

# ACUTE STRESS DISORDERS WITH SEDATIVE, HYPNOTIC, OR ANXIOLYTIC ABUSE

## BEHAVIORAL DEFINITIONS

1. Was confronted with an actual or threatened death or serious injury to self or others.
2. Reported experiencing intense and overwhelming fear, helplessness, or horror during the traumatic event.
3. Displays an absence of emotional responsiveness, episodes of depersonalization, and/or a diminished awareness of his/her surroundings.
4. Reports experiencing recurrent images, thoughts, dreams, or flashback episodes of the traumatic event.
5. Avoids all conversations, places, activities, or persons that could arouse recollection of the traumatic event.
6. Verbalizes a marked increase in symptoms of anxiety (e.g., irritability, sleep problems, poor concentration, gross motor agitation).
7. Demonstrates significant impairment in social, academic, or vocational functioning.
8. Continues to abuse sedatives, hypnotics, and/or anxiolytics, in spite of labile mood, extreme irritability, impaired social functioning, and expressions of concern by the social support system.
9. Engages in numerous deceptive behaviors to obtain the drugs (e.g., fraudulent prescriptions, theft, street marketing, sexual favors).
10. Denies being addicted and emphasizes the physical and psychological necessity of the medication.

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## LONG-TERM GOALS

1. Terminate the abuse of sedative, hypnotic, or anxiolytic medications.
2. Establish a recovery pattern from sedative, hypnotic, or anxiolytic abuse that includes responding to appropriate treatment guidelines and maintaining abstinence while coping with relapse triggers.
3. Respond to treatment efforts designed to resolve the symptoms of the Acute Stress Disorder.
4. Engage in healthy activities of daily living while managing the symptoms of the Acute Stress Disorder.
5. Establish a social network that enhances efforts to maintain a drug-free lifestyle.

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## SHORT-TERM OBJECTIVES

1. Provide information regarding the trauma experienced and the resulting symptoms. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Examine the conditions associated with the onset of the Acute Stress Disorder (e.g., violent death of loved ones, process of grieving loss of loved ones, violent bodily or sexual assault, application of critical incident stress debriefing immediately after the event, ongoing legal proceedings against the perpetrator).
2. Explore the social turmoil and/or psychological pain caused by the Acute Stress Disorder (e.g., detached from emotions, night

- traumas, flashbacks, isolative behavior, dramatic changes in activities of daily living, dramatic increase in irritability).
2. Identify the negative consequences caused by sedative, hypnotic, or anxiolytic abuse. (4)
  3. Describe the level of functioning prior to the occurrence of the traumatic event. (5)
  4. Provide complete information on current mood and thought process in a psychological evaluation. (6)
  5. Complete psychological testing or objective questionnaires for assessing Acute Stress Disorders, related mental health concerns, and substance abuse issues. (7)
  3. Explore the client's current social, occupational, and environmental functioning (e.g., current attitude of client's primary support system toward him/her, ability to engage in social activities, ability to engage in employment and/or academic programs).
  4. Explore the client's level of social turmoil and/or psychological pain associated with patterns of sedative, hypnotic, or anxiolytic abuse (e.g., increase in agitated anxiety, legal problems due to fraudulent access to drugs, financial problems, family conflicts, unmanageable mood swings).
  5. Examine the client's premorbid personal history (e.g., addictive behaviors, psychological concerns, employment history, nature of relationships, spiritual beliefs, other personal strengths).
  6. Refer the client for or perform a psychiatric/psychological evaluation to validate all co-occurring Axis I and Axis II diagnostic features (e.g., Mood Disorders, Depressive Disorders, Posttraumatic Stress Disorder, Personality Disorders, Substance Use Disorders).
  7. Administer to the client psychological instruments designed to objectively assess Acute Stress Disorder, chemical dependence, and other related mental health concerns (e.g., Millon Clinical

