Scientific Research Publishing

Open Journal of Psychiatry, 2026, 16(4), 267-285
https://www.scirp.org/journal/ojpsych
ISSN Online: 2161-7333
ISSN Print: 2161-7325

Rapid Implementation of Psychological First Aid Following Sudden Traumatic Bereavement among Adolescents and Young Adults in Senegal: A Descriptive Field Report

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How to cite this paper: Tandjigora, M.D., Fall, S., Gueye, M., Alexandra, M.O.M. and Gueye, R. (2026) Rapid Implementation of Psychological First Aid Following Sudden Traumatic Bereavement among Adolescents and Young Adults in Senegal: A Descriptive Field Report. *Open Journal of Psychiatry*, **16**, 267-285.
https://doi.org/10.4236/ojpsych.2026.164021

Received: July 27, 2026
Accepted: September 6, 2026
Published: September 9, 2026

Abstract

Background: Sudden traumatic bereavement can cause substantial emotional distress among adolescents and young adults. Psychological First Aid (PFA) provides early psychosocial support focused on safety, compassionate listening, practical assistance, and social connectedness without requiring forced disclosure. **Objective**: To describe the rapid implementation of a PFA intervention following sudden traumatic bereavement among young participants during an international youth stay in Senegal, focusing on organization, immediate field observations, and practical lessons learned. **Methods**: This field report describes an emergency Psychological First Aid (PFA) intervention carried out after the accidental death of a supervisor. The report is based on anonymized field observations, routine clinical notes, and spontaneous feedback shared by participants. Because the priority was to provide immediate psychosocial support, no standardized psychological assessment tools were used. **Results**: Twenty-four participants took part, including 21 aged 16 - 18 years and three supervisors aged 20 - 25 years. All attended a group PFA session, and 11 (45.8%) received individual supportive interviews. Observed reactions included sadness, crying, emotional distress, guilt-related thoughts, uncertainty about personal reactions, and concerns about separation from the group. Participants spontaneously described psychoeducation and supportive listening as helpful, although these perceptions were not objective measures of effectiveness. **Conclusion**: This experience shows that Psychological First Aid can be organized rapidly after a sudden traumatic bereavement, even in resource-limited settings. Restoring safety, providing accessible psychoeducation, respecting individual coping styles, and maintaining social connections appeared

to be important during the immediate aftermath. Further research should examine feasibility, cultural adaptation, and longer-term outcomes.

Keywords

Psychological First Aid, Sudden Traumatic Bereavement, Young People, Emergency Mental Health, Psychoeducation

1. Introduction

Traumatic events involving exposure to actual or threatened death, serious injury, or threats to physical or psychological integrity generate a broad range of emotional, cognitive, behavioral, and physiological responses. People exposed to such events may experience anxiety, sadness, sleep disturbances, irritability, intrusive thoughts, concentration difficulties, or feelings of helplessness, and in many cases these reactions reflect a normal human response to an extraordinary situation rather than a psychiatric disorder [1] [2].

Sudden traumatic bereavement occurring within collective environments—schools, youth programs, camps, humanitarian activities, or international mobility contexts—can affect both individuals and groups, disrupting a shared sense of safety, challenging existing coping resources, and influencing group cohesion. Such loss within a temporary collective environment can be particularly distressing, since individuals may simultaneously experience grief, uncertainty, disruption of routines, and concerns regarding their own safety.

For this reason, early psychosocial interventions primarily aim to restore a sense of safety, reduce immediate distress, strengthen existing coping resources, and facilitate access to additional support whenever needed [3] [4].

Psychological First Aid is an evidence-informed approach developed to provide early psychosocial support following crisis situations. International frameworks, including those developed by the World Health Organization (WHO), the Inter-Agency Standing Committee (IASC), and the National Child Traumatic Stress Network (NCTSN), describe PFA through complementary principles such as Look, Listen, and Link, involving identification of immediate safety needs, respectful and compassionate support, and connection with practical, social, and professional resources [3] [5] [6].

Importantly, Psychological First Aid does not require individuals to recount traumatic experiences or provide detailed descriptions of the event, unlike psychological debriefing, which historically encouraged early trauma narration with the aim of preventing post-traumatic stress disorder (PTSD). However, systematic reviews have not demonstrated the preventive benefits of mandatory psychological debriefing and have raised concerns regarding its routine use immediately after trauma exposure [7].

Contemporary trauma-informed approaches emphasize safety, calming, self-

efficacy, social connectedness, and hope as important components of early intervention [4].

