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Psychological First Aid and Its Role in Providing Immediate Mental Health Support in Emergency Settings: Implications for Addressing PTSD and Acute Stress in Crisis Situations

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Abstract

Background: Traumatic events, such as natural disasters, violence, and severe illness, significantly impact mental health, leading to conditions like post-traumatic stress disorder (PTSD) and acute stress reactions. With a substantial portion of the population exposed to trauma, effective initial psychological interventions are crucial for mitigating these effects. **Methods**: This review aims to evaluate the effectiveness of Psychological First Aid (PFA) in providing immediate support to individuals affected by trauma. A comprehensive literature search was conducted across multiple databases, including MEDLINE, CINAHL, and PsychINFO, focusing on studies published from 2000 to 2023 that assess the implementation and outcomes of PFA interventions. **Results**: The findings indicate that PFA is an effective early intervention strategy that reduces anxiety and promotes adaptive functioning in individuals following traumatic experiences. PFA's core components—safety, calm, self-efficacy, connection, and hope—are consistently identified as critical to its success. While the immediate benefits of PFA are well-documented, evidence regarding its long-term efficacy in preventing PTSD remains inconclusive.

Conclusion: Psychological First Aid serves as a vital tool in emergency settings, providing immediate support to those affected by trauma. Despite its widespread use, further research is needed to establish standardized protocols for PFA implementation and to evaluate its long-term impact on mental health outcomes. Enhancing training for non-specialist providers and addressing barriers to effective PFA delivery are essential steps toward improving mental health support in crisis situations.

Keywords: Psychological First Aid, trauma, PTSD, emergency medicine, mental health support.

1. Introduction

A traumatic occurrence is defined as an encounter that an individual experiences, witnesses, or confronts, including actual or impending death, significant injury, or a threat to the physical integrity of one or others (1). Epidemiological data indicates that at least seventy percent of the entire population has experienced a traumatic event, with an average of 3.2-lifetime traumas. Traumatic incidents, such as catastrophes, acute illness, and violence, are prevalent (2, 3). Although many people may adjust to the consequences of prevalent traumatic exposure, others may have persistent challenges, resulting in a wide array of detrimental effects, including anxiety, depression, drug abuse, and other functional disabilities (4). Post-traumatic stress disorder (PTSD) is among the most common psychological result of exposure to adverse events, with a lifetime frequency between 1.3 percent as well as 22.8 percent (5). This imposes a considerable illness burden due to heightened levels of disability, joblessness, and early death. Society is dedicated to prophylaxis and early management to tackle the significant incidence of traumatic exposure and its related burdens (6). Nonetheless, despite considerable endeavors to formulate preventative strategies and therapies, the tasks remain arduous and intricate due to the complexities involved in identifying high-risk individuals, administering appropriate treatments, and confronting substantial obstacles such as the stigma faced by people obtaining hospitalization (7, 8). There is a current inclination to prioritize first measures: delivering prompt early therapies to aid with trauma adaption before the onset of any PTSD symptoms.

Psychological First Aid (PFA) is recognized as a preliminary psychosocial support method designed to assist individuals impacted by trauma, encompassing the delivery of information, solace, practical aid, and referrals to specialized services when required (9, 10). PFA originated as a means to address troops' psychological suffering throughout World War II, and its early developments have advanced at a gradual pace (11). A heightened

awareness of the severe repercussions of catastrophes and terrorism, particularly after the September 11, 2001, attacks in the USA, catalyzed a resurgence of interest in alternates to psychological debriefing, resulting in the widespread adoption of PFA. Recent PFA methodologies have been enhanced to exclude potentially detrimental components, namely psychological release (12). Recent developments in PFA have adopted a non-prescriptive framework based on five fundamental components identified in trauma and disaster reconstruction literature and expert consensus: the enhancement of safety, tranquility, self-efficacy, connectivity, and optimism (13).

