Brief Contents

Psychiatric–Mental Health Nursing

TENTH EDITION

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Wolters Kluwer

Philadelphia • Baltimore • New York • London
Buenos Aires • Hong Kong • Sydney • Tokyo

Vice President and Publisher: Julie K. Stegman
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Manufacturing Coordinator: Margie Orzech-Zeranko
Prepress Vendor: S4Carlisle Publishing Services

Tenth edition

9 8 7 6 5 4 3 2 1

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

ISBN-13: 978-1-975239-15-2

Library of Congress Control Number: 2025940312

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Preface

The tenth edition of *Psychiatric–Mental Health Nursing* maintains a strong student focus, presenting sound nursing theory, therapeutic modalities, and clinical applications across the treatment continuum. The chapters are short, and the writing style is direct in order to facilitate reading comprehension and student learning.

This edition expands clinical judgment elements while maintaining a strong foundation in the nursing process. The Clinical Judgment Measurement Model (CJMM), developed by the National Council of State Boards of Nursing (NCSBN) and used for the Next Generation NCLEX (NGN) exam, was launched in April 2023. An important distinction is that the CJMM is a model for testing and evaluation, whereas nursing curricula are based on models for teaching and learning as well as evaluation. This tenth edition will be useful for nursing programs, faculty, and students for curricula based on the nursing process as well as programs moving toward a clinical judgment model. Many of the changes in the ninth and tenth editions are based on recommendations of the NCSBN. See https://www.ncsbn.org for more detailed and complete information.

Other specific additions and/or changes in this tenth edition include:

- Concepts have been added at the beginning of each chapter to show how content applies to concepts-based curricula. Some concepts are global in nature but still applicable to nursing, such as Health, Wellness, & Illness or Anxiety.
- Chapter Study Guides now contain case studies rather than clinical examples, with four new additions. These can be adapted to promote clinical judgment development or used as chapter review by students, with the sample answers provided.
- Building Clinical Judgment boxes are a new feature to enhance student learning, either in class or study groups. There is one located in each chapter in Unit 4. A basic situation is provided with questions to begin the activity. Additional data are provided by faculty or other students and the activity continues to develop. Each time the situation is used, different assessment data can be provided to direct the thinking in a different direction.

This text uses therapeutic communication, with examples throughout. Actions focus on all aspects of care, including communication, client and family education, and community resources, as well as their practical applications in various clinical settings. There are also examples of pharmacology throughout.

Assessment data collection and analysis comprise the foundation for identifying problems and establishing priorities of care. Problems replace NANDA nursing diagnoses because the latter are not part of the CJMM and are not used in many practice settings, which is an important part of student learning. However, programs using NANDA nursing diagnoses can still easily substitute those as their problem statements. Sample plans of care retain the "Rationale" feature. Rationale is reframed as "Thinking Like a Nurse," which ties more closely to clinical judgment.

In this edition, all content has been updated to highlight current evidence-based practice. This includes "Evidence-Based Practice" boxes, as well as new U.S. Food and Drug Administration (FDA)-approved medications. Special features include "Concept Mastery Alert" boxes, which clarify important concepts that are essential to students' learning. Additional features "Cultural Considerations" and "Age-Related Considerations" have special headings to help call attention to this important content.

ORGANIZATION OF THE TEXT

Unit 1: Current Theories and Practice provides a strong foundation for students. It addresses current issues in psychiatric nursing as well as the many treatment settings in which nurses encounter clients. It thoroughly discusses neurobiologic theories, psychopharmacology, and psychosocial theories and therapy as a basis for understanding mental illness and its treatment.

Unit 2: Building the Nurse–Client Relationship presents the basic elements essential to the practice of mental health nursing. Chapters on therapeutic relationships and therapeutic communication prepare students to begin working with clients both in mental health settings and in all other areas of nursing practice. The chapter on the client's response to illness provides a framework

for understanding the individual client. An entire chapter is devoted to assessment, emphasizing its importance in nursing.

Unit 3: Current Social and Emotional Concerns covers topics that are not exclusive to mental health settings. These include legal and ethical issues; anger, aggression, and hostility; abuse and violence; and grief and loss. Nurses in all practice settings find themselves confronted with issues related to these topics. Additionally, many legal and ethical concerns are interwoven with issues of violence and loss.

Unit 4: Nursing Practice for Psychiatric Disorders covers all the major categories of mental disorders and reflects current concepts in mental disorders. Chapters include trauma and stressor-related disorders, obsessive–compulsive disorder and related disorders, somatic symptom disorders, disruptive disorders, and neurodevelopmental disorders. Each chapter provides current information on etiology, onset and clinical course, treatment, and caring for clients. The chapters are compatible for use with any medical classification system for mental disorders.

PEDAGOGICAL FEATURES

Psychiatric–Mental Health Nursing incorporates the following pedagogical features designed to facilitate student learning:

- **Learning Objectives** focus on the students' reading and study.
- **Key Terms** identify new terms used in the chapter. Each term is identified in bold and defined in the text.
- **Care of Clients** sections highlight the assessment framework to help students compare and contrast various disorders more easily.
- **Critical Thinking Questions** stimulate students' thinking about current dilemmas and issues in mental health.
- **Key Points** summarize chapter content to reinforce important concepts.
- **Chapter Study Guides** provide workbook-style questions for students to test their knowledge and understanding of each chapter.

Special Features

- **Concepts** listed at the beginning of each chapter make clear how content applies to Concepts-based curricula.
- **Plan of Care** boxes demonstrate a sample plan of care for a client with a specific disorder.
- **Drug Alerts** highlight essential points about psychotropic drugs.
- **Warning Boxes** are U.S. Food and Drug Administration black box drug warnings for specific medications.
- **Cultural Considerations** sections highlight diversity in client care.
- **Age-Related Considerations** sections highlight the key considerations for children, adolescents, and a growing older adult population.
- **Therapeutic Dialogues** give specific examples of the nurse–client interaction to promote therapeutic communication skills.
- **Client and Family Education** boxes provide information that helps strengthen students' roles as educators.
- **Actions** provide a summary of key actions for the specific disorder.
- ***DSM-5-TR* Diagnostic Criteria** boxes include specific diagnostic information for the disorder.
- **Evidence-Based Practice** boxes highlight current evidence-based practice research on a wide variety of practice issues.
- **Self-Awareness Issues** encourage students to reflect on themselves, their emotions, and their attitudes as a way to foster both personal and professional development.
- **Concept Mastery Alert** boxes clarify important concepts that are essential to students' learning and practice.
- **Unfolding Patient Stories**, written by the National League for Nursing, are an engaging way to begin meaningful conversations in the classroom. These vignettes, which appear throughout the book, feature patients from Wolters Kluwer's vSim for Nursing | *Mental Health* (codeveloped by Laerdal Medical) and DocuCare products; however, each Unfolding Patient Story in the book stands alone, not requiring purchase of these products. For your convenience, a list of these case studies, along with their location in the book, appears in the "Case Studies in This Book" section later in this front matter.

A Comprehensive Package for Teaching and Learning

To further facilitate teaching and learning, a carefully designed ancillary package has been developed to assist faculty and students.

Instructor Resources

Tools to assist you with teaching your course are available upon adoption of this text at thepoint.lww.com/Videbeck10e.

- The **Test Bank** lets you put together exclusive new tests from a bank containing hundreds of questions to help you in assessing your students' understanding of the material. Test questions correspond to chapter learning objectives.
- Sample **syllabi** provide guidance for structuring your course.
- An **e-book** allows access to the book's full text and images online.

- **Watch and Learn Videos** depict true-to-life patients displaying mental health disorders, allowing students to gain experience and a deeper understanding of mental health patients. This edition includes five new Watch and Learn videos.
  - An **AACN Essentials Map** relates the textbook content to the current AACN Essentials.
- **Movie Viewing Guides** list current examples of movies that depict various mental health disorders and that are widely available. Viewing points are provided to serve as a basis for discussion in class and among students.
- An extensive collection of materials is provided for each book chapter:
  - **PowerPoint Presentations** provide an easy way for you to integrate the textbook with your students' classroom experience, either via slide shows or handouts. Multiple choice and true/false questions are integrated into the presentations to promote class participation and allow you to use i-clicker technology.
  - **Guided Lecture Notes** walk you through the chapters, objective by objective, and provide you with corresponding PowerPoint slide numbers.
  - An **Image Bank** allows you to use the photographs and illustrations from this textbook in your PowerPoint slides or as you see fit in your course.
  - **Pre-Lecture Quizzes** (and answers) are quick, knowledge-based assessments that allow you to check students' reading.
- **Journal Articles** offer access to current research available in Wolters Kluwer journals.

vSim for Nursing

vSim for Nursing, jointly developed by Laerdal Medical and Wolters Kluwer, offers innovative scenario-based learning modules consisting of web-based virtual simulations, course learning materials, and curriculum tools designed to develop critical thinking skills and promote clinical confidence and competence. vSim for Nursing | *Mental Health* includes 10 mental health scenarios authored by the National League for Nursing. Students can progress through suggested readings, pre- and postsimulation assessments, documentation assignments, and guided reflection questions, and will receive an individualized feedback log immediately upon completion of the simulation. Throughout the student learning experience, the product offers remediation back to trusted Lippincott resources, including *Psychiatric–Mental Health Nursing*, as well as Lippincott Nursing Advisor and Lippincott Nursing Procedures—two online, evidence-based, clinical information solutions used in health care facilities throughout the United States. This innovative product provides a comprehensive patient-focused solution for learning and integrating simulation into the classroom.

Contact your Wolters Kluwer sales representative or visit http://thepoint.lww.com/vsim for options to enhance your mental health nursing course with vSim for Nursing.

Lippincott DocuCare

Lippincott DocuCare combines web-based academic electronic health record (EHR) simulation software with clinical case scenarios, allowing students to learn how to use an EHR in a safe, true-to-life setting, while enabling instructors to measure their progress. Lippincott DocuCare's nonlinear solution works well in the classroom, simulation lab, and clinical practice.

Contact your Wolters Kluwer sales representative or visit http://thepoint.lww.com/DocuCare for options to enhance your mental health nursing course with DocuCare.

A COMPREHENSIVE, DIGITAL, INTEGRATED COURSE SOLUTION

Lippincott® CoursePoint+ is an integrated, digital curriculum solution for nursing education that provides a completely interactive experience geared to help students understand, retain, and apply their course knowledge and be prepared for practice. The time-tested, easy-to-use, and trusted solution includes engaging learning tools, evidence-based practice, case studies, and in-depth reporting to meet students where they are in their learning, combined with the most trusted nursing education content on the market to help prepare students for practice. This easy-to-use digital learning solution of *Lippincott® CoursePoint+*, combined with unmatched support, gives instructors and students everything they need for course and curriculum success!

Lippincott® CoursePoint+ includes the following:

- Leading content provides a variety of learning tools to engage students of all learning styles.
- A personalized learning approach gives students the content and tools they need at the moment they need them, giving them data for more focused remediation and helping to boost their confidence and competence.
- Powerful tools, including varying levels of case studies, interactive learning activities, and adaptive learning powered by PrepU, help students learn the critical thinking and clinical judgment skills to help them become practice-ready nurses.
- Preparation for Practice tools improve student competence, confidence, and success in transitioning to practice.
  - vSim for Nursing: Codeveloped by Laerdal Medical and Wolters Kluwer, vSim for Nursing simulates real nursing scenarios and allows students to interact with virtual patients in a safe, online environment.

- Lippincott Advisor for Education: With over 8,500 entries covering the latest evidence-based content and drug information, Lippincott Advisor for Education provides students with the most up-to-date information possible, while giving them valuable experience with the same point-of-care content they will encounter in practice.
- Unparalleled reporting provides in-depth dashboards with several data points to track student progress and help identify strengths and weaknesses.
- Unmatched support includes training coaches, product trainers, and nursing education consultants to help educators and students implement *CoursePoint+* with ease.

A NOTE ABOUT THE LANGUAGE USED IN THIS BOOK

Wolters Kluwer recognizes that people have a diverse range of identities, and we are committed to using inclusive and nonbiased language in our content. In line with the principles of nursing, we strive not to define people by their diagnoses, but to recognize their personhood first and foremost, using as much as possible the language diverse groups use to define themselves, and including only information that is relevant to nursing care.

We strive to better address the unique perspectives, complex challenges, and lived experiences of diverse populations traditionally underrepresented in health literature. When describing or referencing populations discussed in research studies, we will adhere to the identities presented in those studies to maintain fidelity to the evidence presented by the study investigators. We follow best practices of language set forth by the *Publication Manual of the American Psychological Association*, 7th edition, but acknowledge that language evolves rapidly, and we will update the language used in future editions of this book as necessary.

Acknowledgments

As always, I must thank all the students over the years who have shaped my philosophy of teaching and learning. This includes suggestions for keeping the book user-friendly for both faculty and students, and recommending ways to organize the text so that it is easy to read and understand. A special thanks to my long-time friend and colleague Judy Schultz, who always provides much-needed input and ideas for change. I am also grateful for the support of friends, most of whom are also nurses. They listen to complaints and new ideas, provide feedback that helps improve each edition and, most of all, unwavering support throughout the whole process.

–Sheila L. Videbeck

Contents

Case Studies in This Book

CASES THAT UNFOLD ACROSS CHAPTERS

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BUILDING CLINICAL JUDGMENT BOXES

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UNIT 4

Nursing Practice for Psychiatric Disorders

CHAPTER 13

Trauma and Stressor-Related Disorders

KEY TERMS

- acute stress disorder
- adaptive disclosure
- adjustment disorder
- depersonalization
- derealization
- disinhibited social engagement disorder (DSED)
- dissociation
- dissociative disorders
- exposure therapy
- grounding techniques
- hyperarousal
- posttraumatic stress disorder (PTSD)
- reactive attachment disorder (RAD)
- repressed memories
- survivor

LEARNING OBJECTIVES

After reading this chapter, you should be able to:

1. Discuss the characteristics, risk factors, and dynamics of immediate and longer-term individual responses to trauma and stressors.
2. Examine the occurrence of various longer-term responses to trauma and stress.
3. Describe responses to trauma and stressors, specifically posttraumatic stress disorder (PTSD) and dissociative identity disorder.
4. Provide education to clients, families, and communities to promote prevention and early recognition of trauma and stressor-related responses.
5. Develop a plan of care for clients with trauma or stressor-related diagnoses.
6. Evaluate your own experiences, feelings, attitudes, and beliefs about responses to trauma and stress.

