Diagnosis and Initial Management of Acute Stress Disorder and Post-Traumatic Stress Disorder in the Primary Care Setting

Lindsay Leonard
lindsaybleonard@gmail.com

Blaine Winters
*Brigham Young University - Provo*, Blaine-Winters@byu.edu

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Diagnosis and Initial Management of Acute Stress Disorder and
Post-Traumatic Stress Disorder in the Primary Care Setting

Lindsay Leonard

A scholarly paper submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Master of Science

Blaine Winters, Chair

College of Nursing
Brigham Young University

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Purpose: The purpose of this paper is to equip nurse practitioners (NPs) with resources and tools that will help with the early recognition and treatment of Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) in patients following a traumatic accident.

Background: According to the Centers for Disease Control and Prevention (2019), trauma, or unintentional injury, is the leading cause of death for individuals under the age of 45 and the third leading cause of death for all ages of people in the United States. Patients involved in traumatic accidents often develop adverse psychological sequelae such as PTSD and ASD. Unfortunately, PTSD and ASD can also cause depression, decreased physical functionality, increased risk of suicide, increased risk of rehospitalization, and reduced quality of life (Paredes Molina et al., 2018). As a result, detecting and treating ASD and PTSD in post-trauma patients is crucial.

Most subsequent care after a trauma is provided in an outpatient setting, often by NPs. As patients with serious injuries and their caregivers noted a need for increased screening, recognition, and treatment for psychological problems when transitioning from inpatient to outpatient settings, this paper provides NPs with tools to do so.

Methods: Initial searches included the databases MEDLINE and CINAHL. Search terms included PTSD, ASD, trauma, screening, accident, depression, rehospitalization, psychological outcomes, and suicide. Inclusion criteria included articles published in English since 2008. Articles that focused on pediatric populations and psychological problems following a traumatic brain injury were excluded. UpToDate, the DSM-V, and Porth's Pathophysiology: Concepts of Altered Health States were also referenced to provide NPs with more robust information and treatment guidelines.

Outcomes Achieved: This paper assists NPs identifying PTSD and ASD in the primary care setting by providing a case study for reference. Further, it offers both screening tools and a review of the DSM-V diagnostic criteria used to detect PTSD and ASD following a traumatic accident. Nonpharmacological and pharmacological treatment options are outlined as well as guidelines for when to refer. Lastly, NPs are directed to resources and information that they can provide patients during their treatment.

Conclusions: Traumatic events are common and can unfortunately lead to patients’ subsequent mental and physical ailments. Thus, it is imperative that NP’s identify and begin to treat ASD and PTSD immediately in an attempt to avoid negative outcomes. As NP’s recognize ASD and PTSD through appropriate use of screening tools, manage the diseases with pharmacological options and therapy, and provide patients with education and resources, patients who have suffered through a trauma will have better physical and psychological outcomes and reduce the burden on the healthcare system.

Keywords: ASD, PTSD, screening, primary care
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Diagnosis and Initial Management of Acute Stress Disorder and Post-Traumatic Stress Disorder in the Primary Care Setting

According to the Centers for Disease Control and Prevention (2019), trauma, or unintentional injury, is the leading cause of death and disability for individuals under the age of 45 years and the third leading cause of death for all ages of people in the United States. Traumatic accidents are life altering as they often lead to adverse physical and psychological sequelae. Specifically, Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) are common emotional ailments that plague patients following traumas. For example, PTSD is found in up to 20% of patients within one year after a traumatic accident (Zatzick et al., 2008). PTSD can cause depression, decreased physical functionality, increased risk of suicide, increased risk of rehospitalization, and reduced quality of life (Paredes Molina et al., 2018). As a result, detecting and treating ASD and PTSD in post-trauma patients is crucial.

Although ASD and PTSD may be detected in an inpatient setting, most subsequent care is provided by Nurse Practitioners (NPs) and other Primary Care Providers (PCPs). Thus, the transition from inpatient to outpatient care is fraught with potential hazards as Primary Care is often focused on physical rather than psychological conditions. Patients and their caregivers noted a need for increased screening, recognition, and treatment for psychological problems when transitioning from inpatient to outpatient settings after a traumatic accident (Beaton et al., 2019). The purpose of this paper is to equip PCPs and NPs with resources and tools that will assist with the early recognition and treatment of ASD and PTSD in patients following trauma.
Clinical Presentation

Case Study

A.W. is a 52-year-old male who resides in a rural area and comes in to see his Primary Care NP for re-evaluation following a recent hospitalization. Two weeks ago, the patient was involved in a serious motor vehicle accident and was emergently transported to the nearest trauma center. His workup revealed multiple rib fractures and a Grade 2 spleen laceration. A.W. was admitted to the hospital and discharged after a few days. The appointment with his NP was scheduled prior to his discharge as the patient lived too far to conveniently follow-up with trauma services.

