

# **Al-Mustaqbal University / College of Nursing**

## **Lecture of Psychiatric Nursing /3**

### **Trauma and Stressor-Related Disorder**

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# Trauma and Stressor-Related Disorder

Trauma- and stressor-related disorders are a group of psychiatric disorders that arise following a stressful or traumatic event.

They include posttraumatic stress disorder, acute stress disorder, and adjustment disorder. These three conditions often present similarly to other psychiatric disorders, such as depression and anxiety, although the presence of a trigger event is necessary to confirm a diagnosis.

Because trauma- and stressor-related disorders share many common features, it is imperative to understand the nature of the triggering event, the temporal relationship between the triggering event and symptom occurrence, and the severity of symptoms.

Treatment generally consists of both psychotherapy and pharmacotherapy.

- Traumatic events disrupt the life of anyone who experienced them.
- Traumatic event such as war, terrorist attacks, or a natural disaster—flood, hurricane, or tsunami.
- People at risk are easily affected by stressors.
- Some people return to their usual level of coping and equilibrium.
- However, some individuals continue to have problems coping, managing stress, and control emotions.
- Some individuals may develop an adjustment disorder, acute stress disorder, PTSD, or a dissociative disorder.

# Stressor factors specifically for Iraq



INJURY



Emotional



Career Pressures



Illness



Physical



Environmental

# Types and Subtypes

- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Prolonged Grief Disorder
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder

# 1. Posttraumatic Stress Disorder

- **Criteria PTSD**

1. Person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror.
3. The symptoms occur 3 months or more after the trauma. Client report losing a sense of connection and control over his or her life.
4. Client try to avoid any places or people or situations that may trigger memories of the trauma (avoidance behavior).
5. Client can become isolated over time.

# The symptoms of PTSD are:

- Agitation
- Nervousness and anxiety
- Problems with concentration or thinking
- Problems with memory
- Headaches
- Depression and crying spells
- Suicidal thoughts or attempts
- Mood swings
- Obsessive-compulsive tendencies
- Panic episodes
- Paranoia
- Shakiness
- Substance abuse
- Flashbacks
- Hypervigilance
- Nightmares
- Sleep disturbances

## **Developing PTSD after experiencing a traumatic event depends on:**

1. Severity of the traumatic event.
2. Life experiences.
3. Gender; women are about twice as likely as men to develop PTSD.
4. Adolescents more likely to develop PTSD than children or adults.

## **Traumatic Event Examples causes PTSD**

- Natural Disasters
- Terrorism
- Childhood Trauma and abuse
- Rape
- Horrific Life Events

# Treatments PTSD

1. Inpatient treatment is not indicated for clients with PTSD.
2. Inpatient may be necessary when the client is suicidal, or is being overwhelmed by reexperiencing events of the trauma.
3. Adaptive disclosure.
4. Exposure therapy.
5. Gestalt Therapy: The Empty Chair Technique.
6. Cognitive processing therapy.

# 2. Acute stress disorder

## Definition

The development of a strong psychological reaction to a traumatic event characterized by acute symptom onset and the persistence of symptoms for at least 3 days and up to 1 month

## Epidemiology

- Occurs in up to 50% of individuals experiencing interpersonal violence (e.g., assault, rape)
- Occurs in up to ~ 13% of individuals involved in motor vehicle accidents

## Risk factors

- Preexisting mental disorder
- History of previous trauma
- Poor social support

# Diagnostic criteria (DSM-5)

**1. Exposure to death (actual or threatened), serious injury, or sexual violence that occurs in  $\geq 1$  of the following ways:**

- Direct experience of these events
- Witnessing these events
- Hearing about these events happening to close friends or family
- Repeated exposure to distressing details of traumatic events occurring to others

