



Posttraumatic Stress Disorder Update

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- *Premium service of academic and clinical excellence for complex and high value cases*
- *Exclusive group of senior academics and clinicians of undoubted reputation and expertise*
- *Quality Reports:* diagnostic acumen and thoroughness in assessment of the patient, review of documentation and sorting out the diagnostic, causality, management, impairment and work capacity issues. Concise and clearly written reports enable the client to understand the reasoning and answers to their questions.
- *Timeliness:* 7 day turnaround from time of patient assessment, 14 days for neuropsychology from time of receipt of documents
- *Transparency:* 20% retained if doctor uses own rooms and typing service
- *Lack of Restrictions:* to experts or clients



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Objectives

What is PTSD?

- Definition
- Symptoms/signs
- Associated factors

Prevalence

Risk factors- which increase prevalence of PTSD

Causation

Clinical Management



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PTSD diagnosis

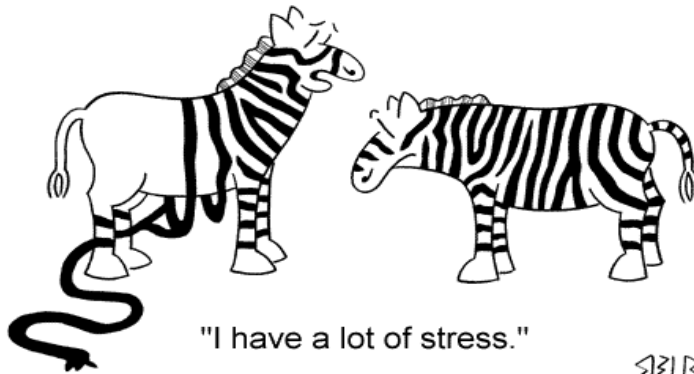
- Most symptoms are entirely subjective and difficult to specify, easy to fabricate and/or exaggerate
- Compensation is often an issue, which may influence both the patient and the clinician in various ways
- May be pressure on clinicians to diagnose PTSD in aftermath of trauma rather than “normal distress” or another psychiatric disorder (for access to treatment and/or compensation) because the etiological connection with the event is “proven”



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"I have a lot of stress."



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Differential Diagnosis

- Adjustment disorder
- Major Depressive Disorder
- Anxiety Disorder eg Panic Disorder or Generalised Anxiety Disorder



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Understanding PTSD

- All psychiatric diagnoses are our best attempt (currently) to make sense of psychological problems
- Classifications operationally define disorders using symptom criteria
- To facilitate communication and improve treatment matching
- The symptom profile is important primarily in identifying (and labelling) the condition: it is an attempt to understand (and improve treatment of) the person's distress and their social and occupational impairment



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PTSD

- What are the symptom criteria (DSM IV)
- Is there enough biopsychosocial evidence to justify the diagnosis of PTSD as a discrete entity?



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PTSD - DSM IV (1994) criteria

Criterion A:

- person experienced, witnessed or was confronted by an event that involved actual or threatened death or serious injury to self or others
- person's response involved intense fear, helplessness or horror

Criterion B:

- The traumatic event is persistently re-experienced:
intrusive thoughts, dreams, flashbacks or psychological / physical distress at reminders

Criterion C:

- Persistent avoidance of stimuli associated with the trauma and numbing of responsiveness: (3 of)
avoidance of thoughts / situations that remind of the event, amnesia, loss of interest, emotionally flat, distant from others

Criterion D:

- Persistent symptoms of increased arousal: (2 of)
sleep problems, anger, poor concentration, alertness for danger, easily startled



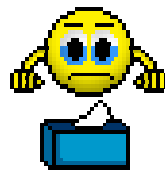
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DSM-IV criteria for PTSD

Symptoms must persist for at least one month

(<1 month = Acute Stress Disorder)

- Symptoms must be accompanied by clinically significant distress and impairment



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**And you thought
there was stress
in your life !**



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Response following trauma

- Physical impairment
- Individual meaning of the illness
- Social circumstances
- Psychological vulnerability and distress
- Nature and quality of medical care
- Reactions of other people- family, friends, employers, doctors



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Risk Factors for poor outcome PTSD

- Believing you were going to die (11 fold increase)

Other correlates (decreasing order)

- Lack of social support posttrauma
- Other life stress posttrauma
- Trauma severity
- Acute responses (esp. arousal, dissociation)
- Childhood trauma – non-sexual
- Low IQ
- Childhood sexual abuse / low SES
- Family psychiatric history / female gender

See Yehuda, 1999; Brewin, 2000; Ozer, 2003



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PTSD associated features

- Anger
- Depression
- Anxiety
- Substance abuse
- Emotional lability
- Impulsive and / or self harming
- Physical complaints
- Relationship breakdown
- Unemployment



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PTSD CO - MORBIDITY

80% or more have:

- Major Depressive Disorder
- Generalized Anxiety Disorder
- Substance Abuse
- Phobias

- Is PTSD a Separate Condition
- In Majority of Cases - Shared Vulnerability with Similar Predictive Factors



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PTSD Prevalence

In Civilian Samples:

- USA -lifetime = 7.8%
12-month prevalence = 3.9% -(Kessler, 1995):
- Australia 1.3% 12-month prevalence
Minimal gender difference (Creamer et al., 2001)
- Following specific traumas (lifetime):
Accidents or witnessing someone killed: up to 10%
Non-sexual assaults: up to 25%
Rape: up to 50%

In Military Exposed to Combat:

- Up to 30% lifetime (20% of Vietnam vets)



