ΑΝΑΓΝΩΡΙΖΟΝΤΑΣ ΤΗ ΔΙΑΤΑΡΑΧΗ ΜΕΤΑΤΡΑΥΜΑΤΙΚΟΥ ΣΤΡΕΣ: ΣΥΝΑΦΕΙΑ ΓΙΑ ΤΗ ΝΟΣΗΛΕΥΤΙΚΗ

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ΠΕΡΙΛΗΨΗ

Εισαγωγή: Η Διαταραχή Μετατραυματικού Στρες (ΔΜΣ) είναι μια διαταραχή άγχους και συχνά μπορεί να αναπτυχθεί αφού ένα άτομο επιβιώσει ή γίνει μάρτυρας απειλητικών για τη ζωή γεγονότων. Ο αυξανόμενος επιπολασμός της ΔΜΣ απαιτεί την ετοιμότητα της νοσηλευτικής σε ότι αφορά την αναγνώριση και αξιολόγησή της.

Σκοπός: Σκοπός του άρθρου είναι να περιγράψει και να αναθεωρήσει τα βασικά εργαλεία διάγνωσης και αξιολόγησης της ΔΜΣ που σχετίζονται με τη νοσηλευτική ως προς την ενδυνάμωση των νοσηλευτών για πιθανή πρώιμη αναγνώριση της ΔΜΣ στην καθημερινή κλινική πράξη.


Αποτελέσματα: Παρόλο που τα διαγνωστικά κριτήρια κατά DSM-5 είναι ο «χρυσός κανόνας» για τη διάγνωση της ΔΜΣ, μια σειρά από κλινικά εργαλεία χρησιμοποιούνται επίσης στην καθημερινή πρακτική. Αυτά περιλαμβάνουν τα εξής: Λίστα Ελέγχου ΔΜΣ (PCL), ΔΜΣ Οδηγός Συμπτωμάτων-Συνέντευξη (PSS-I), Κλίμακα ΔΜΣ η οποία παρέχεται από κλινικούς επαγγελματίες (CAPS), Δομημένη Συνέντευξη για ΔΜΣ (SIP) και Κλίμακα Συμβάντων και Επιπτώσεων (IES). Τα εργαλεία αυτά αναπτύχθηκαν κυρίως από τα τέλη της δεκαετίας του ’70 και χρησιμοποιούνται μέχρι σήμερα.

Συζήτηση: Λόγω της πληθώρας εργαλείων αξιολόγησης και μεθόδων που χρησιμοποιούνται για τη διάγνωση της ΔΜΣ, το ερώτημα που τίθεται είναι ποιά μεθοδολογία θα πρέπει να χρησιμοποιούν οι νοσηλευτές στην κλινική πρακτική ρουτίνα προκειμένου να ανιχνεύσουν πρώιμα συμπτώματα ΔΜΣ αλλάτιο από τους άλλους θόρυβους. Ωστόσο, καθώς οι νοσηλευτές συχνά αντιμετωπίζουν ολιστικό τους ασθενείς και καθώς η ΔΜΣ, όπως και άλλες συναφείς διαταραχές, έχει πολυπαραγοντική αιτιολογία, συμπεριλαμβανόμενων ψυχολογικών, κοινωνικών και βιολογικών παραγόντων, αυτό αποτελεί ταυτόχρονα πρόβλημα και πρόκληση για τη νοσηλευτική.

Συμπεράσματα: Παρόλο που το DSM-5 είναι το «χρυσό πρότυπο» για διαγνωστικούς σκοπούς, οι νοσηλευτές πρέπει να εξειδικευθούν με ένα κλινικό εργαλείο που βελτιώνει τη διαίσθηση και την ενσυναίσθηση τους στην καθημερινή πρακτική, και να παραπέμπουν έγκαιρα τον ασθενή με πιθανή ΔΜΣ για πλήρη ψυχιατρική αξιολόγηση όπου ο νοσηλευτικός ρόλος εκπληρώνεται ως συνήγορος του ασθενούς.

