OTHER TRAUMA-RELATED DISORDERS AND COMPLICATIONS pdf

1: Posttraumatic Stress Disorder, dissociative and trauma disorders information

Trauma disorders are grouped together in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as trauma- and stressor-related disorders. These disorders are similar to each other in that they are all caused, triggered, or worsened by a traumatic event or experience.

Trauma disorders are mental disorders that include the experience of a traumatic or very stressful event. Not everyone who experiences a great deal of stress or trauma will develop a mental health condition, but for those who do the cause can be traced directly to that situation as a causal factor. Trauma disorders must be treated or they can lead to serious complications ranging from problems at work to social isolation to depression and suicide. Disorders related to trauma and stress were once classified as types of, or related to, anxiety disorders. That classification has changed, because although experiencing anxiety is common with trauma disorders, there may be other, more prominent emotional symptoms depending on the individual. Someone struggling with a trauma may experience depression, anger, aggression, or anhedonia more so than anxiety. PTSD is triggered by a frightening and traumatic event, which may be directly experienced or witnessed. This condition causes nightmares and flashbacks, obsessive thoughts about the event, and a lot of fear and anxiety. PTSD can cause serious complications, especially when not treated. These include social withdrawal and isolation, depression, substance use disorders, and suicidal behaviors. When symptoms persist beyond one month they are typically diagnosed as PTSD. There are also some symptoms that are specific to PTSD, such as becoming withdrawn and having negative thoughts about the world. Adjustment disorders are characterized by an abnormal response to stress. Situations like the death of a loved one, having a serious illness, or making a big move can cause stress, but most people adjust within a few months. When a person struggles to adjust and the resulting emotions and behaviors impact relationships and other areas of life, it may be diagnosed as an adjustment disorder. Reactive attachment disorder is a very serious but rare disorder in infants and children that occurs when a child has not formed a healthy attachment to the primary caregiver. It causes withdrawal, listlessness, sadness, fear, and lack of social engagement. Disinhibited social engagement disorder is also caused by poor attachment and occurs in young children. It causes a child to be as comfortable with strangers as with anyone else and a lack of awareness of being safe with a caregiver. This can put a child at risk of being harmed. Facts and Statistics Why some people are better able to cope with stress and trauma and can adjust on their own with time while others cannot is not well understood. However, it is known that trauma disorders are not uncommon. Examples of trauma include sexual or physical abuse, sexual assault or rape, verbal abuse, witnessing abuse or violence perpetrated on someone else, neglect, vehicle accidents, natural disasters, the loss of a loved one, a serious injury, or being involved in or witnessing active combat in war.

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2: Trauma Related Infections | IDCRP

In the United States, the majority of clinical helping professions (e.g., psychology, psychiatry, counseling, social work, and marriage and family), use the Diagnostic and Statistical Manual of Mental Disorders (DSM) to describe and diagnose mental, emotional, and relational difficulties.