## **2. Presence of at least 9 of the following symptoms from any of the five categories below:**

- Intrusion
  - a. Recurrent distressing memories
  - b. Recurrent distressing dreams
  - c. Flashbacks
  - d. Severe psychological distress or physiological responses to internal or external cues related to the event
- Negative mood: inability to feel positive emotions (e.g., happiness, satisfaction, or love)
- Dissociation
  - a. Altered sense of reality
  - b. Loss of memory with regards to important details of the event

- Avoidance
  - a. Avoidance of memories, thoughts, or feelings related to the event
  - b. Avoidance of external reminders (e.g., places, people, conversations, objects) related to the event
- Arousal
  - a. Sleep disturbance
  - b. Irritable behavior
  - c. Hypervigilance
  - d. Poor concentration
  - e. Heightened startle reflex

### **3. Duration: Symptoms last from 3 days to 1 month following the traumatic event.**

- The affected individual has been experiencing significant distress or impaired social and/or occupational functioning since the traumatic event.
- Symptoms are not explained by substance use or another medical condition.

# Treatment and prognosis

- Assess all patients with acute first- and second-hand experiences of trauma for ASD and offer psychological care.
- Determine the setting of psychiatric treatment (inpatient or outpatient) based on the severity of symptoms, the risk of self-injurious behavior and suicide, and the severity of trauma experienced or exposed to.
- Provide education about the broad range of expected reactions to traumatic situations as well as about the natural course of the disorder and treatment options available
- First-line treatment: trauma-focused cognitive behavioral therapy
- Pharmacotherapy: Benzodiazepines are not routinely recommended but may be useful in patients with severe anxiety, agitation, or sleep disturbances.
- Early intervention is important to avoid progression of ASD to PTSD

## **Differed between PTSD and Acute stress disorder**

- Acute stress disorder: The symptoms occur from 3 days to 4 weeks following a trauma.
- PTSD: The symptoms occur 3 months or more after the trauma, but lasts at least 3 days or up to 1 month. The onset can be delayed for months or even years.

# 3. Adjustment disorder

## Definition

A maladaptive emotional (e.g., anxiety) or behavioral (e.g., outburst) response to a stressor, lasting  $\leq 6$  months following resolution of the stressor

## Epidemiology

- Occurs in  $\sim 5\text{--}20\%$  of individuals undergoing outpatient mental health treatment
- Up to one-third of patients with a cancer diagnosis develop this disorder. [12]

## Etiology

A combination of intrinsic and extrinsic stressors (e.g., divorce, losing a job, academic failure, difficulties with a peer group, illness)

# Diagnostic criteria (DSM-5)

- Emotions or behaviors in response to a stressor that occur within 3 months of onset
- Clinically significant responses that include  $\geq 1$  of the following:
  1. A level of distress that is disproportionate to the expected response to the stressor
  2. Impaired functioning in social, occupational, and/or other important areas
- Symptoms are not explained by another mental disorder.
- Symptoms are not explained by a normal response to grief.
- Symptoms last  $\leq 6$  months following resolution of the stressor.

# Differential diagnosis

- Normal stress reaction
- Major depressive disorder: Although some symptoms can be shared between the two conditions, the criteria for MDD are not met. (See Diagnostic criteria for major depressive disorder.)
- Generalized anxiety disorder: If symptoms of adjustment disorder last > 6 months the diagnosis is changed to GAD.

# Treatment and prognosis

- Psychotherapy
  1. First-line treatment: cognitive-behavioral therapy or psychodynamic psychotherapy
  2. May be provided as individual, family, or group support therapy
  3. Interpersonal psychotherapy
- Pharmacotherapy
  - SSRIs: depressed mood
  - Benzodiazepines: anxiety or panic attacks
  - Benzodiazepines or other sedative-hypnotic agents (e.g., zolpidem): insomnia

# 4. Reactive attachment disorder

## Description

- A psychiatric disorder characterized by inhibited, emotionally withdrawn interactions with caregivers and associated with social neglect during early childhood
- An inability to relate interpersonally with peers and adults leads to impaired social development throughout early childhood (e.g. cognitive and/or language delays, academic difficulties, and pervasive anger/resentment)

# Diagnostic criteria (DSM-V)

1. Emotionally withdrawn and inhibited behavior towards caregivers as manifested by the child rarely seeking or responding to comfort when upset.
2. A consistent emotional disturbance and social inhibition characterized by two or more of the following:
  - Limited response to the social and emotional cues of others
  - Blunted affect
  - Caregivers note irritable, fearful, or emotional behavior, even in the absence of a threatening situation.
3. A history of neglect in early childhood (< 2 years of age) as indicated by at least one of the following:
  - Persistent social neglect (inadequate comfort, stimulation, and affection provided by caregivers)
  - Repeated changes in primary caregivers (e.g., foster carers) that impede the development of selective social attachments
  - Childrearing settings with a high child-to-caregiver ratio

4. The inhibited behavior begins after the onset of insufficient or inconsistent care.
5. Not due to other psychiatric disorders (e.g., autistic spectrum disorder)
6. Onset: symptoms manifest before the age of 5 years
7. Developmental age of 9 months or more
8. Specifiers
  - Persistent: duration of disorder > 12 months
  - Severe: presence of all symptoms at high levels of severity

# Treatment

1. Ensuring the presence of an emotionally available attachment figure
  - If the caregiver is emotionally available and not overwhelmed: Encourage sensitive responsiveness and offer coaching the caregiver as a co-therapist in the child's treatment.
  - If the caregiver is emotionally unavailable and/or too overwhelmed: child–parent psychotherapy and/or attachment and biobehavioral catch-up
2. Pharmacotherapy: not recommended and should only be considered with a high degree of caution for related psychiatric comorbidities such as ADHD, mood disorders, and anxiety disorders.

**Complications:** developmental delays associated with neglect (for more information, see “Child neglect”)

# 5. Disinhibited social engagement disorder

## Description

- A psychiatric disorder characterized by uninhibited interactions with unfamiliar adults and associated with social neglect during early childhood
- Affected adolescents are less likely to experience stable peer relationships (e.g., more frequent conflicts)

# Diagnostic criteria (DSM-V)

1. Consistent pattern of disinhibited behavior characterized by at least two of the following:
  - Lack of restraint in approaching and engaging with unfamiliar adults
  - Excessively familiar behavior towards strangers that is inconsistent with age-appropriate or culturally accepted norms
  - Venturing away without checking back with adult caregiver, even in unfamiliar settings
  - Little or no hesitation to accompany unfamiliar adults away from caregiver

2. Disinhibited behavior is not marked exclusively by impulsivity (as seen in ADHD) but must have a social component.
3. A history of neglect in early childhood (< 2 years of age)
  - Persistent social neglect (inadequate comfort, stimulation, and affection provided by caregivers)
  - Repeated changes in primary caregivers (e.g., foster carers) impede the development of selective social attachments.
  - Childrearing settings with a high child-to-caregiver ratio
4. The disinhibited behavior begins after the onset of insufficient or inconsistent care
5. Developmental age of at least 9 months

## Treatment

- Psychotherapy: parent-child interaction therapy, family therapy
- Coaching techniques for primary caregivers

**Complications:** developmental delays associated with neglect (for more information, see “Child neglect”)

# **Nursing intervention for Trauma and Stressor-Related Disorder**

- 1.** Assess degree of anxiety/fear present, associated behaviors, and reality of threat perceived by client.
- 2.** Maintain and respect client's personal space boundaries (approximately 4-foot circle around client).
- 3.** Develop trusting relationship with the client.
- 4.** Identify whether incident has reactivated preexisting or coexisting situations (physical/psychological).
- 5.** Observe for and elicit information about physical injury, and assess symptoms such as numbness, headache, and tightness in chest, nausea, and pounding heart.
- 6.** Evaluate social aspects of trauma/incident (e.g., disfigurement, chronic conditions, and permanent disabilities).

