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Effect of Psychological First Aid Training on Knowledge and Self-efficacy of Nurses: A Randomized Controlled Trial

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Abstract

Psychological first aid (PFA) is an approach used to provide first-hand psychosocial support to individuals who are exposed to the acute aftermath of an adversity such as the COVID-19 pandemic. Even though PFA is being used worldwide at times of disasters or emergencies, few researches have been carried out in terms of PFA training of health care professionals. Hence, the present study aimed to assess the effect of PFA training on knowledge and self-efficacy of nurses. A two-armed randomized controlled trial was utilized in the study. Purposive sampling technique with random allocation and assessments at 3 time points was applied. Data were collected using self-reported questionnaires and socio-demographic variables performa. Statistical analysis was performed using non-parametric tests as data were not normally distributed. The findings of the Wilcoxon sign-rank test ranks of knowledge were ($Z = -3.53$, $P < 0.01$) and ($Z = -1.3$, $P = 1.92$) among experimental and control groups. Meanwhile, scores of self-efficacy for both groups were ($Z = -4.26$, $P < 0.01$) and ($Z = -1.04$, $P = 0.3$). Mann Whitney U-test revealed non-significant scores ($U = 895.00$, $P = 1.99$) for knowledge and significant scores ($U = 798.50$, $P = 0.043$) for self-efficacy. The findings of the Friedman test of differences showed results that were significant (15.24 at $P < 0.01$) in the intervention group and non-significant (2.28 at $P = 0.32$) in the control group for knowledge and self-efficacy. Overall, study findings demonstrated that the necessary training of nurses on PFA aids in building knowledge and self-efficacy in rendering psychosocial interventions.

Keywords: COVID-19 pandemic, Nurses, Psychological first aid training, Randomized controlled trial

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Introduction

Psychological first aid (PFA) became popular after the terrorist attacks of 9/11 in the U.S.A., which was basically introduced to help the survivors of disasters and calamities.[1] PFA otherwise known as PFA, was also termed as "community psychological support" or as "mental health first aid" or "stress first aid."[2] The concept of PFA is not a new concept. PFA now has been conceptually structured and documented through a conference by disaster mental health specialists, with a consensus from available literature by Hobfoll and 19 other experts.[3] So, at the basic level, PFA is not expected to be done by any mental health specialists but can be given by anyone, who is expected to reach the victims of disaster at the frontline.[2] It is rather a structured collection of events pertaining, but not limiting to providing information, emotional care, comfort, and instrumental support to people who have been exposed to disaster and is further planned according to the victim's needs.[4]

PFA can be given to anyone irrespective of age, children, adults, or elderly, in the aftermath of a terrorist act or disaster of any sort. It's even helpful for first responders to the disaster or healthcare workers too.[5] Major scope of PFA is in areas such as acute care settings, shelter homes, hotline numbers, triaging areas and many other community and medical settings. The PFA spans to gathering relevant information in the face of the disaster connect them to social support networks and acknowledging coping efforts by the victims to adapt and empower them as early as possible.[6]

Due to the time-sensitivity for providing psychological interventions, people at or near the trauma location are mostly necessitated for action.[7] Healthcare professionals, especially nurses can be trained for providing PFA so as to help the patients recover not only physically but also psychologically with better resilience. People providing PFA should have proper training in understanding the trauma and reacting appropriately as people with mental distress portray various reactions, like trembling and muscular tension, which need to be understood as a normal reactions to stress.[8]

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Infectious outbreaks have been known to cause severe mental health breakdowns. In the COVID-19 outbreak, we have seen significant mental distress among the general public and especially among healthcare professionals. The fear of infecting others, social stigma, continuous changing of shifts, being exposed to situations never been encountered before, were some of the reasons for these distresses. There have been reports of increased number of domestic violence, exacerbation of pre-existing mental health conditions, increased suicidal ideations, and severe changes in family dynamics and relationships due to COVID-19 among the general population.[9-13]