Λέξεις Κλειδιά: PTSD, PTSD Checklist (PCL), PTSD Symptom Scale-Interview (PSS-I), PTSD Scale Provided by Clinical Professionals (CAPS), Structured Interview on PTSD (SIP) Event and Impact Scale (IES)
POST-TRAUMATIC STRESS DISORDER: EARLY SIGNS FOR NURSES

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ABSTRACT

Introduction: Post Traumatic Stress Disorder (PTSD) is an anxiety disorder and it often may develop after an individual survives or witnesses life-threatening events. Its rising prevalence calls for nursing preparedness regarding its recognition and assessment. Aim: The aim of this paper is to describe and review the main PTSD Diagnostic and Evaluation Tools with relevance to nursing in terms of alerting nurse professionals for possible early PTSD recognition in everyday healthcare delivery. Methods: A critical literature review was undertaken, using the following key words: ‘PTSD’, ‘detection’ and ‘questionnaire’, in Medline, Scholar and Chinal, between 1979 and 2017. After checking for clinical relevance and double entries, 44 papers (including two meta-analyses) were chosen for further analysis and discussion. Results: Although DSM-5 diagnostic criteria are the ‘legae artis’ for PTSD diagnosis, a number of clinical tools are also used in everyday practice. These include the following: PTSD Checklist (PCL), PTSD Symptom Scale- Interview (PSS-I), PTSD Scale Provided by Clinical Professionals (CAPS), Structured Interview on PTSD (SIP) Event and Impact Scale (IES). These were developed mainly from the late ’70s and are in use to the present day. Discussion: Due to a plethora of evaluation tools and methods to use for diagnosis of PTSD, the question that arises is which methodology nurses should use in routine clinical practice in order to detect early signs of PTSD but at the same time not “over-diagnosing” patients. Yet, nurses usually look holistically at patients and as PTSD, like other common disorders, has a multifactorial aetiology, including psychological, social and biological factors, this is both a problem and a challenge for nursing. Conclusions: Although DSM-5 is the gold standard for diagnostic purposes, nurses need to get accustomed with a clinical toolkit that enhances their intuition and empathetic insight to a set of clinical skills adjusted for their routine practice to enable early detection of PTSD. In many cases, PTSD may mask other serious psychiatric disorders and neurological traumas, thus demonstrating the importance of the nurse referring timely the suspected PTSD patient for a full psychiatric evaluation where the nursing role is fulfilled as being the patient's advocate.

Keywords: PTSD, PTSD Checklist (PCL), PTSD Symptom Scale- Interview (PSS-I), PTSD Scale Provided by Clinical Professionals (CAPS), Structured Interview on PTSD (SIP) Event and Impact Scale (IES).
INTRODUCTION

Psychological trauma is the unique personal experience of an event during which a person is overwhelmed and unable to manage his/her emotional experience or the person experiences a threat to his or her life, physical integrity or mental health (Murphy & Busuttil., 2015). All too often, a traumatic event leads to psychological trauma and leaves the person incapable of dealing with it. They then may feel highly emotional, physically and mentally overwhelmed as the circumstances of the event usually includes abuse of power, betrayal of trust, trapping, weakness, pain, confusion, and / or loss (Giller, 2000).

Trauma has many forms and there are enormous differences between those who experience it, but there are significant similarities in how these individuals react.

Historical overview

Post Traumatic Stress Disorder (PTSD) has been officially recognised as a clinical entity since it first appeared in the 3rd Diagnostic and Statistical Manual of Mental Disorder (DSM-III) published by the American Psychiatric Society (APA, 1980). Nevertheless, the disorder was often described before this date and was usually related to the traumas of war whereby it mostly defined as "shell shock", "soldier's heart", and/or "war neurosis" (Rae., 2007; Silva et al., 2000).

"Shell shock" was observed during World War I, where many soldiers had symptoms of loss of speech ability, deafness, generalized tremor, loss of consciousness and inability to stand up or walk. During World War II, there was still no consistency in the views of the experts regarding the exact diagnosis of this condition. Some argued that it was a "psychoneurosis," a disorder with mixed physical and mental causes. Another diagnosis argued was that this was a classic case of a war-related disorder, the treatment of which consisted of various psychoanalytic methods and "catharsis" with the use of "pharmaco-hypnosis" with barbiturates. Later, the term "war neurosis" was used, which was associated with an operational fatigue syndrome, especially in the Air Force (Macleod, 2015; Rae, 2007).

In 1952 when the DSM-I was published, the preliminary name for PTSD was "Gross Stress Reaction" (Andreasen, 2010). However, by 1968, after a long period of relative peace there was a shift in the perception of the diagnosis. Rather than being an inherent weakness of the individual, i.e. a traumatic neurosis, it was seen to be triggered by a traumatic event, with a causative agent outside the individual.