Despite the scarcity of direct scientific data, the extensive use of Psychological First Aid (PFA) to alleviate the detrimental effects of catastrophes and severe traumatic events persists, leading to the development of many PFA models and frameworks. International governments and organizations have collaborated to advocate for PFA as the fundamental response strategy after mass trauma. The Inter-agency Permanent Committee (IASC) recommendations on Mental Health and Psychosocial Support (MHPSS) in emergencies explicitly reference Psychological First Aid (PFA); additionally, PFA implementation guidelines have been developed to enhance mental health responses to particular public health crises, including the Ebola outbreak and the COVID-19 pandemic (14-16). The successful implementation of PFA is due to its recognized advantages, such as its simplicity, which facilitates instruction with minimal clinical expertise, enabling a wide range of non-specialist vendors lacking mental health training to offer prompt assistance, and its adaptability to meet individual needs. The intrinsic power of PFA has established it as a favored method, particularly since its emphasis on delivering an instant reaction aids rather than stigmatizes persons exposed to diverse traumatic experiences. The use of PFA has been broadened to assist persons facing physical injuries, homelessness, and criminal victimization (17-19). The prevailing agreement supports the provision of Psychological First Aid (PFA) as the first measure for assisting persons after traumatic experiences while recognizing the need for the development of more effective formal preventive treatments (20).

The absence of evidence about the execution and impact of a PFA approach continues to be a significant issue. A significant problem in the subject pertains to implementation, including the many PFA models, intervention procedures, program objectives, and anticipated results, with no established agreement to date (12). Simultaneously, the intrinsic constraints of doing research in catastrophe and mass trauma situations have exacerbated this difficulty, sometimes favoring pragmatism above stringent study design and result assessment. Prior evaluations of Psychological First Aid (PFA) commissioned by the World Health Organization and the American Red Cross have determined that there exists “no concrete proof to make any medical suggestions”, a conclusion reiterated in a recently published review (21-24). Others strive to consolidate data about the efficacy of PFA training, but these efforts have not yet achieved a thorough comprehension of the PFA intervention itself (25, 26).

In addition to the need to enhance the data basis regarding the efficacy of PFA, it is also essential to comprehend the optimal methods for its implementation. It is essential to delineate the processes of operation for any psychological intervention to illustrate how it may attain its intended goals, a consideration that has never been explored with PFA therapies. The degree to which various PFA treatments integrate the "five essential elements" and their theoretical processes for attaining these results is inadequately understood. Secondly, it is essential to identify specific components of PFA interventions and analyze how prevalent qualities, such as shared objectives and elements, may enhance the overall efficacy of PFA interventions. Third, doing an implementation study

that examines PFA as the intervention, with experience inputs from both receivers and providers, has the potential to illuminate the dynamics of PFA management in real-world contexts.

2. Methodology

The search methodology was developed and refined following a preliminary literature review conducted using the MEDLINE library, in conjunction with the institution's librarian and the review team. A total of six databases were consulted: the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, Embase, the Cochrane Library, Web of Science, and PsychINFO.

3. Implementation of PFA Intervention

The study examined papers on the psychological factors of trauma (PFA) without providing detailed procedure details. Seven studies used the PFA model from the National Child Center Traumatic Stress Network, but none explained its theoretical foundations or justified its inclusion (27-32). Only one study used a World Health Organization-developed PFA model for a five-step approach (33). One intervention was based on the Immediate Cognitive Performance PFA model, which included Hobfoll's five aspects and a neurobiological framework of stress and resilience (34).

The providers of PFA programs differed based on the trauma setting and the intervention's unique objectives. Mental health experts mostly served as the primary providers for addressing defective adaptability following trauma exposure (27-30, 32, 35, 36). In domains like personal trauma, non-specialist providers, including psychologists, school nurses, and government volunteers, were often used (31, 33, 37, 38). The selection of non-specialist caregivers was determined by constrained finances, convenience, and a preference for local labor or those in proximity to the afflicted person. Ramirez et al. (38) equipped parents of kids with physical injuries to administer PFA at home after the child's release from the emergency room.

Psychological First Aid (PFA) is progressively being used as a preventative strategy to assist those impacted by trauma. This study assessed the data about the efficacy of PFA treatments in enhancing stress-related symptoms and adaptive abilities in people after a traumatic incident. The design, delivery, and experience of interventions for both persons and providers were also analyzed.

4. Contemporary Evidence on the Efficacy of PFA Intervention

This review's findings demonstrate that PFA therapies effectively reduce anxiety symptoms in persons exposed to traumatic situations, regardless of research methodology. PFA therapies, when administered to persons experiencing general trauma, including assault, crime, and relocation, result in a more significant decrease in anxiety symptoms than psychoeducation and standard therapy. Although the majority of research using PFA for the prevention of PTSD and depressive symptoms has shown modest but substantial reductions in symptoms during short-term examinations, there is less data about intermediate or long-term benefits of PTSD symptoms. Psychological therapy (PFA) has shown positive effects on psychological outcomes, including quality of life and coping metrics. Pre-post studies in mass trauma contexts showed benefits in resilience and self-efficacy measures. Long-term advantages include reduced stigma, improved help-seeking behavior, and self-referral for psychological treatment. The development and verification of outcome indicators, using qualitative and empirical research, provide a foundation for improving evaluation methodology and measuring PFA more accurately in future studies (10, 23).