The younger population (21–34 years) seems to be more at distress, mostly as the older generation are more resilient, and

increased exposure to information from social media among the younger population, along with poor tolerance to anxiety and more proximity to contamination.[14] Psychological interventions are essential in the COVID-19 pandemic, as number of deaths and hospitalisations was increasing substantially and instilling fear, anxiety, helplessness, and horror among the people who were infected.[8] One of the main challenges in effectively implementing the PFA is the lack of professionals with appropriate training. Increasing the number of professionals with the skills of providing PFA was the need of the hour.[15]

Even though nurses have very good experience and training in conducting lifesaving procedures like CPR or first aid in most intense situations, still most of the nurses are not trained in dealing with psychological responses, although giving physical as well as psychological aid to people at their most vulnerable states can be impactful.[16] Due to the very nature of the nursing discipline, training nurses with PFA could be very beneficial within a hospital or in a community setup. Nurses with their work experience can identify potential issues within a stressful situation, and also with their communication skills, be very able to identify specific psychological impacts within an individual, in a supportive and compassionate manner.[17] Nursing personnel, with their theoretical and practical knowledge regarding communication, problem-solving abilities, critical thinking, as well as being the largest workforce of health-care system, should be considered best for providing PFA to the population.[18-20]

Nurses, as per their challenging working environment which is consistent with unforeseen circumstances, have to be in a state of good self-efficacy to be comfortable in decision-making and problem-solving tirelessly.[21] Self-efficacy is a reassurance an individual feels when they act upon certain activities with their own effort and performance.[22] So in turn, self-efficacy can enhance the motivation of a person and as the belief gets stronger the motivation towards the activity also increases.[23] On providing PFA training, it is assumed that nurses would be equipped to deal with the emotional aspects of patients as well, which they would otherwise intentionally not engage, due to a lack of belief in their abilities and expect the psychiatric department to manage even the smallest psychological issue of the client. As nurses get more control over managing the emotional aspects of patients as well, the nurses would act with more diligence and be more consistent with the professional standards of patient care in their working environment.[21]

A non-equivalent controlled group study done in the middle of 2019 in Palestine on nurses working in trauma units for the evaluation of PFA training to understand the psychological preparedness towards disasters and emergencies, showed good improvement in self-efficacy after a 9-h training program. They implied that nurses would be better prepared to psychologically deal with emergencies, if they are trained with PFA concepts and principles.[23] Moreover, in a randomized controlled trial (RCT) study comparing simulation-based training with lecture method and self–learning control group on PFA training on 30 nurses working in a medical center in South Korea, showed, on caring for adolescents patients in disaster, that knowledge was significantly higher in simulation-based training as compared to other groups. The lecture method training showed an improvement of 4.10 points as compared to the control group, which showed only 0.6 point improvement in knowledge.[24] Hence, the present study aimed to assess the effect of PFA training on knowledge and self-efficacy among the group of nurses.

Materials and Methods

A two-armed RCT pre-post research design was applied for the study. The study was conducted in All India Institute of medical sciences (AIIMS) Patna, India, comparing the effect of training on PFA participants against a control group. Initially, the team introduced themselves to the participants. The intervention has been replicated according to the World Health Organization (WHO) facilitators' manual for orienting field workers about PFA.[25] The participants were divided into two groups and the training program started with an ice-breaking group session. After that, five sessions with 1 h duration each regarding different aspect of PFA was taken, along with group activities. These sessions included, what is PFA, Therapeutic and non-therapeutic communication, action principles of PFA, warning signs of common mental health problems, and self-care. The training program ended with a 5-min breathing exercise.

The investigators had undergone standardized 1-day PFA training organized by Médecins Sans Frontières/Doctors without borders India. The intervention group attended 1-day training program on July 22, 2021, at the Nursing College, AIIMS, Patna, Bihar. The program was attended by (n = 47) participants and the rest of the members (n = 23) did not show up. The participants were divided into two groups and the training program started with an ice-breaking group session. Once the intervention was completed, they were provided with the outcome assessment measure and feedback form. All the participants completed the post-test. They were also informed to come for follow-up after 14 days. On the 14th day after intervention (n = 41) participants completed their post-test. 3 participants were on leave and 3 participants did not reply to our phone calls.

