THE WETC PSYCHOLOGY NEWSLETTER

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Posttraumatic Stress Disorder (309.81): Definition, Diagnosis & Treatment

One of the most frequently encountered diagnoses in personal injury and workers' compensation litigation is a Posttraumatic Stress Disorder (309.81).

According to the DSM-IV-TR, a Posttraumatic Stress Disorder is diagnosed correctly when an individual has been exposed to an extreme life-threatening traumatic stressor that has led to the development of a set of characteristic signs and/or symptoms that have lasted more than one month. These extreme life-threatening stressors may involve actual or threatened death, a serious injury, a threat to one's physical integrity, witnessing such an event, or learning that a family member or close associate has experienced such an event.

Such traumatic events include, but are not limited to, military combat, violent or personal sexual and/ or physical assaults that may occur during robberies or muggings, being kidnapped, being taken hostage, terrorist attacks, torture, incarceration as a prisoner of war, natural or manmade disasters, severe automobile accidents or being diagnosed with a life-threatening illness. Witnessed events include, but are not limited to, observing a serious injury or the unnatural death of another person due to a traumatic event such as a major accident, a violent assault, a natural disaster, or an act of war. A Posttraumatic Stress Disorder can also be produced by learning that one's child has a life-threatening illness.

Although between 50% and 90% of the population in the United States will experience a traumatic event of a type that can cause a Posttraumatic Stress Disorder, research indicates that only 8% of the population will experience such a disorder during their lifetime. The highest rates of occurrence are among rape victims, combat veterans and individuals who have been targeted for political imprisonment or genocide.

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Clearly, not everyone who has been exposed to the type of stressors that can produce a Posttraumatic Stress Disorder will invariably develop such a disorder. For example, knowing that someone was exposed to a major automobile accident does not necessarily mean they will develop a Posttraumatic Stress Disorder. In this regard, research has shown that only somewhere between 10% and 45% of individuals who have survived a serious automobile accident will develop a Posttraumatic Stress Disorder.

Similarly, the magnitude of a traumatic event is not a perfect predictor of its psychological effect. Thus, what may appear to be a relatively "mild" stressor may have a great effect on a given individual. The variables responsible for differential effects of the same stressor on different people have been researched and it is known that factors that may predispose one to develop a Posttraumatic Stress Disorder include childhood trauma, chronic adversity, and familial stressors. In general, physical proximity to the event, the length of the exposure, the severity of the trauma, and an interpersonal trauma also appear more likely to result in the development of a Posttraumatic Stress Disorder.

As noted below, a Posttraumatic Stress Disorder *cannot* be diagnosed during the month following the trauma since research indicates that many of the symptoms a person experiences during that first month are normal. These symptoms may include sleep disturbances, a loss of concentration, anxiety, depression, guilt, anger, irritability, hypervigilance, flashbacks, and disturbances in social, occupational or educational functioning.

Most importantly, in order to diagnose a Posttraumatic Stress Disorder correctly the doctor must show that the individual meets the DSM-IV-TR criteria that are given below.

A. The person has been exposed to an extreme life-threatening traumatic event in which both of the following were present:

   (1) The person experienced, witnessed, or was in some other way confronted with an event in which there was an actual or threatened death or serious injury to him or herself or others.
   (2) The person responded to this event with intense fear, helplessness and/or horror.

B. The experience of the traumatic event has been persistently re-experienced in at least one of the following ways:

   (1) Distressing recollections of the event that are both recurrent and intrusive.
   (2) Distressing and recurrent dreams of the event.
   (3) Acting and/or feeling as if the traumatic event were recurring, including flashbacks of the event in which the person may feel cut off from the episode as it is occurring.
   (4) When exposed to events and/or thoughts and feelings that resemble and/or symbolize the event, they experience intense psychological distress.
   (5) When exposed to events and/or thoughts and feelings that resemble and/or symbolize the event, they experience intense physical signs and/or symptoms.

