FIRST AID FOR TRAUMATISED PERSONS: THE NIGERIAN PERSPECTIVE

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ABSTRACT

This study aimed at the clarification and documentation of existing concepts of Psychological First Aid (PFA), its adoption and instances of manifestations in Nigeria. It utilised a systematic approach to review empirical studies on psychological first aid both at the national and international levels. It was established that there is no adequate scientific evidence for use of psychological first aid despite being widely supported by both expert's opinion and rational conjectures. In Nigeria for instance, there was no known controlled study concerning the topic of discussion. Again, sufficient evidence supporting a treatment standard or treatment guideline is lacking. The study concludes that psychological first aid no doubt is a vital intervention capable of mitigating against psychological trauma in crises. We, therefore recommend that the Government of Nigeria initiate Psychological First Aid awareness programmes for the citizens.

Keywords: *Crisis, Trauma, Intervention, Psychosocial support, Psychological First Aid, Nigeria.*

INTRODUCTION

That crisis or disasters are instances of traumatic experiences thought inevitable in life endeavours is not in doubt. However, preventive measures that forestall some avoidable situations, may be taken whether or not there are early signs. Trauma is a common experience to all (whether adults and children) across board the world over. It has no respect for boundaries such as age, gender, socio-economic or class status, race, ethnic and ideological leanings, as well as sexual orientation. Being conscious of trauma and its attendant effects are increasingly becoming an integral component of effective behavioural healthcare as well as a significant part of the healing or recovery process. Several scholars have investigated the variability of individual responses resulting from mass casualty events and after-effects of trauma, particularly, regarding the increase of risk and protective factors underlying such variation (Watson, Brymer, & Bonanno, 2011). With the presence of uncertainty or at least, an iota of error in studies, structural buildings, establishments, planning and or implementation of life-related events, exist an inevitable chance for adversities and traumatic occurrences.

For instance, cases of forced displacement from people's homes due to crises often result in trauma, particularly in individuals whose mental well-being depends on a community response or intervention. Thus, once such interventions are targeted at helping persons with traumatic experiences is referred to as psychological intervention. The first of such intervention is known as Psychological First Aid (PFA) defined by Singaravelu (2012) as "a humane, supportive response to a fellow human being who is suffering (for both a sick person and a healthy person) and who may need support"; "an important intervention in responding to the psychosocial needs of people affected by disaster and terrorism. It is designed to ease the initial distress caused by traumatic events and to foster immediate and long-term adaptive functioning and coping".

The imports of traumatic events no doubt places a heavy burden on individuals, families, and communities. Though a vast majority may experience a traumatic event without lasting noticeable negative effects throughout their lives, others may have difficulties dealing with the aftermath of such experiences. Consequently, how an individual responds or reacts to a traumatic experience is largely personal. More so, where there is a strong support system, little or no prior history of trauma, or if the affected individual has palpable resilient qualities (such as self-motivated, self-control, optimistic, empathy, keeping calm when stressed/pressured,

realistic, self-awareness), such experience may not affect his/her mental health. Psychological first aid (PFA) in the words of Vernbeerg et al (2008) is an approach for assisting people in the immediate aftermath of a disaster and humanitarian crisis to reduce initial distress and to foster short and long-term adaptive functioning (Vernberg, Alan, Anne, Melissa, Patricia, Joy, Christopher & Robert, (2008); Gloria, Marirose & Susan (2019). It is largely intended for use by caregivers in contact with those recently impacted by dis-stabilizing events. These include: trained members of staff or health workers' volunteers with no specialized training in either mental health or psychosocial support approaches as well as community health workers, and teachers (World Health Organisation-WHO, 2013).

Despite a widely accepted consensus that PFA should be the first response in the aftermath of a disaster or crisis (Forbes, Lewis, Varker, Phelps, O'Donnell, Wade, Ruzek, Watson, Bryant & Creamer, 2011), controlled evaluations of its possible effects and early training for PFA responders remain largely unavailable or scanty. This study therefore aimed at addressing salient issues surrounding trauma-related experiences in Nigeria to determine whether psychological first aid was provided or not.

Psychological first aid (PFA) as proposed by Singaravelu (2012) is needed in situations like Help with basic needs such as food and shelter, provision of care and support, Protection from further harm, To access needs and concerns, To be connected to information services and social support, Comfort and help to feel calm (emotional support) and To express themselves without pressure and needs person(s) to listen to them.