CONCEPTS

Anxiety
Health Care Disparities
Safety
Self-Esteem
Stress & Coping

INTRODUCTION

People may experience events in their lives that are extraordinarily intense or severe, well beyond the stress of daily life (see Chapter 14). These traumatic events or stressors would be expected to disrupt the life of anyone who experienced them, not just individuals at risk for mental health problems or issues. The trauma or event

may affect a single individual, such as a person with a history of childhood abuse, a child newly diagnosed with type 1 diabetes, or an adult with an acute coronary syndrome such as a myocardial infarction or unstable angina. Large numbers or groups of people may be affected by a traumatic event, such as war or terrorist attacks or a natural disaster like a flood, hurricane, or tsunami. Posttraumatic stress disorder (PTSD) is seen in countries around the world (Shalev & Marmar, 2025).

The global COVID-19 pandemic triggered significant problems for many people. Individuals most at risk for PTSD included health care workers, first responders, and those who suffered serious complications due to COVID-19. Social isolation, economic losses, confinement at home, and disruption of everyday life were some of the issues that almost all people experienced. In addition, family members were also affected. Children, spouses, and partners of first responders with PTSD experienced secondary trauma, vicarious trauma, and/or separation anxiety (May et al., 2023).

All people experiencing traumatic events, such as those mentioned previously, manifest anxiety, insomnia, difficulty coping, grief, or a variety of responses; most work through the experience and return to their usual levels of coping and equilibrium, perhaps even with enhanced coping skills as a result of dealing with the event. However, some individuals continue to have problems coping, managing stress and emotions, or resuming their daily activities. They may develop an adjustment disorder, acute stress disorder, PTSD, or a dissociative disorder, as discussed in this chapter.

POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder (PTSD) is a disturbing pattern of behavior demonstrated by someone who has experienced, witnessed, or been confronted with a traumatic event such as a natural disaster, combat, or an assault. A person with PTSD was exposed to an event that posed actual or threatened death or serious injury, and they responded with intense fear, helplessness, or terror. Box 13.1 displays the

BOX 13.1 Life Events Checklist (LEC-5 Standard)

Event	Happened to Me	Witnessed It	Learned About It	Not Sure	Doesn't Apply
1. Natural disaster (e.g., flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (e.g., car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, at home, or during recreational activity					
5. Exposure to toxic substance (e.g., dangerous chemicals, radiation)					
6. Physical assault (e.g., being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (e.g., being shot, stabbed, threatened with a gun, knife, or bomb)					
8. Sexual assault (e.g., rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war zone (in the military or as a civilian)					
11. Captivity (e.g., being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (e.g., homicide, suicide)					
15. Sudden, accidental death					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Adapted from Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The life events checklist for DSM-5 (LEC-5)—Standard version.* National Center for PTSD. https://www.ptsd.va.gov/professional/assessment/documents/LEC5_Standard_Self-report.PDF

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Life Events Checklist (LEC-5) that is used to screen individuals with a history of exposure to some type of trauma. This checklist is a self-report assessment of events experienced by the individual throughout their entire life.

Clinical Course

The four subcategories of symptoms in PTSD include re-experiencing the trauma through dreams or recurrent and intrusive thoughts, avoidance, negative cognition or thoughts, and being on guard, or **hyperarousal** (Shalev & Marmar, 2025). The person persistently reexperiences the trauma through memories, dreams, flashbacks, or reactions to external cues about the event and therefore avoids stimuli associated with the trauma. They feel a numbing of general responsiveness and show persistent signs of increased arousal such as insomnia, hyperarousal or hypervigilance, irritability, or angry outbursts. They report losing a sense of connection and control over their life. This can lead to avoidance behavior or trying to avoid any places or people or situations that may trigger memories of the trauma. The person seeks comfort, safety, and security but can actually become increasingly isolated over time, which can heighten the negative feelings they are trying to avoid. Box 13.2 is the PTSD Checklist (PCL-5), which details many of the symptoms people experience. Individuals usually choose the most troublesome event from the LEC-5 and self-report symptom severity regarding that event.

BOX 13.2 PTSD Checklist (PCL-5)

If an event on the Life Events Checklist **happened to you** or you **witnessed it**, please complete the following items. If more than one event happened, please choose the one that is **most troublesome to you now.**

The event you experienced was _____ on _____.
(event) (date)

In the Past Month, How Much Were You Bothered By:	Not at All	A Little Bit	Moderately	Quite a Bit	Extremely
1. Repeated disturbing memories, thoughts, or images of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (e.g., heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (e.g., people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (e.g., having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4

(*continued*)

BOX 13.2 PTSD Checklist (PCL-5) (*continued*)

12. Loss of interest in activities you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (e.g., being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "super alert," watchful, or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Adapted from Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *PTSD checklist for DSM-5 (PCL-5)*. National Center for PTSD. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

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In PTSD, the symptoms occur 3 months or more after the trauma, which distinguishes PTSD from acute stress disorder, which may have similar types of symptoms but lasts between 3 days and 1 month. The full expression of PTSD can be delayed for months or even years. Typically, PTSD is chronic in nature, although symptoms can fluctuate in intensity and severity, becoming worse during stressful periods. Often, other life events can exacerbate PTSD symptoms. In addition, many clients with PTSD develop other psychiatric disorders, such as depression, anxiety disorders, or alcohol or substance use disorder. Veterans with PTSD due to experiencing combat situations often have alcohol use disorders and an increased risk of suicide (Walker et al., 2023).

PTSD can occur at any age, including during childhood. Estimates are that up to 60% of people at risk, such as veterans who have been in combat situations and people who experienced violence and natural disasters, develop PTSD. Complete recovery can occur; however, even with treatment, one third of individuals will have persistent symptoms for many years (Shalev & Marmar, 2025). The severity and duration of the trauma and the proximity of the person to the event are the most important factors affecting the likelihood of developing PTSD. One fourth of all people who have experienced physical assault develop PTSD. For women, physical assault and rape are the most frequent precipitating traumatic events (Cox et al., 2023).

Posttraumatic stress disorder

Related Disorders

Adjustment disorder is a reaction to a stressful event that causes problems for the individual. Typically, the person has more than the expected difficulty coping with or assimilating the event into their life. Financial, relationship, and work-related stressors are the most common events. The symptoms develop within a month, lasting no more than 6 months. At that time, the adjustment has been successful, or the person moves on to another diagnosis (Geer, 2023). Outpatient counseling or therapy is the most common and successful treatment. **Acute stress disorder** occurs after a traumatic event and is characterized by reexperiencing, avoidance, and hyperarousal that occur from 3 days to 4 weeks following a trauma. It can be a precursor to PTSD. Cognitive behavioral therapy (CBT) involving exposure and anxiety management can help prevent the progression to PTSD (Fanai & Khan, 2023).

Reactive attachment disorder (RAD) and **disinhibited social engagement disorder (DSED)** occur before 5 years of age in response to the trauma of child abuse or neglect, called grossly pathogenic care. The child shows disturbed inappropriate social relatedness in most situations. Rather than seeking comfort from a select group of caregivers to whom the child is emotionally attached, the child with RAD exhibits minimal social and emotional responses to others, lacks a positive effect, and may be sad, irritable, or afraid for no apparent reason. The child with DSED exhibits unselective socialization, allowing or tolerating social interaction with caregivers and strangers alike. They lack the hesitation in approaching or talking to strangers evident in most children their age (Ellis et al. 2023). Grossly deficient parenting and institutionalization are the two most common situations leading to this disorder.