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6. Sign a release of information form to allow data to be gathered on medical history. (8)
  7. Cooperate with a psychiatric/medical evaluation and take medication as prescribed. (9, 10)
  8. Disclose information on current and/or historical suicide behavior. (11, 12)
- Multiaxial Inventory–III [MCMI-III], Beck Depression Inventory II, Substance Abuse Subtle Screening Inventory [SASSI]); provide feedback on the results to the client.
8. After obtaining appropriate confidentiality releases, contact the client's primary care physician for a report on the client's health issues (e.g., general health assessment prior to the traumatic event, health concerns since the onset of the traumatic event, prescribed medications, signs of depression).
  9. Refer the client to his/her primary care physician or a psychiatrist for a reevaluation of the medications prescribed and a titration from the addictive sedatives, hypnotics, and/or anxiolytics, while replacing them with nonaddictive antianxiety medications or no medication.
  10. Continue close consultation with the prescribing physician or psychiatrist on the client's progress in therapy and any continued substance abuse patterns.
  11. Assess the client for high-risk behavioral, emotional, and social markers associated with completed suicide in the Acute Stress Disorder client, such as an increase in unmanageable anxiety, significant patterns of social isolation and/or emotional detachment, demonstration of unbearable grieving, or voicing a need to join a deceased loved one (see *The Suicide and Homicide Risk Assessment and Prevention Treatment Planner* by Klott and Jongsma).

9. Comply with placement in a medically supervised setting for detoxification and/or stabilization. (13)
10. Write a plan for dealing with situations when mental health issues related to the Acute Stress Disorders become unmanageable. (14)
11. Verbalize an awareness of the need to change attitudes, affect, and behaviors and a desire to do so. (15, 16)
12. Administer objective suicide assessment scales to validate clinical findings (e.g., Beck Scale for Suicide Ideation, Reasons for Living Inventory, Suicide Probability Scale); provide feedback to the client on the results and implications for treatment.
13. If at any time in the therapy process the client displays significant destabilization due to sedative, hypnotic, or anxiolytic abuse place him/her in a medically supervised detoxification setting that can attend to the needs of his/her substance abuse and has a demonstrated capacity to work with related mental health concerns.
14. Develop a written crisis intervention plan to implement during times of severe depression and/or anxiety that present as a risk for relapse into substance abuse; the plan should include agreed-upon guidelines for inpatient psychiatric hospitalization (e.g., demonstrated suicide intent) and a list of positive social supports to be contacted as needed.
15. Assess the client for his/her stage of change associated with both symptoms of the Acute Stress Disorder and substance abuse (e.g., precontemplation; contemplation; preparation; action; or maintenance).
16. Engage the client in Motivational Enhancement Therapy (e.g., reflective listening, person-centered interviewing) when he/she has been identified as being in a stage of change where any resistance or ambivalence exists (e.g.,

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12. Verbalize an understanding of the interaction among Acute Stress Disorder, medication abuse, and related mental health concerns. (17)
13. Identify current stressors, and the resulting symptoms, related to medication abuse, the Acute Stress Disorder, and related mental health concerns. (18, 19, 20)
14. Implement problem-solving skills to manage the identified stressors and symptoms. (21, 22, 23, 24)
15. Identify the client's current stage of change (precontemplation, contemplation, or preparation).
16. Teach the client the interaction between his/her co-occurring disorder (e.g., anxiety) and medication abuse (e.g., anxiety results in abuse, which leads to diminished social and vocational functioning).
17. Teach the client the interaction between his/her co-occurring disorder (e.g., anxiety) and medication abuse (e.g., anxiety results in abuse, which leads to diminished social and vocational functioning).
18. Assist the client in listing current stressors that are attributed to the co-occurring disorders (e.g., social isolation due to fears of reliving the traumatic event, financial problems due to impairment in occupational functioning, legal problems due to acquiring medications by fraudulent means).
19. Explore with the client current symptoms or emotional reactions associated with identified stressors (e.g., depression due to social isolation, fears due to financial problems, guilt and shame caused by legal problems).
20. Assist the client in identifying his/her most disruptive symptoms (e.g., feelings of shame, self-devaluation), how these symptoms are currently mismanaged (e.g., increased abuse of sedative, hypnotic, anxiolytic drugs; suicidal ideation), and the consequences of these maladaptive coping strategies (e.g., turmoil among primary social support systems).
21. Teach the client healthy problem-solving skills over identified stressors (e.g., thoroughly define the problem, explore alternative solutions, list the positives and