On the contrary, PFA does not imply that all survivors must develop one form of mental health complications or the other in the long-run or experience difficulties in the recovery process. Instead, it is expected that survivors of trauma situation will likely experience various early reactionary responses (for instance, they may be physical, psychological, behavioural, or spiritual). These reactions may induce palpable distress that could hamper the victim's adaptive coping or to the extent that their recovery requires PFA as a matter of necessity. Psychological First Aid therefore is indicated for all category of distressed people particularly, those recently exposed to crisis / catastrophic events involving people of all ages (Kiliç, 2017). Its administration may run for days depending on the type and time of implicating disaster, as well as how long it takes individuals to respond. Noteworthy between PFA and related forms of psychological intervention is that while PFA does not require special diagnosis or treatment plan, the acquisition of professional training etc., others may require soft-skills or in-depth counselling before application.

Assessment in Crisis Counselling

Crisis intervention is defined as an emergency first aid for mental health (Ehly, 1986). Assessment in crisis counselling is done rather quickly and with limited information (Hoff, Hallisey, & Hoff, 2009). Hence, the counsellor is expected to distinguish the difference between a client considered to be emotionally upset and another in a crisis state. The emphasis is on accurate assessment because it serves as the minimum benchmark for any intervention or proposed treatment plan. An assessment tool, like the Triage Assessment Form (TAF) is useful for counsellors, in providing quick, effective, and accurate assessments (Myer, Williams, Ottens & Schmidt, 1992). It was developed as a reliable and easy-to-use tool for counsellors with limited assessment skills. In addition to these instruments, the counsellor may introduce informal methods in assessing the client's affective, behavioural, and cognitive states. The essence is to gauge how severe the crisis is, and the client's mobility index, suicidal instincts or lethality as well as the client's ability to appraise the situation logically. After your intervention, if the person (victim) seems more capable of taking care of self and or capable of discharging their responsibilities, then the intervention phase is ended.

Differences in Crisis Intervention and Therapy

Handling clients in crisis may differ significantly from the traditional therapeutic relationship (James, 2008). This is because crisis work is more time-bound than long-term therapeutic interventions. In this case, the counsellor has to establish rapport faster and may encounter more resistant from overwhelmed clients (Miller, 2012). Put differently, what is expected to happen within a few weeks in long-term therapy may need to happen in a matter of hours in the crisis intervention approach. Additionally, crisis work does not require an in-depth exploration of the client's issues. The counsellor seeks to understand the presenting problem without necessarily digging deeper. Again, the therapist does not aim at long-term changes in crisis counselling but his/her overarching goal is moving the client from a state of immobility to mobility intending to restore normalcy (client's pre-crisis state).

According to Everly, McCabe, Sermon, Thompson, and Links (2014), the following should be noted about psychological crises intervention:

1. Psychological crisis intervention can increase the perceptions of personal resilience and preparedness, as well as enhance community resilience.
2. Psychological crisis intervention is superior to "multisession plus therapy post-disaster", for reducing acute stress.

Concept of Psychological First Aid

Jacobs, Gray, Erickson, Gonzalez, and Quevillon (2016)**,** described Disaster mental health (DMH) as a form of psychological care provided by mental health professionals in preparation for response to; or anticipated recovery from disasters. DMH is mostly used to mark services rendered during the emergency phase of disaster management. Its focus is on the mental health needs of victims directly affected by the disaster, as well as others not directly affected by it (Jacobs et al., 2016). It includes crisis intervention, education, advocacy, problem-solving, and, individuals in need of more basic mental health services or referrals (Jacobs & Meyer, 2005). DMH is intended to primarily assist individuals who experienced extraordinary events. In 1992, the American Psychological Association (APA) inaugurated the Disaster Response. Network (DRN; later known as the Disaster Resources Network) during its 100th anniversary (Jacobs et al., 2016). Subsequently, states, provinces, and territories were encouraged to form psychological associations within the United States and to develop DRNs to consolidate on psychologists' efforts in serving their communities in times of disaster. Some state DRNs have also included other mental health professionals in keeping with the American Red Cross's policy of inter-disciplinary collaborations in providing services. The Red Cross according to Jacobs & Jacobs et al (2016) began providing DMH services as part of its disaster relief operations in November 1991, after signing a Statement of understanding with the APA in October 1991 (Jacobs, 1995; Jacobs et al., 2016). Since then, the Red Cross made it mandatory for service providers to complete its course titled: Foundations of Disaster Mental Health. That course has not only evolved over the years but teaches service providers to use their professional skills within the context of the Red Cross regulations. They are required to receive external training in DMH, in order to understand the unique challenges of providing professional services across board in the event of disasters and their attendant aftermaths.