As A.W. is checking in, he mentions to the clinic’s medical assistant (MA) that he has “not felt well” for the past few days. He was noted to have a temperature of 100.6° F, pulse of 102 beats per minute, respiratory rate of 26 breaths per minute, and oxygen saturations of 91% on room air. During physical examination, the NP auscultates diminished breath sounds in the right lower lobe. A chest x-ray done in the clinic shows consolidation in the right lower lobe and A.W. is diagnosed with pneumonia.

In talking with A.W., the NP learns that he was sent home with an incentive spirometer, but he “just hasn’t had the energy” to use it. He also admits to feeling irritable and not sleeping well since his accident. Fortunately, the patient’s NP suspects A.W.’s lack of adherence to his discharge plan could be attributed to psychological factors related to his accident. The NP administers the Primary Care–PTSD Screen for the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (PC-PTSD-5) to the patient and his answers indicate he is likely suffering from ASD as a result of his traumatic accident. Along with starting A.W. on antibiotics, the
provider discusses with him the probable diagnosis of ASD and schedules a follow-up appointment within a few days to more fully address his ASD.

**History of Present Illness**

A.W.’s symptoms started two weeks ago when he was involved in the traumatic accident. He admits to many psychological complaints at this time, including anhedonia, irritability, and sleep disturbances. His symptoms have been progressively worsening since the accident and have been negatively impacting his life. He feels worse when he tries to use his incentive spirometer that he was discharged with and when he gets in a motor vehicle. Unfortunately, nothing alleviates his complaints. His anhedonia, irritability, and sleep disturbances are affecting his ability to function and negatively impacting his relationships. He has not tried any treatments for his ailments because he just does not know what will help him feel better. He is starting to get anxious and worries he will feel like this forever.

**Pathophysiology**

ASD and PTSD are both characterized by the body reacting inappropriately to a stressor. They differ in their respective durations, but the mechanisms behind each disease state are similar. When the body is exposed to a stressor, many systems, including the nervous, immune, and endocrine systems, react by releasing a cascade of hormones. Cortisol and aldosterone are mobilized by the adrenal cortex and the adrenal medulla releases catecholamines such as norepinephrine and epinephrine. The goal of these hormones is to prepare the body for a potentially stressful situation by increasing focus and awareness while also prioritizing blood flow and glucose distribution to the brain, heart, lungs, and muscles (Norris & Gopalakrishnan, 2019). All of these effects help optimize physical performance and functioning in the face of a
physiological or psychological threat. This state is meant to be an acute response from which the body can quickly recover.

Problems arise when a person does not return to homeostasis and suffers prolonged exposure to the stress response, as is the case in ASD and PTSD. Though the pathophysiology of both ailments is not fully understood, it is postulated that alterations in the stress response are responsible for the intrusion, avoidance, and hyperarousal symptoms that accompany a diagnosis of ASD or PTSD (American Psychiatric Association, 2013). People with PTSD have been found to have high levels of norepinephrine and hyperactive α2-adrenergic receptors. Furthermore, neuroanatomic scans of people with PTSD have shown variations in the reactivity and functioning of the amygdala, hippocampus, anterior cingulate, and orbitofrontal areas, which all play a role in the body’s stress and fear responses. The maladaptation of the body’s hormones and brain after a stressful situation are all thought to contribute to the symptoms that plague those who suffer from ASD and PTSD (Norris & Gopalakrishnan, 2019).

**Diagnosis**

**DSM-V Criteria ASD and PTSD**

To diagnose ASD or PTSD, a patient first must have experienced some type of traumatic incident. The DSM-V qualifies a traumatic event as near-death experience, a severe injury, or exposure to sexual violence. These traumatizing experiences can affect the patient directly, as is the case when they themselves have been the victims, or indirectly. Indirect exposure includes witnessing an event, hearing about an event happening to a loved one, or having to deal with repeated contact to similar adverse events (for example, a nurse having multiple patients die of the same illness) (American Psychiatric Association, 2013).
After experiencing trauma, some may experience distressing symptoms that significantly disrupt their lives. First, they may have intrusive symptoms. These include involuntary and disturbing memories or dreams relating to the event, flashbacks of the event, and psychological distress or reactions to cues that remind them of the event. Next, the patient will experience avoidance symptoms. These are defined as extreme avoidance or attempts to avoid any external reminders of the trauma or distressing memories, thoughts, or feelings related to the negative event (American Psychiatric Association, 2013).