Thus, it was widely understood that the key to understanding the scientific basis of PTSD was to understand the root of the psychological trauma (Friedman, 2013).

The Concept of PTSD

According to the DSM-IV (APA., 2000), PTSD is an anxiety disorder and it often may develop after an individual survives or witnesses life-threatening events (McFarlane et al., 2002). High-risk groups include survivors of war and torture, accidents and disasters, violent crimes (for example, physical abuse and assault, bombing and insurrection), refugees, women experiencing traumatic labour, those diagnosed with a life-threatening illness and members of the army, police and emergency personnel (NICE, 2005). After such incidents, it is common to develop a wide range of psychological reactions and symptoms.

For most people these symptoms are transient, but when a specific and distinctive set of symptoms, such as revival of traumatic events, repulsion of emotions and memories and a high sense of threat persists for more than a month after the traumatic event, the person may have developed PTSD (WHO., 2015).

Epidemiology

Exposure to traumatic events during a person’s life is almost inevitable. It has been observed that 61% of men and 50% of women will experience at least one traumatic event during their lifetime (Kessler et al., 2005). Although women are less likely than men to experience a traumatic event, they are more likely to develop PTSD. Also, women are more likely to experience traumatic events in the form of sexual assaults and child abuse than accidents, non-sexual assaults, battles or warfare (Tolin et al., 2006).

However, the prevalence of PTSD varies greatly among different populations. For example, it varies from 0.3% in China to 6.1% in New Zealand. Thus, there is marked high disorder prevalence in high-income countries (de Vries & Olff, 2009). In the general population in the USA, the prevalence of PTSD is around 6.8%, while rates reported among crime victims are up to 75%, those for rape reach 80%. Yet, according to Kessler et al., (2012), nearly half of Americans will meet the criteria for a DSM-IV disorder sometime in their lifetime, with the first onset usually in childhood or adolescence.

War is one of the strongest stressors known to mankind. More recently, the main psychological
disturbances related to war that have been observed in those who experienced traumatic events in Iraq and Afghanistan who presented with PTSD, were anxiety disorder and depression. Thus, in general, the armed forces have a higher prevalence rate of depression, anxiety disorder, alcohol abuse, and PTSD. Fifteen years after the end of the war in Vietnam, 15% of veterans still suffered from PTSD and nearly a third of them were expected to suffer from PTSD for the rest of their lives (Goldberg et al., 2016).

Apart from soldiers, the results of war also affect the inhabitants of a war zone. For example, people living in the Gaza Strip are facing serious problems as a result of income loss, limited access to healthcare and reduced food quality and quantity. A study carried out by El Sarraj et al., (1996) showed that the prevalence of PTSD was 30% among former political prisoners in Gaza.

According to studies conducted around the world, PTSD levels in refugees are high relatively to those of general populations. According to a study by Marshall et al., (2001) 62% of Cambodian refugees who were settled in the US suffered from PTSD two decades after the Cambodian civil war. These rates were much higher than those of the general US population. In another study, 9% of the refugees settling in western countries are suffering from PTSD (Fazel et al., 2005). Finally, a study conducted in Turkey, which investigated the prevalence of PTSD among Syrian refugees, showed an incidence of 33.5% (Alpak et al., 2015).

AIM

The aim of this paper is to describe and review the main PTSD Diagnostic and Evaluation Tools with relevance to nursing in terms of alerting nurse professionals for possible early PTSD recognition in everyday healthcare delivery.

METHODS

A critical literature review was undertaken, using the following key words: ‘PTSD’, ‘detection’ and ‘questionnaire’, in Medline, Scholar and Chinal, between 1979 and 2017. After checking for clinical relevance and double entries, 44 papers (including two meta-analyses) were chosen for further analysis and discussion.

RESULTS

Over time and with the rise of PTSD prevalence in war veterans, the need for immediate diagnosis and evaluation has increased making the development of a tool capable of delivering reliable results necessary. Approximately 20% of veterans suffer from PTSD, therefore nurses who are involved particularly with veteran care are well positioned to provide early detection, prompt referral and advice patients on life-saving treatments. For this purpose, a specialized toolkit was devised in the US, in order to help nurses improve their clinical skills in assessing PTSD, but also to provide a specialized referral procedure that promotes help-seeking behavior among sufferers (Hanrahan et al., 2017; de Jong et al., 2001).