DMH has effectively run since its initiation in the late 90s (Van Ommeren, Saxena, & Saraceno, 2005). But a major challenge has been recruiting considerable numbers of mental health professionals with the requisite skill in Disaster Mental Health particularly, in response to large events. An instance is the 9/11 terror attacks, and the logistics burden of physically moving qualified mental health professionals to victims of the attacks in of PFA. Despite the use of technology, the tasks of matching caregivers with those in need of services are cumbersome and quite overwhelming. This is particularly true in natural disasters, which often affect the

communications infrastructure. For instance, following the aftermath of the September 11th 2001 attack, part of the responses, was that the Red Cross assembled its DMH technical experts to discuss how their services may ameliorate the pains of sufferers and harness salient lessons from the tragic event and various related relief operations. They recommended a Community-Based Model of Psychological First Aid (CBPFA) as part of the strategy to supplement DMH in a bid to provide the required psychological support (Jacobs et al., 2016). The CBPFA metamorphosed into what is currently practised in several nations as Psychological First Aid (PFA) despite its inception dating back to the 1940s. Subsequently, in 2005, the International Federation of Red Cross and the Red Crescent Societies (IFRC) selected CBPFA as the approved method of choice to assist developing countries regarding psychological support programmes (Jacobs & Meyer, 2005; Jacobs et al., 2016).

Again, though CBPFA began in Denmark (Knudsen, Hogsted, & Berliner, 1997), the basic concepts of Psychological First Aid in the American Medical literature is traceable to Blain, Hoch, and Ryan (1945). The central goal in PFA is training members of each community (not only mental health professionals), to provide basic psychological support to immediate families, friends, neighbours, co-workers and to manage their stress levels (Jacobs & Meyer, 2005; Reyes, 2006; Jacobs et al., 2016). Interestingly, the training enables trained persons to recognise when someone's challenges require immediate referral to a mental health professional. CBPFA though adapted for individual communities require consultation between trainers and community representatives on a list of topics. An example of such topics includes: How to be a Helper; Traumatic Stress; Active Listening; Problem Solving; Instrumental (practical) Assistance; When and How to Make a Referral for Professional Assistance; Grief and Bereavement; Self-Care; and Ethics (European Association of Palliative Care, 2019). Psychological First Aid depends largely on the capacity of receiving communities (that is, those intended to serve), by incorporating effective local traditions and values.

In 2008, the former US President George W. Bush insisted a committee be set up for recommendations for DMH response to terrorist attacks against the United States and other public health emergencies such as pandemics. The committee though constituted as a subcommittee of the National Biodefense Science Board (now the National Preparedness and Response Science Board), had six (6) months to make recommendations (NBSB, 2008). One of such recommendations was that the government: "promote the population's psychological resilience" and, specifically, to "promote psychological resilience of individuals, families, and communities through the development of a national strategy for the integration, dissemination, and ongoing evaluation of psychological first aid" (NBSB, 2008). They also noted that there is need for more research on the components of CBPFA training to make a total package the (NBSB) report defined PFA thus:

> "Psychological first aid," as used in this context, refers to psychological support that is both used to improve one's resilience and is provided by non-mental health professionals to family, friends, neighbours, co-workers, and students. Psychological first aid focuses on education regarding traumatic stress and active listening. The term also incorporates more sophisticated psychological support given by primary care providers to their patients. Properly executed, psychological first aid is adapted to the needs of each group or community (that is, group of people with shared interests) implementing it, ensuring that the psychological first aid that is introduced in the community does not conflict with the world view of the group. It also emphasizes the inclusion of effective strategies for psychological support that may be specific to that group. This is done in concert with a representative community committee that helps to ensure responsiveness to the specific community. Psychological first aid includes understanding one's role; the difference between anticipated stress reactions and