The patient, or those in close contact with the patient, will also report undesirable changes to the patient’s mood and cognition. Cognitively, the patient may have difficulty remembering details surrounding the incident or hold onto negative beliefs that the traumatic event was his or her fault. The patient’s mood may be deleteriously impacted by a marked emotional state and feeling less interested in normal activities. Further, patients might feel disconnected from important people in their lives or have difficulty feeling any positive emotions. Lastly, the patient will experience changes in arousal after an event such as irritability, reckless behavior, hypervigilance, being easily startled, difficulties with concentration, or sleep disturbances (American Psychiatric Association, 2013).

To qualify for an ASD diagnosis, a patient must have experienced a traumatic event and then have at least one intrusion symptom, at least one avoidance symptom, at least two negative cognitive or mood alterations, and at least two differences in arousal or reactivity. If these symptoms persist for shorter than one month, the patient is diagnosed with ASD. If symptoms continue for greater than one month, the diagnosis is PTSD. If the full criteria are not met until six months after the event, the patient has PTSD with delayed expression (American Psychiatric Association, 2013).
Screening Options

Clinician-Administered Screening Tools

**Injured Trauma Survivor Screen (ITSS).** The ITSS (Figure 1) is a nine-item screening tool that was specifically designed for individuals who have experienced a traumatic injury. It detects the risk of patients for later development of PTSD and/or depression.

Hunt et al. (2018) studied the effectiveness of the ITSS at recognizing risk for both PTSD and depression development at six months following a traumatic injury. The study found that when the ITSS was used after a traumatic accident, it demonstrated strong sensitivity (85.42%) and a specificity of 67.35% as a screening tool for PTSD 6 months post-injury. Consequently, the ITSS is an appropriate choice as a screening tool as it is sensitive, quick, and easy to administer. The main drawbacks of the ITSS are it may overestimate the number of patients that are at risk for PTSD and may be time-consuming for providers. (Hunt et al., 2018).

**Clinician-Administered PTSD Scale for DSM-V (CAPS-5).** The CAPS-5 is an assessment tool recommended by The National Center for PTSD. It is extremely thorough, and its questions match up with the specific aspects of DSM-V ASD and PTSD diagnoses. For example, there are specific questions discussing a qualifying traumatic event and evidence of intrusion symptoms, avoidance symptoms, alterations to cognition or mood, and changes in arousal or reactivity. The CAPS-5 is especially helpful in determining the severity of PTSD and may be used serially to detect improvement or worsening of symptoms.

CAPS-5 administration requires training of the clinician, which can be completed through the US Department of Veterans Affairs (VA) website. The scale is most effective when administered by those who have experience treating PTSD. The CAPS-5 interview is thorough, taking 45-60 minutes to complete. Untrained clinicians or lack of time to administer can be
barriers to impactful use of the CAPS-5 in a Primary Care setting and it is only available upon request from the VA. Ultimately, the CAPS-5 is considered the gold standard screening tool for PTSD assessment and diagnosis (Weathers et al., 2013). Free access to the scale and more information about it can be requested at: https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp.

**Patient-Administered Screening Tools**

**Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).** The PC-PTSD-5 (Figure 2) is a six-question screen specifically designed for Primary Care. The first question identifies if the patient has had a recent and qualifying traumatic event. If the answer to this question is “no,” the patient is given a score of zero and does not need to complete the rest of the questionnaire. If the patient has suffered trauma, the other five questions in the survey are available to identify to what extent the patient has been affected. Every “yes” answer gives the patient one point, and a diagnosis of ASD or PTSD should be considered if the patient has a score greater than three.

The PC-PTSD-5 is meant to be a preliminary screening tool. If a patient scores high, they should be given a more thorough assessment, preferably the CAPS-5, before confirming an ASD or PTSD diagnosis (U.S. Department of Veterans Affairs, 2018). However, this is a viable option for Primary Care settings because it is easy to use, the patient can complete it independently, and it does not take much time to finish (Prins et al., 2015).

**Posttraumatic Adjustment Scale (PAS).** The PAS (Figure 3) is a 10-item validated measurement developed to screen adults for risk of psychological distress following traumatic injury. The PAS produces two scores: one related to PTSD (PAS-P) and a second linked to depression (PAS-D). The total from questions 1-10 give you the PAS-P score. The total from
questions 1, 2, 4, 7, and 8 give you the PAS-D score. Patients are at risk of developing PTSD after a trauma if they have a PAS-P score greater than or equal to 16 (O’Donnell et al., 2008).

The PAS is not the most effective screening tool for immediate detection of psychological distress in patients receiving follow-up care subsequent to a traumatic accident, though it is clinically useful for predicting later psychological problems (Johnson et al., 2019). The PAS has value because it is a self-administered questionnaire and is fairly straightforward to interpret. Further, if the PAS is administered shortly after a traumatic incident, it can help identify which patients may need closer psychological follow-up or immediate attention. The PAS can help providers make appropriate referrals and use counseling resources judiciously.

**Prognosis**

With appropriate treatment and management, most patients with ASD and PTSD are able to obtain remission from their conditions. According to the National Center for PTSD, 42% of patients with PTSD achieve remission with medication alone and 53% obtain remission with therapy alone (U.S. Department of Veterans Affairs, n.d.). The prognosis further improves when pharmacotherapy and psychological counseling are combined and implemented promptly after the diagnosis of ASD or PTSD are made.

Patients with a poorer prognosis include those who are female, younger, illiterate, and those who suffered a more severe traumatic accident; rates of remission for these patients that go untreated may be as low as 9% (Usman et al., 2015). Additionally, patients with comorbid stress disorders experience a higher risk of developing cancer, gastrointestinal disorders, coronary vascular diseases, and other psychiatric sequelae such as depression, adjustment disorders, and suicidality (Gradus et al., 2017). Suicide is of particular concern because about 10% of people...
with diagnosed PTSD will have suicide attempts (Wilcox et al., 2009) and those with PTSD are twice as likely to die by suicide as their counterparts (Fox et al., 2021).

**Management**

**Nonpharmacological**

Nonpharmacological therapy is the treatment of choice for ASD and PTSD. Specifically, trauma-focused cognitive behavioral therapy (TF-CBT) is the most effective treatment. Other preferred therapies include exposure therapy, a combination of TF-CBT and exposure therapy, and eye movement desensitization and reprocessing (EMDR) (Stein et al., 2020).

**Trauma Focused Cognitive Behavioral Therapy (TF-CBT)**

TF-CBT strives to equip patients with coping mechanisms that can help them relax and deal with stress. Specifically, patients learn to recognize and overcome false or harmful beliefs (Lebow, 2021). TF-CBT is best when done by a trained therapist weekly for 60-90 minutes and delivered over six weeks. It should typically begin within two weeks after exposure to a traumatic event, though delayed therapy may be warranted if the patient is easily triggered in the acute phase (Bryant et al., 2021).

**Cognitive Restructuring, Exposure Therapy, and Eye Movement Desensitization and Reprocessing (EMDR)**

Other interventions for ASD and PTSD include cognitive restructuring and exposure therapy. Cognitive restructuring is a type of therapy that involves altering patients’ maladaptive or improbable beliefs surrounding a traumatic event, including how they responded to it, and what their future holds. Exposure therapy provides a way for patients to face their fears surrounding the trauma in a safe, guided, and therapeutic manner. TF-CBT is the most successful
at treating the acute symptoms of ASD and TF-CBT, cognitive restructuring, and exposure therapy are all efficacious at preventing the progression from ASD to PTSD (Bryant et al., 2021).

EMDR is commonly used in PTSD, though the mechanisms for its success are unclear (Cuijpers et al., 2020). It involves the patient focusing on the trauma while simultaneously following a therapist’s finger with their eyes.

**Responsibility of the NP**

Primary care NPs are not qualified to perform any of these therapies. NPs should either make referrals to psychiatry or encourage clients to start therapy when ASD and/or PTSD is suspected. From that point, a qualified therapist will determine what type of therapy is most appropriate for a patient based on symptoms the patient experiences. For example, a patient with excessive fear and avoidance symptoms would benefit from exposure therapy. If a patient has had at least eight sessions of therapy and is not improving, another type of therapy should be attempted.

