# Understanding Posttraumatic Stress Disorder (PTSD)

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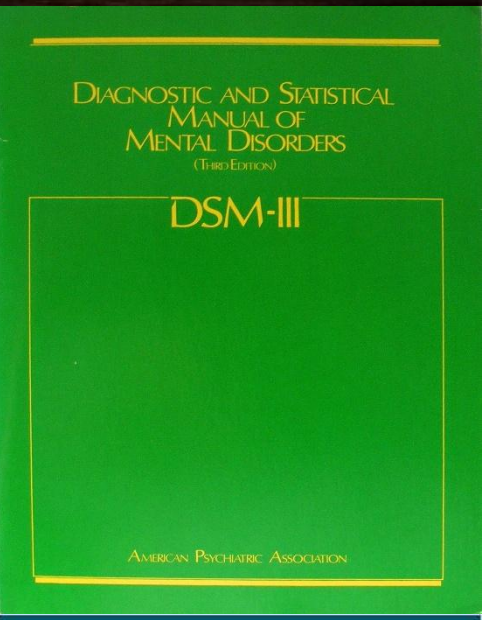
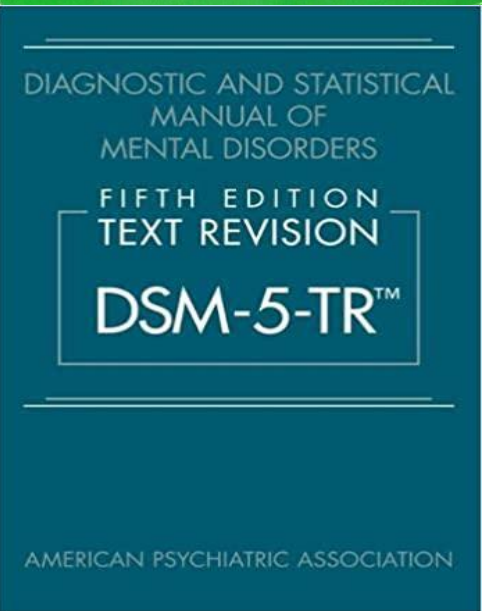
# Charting our Course

- Brief history of Posttraumatic Stress Disorder (PTSD)
- Prevalence rates of trauma and PTSD
- Define trauma and diagnostic criteria of PTSD
- Assessment and treatment of PTSD

# A *Very* Brief History of Posttraumatic Stress Disorder (PTSD)

- DSM = *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association
- First appeared in the DSM-III in 1980
- Latest version in DSM-5-TR (Text Revision), 2022
- The diagnosis has only been for around 45 years
- However, it has gone by previous "unofficial" names such as "shell shock," "combat fatigue/stress," and "war neurosis"



# Trauma and PTSD

- **Psychological trauma** has **two meanings**; or is used in two ways: Trauma;
  - 1). Denotes an actual **experience** or **event** that involves threat of death, serious injury, or sexual violence.
    - E.g., physical assault, shooting incident, rape, etc.
  - 2). Denotes the psychological, emotional, cognitive, and behavioral issues that occur because of the event.
    - E.g., flashbacks, nightmares, avoidance behaviors, agitation, depression, etc.
  - **NOT** the same thing. Not everyone exposed to a traumatic event is "traumatized (experiences symptoms)"

The **Event**

The problems, issues or symptoms the event *causes*

# Prevalence of Trauma and PTSD

## Experience Traumatic Event

- Ruglass and Kendall-Tackett (2015) found that 30-80% of general population have experience
- Kilpatrick et al (2013) reported lifetime prevalence of 89.7%
- Kimley, Van Hasselt, Stripling (2018) indicated over 80% prevalence for first responders

## Develop Posttraumatic Stress Disorder

- Kilpatrick et al (2013) reported lifetime prevalence of 8.3%
- Kimley, Van Hasselt, Stripling (2018) indicated 10-15% prevalence for first responders
- Abbot et al (2015) reported ~20% general population and ~30% of first responders
- Schein et al (2021) found after analyzing 38 studies 3.4%-26.9%, which higher range reflecting first responders

# Posttraumatic Stress Disorder (PTSD) – The Event – DSM-5-TR

**Diagnostic Criteria** **F43.10**

**Posttraumatic Stress Disorder in Individuals Older Than 6 Years**

**Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

   **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

This language describes the specific kind of **event** (known as "Criterion A") the person needs to have experienced to be diagnosed with PTSD.

