



Psychological First Aid: Objectives, Practicing, Vulnerable Groups and Ethical Rules to Follow

Psikolojik İlk Yardım: Amaçları, Uygulanışı, Hassas Gruplar ve Uyulması Gereken Etik Kurallar

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Abstract

Psychological first aid is an early psychosocial intervention approach which is applied during or after traumatic life events as disasters, accidents, terrorist attacks causing negative effects on individual and/or society. It focuses on determining basic physical and mental needs of individuals in major events. The main objectives of psychological first aid are giving psychoeducation about acute stress symptoms, supporting normalization of the process and stabilization, easing going back to normal life before the event, and protecting individuals from long term consequences of the traumatic event. In this review, the main objectives of psychological first aid, application process and research outcomes in different cultures are presented.

Keywords: Psychological first aid, traumatic event, psychoeducation.

Öz

Psikolojik ilk yardım, afet, kaza, terör saldırısı veya bireysel/toplumsal düzeyde olumsuz etkilere neden olan herhangi bir olay sırasında ya da sonrasında gerçekleştirilen bir çeşit erken dönem psikososyal müdahale yaklaşımıdır. Özellikle çok sayıda kişinin etkilendiği olaylarda, bireylerin temel fiziksel ya da psikolojik ihtiyaçlarının tespit edilmesini ve karşılanmasını odağa alır. Psikolojik ilk yardım çalışmalarındaki ana amaçlar, bireylere olay sonrası akut travmatik stres tepkileri konusunda rehberlik etmek, olağanlaştırma ve stabilizasyona destek olmak, bireysel ve toplumsal düzlemde olağan yaşam akışına dönmeyi kolaylaştırmak ve bireyleri travmatik olayın uzun dönemli olası etkilerinden korumaktır. Yapılan bu derleme çalışmasında, psikolojik ilk yardımın amaçları, uygulanışı ve farklı kültürlerde yapılan uygulamalardaki araştırma sonuçlarından örnekler derlenerek sunulmuştur.

Anahtar sözcükler: Psikolojik ilk yardım, travmatik olay, psikoeğitim.

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THE TERM “psychological first aid” was firstly mentioned in the guide prepared by Drayer et al. on behalf of the American Psychiatric Association (Drayer et al. 1954). Focusing on essential interventions for the management of societal crises and disasters, the guide was applied with both children and adults in the wake of various societal events within the forthcoming years and psychological first aid became a concept more commonly employed in studies concerning early psychosocial interventions in the literature.

Disasters and adversities cause environmental damage in their surroundings and physical and/or psychological damage in the affected population and lead to difficulties in the management of their consequences or needs arising therefrom with existing resources (Civaner et al. 2011, Aker 2012). Such organizations as the World Health Organization, the USA National Child Traumatic Stress Network, and the USA National Center for PTSD emphasise the importance of early psychosocial intervention in the aftermath of adversities and propose psychological first aid as an approach (Brymer 2006, World Health Organization 2011). There are myriad first aid guides prepared by various organizations to be employed in the wake of disasters and various adversities. Even though the fundamental steps remain the same, a variety of situations and environments give way to the observation of slight differences with the examples of disaster scenes, hospitals, and oncological studies.

Psychological first aid refers to a type of approach to early psychosocial intervention that is practiced during or after any disaster, accident or terrorist attack or any event that creates negative effects at the individual/societal level (Brymer et al. 2006). Aiming at providing for essential physical or psychological needs of persons during or after any event and minimising, to the extent possible, the effects of such an event on individuals and potential post-traumatic stress symptoms, and supporting short- and long-term adaptive functionality and coping, psychological first aid practices can also be considered as preventive mental health interventions (Brymer et al. 2006).

Psychological first aid is one method employed for interventions in psychological crises rather than a method for diagnosis or treatment (Brymer et al. 2006, Ruzek et al. 2007, Istanbul Provincial Directorate of Disaster and Emergency Management 2009, Everly Jr and Lating 2017). The World Health Organization Manual (World Health Organization 2011) defines psychological first aid as “a humane, supportive response to a fellow human being who is suffering and who may need support”. Accommodating 5 main features including safety, basis in individual and community benefits, relief, support to contact and engagement, and comfort, psychological first aid practices represent evidence-based interventions that allow the scene of any disaster or adversity to be supported in regaining its functionality in social and behavioural terms (Hobfoll et al. 2007, qtd. Gispén and Wu 2018).