- negatives of each solution, select and implement a plan of action, evaluate the outcome, adjust skills as necessary).
22. Assign the client to track daily stressors (e.g., family invitation to a social gathering outside the safety of home), previous maladaptive coping patterns (e.g., declining the invitation, staying at home, abusing anxiolytics), and experiences with newly acquired coping strategies (e.g., attending social gathering, relying on the empathic support of family members).
  23. Teach the client healthy problem-solving skills over identified symptoms related to stressors (e.g., validate current emotional reaction, explore history and function of current emotional reaction, examine alternative emotional reactions to stressors, examine possible replacement of emotional reaction, explore adaptive management skills over harmful emotional reactions).
  24. Assign the client to track daily symptoms (e.g., shame and guilt over refusal to attend important family function), previous maladaptive coping patterns (e.g., increased isolative behaviors and medication abuse), and experiences with newly acquired coping strategies (e.g., managing shame and guilt by apologizing to family).
  25. Explore with the client personal psychological vulnerabilities that may hinder his/her effectively acquiring new problem-solving
15. Resolve identified psychological barriers that hinder effective problem-solving skills. (25, 26)

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- strategies (e.g., cognitive rigidity and lack of personal resiliency, chronic issues of self-doubt and devaluation).
16. Implement strategies to reduce sedative, hypnotic, or anxiolytic abuse. (27, 28, 29, 30)
  26. Teach the client strategies to diminish the influence of the identified vulnerabilities on learning (e.g., acknowledge the existence of the vulnerabilities; examine the source, history, and function of the vulnerabilities; replace vulnerabilities with an adaptive self-identity).
  27. Teach the client techniques of deep muscle relaxation, guided imagery, and diaphragmatic breathing to apply at times of stress and anxiety; assign implementation of relaxation during his/her normal activities of daily living and track effectiveness.
  28. Discuss with the client the benefits of titration off the sedatives, hypnotics, or anxiolytics and a change to nonaddictive antianxiety medication or no medication (e.g., emotional stability, improved self-esteem and confidence, reliance on coping skills rather than drugs).
  29. Continue to use Motivational Enhancement Therapy for the client who remains in the precontemplation stage of medication abuse and refuses the offer of titration.
  30. Reinforce the client's use of relaxation techniques (e.g., deep muscle relaxation, guided imagery, and diaphragmatic breathing) to manage stress.



17. Implement strategies to reduce the symptoms of the Acute Stress Disorder. (30, 31, 32)
18. Verbalize statements of hope that effective stressor and symptom management skills can be learned. (33)
19. Write a plan that incorporates relapse prevention strategies. (34)
20. Complete a re-administration of objective tests of substance abuse, acute stress, depression, and anxiety as a means of assessing treatment outcome. (35)
30. Reinforce the client's use of relaxation techniques (e.g., deep muscle relaxation, guided imagery, and diaphragmatic breathing) to manage stress.
31. Continue to emphasize a client-therapist relationship based upon accurate empathy, warmth, and genuineness, in which a client-centered interpersonal relationship (e.g., creating an atmosphere for the client to openly discuss events and emotions) is the guiding principle.
32. Utilizing reflective listening, encourage the client to verbalize, clarify, and validate all emotions pertaining to his/her current life circumstances.
33. Encourage the client to continue tracking newly-acquired coping and problem-solving strategies and to acknowledge the decrease in the urge to abuse sedatives, hypnotics, or anxiolytics and the easing of the Acute Stress Disorder symptoms when these skills are used.
34. Assist the client in writing a plan that lists the actions that he/she will take to avoid relapse into sedative, hypnotic, or anxiolytic abuse (e.g., continued compliance with physician recommendations, continued review of coping strategies for managing stressors and symptoms).
35. Assess the outcome of treatment by re-administering to the client objective tests on substance abuse and mental health problems related to the Acute Stress Disorder; evaluate the results and provide feedback to the client.

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21. Complete a survey to assess the degree of satisfaction with treatment. (36)

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36. Administer a survey to assess the client's degree of satisfaction with treatment.

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**DIAGNOSTIC SUGGESTIONS:**

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
308.3	F43.0	Acute Stress Disorder
292.89	F13.280	Sedative, Hypnotic, or Anxiolytic-Induced Anxiety Disorder, Use Disorder Moderate or Severe
300.00	F41.9	Unspecified Anxiety Disorder
309.81	F43.10	Posttraumatic Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.02	F41.1	Generalized Anxiety Disorder
305.40	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe
292.0	F13.10	Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild