VIEWPOINT

# Management of Acute Stress, PTSD, and Bereavement
## WHO Recommendations

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**In 2010, the World** Health Organization (WHO) launched the Mental Health Gap Action Program (mhGAP) Intervention Guide for nonspecialized health settings (ie, for general health staff in first- and second-level health facilities, including primary care and district hospital settings) to address the wide treatment gap for mental disorders in low- and middle-income countries.[1-3] Several priority mental disorders, including depression and substance use, have been addressed in previous mhGAP modules and related guidelines.[1,3]

To inform development of a new module on conditions specifically related to stress, WHO developed new guidelines to be released this week[4] for the following symptoms occurring in the first month after trauma exposure: acute traumatic stress symptoms, insomnia, enuresis, dissociative symptoms, and hyperventilation (**Table**). In addition, guidelines were developed for posttraumatic stress disorder (PTSD) and bereavement. These conditions were chosen for their relevance in nonspecialized health settings. This Viewpoint describes work underpinning the expansion of the mhGAP Intervention Guide to include a module on assessment and management of conditions specifically related to stress—using terminology for conditions consistent with proposals for the *International Classification of Diseases*, 11th revision.[5]

Guidelines were developed following WHO's rigorous guideline development methodology.[6] A guideline development group (GDG) was responsible for making recommendations based on systematic appraisal of evidence. Details on the conditions, interventions, and the development of evidence profiles for each question (ie, evidence retrieval, synthesis, and interpretation) can be found in the guidelines.[4]

Acute traumatic stress symptoms include reexperiencing, avoidance, and hyperarousal associated with significant functional impairment that present in the first month after trauma exposure. These symptoms may be similar to those of PTSD, but occur before PTSD is often assessed. For these symptoms, the guidelines recommend against the use of benzodiazepines and antidepressants in adults, adolescents, and children. The guidelines recommend cognitive behavioral therapy with a trauma focus (CBT-T) for adults. Similarly for insomnia, the guidelines recommend against the use of benzodiazepines for adults, adolescents, and children and recommend relaxation techniques and sleep hygiene for adults. For bedwetting in children and adolescents the following is recommended: parenting skills training, simple behavioral interventions, and education of caregivers about the negative effects of punitive responses. No recommendations could be made based on available evidence with regard to psychological interventions for acute traumatic stress symptoms and insomnia in children and adolescents or for dissociative symptoms and hyperventilation in children, adolescents, and adults during the first month after exposure to the event. However, the guidelines recommend against the common practice of rebreathing in a paper bag for hyperventilation in children.

For adults, adolescents, and children with PTSD, recommended treatments include individual or group CBT-T, eye movement desensitization reprocessing (EMDR) and, in adults, stress management (eg, stress inoculation training and relaxation training). Stress management was determined to be less effective than CBT-T and EMDR but was rated high on feasibility, which is important for scaling up interventions in low-resource settings. Consistent with the UK's National Institute for Health and Care Excellence (NICE) recommendations, but in contrast to American Psychiatric Association guidelines,[7] antidepressants were not recommended as a first-line treatment for adults because of the small effect size of these drugs for the treatment of PTSD. The guidelines recommend antidepressants for adults with PTSD when psychological treatments are not available or have not been effective or when people have concurrent moderate to severe depression. The guidelines recommend against the use of antidepressants for PTSD in children and adolescents.

For bereaved adults, adolescents, and children without a mental disorder, the guidelines recommend against use of benzodiazepines and the routine use of structured psychological interventions. The latter recommendation is in contrast to the routinely offered grief counseling after bereavement.

Several key issues were discussed by the GDG. First, the recommendations should be applicable in low- and middle-income countries and nonspecialized health settings, but most evidence comes from specialized settings in high-income countries. Research on task sharing in low- and middle-income countries has shown that with training and supervision, nonspecialized health care staff can effectively implement advanced psychological interventions.[8] Nevertheless, there is uncertainty about the likelihood of health care workers achieving similar treatment effects in routine health care in the absence of strict fidelity and supervision protocols that are common in research settings. The GDG particularly emphasized the importance of sufficient health care worker time and appropriate supervision for CBT-T and EMDR and recognized this requires human resources. Second, for many interventions low-quality evidence was found, especially for children and adolescents. Third, outcome measurement has been too often limited to symptoms, whereas measurement of functionality, adverse effects, and long-term outcomes has been relatively rare, especially for nonpharmacological interventions. Last, the GDG was wary of suggesting that the absence of evidence

Table. New World Health Organization mhGAP Recommendations[4]

| Mental Health Condition | Recommendation | Strength of Recommendation[a] |
|---|---|---|
| Acute stress (first month after exposure to a potentially traumatic event) | | |
| Acute traumatic stress symptoms | Cognitive behavioral therapy with a trauma focus should be considered in adults | Standard |
| | Benzodiazepines should not be offered to adults | Strong |
| | Antidepressants should not be offered to adults | Standard |
| | Benzodiazepines and antidepressants should not be offered to children and adolescents | Strong |
| Secondary acute insomnia | Relaxation techniques and advice about sleep hygiene should be considered for adults | Standard |
| | Benzodiazepines should not be offered to adults | Standard |
| | Benzodiazepines should not be offered to children and adolescents | Strong |
| Secondary nonorganic enuresis | Education about the negative effects of punitive responses should be given to caregivers of children | Strong |
| | Parenting skills training and the use of simple behavioral interventions should be considered. Where resources permit, alarms should be considered | Standard |
| Hyperventilation | Rebreathing into a paper bag should not be considered for children | Standard |
| Posttraumatic stress disorder | Individual or group cognitive behavioral therapy with a trauma focus, eye movement desensitization and reprocessing, or stress management should be considered for adults | Standard |
| | Individual or group cognitive behavioral therapy with a trauma focus or eye movement desensitization and reprocessing should be considered for children and adolescents | Standard |
| | SSRIs and tricyclic antidepressants should not be offered as the first line of treatment in adults. SSRIs and tricyclic antidepressants should be considered if (a) stress management, cognitive behavioral therapy with a trauma focus, and/or eye movement desensitization and reprocessing have failed or are not available or (b) if there is concurrent moderate-severe depression | Standard |
| | Antidepressants should not be used in children and adolescents | Strong |
| Bereavement | Structured psychological interventions should not be offered universally to bereaved children, adolescents, and adults who do not meet criteria for a mental disorder | Strong |
| | Benzodiazepines should not be offered to bereaved children, adolescents, and adults who do not meet criteria for a mental disorder | Strong |

Abbreviation: SSRI, selective serotonin reuptake inhibitors.

[a] Strong indicates that the recommendation should be followed in all or almost all circumstances. Standard indicates that there may be circumstances in which the recommendation does not apply.

means nothing should be done. In these cases, potential courses of action such as referring to existing guidelines were included. For example, for acute stress symptoms a previous WHO GDG had recommended psychological first aid, rather than psychological debriefing.[3]

Prior to the development of these mhGAP recommendations, there were no evidence-based guidelines for managing conditions specifically related to stress in nonspecialized settings in low- and middle-income countries. The recommendations form the basis of a new module to be added to the mhGAP Intervention Guide.[9]

Future research should collect data on a broader range of outcomes, including functionality, adverse effects, and long-term outcomes. Meanwhile, practitioners are offered these evidence-based guidelines to strengthen care for people exposed to extreme stress.

## ARTICLE INFORMATION

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**Disclaimer:** The authors are responsible for the views expressed in this article and, except for the specifically noted recommendations, they do not necessarily represent the decisions, policies, or views of WHO.

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