How is the event determined?

- Subjective vs objective sources

# Posttraumatic Stress Disorder (PTSD) – The Event – DSM-5-TR

- First Responders (e.g., police officers, firefighters, and emergency medical technicians) are often confronted with multiple traumatic events.

> Exposure to multiple traumatic events is common and can take many forms. Some individuals experience different types of traumatic events at different times (e.g., sexual violence during childhood and natural disaster as adults). Others experience the same type of traumatic event at different times or in a series committed by the same person/people over an extended period (e.g., child sexual or physical assault; physical or sexual assault by an intimate partner). Others may experience numerous traumatic events that are the same or different during an extended hazardous period such as deployment or living in a conflict zone. When one is assessing the PTSD criteria in individuals who have experienced multiple traumatic events across their lives, it may be useful to determine if there is a specific, discrete example that the individual considers to be the worst given that the symptomatic expressions of PTSD Criterion B and Criterion C specifically refer to the traumatic event (e.g., recurrent, involuntary, and intrusive distressing recollections of the traumatic event). However, if it is difficult for the individual to identify a worst example, it is appropriate to consider the entire exposure as meeting Criterion A. In addition, some discrete events may incorporate several traumatic event types (e.g., an individual involved in a mass casualty incident sustains a major injury, witnesses someone else being injured, and then learns that a family member was killed in the incident).

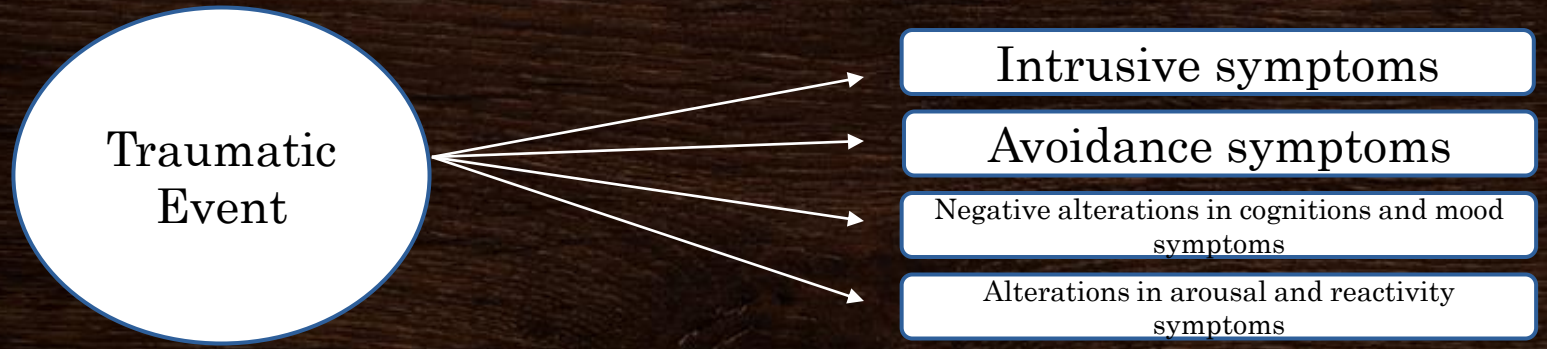
APA, 2022, DSM-5-TR, p. 306

- Cumulative exposure to traumatic events is significantly associated with PTSD in first responders (Geronazzo-Alman et al., 2016)

# Posttraumatic Stress Disorder (PTSD) – Symptoms - DSM-5-TR

- After the person meets the criteria for the traumatic event (Criterion A), then move on to the symptoms
- According to DSM-5-TR, there are **4 symptom clusters for PTSD**
  - Intrusiveness Cluster (need 1 out of 5)
  - Avoidance Cluster (need 1 out of 2)
  - Negative Alterations in Mood and Cognitions Cluster (need 2 out of 7)
  - Alterations in Arousal and Reactivity (Hyperarousal) Cluster (need 2 out of 6)

These symptoms need to be caused by or directly related to the traumatic event(s)



# Posttraumatic Stress Disorder (PTSD) – Symptoms - DSM-5-TR

These symptoms are known as the "**intrusiveness cluster**" – experiences that *intrude* upon the person's experience without control (e.g., flashbacks, nightmares, etc.)