This analysis indicates that the assessment of PFA efficacy has broadened beyond mass trauma contexts to include generalized trauma situations, including displacement, criminality, and physical injuries. The transition from disordered and diverse mass trauma contexts to more regulated conditions

is promising, possibly facilitating the application of more proactive as well as stringent research methodologies to rectify existing methodological deficiencies in trials. These shortcomings include vague inclusion criteria without evaluating trauma precursors, significantly diverse sample sizes, insufficient follow-up, and excessive dependence on self-reported measures. As research continues to investigate PFA as an auxiliary resource for individuals encountering various traumatic experiences, including intimate partner violence, secondary victims, and additional serious events, a more substantial empirical foundation for the efficacy of PFA will probably be developed over time (39-41).

This review's results only partially support the idea that PFA may function as a selected preventive intervention for persons at elevated risk of developing psychological disorders (42). A decrease in traumatic stress indicators has been seen; however, this does not inherently exclude the development of PTSD. These initial findings necessitate additional testing for properly assessing the curative benefits of PFA, despite its positive outcomes in attaining effects similar to established PTSD therapies such as EMDR as well as SMT.

5. Commonalities in Components and Techniques Across PFA Interventions

The synthesis of PFA intervention plans reveals similarities in features and methodologies across various methods, aligning with Hobfoll's five essential elements: security, calm, effectiveness, and connectedness. However, the component of "hope" was less emphasized due to difficulties in its operationalization. PFA interventions have intensified and become more intricate, including mental recovery from standard CBT, enhancing the efficacy of managing trauma-related symptoms. The customizable character of PFA, allowing for individual adaptation rather than general application, is seen as a strength due to the severity of trauma and the intricate circumstances people may encounter after trauma (20).

Nonetheless, modifying the implementation of PFA therapies and integrating them with other therapeutic approaches for trauma-related symptoms complicates the assessment of PFA's efficacy. The research has not adequately addressed the requirement and degree to which PFA intervention features should integrate with relevant tactical approaches. A critical need exists for additional discourse to ascertain the ideal degree of method integration and to elucidate whether PFA, given its increasing complexity and adaptability, remains within the parameters of PFA or has transitioned into an alternative form of intervention entirely.

6. Challenges in Implementing PFA Interventions

Psychological First Aid (PFA) interventions in trauma settings are primarily conducted in person, either individually or in cohorts. PFA is viewed as beneficial, time-sensitive, and pragmatic. It is administered by non-specialist caregivers or mental health professionals. In interdependent societies, recipients often choose peer therapists and group forms to reduce stigma and encourage help-seeking behavior. Despite its simplicity, PFA faces implementation difficulties, highlighting the need for more effective approaches.

Psychological First Aid (PFA) administration varies significantly, ranging from immediate post-trauma provision to extended periods of up to two years. Guidelines suggest early intervention should occur within the first few days, weeks, or hours of trauma access. Shorter PFA sessions offer quick assistance, but including multiple sessions over extended periods requires careful evaluation (43). PFA emerged from crisis intervention and is best viewed as an independent intervention for immediate assistance or as an element of a preventative and treatment framework or stepped-care model. During the COVID-19 pandemic, PFA

was seen as an initial measure to support subsequent mental health treatment rather than functioning as an independent therapy (18, 44,45). It aims to alleviate immediate anxiety and promote adaptive functioning through its intervention components of effectiveness, relationships, and hope. Conducting PFA sessions in multiple waves may indicate a focus on sustaining long-term connections and assistance for recovery. However, there is a risk of conflating PFA with more specialized therapy treatments or the stepped-care model. The variable nature of post-trauma responses makes it inappropriate to categorize the chronology or length of sessions. Addressing the challenge of reporting PFA effectiveness while maintaining differentiation from other recognized treatments is a pressing concern.