Etiology

PTSD and acute stress disorder had long been classified as anxiety disorders, although they differ from other diagnoses in that category; they are now classified in their own category. There has to be a causative trauma or event that occurs prior to the development of PTSD, which is not the case with anxiety disorders, discussed further in Chapter 14. PTSD is a disorder associated with event exposure, rather than personal characteristics, especially with the adult population. In other words, the effects of the trauma at the time, such as being directly involved, experiencing physical injury, or loss of loved ones in the event, are more powerful predictors of PTSD for most people. This is particularly true of single-event trauma, or a triggering event, such as a natural disaster. However, lack of social support, peri-trauma dissociation, and previous psychiatric history or personality factors can further increase the risk of PTSD when they are present pretrauma (Georgescu & Nedelcea, 2023). In addition, people who participate in posttrauma counseling right after the event decrease their risk of PTSD.

For combat-related PTSD, risk factors include lower education, nonofficer rank, combat specialization, number and length of deployments, previous trauma, and previous psychological problems (Mosel, 2023). Certain factors associated with the actual trauma also increase the risk of PTSD, such as firing a weapon, witnessing or causing casualties or death, and death of enemy combatants, prisoners of war, and civilians in the war zone.

DSM-5-TR DIAGNOSTIC CRITERIA: Posttraumatic Stress Disorder in Individuals Older Than 6 Years

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the following corresponding criteria.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing in person the event(s) as it (they) occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or a close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work-related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s).

   Note: In children, there may be frightening dreams without recognizable content.

(*continued*)

DSM-5-TR DIAGNOSTIC CRITERIA: Posttraumatic Stress Disorder in Individuals Older Than 6 Years (*continued*)

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as though the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame themself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

CULTURAL CONSIDERATIONS

Research indicates that PTSD is a universal phenomenon, occurring in countries around the world. There is less information about the meaning of one's culture on PTSD, treatment, and recovery. People leaving their countries because of war or political oppression experience mental defeat, alienation, and lower levels of resilience, as well as poorer long-term outcomes, all of which are associated with PTSD (Bryant et al., 2023). People with a stronger sense of self- and cultural identity are less frequently diagnosed with PTSD and have better long-term outcomes when PTSD is present. This may indicate that strong cultural identity and allegiance to culture contribute to resilience and are therefore highly positive factors.

The assessment and treatment of PTSD can be culturally tailored to patients. Specifically, therapists should try to understand the patients' help-seeking behaviors as well

as their expectations for treatment. Effective treatments, such as CBT, should be strengths based and client driven and include the patient's culturally relevant beliefs about the illness and its symptoms and how they intrude in daily life.

Treatment

Counseling or therapy, individually or in groups, for people with acute stress disorder may prevent progression to PTSD. Therapy on an outpatient basis is the indicated treatment for PTSD. There are some medications that may also contribute to successful resolution, especially when targeting specific issues, such as insomnia. A combination of both therapies produces the best results. Inpatient treatment is not indicated for clients with PTSD; however, in times of severe crisis, short inpatient stays may be necessary. This usually occurs when the client is suicidal or is being overwhelmed by reexperiencing events, such as flashbacks. Short hospitalization for stabilization is discussed later in this chapter.

CBT and specialized therapy programs incorporating elements of CBT are the most common and successful types of formal treatment. The choice of therapy, as well as the choice to seek formal individual or group counseling, can depend on the type of trauma. Self-help groups offer support and a safe place to share feelings.

Exposure therapy is a treatment approach designed to combat the avoidance behavior that occurs with PTSD, help the client face troubling thoughts and feelings, and regain a measure of control over their thoughts and feelings. The client confronts the feared emotions, situations, and thoughts associated with the trauma rather than attempting to avoid them. Various relaxation techniques are employed to help the client tolerate and manage the anxiety response. The exposure therapy may confront the event in reality, for example, returning to the place where one was assaulted, or may use imagined confrontation, that is, mentally placing oneself in the traumatic situation (Cleveland Clinic, 2023). Prolonged exposure therapy has been particularly effective for both active military personnel and veterans.

Adaptive disclosure is a specialized CBT approach developed by the military to offer an intense, specific, short-term therapy for active-duty military personnel with PTSD. It incorporates exposure therapy as well as the empty chair technique, in which the participant says whatever they need to say to anyone, alive or dead. This is similar to techniques used in Gestalt therapy (Darnell et al., 2022). Despite a short format, this approach seems well tolerated and effective in reducing PTSD symptoms and promoting posttrauma growth.

Cognitive processing therapy has been used successfully with people who were sexually assaulted and have PTSD as well as veterans who have experienced combat situations. The therapy course involves structured sessions that focus on examining beliefs that are erroneous or that interfere with daily life, such as guilt and self-blame (e.g., "It was my fault, I should have fought harder" or "I should have died with my fellow Marines"); reading aloud a written account of the worst traumatic experience; recognizing generalized thinking, that is, "No one can be trusted"; and regaining more balanced and realistic ways of appraising the world and themselves (National Center for PTSD, 2022).

Medications may be used for clients with PTSD to deal with symptoms such as insomnia, anxiety, or hyperarousal. Studies show that selective serotonin reuptake inhibitor (SSRI) and selective serotonin and norepinephrine reuptake inhibitor (SSNRI) antidepressants are most effective, specifically fluoxetine, paroxetine, sertraline, and venlafaxine. The atypical antipsychotic risperidone is effective for hyperarousal in many people. Evidence is lacking for the efficacy of benzodiazepines, although they are widely used in clinical practice (Shalev & Marmar, 2025; Tregub et al., 2023). A combination of medications and CBT is considered to be more effective than either one alone.

AGE-RELATED CONSIDERATIONS

PTSD can be diagnosed at any age. Traumatic events such as natural disasters are not clustered in any particular age group.

Studies of adolescents with PTSD indicate they are more likely to develop PTSD than children or adults. Age, gender, type of trauma, and repeated trauma are related to increased PTSD rates. Adolescents with PTSD are at increased risk for suicide, substance use disorder, poor social support, academic problems, and poor physical health. Trauma-focused CBT is beneficial and can be delivered in school or community-based settings. It also has positive long-term effects with both PTSD and other comorbid conditions (Xie et al., 2024). PTSD may disrupt biologic maturation processes contributing to long-term emotional and behavioral problems experienced by adolescents with this disorder that would require ongoing or episodic therapy to deal with relevant issues.

Children are more likely to develop PTSD when there is a history of parental major depression and childhood abuse. Psychopathology in the parents results in a stress-laden environment for the child and is much more likely to end in a PTSD diagnosis. These risks are diminished when postevent counseling occurs soon after the trauma. Parental participation in treatment significantly enhances the benefits of CBT for traumatized children as well as their parents (Greene et al., 2023).

Older adults who fall and fracture a hip can experience PTSD. In addition, the current population of older adults includes veterans of World War II who experienced PTSD, although it was not recognized as such at the time. Often, it was called combat fatigue or shell shock. PTSD was identified as a common disorder in older adults in Europe

and linked to the war as well as the resulting occupation. Veterans of the Vietnam War, now in their 60s, are among some of the first people to be diagnosed with PTSD.

Many among the older adult population have impaired quality of life from PTSD, including a negative impact on physical functioning and general health. Chronic PTSD may be associated with premature aging and dementia. Therefore, it is essential that older adults receive adequate treatment for PTSD (Kaiser et al., 2022).