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   **Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   **Note:** In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

# Posttraumatic Stress Disorder (PTSD) – Symptoms - DSM-5-TR

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

These symptoms are known as the "**avoidance cluster**" – Which include thoughts, feelings, as well as people, places, and things (e.g., avoid talking about the event, avoid area event occurred, etc.)

# Posttraumatic Stress Disorder (PTSD) – Symptoms - DSM-5-TR

These symptoms are known as the "**negative changes in mood and thought cluster**" – Which involves changes in self-esteem, self-confidence, feelings of incompetence, shame, and perceptions of mistrust and constant danger (e.g., "I'm no good at being a police officer," "I'm messed up," as well as the inability to be happy, decreased interest in activities, etc.)

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

# Posttraumatic Stress Disorder (PTSD) – Symptoms - DSM-5-TR

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

These symptoms are known as the "**hyperarousal cluster**" – Which includes challenges in concentration, constant distractions, "head on a swivel," inability to relax or "can't turn it off," etc.

# Additional Criteria for PTSD - DSM-5-TR

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Timeframe – must be at least one month. Therefore, can be 30 days or 30 years after event

What makes the symptoms problematic for a person

Not substance or alcohol related (although this can "cover-up" the symptoms of PTSD)

# Specifiers for PTSD – DSM-5-TR

- Specifiers are used to add *specific* details to the clinical presentation

These dissociative symptoms are *in addition to* the other symptoms of PTSD and contributes to the "disconnected" feeling that is sometimes experienced

A delayed expression of PTSD is not uncommon

*Specify* whether:

**With dissociative symptoms:** The individual's symptoms meet the criteria for post-traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

*Specify* if:

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

# Assessing PTSD

- A comprehensive assessment for PTSD should include two parts: Clinical Interview and Clinical Assessments
- 1). **Clinical Interview** – Two types
  - A). Semi-Structured Clinical Interview, also called *Biospychosocial Interview*, *Biosocial Interview,* or simply *Clinical Interview*
    - Focuses on obtaining a narrative or ***subjective*** account of what the person is dealing with symptomatically.
    - Clinicians generate the questions pertinent to clinical issues (e.g., PTSD)
  - B). Structured Clinical Interview
    - Set questions that are standardized
    - *Clinician-Administered PTSD Scale for DSM-5* (CAPS-5)
      - Gold standard interview for diagnosing PTSD
      - ~45-60 minutes
    - *Structured Interview of PTSD* (SI-PTSD)
      - ~20-30 minutes
    - *PTSD Symptom Scale* (PSS-I-5)
      - ~30-45 minutes

# Assessing PTSD

- 2). **Clinical Assessments**
  - Tests or questionnaires that the client/patient fills out or is administered by the clinician
  - Self-report test examples:
    - *International Trauma Questionnaire* (ITQ)
      - Includes PTSD scale
      - ~5-10 minutes
    - *Posttraumatic Checklist-5* (PCL-5)
      - Includes assessment of symptom clusters, identifies worst event
      - ~5-10 minutes
    - *Posttraumatic Diagnostic Scale* (PDS-5)
      - Identifies the event, assessment of symptom clusters
      - ~5-10 minutes

These are a small sampling of assessments available. Many more are available depending on presenting problem and issues. The psychologist can provide assessments to address the presenting problem(s).