Traumatic life events may occur in various ways and psychological reactions exhibited after such events may affect individuals at different levels (Aker 2012). This situation makes it almost mandatory for community-based interventions to ensure flexibility and adaptability specifically in the wake of traumatic events at a level sufficient to affect masses. Psychological first aid is distinguished from other approaches in that it is able both to offer effectiveness on masses and to observe individual needs as a practical method for early psychosocial intervention. The literature features studies indicating

that psychological first aid practices reduce the risk and improve resilience in the aftermath of traumatic events (Aker 2012, Kılıç and Şimşek 2018).

In addition, such practices are commonly employed by reason of their applicability and practicality under the conditions characterizing disaster scenes, provision for adapted implementation in all developmental stages throughout life, and allowance for a flexible attitude towards culturally induced differences in practice (Brymer et al. 2006). Implemented in eight fundamental steps, psychological first aid offers a wide range of application for trauma and disaster workers as it lends itself to practical use in efforts among children and adolescents, as well as adults. For practices targeting children and adolescents, the same steps are recommended to be followed upon their adaptation to the developmental stages and characteristics of the respective population of children or adolescents (Brymer et al. 2006, Ruzek et al. 2007).

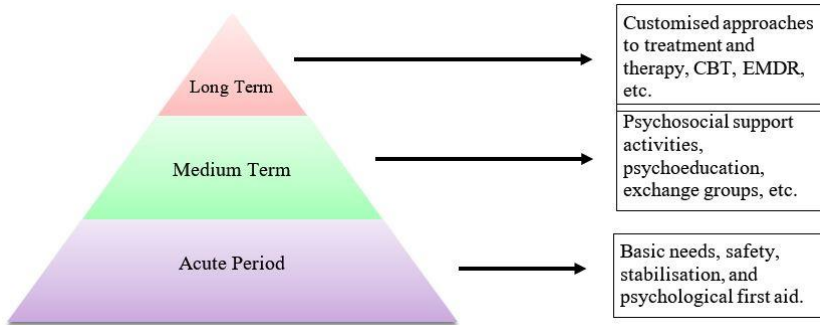


Figure 1. Position of psychological first aid in psychosocial services (Housley and Beutley 2007)

Psychological first aid is positioned as the earliest stage in the psychosocial services provided after disasters or societal adversities. Steps to satisfy the basic needs of affected individuals such as safety and healthcare and to provide them with psychological first aid represent interventions recommended in the acute period. These steps are followed by more comprehensive psychosocial work and, in the long run, such practices as specialised support and psychotherapy (Housley and Beutley 2007). Allen et al. (2010) indicate that the knowledge and practice of psychological first aid allow trauma field workers to feel more confident in their field work with children and adults after disasters.

In addition to trauma work, Gispén and Wu (2018) argue for the importance for all healthcare personnel to know psychological first aid practices. In this approach that offers individuals with the ability to learn and implement the practices in a short period of time, the implementation of psychological first aid methods is argued to have the potential to be effective in reducing the risk for and incidence of secondary traumatisa-tion and preclude more severe traumatic stress symptoms that may arise at later stages. Kılıç and Şimşek (2018) report that a command of psychological first aid practices occupies an important place not only in the provision of patient care, but also in the provision of self-care through the development of skills to cope with stress specifically for nurses by reason of their working conditions being characterised by intensive stress within the hospital environment. At the same time, according to Hart, Cox, and Lucy (2018), teaching psychological first aid practices in schools is considered to raise aware-

ness among the youth on psychological disorders, reduce instances of stigmatisation, support the youth to gain skills for a lifetime, and facilitate the management of any psychological crises. In addition to the use of psychological first aid practices in different fields, practices in different cultures have also become more prominent in recent years. As an example, Wong et al. (2015) showed in their “Mental Health First Aid” practices in China that psychological first aid practices improved the level of knowledge of individuals within the society concerning psychological disorders, reduced instances of stigmatisation, and supported help-seeking behaviours.

