PSYCHOLOGICAL FIRST AID IN PAKISTAN: THE NEED OF THE HOUR

NIGHAT HAIDER[1], IMTIAZ AHMAD DOGAR[2], MOWADAT H RANA[3]

[1]Ph. D. Clinical Psychologist, Department of Psychiatry & Behavioral Sciences, Allied/DHQ hospitals, PMC, Faisalabad.
[2]Professor & Head, Department of Psychiatry & Behavioral Sciences, Allied/DHQ hospitals, PMC, Faisalabad.
[3]Professor & Chief Editor, Journal of Pakistan Psychiatric Society (Sitara e Imtiaz).

Ever since the announcement of Psychological First Aid (PFA) as the theme of Mental Health Day 2016 by WHO[1], PFA has gained the attention it deserves, becoming the focus of interest of mental health platforms worldwide.

Although the WHO provides guidelines for training and usage of PFA, it has yet to be implemented in Pakistan, a country, where only basic medical first aid training is provided to students partaking in civil defense training courses. Even the Red Crescent Society till late did not include PFA in its training of health care providers. Prior to PFA, counselors in the military used a technique known as Debriefing as a form of crisis intervention to help soldiers who had recently experienced a traumatic event. The goal of the technique was to assess whether soldiers were fit to continue the duty and to help reduce the probability of suffering from PTSD in the future [2]. It was later found that the technique was in fact worsening the condition of patients by preventing the natural grief process and therefore hindering recovery[3].

The concept of PFA was first mentioned by National Center for Post Traumatic Stress Disorder (NC-PTSD) in 2006, by a section of US Department of Veteran Affairs, through the online collaboration of more than 25 experts and researchers[4]. This was done with the aim of reducing the incidence of PTSD. The roots of psychological first aid can be traced back to as far as 1922, when the war office in the US initiated a support program for solders who experienced stress due to combat in order to make them 'functional' again. This program was termed BICEPS as it stressed on Brevity, Immediacy, Centrality, Expectancy, Proximity and Simplicity[5]. Subsequently, the term Psychological First Aid was coined by Drayer and his colleagues in 1954 in a paper written for the American Medical Association[6]. Drayer was requested to write guidelines for managing the aftermath of disasters. In 2007, Hobfall and colleagues suggested that safety, calmness, self efficacy/ self empowerment, connectedness and hope needed to be provided immediately after emergencies or disasters[7]. Further programs promoted these factors as essential elements of psychological first aid programs[8].

PFA does not assume that all survivors of traumatic events will develop PTSD or long term psychological problems but is rather based on the understanding that survivors may experience a wide variety of physical, psychological, behavioral, emotional and spiritual early reactions which may cause them considerable distress, hampering their adaptation, coping and recovery. PFA has been introduced as non-invasive, pragmatic care with emphasis on the assessment of needs of the affected. It is defined as an 'evidence-informed modular' approach, used by non professionals or volunteers to assist victims in the immediate aftermath of any kind of disaster. The aim is to help minimize distress and support short term and long term adaptive functioning of the sufferers[9,10]. The objective of psychological fist aid, much like medical first aid, is to reduce further preventable damage. Other aims and objectives of PFA include:

- Communicating with the affected in less/ non stressing conditions without pressure.
- Showing empathy and actively listening.
- Attending to the concerns of those affected and acknowledging them.
- Discussing possible coping strategies.
- Offering and optimizing social support and providing reassurance that support will be provided if needed.
- Making referrals to specialists for severe cases.

PFA programs are usually divided into the following steps:

- Contacting the affected and engaging them.
- Ensuring their safety and comfort.
- Helping them stabilize themselves.
- Gathering information (not necessarily the details of traumatic experience).
- Providing practical assistance.
- Connecting them with social support.
- Lending coping information.
- Liaising with services providers.

In a short span of approximately five years, the concept of psychological fist aid has spread across the globe. Developed countries have introduced psychological first aid into volunteer programs for trauma inducing situations like natural disasters and suicidal bombings amongst other things[11]. The global psychological first aid has a total of four basic standards:

1. It is evidence informed; carries researched evidence of risk and resilience post-trauma.
2. It is community based: applicable and practical in field situation outside the mental health professionals' office and meant to be provided by non professionals.
3. Efficient across life span: It has techniques for all developmental levels (children, adolescents and adults).
4. Culturally informed and flexible; since in most of the cases, it is provided by the members of the same community[9,10].