Community-Based Care

Most care provided to people in the aftermath of traumatic experiences is done on an outpatient basis. Individual therapy, group therapy, and self-help groups are among the most common treatment modalities. In addition, both clients and families can implement many self-care interventions to promote physical and emotional well-being. These suggestions are discussed in "Client and Family Education."

CLIENT AND FAMILY EDUCATION

- Ask for support from others.
- Avoid social isolation.
- Join a support group.
- Share emotions and experiences with others.
- Follow a daily routine.
- Set small, specific, achievable goals.
- Accept feelings as they occur.
- Get adequate sleep.
- Eat a balanced, healthy diet.
- Avoid alcohol and other drugs.
- Practice stress reduction techniques.

Mental Health Promotion

It is not possible to avoid many of the traumatic events in life that can potentially cause mental health problems. Natural disasters such as earthquakes and hurricanes are beyond human control. It is also not possible to avoid all the human-made traumatic events that occur; people have experienced trauma while shopping, watching a movie, or during any other ordinary daily activity. One of the most effective ways of avoiding pathologic responses to trauma is to effectively deal with the trauma soon after it occurs. In addition to first responders for disastrous events, counselors are often present to help people process the emotional and behavioral responses that occur.

Some people more easily express feelings and talk about stressful, upsetting, or overwhelming events. They may do so with family, friends, or professionals. Others are more reluctant to open up and disclose their personal feelings. They are more likely to ignore feelings, deny the event's importance, or insist "I'm fine; I'm over it." By doing that, they increase the risk of future problems such as PTSD.

Concept Mastery Alert

It is essential to have an accurate diagnosis of PTSD. Stress immediately after an event is acute stress disorder, whereas PTSD is delayed in onset. Some individuals will report "having PTSD" but are self-diagnosed. They may have autism spectrum disorder, a grief reaction, or any variety of problems. Effective treatment is possible only with accurate, professional diagnosis.

DISSOCIATIVE DISORDERS

Dissociation is a subconscious defense mechanism that helps a person protect their emotional self from recognizing the full effects of some horrific or traumatic event by allowing the mind to forget or remove itself from the painful situation or memory. Dissociation can occur both during and after the event. As with any other protective coping mechanism, dissociating becomes easier with repeated use. Some clients with PTSD experience dissociative symptoms. See depersonalization/derealization disorder, discussed next.

Dissociative disorders have the essential feature of a disruption in the usually integrated functions of consciousness, memory, identity, or environmental perception. This often interferes with the person's relationships, ability to function in daily life, and ability to cope with the realities of the abusive or traumatic event. This disturbance varies greatly in intensity in different people, and the onset may be sudden or gradual, transient or chronic.

- *Dissociative amnesia*: The client cannot remember important personal information (usually of a traumatic or stressful nature). This category includes a fugue experience where the client suddenly moves to a new geographic location with no memory of past events and often the assumption of a new identity.
- *Dissociative identity disorder* (formerly *multiple personality disorder*): The client displays two or more distinct identities or personality states that recurrently take control of their behavior. This is accompanied by the inability to recall important personal information.
- *Depersonalization/derealization disorder*: The client has a persistent or recurrent feeling of being detached from their mental processes or body (**depersonalization**) or sensation of being in a dreamlike state in which the environment seems foggy or unreal (**derealization**). The client is not psychotic or out of touch with reality.

Dissociative disorders, relatively rare in the general population, are much more prevalent among those with histories of childhood physical and sexual abuse. Some believe the recent increase in the diagnosis of dissociative disorders in the United States is the result of more awareness of this disorder by mental health professionals. Whether dissociative identity disorder is a legitimate diagnosis is still a controversy among psychiatrists in the field (Tracy, 2022).

The media has focused much attention on the theory of **repressed memories** in people who have experienced abuse. Many professionals believe that memories of childhood abuse can be buried deeply in the subconscious mind or repressed because they are too painful for the person who was abused to acknowledge and that the person can be helped to recover or remember such painful memories. If a person comes to a mental health professional experiencing serious problems in relationships, symptoms of PTSD, or flashbacks involving abuse, the mental health professional may help the person remember or recover those memories of abuse. Some mental health professionals believe there is a danger of inducing false memories of childhood sexual abuse through imagination in psychotherapy. This so-called *false memory syndrome* has created problems in families when clients made groundless accusations of abuse. Fears exist, however, that people abused in childhood will be more reluctant to talk about their abuse history because, once again, no one will believe them. Still other therapists argue that people thought to have dissociative identity disorder are suffering anxiety, terror, and intrusive ideas and emotions and therefore need help, and the therapist should remain open-minded about the diagnosis.

BUILDING CLINICAL JUDGMENT PTSD

Background: J.G. is a 20-year-old college student who was sexually assaulted 2 years ago. She had been socially active with friends before the assault, but now doesn't want to go out or see anyone. She just wants to stay home. Her friends are growing tired of her moods. Her mother tells her to go back to living her life. J.G. thinks no one understands what she's been through or how she feels.

Assessment Data: J.G. reports trouble sleeping. She has nightmares and wakes up in a panic, her heart pounding. She is exhausted but afraid to go to sleep. She relives the attack in her nightmares and sometimes has intrusive memories and flashbacks during the daytime. J.G. reports having no appetite and is losing weight. Her class attendance is sporadic, and she doesn't think she can catch up. She had to quit her part-time job to avoid being fired for poor attendance.

Clinical Judgment Development:

- What data are cues that need further assessment?
- What additional questions should the nurse ask J.G.?
- Identify priority problems based on all data and discuss rationale for choices.
- What actions are needed to achieve long-term outcomes? Include collaborative actions for J.G. and her family/friends.

Treatment

People who have experienced abuse and have dissociative disorders are often involved in group or individual therapy in the community to address the long-term effects of their experiences. Therapy for clients who dissociate focuses on reassociation, or putting the consciousness back together. This specialized treatment addresses trauma-based, dissociative symptoms. The goals of therapy are improved quality of life, improved functional abilities, and reduced symptoms. Clients with dissociative disorders may be treated symptomatically, that is, with medications for anxiety or depression or both if these symptoms are predominant.

Short Hospital Treatment for Survivors of Trauma and Abuse

Clients with PTSD and dissociative disorders are found in all areas of health care, from clinics to primary care offices. The nurse is most likely to encounter these clients in acute care settings only when there are concerns for personal safety or the safety of others or when acute symptoms have become intense or overwhelming and require stabilization. Treatment in acute care is usually short term, with the client returning to community-based treatment as quickly as possible.

PLAN OF CARE FOR A CLIENT WITH PTSD

Problem: *Overwhelming stress and emotions*

ASSESSMENT DATA

- Flashbacks or reexperiencing the traumatic event(s)
- Nightmares or recurrent dreams of the event or other trauma
- Sleep disturbances (e.g., insomnia, early awakening, or crying out in sleep)
- Depression
- Denial of feelings or emotional numbness
- Difficulty in expressing feelings
- Anger (may not be overt)
- Guilt or remorse
- Low self-esteem
- Frustration and irritability
- Anxiety, panic, or separation anxiety
- Fears—may be displaced or generalized (as in fear of men by people who have been raped by men)
- Decreased concentration
- Difficulty expressing love or empathy
- Difficulty experiencing pleasure
- Difficulty with interpersonal relationships

EXPECTED OUTCOMES

Immediate

The client will

- Demonstrate decreased physical symptoms within 2 to 3 days.
- Establish an adequate balance of rest, sleep, and activity; for example, sleep at least 4 hours per night within 3 to 4 days.
- Demonstrate decreased anxiety, fear, guilt, and so forth within 4 to 5 days.
- Participate in a treatment program; for example, join in a group activity or talk with staff for at least 30 minutes twice a day within 4 to 5 days.