> traumatic stress; how to engage in active listening; when and where to refer individuals for additional assessment and intervention; and the importance of supervision, ethical behaviour, and self-care. (NBSB, 2008, p. 12)

In keeping with the NBSB report, the U.S. Department of Health and Human Services (HHS) consequently recommended a compulsory PFA training for all volunteer in groups such as Medical Reserve Corps, Assistant Secretary for Preparedness and Response (ASPR), Office of Emergency Management, and National Disaster Medical System (NDMS) disaster responders (HHS, 2014). Ehlers and Clark (2006) quibbled that a good understanding that 'traumatic stress can overwhelm anyone's coping skills' may be the best strategy for building resilience to traumatic stress. Besides, individuals that view traumatic stress symptoms as a mark of weakness, rather than as a natural response to extraordinary events, will likely have long-term challenges with traumatic stress. Similarly, Van Daele, Hermans, Van Audenhove, and Van den Bergh (2012) in a recent study agreed with that perspective adding that a psychoeducation meta-analysis is critical in preparing people of many ages and ethnic backgrounds for coping with traumatic events.

A variety of related studies have equally reported that active listening and its components increase psychological support. Weger, Bell, and Robinson (2014) reported that the use of active listening increased the perception of being supported. Levitt (2001) also stated that active listening used by beginning graduate students in counselling helped the listener to feel more self-efficacious. Maurer and Tindall (1983) reported that even focusing mainly on the use of the nonverbal active listening strategies increased a sense of empathy and helped build an interpersonal relationship between the speaker and listener. From the foregoing, an aspect of CBPFA is the provision of practical assistance in addition to the educating, listening, and problem-solving. Litz, Gray, Bryant, and Adler (2002) investigated instrumental assistance as a vital tool in easing reactions to traumatic events. They suggested initial screening practices for intervention with individuals who show possible risk factors (for instance, prior trauma, low social support, hyperarousal) for developing chronic PTSD. Implicit in this approach is the idea, central to the current article, that many individuals exposed to violent or life-threatening events will show a genuine resilience that should not be interfered with or undermined by a clinical intervention.

The more general term "psychological first aid" (PFA) is used to refer to many different strategies for basic psychological support. Hobfoll et al. (2007) described five elements that need to be included in any programmes targeting traumatic stress: promoting a sense of safety, a sense of calm, a sense of self and collective efficacy, a sense of connectedness, and the installation of hope. This article has been referred to as the gold standard for psychological support programmes and many aspects of CBPFA promote these principles. Also, the National Child Traumatic Stress Network (NCTSN) and the National Centre for Post-Traumatic Stress Disorder (NCPTSD) promote a model for psychological support that uses the term PFA to refer to the work done by both mental health professionals and trained members of the public (Brymer et al., 2006). This perhaps became the best known PFA model in the US. The NCTSN and NCPTSD models combine most elements as indicated by Hobfoll et al. in their 2007 study. This model seems to be a response-team method primarily where individuals are trained to visit affected communities to effectively serve those in need. This approach, however, presents a significant logistic burden in getting caregivers to victims particularly in large-scale events - a problem indicated in the DMH model.

Further, the NCTSN and NCPTSD models describe mental health professionals as doing "first aid." PFA has also been used by some as synonymous with the first efforts of DMH professionals after a disaster (Young, 2006); it also seeks to blend the terms DMH and PFA (Pynoos & Nader, 1988). The varied use of PFA raises concerns on the perspective of precision

because most scholars feel that PFA is more suitable in describing the psychological support efforts of non-mental health professionals. While mental health professionals have broader skills than non-mental health professionals, there is need for a wider range of crisis intervention tools as well as an incisive understanding of when an individual may benefit more from traditional mental health services. This additional skill seems more appropriate in addressing “disaster mental health” or “disaster psychology.”

Since most disasters by nature are largely unpredictable, the need for adequate preparation and the ways of managing whatever devastation they bring cannot be overemphasized. DMH training therefore for mental health professionals is one of such proactive measures particularly in providing psychological support post-disaster. On the contrary, recent large-scale disasters show that alternate approaches to psychological support training are required beyond that of mental health professionals. To this end, CBPFA is such alternate programme that teaches members of the community how to support affected victims be they: friends, family, neighbours, colleagues, or themselves.

