

Clinical Consultation

How Do You Intervene in Posttraumatic Stress Disorder Symptoms Associated with Traumatic Injury?

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Case Study

Corporal Michael Smith, a 22-year-old Hispanic man, returned from his third tour of duty in Iraq. During his last tour, Michael lost his right leg in a roadside explosion by a suicide bomber. Two other men in his squad were killed in this explosion. After medical stabilization and an above-the-knee amputation, he began physical therapy and training in activities of daily living (ADL) at Walter Reed Army Hospital. He then returned home.

Six months later, Michael's wife began to notice changes in his behavior. He became increasingly irritable and moody. Michael was reluctant to go out to events, movies, and concerts that he had enjoyed in the past. Frequently, in response to her pleading, Michael took his wife out but remained in the car while she attended the activity. He particularly avoided activities with fireworks and movies with war themes. Michael became emotionally unavailable to his family and friends. He withdrew and became depressed. His depression and isolation worsened despite the efforts of his family and the rehabilitation team at the Veterans Affairs Hospital. Michael increased his drinking to "help with [his] memories" and "to get to sleep." Michael's wife repeatedly asked him what was bothering him. He finally admitted to recurring thoughts and nightmares about the traumatic event.

Michael became noncompliant with his rehabilitation program. He frequently missed appointments. When he did come in for therapy, Michael was verbally demanding and easily angered if he was not getting what he felt he needed. Michael's rehabilitation was becoming severely compromised by his depression and anger.

Introduction

Posttraumatic stress disorder (PTSD) has been recognized as a psychiatric diagnosis since 1980 (American Psychiatric Association [APA], 1980). Soldiers experiencing PTSD symptoms were labeled as having "shell-shock" or "war neurosis" (Glass, 1969). Often, the soldier was accused of making up symptoms or malingering in order to avoid further exposure to combat (Clark, 1997). After the Vietnam

War, PTSD symptoms were finally accepted and classified as a psychiatric diagnosis. Other types of trauma (e.g., rape, natural disasters) were included and broadened the diagnosis of PTSD (APA, 1980). Recent catastrophic events such as 9/11, Operation Iraqi Freedom, and Hurricane Katrina have emphasized the impact of PTSD as a mental health problem for trauma survivors. Despite heightened public awareness, family members and healthcare providers alike may doubt the reality of PTSD symptoms. The problem in diagnosing and treating PTSD is twofold: PTSD is often misdiagnosed because of its varying clinical features and patients are reluctant to be open about the symptoms for fear of being seen as "psychotic" or "crazy" (Clark, 1997).

Defining PTSD

PTSD is a psychological reaction to the experience of trauma outside the normal range of human experience (APA, 2000). PTSD is one of the most common anxiety disorders affecting 8%–12% of the general population at some time in their lives (Stein et al., 2003). However, Stein and colleagues noted that only 10%–20% of the people exposed to trauma will develop PTSD. Therefore, exposure to trauma does not necessarily lead to the development of PTSD. Predisposing factors that influence the onset of PTSD include sex, type and severity of the trauma, and factors preceding, surrounding, and following the trauma (Stein et al.). Stein and colleagues also reported that PTSD is twice as common in women as in men and appears to last longer.

PTSD typically is a chronic illness with recurrent episodes. *Diagnostic Statistical Manual of Mental Disorders* criteria specify that the duration of the illness must exceed 1 month and that the symptoms must cause clinically significant impairment in functioning (APA, 2000). Acute symptoms may be diagnosed as occurring within 3 months of the traumatic experience. Chronic onset is diagnosed as occurring 3 months or more after the event. *Delayed onset* refers to the appearance of symptoms at least 6 months (possibly years) after the stressor. Delay in onset often makes it difficult for trauma victims to recognize their



KEY WORDS

posttraumatic stress disorder

practice implications

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symptoms as PTSD. The following are diagnostic criteria for PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000):

- exposure to a traumatic event in which the person has responded with intense fear, helplessness, or horror
- reexperiencing the traumatic event in recurrent, intrusive, and distressing images, thoughts, or perceptions
- persistent avoidance of stimuli associated with the trauma accompanied by a numbing or general responsiveness not present before the trauma
- persistent symptoms of increased arousal such as hypervigilance or exaggerated startle response not present before the trauma
- clinically significant distress or impairment in social, occupational, or other areas of functioning.

PTSD is characterized by symptoms in three domains: reexperiencing the trauma (i.e., flashbacks, intrusive and distressing images or thoughts); avoidance of stimuli associated with the trauma accompanied by a general numbing; and symptoms of increased autonomic arousal (i.e., hypervigilance, exaggerated startle response) not present before the trauma (APA, 2000; Reeves, Parker, & Konkle-Parker, 2005). The individual initially experiences symptoms of increased arousal, as are evident in Michael's complaints of being startled by fireworks or other loud noises. General numbing, as noted in Michael's emotional withdrawal, comes later. To summarize, four common PTSD symptoms include reliving the event, avoiding situations (war movies) that remind the person of the event, feeling numb and unable to enjoy activities once enjoyed, and feeling keyed-up, which is often observed by others as increased irritability or anger (Wilkinson, 2007).

PTSD is associated with an increased risk of co-occurring psychiatric disorders. Generalized anxiety disorder, depression, and the use of drugs or alcohol to manage symptoms can coexist with PTSD. Co-occurring disorders are related to the severity of the trauma and complexity of the PTSD reaction by the individual (Stein et al., 2003). Epidemiological studies show that more than 80% of people with PTSD also have a history of at least one other psychiatric disorder (Kessler, 2000). Frequently, the individual will talk about symptoms of depression, anger, or anxiety to his or her primary care provider rather than acknowledging PTSD symptoms resulting from traumatic events. People with PTSD are reluctant to relive or tolerate traumatic memories.

Often, symptoms of depression, anger, or suicidal thinking are the first clinical signs brought to the at-

tention of the healthcare provider. Michael's irritability and moodiness were noticed by his wife. As he continued in his rehabilitation program, he became verbally demanding and angry if he did not get what he felt he needed. After trauma, people may experience increased feelings of sadness and hopelessness, thoughts of suicide, and disruptions in sleep and eating cycles. Michael's sleep cycle was severely compromised by the intrusive PTSD symptoms of traumatic memories and nightmares.

Life-threatening problems such as preoccupation with suicidal thoughts will prompt the person to seek help. PTSD is more strongly associated with suicidal behavior than other anxiety disorders. Ballenger and colleagues (2000) reported a 19% rate of suicidal thinking for people with PTSD. Although Michael is not verbalizing suicidal thinking, a common response of people exposed to trauma is guilt over surviving when others did not. Hopelessness and helplessness associated with these feelings can lead to a preoccupation with death or suicidal thoughts.

An increase in the use of substances for medicating PTSD symptoms may also be revealed during the assessment process. Michael drank in order to manage his memories and prevent the occurrence of his frequent nightmares. Treatment for alcohol or drug abuse becomes the individual's or family's focus instead of the underlying PTSD symptoms. Co-occurring psychiatric disorders not only mask PTSD symptoms but often are the focus of treatment.

Traumatic injury is a primary consideration in its association with symptoms of PTSD. Koren, Norman, Cohen, Berman, and Klein (2005) concluded that bodily injury is a major risk factor for the development of PTSD. Psychological distress and recovery from limb loss is influenced by a number of variables, including younger age, nonwhite racial background, poverty, limited social supports, substance abuse, and a poor ability to become self-sufficient (McCarthy et al., 2003). Conversely, acceptance of limb loss and recovery is greatly influenced by the individual's resilience characteristics, social support, medical care, economic situation, and societal or community attitude toward disabled people (Ferguson, Richie, & Gomez, 2004). Michael's young age, Hispanic background, and lack of social support (other than his wife) significantly affected his recovery. In addition, his substance abuse, withdrawal, and isolation limited his ability to be self-sufficient.

