

Assessment and Management of Conditions Specifically Related to Stress

mhGAP Intervention Guide Module



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Introduction



This Mental Health Gap Action Programme (mhGAP) Intervention Guide module contains assessment and management advice related to acute stress, post-traumatic stress and grief in non-specialized health settings. It is an **annex** to the *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings* (mhGAP-IG 1.0; WHO, 2010).

The guidance reflected in the module is based on formally approved WHO Guideline Development Group recommendations, available at:
www.who.int/mental_health/mhgap/evidence/en/.

This module should always be used together with the *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings* (WHO, 2010), which outlines relevant general principles of care and management of a range of other mental, neurological and substance use disorders.

(www.who.int/mental_health/publications/mhGAP_intervention_guide/en/index.html)

In the future, this module may be integrated with other products in the following ways:

- This module may be integrated – in its full form – into future iterations of the existing *mhGAP Intervention Guide*.
- The module will be integrated – in a simplified structure – into a new product, the *WHO-UNHCR mhGAP Intervention Guide for Humanitarian Settings* (planned for 2014).

In the context of its mhGAP programme, WHO is producing materials related to programme planning; situational analysis; adaptation of clinical protocols to local contexts; training and supervision; and monitoring and evaluation. For further communication on these topics, email mhgap-info@who.int.

Conditions Specifically Related to Stress

STR

Health-care staff frequently encounter people who have been exposed to potentially traumatic events (e.g. serious accidents, physical and sexual violence, disasters) or loss of a loved one. Immediately after the exposure, the vast majority of people will experience distress but will not develop a condition that needs clinical management. A minority of people will develop one or both of the following types of condition:

» **Problems and disorders that are more likely to occur after exposure to stressors but that also occur in the absence of such exposure.**

These include: depressive disorder (» DEP), psychosis (» PSY), behavioural disorders (» BEH), alcohol use disorder (» ALC), drug use disorder (» DRU), self-harm/suicide (» SUI) and other significant emotional or medically unexplained complaints (» OTH). These are already covered in the relevant modules of the existing *mhGAP Intervention Guide*.

» **Problems and disorders that require exposure to stressors.**

These include:

- (a) **significant symptoms of acute stress;**
- (b) **post-traumatic stress disorder (PTSD); and**
- (c) **grief and prolonged grief disorder.**

The assessment and management of these are covered in this module.

After recent exposure to potentially traumatic events, people's reactions tend to be diverse. This module uses the term **symptoms of acute stress** to cover a wide range of emotional, cognitive, behavioural and somatic symptoms occurring within approximately one month of the event(s).

Examples of symptoms occurring in both adults and children include re-experiencing symptoms, avoidance symptoms and symptoms related to a sense of heightened current threat, insomnia, palpitations, mood and behavioural changes, a range of physical complaints and – in children – regressive behaviours, including bedwetting. These symptoms can be indicative of a mental disorder, but often are transient and not part of a mental disorder. Nonetheless, if they impair day-to-day functioning or if people seek help for them, then they are **significant symptoms of acute stress**.

Conditions specifically related to stressors often occur in combination with other mhGAP conditions. **People who meet the criteria for any of the other mhGAP conditions should be assessed and managed according to the relevant module, in addition to the management advice given in this module.**



The mhGAP Intervention Guide is written for non-specialized health staff offering clinical care in low-resource settings. If applied in humanitarian settings, such care should be accompanied with appropriate **inter-sectoral, social interventions**. These are described in: IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2010) *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?* (www.who.int/entity/mental_health/emergencies/what_humanitarian_health_actors_should_know.pdf).

Conditions Specifically Related to Stress

STR 1

Assessment and Management Guide

1. Does the person have significant symptoms of acute stress after **RECENT** (within approximately one month) exposure to a potentially traumatic event?

» **Find out how much time has passed since the potentially traumatic event** (i.e. an extremely threatening or horrific event, such as physical or sexual violence, a major accident).

» **If the event occurred less than a month ago, assess for symptoms of acute stress with onset after the event.**

These may include:

- Insomnia
- Re-experiencing symptoms »STR 2
- Avoidance symptoms »STR 2
- Symptoms related to a sense of heightened current threat »STR 2
- Any disturbing emotions or thoughts
- Changes in behaviour that trouble the person or others around them (e.g. aggressiveness, social isolation/withdrawal and (in adolescents) risk-taking behaviour)
- Regressive behaviours, including bedwetting (in children)
- Medically unexplained physical complaints including hyperventilation and dissociative disorders of movement and sensation (e.g. paralysis, inability to speak or see).¹

YES

If the person meets all of the following criteria:

- » Has experienced a potentially traumatic event within approximately the last month
- » Has symptoms of acute stress with onset after the event
- » Has difficulties in day-to-day functioning or seeks help for these symptoms

then the person is likely to have **significant symptoms of acute stress.**

- » Offer psychological first aid: »STR 3.1
 - Listen. **DO NOT** pressure the person to talk ❌
 - Assess needs and concerns
 - Help the person to address immediate, basic physical needs (e.g. shelter for the night)
 - Help people connect to services, family, social supports and accurate information
 - As far as possible, help protect the person from further harm.
- » Assess for and, if possible, address current stressors, including ongoing abuse. »STR 3.2
- » Consider stress management. »STR 3.3
- » Help people to identify and strengthen positive coping methods and social supports. »STR 3.4
- » **DO NOT** prescribe benzodiazepines or antidepressants to manage symptoms of acute stress. ❌
- » Consider additional management strategies for:
 - Insomnia as a symptom of acute stress »STR 3.5.1
 - Bedwetting as a symptom of acute stress »STR 3.5.2
 - Prominent medically unexplained somatic complaints:
 - For general guidance, see mhGAP-IG 1.0, p.81
 - For guidance on hyperventilation as a symptom of acute stress, »STR 3.5.3
 - For guidance on sensorimotor dissociation as a symptom of acute stress, »STR 3.5.4
- » Offer psychoeducation. Explain that:
 - People often experience acute stress after extreme stressors
 - In most people the acute stress reduces over time.
- » **Ask the person to return for follow-up if the symptoms become more severe, or if there is no improvement at all by one month after the event.**
 - At follow-up, assess for PTSD (see below) and DEP, BEH, ALC, DRU and SUI (»mhGAP-IG 1.0 Master Chart).

¹ The term *dissociative disorders of movement and sensation* is consistent with current draft proposals for ICD-11.

Conditions Specifically Related to Stress

STR 1

Assessment and Management Guide

2. Does the person have post-traumatic stress disorder (PTSD)?

» Find out how much time has passed since the potentially traumatic event (i.e. an extremely threatening or horrific event, such as physical or sexual violence, a major accident).

» If the event occurred at least a month ago, assess for traumatic stress symptoms² (»STR 2 for full definition of these terms and symptoms, including in children):

– **Re-experiencing symptoms**

These are repeated and unwanted recollections of the event as though it is occurring in the here and now (e.g. through frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror).

– **Avoidance symptoms**

These involve deliberate avoidance of thoughts, memories, activities or situations that remind the person of the event.

– **Symptoms related to a sense of heightened current threat**

These involve hypervigilance (excessively watchful for potential threats) or exaggerated startle responses (e.g. easily startled or jumpy with fear).

» Assess for difficulties carrying out usual work, school, domestic or social activities.

YES

If the person meets all of the following criteria:

- » Has experienced a potentially traumatic event at least a month ago
- » Has at least one re-experiencing symptom AND one avoidance symptom AND one hyper-arousal symptom
- » Has difficulties in day-to-day functioning

then the person is likely to have **post-traumatic stress disorder (PTSD)**.

» Assess for and, if possible, address current stressors, including ongoing abuse. »STR 3.2

» Offer psychoeducation. »STR 3.6

» If trained and supervised therapists are available 🧑🏻‍⚕️, consider referral for:

- Individual or group cognitive behavioural therapy with a trauma focus (CBT-T) »INT or
- Eye movement desensitization and reprocessing (EMDR). »INT

» Consider stress management (e.g. breathing exercises, progressive muscle relaxation). »STR 3.3

» Help people to identify and strengthen positive coping methods and social supports. »STR 3.4

» In adults, consider antidepressants 🧑🏻‍⚕️, when CBT-T, EMDR or stress management prove ineffective or are unavailable »DEP 3 (for details on prescribing antidepressants, »mhGAP-IG 1.0 pp.14-15) 🕒

🧑🏻‍⚕️ In children and adolescents, **DO NOT** offer antidepressants to manage PTSD. ❌

» Offer regular follow-up, e.g. after 2–4 weeks:

- Follow-up may be in person at the clinic, by phone or through a community health worker
- At follow-up, re-assess the person for improvement.

² The description of traumatic stress symptoms is consistent with the current draft ICD-11 proposal for PTSD, with one difference: the ICD-11 proposal allows for classification of PTSD within one month (e.g. several weeks) after the event. The ICD-11 proposal does not include non-specific PTSD symptoms such as numbing and agitation.

3. Is the person grieving after loss of a loved one?

YES

The person is grieving.

- » **DO NOT** prescribe benzodiazepines to manage symptoms of grief. ❌
- » Listen without pressing the person to talk.
- » Assess needs and concerns.
- » Discuss and support culturally appropriate mourning/adjustment.
- » Provide or mobilize social support, as needed.

4. Does the person have prolonged grief disorder?³

YES

If the person meets all of the following criteria:

- » Has persistent and severe yearning or preoccupation with the deceased (usually combined with other grief symptoms, such as anger, difficulty accepting the loss) with associated emotional pain
- » Has difficulties in day-to-day functioning
- » Has been grieving persistently for at least six months and for a period that is much longer than what is expected in the person's culture

then the person may have **prolonged grief disorder**.

- ⚠️ In children and adolescents who have lost parents or other carers, address the need for protection and continued supportive caregiving, including socio-emotional support.
- » **CONSULT A SPECIALIST** 🧑‍⚕️ if the person asks for more intense treatment.

- » Assess for the following symptoms (e.g. persistent and severe yearning for the deceased, preoccupation with the deceased or circumstances of the death; bitterness about the loss, difficulty accepting the loss; difficulty progressing with activities or developing friendships; feeling that life is meaningless) with associated emotional pain.
- » Assess for difficulties carrying out usual work, school, domestic or social activities.
- » Ask when the bereavement occurred.

- » **Follow the above advice** (applicable to ALL people who are grieving).
- » **CONSULT A SPECIALIST** 🧑‍⚕️ for further assessment and management.

5. Does the person have a concurrent condition?

YES

The person has a concurrent condition

- » **If there is a concurrent mental, neurological or substance use condition (including risk of suicide/self-harm)**, then manage both the condition specifically related to stress and the concurrent condition.
- » **If PTSD concurs with moderate-severe depression**, consider antidepressants to manage both. 🧑‍⚕️ » **DEP 3**
- » **If moderate-severe depression develops after recent bereavement** (e.g. in the past two months), **DO NOT** ❌ consider antidepressants or psychotherapy as first-line treatment for depression. » **DEP**

- » (Re)consider the possible presence of a mental, neurological or substance use condition (including risk of suicide/self-harm) (» **Master Chart**).

⚠️ Note that the concurrent condition may have existed prior to the event.

³ The term *prolonged grief disorder* is consistent with current draft proposals for ICD-11.

Conditions Specifically Related to Stress

Assessment and Intervention Details

Assessment of Traumatic Stress Symptoms

Advice on assessment can be found in the mhGAP General Principles of Care, the Master Chart and the above Assessment and Management Guide. This section describes three clusters of traumatic stress symptoms that require assessment: re-experiencing symptoms, avoidance symptoms and symptoms related to a sense of heightened current threat.