Several PFA clinical protocols are available. As reported by Everly, Lating, Shernan and Goncher (2016), one of the most predominant protocols is the Johns Hopkins RAPID-PFA. This RAPID PFA model relies on five distinct steps or phases. RAPID is an acronym that denotes the model's constituent phases:

R—Rapport and reflective listening. Effective psychological crisis intervention is predicated on gaining rapport with the person in distress. Consider rapport as a form of interpersonal connectedness that serves as a platform for the remaining aspects of the model.
A—Assessment. The term assessment is used liberally here and consists of screening (Is there any evidence of a need for PFA or other types of intervention?) and appraisal (What is the severity or gravity of need?). This information is generated, not through the use of psychological tests or mental status examinations, but, rather, through the process of listening to the person's story of distress. The story consists of what happened (the stressor event) and the person's reactions (signs and symptoms) in response to the event.
P—Prioritisation. Having heard the story, you must determine how urgent the need is for intervention. This becomes an exercise in psychological triage.
I—Intervention. Having heard the story and the associated reactions, some efforts toward stabilization and mitigation of adverse reactions is often recommended, if not expected. We shall review numerous practical crisis intervention techniques you can use.
D—Disposition. Having heard the story and responded with appropriate intervention, you now must determine what to do next. "Where do we go from here?" is a question you should ask yourself and might even ask the person you have assisted. Most behavioural outcomes are recovery or referral. The Johns Hopkins RAPID PFA model is unique in that it is theory-driven, evidence-informed, and empirically validated.

There are common signs expected from victims of traumatic stress. The signs range from generally, psychological reactions to traumatic events are described in five categories
Physical Reaction (Body Reactions) Increased heart rate, High blood pressure, Sleeping Difficulties, Stomach problems like diarrhoea or nausea, Rapid heart rate, Feeling very tired, Muscle tremors and tension, Back and neck pain due to muscle tension, Headaches, Inability to relax and rest.
Emotional Reaction (Feelings) Mood swings: feeling happy one moment and sad the next moment, Feeling over-emotional, Being quickly irritated, Anger, Depression, sadness, Anxiety and Not feeling any emotions.

Cognitive Reaction (Thinking and decision making) Poor concentration, Feeling confused, Disorganised thoughts, Forgetting things quickly, Difficult making decisions, Dreams or nightmares, Intrusive and involuntary thoughts.
Spiritual Reaction (Beliefs and Values) Feelings of emptiness, Loss of meaning, Feeling discouraged and loss of hope, Increasingly negative about life, Doubt, Anger at God, Alienation and loss of sense of connection.
Behavioural Reaction (Action) Risk-taking (for example, driving recklessly), Over-eating or under-eating, Increased smoking, Having no energy at all, Hyper-alertness, Aggression and verbal outbursts, Alcohol or drug use, Compulsive behaviour, that is, nervous tics and pacing, Withdrawal and isolation. Increase in substance abuse (alcohol or other drugs) is a recurrent decimal. A related behavioural change in the aftermath of traumatic events is an increase in family difficulties, including an increase in physical and emotional abuse of both children and spouses. This probably results in part from an increase in substance abuse, especially when coupled with increases in anger.

Parents may become overprotective of their wards or family members. These manifest as parents not allowing family members to leave their sight, and if unchecked could affect their schooling or work. Children may equally feel these concerns. It is also possible for individuals to become excessively busy. This is often interpreted as an attempt to avoid intrusive memories. Others may realise that they are very alert or easily startled. Another behavioural reaction that requires special attention for caregivers is to identify individuals that deliberately isolate themselves from others. If this is different from the individual's pre-event behaviour, it may predict some difficulty in working through the traumatic stress reaction, just as with the emotional withdrawal mentioned previously

The Nigerian Perspective

"When terrible things happen, we want to reach out a helping hand to those who have been affected. Psychological First Aid is … an approach to help people recover by responding to their basic needs and showing them concern and care, in a way that respects their wishes, culture, dignity and capabilities. – Psychological First Aid Brief, WHO for World Mental Health Day, 2016".

