

# POSTTRAUMATIC STRESS DISORDER

## DSM-IV

309.81 Posttraumatic stress disorder (specify acute, chronic, or delayed onset)

308.3 Acute stress disorder

An anxiety disorder resulting from exposure to a traumatic event in which the individual has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death/serious injury or a threat to the physical integrity of the self or others. The individual's response involved intense fear, helplessness, or horror. (A thorough physical examination should be done to rule out neurological organic problems.) Additionally, a newly recognized phenomenon is the development of PTSD-like symptoms in some individuals who have been involved over a long period of time in the treatment of (or living with) clients with PTSD.

## ETIOLOGICAL THEORIES

### Psychodynamics

The client's ego has experienced a severe trauma, often perceived as a threat to physical integrity or self-concept. This results in severe anxiety, which is not controlled adequately by the ego and is manifested in symptomatic behavior. Because the ego is vulnerable, the superego may become punitive and cause the individual to assume guilt for traumatic occurrence; the id may assume dominance, resulting in impulsive, uncontrollable behavior.

### Biological

(Refer to CP: Generalized Anxiety Disorder.)

Some studies have revealed abnormalities in the storage, release, and elimination of catecholamines affecting function of the brain in the region of the locus coeruleus, amygdala, and hippocampus. Hypersensitivity in the locus coeruleus may lead to "learned helplessness." The amygdala appears to be the storehouse for memories, while the hippocampus provides narrative coherence and a location in time and space. Hyperactivation in the amygdala may prevent the brain from making coherent sense of its memories resulting in the memories being stored as nightmares, flashbacks, and physical symptoms.

Research is exploring the possibility of a genetic vulnerability including the belief that neurological disturbances in the womb or during childhood may influence the development of PTSD.

### Family Dynamics

(Refer to CP: Generalized Anxiety Disorder.)

Types of formal education, family life, and lifestyle are significant forecasters of PTSD. Below average or lack of success in education, negative parenting behaviors, and parental poverty have been identified as predictors for development of PTSD, as well as for peritraumatic dissociation.

Current research also suggests that the effects of severe trauma may last for generations, meaning someone else's traumatic experience can be internalized by another, intruding into the second individual's own mental life.

## CLIENT ASSESSMENT DATA BASE

### Activity/Rest

Sleep disturbances, recurrent intrusive dreams of the event, nightmares, difficulty in falling or staying asleep; hypersomnia (intrusive thoughts, flashbacks, and/or nightmares are the triad symptomatic of PTSD)

Easy fatigability, chronic fatigue

## **Circulation**

Increased heart rate, palpitations; increased blood pressure  
Hot/cold spells, excessive perspiration

## **Ego Integrity**

Various degrees of anxiety with symptoms lasting days, weeks, or months (2 days to maximum of 4 weeks occurring within 4 weeks of traumatic event [acute stress disorder]; duration of symptoms less than 3 months [acute PTSD], more than 3 months [chronic PTSD], or onset at least 6 months after traumatic event [delayed])

Difficulty seeking assistance (e.g., medical, legal) or mobilizing personal resources (e.g., telling family members/friends of experience)

Feelings of guilt, helplessness, powerlessness, isolation

Feeling shame for own helplessness; demoralization

Sense of a bleak or foreshortened future (e.g., expects failing relationships, early death)

## **Neurosensory**

Cognitive disruptions, difficulty concentrating and/or completing usual life tasks

Hypervigilance (result of inability to assimilate and integrate experiences)

Excessive fearfulness of objects and/or situations in the environment triggered by reminders or internal cues that resemble or symbolize the events; e.g., startle response to loud noises (someone who experienced combat trauma/bombing), breaking out in a sweat when riding an elevator (for someone who was raped in an elevator)

Persistent recollection (illusions, dissociative flashbacks, hallucinations) or talk of the event, despite attempts to forget; impaired/no recall of an important aspect of the trauma

Poor impulse control with unpredictable explosions of aggressive behavior or acting-out of feelings such as anger, resentment, malice, and ill will (in high dudgeon)

**Mental Status:** Change in usual behavior (moody, pessimistic, brooding, irritable); loss of self-confidence, depressed affect; feelings seem unreal, business of life no longer matters

Muscular tension, tremulousness, motor restlessness

## **Pain/Discomfort**

Pain/physical discomfort of the injury may be exaggerated beyond expectation in relation to severity of injury

## **Respiratory**

Increased respiratory rate, dyspnea

## **Safety**

Angry outbursts, violent behavior toward environment/other individuals

Suicidal ideation, previous attempts

## **Sexuality**

Loss of desire; avoidance of/dissatisfaction with relationships

Inability to achieve sexual satisfaction/orgasm; impotence

## **Social Interactions**

Avoidance of people/places/activities that arouse recollections of the trauma, decreased responsiveness, psychic numbing, emotional detachment/estrangement from others; inability to trust

Markedly diminished interest/participation in significant activities, including work

Restricted range of affect, absence of emotional responsiveness (e.g., absence of loving feelings)

## Teaching/Learning

Occurrence of PTSD often preceded or accompanied by physical illness/harm  
Use/abuse of alcohol or other drugs

## DIAGNOSTIC STUDIES

(Refer to CPs: Generalized Anxiety Disorder; Pain Disorders/Phobias.)