On the other hand, the present review considers the concept of psychological first aid from a wider perspective and addresses the aim and methodology in psychological first aid practices, points of consideration in practice (vulnerable groups and ethical matters), and its practical results in different environments and cultures. The review also discusses the types of studies required in this field in the forthcoming process.

Psychological First Aid Practice

The main goals in psychological first aid practices implemented after disasters and adversities can be summarised as; identifying basic physical or psychological needs immediately after a given event and assisting in meeting such needs; offering guidance for psychiatric emergencies as necessary through psychological triage on site; guiding individuals on acute post-event traumatic stress reactions; supporting restoration and stabilisation; facilitating the restoration of the normal flow of life at individual and societal levels; and protecting individuals against the possible long-term effects of a given traumatic event (World Health Organization 2011, Everly Jr and Lating 2017). In addition, psychological first aid aims to support the mobilisation of healthy coping mechanisms and resilience already available to individuals also in the wake of disasters. The identification of needs and provision of relevant guidance are also among the aims pursued in psychological first aid with a view to allowing individuals to receive support in the longer term in certain cases (Everly Jr and Lating 2017).

The basic principles concerning how, in which environments, and by whom psychological first aid practices can be implemented are prescribed in guides published by various national and international organisations. According to such guides, this intervention method operating on the basis of the fundamental principles of “look, listen, link, and guide” has not been structured as a method to be employed merely by mental health professionals as it does not represent a means of psychological guidance or psychotherapy or include any treatment-related elements (World Health Organization 2011). The psychological first aid implementing guides published by national and international organisations emphasise that everyone that has received such training may implement psychological first aid practices (Brymer et al. 2006, World Health Organization 2011, Arslan Tomas and Şavur 2018, Gispen and Wu 2018). Psychological first aid practices can also be implemented through the training of individuals known to and trusted by the local community such as village heads, imams, nurses, or teachers who live in the affected locality and are willing to support the field work by the trained psychosocial work team responding to the scene of a disaster or crisis affecting large masses and the implementation of psychological first aid practices by such individuals upon training (Australian Psychological Society 2013, Arslan Tomas and Şavur 2018).

As an early intervention, psychological first aid may also be applied during or immediately after a given event. The completion of the relevant intervention takes only a few minutes in certain cases, while others there may be a need for days or weeks of interventions. Such variability stems from the wide scope of psychological first aid practices, because every type of psychosocial support interventions compatible with the principles of psychological first aid and implemented for affected individuals in the scene of a disaster or crisis may be included in this scope (World Health Organization 2011).

Psychological first aid is mostly practiced at the scene of the event or disaster or in the affected locality. In addition, practices may also be undertaken in various other areas depending on emerging needs including treatment centres, schools, hospitals, households, businesses, airports, and community centres (Australian Psychological Society 2013). The most important point of consideration with respect to the area of practice is the selection of an area that is safe for relevant individuals regardless of the location. An environment should be secured in the disaster area to secure privacy and safety and to allow individuals to feel comfortable.

As one of the guides employed in this field John Hopkins PFA RAPID Model (Everly Jr and Lating 2017) refers to 5 basic stages to be followed with a view to achieving the aforementioned goals in psychological first aid. These include the following: R-Rapport and reflective listening; A-Assessment; P-Prioritisation; I-Intervention; and D-Disposition.

A wider perspective on the matter on the basis of the models employed in different guides leads us to examine the steps taken in a Psychological First Aid intervention in three stages. These steps refer to practical preparation, psychological triage for prioritisation on the basis of needs and demands, and implementation of the 8-step psychological first aid model.

a. Preparation

The first step in psychological first aid consists of certain preparatory stages to be completed by individuals to be commissioned in the field before their arrival. This is an important preliminary step with a view to ensuring that the person delivering psychological first aid protects themselves in psychological terms and improving the quality of psychological first aid services delivered. The preparation stage can be examined under two headings, i.e. individual level and event-specific level (Demircioğlu 2017).

