,500 subjects it was found that training in the RAPID PFA model led to improvements in participant knowledge, confidence, and preparedness for applying PFA as well as personal resilience (Everly, McCabe, et al., 2014), a finding consistent with Noullet, et al., (2018) and supporting the notion that knowledge engenders resilience related self-efficacy. An interesting and unexpected aspect of PFA training (SAFER-R model) was revealed in a study by Noullet et al., (2018). The authors assessed the effects of PFA training on resilience and compassion fatigue in faith-based leaders who were themselves learning to administer PFA. The study employed a longitudinal within-subjects design for 39 clergy who completed a three-day course. The clergy who received the training evidenced significantly higher resilience scores ( $d = .95$ ) and significantly lower compassion fatigue scores ( $d = .71$ ), including burnout and secondary traumatic stress, approximately one year after the training despite repeated exposure. This is the first known long-term study to assess the benefits of providing formal training in PFA to those who endeavor to provide crisis intervention services.

## PSYCHOLOGICAL FIRST AID (PFA)

In another series of investigations, it was revealed that the training model with preparedness components not only added increased personal preparedness knowledge and attitudes but increased community preparedness and resilience planning when additional components were added (McCabe, et al., 2014).

Having demonstrated the content validity of the RAPID PFA training, a randomized clinical trial was initially conducted. RAPID PFA was associated with a decline in acute distress compared to a cathartic ventilation process alone (Everly, Lating, Sherman, et al., 2016). Effect sizes (Cohen's *d*) averaged around .4 for within subjects and between subjects, comparisons on measures of state anxiety and mood. No subsequent mental health interventions were necessary, despite their availability.

Following that investigation, the natural empirical corollary was deemed to extend the PFA model to a small group delivery process. Despeaux et al. (2019) conducted a randomized controlled trial of the small group delivery format of RAPID PFA. The PFA condition was associated with within group declines in negative affect, declines in state anxiety, and increases in positive affect interpreted by the authors as instillation of hope. The control condition consisted of the most common elements found in "listen and refer" models of psychological first aid (listening, paraphrasing, connecting to other resources) absent a cognitive-behavioral mechanism of action. The PFA group showed significant between-group improvements on anxiety and positive affect at final follow-up compared to the control. No subsequent mental health interventions were necessary, despite their availability. All interventionists received about 10 hours of standardized training.

These initial studies on the Hopkins' RAPID PFA model and its precursors would appear to provide initial support for its efficacy as a form of psychological crisis intervention. The next question would be how to best scale PFA for wide-spread use in resource-poor environments and developing areas. With the rise of telehealth has come interest in applying PFA models to mobile apps. Once again there is heavy reliance upon the "listen and refer" applications wherein the utilization of formal mental health resources for follow-up care plays an important role. This does little to reduce the burden on the public health infrastructure and is simply impossible in many high need areas of the world. As of this writing there are no known apps at work in the relief and humanitarian aid sectors in developing areas to assist survivors and indigenous peoples. The case could also be made that such an app would have value in the

development of "peer support" teams designed to aid field workers themselves.

### Conclusion

In the wake of adversity, it is a truism that there will be more psychological "casualties" than physical casualties wherein the mental health surge will often be greater than the physical health surge. Given a paucity of traditional mental health resources new models will need to be employed to best meet this challenge. Psychological first aid (PFA) has been universally endorsed as an important addition to the corpus of mental health-related support services. PFA may be considered a psychological crisis intervention designed to foster human resilience. This paper argues PFA may prove of value in fostering resiliency in underserved and access-compromised areas.

In the final analysis, consonant with World Health Organization (2019) goals and recommendations, PFA may even be used as an intervention to foster the achievement of universal mental health coverage delivered not only in non-specialized health settings, but via non-traditional community-based mechanisms, as well.

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## PSYCHOLOGICAL FIRST AID (PFA)

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## PSYCHOLOGICAL FIRST AID (PFA)

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