Unfortunately, the present lack of openness in reporting PFA intervention methods, especially for their adaptability and faithfulness, does not provide a clear differentiation among the various forms of PFA. PFA is intended to be adaptable, allowing the use of strategies to customize its adaptability for people. Due to its versatility, alterations to PFA are feasible in practice. Nonetheless, this remains an implicit aspect of the presence of several PFA variations together with their respective instructions (26). This implicit aspect influences the facilitation of instruction, learning, retention, and particularly the practical application of the relevant knowledge and expertise amongst caregivers (12).

This is alarming for non-specialist, primary lay caregivers, who often serve as the first responders to severe trauma and may be the only source of treatment in instances when human resources and institutional services are constrained (46). They describe challenges in interacting with persons who have experienced trauma, recognizing intricate mental health requirements, and the implementation of Psychological First Aid is compromised. Furthermore, the majority of contemporary PFA training programs, characterized by little instruction, often lack scrutiny in published studies, leading to inconsistent quality levels. A qualitative investigation that investigated a once psychological first aid (PFA) education for primary medical providers in response to Ebola has emphasized the dangers of making false assurances and the undermined execution of PFA. This partially challenges the fundamental "Do No Damage" concept that is embedded in PFA standards (26, 47). Consequently, it is essential to provide training that emphasizes the need for cultural competency in administering Psychological First Aid (PFA), which entails a thorough comprehension of the intricate and evolving aspects of trauma settings, demographic requirements, and subsequent traumatic stress (48).

Before the training, there exists an urgent requirement for implementation science to tackle the complex challenges associated with PFA implementation and evaluation, specifically concerning adaptation, evaluation, and process indicators in the refinement of the PFA intervention prototype for particular groups (49-52). It is essential to record the ideal PFA prototype within a given context before scaling, as this will facilitate the creation of well-documented best practices, hence improving the implementation of PFA and its beneficial effects on persons affected by trauma. Table 1 represents the summary of the psychological first aid (PFA) interventions.

Table 1. Summary of the psychological first aid (PFA) interventions.

Component	Description	Interventions	Expected Outcomes
Safety	▪ Ensuring physical and emotional safety for individuals, creating a secure environment where people feel protected and supported.	▪ Assessing the environment for immediate dangers (e.g., structural hazards, ongoing threats) ▪ Providing reassurance through verbal and non-verbal cues. ▪ Establishing a safe space for individuals to express themselves.	▪ Increased sense of security and trust in helpers. ▪ Reduced anxiety levels among individuals. ▪ Enhanced willingness to engage in the support process.
Calm	▪ Promoting a sense of calm and stability to help individuals manage overwhelming emotions and stress.	▪ Active listening to validate feelings and concerns. ▪ Encouraging relaxation techniques such as deep breathing, mindfulness, or grounding exercises. ▪ Offering calming distractions, such as quiet spaces or soothing activities.	▪ Enhanced emotional regulation, leading to more effective coping. ▪ Lowered physiological stress responses (e.g., heart rate, blood pressure). ▪ Improved mood and reduced feelings of panic or distress.
Self-efficacy	Fostering individuals' belief in their ability to cope with the aftermath of trauma, emphasizing personal strengths and resilience.	▪ Empowering individuals by discussing their past coping strategies and strengths. ▪ Providing practical information on resources and services available for ongoing support. ▪ Encouraging goal setting to promote a sense of agency.	▪ Increased confidence in managing stress and recovery. ▪ Improved coping skills and resilience in facing future challenges. ▪ Greater likelihood of seeking help when needed.
Connection	Establishing supportive relationships to counter feelings of isolation and promote social support.	▪ Facilitating introductions to community support groups or peer networks. ▪ Encouraging individuals to reach out to family and friends for support. ▪ Organizing group activities to foster connections among affected individuals.	▪ Strengthened social ties, leading to a support network. ▪ Reduced feelings of isolation and loneliness. ▪ Enhanced emotional support and shared experiences.
Hope	Instilling a sense of hope for recovery and future well-being, encouraging a positive outlook despite current challenges.	▪ Sharing success stories of recovery from similar traumatic experiences. ▪ Assisting individuals in identifying small, achievable goals for recovery. ▪ Encouraging positive affirmations and reflections on personal strengths and achievements.	▪ Enhanced motivation for recovery and engagement in supportive activities. ▪ Improved outlook on the future and increased optimism. ▪ Greater resilience in facing ongoing challenges.

