IDENTIFYING PTSD IN A WORLD OF MISDIAGNOSIS

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In general…

- 50 to 60% of persons have been exposed to PTSD level trauma
- Among those persons with trauma exposure, approximately 5-20% will develop PTSD
- Approximately half of those with trauma-related symptoms will be largely or wholly symptom free within three months.
- The DSM-5 explicitly cautions that a diagnosis of PTSD should not be made when the subject's symptom presentation can be explained on the basis of another diagnosis.

THE NATURE OF THE TRAUMA MATTERS

- Trauma that involves aggression between humans results in the highest rates of PTSD.
- In particular, rape and combat trauma result in the highest rates of PTSD, measured between 25 and 50 %, depending upon a number of variables (age at time of trauma, number of traumatic events, intensity of trauma, presence or absence of pain, threatened loss of life, etc.)

THE EXAMPLE OF COMBAT TRAUMA

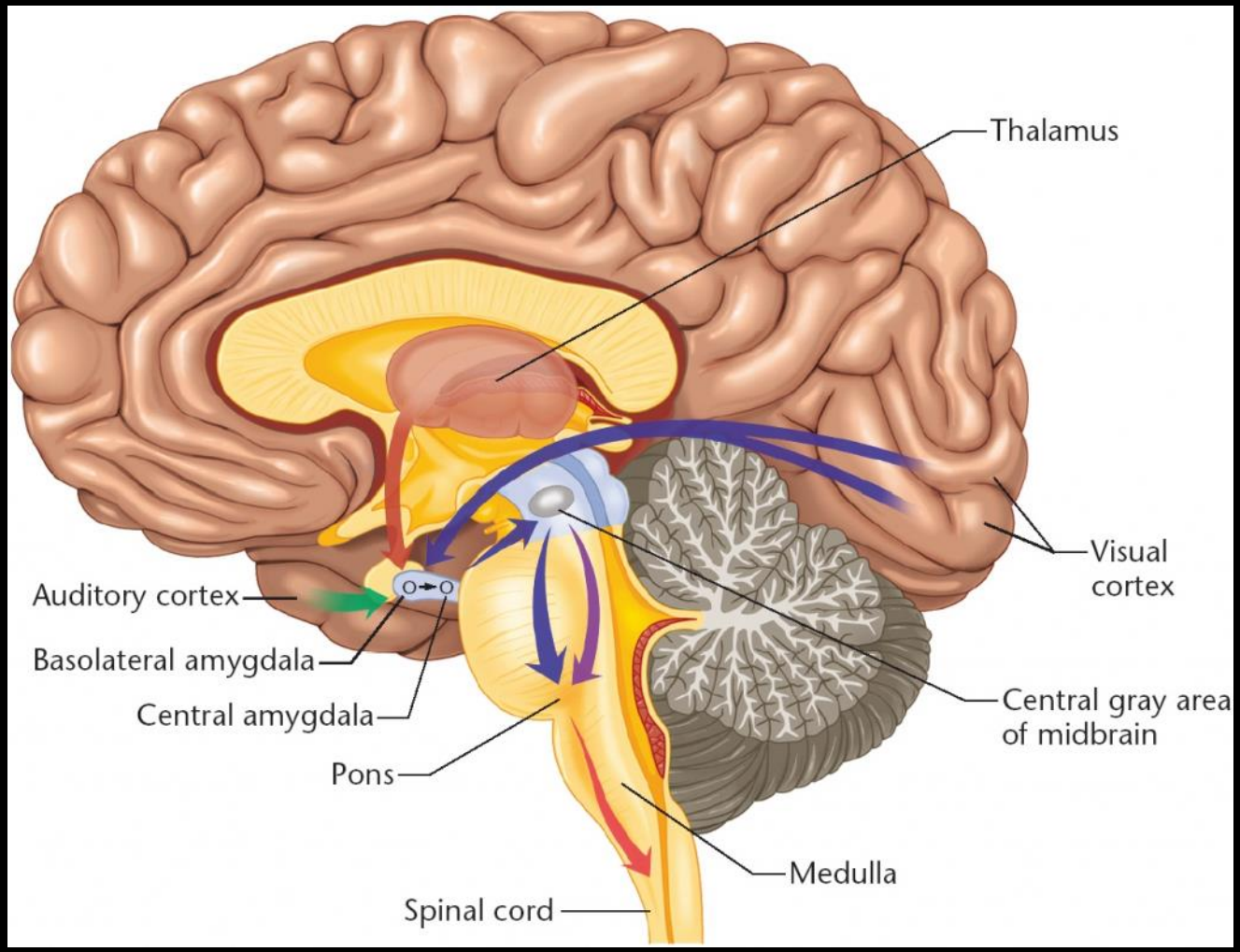
- Ten years after the end of the Vietnam war, 28% of Veterans who fought in the war had PTSD (sample controlled for degree of combat exposure)
- Forty years after the end of the Vietnam war, 11% of Veterans who fought in the war had PTSD.
- Studies from the Iraq and Afghanistan wars show an overall average of 6 % developing PTSD, and 13% in combat-exposed infantry units
- The "dose-response" curve associated with PTSD shows that rates of PTSD increase with increased combat exposure, but they top out at 25-30%, and go no higher even when combat exposure continues