Received Jul 14; Accepted Sep The use, distribution or reproduction in other forums is permitted, provided the original author s or licensor are credited and that the original publication in this journal is cited, in accordance with accepted academic practice. No use, distribution or reproduction is permitted which does not comply with these terms. This article has been cited by other articles in PMC. Introduction It is well documented that being diagnosed and treated for cancer is understandably, a challenging experience associated with heightened distress. To this end, in , the International Psycho-Oncology Society endorsed distress as the sixth vital sign in cancer care 1. Since , there has been a proliferation of studies investigating the prevalence and characteristics of cancer-related PTSD ca-PTSD [see reviews, 3 , 4]. With the Fifth Edition of DSM [DSM-5; 5], there are some notable changes to screening for stress-related disorders and which have important implications for screening cancer patients and survivors. The purpose of this paper is to evaluate the changes to the PTSD criteria in DSM 5, and the repercussions this has for screening, assessment, and treatment practices for cancer-related stress problems. Friedman and his colleagues 6 assert that there is heuristic value in grouping this set of disorders in a specific stress-related category as it enables clinicians to differentiate between normal non-pathological distress, from acute, diffuse clinically elevated stress reactions indicative of AD, to more severe and chronic psychopathology including PTSD. This heuristic framework also has potential utility for delineating psychological disturbances arising from cancer-related stress. These mixed outcomes may in part be due to differences in the timing of the assessment i. A close inspection of the ca-PTSD literature indicates that a greater proportion of patients meet sub-threshold symptoms for PTSD rather than full diagnostic criteria [e. However, the majority of cancer studies which have assessed PTSD symptoms, have not considered whether AD, or even another anxiety or mood disorder may better represent the symptom profile for at least some cancer patients who elicit persistent distress for more than one month. To this end, the changes to some core criteria for PTSD in DSM-5 will necessitate a more differential approach to assessing the symptom profile of stress reactions in cancer patients. Hence, a diagnosis or being treated for cancer per se with no adverse events is not necessarily sufficient to qualify for a PTSD diagnosis. Similarly, this exclusion criterion is also applicable for persons who learn that they have a genetic vulnerability to developing cancer in terms of carrying a particular cancer gene. In such circumstances, although this information is stressful, if a person elicits heightened, persistent stress reactions, an alternative diagnosis needs to be considered contingent on profile and duration of symptoms, including AD, Generalized Anxiety Disorder, as well considering the relevancy of Illness Anxiety Disorder, or Somatic Symptom Disorder. This change is in line with at least 10 published factor analytic studies [see Ref. This has the propensity to tighten the sensitivity threshold in identifying persons whose stress reactions reflect PTSD relative to other anxiety and mood disorders. This is in contrast to individuals worrying about their future health including fear of cancer recurrence. Similarly, Criteria B2, B4, and B5 distressing dreams, emotional, and physiological symptoms need to also be assessed in context of AD and other anxiety disorders, particularly if the individuals fears are primarily future-oriented. Three of the seven symptoms Criterion D2, D3, and D7 are new or amended criteria. Criterion D3 assesses whether a person elicits unrealistic blame of self or others pertaining to the cause or consequences of their stressor experience. However, attributions of self-blame may be grounded in reality for some cancer patients. For example, a person who has been a chronic smoker and subsequently develops lung cancer may understandably elicit self remorse for their lifestyle choice. However, if these symptoms are accompanied by exaggerated self-deprecating schemas, this may also be indicative of depression. Criterion D4 expands upon the previous subjective Criterion A2 in DSM-IV in order to capture a wider range of pervasive emotional reactions post-trauma which includes feelings of guilt, shame, and anger. The fourth cluster, Criterion E now includes reactive as well as arousal symptoms.