The control group participants were invited to the nursing college building for the baseline assessment, for which (n = 50) out of 70 participants attended. After their baseline assessment was completed, they were asked to return to the same venue after 8 h, where their second assessment was done, mimicking the time for completion of intervention, for which (n = 45) attended, because 3 participants reported to be on duty, and another 2 participants did not reply to our call. These participants were also asked to do their second post-test after 14 days at the same venue for which (n = 20) completed the post-test. Participants, who did not complete the first post-test, were excluded from the second post-test. Among study participants, two of them resigned, eight of them were on leave and 15 participants did not show up or reply to our phone calls or messages. The control group was provided with the same training after the completion of the study.

Sample selection was done through purposive sampling. Participants were randomly allotted to experimental (n = 47) and control group (n = 50) using software (randomiser.org). Nursing officers (n = 140) working in the COVID-19 inpatient units of AIIMS, Patna were enrolled as participants in the study. AIIMS, Patna is a central government tertiary care hospital which was converted to a fully dedicated hospital for COVID-19 in the north Indian state of Bihar.

To compile a cross-section of the nurses in the hospital, all nurses who have been involved in COVID-19 nursing care were included in the sampling pool. The nurses who had already attended any training on PFA or who did not complete their questionnaire were excluded. The sampling frame was prepared by the list of nurses who had worked in the COVID-19 units in AIIMS Patna till June of 2021. The nurses were then randomly

assigned using free software for randomization (randomiser.org). Total number of nurses (n = 1158) were administered to software with intention of obtaining two groups of 70 members each. It was decided beforehand that the group numbered one will be considered as control group and the other group will be for the intervention group. The random numbers received from the software were subsequently attached to the serial numbers of the nurses in the list and the total number of 140 nurses were randomly allocated to the control and intervention group. Assessments were carried out in 3 time points namely baseline (pre-test), post-test immediately after intervention, and 14-day follow-up.

Socio-demographic data were collected by a structured tool developed by the researchers for the current study itself. The tool collected data regarding age, sex, type of nursing qualification, years of experience in nursing practice, and language used for communicating with patients. Knowledge questionnaire utilized for the study is a standardized and available in the annexure of a Facilitator's manual for orienting field workers to PFA by WHO in the year 2013.[26] The questionnaire consists of 15 items with two response options (yes/no) with the correct option is scored 1 point and wrong option as 0 point. To know about the retention of knowledge about PFA, all the scores of the items were added; and it was to be concluded more the score better the knowledge of participants. The correct option for 8 items is "No" and the rest 7 items are "Yes."

The self-efficacy questionnaire (SE-12) is a scale intended to collect the prolonged patient-centered communication by professional groups, such as doctors, nurses, physiotherapists, or occupational therapists. The questionnaire consists of 12 items signifying general clinical communication and another 5 items reflecting specific communication skills. A 10-point response scale has been added to each item from 1 (very uncertain) to 10 (very certain), which the participants could make as most appropriate to them. A "NR" response is also included for marking as "not relevant," that the participants were asked to mark only if they find that particular item is not relevant to their clinical practice. A score range from 17 to 170 was present and higher scores reflected higher self-efficacy.[27]

The investigators had planned to conduct the assessments of all time points for the control group before the actual intervention was provided to the intervention group so as to avoid any sample contamination. Fortunately, nobody was excluded due to their previous attendance to any PFA training or due to incompletion of their questionnaire, but a few participants (n = 43) were unable to participate in the study. Therefore, the current study included only 97 participants. Out of this, 50 participants were included in the control arm, whereas the 47 participants were allotted for receiving the PFA training, through random assignment. There was no significant difference between the two groups with respect to age, gender or educational qualification ([Table 1] for the complete socio-demographic details). In the current study, consolidated standards of reporting trials guidelines were used to report data. The analyses of scores for primary outcomes were analyzed by IBM SPSS 24 using Wilcoxon Sign rank test and Friedman test, as the data collected followed non-normal distribution in Kolmogorov-Smirnov test (Knowledge [KS = 0.126, $P \leq 0.01$] and Self Efficacy [KS test=0.152, $P \leq 0.01$]).