## NURSING PRIORITIES

1. Provide safety for client/others.
2. Assist client to enhance self-esteem and regain sense of control over feelings/actions.
3. Encourage development of assertive, not aggressive, behaviors.
4. Promote understanding that the outcome of the present situation can be significantly affected by own actions.
5. Assist client/family to learn healthy ways to deal with/realistically adapt to changes and events that have occurred.

## DISCHARGE GOALS

1. Self-image improved/enhanced.
2. Individual's feelings/reactions are acknowledged, expressed, and dealt with appropriately.
3. Physical complications treated/minimized.
4. Appropriate changes in lifestyle planned/made.
5. Plan in place to meet needs after discharge.

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### NURSING DIAGNOSIS

#### May Be Related to:

#### Possibly Evidenced by:

#### Desired Outcomes/Evaluation Criteria— Client Will:

### ANXIETY [severe to panic]/FEAR

Current memory of past traumatic life event, such as natural disasters, accidental/deliberate manmade disasters, and events such as rape, assault, or combat

Threat to self-concept/death, change in environment

Negative self-talk (preoccupation with trauma)

Increased tension/wariness; restlessness

Sense of helplessness; apprehension, fearfulness, uncertainty/confusion

Somatic complaints; sympathetic stimulation (e.g., palpitations, shortness of breath, diaphoresis, pupil dilation)

Sense of impending doom; fright, terror, panic, and/or withdrawal

Verbalize awareness of feelings of anxiety/sense of control over fearful stimuli.

Identify healthy ways to manage feelings.

Demonstrate ability to confront situation using problem-solving skills.

Report/display reduction of physiological symptoms.

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## ACTIONS/INTERVENTIONS

## RATIONALE

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### **Independent**

Assess degree of anxiety/fear present, associated behaviors, and reality of threat perceived by client.

Identifies needs for developing plan of care/interventions. Clearly understanding client's perception is pivotal to providing appropriate assistance in overcoming the fear.

Maintain and respect client's personal space boundaries (approximately 4-foot circle around client).

Entering client's personal space without permission/invitation could result in an overwhelming anxiety response, resulting in an overt act of violence. (**Note:** Clients with PTSD have an expanded sense of personal space.)

Develop trusting relationship with the client.

Trust is the basis of a therapeutic nurse/client relationship and enables them to work effectively together. Client may be slow to form a therapeutic alliance and may need to participate in group situations, hearing others relate their own experiences, before being able to speak out or begin to trust others. **Note:** Some clients may distrust/view therapist as an authority figure affecting progress of individual counseling.

Identify whether incident has reactivated preexisting or coexisting situations (physical/psychological).

Concerns/psychological issues will be recycled every time trauma is reexperienced and affect how the client views current situation.

Observe for and elicit information about physical injury, and assess symptoms such as numbness, headache, tightness in chest, nausea, and pounding heart.

Physical injuries may have occurred during incident/panic of recurrence, which may be masked by anxiety of current situation. These need to be identified and differentiated from anxiety symptoms so appropriate treatment can be given.

Note presence of chronic pain or pain symptoms in excess of degree of physical injury.

Psychological responses may magnify/exacerbate physical symptoms.

Evaluate social aspects of trauma/incident (e.g., disfigurement, chronic conditions, permanent disabilities).

Problems that occurred in the original trauma may have left visible reminders that have to be dealt with daily.

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.

Although these are normal responses at the time of the trauma, they will recycle again and again until they are adequately dealt with.

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, inability to sit still/pacing).

May indicate inability to handle current happenings (e.g., feelings or therapy, suggesting need of more intensive evaluation/intervention).

Identify development of phobic reactions to ordinary articles (e.g., knives), situations (e.g., strangers ringing doorbell, walking in crowds of people), occurrences (e.g., car backfires).

Stay with client, maintaining a calm, confident manner. Speak in brief statements, using simple words.

Provide for nonthreatening, consistent environment/atmosphere.

Gradually increase activities/involvement with others.

Discuss with client perception of what is causing anxiety.

Assist client to correct any distortions being experienced. Share perceptions with client.

Help client identify feelings being experienced and focus on ways to cope with them. Encourage client to keep a journal about feelings, precipitating factors, associated behaviors.

Explore with client the manner in which the client has coped with anxious events before the trauma.