2.1 Re-experiencing symptoms

- » Affected persons may have repeated and unwanted recollections of the traumatic event as though it is occurring in the here and now, and accompanied by intense fear or horror. These recollections might occur through intrusive memories, frightening dreams or in more severe cases through flashbacks. The recollections may be experienced in the form of images, sounds (e.g. sound of a gun) and smells (e.g. odour of assailant).
 - An intrusive **memory** is **unwanted**, usually **vivid** and **causes intense fear or horror**.
 - A flashback is an episode where the **person believes and acts for a moment as though they are back at the time of the event**, living through it again. People with flashbacks lose touch with reality, usually for a few seconds or minutes.
 - In adults 🧑, the **frightening dreams** must be of the event or of aspects related to the event.
 - In children 🧒, symptoms of re-experiencing may also be displayed through frightening dreams without clear content, night terrors or trauma-specific re-enactments in repetitive play or drawings.

2.2 Avoidance symptoms

- » These include purposely avoiding **situations, activities, thoughts or memories** that remind the person of the traumatic event. For example, this may include wishing not to talk about the traumatic event with the health-care provider.
- » People usually use these strategies as a way to avoid re-experiencing symptoms that cause them significant distress. Paradoxically, such avoidance strategies tend to increase the occurrence of re-experiencing symptoms.

2.3 Symptoms related to a sense of heightened current threat

- » Affected persons may incorrectly feel that they remain in acute danger. This experience of heightened current threat can make the person hypervigilant and prone to experiencing exaggerated startle responses.
 - **Hypervigilance:** exaggerated concern and alertness to danger (e.g. being much more watchful in public than others, unnecessarily selecting “safer” places to sit, etc.).
 - **Exaggerated startle response:** being easily startled or jumpy, i.e. reacting with excessive fear to unexpected sudden movements or loud noises. These reactions are considered excessive when the person reacts much more strongly than others and takes considerable time to calm down.

2.4 Features associated with PTSD

- » In all age groups, features associated with PTSD include anxiety, depression, anger, insomnia, numbing and medically unexplained complaints. In addition children with PTSD often display regressive behaviours, such as bedwetting, clinging and temper tantrums. In adolescents with PTSD, risk-taking behaviour is a common feature. Alcohol and drug use problems are common in adults and adolescents with PTSD.


Intervention details

3.1 Psychological first aid

- » For further guidance on psychological first aid, see: WHO, War Trauma Foundation, World Vision International. *Psychological first aid: Guide for field workers*. WHO: Geneva, 2011. (whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf)

3.2 Addressing current psychosocial stressors

- » **Ask about current psychosocial stressors.** As far as possible, use **problem-solving techniques** to help the person reduce major psychosocial stressors or relationship difficulties. Involve community services and resources, as appropriate (e.g. with the person's consent).
- » Assess and manage any situation of abuse (e.g. domestic violence) and neglect (e.g. of children or older people). Such assessment requires a private, confidential space. Contact legal and community resources (e.g. social services, community protection networks) to address any abuse, as appropriate (e.g. with the person's consent).
- » As appropriate, identify **supportive family members** and involve them as much as possible.

- » In children and adolescents: 
 - Assess **maltreatment, exclusion or bullying**. Ask the child or adolescent directly about these in private. As far as possible, work with family, school and community to ensure the child's or adolescent's safety.
 - Assess and manage mental, neurological and substance use disorders (particularly depression) (» **Master Chart**) and psychosocial stressors in **carers** of children and adolescents.

3.3 Stress management

Consider training people in breathing exercises, progressive muscle relaxation and cultural equivalents.