Specifically, Criterion E1 has been expanded to include unprovoked anger outbursts, and the new Criterion E2 captures reckless or self-destructive behavior. Although these symptoms have been reported in veteran and non-medical trauma samples, there is a paucity of studies that have indicated whether such symptoms also arise in distressed cancer patients. This is because there is an increasing body of literature that demonstrates that most distressed cancer patients tend to be worried about current and future health concerns, including fears of cancer recurrence [e. Moreover, with the inclusion of AD in the new category of Trauma and Stress-Related Disorders, it is timely for the psycho-oncology field to re-consider the utility of AD as well as other anxiety and mood disorders in screening for clinical stress reactions in cancer patients. Rather, these changes have important clinical implications in identifying cancer patients and longer-term survivors who are experiencing psychopathology. It is recommended that clinicians and researchers carefully consider differential diagnostic parameters as well as screening for psychological history pre-cancer diagnosis when evaluating stress reactions in cancer patients. Moreover, this has important treatment implications in ensuring an appropriate evidence based therapy is recommended to patients. Hence, accuracy in diagnosing ca-PTSD relative to AD and other types of anxiety and mood disorders has direct implications for selecting appropriate treatments for client benefits. Bultz BD, Johansen C. Screening for distress, the 6th vital sign: American Psychiatric Association Press; Andrykowski MA, Kangas M. Posttraumatic stress disorder associated with cancer diagnosis and treatment. Oxford Textbook of Psycho-Oncology. Oxford University Press; Posttraumatic stress disorder following cancer: Clin Psychol Rev Depress Anxiety The prevalence of psychiatric disorders among cancer patients. JAMA 6: Difficulties in screening for adjustment disorder, part I: Palliat Support Care 2: The course of psychological disorders in the 1st year after cancer diagnosis. J Consult Clin Psychol Posttraumatic stress disorder in breast cancer patients following autologous bone marrow transplantation or conventional cancer treatments. Behav Res Ther Psychiatric disorders following first breast cancer recurrence: Jpn J Clin Oncol 35 6: Mehnert A, Koch U. Prevalence of acute and posttraumatic stress disorder and comorbid mental disorders in breast cancer patients during primary cancer care: Relation of psychological vulnerability factors to posttraumatic stress disorder symptomatology in bone marrow transplant recipients. Psychosom Med Prevalence of posttraumatic stress disorder in women with breast cancer. Prevalence and predictors of posttraumatic stress in women undergoing an ovarian cancer investigation. Psychol Serv 7 4: PTSD diagnoses, subsyndromal symptoms, and comorbidities contribute to impairments for breast cancer survivors. J Trauma Stress Yufik T, Simms LJ. A meta-analytic investigation of the structure of posttraumatic stress disorder symptoms. J Abnorm Psychol Construct validity of the posttraumatic stress disorder checklist in cancer survivors: Psychol Assess Fear of cancer recurrence in adult cancer survivors: J Cancer Surviv 7 3:

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3: Trauma Disorders - Bridges to Recovery

Trauma- and stressor-related disorders involve exposure to a traumatic or stressful event. Two of the trauma-related disorders are acute stress disorder (ASD) and posttraumatic stress disorder (PTSD). ASD and PTSD are similar except that ASD typically begins immediately after the trauma and lasts.

Your doctor can diagnose your condition and help to prevent complications associated with certain blood disorders. To diagnose a bleeding disorder, your doctor will ask you about your symptoms and medical history. They will also perform a physical examination. During your appointment, make sure to mention: These tests may include: Iron supplementation Your doctor may prescribe iron supplements to replenish the amount of iron in your body if you have significant blood loss. A low iron level can result in iron deficiency anemia. This condition can make you feel weak, tired, and dizzy. Blood transfusion A blood transfusion replaces any lost blood with blood taken from a donor. The donor blood has to match your blood type to prevent complications. This procedure can only be done in the hospital. Other treatments Some bleeding disorders may be treated with topical products or nasal sprays. Other disorders, including hemophilia, can be treated with factor replacement therapy. This involves injecting clotting factor concentrates into your bloodstream. These injections can prevent or control excessive bleeding. You can also get fresh frozen plasma transfusions if you lack certain clotting factors. Fresh frozen plasma contains factors V and VIII, which are two important proteins that help with blood clotting. These transfusions must be done in a hospital. Most complications associated with bleeding disorders can be prevented or controlled with treatment. Complications often occur when bleeding disorders are treated too late. Common complications of bleeding disorders include:

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4: Help HER - Â» For Health Professionals | Complications | Post Tramatic Stress Disorder