Engage client in learning new coping behaviors (e.g., progressive muscle relaxation, thought-stopping).

Give positive feedback when client demonstrates better ways to manage anxiety and is able to calmly and/or realistically appraise own situation.

## Collaborative

Administer medications as indicated, e.g.:  
Antidepressants: fluoxetine (Prozac), amoxapine (Asendin), doxepin (Sinequan), imipramine (Tofranil), MAO inhibitor phenelzine (Nardil);

These may trigger feelings from original trauma and need to be dealt with sensitively, accepting reality of feelings and stressing ability to client to handle them. (Refer to CP: Panic Disorders/Phobias.)

Can help client to maintain control when anxiety is at a panic level.

Minimizes stimuli, reducing anxiety and calming the individual, and helps break the cycle of anxiety/fear.

As anxiety (panic) level is decreased, client can begin to tolerate interaction with others. Activity further releases tension in an acceptable manner. (Refer to ND: Violence, risk for, directed at self/others.)

Increases ability to connect symptoms to subjective feeling of anxiety, providing opportunity for client to gain insight/control and make desired changes.

Perceptions based on reality will assist to decrease fearfulness. How the nurse views the situation may help client to see it differently.

Increases awareness of affective component of anxiety and ways to control and manage it. Therapeutic writing can provide a release for anger, stress, and grief, and provide new insights.

Helps client regain sense of control and recognize significance of trauma.

Replacing maladaptive behaviors can enhance ability to manage anxiety and deal with stress. Interrupting obsessive thinking allows client to use energy to address underlying anxiety, while continued rumination about the incident can actually retard recovery.

Provides acknowledgement and reinforcement, encouraging use of new coping strategies. Enhances ability to deal with fearful feelings and gain control over situation, promoting future successes.

Used to decrease anxiety, lift mood, aid in management of behavior, and ensure rest until client regains control of own self. Helpful in suppressing intrusive thoughts and explosive anger. **Note:** Research suggests selective serotonin reuptake inhibitors (SSRIs) such as Prozac are more beneficial than other antidepressants.

Beta Blockers, e.g., propranolol (Inderal);

Reduces restlessness and anxiety by depressing the sympathetic nervous system.

Valproic acid (Depakene), carbamazepine (Tegretol), or clonidine (Catapres);

May be used in combination with tricyclic antidepressants or beta-adrenergic receptor antagonists to counter a lower threshold for arousal in the limbic system of the brain.

Benzodiazepines, e.g.: alprazolam (Xanax), clonazepam (Klonopin);

May be used in combination with Nardil or Prozac to relieve anxiety and insomnia. **Note:** Use with caution as some degree of unpredictable disinhibition may occur.

Antipsychotics, e.g.: phenothiazines: chlorpromazine (Thorazine).

Low doses may be used for the reduction of psychotic symptoms when loss of contact with reality occurs, usually for client's with especially disturbing flashbacks.

Provide additional therapies, e.g.: hypnosis; Eye Movement Desensitization/Reprocessing (EMD/R) or Thought Reprocessing Therapy as appropriate.

When used by trained therapists, these short-term methods of therapy are particularly effective with individuals who have been traumatized or who have problems with anxiety and depression. Systematic desensitization, reframing, and reinterpretation of memories may be achieved through hypnosis.

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## NURSING DIAGNOSIS

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## POWERLESSNESS

### May Be Related to:

Interpersonal interaction (lack of control of traumatic event)

Being overwhelmed by symptoms of anxiety (e.g., intrusive thoughts, flashbacks; physical manifestations)

Lifestyle of helplessness/poor coping skills

### Possibly Evidenced by:

Verbal expression of lack of control over present situation/future outcome; passivity and/or anger

Reluctance to express true feelings

Dependence on others

Nonparticipation in care or decision-making when opportunities are provided

### Desired Outcomes/Evaluation Criteria—

Identify areas over which individual has control.

### Client Will:

Express sense of control over present situation/future outcome.

Demonstrate involvement in care and planning for the future.

## ACTIONS/INTERVENTIONS

## RATIONALE

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### **Independent**

Identify present/past effective coping behaviors and reinforce use.

Note ethnic background, cultural/religious perceptions and beliefs about the occurrence (e.g., retribution from God).

Formulate plan of care with client, setting realistic goals for achievement.

Encourage client to identify factors under own control as well as those not within own ability to control.

Assist client to identify precipitating factors when feelings of powerlessness and loss of control began.

Explore actions client can use during periods of stress (e.g., deep breathing, counting to 10, reviewing the situation, reframing).

Give positive feedback when client uses constructive methods to regain control.

Promote involvement in group therapy.

### **Collaborative**

Involve in assertiveness training as appropriate.

Awareness of past successes enhances self-confidence and increases options for current use, promoting a sense of control.