Effective treatment of PTSD has not been well established. Treatment choices include pharmacotherapy (antidepressants) and psychotherapy (Stein et al., 2003). Recent studies indicate that the strongest clinical evidence supports treatments that combine cognitive and behavioral techniques to alleviate PTSD

symptoms (Bisson et al., 2005; Bradley, Greene, Russ, Dutra, & Westen, 2005; Foa, 2006; Harvey, Bryant, & Terrier, 2003). Cognitive behavior therapy theorizes that psychiatric disorders arise from irrational beliefs and distorted attitudes about the self resulting from exposure to a traumatic experience or other life events. The goal of cognitive behavior therapy is twofold: to work on changing the faulty thinking and to change the ineffective behavior (Schwecke, 2007). Treatment is accomplished through a variety of guided exercises, journaling, and homework assignments. Successful strategies for preventing PTSD or treating chronic PTSD have just begun to be studied (Davidson, 2004). Recent government initiatives have mandated that diagnosis and prompt, effective treatment of PTSD are a healthcare imperative.

Implications for Practice

In traumatic injury, it is vital for the nurse on the rehabilitation team to be knowledgeable about PTSD and assess for its presence. Cooccurring psychiatric disorders may delay recognition of PTSD. Grief reactions can also be a part of the clinical picture. Grief over the loss of fellow soldiers during the traumatic event must be treated as a separate issue (Pivar, 2006). According to Pivar, *traumatic grief* is a prolonged disorder caused by traumatic circumstances that threaten the individual's survival. Grief counseling is indicated. A psychiatric referral to a clinician skilled in diagnosing PTSD and identifying traumatic grief or cooccurring mental disorders is important.

The nurse plays a critical supportive role during rehabilitation. The therapeutic goal is patient empowerment. The nurse helps the patient regain control over the symptoms of PTSD. A sense of helplessness over intrusive, unbidden memories or symptoms can preoccupy the patient's thoughts and behaviors. Teaching the patient and his or her significant others about the causes and symptoms of PTSD is necessary. Often, family members or significant others are so grateful to have the returning soldier home that they minimize or ignore PTSD symptoms in the face of other health problems demanding a lengthy physical rehabilitation. Loss of control during trauma leaves the victim unable to trust others. Nursing interventions should reinforce the patient's efforts to reconnect emotionally with family and friends. Psychological recovery can be facilitated with a social support system (Clark, 1997; Ferguson et al., 2004).

If suicidal or homicidal thinking is observed during the patient-nurse interaction, immediate assessment and documentation of these symptoms must occur. Trauma victims can express suicidal intent as a result of survivor guilt ("I should not be alive when everyone else died") or become preoccupied

Key Practice Points

1. Clinical evidence supports mental health treatment that combines cognitive and behavioral techniques with the goal of changing faulty thinking and ineffective behavior.
2. Use of communication techniques involving the development of trust, listening, normalizing responses, and reframing the traumatic event are the basis of the clinical nursing practice.
3. The treatment outcome is for the patient to view posttraumatic stress disorder (PTSD) symptoms not as a disabling condition but as a challenge to readapt and recover from the trauma.
4. Symptoms of PTSD are serious and require intervention, however, PTSD is treatable and combat veterans can recover (Uniformed Services University, 2006).

with thoughts of retaliation against the perpetrators of the trauma. Psychiatric intervention in light of suicidal or homicidal ideation is imperative.

Specific PTSD symptoms can be managed with a variety of cognitive and behavioral coping strategies. Uncontrollable flooding of traumatic memories can be improved with journaling, which allows victims to identify trigger situations (Bostrom & Schwecke, 2007). Deep breathing, relaxation, and physical exercise also diffuse the severity of symptoms associated with persistent increased arousal (Falsetti, Resnick, & Davis, 2005). Psychological numbing and dissociation are both avoidance responses that can be treated by reorienting the patient to the present time (Clark, 1997). Anticipation of traumatic nightmares increases the victim's level of anxiety. Teaching the patient to positively dream is a coping strategy that encourages the patient to mentally create the dream's ending before going to sleep (Clark).

