PSYCHOLOGICAL FIRST AID (PFA)

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The Inter-Agency Standing Committee (IASC), in its guidelines for mental health response, specifically mentions PFA and enumerates it as follows:

"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.

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. 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 model of PFA (RAPID-PFA) emerged as a result of efforts from the Center for Public Health Preparedness in the Johns Hopkins Bloomberg School of Public Health funded by the United States Centers for Disease Control and Prevention. 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). The componential infrastructure was refined using repeated structured equation modeling. Consensus guidelines were then

employed to guide curriculum and mechanism development (McCabe, Everly, Brown, et al. 2014). The next step involved conducting content validation studies using more than 1,500 subjects wherein 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 (a finding consistent with Noullet, et al., 2018; and, supporting the notion that knowledge engenders resilience related self-efficacy (Everly, McCabe, Semon, Thompson, & Links, 2014). 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 (McCabe, Semon, Thompson, et al., 2014).

Having demonstrated the content validity of the RAPID PFA training, a relatively small 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, & Goncher, 2016). Effect sizes (Cohen's d) averaged around .4 for within subjects and between subjects comparisons on measures of state anxiety and mood.

Following that investigation, the natural empirical corollary was deemed to extend the PFA model to a small group delivery process. Despeaux, Lating, Everly, Sherman, & Kirkhart (2019) conducted a randomized controlled trial of the small group delivery format of RAPID PFA in response to a highly stressful video. At 30-40 minute follow-up, 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 (PFA intervention group, n=59) compared to the immediate post video assessment. The control condition (n=60) consisted of the most common elements found in other models of psychological first aid (listening, paraphrasing, connecting to other resources). The control condition also experienced within group declines in negative affect and anxiety after the control intervention, but no meaningful improvement in positive affect using effect size analysis. At immediate post intervention and 30-40 minute follow-ups, the control condition failed to return to baseline whereas the PFA reached levels below baseline at 30-40 minute follow-up on the measure of state anxiety. The PFA group showed significant between group improvements on anxiety and positive affect at final follow-up compared to the control. All interventionists received standardized training.

These initial studies on the Hopkins' RAPID PFA model would appear to provide initial support for its efficacy as a form of psychological crisis intervention.

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The author reports he has received speaker fees and book royalties related to Psychological First Aid and disaster response.