There's a difference between…

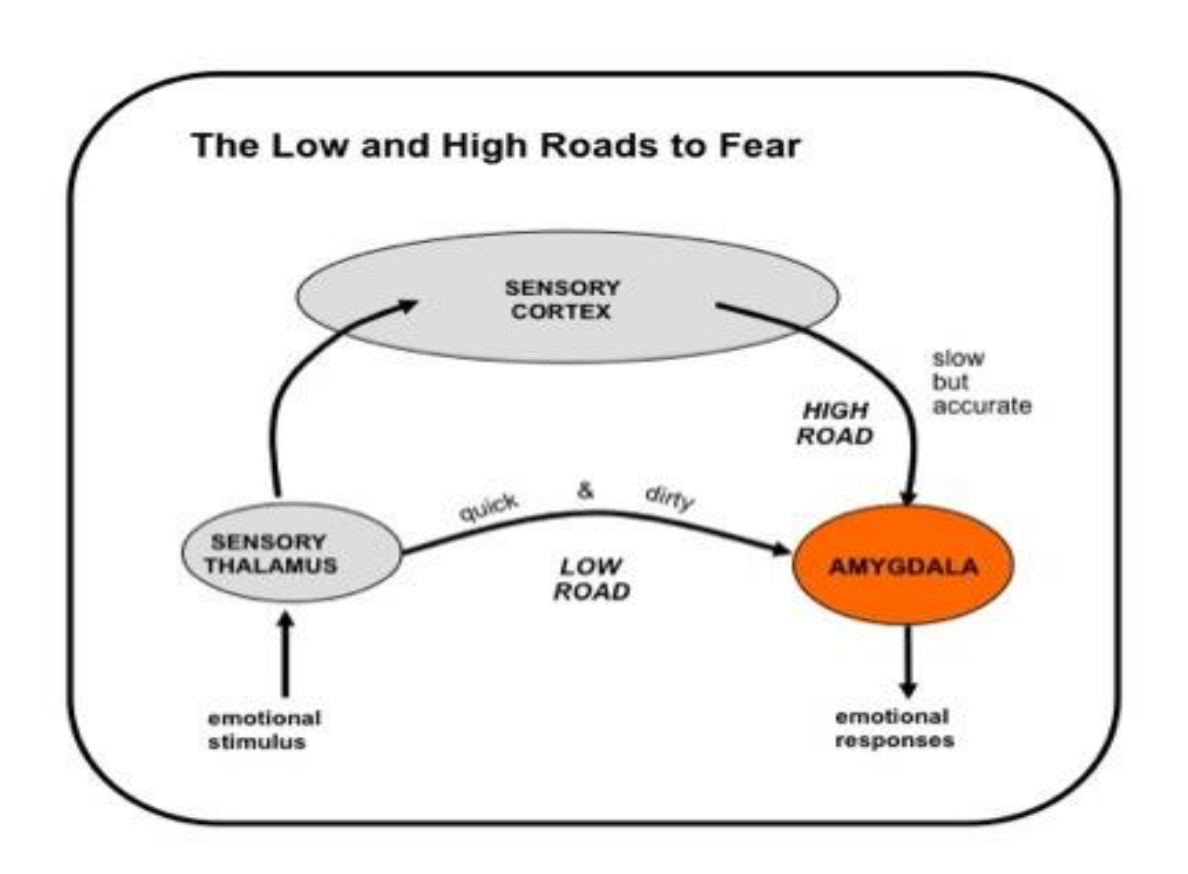
…and a minor car crash

Research suggests that alcohol and opioid interfere with the brain chemistry that underlies development of PTSD creating a protective effect

WHY ARE THESE DRUGS PROTECTIVE?