Sense of own responsibility (blame) and guilt about not having done something to prevent incident or not having been “good enough” to deserve surviving are strong beliefs in individuals who are influenced by background and cultural factors.

Actively involves client, providing a measure of control over life situation.

Recognition of areas of control decreases sense of helplessness. Confronting issues outside of client’s control may encourage acceptance of that which cannot be changed.

Increases understanding of sources of stressful events that trigger these feelings.

Provides information to assist client with learning constructive ways to cope with feeling of powerlessness and to regain control. Reframing stressors/situation in other words or positive ideas can help client recognize and consider alternatives.

Acknowledgement and reinforcement encourage repetition of desirable behaviors.

Provides an opportunity for client to learn new coping behaviors from peers who have experienced similar traumatic events/reactions in the past. **Note:** Often guilt and anger are not dissipated until client talks about own life with someone who has had similar experiences and can empathize with the client on a personal level.

Learning to problem-solve in areas of social skills and anger control provides a sense of power to the individual for dealing with life in general.

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**NURSING DIAGNOSIS****Related/Risk Factors May Include:****May Be Evidenced by/[Possible Indicators]:****Desired Outcomes/Evaluation Criteria—  
Client Will:****VIOLENCE [actual]/risk for, directed at self/others**

Intrusive memory of event causing a sudden acting out of a feeling as if the event were occurring; startle reaction

Rage Reactions: Breaking through of rage that has been walled off, rage at the sense of helplessness/dependency or at those who were exempted from the trauma

Increased motor activity (pacing, excitement, irritability, agitation)

Argumentative, dissatisfied, overreactive, hypersensitive, provocative behaviors; hostile, threatening verbalizations

Overt and aggressive acts; goal-directed destruction of objects in environment

Self-destructive behavior (including substance abuse) and/or active, aggressive, or suicidal/homicidal acts

Acknowledge realities of the situation and precipitating factors.

Verbalize awareness of positive ways to cope with feelings.

Demonstrate self-control as evidenced by relaxed posture/manner, use of problem-solving rather than threats or assaultive behavior to resolve conflicts and/or cope.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Evaluate for presence of self-destructive and/or suicidal/homicidal behaviors (e.g., mood/behavior changes, increasing withdrawal). Assess seriousness of threat (e.g., gestures, previous attempts). (Use scale of 1–10 and prioritize according to severity of threat, availability of means.)

Encourage client to identify and verbalize triggering stimuli, causative/contributing factors that lead to potential or actual violence by client.

Negotiated contract with client regarding actions to be taken when feeling out of control.

Client may be in such despair or self-esteem may be so low that behaviors may be engaged in that are violent toward self/others with conscious or unconscious wish for suicide. (**Note:** If scale is high, this may be no. 1 nursing concern.)

Client needs to learn to recognize what precipitates anger and tension. Early recognition and prompt intervention may prevent occurrence of violence.

Contracting to let nurse/significant person know when feeling overwhelmed helps the client obtain assistance as needed and maintain a sense of control. **Note:** Client may project accumulated anger at therapist.

Assist client to understand that feelings of anger may be appropriate in the situation but need to be expressed verbally or in an acceptable manner rather than acted on in a destructive way.

Monitor level of anger (e.g., questioning, refusal, verbal release, intimidation, blow-up).

Tell the client to STOP violent behaviors. Use environmental controls (such as providing a quiet place for client to go, holding the client) if behavior continues to escalate. Talk gently and quietly.

Institute de-escalation actions as indicated, e.g.:

Distance self from client, by at least 4 armlengths, position self to one side; remain calm, stand or sit still, assume "open" posture with hands in sight.

Speak softly, call client by name, acknowledge client's feelings, express regret about situation, show empathy;

Avoid pointing, touching, ordering, scolding, challenging, interrupting, arguing, belittling, or intimidating client;

Request permission to ask questions, try to discern triggering event and any underlying emotions, such as fear, anxiety, or humiliation; offer solutions/alternatives.

Give client as much control as possible in other areas of life, helping to identify more appropriate solutions and responses to tension and anxiety.

Involve in exercise program, in outdoor activity program (hiking, wall/rock climbing, etc.); encourage sporting activities (group or individual).

## **Collaborative**

Use seclusion or restraints until control is regained, as indicated.

Administer medications, as indicated, e.g., lithium carbonate (Eskalith).

Learning to discharge anxiety and affect in a socially acceptable manner reduces likelihood of violent outbursts.

Stage of anger affects choice of interventions.

Saying "Stop" may be sufficient to assist client to regain control, but external controls may be required if client is unable to call up internal controls. **Note:** Physical holding can provide a sense of contact and caring that may help client regain control.

These actions can prevent escalation of violent behaviors and prevent injury to client/caregivers or bystanders.

Reduces possibility that client will feel confronted or blocked. Gives client some control over situation.