- » **Breathing exercises**
This technique involves explaining that anxiety is associated with rapid, shallow chest breathing and that focusing on slow, regular, abdominal breathing reduces anxiety. The technique involves training the person to breathe from their diaphragm.
- » **Progressive muscle relaxation**
This technique involves explaining that anxiety is associated with tense muscles and that systematically relaxing one's muscles reduces anxiety. The technique involves training the person to systematically tense and relax key muscle groups, usually working up from the feet to the top of the body. An example of a progressive muscle relaxation protocol can be found as an annex of:
WHO, War Trauma Foundation, World Vision International. *Psychological first aid: Facilitator's manual for orienting field workers*. WHO: Geneva, 2013.

3.4 Strengthening of positive coping methods and social supports

- » Build on the person's **strengths and abilities**. Ask them what is going well. How do they keep going? How have they previously coped with hardship?
- » Ask the person to **identify people who give** them **emotional support**. Ask the person to identify other people they trust. These may be selected family members, friends or people in the community. Encourage the person to spend time with and talk to trusted people about their difficulties.
- » Encourage **resumption of social activities and normal routines** as far as possible (e.g. school attendance, family gatherings, visiting neighbours, social activities at work, sports, community activities, outings with friends).
- » Alert the person to the fact that alcohol and drugs do not help recovery, and that heavy use of alcohol and drugs – including medicines bought without prescription at pharmacies – can lead to new health and social problems.

Conditions Specifically Related to Stress

Assessment and Intervention Details

3.5 Additional management strategies for distinct symptoms of acute stress after a recent stressful event of an extremely threatening or horrific nature

3.5.1 Insomnia as a symptom of acute stress

- » Apply general management strategies for symptoms of acute stress (» STR 3.1–3.4).
- » Rule out external causes of insomnia (e.g. noise). Rule out and manage possible physical causes (e.g. physical pain), even if the insomnia started immediately after a stressful event.
- » Ask for the person's explanation of why insomnia may be present.
- » Advise about sleep hygiene (including advice about avoiding psychostimulants, such as coffee, nicotine and alcohol).
- » Explain that people often develop this problem after experiencing extreme stressors.

ⓘ In exceptional cases, in adults, when psychologically oriented interventions (e.g. relaxation techniques) are not feasible, short-term treatment (3–7 days) with benzodiazepines (e.g. diazepam 2–5 mg/day, lorazepam 0.5–2 mg/day on the WHO Model List of Essential Medicines) may be considered a treatment option for insomnia that severely interferes with daily functioning. In that case, the following precautions should be taken into account:

- Use of benzodiazepines can quickly lead to dependence in some people. Benzodiazepines are often overprescribed. They should only be prescribed for insomnia for a very short time and in exceptional cases.
- In the elderly ⓘ, lower doses are generally needed (e.g. half of the above-mentioned adult doses) and short-acting benzodiazepines (e.g. lorazepam) should be preferred if available.
- During pregnancy and breastfeeding ⓘ, benzodiazepines should be avoided.
- For concurrent medical conditions: before prescribing benzodiazepines, consider the potential for drug/disease or drug/drug interaction. Consult the National or WHO Formulary.

» In children and adolescents ⓘ, **DO NOT** prescribe benzodiazepines for insomnia.

» If the problem persists after one month, re-assess for and treat any concurrent mental disorder (» **Master Chart**). If there is no concurrent mental disorder or if there is no response to treatment of a concurrent mental disorder, **CONSULT A SPECIALIST**. ⓘ

3.5.2 Bedwetting as a symptom of acute stress in children

- » Apply general management strategies for symptoms of acute stress (» STR 3.1–3.4).
- » Obtain a history of bedwetting to confirm whether the problem started only after a stressful event. Rule out and manage possible physical causes (e.g. when the child has signs suggestive of urinary tract infection), even if the bedwetting started within one month of the potentially traumatic event.
- » Assess for and manage carers' mental disorders and psychosocial stressors.
- » Educate carers. Explain that they should not punish the child for bedwetting. Explain that bedwetting is a common reaction in children who experience stressors and that punishment adds to the child's stress. Explain to carers the importance of being calm and emotionally supportive. Educate carers not to overly focus on the symptoms and to give positive attention to the child at other times.
- » Consider training parents in the use of simple behavioural interventions (e.g. rewarding avoidance of excessive fluid intake before sleep, rewarding toileting before sleep). The rewards can be extra play time, stars on a chart or a local equivalent.
- » If the problem persists after one month, re-assess for and treat any concurrent physical or mental disorder (see » **Master Chart**). If there is no concurrent mental disorder or if there is no response to treatment of a concurrent mental disorder, **CONSULT A SPECIALIST**. ⓘ

Conditions Specifically Related to Stress

STR 3

Assessment and Intervention Details

3.5.3 Hyperventilation as a symptom of acute stress

- » Apply general management strategies for symptoms of acute stress (» **STR 3.1–3.4**).
- » Rule out and manage possible physical causes, even if the hyperventilation started immediately after a stressful event. Always conduct essential medical investigations to identify possible physical causes.
- » Explain that people sometimes develop this problem after experiencing extreme stressors.
- » Maintain a calm approach, where possible remove the sources of anxiety and teach how to breathe appropriately (i.e. encourage normal breathing, not deeper and quicker than usual).
- » Note that re-breathing into a paper bag is a widely used technique but has not been well researched. There are risks if this technique is used with people who have heart disease or asthma.
- » **DO NOT** ❌ encourage children to re-breathe into a paper bag.
- » If the problem persists after one month, re-assess for and treat any concurrent mental disorder (» **Master Chart**). If there is no concurrent mental disorder or if there is no response to treatment of a concurrent mental disorder, **CONSULT A SPECIALIST.** 🚑

3.5.4 Sensorimotor dissociation (e.g. medically unexplained paralysis, medically unexplained inability to speak or see) as a symptom of acute stress

- » Apply general management strategies for symptoms of acute stress (» **STR 3.1–3.4**).
- » In addition, always examine the patient and conduct essential medical investigations to identify, manage or rule out possible physical causes, even if the problem started immediately after a stressful event.
- » Ask for the person's explanation of the symptoms.
- » Acknowledge people's suffering and maintain a relationship of respect, while being careful to avoid reinforcing any subconscious gain that the person may get from the symptoms.
- » Explain that people sometimes develop this problem after experiencing extreme stressors.
- » Apply the general guidance on the management of medically unexplained somatic symptoms (» **OTH**).
- » Consider the use of culturally specific interventions that do not harm, as appropriate.
- » If the problem persists after one month, re-assess for and treat any concurrent conditions (» **Master Chart**). If there is no concurrent mental disorder or if there is no response to treatment of a concurrent mental disorder, **CONSULT A SPECIALIST.** 🚑

Conditions Specifically Related to Stress

STR 3

Assessment and Intervention Details

3.6 Psychoeducation for PTSD

The following guidance on psychoeducation is written for people with post-traumatic stress disorder (PTSD) and their carers. For guidance on psychoeducation for people with symptoms of acute stress, see the Assessment and Management Guide above).

» Explain the course of symptoms

- In the first few days to weeks following an extremely threatening or horrific event most people will have some stress-related reactions, such as feeling tearful, frightened, angry or guilty. There may be physical reactions, jumpiness or difficulty sleeping, frightening dreams or continual replaying of the event in one's mind. Most people recover from these reactions naturally.
- When these reactions last more than a month, become a continuing problem and cause difficulties in the person's daily functioning, this may indicate PTSD.
- Many people recover from PTSD over time without treatment. However, treatment will speed up the process of recovery.

» Explain the nature of PTSD

- People with PTSD frequently feel that they are still in danger and consequently can be very tense. They may be easily startled ("jumpy") or may be constantly on the watch for danger.
- People with PTSD experience unwanted recollections of the traumatic event. When reminded of the event they may experience emotions such as fear and horror, similar to the feelings they experienced when the event was actually happening. Sometimes they may feel that the event is happening again. They may also have frightening dreams.
- Such intrusive thoughts and memories of the traumatic event are extremely disturbing. Consequently people with PTSD naturally try to avoid any reminders of the event. Unfortunately such avoidance can cause problems in their lives. For example, if a man with PTSD avoids going to work because he was assaulted there, then this will affect his livelihood.