In 2001, WHO published psychological first aid's field guide, specially designed for LAMI countries. It clarified exactly what the psychological first aid was NOT[12]:

- It is not something that only professionals can do
- It is not professional counseling
- It is not psychological debriefing
- It is not asking someone to analyze what happened to them or to arrange time and events in order.
- PFA does involve being available for the people in terms of listening and analyzing; but it is not about pressuring them into expressing their feelings and reactions to the event in question.

WHO and other organizations have broadened the situations where PFA may be used; other than war veterans, it addresses natural disasters, road and other accidents, fires, interpersonal violence including sexual violence and terrorist attacks.

Additionally, and of particular relevance in Pakistan, are the internally displaced people and refugees and survivors of acts of terrorism and war against terror, and the soldiers committed in the war on terror and their families. Our country is also subjected to earth quakes, yearly floods, land slides in Northern Areas and famine in deserts. The individual level includes those challenged by sexual assaults, robberies, kidnapping, and suicide survivors. Special groups, more vulnerable to these forms of stress and trauma include children, adolescents, elderly, people with physically and mentally compromised conditions, segments susceptible to discrimination[13].

The degree, frequency, and diversity of these challenges, alongside the sizes of the affected and vulnerable communities that are in need of PFA in Pakistan signify its relevance as a public health intervention in our country. It is, therefore, the need of the hour that policy makers and members of the Pakistan Psychiatric Society join hands to launch a national program to train volunteers in PFA. The first stop for this program could be a collaboration of the mental health professionals with the National Disaster Management Authority, and Pakistan Red Crescent Society. A subsequent step could be to extend this training of volunteers to schools and colleges and NGOs dedicated to the disaster relief work. An important step would be to train the traffic wardens, motorway police, firefighters and rescue teams of 1122 in the provision of psychological first aid.

The 21st International Psychiatric Conference of Pakistan Psychiatric Society in Quetta in 0ctober 2016 could serve as a launching pad for ch an initiative.

REFERENCES:

1. Retrieved from http://www.who.int/mental-health/world-mental-health-day/2016/en/
2. Mitchell JT, Everly GS. The scientific evidence for critical incident stress management. Journal of Emergency Medical service. 1997; 22: 86-93.
3. Litz BT, Gray MJ, Bryant RA, Adler AB. Early intervention for trauma: Current status and future directions. Clinical psychology: science and practice. 2002; 9(2): 112-134.
4. Bisson JI, Lewis C. Systematic review of Psychological First Aid. WHO.2009.
5. Main T. The ailment and other psychoanalytic essays. London: Free Association Press. 1989. In Weisaeth L, Dyb G & Heir T. Disaster Medicine and mental health: Who, how, when of international and national disasters. Psychiatry. 2007; 70 (4): 337-344.
6. Retrieved from http://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp
7. Drayer CS, Cameron DC, Woodward WD, Glass AJ. Psychological first aid in community disasters. Journal of American Medical association. 1954; 156 (1): 36-41.
8. Hobfall SE, Watson P, Bell CC, Bryant RA, Brymer MJ, Friedman MJ et al. Five essential elements of immediate and midterm mass trauma intervention: Empirical evidence. Psychiatry. 2007; 70 (4): 283-315.
9. Benedek DM, Fullerton CS. Translating five essential elements into programs and practice. Psychiatry. 2007; 70 (4): 345-349.
10. Ruzek J, Brymer M, Jacobs AK, Layne C, Vernberg EM, Watson PJ. Psychological first aid. Journal of Mental Health Counseling. 2007; 29 (1): 17-49.
11. Brymer ML, Jacobs A, lane C, Pynoos R, Ruzek J, Steinberg A, Vernberg E, Watson P. Psychological first aid: field operation Guide, 2nd edition. United satates: National Child Traumatic Stress Network and National Center for PTSD. 2006.
12. Retrieved from http:// http://www.redcross.org.au/resilience-newsletter/issue2/articles/Psychological-first-aid/
13. World Health Organization. Psychological First Aid: Guide for field workers. Geneva: WHO Press. 2011.