However, after an initial nursing referral, PTSD diagnosis is needed on the basis of a solid clinical methodology. A detailed analysis of the methods for diagnosing and measuring the severity of PTSD, designed in the form of interviews and questionnaires based on the DSM-V manual is given as follows: The DSM-V criteria are an APA manual that includes all recognized mental illnesses. The basic features are described and underlined with acceptable way to distinguish each condition from other similar conditions. Thus, the DSM-V criteria are a diagnostic and disease discrimination tool based on relevant questionnaires and examinations for each psychological disorder. In particular, the DSM-V criteria for PTSD are divided into eight diagnostic criteria-domains that need to be met in order to diagnose PTSD.

Criterion A: stressor (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B: intrusion symptoms (one required): The traumatic event is persistently re-experienced in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders
Criterion C: avoidance (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related external reminders

Criterion D: negative alterations in cognitions and mood (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E: alterations in arousal and reactivity: Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F: duration (required): Symptoms last for more than 1 month.

Criterion G: functional significance (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion (required): Symptoms are not due to medication, substance use, or other illness.

The DSM-5 criteria outline the vital process of defining PTSD according to the duration of occurrence. It should be noted that the duration of the discomfort (symptoms of Criteria B, C and D) should exceed one month and that there is great disruption in the person's personal, social, professional or other aspect of life. Acute PTSD is characterized when the symptoms last less than 3 months while chronic when the symptoms go beyond this (American Psychiatric Association, 2013). Finally, if a Likert scale is used alongside the DSM-5 criteria, the sum of responses for a symptom severity score can be added to calibrate positive diagnoses wherever possible (Shiromani et al., 2009).

Structured Clinical Interview (SCI)
Another clinical tool used for assessing PTSD is the SCI as designed by First et al., (2007), on the basis of the DSM-IV Response Assessment Criteria and is able to diagnose a multitude of psychological disorders belonging to Axis I and II. The interview is divided into sections that focus on each of the earlier DSM-IV diagnostic criteria in which the interviewer notes the presence and severity of each symptom according to the training he has received based on the respondent's answers (Bryant et al., 2011). This tool is intended for use only by clinicians or other individuals who have received special training, as further questions are required based on the respondent's answers. Although, due to the extent of mental illness covered, the use of this diagnostic tool may be time-consuming, the separation that has been made on each mental disorder can help reduce the time required to diagnose PTSD.

Possible shortcomings of this questionnaire are the scoring which is done only at the level of presence or absence of symptom, without weight or frequency assessment, as well as the questions about PTSD that refer only to the worst traumatic experience thus negating other important traumatic experiences that can contribute to the appearance of PTSD.

PTSD Checklist (PCL)
PCL was developed at the PTSD International Center in the early ‘90s and consists of 17 questions based on the DSM-IV criteria. It is a questionnaire that does not require a formal interview by trained personnel and can be answered by the subject himself (Weathers et al., 1993). Thus, the person is asked to respond by rating on the Likert scale on how often he has been disturbed by each symptom in the last month. Initially, the psychometric data was obtained using the PCL-M military version used on Vietnamese veterans with a high percentage of specificity precision as well as severity of gravity. Specifically, on a general scale, the accuracy was 97%, while in each subclass the accuracy was 92-93%. Other researchers checked the reliability and accuracy of the PCL-C version with equally high rates (Wilson & Keane, 2004).

In the version for citizens, a specific traumatic event is not recognized giving a larger response, but for this reason findings obtained using PCL-C cannot be compared or merged with findings from PCL-M. Due to this limitation, the acquisition and comparison of psychometric data using PCL-C is limited. In many
cases a point-limit can be used in the questionnaire score above which is considered a positive diagnosis of PTSD. But this requires special attention from the researcher and is not recommended because the DSM-IV criteria clearly distinguish the sufferers from the non-responders. The completion of this questionnaire does not exceed 10 minutes.

**PTSD Symptom Scale- Interview (PSS-I)**

PSS-I was developed by Foa et al., in 1993 based on DSM-III-R criteria to evaluate the 17 basic symptoms of PTSD in patients with known history of experiencing traumatic reminiscence. The questionnaire uses a Likert scale to determine the incidence of PTSD symptoms in the previous two weeks instead of the one month considered necessary time by the DSM criteria for the diagnosis of PTSD.