Stabilization

The client will

- Express feelings directly and openly in nondestructive ways.
- Identify strengths and weaknesses realistically; for example, make a list of abilities and review with staff.
- Demonstrate an increased ability to cope with stress.
- Verbalize knowledge of illness, treatment plan, or safe use of medications, if any.

Community

The client will

- Demonstrate initial integration of the traumatic experience into their life outside the hospital.
- Identify a support system outside the treatment setting; for example, identify specific support groups, friends, or family and establish contact.
- Implement plans for follow-up or ongoing therapy, if indicated; for example, identify a therapist and schedule an appointment before discharge.

IMPLEMENTATION

Actions	Rationale—Thinking Like a Nurse
When you approach the client, be nonthreatening and professional.	The client's fears may be triggered by authority figures with different characteristics (e.g., gender and ethnicity).
Educate yourself and other staff members about the client's experience and about posttraumatic behavior.	Learning about the client's experience will help prepare you for the client's feelings and the details of their experience.
Remain nonjudgmental in your interactions with the client.	It is important not to reinforce blame that the client may have internalized related to the experience.
Be consistent with the client; convey acceptance of them as a person while setting and maintaining limits regarding behaviors.	The client may test the limits of the therapeutic relationship. Problems with acceptance, trust, or authority often occur with posttraumatic behavior.

PLAN OF CARE FOR A CLIENT WITH PTSD (*continued*)

Actions	Rationale—Thinking Like a Nurse
Be aware of the client's use or misuse of substances. Set limits and consequences for this behavior; it may be helpful to allow the client or group to have input into these decisions.	Substance use undermines therapy and may endanger the client's health. Allowing input from the client or group may minimize power struggles.
Encourage the client to talk about their experience(s); be accepting and nonjudgmental of the client's accounts and perceptions.	Retelling the experience can help the client identify the reality of what happened and help identify and work through related feelings.
Encourage the client to express their feelings through talking, writing, crying, or other ways in which the client is comfortable.	Identification and expression of feelings are central to the grieving process.
Especially encourage the expression of anger, guilt, and rage.	These feelings often occur in clients who have experienced trauma. The client may feel survivor's guilt that they survived when others did not or guilt about the behavior they undertook to survive (e.g., killing others in combat, enduring a rape, or not saving others).
Give the client positive feedback for expressing feelings and sharing experiences; remain nonjudgmental toward the client.	The client may feel that they are burdening others with their problems. It is important not to reinforce the client's internalized blame.
Help the client learn and practice stress management and relaxation techniques, assertiveness, self-defense training, or other skills as appropriate.	The client's traumatic experience may have resulted in a loss of or decrease in self-confidence, sense of safety, or ability to deal with stress.
As tolerated, encourage the client to share their feelings and experiences in group therapy, in a support group related to posttrauma, or with other clients informally.	The client needs to know that their feelings are acceptable to others and can be shared. Peer or support groups can offer understanding, support, and the opportunity for sharing experiences.
Encourage the client to identify relationships or social or recreational situations that have been positive in the past.	The client may have withdrawn from social relationships and other activities following the trauma; social isolation and lack of interest in recreational activities are common following trauma.
Encourage the client to identify and contact supportive resources in the community or on the internet.	Many community or internet resources can be helpful to clients with PTSD and to their families or significant others.

CARE OF CLIENTS WITH PTSD

Assessment Data

The health history reveals that the client has a history of trauma or abuse. It may be abuse as a child or in a current or recent relationship. It is generally not necessary or desirable for the client to detail specific events of the abuse or trauma; rather, in-depth discussion of the actual abuse is usually undertaken during individual psychotherapy sessions.

General Appearance and Motor Behavior

The nurse assesses the client's overall appearance and motor behavior. The client often appears hyperalert and reacts to even small environmental noises with a startle response. They may be uncomfortable if the nurse is too close physically and may require greater distance or personal space than most people. The client may appear anxious or agitated and may have difficulty sitting still, often needing to pace or move around the room. Sometimes, the client may sit very still, seeming to curl up with arms around knees.

Mood and Affect

In assessing mood and affect, the nurse must remember that a wide range of emotions is possible, from passivity

to anger. The client may look frightened or scared or agitated and hostile depending on their experience. When the client experiences a flashback, they appear terrified and may cry, scream, or attempt to hide or run away. When the client is dissociating, they may speak in a different tone of voice or appear numb with a vacant stare. The client may report intense anger, feel dead inside, or may be unable to identify any feelings or emotions at all.

Thought Process and Content

The nurse asks questions about thought process and content. Clients who have been abused or traumatized report reliving the trauma, often through nightmares or flashbacks. Intrusive, persistent thoughts about the trauma interfere with the client's ability to think about other things or to focus on daily living. Some clients report hallucinations or buzzing voices in their heads. Self-destructive thoughts and impulses as well as intermittent suicidal ideation are also common. Some clients report fantasies in which they take revenge on their abusers.

Sensorium and Intellectual Processes

During assessment of sensorium and intellectual processes, the nurse usually finds that the client is oriented to reality except if the client is experiencing a flashback or dissociative episode. During those experiences, the client may not respond to the nurse or may be unable to communicate at all. The nurse may also find that clients who have been abused or traumatized have *memory gaps*, which are periods for which they have no clear memories. These periods may be short or extensive and are usually related to the time of the abuse or trauma. Intrusive thoughts or ideas of self-harm often impair the client's ability to concentrate or pay attention.

Judgment and Insight

The client's insight is often related to the duration of their problems with dissociation or PTSD. Early in treatment, the client may report little idea about the relationship of past trauma to their current symptoms and problems. Other clients may be quite knowledgeable if they have progressed further in treatment. The client's ability to make decisions or solve problems may be impaired.

Self-Concept

The nurse is likely to find these clients have low self-esteem. They may believe they are bad people who somehow deserve or provoke the abuse. Many clients believe they are unworthy or damaged by their abusive experiences to the point that they will never be worthwhile or valued. Clients may believe they are going crazy and are out of control with no hope of regaining control. Clients may see themselves as helpless, hopeless, and worthless.

Roles and Relationships

Clients generally report a great deal of difficulty with all types of relationships. Problems with authority figures often lead to problems at work, such as being unable to take direction from another or have another person monitor performance. Close relationships are difficult or impossible because the client's ability to trust others is severely compromised. Often the client has quit work or been fired, and they may be estranged from family members. Intrusive thoughts, flashbacks, or dissociative episodes may interfere with the client's ability to socialize with family or friends, and the client's avoidant behavior may keep them from participating in social or family events.

Physiological Considerations

Most clients report difficulty sleeping because of nightmares or anxiety over anticipating nightmares. Overeating or lack of appetite is also common. Frequently, these clients use alcohol or other drugs to attempt to sleep or to blot out intrusive thoughts or memories.