Results

Out of 140 nurses who were randomly selected through the randomiser.org website, only 97 (69.2%) nurses showed up for the study. Majority of the nurses were unwilling to participate (30%) due to difficulty in managing their duties, spending a whole day for intervention, not understanding the importance of the training, or not receiving any training for the control group. 47 (67.1%) nurses received the complete intervention and all of them completed the first post-intervention as it was administered immediately after the intervention. On the other hand, out of 50 (71.4%) nurses who completed the baseline assessment from control group, 5 (10%) nurses did not report for first post intervention assessment. Attrition was even more severe for the second post-intervention as only 20 (44%) nurses completed the assessment out of 45 nurses from the first assessment in control group, whereas 41 (87.2%) reported for second post-intervention in intervention group [Figure 1].

Fifty two percent (n = 50) of the total participants were females, and there were more nurses aged <30 years (81.25%) than others. The majority of the participants have completed their Basic B.Sc. Nursing (48.2%), but similarly most participants (40.7%) have registered themselves as nurses after General Nursing and Midwifery, which is a diploma program which also complements the nursing workforce, as compared to participants who have completed their lateral degree program of Post Basic B.Sc. Nursing (9.3%) and M.Sc. Nursing (6.2%). Seventy-five percent of the participants had experience of <5 years, followed by participants having experience between 6 and 10 years (23%), and only two participants had experienced more than 10 years. Comparisons between the two groups showed no significant difference. Couple of participants even reported to have attended psychological support training provided for nurses at the early stages of the pandemic, which was different from the principles of PFA, so they were included in the study. The baseline characteristics for intervention and control group have been presented in Table 1.

The Wilcoxon sign rank test was run as the data were non-normal and through the analysis it was observed that the post-test ranks were significantly higher than the pre-test ranks ($Z = -3.53$, $P < 0.01$) for knowledge regarding PFA in the intervention group. On the other hand, the control group did not show any significant change in the post-test and pre-test ranks ($Z = -1.3$, $P = 1.92$) with regard to knowledge about PFA. Similar was the case for self-efficacy among the nurses after the intervention where it showed significant increase in the post-test ranks from pre-test ranks ($Z = -4.26$, $P < 0.01$), and the control group did not report any changes in ranks ($Z = -1.04$, $P = 0.3$) [Table 2].

The Mann–Whitney U-test between the independent first post-test groups of the intervention group and control groups were also analyzed. Through the analysis, it was observed that there was the non-significant change of knowledge between the intervention and control group after the intervention ($U = 895.00$, $P = 1.99$). On the other hand, for the self-efficacy of the nurses the Mann-Whitney test showed a significant difference among the post-tests of the intervention group and control group after the intervention ($U = 798.50$, $P = 0.043$) [Table 3].

In addition, a non-parametric Friedman test of differences was used to analyze the knowledge assessments for 3 time points i.e., baseline, immediately after intervention and 2 weeks post intervention and rendered a Chi-square value of 15.24 which was significant at $P < 0.01$. On the other hand, on conducting the same test of difference on participants in the control group after 3 time point assessment showed Chi-square of 2.28 which was non-significant ($P = 0.32$). Similarly, with regard to scores of self-efficacies, the Friedman test of difference rendered a Chi-square