7. Identify psychological responses (e.g., anger, shock, acute anxiety [panic], confusion, denial). Note laughter, crying, calm or agitation, excited (hysterical) behavior, expressions of disbelief and/ or self-blame. Record emotional changes.
8. Determine degree of disorganization. Indicator of level of intervention that is required (e.g., may need to be hospitalized when disorganization is severe). Note signs of increasing anxiety (e.g., silence, stuttering, and inability to sit still/pacing).
9. Administer medications as indicated, e.g.: Antidepressants: fluoxetine (Prozac), amoxapine (Asendin), doxepin (Sinequan), imipramine (Trofranil), MAO inhibitor phenelzine
10. Promote Client's Safety
  1. Discuss self-harm thoughts.
  2. Help the client develop a plan for going to a safe place when having destructive thoughts or impulses.

## **11. Help Client Cope with Stress and Emotions**

1. Use grounding techniques to help client who is dissociating or experiencing flashbacks.
2. Validate client's feelings of fear, but try to increase contact with reality.
3. During dissociative experience or flashback, help the client change body position, but do not grab or force the client to stand up or move.
4. Use supportive touch if the client responds well to it.
5. Teach deep breathing and relaxation techniques.
6. Use distraction techniques such as participating in physical exercise, listening to music, talking with others, or engaging in a hobby or other enjoyable activity.
7. Help to make a list of activities and keep materials on hand to engage the client when the client's feelings are intense.

## **12. Help Promote Client's Self-Esteem**

1. Refer to the client as “survivor” rather than “victim.”
2. Establish social support system in community.
3. Make a list of people and activities in the community for the client to contact when he or she needs help.

# Dissociative disorders

**Dissociation** is the mechanism that allows our mind to separate certain memories, most often of unpleasant situations or traumatic events from conscious awareness. These separated parts are kept in the unconscious, or are repressed, and may re-emerge at any time.

**Dissociation** is a disconnection between a person's thoughts, memories, feelings, actions or sense of who he or she is. This is a normal process that everyone has experienced.

Examples of mild, common dissociation include daydreaming, highway hypnosis or “getting lost” in a book or movie, all of which involve “losing touch” with awareness of one's immediate surroundings.

# Types of Dissociative Disorders

In the DSM-5, the disorders include three main categories that include

- 1- dissociative amnesia includes(dissociative fugue),**
- 2- dissociative identity disorder,**
- 3- depersonalization/derealization disorder**

# 1. Dissociative Amnesia

**Dissociative amnesia** is characterized by an inability to remember important personal information, usually of a traumatic or stressful nature.

This lack of recall includes a loss of information beyond ordinary forgetfulness. The void may cover the entire scope of the person's life or may be confined to certain details related to the traumatic event itself.

# Common Signs and Symptoms of Dissociative Amnesia

- Inability to recall portions or all of memory or identity
- Impaired social and occupational relationships
- Inability to recall some or all of one's past or identity
- Memory loss not attributed to forgetfulness
- No medical explanation for loss of memory

## Types of Dissociative Amnesia

- **localized** – unable to remember an event or period of time (most common type)

- **selective** – unable to remember a specific aspect of an event or some events within a period of time

- **generalized** – complete loss of identity and life history (rare)

## Incidence and Etiology



Dissociative amnesia can occur in any age group from children to adults. The main manifestation is a gap in memory for past events that may cover minutes or years.

There is a recent increase in incidence, perhaps because of more awareness and newer therapeutic approaches that address traumatic childhood memories.

# Dissociative amnesia with dissociative fugue

**Dissociative amnesia with dissociative fugue** is demonstrated by the inability to recall some or all of a person's past or identity, accompanied by the sudden and unexpected travel of the person away from home or place of employment.