**Pharmacological**

Medications can be used to treat ASD and PTSD, though they appear to be more effective for PTSD. Psychotherapy is preferred over pharmacological measures, yet the combination of psychotherapy and medications also demonstrates effectiveness in the management of stress disorders. If psychotherapy is not available, medications do provide effective symptom management (Stein et al., 2020).

**Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)**

SSRIs are the first-line treatment choice for ASD and PTSD. Sertraline and Paroxetine are approved by the Food and Drug Administration (FDA) for treatment of stress disorders.
Sertraline is more commonly used as Paroxetine tends to negatively affect sexual function and lead to medication compliance. SSRIs should be started immediately because these medications usually take four to six weeks to reach full therapeutic effect. Common side effects of SSRIs include headache, nausea, vomiting, insomnia, sexual dysfunction, dizziness, and suicidal ideations. Side effects, however, are minimalized if a patient is started on small doses and the doses are gradually increased. If a patient given the highest dose of an SSRI has no improvement after eight to ten weeks, another SSRI should be attempted.

If SSRIs have not proven to be effective for the patient, Venlafaxine, a serotonin norepinephrine reuptake inhibitor (SNRI), may be prescribed (Stein et al., 2020). Venlafaxine’s side effects are similar to side effects of SSRIs. If neither an SSRI or SNRI provide desired symptom relief, a second-generation antipsychotic such as quetiapine or risperidone may be used as a complement. Patients should be instructed to continue taking medications for at least six months to a year to avoid relapse of symptoms.

**Additional Adjunct Therapies**

For those who experience nightmares, prazosin (an α-1 blocker) can be prescribed (Stein et al., 2020). Prazosin is usually started at one mg taken before bedtime. It should gradually be titrated with increased dosages every few days or every week. The target dose is six to ten mg, though resolution of nightmares has been seen at lower doses. Common side effects include hypotension, lightheadedness, and syncope. These are mostly mitigated by beginning with a low-dose and gradual titration. Older adults or those with low body weight should remain on lower doses to avoid the aforementioned adverse effects (Zak & Karippot, 2021).

Patients may need short-term medications to abate their ASD/PTSD symptoms until the SSRIs start fully working. Those commonly prescribed for this situation include hydroxyzine,
propranolol, clonidine, and gabapentin. Benzodiazepines can also be used for acute relief of stress and anxiety but should be used as a last resort because of their addictive potential.

**When to Refer**

Suicidal patients should be immediately referred to the Emergency Department or to a mental health provider for imminent evaluation. Patient should also be referred to a mental health provider if they need an ASD/PTSD diagnosis or psychotherapy, as those fall outside of a Primary Care NP’s scope of practice. First-line treatments like TF-CBT, exposure therapy, and EMDR need to be conducted by certified professionals. NPs can initiate pharmacological interventions, and should especially consider doing so if treatment from a mental health professional will be delayed. However, an NP should not continue to treat a patient if multiple medications have been trialed without improvement. Ultimately, NPs need the tools necessary to recognize ASD or PTSD in patients, begin pharmacological management, and then refer them to a mental health provider for continued management.

**Patient Education**

**Self-Care**

Educating patients about self-care will equip them with productive coping mechanisms to combat their stress. Patients should implement self-care strategies in tandem with any therapies already in place. NPs can teach patients relaxation techniques, such as mindfulness, meditation, and listening to music. Participating in mindfulness or meditation may be helpful in allowing the mind and body to relax, decreasing muscle tension (Norris & Gopalakrishnan, 2019).

Mindfulness and meditation exercises can be found online or on various free smartphone applications. Music is also a powerful coping mechanism as listening to music can reduce anxiety, pain, loneliness, and isolation (Norris & Gopalakrishnan, 2019).
Exercising and eating well will also help patients manage their symptoms. It is recommended that patients exercise as a form of self-care. NPs should encourage patients to do any exercise they find enjoyable and manageable. Bichler, et al. (2021) found that psychiatric patients starting new exercise regimes are more likely to try yoga or walking as opposed to cycling, running, or hiking. Further, those with stress disorders report that yoga, swimming, walking, or tai chi are the most helpful for decreasing stress and improving mood since these activities also incorporate aspects of mindfulness (Netz & Lidor, 2003).

To promote healing, NPs should also teach patients about balanced, nutritious diets rich in fruits, vegetables, proteins, whole grains, and healthy fats. Prescribing Omega-3 Fish Oil for patients after a trauma may help abate psychophysiological symptoms, such as palpitations (Matsumura, et al., 2017), and should be considered by the NP. Further, Omega-3 Fish Oil administration is correlated with preventing memory impairment caused from PTSD (Alquraan et al., 2019).