PTSD Self Report Measures - National Center for PTSD

# Assessing PTSD

- 2). <u>Clinical Assessments (cont.)</u>
  - **Self-report tests are not the only types of assessments available. Other tests have validity scales to assess for over-reporting or feigning symptoms**
    - *Traumatic Symptom Inventory-2* (TSI-2)
      - Includes scales specific to PTSD and a validity scale (Atypical Response Scale).
      - ~60+ minutes
    - *Personality Assessment Inventory* (PAI)
      - Includes scales related to PTSD symptoms and a Malingering Index
      - ~50-60 minutes
    - *Structured Interview of Malingered Symptomology (SIMS)*
      - Screens for feigned or exaggerated symptoms or cognitive dysfuction
      - ~15 minutes
    - *Miller Forensic Assessment of Symptoms Test* (M-FAST)
      - Assesses the likelihood of feigning psychological symptoms
      - ~15 minutes
    - *Structured Interview of Reported Symptoms-2* (SIRS-2)
      - Specifically assesses over-reporting and feigning symptoms
      - ~30-45 minutes

These are standalone tests for assessing over-reporting or feigning psychological symptoms

# Trauma Treatments

- ***PTSD is highly treatable***
- Evidenced-Based Therapies
  - Prolonged Exposure (PE)
    - 8-15, 60 to 90-minute weekly sessions
  - Eye Movement Desensitization and Reprocessing (EMDR)
    - 12-15, 90-minute weekly sessions
  - Cognitive Processing Therapy (CPT)
    - 12 weekly sessions, 60 to 90-minute sessions

These three therapies are the more common ones recommended (i.e., "gold standard"), as they enjoy robust research support for their efficacy

- Symptom reduction across several or all symptom clusters

Treatments for PTSD - National Center for PTSD

# Trauma Treatments

- Treatment may also involve supportive and coping strategy-based work *before* exposure therapies and as follow-up care
  - Deep breathing and other breathing strategies (e.g., 4-7-8 technique, box breathing, etc.)
  - Guided imagery
  - Progressive muscle relaxation
  - Mindfulness or meditation practices
  - Emotional regulation
  - Distress tolerance
  - Behavioral activation/scheduling
  - Expressive writing
- Medications
  - These may be used to *reduce* some of the PTSD symptoms.
    - Sertraline (Zoloft) – Selective Serotonin Reuptake Inhibitor
    - Paroxetine (Paxil) – Selective Serotonin Reuptake Inhibitor
    - Venlafaxine (Effexor) – Serotonin-Norepinephrine Inhibitor

These three have the most clinical evidence. Sertraline and Paroxetine are the only ones FDA approved

# Treatment Outcomes

- *PTSD is highly treatable*
- According to the National Center for PTSD, ~53% who receive PE, CPT, or EMDR will no longer meet the diagnostic criteria for PTSD.*
- With medication alone, ~42% will achieve remission.*
- Many more people may experience significant symptom reduction although some symptoms will remain.
- ”Anticipating the *foreseeable* impact of the cumulative burden and early identification of individuals at risk of PTSD could lead to timely interventions.” (Geronazzo-Alman et al., 2016)

Veteran's Affairs Research and Outcomes

# Concluding Remarks

- PTSD is a serious condition that may result in long term problems
- Diagnosing PTSD properly requires a comprehensive assessment
- The symptoms must be causes by the traumatic event (Criterion A)
- PTSD is highly treatable and there are a variety of treatments available

# Concluding Remarks for Boards

- Ask *specific* questions you want answered in the independent medical examiner (IME)(psychological) report
  - For example, maximum medical improvement (MMI) status, therapy interventions, etc.
  - Follow-ups to IME reports
- When selecting an IME psychologist (not psychiatrist):
  - The IME report contains validity scales (over-reporting symptoms)
  - Explain the connection between the diagnosis and the reported cause (if there is one)
- Provide the medical records of the event or events made by the claimant in the application
  - This information provides objective data on the event

# Selected References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- Klimley, K.E., Van Hasselt, V.B., Stripling, A.M. Posttraumatic stress disorder in police, firefighters, and emergency dispatchers, *Aggression and Violent Behavior*, Volume 43, 2018, pp 33-44
- Kilpatrick, D.G., Resnick, H.S., Milanak, M.E., Miller, M.W., Keyes, K.M. and Friedman, M.J. (2013), National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using *DSM-IV* and *DSM-5* Criteria. *Journal of Traumatic Stress, 26*, pp. 537-547.

Thank you for your time!

Questions?

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- There is a significant increase in Workers' Compensation PTSD claims in recent years

- FL Statute 112.1815 – First Responders special provisions for employment related accidents and injuries

- Malingering occurs in ~20-30% of personal injury claims of PTSD and ~20% of combat veterans