Communicates sense of respect, belief that individual can be trusted to control self, and that caregiver is available to assist client with resolution of situation. **Note:** "Expect the unexpected" and be prepared for unanticipated movement.

These actions may be viewed as threatening and may provoke client to violent actions.

Involves client in problem-solving and gives client some control over situation.

Learning new ways of responding to impulsive tendencies increases capacity for controlling impulses.

Relieves tension and increases sense of well-being, promotes self-confidence. When activity is geared to individual interests, participation and therapeutic benefits are enhanced. **Note:** Exercise therapy does not need to be aerobic or intensive to achieve desired effect.

Provides external control to prevent injury to client/staff/others.

Low-dose therapy may be used to limit mood swings and suppress explosive behavior.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Client Will:****COPING, INDIVIDUAL, ineffective**

Personal vulnerability; unmet expectations; unrealistic perceptions

Inadequate support systems/coping method(s)

Multiple stressors, repeated over period of time; overwhelming threat to self

Verbalization of inability to cope or difficulty asking for help

Muscular tension/headaches

Emotional tension; chronic worry

Identify ineffective coping behaviors and consequences.

Verbalize awareness of own coping abilities.

Express feelings appropriately.

Identify options and use resources effectively.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Identify and discuss degree of dysfunctional coping (e.g., denial, rationalization), including use/abuse of chemical substances.

Review consequences of behaviors, how relationships/functioning are affected.

Be aware of, and assist client to use ego strengths in a positive way, acknowledging ability to handle what is happening.

Permit free expression of feelings at client's own pace. Do not rush client through expressions of feelings too quickly; avoid reassuring . inappropriately

Encourage client to become aware and accepting of own feelings and reactions when identified.

Identifies needs/depth of interventions required. Individuals display different levels of dysfunctional behavior in response to stress, and often the choice of alcohol and/or other drugs is a way of deadening the psychic pain.

Helps client recognize negative impact of life and provides focus to begin addressing problems.

Often the firm statement of the nurse's conviction that the client can handle what is happening connects with the inner self-belief that is inherent in people.

Nonjudgmental listening to all feelings conveys acceptance of the worth of the client. Taking own time to talk about what has happened and allowing feelings to be fully expressed aids in the healing process. If rushed, client may believe pain and/or anguish is misunderstood. Statements such as "You don't understand" or "You weren't there" are a defense, a way of pushing others away.

There are no bad feelings, and accepting them as signals that need to be attended to and dealt with can help the client move toward resolution.

Give “permission” to express/deal with anger at the assailant/situation in acceptable ways.

Keep discussion on practical and emotional level, rather than intellectualizing the experience.

Identify supportive persons available for the client.

### **Collaborative**

Provide for sensitive counselors/therapists who are especially trained in crisis management and the use of therapies such as psychotherapy (in conjunction with medications), implosive therapy, flooding, hypnosis, relaxation, Rolfing, memory work, or cognitive restructuring.

Refer to occupational therapy, vocational rehabilitation.

Being free to express anger appropriately allows it to be dissipated so that underlying feelings can be identified and dealt with, strengthening coping skills.

When feelings (the experience) are intellectualized, uncomfortable insights and/or awareness are avoided by the use of rationalization, blocking resolution of feelings and impairing coping abilities.

Having unconditional support from loving/caring others can assist the client to confront situation, cope with it, and move on to live more fully.

Although it is not necessary for the helping person to have experienced the same kind of trauma as the client’s, sensitivity and listening skills are important to helping the client confront fears and learn new ways to cope with what has happened. Therapeutic use of desensitization techniques (flooding, implosive therapy) provides for extinction through exposure to the fear. Body work can alleviate muscle tension. Some techniques (Rolfing) help to bring blocked emotions to awareness as sensations of the traumatic event are reexperienced.

Assistance with new activities and learning new skills may be needed to help the client develop coping skills to reintegrate into the work setting. New activities/work skills, while generating some anxiety, will help with the process of desensitization and reduction/elimination of anxiety.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

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### **GRIEVING, dysfunctional**

Actual/perceived object loss (loss of self as seen before the traumatic incident occurred, as well as other losses incurred in/after the incident)

Loss of physiopsychosocial well-being

Thwarted grieving response to a loss; absence of anticipatory grieving; lack of resolution of previous grieving response

Verbal expression of distress at loss; difficulty in expressing loss; expression of guilt

Expression of unresolved issues; reliving of past experiences

Denial of loss; anger, sadness, crying; labile affect

Alterations in eating habits, sleep and dream patterns, activity level, libido

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Alterations in concentration and/or pursuit of tasks

Demonstrate progress in dealing with/movement through stages of grief.

Participate in work and self-care/activities of daily living as able.

Verbalize a sense of progress toward resolution of the grief and hope for the future.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Note verbal/nonverbal expressions of guilt or self-blame.

“Survivor’s guilt” affects most people who have survived trauma in which others have died, and client questions “Why was I spared?” or perhaps believes, “I am not worthy, and others were.”

Acknowledge reality of feelings of guilt, and assist client to take steps toward resolution.

Acceptance of feelings and support of new coping skills allow for taking risk of new behaviors.

Reinforce that client made the best decision he or she could have made at the time.

Regardless of the choices made, the client survived the event(s). The client needs unconditional positive acceptance and validation of decisions in order to resolve feelings of guilt and begin to deal with grief.

Note signs and stage of grieving for self and/or others (e.g., denial, anger, bargaining, depression, acceptance).

Identification and understanding of stages of grief assist with choice of interventions, planning of care, and movement toward resolution.

Be aware of avoidance behaviors (e.g., anger, withdrawal).

Client has avoided dealing with the feelings, which has led to her or his current situation. Recognition at this time can help with beginning new approach to solving the problem(s). **Note:** Avoidance should not be confused with extinction, a progressive and often spontaneous alleviation of memory-induced pain; although both attempt to distance the client from the traumatic event(s), extinction is adaptive.

Provide information about normalcy of feelings/actions in relation to stages of grief.

Individual may believe it is unacceptable to have these feelings, and knowing they are normal can provide sense of relief.

Give “permission” for client to be depressed—“to be at this point at this time.”

Provides opportunity for the client to accept self and feel satisfied with current progress.

Encourage verbalization without confrontation about realities.

Helps client to begin resolution and acceptance. Confrontation may convey lack of acceptance and actually impede progress.

Identify cultural factors and ways individual has dealt with previous loss(es). Point out individual strengths/positive coping skills.

Reinforce use of previously effective coping skills.

Assist significant other(s) to cope with client's response.

### **Collaborative**

Refer to other resources (e.g., peer/support group, counseling, psychotherapy, spiritual advisor).

Different cultures deal with loss in different ways, and it is important to allow client to deal with situation in own healthy way. How the client has dealt with losses in the past can be a reliable predictor of how current losses are being dealt with and how they may be dealt with in the future, effectively or ineffectively. Client may discount/sabotage own capabilities.

Identification of helpful ways client is already dealing with problems allows client to feel positive about self.

Support and understanding of reasons for client's behavior provides opportunity for family to work with client in development of new coping skills to resolve grief.

May need additional help to resolve situation/concomitant problems.

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## **NURSING DIAGNOSIS**

### **May Be Related to:**

### **Possibly Evidenced by:**

### **Desired Outcomes/Evaluation Criteria— Client Will:**

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## **SLEEP PATTERN disturbance**

Psychological stress (anxiety, depression with recurring disruptive dreams)

Verbal reports of difficulty in falling asleep/not feeling well rested

Insomnia that causes awakening

Reports of sleep disturbances (e.g., nightmares, dreams of personal death, disaster-related dreams, flashbacks, intrusive/trauma images, fear of re-experiencing the event)

Hypersomnia (as a way of avoiding behaviors, events, or situations that arouse recollections)

Verbalize understanding of sleep disorder/problem.

Identify behaviors to promote sleep.

Sleep adequate/appropriate number of hours for individual needs.

Report increased sense of well-being and feeling rested.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

### **Independent**

Assess sleep pattern disturbance by observation and reports from client and/or SOs.

Subjective and objective information provides assessment of individual problems and direction for interventions.

Identify causative and contributing factors (e.g., intrusive/repetitive thoughts, nightmares, severe anxiety level). Note use of caffeine and/or alcohol, other drugs.

These factors interfere with both the ability to fall asleep and the REM cycle of sleep, affecting quality of rest.

Provide a quiet environment; arrange to have uninterrupted sleep as much as possible.

Assists in establishing optimal sleep/rest routine.

Encourage client to develop behavior routine when insomnia is present (e.g., no napping after noon, having warm bath/milk before bed, relaxing thoughts, getting out of bed 10 minutes after awakening if unable to fall asleep again, limiting sleep to 7 hours each night).

Rituals help decrease anxiety and fear of facing a sleepless night. **Note:** L-tryptophan in milk is believed to induce sleep.

### **Collaborative**

Administer sedative, hypnotic, or antianxiety drugs as indicated. (Refer to ND: Anxiety [severe to panic]/Fear.)

May require short-term drug therapy to decrease sense of exhaustion/fear and promote relaxation to enhance sleep. (These drugs should be used sparingly to avoid dependence and addiction.)