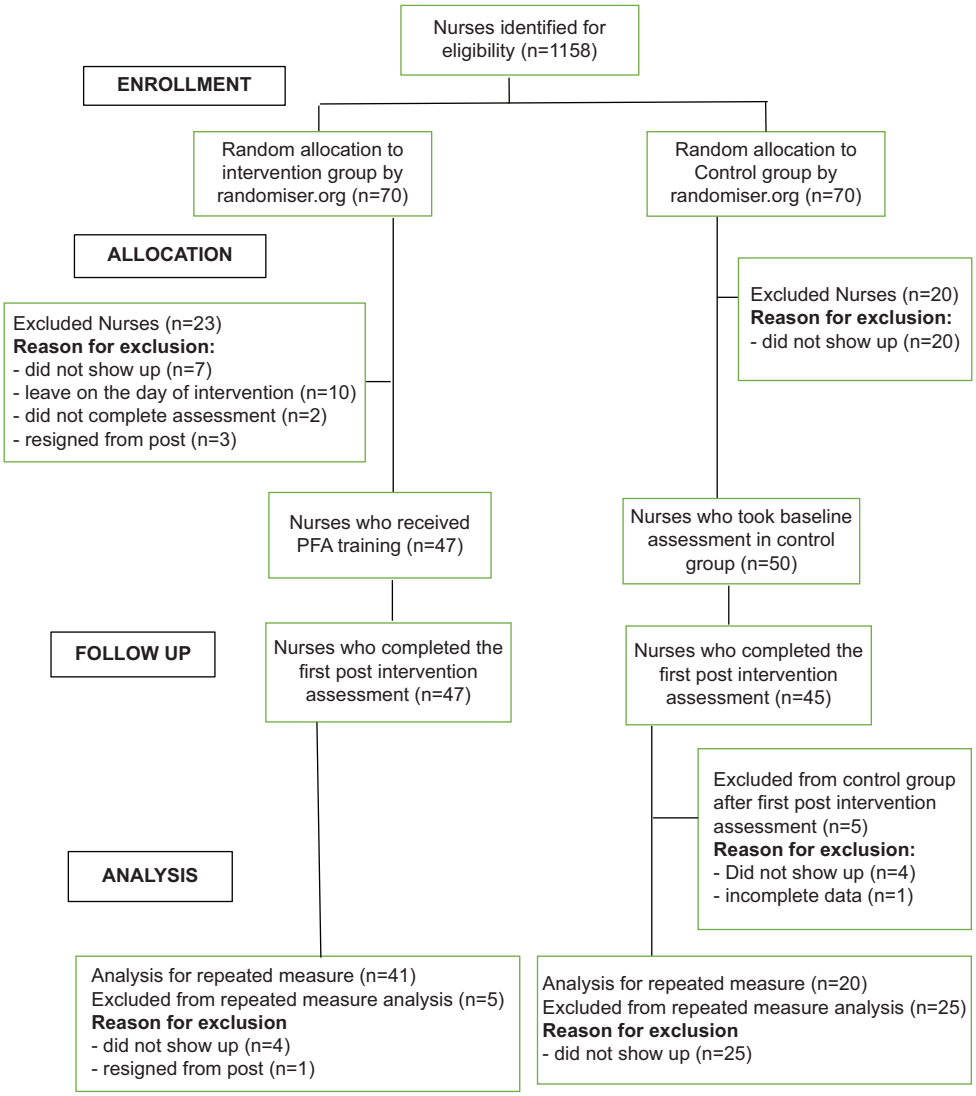

Figure 1: Flow chart

value of 20.95 which was significant at ($P < 0.01$) in the intervention group, and the control showed a Chi-square of 1.56, which was observed to be non-significant ($P = 0.45$) [Table 4].

Discussion

The aim of the present study was to assess the effect of group PFA training on nurses in terms of knowledge about the PFA and Self-efficacy. It demonstrates the effectiveness of PFA training on enhancing knowledge about PFA of nurses even after 2 weeks of intervention. The same was true for self-efficacy, where nurses had significantly showed improvement in the application of communication and increased their engagement with patients with COVID-19. Such kind of trainings are required at a time when patients were dealing with multiple psychosocial issues; nurses who are equipped with PFA skills would make a significant impact and help in reducing the mental distress of the patients. The present study also tried to find if such training would also imbibe confidence among the nurses to communicate with their patients. Communication being an integral part of nursing care, is also a prime applicator of PFA.