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Responses not congruent with the present context or situation Excessive intellectualization Briere, a The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors Kirmayer, If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process. Behavioral Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating e. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma. Behavioral reactions are also the consequences of, or learned from, traumatic experiences. Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions. Reenactments A hallmark symptom of trauma is reexperiencing the trauma in various ways. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: Self-harm and self-destructive behaviors Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways. Resilient Responses to Trauma Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include: Increased bonding with family and community. Redefined or increased sense of purpose and meaning. Increased commitment to a personal mission. Increased charitable giving and volunteerism. Marco Marco, a year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soul-mate and has had a difficult time understanding her actions or how he could have prevented them. In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment. In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. Among the self-harm behaviors reported in the literature are cutting, burning skin by heat e. Cutting and burning are among the most

common forms of self-harm. Self-mutilation is also associated with and part of the diagnostic criteria for a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders. It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term. Working With Clients Who Are Self-Injurious Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should: Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment. Teach the client coping skills that improve his or her management of emotions without self-harm. Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming e. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses. Document such consultations and the decisions made as a result of them thoroughly and frequently. Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior e. In other cases, it can decrease the behavior e. In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping. Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her. Counselors can also help the client prepare a safety card that the client can carry at all times. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences. All professionalsâ€”and in some States, anyoneâ€”could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations. However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persistâ€”or worsenâ€”without intervention. Consumption of substances Substance use often is initiated or increased after trauma. Clients in early recoveryâ€” especially those who develop PTSD or have it reactivatedâ€”have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, , more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana about , people increased their consumption. Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, Others, who lost their income and could no longer support their habit, enrolled in methadone programs Weiss et al. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow

themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression. Avoidance Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas e. For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidanceâ€”in essence, becoming desensitized to traumatic memories and associated symptoms. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned. Survivors may readily rely on family members, friends, or other social supportsâ€”or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately. Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers.

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5: DSM-5 Trauma and Stress-Related Disorders: Implications for Screening for Cancer-Related Stress

Trauma and Stress-Related Disorders in DSM-5 trauma-related stimuli. - persistent complex bereavement disorder - ataques nervios and other cultural symptoms.

During the recent wars in Afghanistan Operation Enduring Freedom and Iraq Operation Iraqi Freedom and New Dawn , the deployment of forward surgical assets, utilization of rapid evacuation to medical care, and use of body armor have culminated in a greater number of casualties surviving their initial injury. As an unintended consequence, a high incidence of infections among the wounded warriors has been reported. In addition, mechanisms of injury have changed over the years, resulting in a greater number of severe, complex wounds from improvised explosive devices. This has led to a higher rate of injuries involving the extremities, including limb loss. In response to the severity of injuries, broader spectrum antimicrobials have been increasingly used to treat these battlefield wounds after reaching medical care. Lastly, late onset or recurrent infections, such as skin and soft-tissue or osteomyelitis, lead to further morbidity and healthcare costs. Although some studies have evaluated infections in war-wounded subjects from the recent wars in Afghanistan and Iraq, these studies are limited by several factors. First, the studies are mostly from single centers and have not evaluated factors across multiple levels of care from the battlefield to treatment facilities in the U. Second, the information gathered in the published studies has not been comprehensive including information on both surgical management and medical management with a focus on microbiology results and antibiotic administration. Further, the studies have not used a priori definitions of infectious disease syndromes. Lastly, the studies have not focused on outcomes. Given that randomized, controlled trials would be difficult to conduct in a protected population with severe injuries, comprehensive studies on combat-related trauma infections with systematic data collection across multiple levels of care are needed in order to mimic clinical trials and inform prevention and treatment efforts. Research Area Description Infections following battlefield trauma remain one of the most military-specific and highest DoD priorities for improved prevention and clinical management. Complex blast-injured patient management is further challenged by emerging virulent and multidrug-resistant pathogens. To address knowledge gaps in the prevention and clinical management of combat-related infections, the aims of the research area were refined emphasizing blast injuries, multidrug-resistant bacterial infections, long-term outcomes and quality of life, and Joint Trauma System clinical practice guideline initiatives and antibiotic stewardship. TIDOS systematically collected infection-related medical management and clinical outcomes from military personnel wounded during deployment from through Follow-up data continues to be captured from cohort enrollees through the military, as well as Veterans healthcare through a collaboration with the St. Extremity wounds are the most common injury sites and are frequently complicated by infections. During , comprehensive analyses of extremity wound infection data collected from the first three years of TIDOS regarding epidemiology, wound microbiology, risk factors, and antibiotic practice patterns were completed. Furthermore, an analysis to examine the effectiveness of specific antimicrobial regimens related to the treatment deep soft-tissue infections is underway. Invasive fungal wounds infections IFIs are a serious complication of blast trauma with high morbidity and mortality and early diagnosis is crucial for optimal management. As a result, Dr. Anuradha Ganesan led the IFI Molecular Diagnostics Protocol, funded under the Defense Medical Research Program, to critically assess the molecular diagnostics methods to support earlier and more accurate diagnosis. During , archived formalin-fixed wound tissue specimens collected during surgical procedures were examined using a polymerase chain reaction PCR -based assay. A technical report with the findings of the analysis was presented to a panel of subject matter experts in November for a roundtable discussion of the utility of the assay and incorporation of the findings into clinical practice guideline recommendations. Osteomyelitis is a serious, often chronic, complication that frequently results in multiple surgeries, prolonged use of antibiotics, and extended hospitalization and ambulatory care. Tribble, evaluated risk factors for the development of osteomyelitis among combat casualties with open fractures of the tibia, femur, and arm long bones. Presently, all analyses have been completed and the first manuscript with findings of the tibia case-control risk factor