**Patient Resources**

Many resources are readily available to help patients and their families navigate a diagnosis of ASD or PTSD. Most resources are geared towards assisting patients diagnosed with PTSD, though PTSD resources can also be applied to a patient with ASD. The NP should recommend ptsd.va.gov as a resource for all patients diagnosed with PTSD and ASD. Though this website is produced by the U.S. Department of Veterans Affairs, it does not focus solely on veterans struggling with PTSD. For example, the website provides information about different kinds of trauma, describes various forms of therapy, and teaches how families, friends, and providers can help someone with PTSD. The Veterans Health Administration also has a
YouTube channel with a playlist called “PTSD” that features real people and their struggles with PTSD. Patients may find these videos relatable and validating.

The NP may want to recommend books such as *The Complex PTSD Workbook: A Mind-Body Approach to Regaining Emotional Control and Becoming Whole* by Arielle Schwarz and *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms* by Mary Beth Williams and Soili Poijula. These highly acclaimed books provide exercises and evidence-based tools to give readers a hands-on approach to their own recoveries. Empowering patients with resources will further aid them with recovery and healing.

**Conclusion**

Traumatic events are common and can subsequently lead to patients developing ASD and PTSD. Thus, NPs need to identify and begin to treat ASD and PTSD to help avoid negative outcomes such as rehospitalizations, substance use disorders, and suicide. NPs using screening tools, appropriately managing symptoms, and providing patients with education and resources will ultimately promote an increased quality of life in patients.
References


Figure 1

**Injured Trauma Survivor Screen**

<table>
<thead>
<tr>
<th>Before this injury</th>
<th>PTSD</th>
<th>DEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever taken medication for, or been given a mental health diagnosis?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Has there ever been a time in your life you have been bothered by feeling down or hopeless or lost all interest in things you usually enjoyed for more than 2 weeks?</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**When you were injured or right afterward**

| 3. Did you think you were going to die? | 1 0   |
| 4. Do you think this was done to you intentionally? | 1 0   |

**Since your injury**

| 5. Have you felt emotionally detached from your loved ones? | 1 0   |
| 6. Do you find yourself crying and are unsure why? | 1 0   |
| 7. Have you felt more restless, tense or jumpy than usual? | 1 0   |
| 8. Have you found yourself unable to stop worrying? | 1 0   |
| 9. Do you find yourself thinking that the world is unsafe and that people are not to be trusted? | 1 0   |

≥ 2 is positive for PTSD risk
≥ 2 is positive for Depression risk
SUM =

*(Hunt & deRoon-Cassini, n.d.)*

Figure 2

**Primary Care PTSD Screen for DSM-5**

**In the past month, have you ...**

| 1. had nightmares about the event(s) or thought about the event(s) when you did not want to? | YES | NO |
| 2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? | YES | NO |
| 3. been constantly on guard, watchful, or easily startled? | YES | NO |
| 4. felt numb or detached from people, activities, or your surroundings? | YES | NO |
| 5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the events may have caused? | YES | NO |

Total score is sum of “YES” responses in items 1-5.

*(Prins et al., 2015)*
Figure 3

*Posttraumatic Adjustment Scale*

This questionnaire asks you questions that relate to factors that occurred before, during or after the event that caused your injuries. Circle the response that best describes how much you agree with the following statements.

<table>
<thead>
<tr>
<th>Q</th>
<th>Question</th>
<th>Not at all</th>
<th>To a small extent</th>
<th>To a moderate extent</th>
<th>To a large extent</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have needed professional help to deal with emotional problems in the past.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Previously traumatic events have impacted negatively on my life in the past (e.g., assault, sexual abuse, previous combat duty, natural disasters, witnessing traumatic events).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>In the past I was able to talk about my thoughts and feelings with my family members or friends</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>In the past I was satisfied with the support that I had from my friends and family.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>At the time of the event, I felt terrified, helpless or horrified.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>During the event, I thought I was about to die.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>I have felt irritable or angry since the event.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>I have found it difficult to concentrate on what I was doing or things going on around me since the event.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>I am confident that I can deal with the financial stressors that may arise as a consequence of being injured.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>I can accept what happened to me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

PAS_P score _____________
PAS_D score _____________

*(O’Donnell et al., 2008)*