Nigeria is the most populated country in Africa whose numerical strength is projected to be over 200 million people by the National Bureau of Statistics (NBS, 2020). Most recently, various forms of disasters at both domestic and international homefronts have been reported the world over. (Egbue, Nwankwo & Alichie, 2015) and Nigeria is also caught in the frenzy of terrorism to a degree and intensity never experienced before. Nigeria is confronted with daunting challenges to its political stability occasioned by insurgency, banditry, terrorism and militancy. Up till date, Nigeria works with the 2007 Inter-Agency Standing Committee (IASC) report, where IASC published the IASC Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being during an emergency. These activities are described in a layered system known as the Intervention Pyramid for MHPSS which can only be carried out by trained personnel (Aderibigbe, 2014). Although, there is a disaster response policy in Nigeria (The National Disaster Response Plan (NDRP), and provision of psychosocial support for survivors as stated. However, there is currently no specific framework or detailed implementation plan in the Federal Ministry of Health (FMoH) and National Emergency Management Agency (NEMA) that is developed for MHPSS or PFA in emergencies (Abdulmalik *et al.* 2013). Worthy to mention is the fact that, in the phase of a disaster, it is estimated that

there will be an increased demand for mental health services that could range from 15-20% of the population directly affected.

Traumatic events are sustained psychological experiences that tend to significantly impair a person's daily functions and are identified by symptoms constellations that are contained in the International Classification of Diseases (ICD-10) or the Diagnostic and Statistical Manual of Mental Health 5th edition (DSM-V-TR) (Abiola & Ignatius, 2018). It should be noted that PFA is as old as trauma itself. This means that PFA activities take place as soon as any form of disaster occurs. In Nigeria, the Boko Haram insurgencies have bedevilled the northern region for over 11 years and whenever any of such occurrences take place, individuals, governmental as well as non-governmental organisations come to the aid of the affected persons suffering from one trauma or the other. It is important to note that psychological first aid is the first response given to victims of disasters who are traumatised, and these first aids can be rendered by both individuals or organisations. In the case of individuals, it might not be too conspicuous because even some of them who are members of the community are even traumatised as a result of their affected relatives or communities.

People in the various IDP camps which comprises mainly women and children who are constantly being traumatised as they recount losses of lives and properties to the unfortunate incidents. According to Onyekach et al., (2019), among internally displaced adolescents (IDAs) populations, it is estimated that approximately 45% develop mental health problems due to traumatic exposure and disruption of adolescent's life. Displacement may cause disruptions to many facets of an adolescents' life which can have far-reaching impacts on areas such as family support networks, continuing education, among others. In a nutshell, PFA first appeared in the Nigeria literature in the year 2009 (Aderibigbe, 2014), when the first attack of the Boko haram fighters took place in the north-west region of Nigeria.

The Awareness of Psychological First Aid in Nigeria: (The Lagos-Itafaaji Building Collapse)

Nigeria joined other nations of the world on the 10th of October, 2016 to celebrate the World Mental Health Day which was themed "Psychological First Aid", but then PFA still did not gain the much-expected awareness it deserved in Nigeria until the sad event that took place in the southwestern, Nigeria in 2019. The challenges posed by the tragedy of the collapsed building in Lagos on the 13th of March 2019 remain unmitigated for many persons. In response to that, the Commissioner for Physical Planning and Urban Development, Mr Rotimi Ogunleye, hinted during the inauguration in Alausa, that members were carefully selected to provide sound advice for government to effectively respond to the plight of victims.

The tragic event left above 20 persons dead and many others injured. One of the floors even housed a nursery/primary school. However, aids were supposedly given including PFA that the families of those who lost their lives truly needed. The Red Cross Society alongside other institutions came to the rescue of victims. Besides the presence of Lagos State Government, many Individuals and Groups actively supported to improve the lives of affected victims and families and they include Niara Development Initiative (NDI), the Nigerian Psychological Association (NPA), Asads.ei, MentallyAwareng, Psyche_care Humaniterex Foundation, Lagosshapers, LASEMA, House of Prayer and the team of Christians from Kingdom Community, High Life Church, Promise Kept Foundation, Fruitful Vine Initiative, Lagos Moms, Ikoyi Baptist Church, Cadbury, Total Cooperative, Mental Health Support Initiative, Inner City Mission and a host of others.

Methods: Standard databases were searched by an expert panel from 2009 to October 2020 using the keyword phrase "psychological first aid in Nigeria". Documents were included if the process was referred to as care provided to victims, first responders, or volunteers and

excluded if it was not associated with a disaster or mass casualty event, or was used after individual non-disaster traumas such as rape and murder. This search yielded over 37 citations.