analysis was submitted for journal consideration. Through collaboration with the St. Louis VA Health Care System, collection of data is nearing finalization, which will extend follow-up beyond a decade in many cases. Additional analyses are being planned or are underway to evaluate the bacterial microbiome, antimicrobial resistance emergence, interaction of common wound bacteria e. During , two proposals submitted to the Military Infectious Disease Research Program were selected for funding. As military personnel shifted to different operational theaters, injury patterns, severity, and mechanisms changed resulting in unexpected complications, such as the increased number of cases of invasive fungal infections IFIs among combat casualties who sustained complex dismounted blast trauma. Moreover, the rising proportion of colonization by multidrug-resistant organisms MDROs creates further difficulties for clinicians. Using prospective data gained from a cohort of military personnel with deployment-related injuries has provided further understanding of risk factors, treatment strategies, and outcomes associated with infectious complications and support improvement in the prevention and management of infections. On June 1, , the U. This ongoing multisite project is an observational cohort study of short- and long-term infectious complications among U. Enrolled patients are prospectively followed for a period of five years. Patients are eligible for inclusion if they are either active duty personnel or DoD beneficiaries, at least 18 years of age, injured during deployment requiring medical evacuation to Landstuhl Regional Medical Center LRMC in Germany before transfer to a participating U. In addition, as part of TIDOS, bacterial isolates collected from wounded military personnel are stored in a repository for research purposes. Army Institute of Surgical Research Joint Trauma System in support of clinical practice guidelines and process improvement initiatives. Overall, the strengths and opportunities presented by the research area present a robust platform to support development and refinement of evidence-based clinical practice guidelines for the management of combat trauma-related infections during future conflicts. After publishing a comprehensive review in on the subject, an updated executive summary on IFI research was sent to the Pentagon. We will also continue to support Senior-level responses to queries for Wounded Warrior care and outcomes e. From Battlefront to Homefront. Both forces have sustained significant number of complex blast injuries, increasing the risk of infectious complications. Similarly, both militaries have relied on combat trauma registries to inform real-time improvements in prevention and management of battlefield injuries. Joint proposal and data-sharing agreements are currently under review. Initial analysis will focus on findings and management approaches for blast-related invasive fungal wound infections which affected both forces. Journal of Orthopaedic Trauma. Infectious Complications after Deployment Trauma: Association of Enterococcus spp. Journal of Trauma and Acute Care Surgery. Diagnostic Microbiology and Infectious Disease. British Journal of Surgery. Diagnostic Microbiology and Infectious Diseases.