Individual Preparation

Self-evaluation by the persons to be employed in psychological first aid processes in various areas before their arrival in the field will assist in the start of a process for mental preparation. As is the case with everyone, preparedness represents a factor that protects persons delivering psychological first aid against the effects of traumatic stress and facilitates the steps to overcome possible difficulties that may arise during the actual field work. It is important for a person to be deployed in this field to ask questions similar to those provided below and to conduct self-evaluation within the scope of pre-duty individual preparation:

- i. Have I worked with a similar event before?
- ii. Is there any aspect to the event itself or to working with certain groups affected by the event that may lead to difficulties for me?
- iii. Is my current state of health suitable for working with this event?

- iv. Are the working conditions inherent to the mission compatible with my current living conditions? (Travel restrictions, long duration of stay in the field, presence of dependants in the family, etc.)
- v. Do I know and practice the points of consideration on psychological self-care to be observed while working with such events? (Demircioğlu 2017)

Event-Specific Preparation

Every disaster, crisis or adversity features specific characteristics, which may have an impact on all processes including the planning, implementation, and conclusion of post-event work. Even though the basic principles applying to the approach to adversities or psychological first aid are fixed, event-specific characteristics cause multiple variations in respective practices. For a practitioner of psychological first aid, a self-assessment before commencing the field work will be beneficial with the following event-specific preparatory questions:

- i. Do I have enough information on the event? What happened? When did it happen? How many people were affected? Are there any other aspects to the event that should be known?
- ii. What are the sociocultural characteristics of persons or groups affected by the event?
- iii. Which body is in charge of coordinating psychosocial services to be delivered in the aftermath of the event? Which other institutions are included in such coordination? Where/how is the organisation I am working under positioned in such planning? What is the scope of my duties and responsibilities? (Demircioğlu 2017)

b. Triage

Individuals present in the scene of a disaster or societal adversity may experience shock reactions after such events. These symptoms may manifest in varying ways or at varying degrees of intensity and in certain cases, it is of great importance to notice and guide individuals exhibiting specific symptoms (Everly Jr and Lating 2017). Psychological triage represents an intervention that allows the sorting out and prioritisation of persons exhibiting a high level of response and severe psychological reactions, thereby allowing the highest number of individuals possible to be provided with the fastest and most effective relief possible (Stroud 2012, Demircioğlu 2017). Reactions requiring emergency response in psychological triage can be specified as orientation problems, confusion, freezing, intensive verbal or physical agitation, extreme reactions of anger, panic or extreme reactions of anxiety, disassociation, risk of self-harm, psychosis, or alcohol or substance use disorders (McCabe et al. 2014). Specifically for work undertaken on site during the acute period, careful field observation allows for the identification of individuals to be prioritised in psychological triage and their guidance to medical support as necessary without delay.

c. Eight Step Psychological First Aid Model (Brymer et al. 2006)

1. Contact and engagement

This stage constitutes the initial phase that marks the start of communication between a provider of psychological first aid and an affected individual. With a view to building equitable engagement based on trust and respect, a functional first step will be for the provider of psychological first aid to introduce themselves, stating their name, the organisation they are affiliated with under the current mission, and the aim they pursue in speaking with the respective person. In cases where initial contact has been establis-

hed during the acute period immediately after the event, it is important to ask individuals about their needs and to provide them with basic necessities such as water, blankets, clean clothing, or food, since they may require such necessities after a disaster/event before starting with in-depth interviews or a different step in psychological first aid (Brymer et al. 2006).

2. Safety and comfort

The primary priority for any disaster or crisis is to ensure the safety of individuals. A provider of psychological first aid may implement measures for safety of life including the transfer of affected individuals to a safe location, their removal from hazards and high-risk areas within the scene of disaster/event, or their gathering in safe areas. In addition to the aforementioned measures, this scope may also feature interventions put forth with the aim of providing affected individuals with psychological sense of safety and a sense of comfort by relieving their concerns (Brymer et al. 2006).