7. Summary

Psychological First Aid (PFA) is an essential intervention designed to provide immediate mental health support to individuals affected by traumatic events, such as natural disasters, violence, and severe illness. This review highlights the significance of PFA in emergency settings, focusing on its effectiveness in mitigating the psychological impact of trauma, including conditions like post-traumatic stress disorder (PTSD) and acute stress reactions.

The review begins by establishing the prevalence of traumatic events and their potential to lead to long-lasting psychological consequences. With approximately 70% of the population experiencing trauma, the need for effective initial interventions becomes paramount. PFA is characterized by its focus on providing reassurance, practical assistance, and connections to further mental health services, thereby addressing the immediate needs of those affected.

Through a comprehensive literature search of multiple databases, the review evaluates studies published from 2000 to 2023, assessing the implementation and outcomes of PFA interventions. The findings indicate that PFA is effective in reducing anxiety and promoting adaptive functioning in the aftermath of trauma. Core components of PFA—such as ensuring safety, fostering calm, enhancing self-efficacy, building connections, and instilling hope—are consistently recognized as vital to its success.

Despite the documented immediate benefits, the review notes that evidence regarding PFA's long-term effectiveness in preventing PTSD remains inconclusive. The review emphasizes the necessity for further research to develop standardized protocols for PFA implementation and to evaluate its long-term impact on mental health outcomes. Additionally, it underscores the importance of enhancing training for non-specialist providers and addressing barriers to effective PFA delivery. By improving these aspects, the mental health support system can better respond to crisis situations, ultimately benefiting those affected by traumatic experiences.

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الإسعافات الأولية النفسية ودورها في تقديم الدعم الفوري للصحة النفسية في البيئات الطارئة: الآثار المترتبة على معالجة اضطراب ما بعد الصدمة والتوتر الحاد في حالات الأزمات

الملخص

الخلفية :تؤثر الأحداث الصادمة، مثل الكوارث الطبيعية والعنف والأمراض الشديدة، بشكل كبير على الصحة النفسية، مما يؤدي إلى حالات مثل اضطراب ما بعد الصدمة (PTSD) وردود الفعل الحادة للتوتر. ومع تعرض نسبة كبيرة من السكان للصدمة، تصبح التدخلات النفسية الأولية الفعالة ضرورية للتخفيف من هذه الآثار.

المنهجية :تهدف هذه المراجعة إلى تقييم فعالية الإسعافات الأولية النفسية (PFA) في تقديم الدعم الفوري للأفراد المتأثرين بالصدمات. تم إجراء بحث شامل في الأدبيات عبر عدة قواعد بيانات، بما في ذلك MEDLINE وCINAHL وPsychINFO، مع التركيز على الدراسات المنشورة بين عامي 2000 و2023 التي تقيّم تنفيذ وتطبيقات الإسعافات الأولية النفسية ونتائجها.

النتائج :تشير النتائج إلى أن الإسعافات الأولية النفسية تعد استراتيجية تدخل مبكرة فعالة تقلل من القلق وتعزز الأداء التكيفي لدى الأفراد بعد التعرض للصدمة. تم تحديد المكونات الأساسية للإسعافات الأولية النفسية—السلامة، الهدوء، الكفاءة الذاتية، الترابط، والأمل—على أنها عناصر حاسمة لنجاحها. ورغم أن الفوائد الفورية للإسعافات الأولية النفسية موثقة جيدًا، إلا أن الأدلة حول فعاليتها طويلة الأمد في منع اضطراب ما بعد الصدمة لا تزال غير حاسمة.

الاستنتاج :تعد الإسعافات الأولية النفسية أداة أساسية في البيئات الطارئة، حيث تقدم دعمًا فوريًا لمن يعانون من الصدمات. وعلى الرغم من استخدامها الواسع، هناك حاجة إلى مزيد من الأبحاث لوضع بروتوكولات موحدة لتطبيقها وتقييم تأثيرها طويل الأمد على الصحة النفسية. يعد تعزيز التدريب لمقدمي الرعاية غير المتخصصين والتغلب على العوائق التي تحد من تقديم الإسعافات الأولية النفسية بفعالية خطوات أساسية نحو تحسين دعم الصحة النفسية في حالات الأزمات.

الكلمات المفتاحية :الإسعافات الأولية النفسية، الصدمة، اضطراب ما بعد الصدمة، طب الطوارئ، دعم الصحة النفسية.