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6: Bulimia and Underlying Trauma

Post-traumatic Stress Disorder (PTSD) is a medical diagnosis given when the transition between a trauma event and non-crisis functioning has not been fully completed. In PTSD, trauma symptoms, or disturbances in thought, emotion, perception, physical functioning and behavior, continue past the initial shock and usual post-trauma recuperative time.

Home For Health Professionals Complications Post Tramatic Stress Disorder Post Traumatic Stress Disorder With the advances in nutrition and fluid replacements, most women survive hyperemesis gravidarum with fewer life-threatening complications. However, being treated and surviving hyperemesis can cause psychological problems for some people. Posttraumatic stress symptoms following pregnancy complicated by hyperemesis gravidarum. Survivors of hyperemesis may have problems with self-esteem, intimacy, guilt, and conditioned food aversions. Some survivors of hyperemesis experience trauma-related symptoms, such as avoiding situations, continuously thinking about problems, and being over-excited. These symptoms are similar to symptoms experienced by people who have survived highly stressful situations, such as combat, natural disasters, rape, or other life-threatening events. It is more common in women than in men. People with histories of hyperemesis are at risk for PTSD. The sensation of suffocation that accompanies forceful, unrelenting retching or vomiting can be quite traumatic. In fact, inducing that sensation is a torture technique that is documented to cause psychological trauma. Hyperemetic women also may undergo painful and invasive procedures, as well as be faced with possible guilt as they decide whether they can continue the pregnancy when they are so sick. Relationships are strained and she may feel misunderstood and alone. They may be in the hospital for a few days or weeks, leading to feelings of frustration, isolation and loss of control. They may be unable to care for themselves or their family for weeks or months. These experiences may lead to feelings of helplessness, especially for women who have certain risk factors, such as having little social support, experiencing a trauma, being victimized in the past, or having a history of mental disorder. Because the hyperemesis experience involves so many upsetting events, it is much more difficult to single out one event as a cause of stress than it is for other traumas, such as natural disasters or rape. For hyperemesis women, the stressful incident may be related to frequent episodes of vomiting, many relapses with a worsening of symptoms, painful or stressful procedures, fear of death, loss of unborn child, complications such as severe infection or convulsions, scary scenes such as vomiting blood, treatment delays or insufficient treatment, and not being taken seriously. Some women may also experience abandonment and abuse, causing further trauma. Diagnosis PTSD is defined as the development of certain symptoms following a mentally stressful event that involved actual death or the threat of death, serious injury, or a threat to oneself or others. These events may include being diagnosed with a potentially life-threatening illness. In the case of hyperemesis, the illness threatens the baby and mother if left untreated or inadequately treated. Many hyperemetic women fear death, especially those with more severe symptoms that do not respond to prescribed treatment. These events may cause responses of extreme fear, helplessness, or horror and may trigger PTSD symptoms. These symptoms include re-experiencing the trauma nightmares, flashbacks, and interfering thoughts , continuously avoiding reminders of the trauma avoiding situations, responding less to people, and showing less emotion , and being continuously excited for example, having sleeping problems or being overly defensive, watchful, or irritable. Other common emotional responses include unhappiness, guilt over actions taken or not taken, and overwhelming loss. It is common for some women with hyperemesis to experience this for months or years after pregnancy. Prevalence In hyperemesis, as in other stressful major life events, over-excitability, avoiding certain thoughts and reminders, and having intrusive thoughts may occur during or after pregnancy. The number of women with these symptoms is unclear and has not been studied to date. Thus, the number with PTSD may be close to that number, or perhaps greater. It is not uncommon for women to seek information on hyperemesis for many years postpartum, trying to get answers to their questions. They may even become quite emotional discussing or thinking about their experience for years afterwards. Childbirth is also a known risk factor for PTSD. If the childbirth experience is perceived as traumatic due to complications or difficulties, the risk of PTSD is likely greater in women with hyperemesis. Future