Thalamus
Visual cortex
Auditory cortex
Basolateral amygdala
Central amygdala
Central gray area of midbrain
Pons
Medulla
Spinal cord

HIGH ROAD, LOW ROAD BRAIN PROCESSING



TRUE PTSD INVOLVES A CHANGE IN THE STRUCTURE OF THE BRAIN AT A CELLULAR LEVEL

- When people are traumatized, fear and/or injury initiates the flight or fight response
- Part of this hormonal cascade involves the discharge of cortisol, which has a resource allocation and protective function
- Studies show that persons who have PTSD, have an abnormally low discharge of cortisol under stress
- This is genetic in origin
- These abnormally low cortisol levels result in the brain systems involved in memory coding the memory abnormally
- Insufficient glucocorticoid signaling results in enhanced consolidation of traumatic memories

THE SEDATIVE EFFECTS OF OPIOIDS AND ALCOHOL DIMINISH THE FIGHT OR FLIGHT RESPONSE

TAKEAWAY POINTS SO FAR

- The nature of the trauma matters, but trauma alone does not predict the onset or duration of PTSD
- PTSD is caused by external factors interacting with genetics
- This is why there is no trauma that would cause everyone to develop PTSD, no matter how intense the trauma
- Only those individuals who have certain vulnerabilities will develop PTSD
- Under no conditions will the majority of persons exposed to a given trauma develop PTSD

DSM-5
POST-TRAUMATIC STRESS DISORDER
(“PTSD”)
DIAGNOSTIC CRITERIA

Criterion 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 repeated 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.

Criterion B

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

- **Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).**
- **Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).**
- **Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic events were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)**
- **Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).**
- **Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).**

“Flashbacks” must involve reexperiencing that departs from “here and now” reality

Flashbacks do not occur in sleep, and they are not merely intense thoughts or memories of the trauma

Criterion 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:

- **Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).**

- **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).**

Criterion 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:

- **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).**
- **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").**
- **Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.**
- **Persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame).**
- **Markedly diminished interest or participation in significant activities.**
- **Feelings of detachment or estrangement from others.**
- **Persistent inability to experience positive emotions (e.g. inability to experience happiness, satisfaction, or loving feelings).**

Criterion 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:

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

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

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

Significant Distress or Impairment

- Work Records

- Relationships

If you don't meet "G", you don't have PTSD

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

PTSD IS EASY TO MALINGER

BECAUSE MANY OF THE SYMPTOMS ARE SUBJECTIVE IN NATURE

THERE ARE NO DEFINITIVE PSYCHOMETRICS THAT CAN VERIFY, OR RULE OUT, THE PRESENCE OF PTSD.

NONE.

THE PROPER DIAGNOSIS OF PTSD IS INTENSELY CLINICAL, SUPPLEMENTED BY A CAREFUL REVIEW OF RECORDS

UNEXPERIENCED, OR POORLY TRAINED PSYCHOTHERAPISTS FREQUENTLY OVER-DIAGNOSE AND MISDIAGNOSE PTSD

THEY ALSO TEACH THE PATIENT ABOUT PTSD IN A WAY THAT ENABLES THE PATIENT TO MALINGER PTSD

SCREENING INSTRUMENTS FOR PTSD IN THE PLAINTIFF'S PSYCHOLOGICAL EXAMINATION ALSO TEACH THE PLAINTIFF ABOUT PTSD, AND ENABLE MALINGERING

A DIAGNOSIS OF PTSD IS MORE OFTEN WRONG THAN RIGHT.

THERE MAY BE A PSYCHIATRIC DIAGNOSIS, BUT IT IS NOT LIKELY TO BE PTSD. AND, IT MAY BE UNRELATED TO THE SUBJECT INCIDENT, EVEN THOUGH MANY PROVIDERS HAVE ATTRIBUTED IT TO THAT INCIDENT.

PAY ATTENTION TO:

PRE-INJURY HISTORY – HAVE THEY LOST FUNCTIONALITY? ARE THEY FUNCTIONING BETTER?

HAS THEIR RELATIONSHIP STATUS CHANGED?

HOW DO THEY BEHAVE IN THE EXAMINATION PROCESS?

DO THEY SHOW AN EMOTIONAL RESPONSE WHEN DISCUSSING THE TRAUMA?

DO THEY SEEM EAGER TO DISCUSS THE TRAUMA?

QUESTIONS AND ANSWERS