The person often assumes a new identity in the new geographic location. Travel may include simple short trips for a few hours or days, or more extensive travel across many miles over a period of weeks or months.

# Signs and Symptoms

Although people with dissociative fugue forget their name, family, and where they live, they seem to remember things unrelated to their identity, such as how to drive a car or how to read.

When they suddenly return to their former self, they are unable to remember the time of the altered identity or fugue itself.

# Incidence and Etiology

Few people have actually been diagnosed with dissociative fugue. However, its prevalence may increase during times of extremely stressful events.

These can include the impact of war and combat, events such as the terrorist attacks of September 11, 2001, or natural disasters as seen in the devastation of hurricanes, earthquakes, or tornadoes.

It is important to recognize that this type of dissociation may also occur in people who are trying to avoid a legal, financial, or unwanted personal situation. This is referred to as malingered

fugue and is especially relevant in forensic or criminal activity.

## **2-Dissociative Identity Disorder(DID)**

In dissociative identity disorder (formerly known as multiple personality disorder), two or more distinct identities or personalities are present in the same person.

These identities alternate in assuming control of the person's behavior. People with this disorder are unable to connect various aspects of their identity with the past and the present, resulting in fragmentation of the original personality.

# Signs and Symptoms of Dissociative

- Inability to recall relevant personal information
- Inability to associate the identity with the past and present in organized way
- Multiple personality states, switching from one identity to another
- Migraine headaches
- Nightmares
- Hyperactive startle reflex
- Self-injurious behaviors

# Incidence and Etiology

Adult dissociative identity disorder is diagnosed more frequently in adult women, and they also tend to have more identities than adult men.

The disorder tends to run a lengthy and chronic course from symptom recognition to diagnosis, with the average onset during the early school years.

The disorder is less pronounced after age 40. People with this disorder often report a history of severe physical and sexual abuse, particularly during childhood.

### 3-Depersonalization/ Derealization Disorder

**Depersonalization** is marked by a persistent and repetitious feeling of being detached from one's mental thoughts or body without the presence of disorientation.

The person with this disorder has a feeling of not recognizing himself or is unsure about his personal information and identity. The person may sense that his body is imaginary, in an altered state, or disappearing.



**Derealization-**: persistent or recurrent experiences of unreality of surroundings

People and objects may seem to change in size or shape and sounds may seem different. All these feelings can be associated with feelings of anxiety, including dizziness and fears of going insane, or with depression.

# Common Sign and Symptoms

- Feelings of detachment from one's body or thoughts
- Inability to recognize oneself or personal information
- Anxiety or panic
- Depression
- Obsessions
- Impaired activities of daily living
- People seem unfamiliar

# Incidence and Etiology

The prevalence of this as a chronic disorder is unknown. It is estimated that perhaps half of all adults may have experienced a single brief episode of depersonalization, usually precipitated by severe stress or life-threatening situational experience. This feeling can also occur with sleep deprivation or after taking certain mind-altering drugs such as marijuana, hallucinogens

# Treatment of Dissociative Disorders

- Encourage the client to keep a daily journal of thoughts and feelings.
- Develop a contract between the client and staff for dealing with self-destructive behaviors.
- Promote a safe environment to protect the client from self-injury or injury to others.
- Assist the client in developing effective coping skills.
- Identify environmental stressors that trigger the dissociative symptoms.
- Decrease anxiety-producing stimuli.

# Cont.

- Use stimuli that stimulate pleasant memories and pleasurable feelings for the client. This assists the client to remember past experiences without the risk of precipitating increased trauma.
- Avoid flooding the client with details of past traumatic events. This may cause the client to regress further into the dissociative state that is serving to protect the person from the emotional pain.
- Assist the client to identify alternatives to self-injury such as physical exercise, written methods of expression, or creative art and task-oriented activities,
- Help the family to provide encouragement and reinforcement of positive client behaviors.

THANKS FOR ALL