C. The individual persistently avoids stimuli associated with the trauma and/or there is a numbing of their general responsiveness, as shown by the presence of three or more of the following:

   (1) The individual makes an effort to avoid thoughts, feelings, and/or conversations associated with the trauma.
   (2) The individual makes an effort to avoid activities, places, and/or people that bring back recollections of the trauma.
   (3) The individual displays an inability to recall an important aspect of the trauma.
   (4) The individual shows a marked diminished interest and/or participation in significant activities that they previously engaged in.
   (5) The individual feels detached and/or estranged from others.
   (6) The individual has a restricted range of affect or feelings that they previously had.
   (7) The individual has a sense of having a shortened future as shown by expectations such as the belief that they will not have a normal life span, career, and/or family.

D. The individual shows persistent signs and/or symptoms of increased arousal as indicated by two or more of the following:

   (1) Difficulty initiating or maintaining sleep.
   (2) Irritability and/or outbursts of anger.
   (3) Difficulty concentrating.
   (4) Hypervigilance or a state of exaggerated oversensitivity to a class of events the purpose of which is to detect threats.
   (5) An exaggerated startle response, which is an overreaction to a sudden and unexpected occurrence.

E. The disturbances noted above have been present more than one month.

F. The disturbances noted above cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

Posttraumatic Stress Disorders can be diagnosed with "specifiers." Specifiers further describe the precise nature of the disorder's presentation. "Acute" can be specified if the disorder has been present for less than three months. "Chronic" is the specifier used if the disorder has been present for three months or more. "With Delayed Onset" is specified if the onset of the signs and symptoms of the disorder occurred six months or longer after the stressor. "In Partial Remission" is the specifier used if the full criteria for the disorder were previously met, but at the time of the doctor's evaluation only some of the signs or symptoms remain. "In Full Remission" is the specifier used if there are no longer any signs or symptoms of the disorder but the disorder's presence in the past is of clinical interest.

In conducting a psychological evaluation to determine if someone has a Posttraumatic Stress Disorder the doctor must follow the normal psychodiagnostic procedures by:

1. giving a Mental Status Examination
2. taking a complete life history including the patient's complaints or, as they are sometimes called, symptoms

3. administering a battery of objective psychological tests
4. reading the available medical records to see what other mental health practitioners have found
5. obtaining collateral sources of information in the form of interviews with the patient's relatives, friends and/or occupational associates

Once a Posttraumatic Stress Disorder has been diagnosed correctly the treatment usually consists of a combination of medication and psychotherapy. In this regard, selective serotonin reuptake inhibitors (SSRI's) such as Celexa, Lexapro, Prozac, Luvox, Paxil and Zoloft as well as tricyclic antidepressants such as Elavil, Anafranil, Sinequan, Tofranil, Pamelor and Vivactil have been shown to be effective in reducing the patient's symptoms although they are rarely sufficient in themselves to produce a complete remission.

With respect to psychotherapy, a variety of approaches such as exposure therapy and cognitive therapy have been shown to be effective in the treatment of Posttraumatic Stress Disorders. In this regard, exposure therapy involves helping the patient confront their distressing memories in order to facilitate what is called habituation, desensitization or adaptation. Simply put, habituation, desensitization or adaptation are different terms that all mean that the ability of the memory, and the neurological residual of the traumatic experience to produce symptoms, has been blunted. This blunting typically is produced by exposing the patient to thoughts and images of the stressful experience or by using *in vivo* exposures at the trauma's site.

Similarly, cognitive therapy helps the victim restructure the meaning they attribute to the experience and re-organize their memory of the trauma by helping them to assess the traumatic experience in a more integrated and less distressing manner. This treatment may also require *in vivo* exposures at the trauma's site and often uses relaxation techniques to reduce the patient's adverse reaction to the trauma-related cues and to desensitize or harden them to their anxiety or fears.

This is the seventh of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.

2009 Newsletters

February, 2009 –Litigation problems with the GAF
March, 2009 – Common flaws in psych reports
April, 2009 – The Minnesota Multiphasic Personality Inventory (MMPI)
May, 2009 – Apportioning psychiatric disability in workers' compensation cases and assessing aggravation in personal injury cases
June, 2009 - Subjectively interpreted projective psychological tests
July, 2009 – Sleep disorders and psychiatric injuries