Assessment of PTSD Symptoms in Workers' Compensation Injuries

David Rosmarin, M.D. 617-699-8113
Director, Forensic Psychiatry Service rosmarin.david@gmail.com

Disclaimer

No commercial or other conflicts of interest.

Opinions expressed are my personal ones, and not those of McLean or Harvard Medical School.

2

Old Illness New Diagnosis

- Debut in psychiatric nomenclature in 1980
- DSM-5 broadened criteria in exposure criterion A
- Truly a debilitating and painful illness for many
- More complex when combined with TBI
- More debilitating with concurrent injuries (burns, orthopedic, sexual organs)
- First notoriety when used as an insanity defense
- Cottage industry in negligence and disability law
- People vary widely in resilience
- PTSD is associated with poorer physical health
- Many adults get better, even without treatment

3

Diagnosis requires criterion A

- Exposure to actual or threatened death, serious injury, or sexual violence in one or more way

1. Directly experiencing
2. Witnessing in person trauma to others
3. Learning event happened to close family member or friend—must be violent or accidental if actual or threatened death
4. Experience repeated or extreme exposure to aversive details of traumatic event (e.g. first responders to human remains or child abuse)
   (media exposure only if work-related)

4

Four symptom complexes result

1. **Intrusion**: (1of 4) memories, dreams, flashback, cue distress, marked physiological actions to cues or symbolic
2. **Avoidance: persistent** (1 of 3) efforts to avoid thinking of associated thoughts feelings or external cues

5

Four symptom complexes result

3. **Negative alterations in cognitions and mood associated with traumatic events** (2 of 7)

- Dissociative amnesia for important aspect
- Persistent negative beliefs or expectations
- Persistent distorted cognitions about trauma's cause or consequent
- Persistent negative emotional state (horror, anger, guilt)
- Marked diminished interest or participation
- Feeling detached or estranged from others
- Persistent inability for positive emotions (happy, love, satisfaction)

6

Four symptom complexes result

4. **Marked** alterations in arousal and reactivity (2 of 6)

- Irritability, angry outbursts
- Reckless or self-destructive behavior
- Hyper-vigilance
- Exaggerated startle
- Concentration problems
- Sleep disturbance

7

Duration Distress Impairment

F. Lasting more than one month--otherwise Acute Stress Disorder

(E and F, if properly applied, lower diagnosis rate)

G. Symptoms cause clinically significant distress or impairment in social, occupational or other

Specifiers:

With or without depersonalization or derealization

With or without delay of 6 months for all criteria to be met

8

20 possible symptoms, 6 required

- Some symptoms overlap
- More than sufficient symptoms to make the diagnosis by self-report alone with non-observable symptoms
- Intrusion: thoughts, dreams, flashbacks
- Avoidance: thoughts, feelings, memories, things
- Cognition/mood: amnesia, negativism, causes, horror/guilt, interest, detachment/estrangement, dissatisfaction, loveless, unhappy
- Arousal/reactivity: hypervigilance, conscentration, sleep

9

Factitious Disorder

- Falsification of physical or psychological signs or sx, or induction of injury or disease associated with identified deception
- Presents self as ill, injured, or impaired
- No apparent external rewards--vs. malingering
- The reward is assuming the sick role
- Fabrication, induction, exaggeration, simulation

10

Malingering

- Conscious—for secondary gain
- Legal cautions
- False or exaggerated physical or psychological sx
- Pure malingering= fabrication
- Partial malingering= exaggeration
- False imputation= intentional misattribution
- Studies have shown untrained, non-ill people can correctly mimic PTSD using a symptom checklist

11

Clues

- Thrust forward sx OR uncooperative/evasive
- Overplay the part, or practiced recitation
- Resist sharing records or corroboration
- Trauma uncorroborated or vague
- Inconsistency of reported sx vs. functioning (can't concentrate but gambles successfully and does taxes) "Giving up" but travels, day-trades
- No waxing and waning of sx
- No coping strategies
- Refuses treatment, including meds
- Antisocial traits, poor social/occupational function

12

Clues

- Respond “I don’t know”--i.e. “correct” answer
- Inconsistencies on psych testing, MMPI, SIRS, M-FAST, Clinician-Administered PTSD Scale (CAPS), Morel Emotional Numbing Test (forced choice)
- Inconsistent versions
- Not getting better with time
- Comments about examiner credulity
- Rape 80%, seeing killing 25%, physical assault 25%, accident 12%
- 75% claimants report nightmares, assess thrashing
- Mostly REM can be non REM, may be repetitive (or not)—one study said 50% another only 20%

13

Approach

- Awareness that some PCPs miss anxiety sx
- Non-challenging, open ended questions
- Insist on details about sx for that, not just recitation “I get nightmares” “ I have anhedonia”
- Assess sx and functioning before and after trauma
- Offer and see if patient endorses highly improbable sx or sx rarely seen in PTSD
- Avoid third parties in exam room
- Care in parsing out concurrent or head trauma
- Care in parsing out SA, other mental disorders
- Risk factors: prior, especially childhood trauma

14

Clues

- Flashbacks 9% Gulf War Vets

15

Tale of two firefighters

16