3. Stabilisation

Individuals may exhibit acute traumatic stress reactions at varying degrees of severity and intensity after disasters or adversities. Specifically, shock reactions, panic or freezing reactions, dysmnnesia, absence and difficulties in focusing attention, startle and vigilance responses, difficulty in reasoning and decision-making, emotional numbing, and perception of the environment as different, bizarre or unreal that may be observed within the first 24 hours following a disaster may require intervention. Therefore, stabilisation methods are employed with the aim of assisting the process of bringing individuals back to psychological stability and to emotional calmness and balance. For the processes of sorting out, prioritising, and providing correct practices to individuals that may require stabilisation among the affected population, it is of great importance for the provider of psychological first aid to have knowledge on acute and advanced traumatic stress reactions and stabilisation techniques (Brymer et al. 2006).

One of the prominent methods used for the purposes of stabilisation consists of grounding techniques. These techniques aim at allowing an individual's attention to be directed outwards, thereby to balance their emotions.

- i. Sit in a comfortable position with your hands and feet free.
- ii. Start to take slow and deep breaths.
- iii. Look around you and tell me the names of five objects that do not cause you any sense of discomfort or stress.
- iv. Keep breathing slowly and deeply.
- v. Now listen to the noises around you and tell me five noises that do not cause you any sense of discomfort or stress.
- vi. Keep breathing slowly and deeply.
- vii. And now, try to pay attention to your bodily sensations and how you feel and tell me five senses that do not cause you any sense of discomfort or stress.
- viii. Take slow and deep breaths.

A similar practice may be implemented for children with shorter and simpler expressions. Grounding practices for children are recommended to use colours while directing their attention to external stimuli. Instructions for practical examples can be seen below (Brymer et al. 2006): :

"Now, look around you from your sitting position and tell me five colours you can see."

"Do you see anything green in this room?" How many yellow objects are there? How many blue ones are there?"

In addition to visual or auditory stimuli, grounding work may also employ tactile or kinaesthetic senses. To this end, an individual may be asked to move from one chair to another in the interview room or to select, focus on, or keep in hand a comforting object in the room. Moreover, exercises for contact with hot/cold objects with the use of various simple setups or objects can be listed as examples to tactile grounding work. Furthermore, grounding work is recommended to employ smells of perfumes, cologne, or coffee given the fact that smell can create a strong impact for grounding. In addition to the aforementioned, it is stated that the individuals may be recommended for grounding to take up daily life activities such as cooking, ironing or knitting during the times outside interviews with a view to promoting stabilisation (Fisher 1999).

4. Information gathering

This stage carries importance for the identification of psychosocial support services and the planning of interventions that will be delivered in the psychological first aid process. Understanding the physical or psychological necessities of individuals after an event is required to plan interventions suitable for them specifically. To this end, the information gathering stage is implemented through observations held by the provider of psychological first aid in the field, interviews with individuals, and/or needs analysis forms (Brymer et al. 2006).

5. Practical assistance

One of the most important stages in psychological first aid concerns the provision of assistance to individuals with respect to their necessities. Efforts are to be put forth to meet the needs of individuals in line with the conclusions obtained at the information gathering stage. The correct *modus operandi* will be to take action initially to respond to basic and urgent needs and to formulate a plan as to when and how the needs of lower priority will be covered. This stage will assist in the relief of concerns and the restoration of the sense of safety and control even if to some extent among individuals that have experienced a disaster or an adversity. It will be appropriate during all of these stages to position the provider of psychological first aid as a bridge between individuals and resources available. Therefore, it is important for a provider of psychological first aid to have information on the other units, organisations, and persons working in the field with a view to offering correct guidance (Brymer et al. 2006).

6. Connection with social supports

Social support is considered to be a pertinent factor in the post-traumatic recovery period. Individuals possessing and utilising healthy social mechanisms return to their normal daily lives before the event faster and cope with traumatic stress better (Guay et al. 2006). Therefore, providers of psychological first aid may take up a series of activities to mobilise the already existing social support mechanisms of individuals affected by an event. In addition to merely bridging individuals with social resources available or increasing instances of social exchange, it will be beneficial to form hobby groups, exchange meetings or activity groups for children, adolescents or adults and to build sustainable social support mechanisms.