- Paradoxically, trying to avoid thinking about something usually results in thinking about it more. Ask the person to try this thought experiment: "Try not to think about a white elephant for one minute. How successful were you? You probably found that white elephant impossible to keep out of your head. The same is true for traumatic memories when you have PTSD: the more you try to avoid thinking about them, the more you think about them."
- Explain, as applicable to the person, that people with PTSD may sometimes have concurrent problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood.

» Explain that effective treatment is possible

- Effective treatment exists.
- It is likely to take several weeks of treatment before the person feels any reduction in their PTSD symptoms.

» Emphasize the following messages.

- Tell the person with PTSD to:
- Continue normal daily routines as far as possible.
 - Talk to trusted people about how they feel or what happened but only when they are ready to do so.
 - Engage in relaxing activities to reduce anxiety and tension (» STR 3). Discuss culturally appropriate forms of relaxation.
 - Do regular physical exercise.
 - Try to maintain a regular sleep cycle (i.e. go to bed at the same time every night, try to sleep the same amount as before, avoid sleeping too much).
 - Avoid using alcohol or drugs to cope with PTSD symptoms.
 - Recognize thoughts of suicide and come back for help when these occur.

For the purposes of the mhGAP Intervention Guide, the term “advanced intervention” refers to an intervention that takes more than a few hours of a health-care provider’s time to learn and typically more than a few hours to implement. Such interventions are typically offered by specialists.

This section provides brief descriptions of two advanced interventions. Within the module, these interventions are marked by the abbreviation **»INT**, indicating that they require an intensive use of human resources. Protocols for these interventions are not included here.

The advanced interventions described below should be considered when the person is within a safe environment, i.e. there are no ongoing traumatic events and the person is not at imminent risk of further exposure to traumatic events. Expert opinion is divided about their appropriate use in unsafe environments.

Cognitive behavioural therapy with a trauma focus (CBT-T)

Individual or group cognitive behavioural therapy with a trauma focus (CBT-T) is based on the idea that people with PTSD 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.

Eye movement desensitization and reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) 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-T, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT-T, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure or (d) homework.

Appendix



Suggested adjustments to the existing mhGAP Intervention Guide to fit in the module on Conditions Specifically Related to Stress (STR)

- » **Master Chart:** Add a footnote stating: “The module on Conditions Specifically Related to Stress (STR) is accessed through the Depression module.” Alternatively, indicate clearly on the Master Chart that the listed presenting somatic and emotional symptoms of DEP are also valid for STR.
- » **Depression module:** The skip-out box now says “Exit this module, and assess for Other Significant Emotional or Medically Unexplained Somatic Complaints » OTH”. This box may be changed to ask whether the person is distressed because of exposure to extreme stressors (losses, traumatic events). If the person says YES, then the clinician would be referred to the STR module. If the person says NO, then the clinician would be referred to the OTH module.
- » **OTH module:** Responding YES to the question “Has the person been recently exposed to extreme stressors (losses, traumatic events)?” would need to lead back to the STR module.
- » **Links:** Links to the STR module (as a possible concurrent condition) would need to be made in the DEP, PSY, DEV, BEH, ALC, DRU and SUI modules.
- » **Advanced Psychosocial Interventions:** This section would need to be updated to include the above definitions of CBT-T and EMDR.

This mhGAP Intervention Guide module contains assessment and management advice related to acute stress, post-traumatic stress and grief in non-specialized health settings. It is an annex to the *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings* (WHO, 2010). The guidance reflected in the module is based on formally approved WHO Guideline Development Group recommendations.

This module should always be used together with the *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings* (WHO, 2010), which outlines relevant general principles of care and management of a range of other mental, neurological and substance use conditions.

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