Conclusion

Conclusively, Psychological First Aid no doubt is a necessary support for trauma victims. It was determined that adequate scientific evidence for psychological first aid is lacking but widely supported by expert opinion and rational conjecture. No controlled studies were found in Nigeria. There is insufficient evidence supporting a treatment standard or a treatment guideline.

This program has been effective in more advanced nations like the USA, Great Britain, The Netherlands but is hardly known among low/middle-income countries like Nigeria. More so, basic training in PFA is advised to prepare against some inevitable disasters, and ensure effectiveness and reduce the risk of any adverse outcomes (Everly & Lating, 2017). PFA is an intervention provided by volunteers without professional mental health training for people who have experienced a traumatic event. Further outcome research is recommended. Based on the findings, this study recommends the following:

i. The government should establish a Psychological First Aid awareness programme for the citizens
ii. Formally incorporate PFA as an independent Organisation across states.
iii. Train more persons for effective service delivery where applicable.
iv. Increase awareness against incompetency in the construction sector to help eliminate uncertified building plans for safety reasons.
v. Though specialised caregivers in disaster management and public health professionals have been trained in PFA, more hands should be educated the world over to facilitate a quicker response.
vi. As demonstrated in the event of the collapsed building, such concepts can be transferred to other aspects of life during a crisis particularly, the need for PFA is ongoing pandemic.
vii. A crisis is a ubiquitous experience, and all counsellors will inevitably encounter a client who is in crisis or has experienced a traumatic event. Thus, all counsellors need to have a basic understanding of crisis and trauma theories, assessment, and interventions.
viii. Furthermore, building indigenous and regional surveillance as well as acute intervention resources seems useful alternative to the widespread of such services due to the former's response efficiency. This would help in the sensitivity to local culture, familiarity with local roads, neighbourhoods and geography.

REFERENCES

Abdulmalik J., Kola L., Fadahunsi W., Adebayo K., Yasamy M. T., Musa E., & Gureje O. (2013). Country contextualization of the mental health gap action programmes intervention guide: a case study from Nigeria. *PLoS Medicine*, *10*(8), e1001501. https://doi.org/10.1371/journal.pmed.1001501

Abiola A., & Ignatius I. (2018). Psycho-Social Traumatic Events among Women in Nigeria. *Madridge Journal of AIDS. 2*. 17-28. 10.18689/mja-1000104.

Aderibigbe O.O. (2014). *Review of mental health and psychosocial needs and Responses during emergencies in Nigeria.* Amsterdam: KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam..

American Red Cross (2010). Coping with deployments: psychological first aid for military families. Washington DC: American Red Cross. Retrieved from https://intranet.redcross.org/content/redcross/categories/our_services/service_to_the_armedforces/coping_with_deployments.html (NOT AVAILABLE TO THE PUBLIC)

American Red Cross (2012). Psychological first aid: Helping others in times of stress. Washington DC: American Red Cross. Retrieved from https://intranet.redcross.org/ content/redcross/categories/our_services/disaster-cycle-services/dcs-capabilities/ individual_clientservices/disaster-mental-health- toolkit/psychological-first-aid-faq.html (NOT AVAILABLE TO THE PUBLIC)

American Red Cross. (2014). Coping in today's world. Washington DC: American Red Cross. Retrieved from https://intranet.redcross.org/content/ Redcross/categories/our_ services/disaster-cycle-services/dcs-capabilities/individual_clientservices/disaster-mental-health-toolkit/coping-in-today-s-world.html (NOT AVAILABLE TO THE PUBLIC

Blain D., Hoch P., & Ryan V. G. (1945). A course in psychological first aid and prevention. *American Journal of Psychiatry, 101*, 629–634.

Egbue N., Nwankwo I. U., & Alichie B. (2015). Curbing Boko Haram Terrorist Insurgency in Nigeria: Imperatives of Quadruple Action Package of Limited Military Response, Improved Social Services, Conflict Resolution Initiatives and Modified Pacifism. *British Journal of Arts and Social Sciences. 20*. 2046-9578.

Ehly S. (1986). *Crisis intervention handbook.* Washington, D.C.: National Association of School Psychologists.