7. Information on coping support

The provision of information to affected individuals with respect to various matters

stands out as an important stage in the psychological first aid process after disasters or adversities. Specifically after high-impact events, individuals may at times experience confusion about what has come to pass in shock and mental fog and informing them on such matters may assume critical importance for the prevention of any increases in severity in their concerns (Brymer et al. 2006).

When it comes to large-scale events, individuals may have questions as to when, how, from where, and in what manner their certain basic necessities such as shelter, healthcare or food will be provided for. The provision of guidance and information to them on such matters is of significance to eliminate uncertainty and any concerns arising from such uncertainty. Another aspect to this stage is to offer information to individuals on post-traumatic stress reactions. Such information may also cover possible physical, mental, behavioural and emotional changes arising from the event and methods to assist individuals in coping with such changes (Interagency Standing Committee 2007). In addition to the aforementioned, training and information activities on such subjects as sleep hygiene to allow them to cope with symptoms that may have a direct impact on the life course such as sleep disorders that may be observed among the majority of affected individuals. Beside the aforementioned measures, mini-training programmes may be organised on breathing and relaxing exercises to secure a state of coping with anxiety and of relaxation and activity planning may be taken up to bring individuals back to their pre-event life and habits (Brymer et al. 2006).

8. Linkage with collaborative services

Linkage with collaborative services for individuals is required at every step from the beginning to the end of the psychological first aid process, since psychological first aid represents a multi-dimensional psychosocial intervention offering the possibility of running multiple stages concurrently (De Jong 2011). A provider of psychological first aid both supports the linkage between affected individuals and persons, teams, and organisations and offers information concerning any changes or rotations in teams arising from completed tasks. The provision of information on such matters as the completion or termination of the psychological first aid process or the organisations or persons to maintain the work upon any change in teams will offer significant facilitation for the entire process (World Health Organization 2011). Such linkage activities are of importance for the adaptation of individuals and avoidance of any interruptions in service.

Psychological First Aid Practices for Vulnerable Groups

Children and Adolescents

Children may develop varying reactions in the face of challenging life events depending on their age and developmental characteristics. It is important to inform children on the traumatic stress reactions and behavioural changes that may be observed among children. Both children and their families may be supported through guidance provided to parents and other caregivers on what they can do and how they can act to cope with such states which they may observe in their children. Care must be taken to use a language suitable to respective developmental levels and to keep children at the eye level specifically when in communication during one-to-one interviews with them. It is important to allow children to express their emotions when they are ready and in a

manner they are ready for (World Health Organization 2013). During work undertaken with adolescents, observations should be conducted to identify any risky behaviour and measures be taken as necessary to protect them from the risk of abuse in addition to the aforementioned points of consideration for children. Especially during work conducted with children and adolescents that have left their caregivers, it is of great significance to exhibit utmost care, to secure their safety, to identify the person in charge of their supervision, and to protect them from abuse (World Health Organization 2013).

Individuals with Health Problems

The elderly, the disabled and individuals suffering from chronic diseases represent vulnerable groups that merit attention in case of a disaster or crisis. While working with such groups, securing the support of their relatives offers a facilitative element for the respective psychological first aid worker. During psychological first aid practices implemented with individuals from these groups, the primary step should be to check whether they have a relative offering them care or support and if an individual does not enjoy the presence of a caregiver, but is in need of such care, a plan should be formulated for their referral to an institution offering such services or for the use of other available solutions. Another point of consideration relates to information gathering on regularly used medicine with a sensitive approach and the provision of support to them for the procurement of such medicine, if not already available. In addition, it will be beneficial to offer them detailed information on where they can apply to and whom they can request assistance from in case of any health problem and, if necessary, to share with them the relevant contact information in writing (World Health Organization 2013).