Similar findings were seen in a randomized controlled study on nursing students of Turkey, for whom PFA training was administered, but instead of 1 day training, training of 1-h sessions once a week for 6 weeks was provided. General self-efficacy scale was used to measure the self-efficacy of participants. It reported a significantly high self-efficacy as compared to control group, which concludes that the perception of nursing students about self-efficacy have improved significantly after the PFA training.[28]

A cluster randomized trial done in 129 Peripheral Health Centres of post-Ebola Sierra Leone with 206 primary health-care workers receiving 1 day PFA training and 210 participants in the control group. The study was done with the aim to assess the effectiveness of the PFA training on knowledge and skills in the immediate aftermath of the Ebola-hit Peripheral health center workers, which is a similar situation as our participants too, who were exposed to the devastating second wave of COVID-19 in India. The study showed a strong increase in knowledge ($d = 0.50$; $P < 0.001$) post-assessment and even after 6 months ($d = 0.43$; $P < 0.01$), which is similar to our study findings too.[29]

The strength of the 1-day PFA training was seen in the measures that were used in our study. Nurses showed an increased

Table 1: Baseline characteristics

Baseline characteristics	*PFA training, n (%)*	*Control, n (%)*	*Chi-square*	*df*	*P*
Age (years)					
21–30	35 (74.4)	44 (88)	2.935	1	0.87[a]
31–40	12 (25.5)	6 (12)			
Sex					
Male	23 (48.4)	24 (48)	0.009	1	0.93[a]
Female	24 (51.1)	26 (52)			
Education					
GNM	21 (44.7)	18 (36)	4.756	3	0.19[b]
B.Sc. Nursing	19 (40.4)	28 (56)			
Postbasic B.Sc. Nursing	5 (10.6)	4 (8)			
M.Sc. Nursing	2 (4.2)	0			
Years of experience					
1–5	29 (61.7)	44 (88)	10.501	3	0.015[b]
6–10	16 (34)	6 (12)			
11–15	1 (2.1)	0			
>15	1 (2.1)	0			
Language commonly used during patient interaction					
Hindi	46 (97.9)	46 (92)	2.340	2	0.31[b]
English	1 (2.1)	3 (6)			
Bhojpuri	0	1 (2)			
Have you attended any other training on PFA?					
Yes	2 (4.2)	6 (12)	2.011	1	0.16[b]
No	45 (95.7)	44 (88)			

[a]Chi-square tests, [b]Likelihood ratio. PFA: Psychological first aid

Table 2: Wilcoxon sign rank test for comparing effectiveness between baseline data and first postintervention data

Group	*Time points*	*Median (IQR)*	*Z*	*P*
Experimental (knowledge)	Baseline	7.0 (5.00–9.00)	−3.53	<0.01*
	First postassessment	9.0 (8.00–10.00)		
Control (knowledge)	Baseline	8.0 (7.00–9.00)	−1.30	0.192
	First postassessment	8.0 (7.00–10.00)		
Experimental (self-efficacy)	Baseline	127.0 (107.0–142.0)	−4.26	<0.01*
	First postassessment	141.0 (129.0–154.0)		
Control (self-efficacy)	Baseline	128 (111.5–145.5)	−1.046	0.296
	First postassessment	138.0 (113.0–147.5)		

**P*<0.01 is significant. IQR: Interquartile range

Table 3: Mann–Whitney U-test for the analysis of independent intervention and control group posttests for knowledge and self-efficacy

Variable	*Group*	*n*	*Median (IQR)*	*U*	*P*
Knowledge	Intervention	47	9.0 (7.0–10.0)	895.00	0.19
	Control	45			
Self-efficacy	Intervention	47	140.0 (125.0–150.0)	798.50	0.043*
	Control	45			

**P*<0.05 is significant. IQR: Interquartile range

understanding of the key matters and principles of PFA, and which in turn improved their initiation and engagement with the patients. The follow-up scores, however, made it apparent that the increase in self-efficacy was not more after 2 weeks than immediately after intervention (first assessment = 141.32 vs. second assessment = 138.10); this might be because the nurses found their opportunity to put knowledge to practice were able to reach at a more practical level. The same pattern was observed with the control group too (first assessment = 129.70 vs. second assessment = 124.30), which we believe would mostly be a pretesting effect as the first follow-up assessment was taken few hours after the baseline assessment.