Data Analysis and Priorities

Common problems in the acute care setting when working with clients who dissociate or have PTSD related to trauma or abuse include:

- Risk of self-mutilation
- Risk of suicide
- Ineffective coping
- Feeling overwhelmed by stress and emotions
- Difficulty managing emotions
- Chronic low self-esteem
- Feelings of helplessness or hopelessness

In addition, the following problems may be pertinent to clients over longer periods, although not present for each client:

- Disturbed sleep (e.g., insomnia, nightmares)
- Sexual dysfunction
- Social isolation
- Not eating or overeating

Risk of suicide and risk of self-mutilation are potentially dangerous; therefore, if either one of these is present, it is a priority. Disruptions in healthy eating and restful sleep are important to address if the client is to have the energy and strength to engage in therapy.

Outcome Identification

Treatment outcomes for clients who have survived trauma or abuse may include:

1. The client will be physically safe.
2. The client will distinguish between ideas of self-harm and taking action on those ideas.
3. The client will demonstrate healthy, effective ways of dealing with stress.

4. The client will express emotions nondestructively.
5. The client will establish a social support system in the community.

Actions

Promoting the Client's Safety

The client's safety is a priority. The nurse must continually assess the client's potential for self-harm or suicide and take action accordingly. The nurse and treatment team must provide safety measures when the client cannot do so (see Chapters 10 and 15). To increase the client's sense of personal control, they must begin to manage safety needs as soon as possible. The nurse can talk with the client about the difference between having self-harm thoughts and acting on those thoughts; having the thoughts does not mean the client must act on them. Gradually, the nurse can help the client find ways to tolerate the thoughts until they diminish in intensity.

ACTIONS

Promote Client's Safety

- Discuss self-harm thoughts.
- Help the client develop a plan for going to a safe place when having destructive thoughts or impulses.

Help Client Cope With Stress and Emotions

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

Help Promote Client's Self-Esteem

- Refer to the client as a "survivor" rather than a "victim."
- Establish social support system in community.
- Make a list of people and activities in the community for the client to contact when they need help.

The nurse can help the client learn to go to a safe place during destructive thoughts and impulses so that they can calm down and wait until these feelings pass. Initially, this may mean just sitting with the nurse or around others. Later, the client can find a safe place at home, often a closet or small room, where they feel safe. The client may want to keep a blanket or pillows there for comfort, as well as pictures or a tape recording to serve as reminders of the present.

Helping the Client Cope With Stress and Emotions

Grounding techniques are helpful to use with the client who is dissociating or experiencing a flashback. **Grounding techniques** remind the client that they are in the present, are an adult, and are safe. Validating what the client is feeling during these experiences is important: "I know this is frightening, but you are safe now." In addition, the nurse can increase contact with reality and diminish the dissociative experience by helping the client focus on what they are currently experiencing through the senses:

- "What are you feeling?"
- "Are you hearing something?"
- "What are you touching?"
- "Can you see me and the room we're in?"
- "Do you feel your feet on the floor?"
- "Do you feel your arm on the chair?"
- "Do you feel the watch on your wrist?"

For the client experiencing dissociative symptoms, the nurse can use grounding techniques to focus the client on the present. For example, the nurse approaches the client and speaks in a calm and reassuring tone. First, the nurse calls the client by name and then introduces themself by name and role. If the area is dark, the nurse turns on the lights. The nurse can reorient the client by saying the following:

"Hello, J., I'm here with you. My name is S. I'm the nurse working with you today. Today is Wednesday, September 18, 2022. You're here in the hospital. This is your room at the hospital. Can you open your eyes and look at me? J., my name is S."

The nurse repeats this reorienting information as needed. Asking the client to look around the room encourages them to move their eyes and avoid being locked in a daze or flashback.

As soon as possible, the nurse encourages the client to change positions. Often during a flashback, the client curls up in a defensive posture. Getting the client to stand and walk around helps dispel the dissociative or flashback experience. At this time, the client can focus on their feet moving on the floor or the swinging movements of their arms. The nurse must not grab the client or attempt to force them to stand up or move. The

client experiencing a flashback may respond to such attempts aggressively or defensively, even striking out at the nurse. Ideally, the nurse asks the client how they respond to touch when dissociating or experiencing a flashback before one occurs; then the nurse knows whether using touch is beneficial for that client. Also, the nurse may ask the client to touch the nurse's arm. If the client does so, then supportive touch is beneficial for this client.

Many clients have difficulty identifying or gauging the intensity of their emotions. They may also report that extreme emotions appear out of nowhere with no warning. The nurse can help clients to get in touch with their feelings using a log or journal. Initially, clients may use a "feelings list" so they can select the feeling that most closely matches their experience. The nurse encourages the client to write down feelings throughout the day at specified intervals, for example, every 30 minutes. Once clients have identified their feelings, they can gauge the intensity of those feelings, for example, rating each feeling on a scale of 1 to 10. Using this process, clients have a greater awareness of their feelings and the different intensities; this step is important in managing and expressing those feelings.

After identifying feelings and their intensities, clients can begin to find triggers, or feelings that precede the flashbacks or dissociative episodes. Clients can then begin to use grounding techniques to diminish or avoid these episodes. They can use deep breathing and relaxation, focus on sensory information or stimuli in the environment, or engage in positive distractions until the feelings subside. Such distractions may include physical exercise, listening to music, talking to others, or engaging in a hobby or activity. Clients must find which distractions work for them; they should then write them down and keep the list and the necessary materials for the activities close at hand. When clients begin to experience intense feelings, they can look at the list and pick up a book, listen to a tape, or draw a picture, for instance.

Helping Promote the Client's Self-Esteem

It is often useful to view the client as a **survivor** of trauma or abuse rather than as a victim. For these clients, who may believe they are worthless and have no power over the situation, it helps to refocus their views of themselves from being victims to being survivors. Defining themselves as survivors allows them to see themselves as strong enough to survive their ordeal. It is a more empowering image than seeing oneself as a victim.

Establishing Social Support

The client needs to find people or activities in the community that can be of support to them. The nurse can help the client prepare a list of people who can provide support. Problem-solving skills are difficult for these clients when under stress, so having a prepared list eliminates confusion or stress. This list should include a local crisis hotline to call when the client experiences self-harm thoughts or urges as well as friends or family to call when the client is feeling lonely or depressed. The client can also identify local activities or groups that provide a diversion and a chance to get out of the house. The client needs to establish community supports to reduce dependency on health care professionals.

Local support groups can be located by calling the county or city mental health services or the Department of Health and Human Services. A variety of support groups, both online and in person, can be found on the internet.

Evaluation

Long-term treatment outcomes for clients who have survived trauma or abuse may take years to achieve. These clients usually make gradual progress in protecting themselves, learning to manage stress and emotions, and functioning in their daily lives. Although clients learn to manage their feelings and responses, the effects of trauma and abuse can be far-reaching and can last a lifetime.

EVIDENCE-BASED PRACTICE: Trauma-Informed Care in Long-Term Care Settings

By the time they reach older adulthood, many adults will have experienced traumatic events. Moreover, it is common for older adults to experience the loss of loved ones, negative effects from aging, and medical illness—all of which can increase the risk of PTSD. The patients in long-term care settings are often older adults. Yet, the authors found no models for trauma-informed care in long-term care settings. They recommend that targeted, evidence-based training for primary caregivers in long-term settings would greatly improve treatment and care for residents.