pregnancies may bring about significant anxiety and panic attacks, symptoms of PTSD. PTSD is often overlooked or undiagnosed in women with a history of hyperemesis. Instead, they may be diagnosed with depression and anxiety that may be chronic. In studies of cancer patients, some have these symptoms even 6 years after their last treatments. It is unknown how long women with hyperemesis will experience symptoms. Some hyperemesis survivors may have higher levels of general mental distress. People with a history of PTSD may be at risk for developing ongoing emotional problems. Symptoms typical of PTSD may be seen in family members of hyperemesis survivors. It is not uncommon for children to have anxiety and fear the death of their mother. These symptoms may lessen over time, however, assistance may be needed from health professionals. It is caused by an extremely upsetting event; however, this one event alone does not explain why some people get PTSD. Not everyone who experiences these upsetting events develops PTSD. For some people, mental, physical, or social factors may make them more likely to experience it. PTSD symptoms develop due to both adapting and learning. Adapting explains the fear responses caused by certain triggers that were first associated with the upsetting event. Triggers such as, smells, sounds, and sights that occurred at the same time as symptoms for example, bathroom cleaners smelled while vomiting may cause anxiety, upset, and fear when occurring alone, even after the trauma has ended. Once established, PTSD symptoms are continued through learning. That is, avoiding certain triggers continues because this avoidance prevents unpleasant feelings and thoughts. The most critical factors in determining which women develop PTSD due to hyperemesis seem to be the severity and duration of the symptoms. While the type of event is the main factor in how a person responds to a traumatic event, other individual and social factors may also play a role. Previous psychological problems, history of trauma, high levels of mental distress, and ineffective coping skills have been linked to a risk of PTSD. Genetic and other biologic factors for example, hormone changes may also make some people more at risk for PTSD. The amount of social support available has also been shown to affect the risk of PTSD, and may influence severity of hyperemesis as well.

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7: Post Traumatic Stress Disorder and Addiction | Dual Diagnosis

Disorders related to trauma and stress were once classified as types of, or related to, anxiety disorders. That classification has changed, because although experiencing anxiety is common with trauma disorders, there may be other, more prominent emotional symptoms depending on the individual.

Overwhelming guilt Shame The inclination towards self-destructive behavior opens up for an eating disorder to begin. In patients who had PTSD and binge ate, they were deflecting the stress and desire to not remember by focusing on eating. Patients who have experienced some form of sexual abuse are also more likely to develop an eating disorder. The trauma incurred during abuse psychologically effects patients. The ramifications upon the psyche are often detrimental and lead to different disorders. Binge eating is a way for patients to maintain control while distancing themselves from the pain. Binge eating thus becomes the destructive outlet for the individual to deal with their pain. Treating Eating Disorders That Result From Trauma The correlation between trauma and binge eating has long been suspected, but only recently have studies started to examine patients in order to derive a complete analysis. This discovery and new research will help doctors to be able to deliver better treatment to their patients. In rehab facilities, psychologists and therapists are there to listen and help patients who are experiencing any of these symptoms. It has been proven that patients respond better when they have a supportive and understanding therapist. Most patients associate a positive recovery experience based upon their relationship with their therapist, so choosing a facility where the employees are respectful and trustworthy is quite important. Our mission is to provide individuals who are struggling with eating disorders the individualized care that they need to triumph over their disorders and enjoy a lifetime of recovery. Eating disorders like anorexia nervosa, bulimia nervosa, binge eating disorder, orthorexia and compulsive overeating, can be devastating and fatal if left untreated. We want to help you survive and recover. We understand what you are going through and can help. Retrieved August 5, Feeding and Eating Disorders. Retrieved August 5, , from http: Post-traumatic stress disorder PTSD. Effective treatment of anorexia nervosa: Trans Anal J ; Search Eating Disorder Hope.

8: Correlation Between Binge Eating Disorder and Trauma

Trauma- and Stressor-Related Disorders 1. Posttraumatic Stress Disorder 2. Acute Stress Disorder 3. Adjustment Disorders 4. Reactive Attachment Disorder.

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