Yet, a limitation of this tool is that the interviewer should be able to recognize the clinical picture of the person who has experienced traumatic experience, as the authors of the questionnaire pointed out, hence a highly skilled health professional is needed for its administration. This particular questionnaire, according to Kilpatrick et al., (2013), has excellent precision, especially when it is supplemented by people who have been sexually criminalized.

**PTSD Scale Provided by Clinical Professionals (CAPS)**

Developed in 1990 by National Center for PTSD, CAPS is still quite a popular means to diagnose and evaluate the condition due to being short but effective (Fleming & Difede., 1999). Like SCID, CAPS covers all DSM-IV assessment criteria, with a major difference in that CAPS includes the possibility of assessing PTSD severity and duration of symptoms, not the mere presence of them. The interview takes about one hour, but can be reduced by half if only 17 questions are used which is sufficient for DSM-IV assessment. Like SCI, CAPS requires a trained clinical practitioner for proper application.

The CAPS questionnaire has been used in many surveys in a variety of populations, such as war veterans, with results consistent with those of the detailed SCI interview (Weathers et al, 2001).

**Structured Interview on PTSD (SIP)**

Developed by Davidson et al., (1997), SIP has been designed to assess the severity of PTSD symptoms. Like other similar tools, SIP is based on the 17 main symptoms of PTSD, as identified by the DSM-IV criteria, plus two additional mental disorders that may coexist with PTSD, the guilt of survivors and behavior guilt. The symptom calibration is conducted by an interviewer who needs a brief training to be able to use the tool. The interview lasts between 10-30 minutes depending on the existing symptomatology.

**Event Impact Scale (IES)**

This early tool was developed in 1979 by Horowitz et al., and was the first PTSD questionnaire and still remains one of the most widely used. The initial version consisted of 15 questions that focused only on DSM criteria B and C, i.e. the symptoms of invasion and avoidance, but with the adoption of the DSM-IV criteria, a renewed 22-question tool was published, including the symptoms of over-stimulation. In this updated version, the examiners score how disturbed by each symptom in the past last week on a Likert scale. This questionnaire takes about 10 minutes to complete.

**DISCUSSION**

It is often difficult to distinguish PTSD from other conditions because they may initially present as general symptoms such as sleep disturbances, irritability, persistent anxiety or depressed mood, multiple persistent physical symptoms (without apparent physical cause) e.g. headaches or tachycardia (WHO., 2015). However, further questioning may reveal the characteristic symptoms of PTSD. The most typical symptom of the condition is the revival of initial traumatic events.

People with PTSD experience inadvertent aspects of the traumatic event in a documentary and painful way. Symptoms include constant relapsing into the past, in which the person behaves or feels as though they are living a recurring nightmare or experiencing repetition of painful images or sensory impressions from the initial trauma. This causes intense negative feelings and/or adverse psychological reactions. Other major symptoms are high alertness to a possible threat, excessive reaction to a sudden stimulus, sleep problems, irritability, difficulty in concentrating, and avoidance of painful memories. Among other things, patients with PTSD show emotional numbness, including the inability to feel emotions, feel isolated from their surroundings, resign from previous important activities (work, social life) and the return of traumatic experiences (Karlin et al., 2010).

Due to a plethora of evaluation tools and methods to use for diagnosis of PTSD, the question that rises is which methodology nurses should use in routine clinical practice in order to detect early signs of PTSD but at the same time not “over-diagnosing” patients.
Yet, nurses usually look holistically at patients and as PTSD, like other common disorders, has a multifactorial aetiology, including psychological, social and biological factors, this is both a problem and a challenge for nursing.

In a large meta-analysis, 14 risk factors for PTSD were examined. The results showed three clusters of predisposing factors:

- Age, gender, and race often predict PTSD in some populations, but not others.
- Level of education, previous trauma and difficult childhood, may predict PTSD more accurately.
- Previous psychiatric symptomatology, childhood abuse and family history of mental disorder.

More generally, the degree of impact of all factors was moderate, but traumatic and post-traumatic factors such as the severity of traumatic experience, lack of social support as well as daily anxiety appear to have a greater effect than pre-traumatic factors (Brewin., 2015).

In another meta-analysis on 68 studies which looked at the factors that may predict the occurrence of PTSD, seven prognostic factors were identified: 1. Previous trauma, 2. Previous psychological adjustment, 3. Family history of psychopathology, 4. Life threatening elements during the traumatic experience, 5. Level of post-traumatic social support, 6. Peritraumatic emotional responses, and 7. Peritraumatic dissociation.