Different Cultures

One of the most important points of consideration for psychological first aid work with individuals from different cultures concerns the knowledge of culture-specific characteristics of the respective population. Acting in line with the cultural characteristics of individuals or groups to be addressed with psychological first aid work is among the most essential requirements of the psychological first aid process. One of the most challenging factors encountered in the context of cultural differences is the language barrier. This is a factor that may influence the planning for the entire psychological first aid process. In addition, it is extremely important to take into consideration handshaking and greeting behaviours, rules and perceptions governing clothing styles, attitudes towards intersexual communication or religious characteristics that may exhibit intercultural differences (World Health Organization 2011).

Individuals at Risk for Discrimination or Violence

Women, children, young individuals, mentally disabled individuals and individuals from different ethnic or religious groups are considered to be included in the group at risk for discrimination or violence after disasters or adversities. Such individuals may not have received the necessary support or enjoyed their rights. They may also be targeted by violent acts. While working with these groups, risks applying to such groups should be specifically considered and their safety secured as necessary by taking them under protection in the crisis environment at the stage marked by evaluations and prio-

ritisation. Making sure that they are safe and supporting them in contacting their relatives and in availing themselves of the necessary basic services are among the fundamental steps to be taken in this context (World Health Organization 2011).

Ethical Concerns in Psychological First Aid Interventions

The most essential ethical concern in the implementation of psychological first aid is the mandatory focus on the principle of 'primum non nocere'. The most fundamental rule concerns the preservation of the state of wellness among individuals and the implementation of interventions without doing them any harm. Another ethical rule of importance is represented by the principle of 'confidentiality'. Keeping information imparted by individuals confidential and taking care in maintaining their privacy lie within the basic responsibilities assumed by all practitioners (World Health Organization 2013). In addition to the aforementioned, great importance is attached for providers of psychological first aid to refrain from making commitments, forcing individuals not to disclose their experiences, or accepting any money or gift in return for their support. Avoiding any judgment during or after the disclosure of information by individuals is also among ethical rules of significance (World Health Organization 2013). Another point of importance is for providers of psychological first aid to refrain from misinforming individuals. A practitioner of psychological first aid should obtain the necessary information on their environment or the scene of disaster and offer accurate information to relevant individuals. They should not share any information of dubious accuracy. Finally, practitioners should avoid exaggerations with respect to their own skills and capabilities and implement interventions to processes only within the limits of their own authorities and skills (World Health Organization 2013).

Conclusion

Psychological first aid practices are commonly implemented in varying environments and cultures. Numerous trauma workers and specialists report on the basis of their observations that such practices are functional and facilitate adaptation. In addition, relevant scientific studies fail to provide sufficient evidence concerning the preclusion of long-term development of traumatic stress symptoms by psychological first aid practices from a wider perspective (Fox et al. 2012). Despite the availability of a large number of guides compatible with different cultures and languages on how psychological first aid should be implemented, the literature remains insufficient for the examination of practical results and effectiveness.

The flexibility afforded by psychological first aid practices and their adaptability to environments and cultures are considered to be factors that may add difficulty to objective and empirical measurement in scientific studies. Therefore, practical results reported in the literature are seen to be based on the observations of practitioners in general. Furthermore, research on the long-term effects of practices undertaken in this context is of great importance. For this reason, it is considered to be significant for specific standards to be developed and agreed on for implementing stages and for studies to be conducted by authors under such uniform standards. To explain this recommendation further with an example, studies may be conducted for the identification of stabilisation techniques and for the follow-up of processes through post-intervention interviews with

individuals that have received psychological first aid services.

The conduct of a higher number of studies on the functionality of the practice and its long-term results is considered necessary in forthcoming years. At the same time, it is recommended that practices in different cultures be disseminated further and studies on the effects of such flexibility on results be undertaken in this field.