European Association of Palliative Care – (EAPC) (2019). Abstracts: *Palliative Medicine, 33(1)*, 118–589. https://doi.org/10.1177/0269216319844405

Everly Jr. G.S., & Lating J.M. (2017). *The Johns Hopkins Guide to Psychological First Aid* JHU Press.

Everly Jr. G.S., Lee M. O, Semon N.L., Thompson C.B., & Links J.M. (2014). The development of a model of psychological first aid for non-mental health trained public health personnel: the Johns Hopkins RAPID-PFA. J Public Health Manag Pract. 2014 Sep-Oct;20 Suppl 5: S24-9. DOI: 10.1097/PHH.0000000000000065. PMID: 25072485.

Forbes D., Lewis V., Varker T., Phelps A., O'Donnell M., Wade D.J., Ruzek J.I.,Watson P., Bryant R.A., & Creamer M.
(2011). Psychological first aid following trauma: Implementation and evaluation framework for high-risk organizations. *Psychiatry,74*, 224–239.

Glory G., Marirose B., & Susan O. (2019). Psychological First Aid: A Model for Disaster Psychosocial Support for the Perinatal Population. *The Journal of Perinatal & Neonatal Nursing. 33.* 10.1097/JPN.0000000000000419.

Hoff L., Hallisey B., & Hoff M. (2009). People in crisis: Clinical and diversity perspectives (6th ed.). New York: Routledge

Inter-Agency Standing Committee -IASC (2007). *IASC guidelines on mental health and psychosocial support in emergency settings.* Geneva: IASC; 2007.

Jacobs G. A. (1995). The development of a national plan for disaster mental health. *Professional Psychology: Research and Practice, 26,* 543–549. DOI:10.1037/0735-7028.26.6.543

Jacobs G. A., & Meyer D. (2005). Psychological first aid: Clarifying the concept. In L. Barbanel & R. J. Sternberg (Eds.), *Psychological interventions in times of crisis* (pp. 57–71). New York: Springer Publishing

Jacobs G. A., Gray B. L., Erickson S. E., Gonzalez E. D., & Quevillon R. P. (2016). Disaster Mental Health and Community-Based Psychological First Aid: Concepts and Education/Training. *Journal of Clinical Psychology*, *72*(12), 1307–1317. https://doi.org/10.1002/jclp.22316

James, R. K. (2008). Crisis intervention strategies (6th ed). Belmont, CA: Thomsan Brooks/Cole.

Kiliç N. (2017). Psychological first aid and nursing. *Journal of Psychiatric Nursing. 10.*14744/PhD.2017.76376.

Miller G. (2012). *Fundamentals of crisis counseling.* Hoboken, NJ: John Wiley & Sons, Inc.

Myer R. A., Williams R. C., Ottens A. J., & Schmidt A. E. (1992) Crisis intervention: A three-dimensional model of triage. *Journal of Mental Health Counseling, 14(2),* 137-148.

Nigeria Bureau of Statistics (2020). https://www.nigerianstat.gov.ng/index.php

Odeyemi S. O., Giwa Z. T., & Abdulwahab R. (2019). Building Collapse in Nigeria (2009- 2019), Causes and Remedies – A Review. *USEP: Journal of Science and Engineering Production*, *1*(1), 123–135.

Onyekachi DP, et al. (2019). Insomnia, Depression and Anxiety as Associated by Traumatic Events, Coping Strategies and Coping Resources among Internally Displaced Adolescents in North-East Nigeria. Psychol Psychology Res Int J 2019, 4(3): 000210.

Singaravelu V. (2012). *Psychological First Aid: Field Worker's Guide* (pp. 1–27). pp. 1–27. https://doi.org/10.1111/j.1746-1561.1963.tb00427.x

Vernberg E., Steinberg A., Jacobs A., Brymer M., Watson P., Osofsky J., Layne C., Pynoos, R., & Ruzek J. (2008). Innovations in Disaster Mental Health: Psychological First Aid. Professional Psychology: *Research and Practice. 39.* 381-388. 10.1037/a0012663.

Watson P. J., Brymer M. J., & Bonanno G. A. (2011). Postdisaster Psychological Intervention Since 9/11. *American Psychologist*, *66*(6), 482–494. https://doi.org/10.1037/a0024806

World Health Organization – WHO (2013). Psychological First Aid: Facilitator's Manual for Orienting Field Workers; World Health Organization: Geneva, Switzerland, 2013.

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