As part of the rehabilitation treatment team, the nurse is often the first professional to detect the presence of PTSD symptoms. Use of therapeutic communication techniques will facilitate the patient's ability to regain emotional control. Nurses are in the unique position of having extended time periods to talk with patients and hear their concerns, feelings, and needs (Sheldon, Barrett, & Ellington, 2006). Communication guidelines include developing trust, listening, normalizing responses, and reframing (Bostrom & Schwecke, 2007; Clark, 1997). Each of these techniques will be discussed briefly.

The person with PTSD struggles with suspiciousness and a mistrust of others. He or she feels "No one can understand what I've been through." An appropriate therapeutic response from the nurse conveys "I have not had your experience but the more you tell me, the better I will understand" (Bostrom &

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Schwecke, 2007). This promotes the establishment of trust and offers a feeling of connection. The patient needs to be reassured that he or she is “not crazy” but is experiencing reactions to or symptoms of a serious traumatic experience.

The nurse needs to listen to the patient’s reactions of shock, anger, or depression. The nurse must accept those feelings and acknowledge the injustices of the trauma. The nurse’s role is to listen and avoid giving false reassurance. Attempting to “fix” the situation or problem solve before the patient is ready to do so will undermine the therapeutic communication. The patient will experience frustration at not being able to express his or her feelings because the nurse is already engaged in solving his or her problem for him or her.

Normalizing the patient’s responses involves the nurse identifying the trauma reaction as being useful for the patient’s survival at the time. More appropriate healthy coping skills can then be learned in place of those reactions. Identifying and reinforcing the patient’s strengths and resilience establish a framework for developing effective coping strategies. Approaching the patient in terms of his or her strengths and abilities can be more therapeutic than focusing on problems listed on the treatment plan.

Finally, the nurse therapeutically communicates with the patient to reframe the traumatic event. The nurse must help the patient acknowledge that it was random bad luck (“being in the wrong place at the wrong time”) that resulted in the trauma. The patient wasn’t “bad” and did not deserve the traumatic experience. People who have PTSD get stuck in thinking that they did something “bad” or “wrong.” Consequently, reframing the person’s experience gives him or her permission to move beyond the trauma event into the present.

The treatment outcome for the patient with PTSD is to view symptoms not as a disabling clinical disorder but as a challenge in readaptation and recovery from the traumatic event. Recovery begins with the initial awareness that positive change is possible. Recovery is a journey of healing that enables the person with a mental health problem to live a meaningful life (U.S. Department of Health and Human Services, 2004). Symptoms of PTSD are serious and warrant intervention. However, PTSD is treatable and combat veterans can recover (Uniformed Services University, 2007).

Conclusion

The nurse on the rehabilitation team needs to gauge the patient’s readiness to talk about the symptoms of PTSD. Using communication techniques such as developing trust, listening, normalizing, and reframing will give the patient a sense of emotional

control. Distinguishing between PTSD symptoms, grief over loss of a limb, and other cooccurring psychiatric disorders is difficult. Formal trauma work should be done through a PTSD program or in individual therapy. PTSD programs are available in the Veterans Affairs healthcare system or in local community hospitals.

Self-awareness regarding the nurse’s therapeutic communication skills is essential. Sheldon and colleagues (2006) conducted a study on difficult communication with six focus groups involving 30 nurse participants. One theme identified by nurses in all groups was their struggle to cope with their own reactions and emotions in response to topics expressed by patients. Finding the right words to ease the hopelessness and sadness expressed by trauma victims may seem impossible. Seek consultation from a mental healthcare provider or an advanced practice psychiatric nurse if the patient’s emotional issues and traumatic experience are overwhelming.

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