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Course of PTSD

- ½ those who develop PTSD recover in first 12 months
- Symptoms improve over next 6 years
- 40% had symptoms which did not remit after many years
- Less likely to be chronic if treatments instituted (1/3 unlikely to benefit)
- PTSD is a high burden disorder

Australian National Survey of Mental Well Being (Creamer, Burgess, & McFarlane)



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Mechanisms: Biological Models

- Functional neuroimaging with trauma related stimuli in PTSD:
 - Increased activity in amygdala (high fear / threat detection and response)
 - Increased activity in right anterior para-limbic system (high emotional memory)
- Structural neuroimaging: reduced hippocampal volume



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Mechanisms: Biological Models

- Exaggerated startle response – increased amplitude and failure to habituate
- Conditioned responses – greater conditionability & slower extinction
- Adrenalin – strengthens memory (survival value)



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Mechanisms: Psychological Models

- Classical conditioning / fear conditioning
- Operant conditioning / reinforcement of avoidance
- Two-factor model: classical followed by operant
- Information processing models
 - Appraisals of the event (and sequelae)
 - Formation of traumatic memory network
 - Stimulus, response, and meaning components
 - Secondary gain



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Issues of Causation

Mr RG was a 56 year old insurance broker and former armed services member. He had not been able to work for the last 2 years and had been treated as an inpatient for major depressive disorder. His illness developed in association with financial difficulties arising from marital breakdown. He later claimed that he had PTSD due to his experiences in the armed services more than 30 years prior and that he had *repressed memories* of these.



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Clinical Course and Management

50-60% of cases recover.

Treatment

- Evidenced based treatments
- Is the treatment adequate?
- What questions to ask treating doctor and IMEs about treatment



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PTSD: Stages of Treatment

- 1: Stabilisation and engagement
(not post trauma counselling for all)
- 2: Education and information
- 3: Anxiety management
- 4: Trauma exposure
- 5: Cognitive restructuring
- 6: Relapse prevention and maintenance



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Confronting the Memories

Trauma focussed CBT- strong evidence for reducing PTSD diagnosis and severity of symptoms

- Imaginal and, where possible, in vivo exposure
- Confront situations, people and places avoided
- Gradually think and recall traumatic memories until they no longer create high levels of distress
- Rehearsing coping and mastery responses

Eye Movement Desensitisation Reprocessing

-Limited evidence



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Trauma Focussed Cognitive Restructuring

- Identify maladaptive and distorted thoughts and memories of traumatic experience
- Re-evaluate on the basis of evidence
- Challenge and replace maladaptive automatic thoughts and beliefs



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Case example

Mr.Z was a senior federal police officer who was sent home from a European posting by economy air-travel (36 hours duration). On arrival home he developed a massive pulmonary embolism and was in intensive care for 1 month. He has been told that a clot could dislodge from lung vessels at any time and cause further problems such as stroke or even death.



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Psychological Treatments

8 – 12 sessions usually enough
More sessions: Multiple traumatic events, comorbidity



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Drug Treatment of PTSD

- SSRIs:
 - Clinician's drug of choice, FDA approval for sertraline & paroxetine
 - Broad spectrum of action on all 3 symptom groups
- TCAs, MAOIs: moderate effects; anticonvulsants may help with explosive anger; NOT benzodiazepines; interest in new generation antipsychotics
- Pharmacotherapy should be a second line treatment where CBT is not available, rejected, or failed (NICE, 2005)



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Mrs AB was a 56 year old woman. She and her husband had delivered their grapes to the winemaker and were returning along the highway in their own truck when a car crossed the dividing line and headed straight for them. She suffered massive physical injuries and developed PTSD.



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Litigation

- PTSD symptoms higher in those undergoing litigation
 - May suggest over-reporting of symptoms
- PTSD symptom severity not a function of compensation settlement
- Litigation had no effect on return to work
- Similar proportion of those settled or not settled were undergoing psychological therapy
- Litigation did not effect response to therapy
- Litigation stress may contribute to elevation of symptoms
- Individuals who are more injured or have comorbid psychological problems may be more likely to litigate



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What can we do to get people back to any work?

- Baby steps
- Structured
- Small hours
- The positive effects of work

Question for IME ?

Would any form of work help this person proceed through life



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Using IME Psychiatrist

- to help you understand the case
- to generate questions to ask treating doctor/psychiatrist
- To provide time line for return to any work
- Look for discrepancies



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Questions for IME

Ms LG was a 40 year old woman who had been working as a senior claims manager and had no past psychiatric history. She developed severe PTSD and Major depressive disorder after working with two male colleagues who she alleges continually sexually harrassed and bullied her. 4 years later her marriage had broken down, her children had gone to live with their father, she was housebound, continually distressed and socially isolated and unable to work.



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Psychiatric History Taking

- Personal development
- Education
- Occupational history
- Social and sporting interests
- Relationship history
- Past medical and psychiatric history
- Significant family history
- Past litigation history
- Alcohol intake, cigarette consumption, and drugs
- *History of the incident*
- Description of the incident
- Response to incident
- Current social functioning
- Current Mental State
- Current Medication:
- In Answer to Your Specific Questions



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How law firms shape questions

- Does the claimant suffer from a psychiatric or psychological condition and if so what is the disorder?
- Is the condition related to the incident ?
- Treatment requirement
- Prognosis



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Conclusions - PTSD

- Group of characteristic symptoms and signs=syndrome
- Increased prevalence with severity of stressor
- High co-morbidity
- Treatment modalities- CBT ± psychotropic medication



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