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## **NURSING DIAGNOSIS**

### **May Be Related to:**

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## **SOCIAL ISOLATION/SOCIAL INTERACTION, impaired**

Reduced involvement with the external world; numbing of responsiveness to the environment/affective numbing; difficulty in establishing and/or maintaining relationships with others

Feelings of guilt and shame/survivor's guilt

Unacceptable social behaviors/values

### **Possibly Evidenced by:**

Conflicts with family, significant others; withdrawal from and avoidance of others/absence of supportive others; expressed feelings of rejection/alienation; observed discomfort in social situations/use of unsuccessful social interaction behaviors

Chronic loss of interest and energy for work and relationships

Sense of vulnerability over fear of loss of control of aggressive impulses

Sense of responsibility (guilt) for inciting event or failing to control it; rage at those exempted from loss or injury

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Drug (alcohol) abuse

Verbalize recognition of causes of impaired interactions/isolation.

Acknowledge willingness to be more involved with others.

Demonstrate involvement/participation in appropriate activities and programs.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Assess degree of isolation. Note withdrawn behavior and use of denial. Ascertain client's perceptions of reasons for problems.

Indicates need for/choice of interventions. Withdrawing and denial can inhibit/sabotage participation in therapy.

Help client differentiate between isolation and loneliness/aloneness.

Time for the client to be alone is important to the maintenance of mental health, but the sadness created by isolation and loneliness needs different interventions.

Identify support systems available to client (e.g., family, friends, coworkers).

Involvement of significant others can help to build and/or reestablish support system and reintegrate client into a social network.

Explore with client and role-play ways of making changes in social interactions/behaviors.

Developing and practicing strategies promotes and enhances possibility of change.

Acknowledge any positive efforts client makes in establishing contact with others.

Positive reinforcement of movement toward others can decrease sense of isolation and encourage repetition of behaviors, enhancing socialization.

**Collaborative**

Encourage client to continue and/or seek outside or outpatient therapy/peer group activities.

Will need ongoing support and encouragement to reestablish social connections and develop/strengthen relationships.

Refer client for employment counseling, if indicated. (Refer to ND: Coping, Individual, ineffective.)

Interpersonal difficulties may have affected work relationships and performance, and client may need help to reintegrate into current job or relocate.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—****Family Will:****FAMILY PROCESSES, altered**

Situational crises, e.g., trauma, disabling responses, change in roles, economic setbacks

Failure to master developmental transitions

Expressions of confusion about what to do and that family is having difficulty coping with situation; difficulty accepting/receiving help appropriately

Not adapting to change or dealing with traumatic experience constructively; ineffective family decision-making process

Difficulty expressing individual and/or wide range of feelings

Family system does not meet physical, emotional, or spiritual needs of its members

Express feelings freely and appropriately.

Verbalize understanding of trauma, treatment regimen, and prognosis.

Demonstrate individual involvement in problem-solving processes directed at appropriate solutions for the situation.

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**ACTIONS/INTERVENTIONS****RATIONALE**

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**Independent**

Determine family members' understanding of client's illness/PTSD.

Identify patterns of communications in the family, e.g.: Are feelings expressed clearly and freely? Do family members talk to one another? Are problems resolved equitably? What are interactions among/between members?

Encourage family members to verbalize feelings (including anger) about client's behavior.

Family members and SO(s) often do not recognize that client's present behavior is the result of trauma that has occurred.

How family members communicate provides information about their ability to problem-solve, understand one another, cooperate in making decisions, and resolve problems resulting from trauma.

SO/spouse may feel angry/unloved and believe client is rejecting, rather than recognizing behaviors as a sign of client's pain.

Acknowledge difficulties each member is experiencing while reinforcing that conflict is to be expected and can be used to promote growth.

Identify and encourage use of previously successful coping behaviors.

Encourage use of stress-management techniques, e.g., appropriate expression of feelings, relaxation exercises, guided imagery.

Present information about PTSD and provide opportunity to ask questions/discuss concerns.

### **Collaborative**

Refer to other resources as indicated, e.g., support groups, spiritual advisor, psychological/family therapy, marital counseling.

Recognition of what the person is feeling/going through provides a sense of acceptance. Most people have the fantasy that once the conflict has been resolved, everything will be fine. Discussing conflict as an ongoing problem that can be resolved so all parties win can help family members begin to believe a new method of handling it can be learned.

In the stress of current situation, family members tend to focus on negative behaviors, feel hopeless, and neglect looking at positive behaviors used in the past.

Reduction of stress enables individuals to begin to think more clearly/develop new behaviors to cope with client.

These materials can help family members learn more about client's condition and assist in resolution of current crisis.

Additional/ongoing support and/or therapy may be needed to help family resolve family crisis and look at potential for growth. Client problems affect others in family/relationships, and further counseling may help resolve issues of enabling behavior/communication problems.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

#### **Desired Outcomes/Evaluation Criteria— Client/Partner Will:**

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### **SEXUAL dysfunction/SEXUALITY PATTERNS, altered**

Biopsychosocial alteration of sexuality (stress of posttrauma response)

Loss of sexual desire

Impaired relationship with a significant other

**Alterations in achieving sexual satisfaction/relationship** with significant other

Change of interest in self and others; preoccupation with self

Irritation, lack of affection

Verbalize understanding of reasons for sexual problems/changes that have occurred.