Despite increasing international recognition, published descriptions of rapid Psychological First Aid implementation remain limited, particularly among young people exposed to sudden traumatic bereavement in sub-Saharan African contexts. Existing publications have mainly focused on disasters, armed conflicts, refugee populations, or large-scale humanitarian crises, whereas operational experiences from African settings involving sudden traumatic loss in non-disaster contexts remain insufficiently documented, and descriptions of PFA implementation among young participants experiencing bereavement during temporary international mobility programs remain especially rare.

On 18 July 2026, an emergency Psychological First Aid intervention was organized following the accidental death of a supervisor during an international youth stay in Senegal. The intervention was conducted by psychiatry trainees from the Department of Psychiatry of the Centre Hospitalier National Universitaire de Fann (CHNU Fann), Dakar, Senegal, before the participants' emergency return to Belgium. This report describes the organization of the intervention, the immediate field observations, and the practical lessons learned from this experience.

2. Methods

2.1. Study Design

This manuscript presents a descriptive field report documenting the rapid implementation of an emergency Psychological First Aid (PFA) intervention following sudden traumatic bereavement. Rather than evaluating the effectiveness of Psychological First Aid, this report describes how the intervention was organized in a real emergency, what was observed during its implementation, and the practical lessons that emerged from the experience.

Descriptive reports of emergency mental health responses may provide useful information regarding operational challenges, contextual adaptations, and implementation strategies, particularly in settings where interventions must be delivered rapidly under complex circumstances. Participants were not recruited for research purposes. They were individuals receiving emergency psychosocial support following a traumatic event.

The intervention was conducted according to internationally recognized Psychological First Aid principles, including the World Health Organization framework emphasizing safety, supportive listening, practical assistance, and linkage with available resources [3]. This report was prepared according to principles of transparency recommended for descriptive reports of clinical and humanitarian field experiences.

2.2. Setting and Context

The intervention took place on 18 July 2026 in Senegal following the accidental death of a supervisor during an organized international youth stay. During the

night of 17 - 18 July 2026, one of the supervisors, who had chosen to sleep outdoors because of high temperatures, died accidentally following a structural collapse.

The following morning, two supervisors discovered the deceased individual. The event had a profound emotional impact on those who discovered the deceased and quickly affected the entire group after the news was shared. The sudden traumatic loss of a familiar adult figure within their temporary living environment represented a potentially traumatic experience because it affected participants' perception of safety, stability, and predictability during their stay abroad.

Given the psychological impact of the event, the head of the Department of Psychiatry of the Centre Hospitalier National Universitaire de Fann (CHNU Fann), Dakar, Senegal, requested the rapid mobilization of a psychological support team. The intervention team travelled from Dakar to the location of the event and arrived on the same day.

Initially, participants were expected to remain in Senegal until 30 July 2026. However, following the traumatic bereavement, the organizers, in collaboration with Belgian diplomatic representatives, arranged an early return to Belgium on 18 July 2026. Before the psychological intervention began, participants were transferred from the accommodation site where the death had occurred to another location.

This decision was consistent with early trauma intervention principles emphasizing restoration of safety, reduction of exposure to distressing reminders, and creation of an appropriate environment for psychosocial support [3] [4].

2.3. Intervention Timeline

The Department of Psychiatry of the Fann National University Hospital Center (CHNU Fann) was notified of the incident at approximately **09:15 a.m.** on 18 July 2026. The intervention team subsequently organized the mission, prepared the required materials, and obtained the exact location of the event before departing Dakar at approximately **1:00 p.m.** Due to heavy traffic, the team arrived at the intervention site at approximately **5:00 p.m.**

Before the team's arrival, participants had already been transferred from the location where the fatal accident had occurred to another villa in order to provide a safer and more supportive environment for the intervention. Approximately **15 minutes after arrival**, the intervention team initiated a single group Psychological First Aid session attended by **all 24 participants**. The group session lasted approximately **30 minutes**. Immediately afterward, optional individual supportive interviews were conducted and required approximately **90 minutes** to complete. Following completion of the intervention, participants continued preparations for their emergency return to Belgium.

2.4. Participants

The intervention involved 24 young participants who had been exposed directly

or indirectly to the traumatic event. Participants included 21 young participants aged 16 - 18 years (87.5%) and 3 supervisors aged 20 - 25 years (12.5%).

All participants belonged to the same youth group and shared a common exposure context related to the sudden accidental death of a supervisor during an international youth stay in Senegal. Participation in the Psychological First Aid intervention was voluntary.

Before the session began, participants were informed that attendance was entirely voluntary, that they could choose whether or not to speak, and that they would not be expected to describe the circumstances surrounding the death. For participants aged 16 - 18 years, safeguarding measures were implemented in collaboration with responsible supervisors and youth program organizers to ensure an appropriate supportive environment.

