Guidelines for the Management of Conditions Specifically Related to Stress

mhGAP

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Table of content

Glossary

Acute traumatic stress symptoms: Symptoms of intrusion, avoidance and hyperarousal in the first month after exposure to potentially traumatic events.

Cognitive-behavioural therapy (CBT) with a trauma focus: This therapy (CBT) is based on the idea that people with posttraumatic stress disorder (PTSD) and acute traumatic stress symptoms have unhelpful thoughts and beliefs related to a traumatic event and its consequences. These thoughts and beliefs result in unhelpful avoidance of reminders of the event(s) and maintain a sense of current threat. Cognitive-behavioural interventions with a trauma focus usually include (imaginal and/or in vivo) exposure treatment and/or direct challenging of unhelpful trauma-related thoughts and beliefs.

The term cognitive-behavioural therapy (CBT) with a trauma focus is synonymous with the term trauma-focused CBT (TF-CBT), as used in the National Institute for Clinical Evidence (NCCMH, 2005) Guidelines and in Cochrane reviews (e.g. Bisson & Andrew 2005). It is noted that in the traumatic stress literature the latter term also has a more narrow definition for a very specific and widely disseminated multi-component CBT protocol for children and adolescents developed by Cohen and colleagues (2000).

Early psychological interventions: Psychological intervention delivered in the first month after exposure to a potentially traumatic event.

Eye movement desensitization and reprocessing (EMDR): This therapy is based on the idea that negative thoughts, feelings and behaviours are the result of unprocessed memories. The treatment involves standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements.

Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.

mental health Gap Action Programme (mhGAP): The mental health Gap Action Programme was launched by the World Health Organization in 2008 to address the lack of mental health care for people especially in low- and middle-income countries. This program included the formulation of evidence-based guidelines for use in non-specialized (e.g. primary care) settings.

Problems and disorders specifically related to stress: These problems include posttraumatic stress disorder, acute stress reaction and bereavement reactions.

There are numerous other stress-related disorders and problems (e.g. depression, behavioural disorders, alcohol/substance use problems, self-harm/suicide, medically unexplained somatic complaints), but these are not specifically *related to stress (i.e. they also occur in the absence of identifiable stressful life events) and these have been covered previously in WHO mhGAP Guidelines.*
It is anticipated that acute stress reaction will no longer be classified as a mental disorder in ICD-11 and, accordingly, the current guidelines make recommendations for symptoms of acute (traumatic) stress rather than for acute stress reaction.

Psycho-education: The provision of information about the nature of a mental disorder and its symptoms, and what to do about them (Wessely et al., 2008).

Psychological debriefing: The promotion of ventilation by encouraging the person to briefly but systematically recount perceptions, thoughts and emotional reactions experienced during a recent, stressful event (WHO, 2010).

Psychological first aid (PFA): Humane, supportive response to a fellow human being who is suffering and who may need support. It entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk, assessing needs and concerns, ensuring that basic needs are met, encouraging social support from significant others and protecting from further harm (WHO, 2010).

Stress management: Psychological treatments that use cognitive or behavioural techniques (e.g. relaxation, stress inoculation training) that do not focus on the traumatic event (Bisson & Andrew, 2007).

Structured psychological interventions: Psychological interventions that go beyond general application of psychological principles of care that are part of health and social care. Examples of such principles of care are good communication and mobilizing and providing social support (cf. the mhGAP Intervention Guide, p.6, WHO, 2010).

Symptoms of acute stress: Psychological symptoms in the first month after exposure to potentially traumatic events.

Examples of such symptoms include:

- *Acute traumatic stress symptoms (defined above)*
- *Dissociative symptoms, including somatoform conversion*
- *Enuresis (bedwetting)*
- *Hyperventilation*
- *Insomnia.*

Universally applied bereavement interventions: Interventions that are offered to all people who have experienced bereavement, regardless of whether bereaved people are experiencing symptoms of mental disorder.

Executive summary

Why these guidelines were developed

There are currently no suitable, evidence-based guidelines for managing problems and disorders related to stress in primary health care and other non-specialized health-care settings. Agencies working in post-conflict and natural disaster settings are increasingly interested in mental health care. This requires the development and testing of a module on the management of problems and disorders specifically related to stress.

Objectives and scope of the document

This document was developed to provide recommended management strategies for problems and disorders that are specifically related to the occurrence of a major stressful event. The recommended strategies will form the basis of a new module to be added to the WHO (2010) mhGAP Intervention Guide for use in non-specialized specialized health-care settings.

The scope of the problems covered by these guidelines is:

- symptoms of acute stress in the first month after a potentially traumatic event, with the following subtypes:
    - symptoms of acute traumatic stress (intrusion, avoidance and hyperarousal) in the first month after a potentially traumatic event;
    - symptoms of dissociative (conversion) disorders in the first month after a potentially traumatic event;
    - non-organic (secondary) enuresis in the first month after a potentially traumatic event (in children);
    - hyperventilation in the first month after a potentially traumatic event;
    - insomnia in the first month after a potentially traumatic event;
- posttraumatic stress disorder (PTSD);
- bereavement in the absence of a mental disorder.

Who should use these guidelines

The primary audience is non-specialized specialized health-care providers working at first- and second-level health-care facilities. They include general physicians, family physicians, nurses and clinical officers. They also include those specialist medical doctors who work in areas other than mental health and substance abuse, such as paediatricians, emergency medicine physicians, obstetricians, gynaecologists and internists. A secondary audience is those tasked with the organization of health care at the district