Identify stresses involved in lifestyle that contribute to the dysfunction.

Demonstrate improved communication and relationship skills.

Participate in program designed to resume desired sexual activity.

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## ACTIONS/INTERVENTIONS

## RATIONALE

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### **Independent**

Inquire in a direct manner if there has been a change in sexual functioning/if problems exist, preferably in a conjoint session.

Client may prefer to dwell on reliving details of trauma and may not complain about this area of life. SO may not recognize relation of trauma to marital discord/sexual problems, and being with the client provides an opportunity for them to begin to talk realistically about what is happening. **Note:** Men typically have loss of sexual desire and occasional impotence; women often experience lack of sexual pleasure and anorgasmia.

Determine intimate behavior/closeness between couple recently and in comparison to quality of sexual relationship before the trauma, when appropriate.

May reveal problems that have not been acknowledged previously by the couple. Client may deny existence of difficulties, excusing self as being "sick" or "needing time to recover from trauma."

Provide information about the effect anxiety and anger have on sexual desire/ability to perform.

When partner does not know this, it is easy to feel unloved and not cared about or believe mate is having an affair. With understanding/insight into cause(s), partner's anxiety may be relieved, and support and affection can be extended to the client.

Encourage expression of feelings and emotions (e.g., crying) openly and appropriately.

Client/partner may believe they are helping by being stoic and not expressing feelings of powerlessness, helplessness, fear, etc. to each other.

Help client who has been the victim of sexual assault and partner to understand relationship of reluctance to have mate touch/make sexual advances to the event that occurred.

Client may have difficulty recognizing and feel embarrassed by the fact that mate's advances are reminder(s) of the trauma. Partner may view client's reluctance as rejection by the client.

Discuss substance use and relationship to sexual difficulties.

Some clients use alcohol and other drugs to dull the pain of PTSD. These substances interfere with sexual functioning, causing diminished desire and inability to achieve and maintain an erection. **Note:** It is not known what effect chronic use of alcohol has on female sexual functioning.

Review relaxation skills. (Refer to ND: Coping, Individual, ineffective.)

Learning to relax assists with reduction of anxiety and allows client/partner to focus on learning skills to regain/enhance sexual functioning.

### **Collaborative**

Refer to other resources as indicated (e.g., sex therapist).

Specific techniques may be used to assist the couple in regaining comfort level/ability to engage in nongenital/genital activity and intimacy.

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**NURSING DIAGNOSIS****KNOWLEDGE deficit [LEARNING NEED] regarding situation, prognosis, and treatment needs****May Be Related to:**

Lack of exposure to/misinterpretation of information  
Unfamiliarity with information resources  
Lack of recall

**Possibly Evidenced by:**

Verbalization of the problem; statement of misconception  
Inaccurate follow-through of instruction  
Inappropriate or exaggerated behaviors (e.g., hysterical, hostile, agitated, apathetic)

**Desired Outcomes/Evaluation Criteria—**

Participate in learning process.

**Client Will:**

Assume responsibility for own learning and begin to look for information/ask questions.  
Identify stressful situations and specific action(s) to deal with them.  
Initiate necessary lifestyle changes and participate in treatment regimen.

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**ACTIONS/INTERVENTIONS****RATIONALE**

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**Independent**

Provide information about what reactions client may expect, and let client know these are common reactions. Phrase in neutral terms (e.g., “[blank] may or may not happen”).

Knowing what to expect can reduce anxiety and help the client in learning new behaviors to handle stressful feelings/situations. Having information about the commonality of experiences helps the individual feel less alone/strange, aiding in acceptance of these feelings.

Assist client to identify factors that may have created a vulnerable situation and that he or she may have power to change to protect self in the future. Avoid making value judgments.

Separates issues of vulnerability from blame. Factors such as body stance, carelessness, and not paying attention to negative cues may provide opportunity for tragic consequences that could possibly have been avoided/minimized. However, any inference that client is responsible for the incident is not therapeutic.

Discuss contemplated changes in lifestyle and how they will contribute to recovery.

Client needs to be able to look at these changes, what will be accomplished, and determine whether they are realistic/necessary.

Assist client to learn stress-management techniques.

Relaxation is a useful coping skill for dealing with stress of recurrent fears/exaggerated stress response.

Discuss recognition of and ways to manage “anniversary reactions,” letting client know normalcy of thoughts and feelings at this time.

Planning ahead and knowing some skills to handle this time can help to avoid severe regression.

Identify available community resources (e.g., support groups for client/family, social or veteran services, vocational/educational counseling).

These resources may be helpful to client/SO in establishing a satisfying and productive life.