These procedures were consistent with trauma-informed principles emphasizing autonomy, choice, respect, and avoidance of forced disclosure following potentially traumatic experiences [3] [4]. Exposure to the traumatic event differed among participants. The **three supervisors** were directly exposed because they discovered the deceased supervisor. The remaining participants were informed of the death afterward and were therefore **secondarily exposed**. To preserve confidentiality, these exposure categories are reported only in aggregated form.

2.5. Intervention Team

The Psychological First Aid intervention was conducted by five psychiatry trainees from the Department of Psychiatry of the Centre Hospitalier National Universitaire de Fann (CHNU Fann), Dakar, Senegal:

- Massale Doucoure TANDJIGORA, psychiatry resident, coordinator of the intervention;
- Safia Fall, psychiatry resident;
- Moustapha Gueye, psychiatry resident;
- MBANG ONDOUA Mathe Alexandra, psychiatry resident specializing in child and adolescent psychiatry;
- Rokhaya Gueye, Psychiatrist.

The members of the intervention team had clinical experience in psychiatry and training in psychological support approaches. The team's role was to provide immediate psychosocial support based on Psychological First Aid principles rather than deliver trauma-focused psychotherapy.

The intervention followed internationally recognized Psychological First Aid frameworks, including principles described by WHO, IASC, and NCTSN, while being adapted to the immediate clinical and cultural context [3] [5] [6]. The intervention focused on ensuring safety; providing compassionate and respectful listening; identifying immediate needs; offering practical support and facilitating connection with additional resources when required.

2.6. Data Collection

Information was compiled from anonymized observations recorded during and

immediately after the intervention, together with routine clinical notes and spontaneous comments shared by participants. The documented elements included participant characteristics; attendance and participation during the group session; emotional reactions observed during the intervention; themes emerging during individual supportive interviews and spontaneous feedback provided by participants regarding their experience.

Following completion of the intervention, routine clinical notes and participants' spontaneous feedback were retrospectively reviewed by the clinicians involved in the intervention. Only observations that had been consistently documented during routine clinical practice were retained for inclusion in this report. Direct observations made by clinicians during the intervention were distinguished from concerns and experiences spontaneously reported by participants during the group discussion or individual supportive interviews. The synthesis of observations was performed collectively by the intervention team to improve consistency and reduce individual interpretative bias.

2.7. Intervention Procedure

The intervention was structured according to the Psychological First Aid model based on Look-Listen-Link [3]. The intervention included two components: structured group Psychological First Aid session and optional individual supportive interviews for participants requiring additional emotional support.

Phase 1: Group Psychological First Aid Session

1) Establishing safety and supportive conditions

At the beginning of the session, the intervention consisted of a **single group session attended by all 24 participants**. The session was conducted in **French**, the common language spoken by both participants and clinicians. It took place in a **villa different from the site where the fatal accident had occurred**, thereby minimizing continued exposure to distressing reminders. The session lasted approximately **30 minutes**. No interpreter was required, and no culturally adapted written materials were used because all participants were French-speaking and shared a common linguistic context with the intervention team. The intervention team introduced themselves and explained the purpose and limits of the meeting.

Participants were informed that emotional reactions vary between individuals; there is no single expected way to react after a traumatic event; they were not required to share personal details about the death and they could express themselves only if they wished to do so. This approach followed trauma-informed principles emphasizing autonomy, respect, choice, and avoidance of forced trauma disclosure [3] [4].

2) Immediate Risk Assessment and Referral

Throughout both the group session and the individual supportive interviews, no participant required emergency psychiatric hospitalization, urgent referral, or immediate specialist intervention during the mission. Because participants returned to Belgium shortly after the intervention, arrangements had already been

established by the organizers for **systematic follow-up with mental health professionals in Belgium**, ensuring continuity of psychological care when required.

3) Psychoeducation component

A structured psychoeducation session was provided to help participants understand common psychological reactions following trauma exposure. The objective was to provide a framework for understanding possible stress responses, reduce uncertainty regarding reactions, and identify available coping resources.

The intervention team explained that traumatic experiences may temporarily influence emotions; thoughts; physical sensations and behaviors. Common trauma-related reactions discussed included sleep difficulties; anxiety; sadness; irritability; intrusive thoughts or memories; concentration difficulties; emotional fluctuations and increased alertness.

Participants were informed that these reactions may represent understandable responses to an extraordinary event and do not necessarily indicate psychological deterioration or the presence of a mental disorder [1] [2].

4) Simplified explanation of stress mechanisms

A brief explanation of stress-related biological mechanisms was provided using accessible language adapted to participants' age and level of understanding. The intervention team explained that exposure to danger activates the body's stress response systems, which may temporarily influence emotional regulation; attention; memory and sleep.