References

- Aker T (2012) Temel Sağlık Hizmetlerinde Ruhsal Travmaya Yaklaşım. Ankara, Türkiye Psikiyatri Derneği.
- Allen B, Brymer MJ, Steinberg AM, Vennberg EM, Jacobs A, Speier AH et al (2010) Perceptions of psychological first aid among providers responding to hurricanes Gustav and Ike. *J Trauma Stress*, 23: 509-513.
- Arslan Tomas S, Şavur E (2018) Afet ve Acil Durumlarda Psikososyal Destek Hizmetleri Saha Çalışanları için El Kitabı. Ankara, UNICEF Türkiye Temsilciliği.
- Australian Psychological Association (2013) Psychological First Aid An Australian Guide to Supporting People Affected by Disaster. Melbourne, Australian Psychological Society.
- Brymer M, Layne C, Jacobs A, Pynoos R, Ruzek J, Steinberg A et al (2006) Psychological First Aid Field Operations Guide, 2nd Edition. Los Angeles, National Child Traumatic Stress Network and National Center for PTSD.
- Civaner M, Vatansever K, Balcıoğlu H, Yavuz C I, Sarıkaya Ö (2011) Olağandışı durumlarda sağlık hizmetleri eğitimi: mezuniyet öncesi tıp eğitimi için önemli bir gereklilik. *Balkan Med J*, 28:344-350.
- De Jong K (2011) Psychosocial and Mental Health Interventions in Areas of Mass Violence A Community-Based Approach. Second Edition. Amsterdam, Médecins Sans Frontières.
- Demircioğlu M (2017) Olağandışı koşullarda psikolojik ilk yardım. Türkiye Psikiyatri Derneği 21. Yıllık Toplantısı ve Klinik Eğitim Sempozyumu. Antalya. Türkiye Psikiyatri Derneği: 66.
- Drayer CS, Cameron DC, Woodward WD, Glass AJ (1954) Psychological first aid in community disaster. *JAMA*, 156:36-41.
- Everly Jr GS, Laster JM (2017) The Johns Hopkins Guide to Psychological First Aid. Baltimore, John Hopkins University Press.
- Fisher J (1999) The work of stabilization in trauma treatment. The Trauma Center Lecture Series 1999.
- Fox J H, Burkle FM Jr, Bass J, Pia FA, Epstein JL, Markenson D (2012) The effectiveness of psychological first aid as a disaster intervention tool: research analysis of peer-reviewed literature from 1990-2010. *Disaster Med Public Health Prep*, 6:247-252.
- Gispen F, Wu AW (2018) Psychological first aid: CPR for mental health crises in healthcare. *J Patient Saf Risk Manag*, 23(2):51-53.
- Guay S, Billette V, Marchand A (2006) Exploring the links between posttraumatic stress disorder and social support: processes and potential research avenues. *J Trauma Stress*, 19:327-338.
- Hart LM, Cox GR, Lees L (2018) Teaching mental health first aid in the school setting: a novel approach to improving outcomes for common adolescent mental disorders. *Curr Opin Pediatr*, 30:478-482.
- Housley J, Beutler LE (2007) Treating Victims of Mass Disaster and Terrorism. Ashland, OH, Hogrefe & Huber.
- İstanbul İl Afet ve Acil Durum Müdürlüğü (AFAD) (2009) Afetlerde Psikolojik İlk Yardım. İstanbul, İstanbul İl Afet ve Acil Durum Müdürlüğü.
- Kılıç N, Şimşek N (2018) Psychological first aid and nursing. *Journal of Psychiatric Nursing*, 9:212-218.
- Kuruluşlar Arası Daimi Komite (IASC) (2007) IASC Acil Durumlarda Ruh Sağlığı ve Psikolojik Destek Kılavuzu. Cenevre, IASC.
- McCabe OL, Everly Jr GS, Brown LM, Wendelboe AM, Abd-Hamid NH, Tallchief VL et al. (2014) Psychological first aid: a consensus-derived, empirically supported, competency-based training model. *Am J Public Health*, 104:621-628.
- Stroud ML (2012) Psychological triage in general practice. *Aust Fam Physician*, 41:508-512.
- Wong DFK, Lau Y, Kwok S, Wong P, Tori C (2015) Evaluating the effectiveness of mental health first aid program for Chinese people in Hong Kong. *Res Soc Work Pract*, 27:59-67.
- World Health Organization (2011) Psychological First Aid: Guide for Field Workers. Geneva, World Health Organization.
- World Health Organization (2013) Psychological First Aid: Facilitator's Manual for Orienting Field Workers. Geneva, World Health Organization.

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