All factors showed a significant effect, with a higher predictor being peritraumatic dissociation. Finally, the results showed that the personal characteristics are not the best factors that may predict PTSD (Ozer et al., 2003).

As stated earlier, the onset of symptoms in PTSD usually begins in the first month after the traumatic event, but in a small percentage of cases there may be a delay in the onset of symptoms from months to years (McNally, 2003). PTSD is mostly treated during the first few months or years after a traumatic event. While many of the survivors of a traumatic event initially show symptoms, a significant number will overcome it without treatment. However, at least one third of those who initially developed PTSD remain symptomatic for at least 3 years and are at risk of developing secondary ailments, such as substance abuse (Kessler et al., 2012).

About 84% of PTSD sufferers may have co-existing conditions including drug and alcohol abuse, shame, despair, physical symptoms, work problems, marital problems or divorce and violence, namely experiences that make life more difficult. It is common for the sufferer to lose their job, either due to the resurgence of the events and problems of sleep and concentration, or because they cannot cope with reenactment of the traumatic experience while at work. Financial problems can add another stress to everyday life and may even involve homelessness (NICE, 2005).

Nurses in routine practice should be aware that PTSD may contribute to the development of multiple disorders such as: anxiety disorders displayed as panic attacks (9.5%), agoraphobia (28%), major depressive disorder (48%), substance abuse/addiction (31%), alcohol dependence (40%), behavioral disorder (29%) and mania (9%). Finally, individuals diagnosed with PTSD are more likely to develop other health issues including circulatory or musculoskeletal diseases (Ouimette et al., 2004). Depression is characterized by reduced mood, fatigue, lack of energy, indifference, lack of mood for doing what usually pleases the individual and suicidal ideation but may not have trauma as a causative agent. Adaptation disorders are situations of subjective discomfort and emotional disorder in which the person is required to adapt to a major change in his/her life or a stressful event. Such events may be divorce, retirement, immigration, and may cause a wide range of reactions, such as depressed mood, anxiety or failure to deal with the situation (Bliese et al., 2008; Ehlers & Clark., 2000).

Disruptive disorders are characterized by partial or complete loss of the ability to connect with past memories, knowledge of their identity and immediate sensations and control of physical movements. Disturbance disorders include distractive amnesia, distractions of sensation and movement, and distortion of identity. Individuals with PTSD may occasionally have some distractive symptoms that can be associated with breakthrough amnesia for an aspect of the traumatic event. However, such disorders are likely to co-exist with social, physical and other problems, which make it more urgent for proper diagnosis and immediate treatment (Lukaschek et al., 2013).

Screening patients for mental stress should be commonplace practice for those visiting a healthcare setting, especially when references are made to suggest trauma and PTSD. Nurses are said to be closer to the patient than any other healthcare professional, all too often listening to patients’ experiences or personal life stories. This is an important part of the nursing process but can be sometimes extremely emotional for the patient. While the actual screening process for PTSD may be arranged by the physician, nurses can be a part of it by building a rapport with the patient and
securing a safe environment when the patient is more inclined to feel comfortable.

**CONCLUSIONS**

Overall, it should be noted that PTSD is the only disorder in the DSM-5 whose diagnosis is based on a causative factor, that is, to diagnose someone with PTSD there must have been a traumatic event. Although DSM-5 is the gold standard for diagnostic purposes, nurses need to get accustomed with a clinical toolkit that enhances their intuition and empathetic insight to a set of clinical skills adjusted for their routine practice to enable early detection of PTSD.

Contemporary nurses as part of a interprofessional health care team should be aware of the clinical tools and toolkits that may assist with early detection and appropriate referral for a formal diagnosis. Yet, nurses should be aware that when suspected symptoms of PTSD are observed, care must be taken not to overlook other conditions that may present after a traumatic event. In many cases, a number of disorders other than PTSD may be diagnosed following further psychiatric assessment, uncovering other serious disorders such as depression, phobia, adaptation disorder, schizoid disorders, and neurological traumas due to possible injury and psychosis. Overall, this demonstrates the importance of the nurse referring timely the patient for a full psychiatric evaluation where the nursing role is fulfilled as being the patient’s advocate.

**REFERENCES**