The objective was not to medicalize normal reactions but to provide participants with a framework for understanding possible changes in emotions, thoughts, and physical sensations following trauma exposure.

3. Results

3.1. Participant Characteristics and Intervention Attendance

A total of **24 participants** took part in the Psychological First Aid (PFA) intervention. All participants included in the intervention attended the group Psychological First Aid session.

The group included **21 young participants aged 16 - 18 years (87.5%)** and **3 supervisors aged 20 - 25 years (12.5%)**. All participants shared a common exposure context related to the sudden accidental death of a supervisor during an international youth stay in Senegal.

Following the group session, **11 participants (45.8%)** received optional individual supportive interviews. These interviews were offered to participants who requested additional support, appeared significantly distressed during the session, or expressed concerns requiring a more individualized discussion.

Participant characteristics and intervention attendance are summarized in **Table 1**.

3.2. Observations during the Group Psychological First Aid Session

During the group Psychological First Aid session, participants were provided with

an opportunity to express emotions, concerns, and questions regarding their reactions following the traumatic bereavement. During the group session, participants expressed a wide range of emotional and cognitive reactions commonly reported after a traumatic loss.

Table 1. Characteristics of participants involved in the Psychological First Aid intervention.

Characteristics	Number (%)
Total participants	24 (100%)
Young participants aged 16 - 18 years	21 (87.5%)
Supervisors aged 20 - 25 years	3 (12.5%)
Participants attending group PFA session	24 (100%)
Participants receiving individual supportive interviews	11 (45.8%)

Some participants displayed visible emotional distress, including sadness, crying episodes, and difficulty expressing their experiences verbally. At the beginning of the session, some participants questioned whether their emotional reactions were "normal" and whether their responses corresponded to what might be expected following such an event.

Some participants compared their own reactions with those of other group members and expressed concerns regarding differences in emotional expression. The psychoeducation component focused on explaining the variability of trauma-related reactions and supporting recognition of individual differences in emotional responses.

The discussion emphasized that people do not all respond to trauma in the same way and that differences in emotional expression should not be interpreted as differences in empathy, attachment, or concern for the deceased. During the discussion, participants verbally acknowledged that individuals may experience and express distress differently following traumatic events. This observation was based on spontaneous exchanges during the intervention and does not represent an objective measurement of psychological change.

3.3. Individual Supportive Interviews

Following the group session, **11 participants (45.8%)** received individual supportive interviews. Three participants experienced persistent crying throughout most of the group session. Based on these observations, clinicians privately offered these participants an individual consultation without any pressure or obligation. All three accepted after confirming that they felt they needed additional psychological support. The remaining **eight participants** requested an individual interview spontaneously in order to discuss personal concerns in a confidential setting.

No psychiatric diagnosis was established during these interviews, as their purpose was immediate psychological support and stabilization rather than formal

clinical assessment. The main psychological reactions and concerns identified during individual supportive interviews are summarized in Table 2.

Table 2. Main psychological reactions and concerns identified during individual supportive interviews.

Psychological reaction or concern	Field observations
Sadness	Frequently expressed following the loss
Crying episodes	Frequently observed during emotional expression
Emotional distress	Commonly observed among participants
Guilt-related thoughts	Reported by several participants
Anxiety regarding future psychological reactions	Concerns regarding possible persistence of distress
Fear related to returning home	Some participants expressed concerns about losing group support
Need for reassurance	Participants sought explanations regarding the meaning and variability of their reactions

3.4. Emotional Reactions and Guilt-Related Thoughts

A recurrent theme identified during individual discussions was the presence of guilt-related thoughts. Some participants questioned whether their own emotional responses were appropriate following the traumatic bereavement.

One supervisor expressed concern because he had not cried immediately after discovering the deceased person, whereas other members of the group had displayed more visible emotional reactions. The intervention team addressed these concerns through psychoeducation and supportive discussion.

Participants were informed that emotional responses immediately following traumatic events may vary considerably between individuals. Temporary emotional numbness, shock reactions, emotional inhibition, or delayed emotional expression may occur during overwhelming situations and should not automatically be interpreted as a lack of empathy, attachment, or concern.

These discussions aimed to provide participants with a broader understanding of human responses to traumatic events. Such variability in acute trauma responses has been described in trauma literature, where immediate reactions may differ substantially according to individual factors, previous experiences, perceived threat, social context, and available support resources [2] [4].

3.5. Participants' Perceptions of the Intervention

At the end of the intervention, several participants spontaneously shared their perceptions regarding the psychological support provided. The main perceived contributions included improved understanding of trauma-related reactions; reassurance regarding variability in emotional responses; clarification of possible psychological reactions following trauma exposure and increased awareness of available psychological support resources.