This study used RCT to find the effectiveness of the PFA training, whose content has been similar to WHO structured content. The scale that was used for knowledge was a pretesting tool attached as an appendix to the WHO PFA content. Moreover, this study focuses on PFA training of the nurses who have worked in dedicated COVID-19 units. The training provided to nurses is directly benefitting the patients affected with COVID-19. At a time, when the public is overwhelmed by the information about rates and deaths are pushing them to issues like negative thoughts, depression, anxiety or anger.[28]

COVID-19 has been a global disaster[30] and during the disasters it has been frequently observed that there is an increasing demand for evidence based studies for psychosocial support.[31] Moreover, study by evidence aid initiative to identify high priority interventions to address at the time of adversities, has also reported that the psychosocial and mental health interventions at the top 10 themes identified for researchers towards disaster research.[32,33] So, our study has been an attempt to increase the knowledge base among the frontline health workers required at a time when the global pandemic is evidently abrupting mental health of society. In a study done for capacity building of psychosocial support during the Ebola outbreak reported the ineffectiveness of 1-day training programs for non-specialist participants, and the need for continued follow-up training.[34] However, we have selected registered nurses for our study and they are not new to the situation. The nurses have shown active participation and response toward the intervention and have been part of psychosocial training before as well.

Table 4: Friedman test of differences for the repeated measures analysis of knowledge and self-efficacy

Group	*Time points*	*Median (IQR)*	*Chi-square*	*df*	*P*
Experimental (knowledge)	Baseline	7.0 (5.0–8.5)	15.24	2	<0.01*
	First postassessment	9.0 (8.0–10.5)			
	Second postassessment	9.0 (7.0–10.5)			
Control (knowledge)	Baseline	8.0 (7.0–9.0)	2.28	2	0.32
	First postassessment	8.0 (7.0–10.0)			
	Second postassessment	8.50 (7.0–10.0)			
Experimental (self-efficacy)	Baseline	127.0 (110.5–140.5)	20.96	2	<0.01*
	First postassessment	141 (129.5–154.5)			
	Second postassessment	144 (131.5–156.0)			
Control (self-efficacy)	Baseline	132.0 (115.5–147.5)	−1.046	2	0.46
	First postassessment	135.0 (116.75–147.5)			
	Second postassessment	130.5 (103.75–144.0)			

*P<0.01 is significant. IQR: Interquartile range

Limitations of Study

Despite positive outcomes in the study findings, there are certain limitations that should be taken into consideration. The same questionnaires were utilized in all three assessments, which might increase the possibility of participants being accustomed to questions. Changes in nursing practice were not observed by researchers but were self-reported and based on their perception of the efficacy they held. The current study evaluated the effect of the training program shortly after the intervention, which makes it unclear if it is generalizable in terms of long-term effects. Future studies could focus on health-care professionals other than nurses and in multiple centers rather than a single setting.

Conclusion

The study findings suggest that 1-day PFA training should be mandated for all nurses who are attending to patients in this global crisis. The training has been shown to improve better communication and confidence among the nurses, which is a necessity more than a skill, at a time of psychosocial disturbances in society. RCT gives quality contribution to the knowledge base for the interventions, which is well underway, but still, the evaluation for specific groups and measures is limited.

Ethical Approval

Institute ethics committee approval was taken before the inclusion of the subjects in the study (Ref no. AIIMS/Pat/IEC/2020/626) and was also registered with the Clinical Trial Registry of India (CTRI number: CTRI/2021/02/031009 registered on February 04, 2021). Study details were explained, and informed consent was taken from participants.

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