O'Malley, K. A., Sullivan, J. L., Mills, W., Driver, J., & Moye, J. (2023). Trauma-informed care in long-term care settings: From policy to practice. *Gerontologist*, *63*(5), 803–811. https://doi.org/10.1093/geront/gnac072

SELF-AWARENESS ISSUES

It is essential for nurses to deal with their own personal feelings to best care for individuals affected by traumatic events. These events may be horrific in nature. Natural disasters can affect thousands of people; attacks on individuals or groups are sometimes senseless, random violence; and combat experiences in war can devastate the individuals involved. If the nurse is overwhelmed by the violence or death in a situation, the client's feelings of being victimized or traumatized beyond repair are confirmed. Conveying empathy and validating clients' feelings and experiences in a calm yet caring professional manner are more helpful than sharing the client's horror.

When the client's traumatic event is a natural disaster or even a random violent attack, the nurse may easily support the client, knowing the client had nothing to do with what happened. But when the client has trauma due to causing a car accident that injured or killed others, it may be more challenging to provide unconditional support and withhold judgment of the client's contribution. Remaining nonjudgmental of the client is important but doesn't happen automatically. The nurse may need to deal with personal feelings by talking to a peer or counselor.

Points to Consider When Working With Clients Who Have Experienced Abuse or Trauma

- Clients who participate in counseling, groups, and/or self-help groups have the best long-term outcomes. It is important to encourage participation in all available therapies.
- Clients who survive a trauma may have survivor's guilt, believing they "should have died with everyone else." Nurses will be most helpful by listening to clients' feelings and avoiding pat responses or platitudes such as "Be glad you're alive" or "It was meant to be."
- Often clients just need to talk about the problems or issues they're experiencing. These may be problems that cannot be resolved. Nurses may want to fix the problem for the client to alleviate distress but must resist the desire to do so and simply allow the client to express feelings of despair or loss.

CRITICAL THINKING QUESTIONS

1. Veterans who have been in combat situations are often reluctant to discuss war experiences with anyone outside their unit. What steps should be taken to ensure they get needed debriefing or counseling? How would the nurse approach the veteran?
2. Following a traumatic event such as rape or accumulated trauma such as childhood abuse, some people refuse to talk about it and refuse to seek treatment of any kind. Should counseling be required? Is it possible for people to benefit from counseling if they don't want to participate?

KEY POINTS

- Intense traumatic events that disrupt peoples' lives can lead to an acute stress disorder from 2 days to 4 weeks following the trauma. Autism spectrum disorders can be a precursor to PTSD.
- PTSD is a pattern of behavior following a major trauma beginning at least 3 months after the event or even months or years later. Symptoms include feelings of guilt and shame, low self-esteem, reexperiencing events, hyperarousal, and insomnia.
- Clients with PTSD may also develop depression, anxiety disorders, or alcohol and drug use disorders.
- PTSD can affect children, adolescents, adults, or older adults.
- PTSD occurs in countries around the world. People who flee their native countries for asylum benefit from remaining connected to their cultures.
- Treatment for PTSD includes individual and group therapy, self-help groups, and medication, usually SSRI antidepressants, venlafaxine, or risperidone.
- Counseling offered immediately after a traumatic event can help people process what has happened and perhaps avoid PTSD.
- Dissociation is a defense mechanism that protects the emotional self from the full reality of abusive or traumatic events during and after those events.
- Individuals with a history of physical and/or sexual abuse in childhood may develop dissociative disorders.
- Dissociative disorders have the essential feature of disruption in the usually integrated functions of consciousness, memory, identity, and environmental perception.
- Survivors of trauma and abuse may be admitted to the hospital for safety concerns or stabilization of intense symptoms such as flashbacks or dissociative episodes.
- The nurse can help the client minimize dissociative episodes or flashbacks through grounding techniques and reality orientation.
- Important nursing interventions for survivors of abuse and trauma include protecting the client's safety, helping the client learn to manage stress and emotions, and working with the client to build a network of community support.

- Important self-awareness issues for the nurse include managing their own feelings about and reactions to traumatic events, remaining nonjudgmental regardless of circumstances, and listening to clients' expressions of despair or distress.

Unfolding Patient Stories: R.A. • Part 2

Think back to Chapter 3's story of R.A., a veteran with symptoms of posttraumatic stress disorder (PTSD) and neurocognitive symptoms, which manifested after a recent car accident. He has resisted getting care from the Veterans Affairs hospital. How can he benefit from group therapy and be encouraged to attend? How can the nurse foster communication when R.A. has decreased concentration and difficulty expressing his feelings?

Care for R.A. and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (http://thepoint.lww.com/vSimMentalHealth). Practice documenting these patients' care in DocuCare (http://thepoint.lww.com/DocuCareEHR).

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Chapter Study Guide

MULTIPLE CHOICE QUESTIONS

Select the best answer for each.

1. Which behavior might the nurse assess in a 3-year-old child with RAD?
   a. Choosing the mother to provide comfort
   b. Crying when the parents leave the room
   c. Extreme resistance to social contact with parents and staff
   d. Seeking comfort from holding a favorite stuffed animal

2. Which action would be most helpful for a client with dissociative disorder having difficulty expressing feelings?
   a. Distraction
   b. Reality orientation
   c. Journaling
   d. Grounding techniques

3. Which statement is true about touching a client who is experiencing a flashback?
   a. The nurse should stand in front of the client before touching.
   b. The nurse should never touch a client who is having a flashback.
   c. The nurse should touch the client only after receiving permission to do so.
   d. The nurse should touch the client to increase feelings of security.

4. Clients from other countries who suffered traumatic oppression in their native countries may develop PTSD. Which is least helpful in dealing with their PTSD?
   a. Assimilating quickly into the culture of their current country of residence
   b. Engaging in their native religious practices
   c. Maintaining a strong cultural identity
   d. Social support from an interpreter or fellow countryperson

5. The nurse working with a client during a flashback says, "I know you're scared, but you're in a safe place. Do you see the bed in your room? Do you feel the chair you're sitting on?" The nurse is using which technique?
   a. Distraction
   b. Reality orientation
   c. Relaxation
   d. Grounding

6. Nursing interventions for clients with PTSD who are hospitalized include
   a. encouraging a thorough discussion of the original trauma.
   b. providing private solitary time for reflection.
   c. time-out during flashbacks to regain self-control.
   d. use of deep breathing and relaxation techniques.

MULTIPLE RESPONSE QUESTIONS

Select all that apply.

1. The nurse who is assessing a client with PTSD would expect the client to report which data?
   a. Inability to relax
   b. Increased alcohol consumption
   c. Insomnia even when fatigued
   d. Suspicion of strangers
   e. Talking about problems to friends
   f. Wanting to sleep all the time

2. Education for clients with PTSD should include which information?
   a. Avoid drinking alcohol.
   b. Discuss intense feelings only during counseling sessions.
   c. Eat well-balanced, nutritious meals.
   d. Find and join a support group in the community.
   e. Get regular exercise, such as walking.
   f. Try to solve an important problem independently.

CASE STUDY

R.T. has been diagnosed for several years with dissociative identity disorders. During stressful times in her life, she is increasingly anxious, has poor sleep with nightmares, and finds herself "checked out" at times. She will not remember what she has done recently, which only increases her stress and anxiety. She seeks help at the clinic to regain her stability.

1. What additional assessment does the nurse need to make?
2. Identify two priority problems for R.T.
3. What actions would help R.T. avoid future episodes and remain more stable?