Several participants verbally reported that explanations regarding trauma-related reactions helped them better understand changes in their emotions, thoughts,

or behaviors following the event. Supportive listening provided by the intervention team was also perceived as helpful in creating a respectful environment where participants could express concerns without fear of judgment.

These comments reflected participants' own impressions of the intervention and should not be interpreted as evidence of its effectiveness. This distinction is important because available evidence supports Psychological First Aid as a recommended early psychosocial approach, but the evidence base regarding its direct impact on long-term psychological outcomes remains evolving [3] [8].

3.6. Return Home and Role of Social Connectedness

The planned return to Belgium generated different emotional responses among participants. For some participants, leaving the location where the traumatic event occurred was experienced as reassuring because it represented physical distance from reminders associated with the event and a return toward a familiar environment.

However, other participants expressed concerns about returning home. They explained that remaining together as a group provided emotional reassurance and a sense of mutual support.

Some participants expressed concerns that separation from the group could reduce this source of comfort during the adaptation period following the event. This observation suggested that social connectedness was perceived as an important source of support during the immediate aftermath of trauma exposure.

This interpretation is consistent with the framework proposed by Hobfoll and colleagues, which identifies connectedness as one of the empirically supported principles considered important in early responses to mass trauma, alongside safety, calming, self-efficacy, and hope [4]. In Senegal, as in many contexts where family and community networks play an important role in social support, considering existing relational resources may be particularly relevant when planning early psychosocial responses after traumatic events.

However, cultural adaptations should remain context-specific and based on the needs and preferences of affected individuals.

The main components of the intervention and their correspondence with Psychological First Aid principles are summarized in **Table 3**.

Table 3. Components of the intervention and corresponding psychological first aid principles.

Intervention component	Psychological First Aid principle
Transfer to a safer accommodation environment	Restoration of safety and reduction of exposure to distressing reminders
Group Psychological First Aid session	Compassionate support and emotional stabilization
Psychoeducation regarding trauma-related reactions	Calming and reinforcement of self-efficacy
Individual supportive interviews	Identification of individual needs and connection with additional resources
Maintenance of group cohesion before return home	Strengthening social connectedness

3.7. Immediate Field Observations

Understanding of trauma-related reactions: Participants expressed questions regarding the meaning of their emotional and cognitive responses following traumatic exposure. The psychoeducation component provided a framework for considering these reactions as possible responses to an extraordinary event rather than as signs of personal weakness.

This approach is consistent with trauma-informed recommendations emphasizing normalization, supportive information, and empowerment during early psychosocial responses [3] [4].

Uncertainty regarding personal reactions: Some participants expressed concerns about whether their own reactions were appropriate compared with those of others. Discussion and psychoeducation focused on explaining that variations in emotional expression are commonly reported after traumatic events.

Need for individualized support: Although the group intervention allowed shared discussion and normalization, individual supportive interviews provided a private space for participants who wished to discuss personal concerns. This complementary approach allowed attention to both collective and individual needs.

Importance of social connectedness: The group context appeared to represent an important source of emotional support during the immediate period following the traumatic event. Maintaining supportive relationships appeared particularly relevant during the transition period before returning to participants' usual environments.

3.8. Summary of Main Findings

This Psychological First Aid intervention involved **24 young participants** following the sudden traumatic loss of a supervisor.

The main field observations were that all participants attended the group Psychological First Aid session; nearly half of participants received individual supportive interviews; sadness, crying episodes, emotional distress, guilt-related thoughts, uncertainty regarding reactions, and concerns related to separation from the group were the main themes identified; psychoeducation and supportive listening were spontaneously perceived by participants as useful elements of support; social connectedness appeared to represent an important source of support during the immediate aftermath of trauma exposure.

Overall, this experience suggests that a Psychological First Aid response can be operationally organized following traumatic bereavement involving young people, particularly when rapid coordination, trained responders, and adaptation to contextual needs are available. Combining group-based support with opportunities for individualized discussion may help address both collective and personal emotional needs during the acute phase following trauma exposure.

4. Discussion

This descriptive field report describes the rapid implementation of a Psychological

First Aid (PFA) intervention following sudden traumatic bereavement involving young participants during an international youth stay in Senegal.

Our experience highlights how an early psychosocial response can be organized despite limited time, logistical constraints, and the need for rapid coordination between healthcare providers, youth program organizers, and institutional partners.

The objective of this report was not to demonstrate the efficacy of Psychological First Aid, as no standardized outcome measures or comparative design were used. Rather, it contributes to the limited literature describing the practical implementation of PFA in real-world settings, particularly in sub-Saharan Africa.

Several practical lessons emerged from this intervention. Restoring safety appeared to be the first priority, psychoeducation helped participants make sense of their reactions, social connectedness played an important supportive role, and the experience underscored the need for better preparedness in emergency mental health.

4.1. Restoring Safety as the First Priority after Traumatic Exposure

Restoring a sense of safety is one of the fundamental objectives of early psychosocial responses following potentially traumatic events; international recommendations emphasize that such responses should focus on protection, stabilization, practical needs, and emotional support rather than immediate psychological processing of the traumatic experience [3] [4].

In this intervention, transferring participants away from the accommodation site where the death occurred represented an important initial step, since that environment had become associated with the traumatic event and could act as a reminder of it. Relocating participants provided a different setting for psychological support, consistent with the objective of reducing continued exposure to distressing reminders and promoting a safer context for recovery [3].

However, this experience also illustrated that safety extends beyond the physical environment: although leaving the location of the event was reassuring for some participants, others expressed concerns about losing the emotional security provided by the group after returning home. These observations suggest that psychological safety is also shaped by social relationships, emotional support, predictability, and access to trusted individuals.

This perspective is consistent with the framework proposed by Hobfoll and colleagues, which identifies five empirically supported principles considered important in early responses to mass trauma: safety, calming, self-efficacy, connectedness, and hope [4].

4.2. Psychological First Aid and Avoidance of Forced Trauma Disclosure

A central characteristic of Psychological First Aid is that it does not require indi-

viduals to immediately describe or repeatedly revisit traumatic experiences. Historically, psychological debriefing was widely used following traumatic events based on the assumption that early emotional expression could prevent post-traumatic stress disorder (PTSD).

However, systematic reviews have not demonstrated preventive benefits of mandatory psychological debriefing and have raised concerns regarding its routine use immediately after trauma exposure [7]. Current trauma-informed approaches therefore emphasize supportive interventions that respect individual differences and avoid pressuring individuals to disclose traumatic experiences before they are ready [3] [5].

During this intervention, participants were explicitly informed that they were not required to describe the circumstances surrounding the death. They were encouraged to share only what they personally wished to discuss.

This approach appeared appropriate given the diversity of participants' needs. Some participants appeared to seek verbal expression and emotional sharing, whereas others appeared to benefit mainly from information, reassurance, and the presence of a supportive environment.

Respecting these differences is consistent with trauma-informed principles emphasizing autonomy, choice, and variability in responses following traumatic experiences [3] [4].

4.3. Psychoeducation as a Component of Early Psychological Support

Psychoeducation represented one of the central components of this intervention. Following traumatic exposure, distress may be intensified when individuals do not understand their own emotional, cognitive, or physical reactions.

Experiences such as crying, emotional numbness, intrusive thoughts, sleep disturbances, anxiety, or emotional fluctuations may sometimes be interpreted as signs of weakness or inability to cope.

Providing clear and accessible information about common trauma reactions may help people better understand what they are experiencing and identify appropriate ways of coping during the early aftermath of a traumatic event. In this field experience, participants spontaneously reported that explanations regarding trauma-related reactions helped them better understand differences in emotional responses within the group.

This was particularly relevant for participants who questioned whether their own reactions were appropriate compared with those of others. The discussions highlighted that differences in emotional expression do not necessarily reflect differences in empathy, attachment, or the importance of the relationship with the deceased person.

These observations support the clinical relevance of psychoeducation as an accessible component of early psychosocial support, particularly in emergency settings where extensive psychological interventions may not be immediately feasible

[3] [8]. However, these observations represent participant perceptions and cannot be interpreted as evidence of clinical effectiveness.

4.4. Social Connectedness as a Supportive Factor after Trauma

One of the main observations from this intervention was the importance of social connectedness. Participants experienced a shared traumatic event within a defined group context. The group therefore represented both a context associated with the traumatic experience and an important source of emotional support.

While some participants experienced leaving the location of the event as reassuring, others expressed concerns about losing the support and sense of belonging provided by the group after returning home. These different reactions illustrate that recovery after trauma is influenced not only by the physical environment but also by the quality of the social support available to those affected. [3] [6].

In this experience, group cohesion appeared to provide several supportive elements: shared recognition of a difficult experience; emotional validation; normalization of individual reactions; reduction of feelings of isolation and reinforcement of belonging during a period of uncertainty. Therefore, early psychosocial responses should aim not only to reduce exposure to traumatic reminders but also to preserve supportive social connections whenever possible [4].

In Senegal, as in many contexts where family and community networks play an important role in social support, considering existing relational resources may be particularly relevant when planning early psychosocial responses. However, cultural adaptations should remain context-specific and based on the needs and preferences of affected individuals.

4.5. Lessons Learned and Implications for Emergency Mental Health Practice

4.5.1. Rapid Coordination and Preparedness Are Essential

The intervention required coordination between psychiatry trainees, healthcare institutions, youth program organizers, and diplomatic representatives within a very short timeframe. One of the main lessons from this intervention was the importance of being prepared to respond rapidly to the psychological consequences of traumatic events through effective coordination and timely mental health support.

In many low- and middle-income countries, mental health remains insufficiently integrated into emergency preparedness plans despite the psychological consequences associated with traumatic events. The Lancet Commission on global mental health and sustainable development emphasized the importance of strengthening mental health systems and integrating psychosocial care into broader health strategies, particularly in settings where resources remain limited [9].

Integrating trained mental health professionals into emergency response systems may strengthen healthcare capacity to address psychological consequences of crises [6] [10].

4.5.2. Safety Restoration Should Precede Psychological Processing

The first priority following traumatic exposure was not detailed discussion of the event but restoration of safety, emotional stabilization, and identification of immediate needs. This approach was consistent with trauma-informed principles and the objectives of Psychological First Aid [3] [4].

4.5.3. Group and Individual Approaches Are Complementary

The group session facilitated shared understanding, normalization, and social support. Individual supportive interviews provided a more private context for participants who wished to discuss personal concerns.

The combination of both approaches allowed attention to collective and individual needs.

4.5.4. Psychoeducation May Be Particularly Valuable When Uncertainty Is High

Participants frequently questioned whether their reactions were normal. Providing accessible explanations about trauma-related responses appeared to address uncertainty and offered a framework for understanding individual experiences.

This observation supports the importance of clear communication and accessible psychological information during early crisis responses [3].

4.5.5. Training of Responders Should Be Strengthened

This experience highlights the importance of preparing healthcare professionals to respond to psychological consequences of traumatic events. Psychiatry training should include competencies related to crisis communication, trauma-informed approaches, and early psychosocial interventions.

Psychological First Aid training should not be limited exclusively to psychiatrists and psychologists. When appropriately trained and supervised, healthcare workers, educators, and community responders may contribute to early psychosocial support during emergencies [3] [6].

Emergency preparedness plans should systematically include mental health components alongside medical, logistical, and security responses.

4.5.6. Importance of Culturally Adapted Interventions

Responses to traumatic events occur within specific cultural, social, and family contexts. Emergency mental health interventions, particularly in low- and middle-income countries, should consider:

- cultural representations of suffering and grief;
- family and community support systems;
- availability of mental health services;
- possibilities for long-term follow-up.

To our knowledge, published descriptions of rapid Psychological First Aid implementation among young people exposed to sudden traumatic bereavement in sub-Saharan African contexts remain limited. This field experience therefore contributes practical information regarding the application of PFA in an African setting where specialized mental health resources may be limited.

Although the intervention followed internationally recognized principles, adaptation to local realities, available resources, and cultural expectations remains essential.

5. Limitations

This report has several limitations.

First, the small number of participants limits the generalizability of the observations.

Second, standardized psychological assessment instruments were not used before or after the intervention. Therefore, changes in psychological symptoms could not be objectively measured.

Third, no long-term follow-up assessment was available after participants returned to Belgium. Consequently, the evolution of trauma-related symptoms, adaptation over time, and access to subsequent support could not be examined.

Fourth, as a descriptive field experience report, this manuscript cannot establish causal relationships or demonstrate the effectiveness of Psychological First Aid.

Fifth, observations were based mainly on clinical impressions and spontaneous participant feedback, which may introduce observer bias.

The members of the intervention team were also the authors of this report and were directly involved in delivering the Psychological First Aid intervention. Their involvement may have influenced the interpretation and selection of field observations reported in this manuscript.

To reduce this risk, observations were synthesized collectively by the intervention team and presented as descriptive field observations rather than individual clinical assessments.

Although these limitations should be acknowledged, this report provides practical insight into how Psychological First Aid can be organized in a real emergency within a sub-Saharan African setting where published field experiences remain scarce.

6. Conclusions

Our experience suggests that Psychological First Aid can be implemented rapidly after sudden traumatic bereavement involving young people. Beyond describing the intervention itself, this report highlights the importance of restoring safety, providing compassionate support, offering practical psychoeducation, respecting individual coping strategies, and preserving social connectedness during the immediate aftermath of trauma.

The experience also highlights the need to strengthen emergency mental health preparedness and integrate Psychological First Aid training into psychiatry residency programs and healthcare systems, particularly in low- and middle-income countries.

Further research is needed to evaluate implementation strategies, cultural ad-

aptations, feasibility, and long-term outcomes of Psychological First Aid interventions in diverse settings.

7. Ethics Approval and Consent to Participate

This manuscript reports a retrospective descriptive analysis based exclusively on anonymized observations collected during routine Psychological First Aid provided after a traumatic event. The intervention was conducted as part of routine emergency psychosocial care and was not originally designed as a research study.

Authorization to prepare this retrospective report was obtained from the Department of Psychiatry of the Fann National University Hospital Center (CHNU Fann), which coordinated the intervention. The analysis was performed exclusively on anonymized data collected during routine clinical practice. No additional data were collected for research purposes, and no information that could identify individual participants was included in this manuscript.

Participation in the intervention was voluntary. Before receiving Psychological First Aid, participants were informed of the supportive nature of the intervention and were free to decline or discontinue their participation at any time without any consequences. They were not required to disclose personal experiences or discuss details of the traumatic event.

For participants aged 16 - 18 years, the intervention was conducted in collaboration with the youth-program organizers and the responsible accompanying adults, in accordance with the organizational arrangements established for the activity. These individuals were also informed that anonymized observations from routine care could be used to prepare a retrospective descriptive report.

Throughout the intervention and the preparation of this manuscript, confidentiality, participant privacy, autonomy, and trauma-informed care principles were respected. No names, photographs, audio recordings, videos, or other identifiable personal information were collected or reported.

8. Availability of Data

The information supporting this report consists of anonymized field observations collected during the Psychological First Aid intervention.

Because of confidentiality considerations and the absence of identifiable research data, the dataset is not publicly available.

Additional information may be obtained from the corresponding author upon reasonable request, provided that confidentiality and ethical requirements are maintained.

Acknowledgments

The authors would like to thank all participants who accepted to take part in the Psychological First Aid intervention during this particularly difficult period.

The authors also acknowledge the diplomatic representatives involved in facilitating the emergency response process, and all individuals who contributed to

creating a supportive environment following the traumatic event.

The authors express their gratitude to the Department of Psychiatry of the Centre Hospitalier National Universitaire de Fann (CHNU Fann), Dakar, Senegal, for supporting the involvement of psychiatry trainees in emergency mental health responses.

Author Contributions

1) Conceptualization and coordination

MDT conceptualized the report and coordinated the intervention and the manuscript preparation.

2) Investigation and data collection

MDT, SF, MG, MOMA, and RG delivered the Psychological First Aid intervention and collected the field observations.

3) Supervision and formal synthesis

RG supervised the intervention and the collective synthesis of field observations. MDT drafted the original manuscript.

4) Writing: review and editing

All authors critically reviewed the manuscript, contributed to interpretation of observations, and approved the final version.

Conflicts of Interest

The authors declare that they have no competing interests.

References

[1] Bisson, J.I., Cosgrove, S., Lewis, C. and Roberts, N.P. (2015) Post-Traumatic Stress Disorder. *BMJ*, **351**, h6161. https://doi.org/10.1136/bmj.h6161

[2] Shalev, A.Y., Gevonden, M., Ratanatharathorn, A., Laska, E., van der Mei, W.F., Qi, W., *et al.* (2019) Estimating the Risk of PTSD in Recent Trauma Survivors: Results of the International Consortium to Predict PTSD (ICPP). *World Psychiatry*, **18**, 77-87. https://doi.org/10.1002/wps.20608

[3] World Health Organization, War Trauma Foundation and World Vision International (2011) Psychological First Aid: Guide for Field Workers. World Health Organization. https://www.who.int/publications/i/item/9789241548205

[4] Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J., *et al.* (2007) Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. *Psychiatry*: *Interpersonal and Biological Processes*, **70**, 283-315. https://doi.org/10.1521/psyc.2007.70.4.283

[5] Inter-Agency Standing Committee (2007) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Inter-Agency Standing Committee. https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings

[6] Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., *et al.* (2006) Psychological First Aid: Field Operations Guide. 2nd Edition, National Child Traumatic Stress Network and National Center for PTSD.

[7] Rose, S.C., Bisson, J., Churchill, R. and Wessely, S. (2002) Psychological Debriefing

for Preventing Post Traumatic Stress Disorder (PTSD). *Cochrane Database of Systematic Reviews*, No. 2, CD000560. https://doi.org/10.1002/14651858.cd000560

[8] Shultz, J.M. and Forbes, D. (2013) Psychological First Aid: Rapid Proliferation and the Search for Evidence. *Disaster Health*, **2**, 3-12. https://doi.org/10.4161/dish.26006

[9] Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., *et al.* (2018) The Lancet Commission on Global Mental Health and Sustainable Development. *The Lancet*, **392**, 1553-1598. https://doi.org/10.1016/s0140-6736(18)31612-x

[10] World Health Organization and United Nations High Commissioner for Refugees (2015) mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies. World Health Organization. https://www.who.int/publications/i/item/9789241548922