# POSTTRAUMATIC STRESS DISORDER - DIAGNOSTIC CONFUSION

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Although frequently diagnosed by physicians, PTSD does not arise inevitably from a serious personal injury.

*Posttraumatic Stress Disorder* as a diagnosis emerged after the Vietnam War. Prior to then, "shell-shock" was the terminology used in the WWII and Korean wars. The Diagnostic and Statistical Manual (DSM III) classified the diagnosis as an anxiety disorder, and further refined diagnostic criteria in subsequent editions. The diagnosis as it exists in today's DSM-5 utilizes the most specific criteria yet, re-categorizing PTSD as a *stress (trauma) related disorder*.[1]

In most states, PTSD (or any other mental injury) is not compensable under workers' compensation without a preceding physical injury. Nonetheless, some employers will authorize an evaluation for a significant emotional trauma (i.e., robbery) in the absence of tissue damage.

As an attorney, you may be bringing or defending a claim of Posttraumatic Stress Disorder. While diagnosing the disorder is a clinical process, as you weigh the evidence for likelihood of PTSD, here are some data to guide your assessment.

## MORE THAN ONE FORM OF PTSD

*Acute Stress Disorder* - a trauma that occurred more than three days but less than four weeks ago

*Posttraumatic Stress Disorder (Acute)* - the symptoms have been present between four weeks and three months

*Posttraumatic Stress Disorder (Chronic*) - the symptoms have been present longer than three months.

*Posttraumatic Stress Disorder (Delayed Expression)* - symptoms that first arise > 6 months after the trauma.

Further refinement of the diagnosis depends upon severity and degree of impairment in functioning. Extreme symptoms may include *depersonalization,* or the feeling of being an outside observer of one's body; *derealization*, or unreal and dreamlike surroundings. Both symptoms fall into the category of *Dissociative Symptoms*. Children under 18 require a different set of criteria. Children can be very sensitized to the traumas encountered by their parents.

## SYMPTOMS & DIAGNOSIS

In personal injury claims, the diagnosis of PTSD is commonly associated with motor vehicle accidents, fires, airplane incidents, amputations, and assaults. Chronic back pain from an injury is unlikely to result in PTSD unless the injury itself was traumatic (such as falling from height or being struck by a car).

What are the criteria for a valid claim of Posttraumatic Stress Disorder, and why is the diagnosis so often misapplied by primary physicians? A review of the eight criteria for true PTSD[2] indicates:

A. There must be a triggering event: exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:

   i. Direct experience of the event

   ii. Witnessing the event as it occurred to others

   iii. Learning that the (accidental or violent) event happened to a close family member or friend

[1] http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf

[2] *Desk Reference to the Diagnostic Criteria from DSM*-5, American Psychiatric Publishing, Washington DC, 2013

iv. Repeatedly experiencing personal (not via media) exposure to the trauma (such as 911 first responders)

B. A diagnosis of PTSD requires one or more of these symptoms be present *following* the event:

i. Recurrent intrusive memories that are involuntary

ii. Nightmares of the event –police officers may dream that their family is in great danger and they are powerless to save them.

iii. Flashbacks – the person feels or acts as though the event is happening again

iv. Extreme psychological distress with exposure to internal or external cues of the event (smells, sounds)

v. Extreme physical reactions to internal or external cues of the event (GI upset or vomiting)

C. The patient persistently avoids reminders of the event in one or more ways:

i. Avoids memories of the event in all forms

ii. Avoids external reminders of the event (people, places, objects, etc)

D. Changes in mood or cognition in one or more of the following ways:

i. Amnesia for important aspects of the event

ii. Pan-negative beliefs about self or the world

iii. Irrational self-blame

iv. Persistent negative emotions of fear, anger or shame

v. Withdrawal from activities

vi. Withdrawal and detachment from others

vii. Anhedonia, or the inability to experience happiness or pleasure

E. One or more of the following behaviors are *atypical* (not in evidence) <u>prior</u> to the event:

i. Extreme irritability or aggression

ii. Reckless or self-destructive behavior

iii. Extremely on guard for surroundings/safety

iv. Exaggerated startle response

v. Difficulty concentrating

F. The symptoms in Criteria B-E have lasted > 4 weeks

G. The symptoms are severe enough to impair functioning in social, occupational or other areas of functioning

H. The symptoms are not the result of medication or other medical conditions

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## WHO IS THE VICTIM?

Bystander exposure to a horrific event, such as a plane crash, can result in valid symptoms. If the victim tells his wife about the event, which did not happen to him personally, she would not have a valid claim of PTSD. She may, however, have loss of consortium if the husband has ongoing disruptive symptoms.

Often, the patient with PTSD may not be able to describe it in detail. The brain often represses all or part of a traumatic memory, even while the symptoms persist in the absence of conscious thought. This protective repression can contribute to intrusive thoughts that erupt when least expected. Untreated, or treated improperly, Posttraumatic Stress Disorder can become a chronic condition resistant to care.

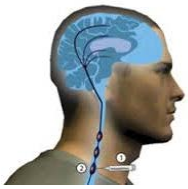
## TREATMENT

One treatment for Posttraumatic Stress Disorder is *EMDR – Eye Movement Desensitization Retraining*. The patient forcefully recalls the event while concentrating on a visual distraction – blinking lights, repetitive movements, or sounds that disrupt the neural pathways and reprogram the recall of the memory. It works for many, but competently trained clinicians can be difficult to locate.

Slowly re-experiencing or reintroducing a person to the scene of an accident is required if the scene is an unavoidable part of daily life. Over time, the symptoms may diminish and gradually resolve.

*Cognitive Behavioral Therapy* is a problem-oriented approach to psychotherapy focusing upon practical solutions and identifying the relationship between situations and emotions. PTSD is not responsive to the insight-oriented, inwardly focused approach of traditional psychotherapy.[3]

Some antidepressants lessen the symptoms of PTSD. Paxil, Zoloft, and Seroquel, alone or in combination can lessen the severity of symptoms. Contraindicated are medications that promote vivid dream activity, such as amitriptyline. Ambien (zolpidem) promotes sleep onset, but results in unusual and dysregulated nighttime behaviors in some patients.



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Recent research suggests that performing stellate ganglion blocks (injections) at the level of C6 provides partial relief in symptom severity. The term for this usage is "off label".[4] The stellate ganglion (nerves originating from the cervical spine) has "second and third-order neuron connections with the central nervous system nuclei that modulate the manifestations of PTSD...it seems reasonable to us that SGB may reset the area of the brain responsible for anxiety to its pretrauma state..."[5] Although not definitive, preliminary research is promising.

What does not work...what is counterproductive to any patient's welfare...is well-meaning, but excessive handholding that promotes dependency, whether provided by a doctor, family member, or a law practice.

## DAMAGES

In combination with physical sequela, the symptoms of PTSD may require medication, psychological therapy, job change or on occasion, result in permanent partial disability.

## FURTHER READING

[3] http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Treatments_and_Supports/Cognitive_Behavioral_Therapy1.htm
[4] http://journals.psychiatryonline.org/article.aspx?articleid=1209447
[5] http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-11-00328

The military history of PTSD: http://www.vva.org/archive/TheVeteran/2005_03/feature_HistoryPTSD.htm

Seventy-two articles/blogs from Dr. David B. Adams on PTSD – diagnosis, treatment and complications
http://www.psychological.com/forums/search.php?searchid=929502

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