MMRO

Post Traumatic Stress Disorder and Disability

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Stressful events are a part of life; one cannot avoid being exposed to stress or stressful events. In fact, most people (up to 70% of people) will experience a traumatic event at some point in their lives. A subset will go on to experience distressing symptoms associated with these events, such as intrusive thoughts, nightmares, flashbacks of the traumatic event, avoidance of reminders of the trauma, hypervigilance, and sleep disturbance. These symptoms could affect social, occupational, and interpersonal functioning, impacting all areas of a person's life. This raises the question: Can one continue to work after trauma?

PTSD Defined

PTSD can be a severe, chronic, and disabling disorder that develops in some people after exposure to one (or more) traumatic event. It is characterized by intrusive thoughts, nightmares, flashbacks of the traumatic event, avoidance of reminders of the trauma, hypervigilance, and sleep disturbance. The symptoms of PTSD can lead to social, occupational, and interpersonal dysfunction, impacting all areas of a person's life.

DSM-5 defines PTSD in the following way:

Criterion A (1 required)	
The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):	✓ Direct exposure ✓ Witnessing the trauma ✓ Learning that the trauma happened to a close relative or close friend ✓ Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)
Criterion B (1 required)	
The traumatic event is persistently re-experienced in the following way(s):	✓ Unwanted, upsetting memories ✓ Nightmares ✓ Flashbacks ✓ Emotional distress after exposure to traumatic reminders ✓ Physical reactivity after exposure to traumatic reminders
Criterion C (1 required)	
Avoidance of trauma-related stimuli after the trauma, in the following way(s):	✓ Trauma-related thoughts or feelings ✓ Trauma-related reminders
Criterion D (2 required)	
Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):	✓ Inability to recall key features of the trauma ✓ Overly negative thoughts and assumptions about oneself or the world ✓ Exaggerated blame of self or others for causing the trauma ✓ Negative affect ✓ Decreased interest in activities ✓ Feeling isolated ✓ Difficulty experiencing positive affect
Criterion E (2 required)	

Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):	✓ Irritability or aggression ✓ Risky or destructive behavior ✓ Hypervigilance ✓ Heightened startle reaction ✓ Difficulty concentrating ✓ Difficulty sleeping
Criterion F (required)	
	✓ Symptoms last for more than 1 month
Criterion G (required)	
	✓ Symptoms create distress or functional impairment (e.g., social, occupational)
Criterion H (required)	
	✓ Symptoms are not due to medication, substance use, or other illness

Two specifications:

Dissociative Specification
In addition to meeting the criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- o Depersonalization. Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
- o Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real").

Delayed Specification
Full diagnostic criteria are not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

PTSD Epidemiology

Given the nature of stress and trauma, PTSD can develop as the result of many different types of life events. The most common types of traumatic events that result in PTSD are:

- ✓ sexual violence;
- ✓ the unexpected death of a loved one, life-threatening illness of a child, or other traumatic event of a loved one;
- ✓ interpersonal violence;
- ✓ exposure to “organized” violence (refugee, kidnapped, civilian war zone);
- ✓ participation in “organized” violence (military combat, witnessing death/serious injury of another, accidental or purposefully caused death/serious injury);
- ✓ other life-threatening events (life-threatening motor vehicle accident, natural disaster, etc.)

PTSD has a lifetime prevalence that ranges from 6.1% - 9.2% of the general adult population in the USA and Canada. The one-year prevalence rates of PTSD have been reported as 3.5%-4.7%. PTSD rates in law enforcement officers range from 6%-32%, EMT/paramedics from 9%-22%, and firefighters from 17%-32%. The development of PTSD is not predictable given that the vast majority of individuals exposed to trauma do not go on to develop a long-term trauma-related syndrome. Risk factors for the development of PTSD include:

- ✓ History of trauma exposure prior to the index traumatic event
- ✓ Less education
- ✓ Lower socioeconomic status
- ✓ Childhood adversity (including childhood trauma/abuse)
- ✓ Personal and family psychiatric history
- ✓ Gender
- ✓ Race
- ✓ Poor social support
- ✓ Physical injury (including traumatic brain injury) as part of the traumatic event
- ✓ Initial severity of reaction to the traumatic event

Given the unpredictable nature of developing PTSD, individual characteristics of the person exposed, as well as the nature and intensity of the traumatic event have been found to have an impact on whether an individual develops PTSD. It has been found that intentional trauma (involves the deliberate infliction of harm – i.e. warfare, arson, torture, terrorism, sexual assault, etc.) has a higher association with PTSD than unintentional/non-assaultive traumatic events. The duration of exposure to trauma has also been associated with a higher risk of developing PTSD.

Co-Occurring Disorders

There is a high prevalence of co-occurring psychiatric conditions with PTSD. The National Comorbidity Survey showed that 59% of men and 44% of women with PTSD met the criteria for 3 or more other psychiatric conditions. The most common comorbid conditions were mood disorders (particularly depression), anxiety disorders, and substance use disorders.

The diagnostic overlap of PTSD with other psychiatric conditions makes it difficult to separate which condition is causing what symptoms and also complicates the assessment in a disability setting. Symptoms such as sleep disturbance, poor concentration, and guilt are common in both depression as well as PTSD. Panic attacks and avoidance of triggers are common in anxiety disorders and PTSD. Given the overlap in symptoms, it has been suggested that when an individual presents with this constellation of symptoms their condition should be considered as a whole, and not as separate conditions. Regardless, in the disability setting it is critical to determine the specific complaints, symptoms, and functional capacities of the individual.

Substance use disorders are 2-4 times more prevalent in people with PTSD. Substance misuse is often the result of a person's attempt to decrease PTSD symptoms and reduce distress from the trauma. Another explanation for the relationship between substance use and PTSD is due to the high-risk lifestyle associated with substance use and that individuals are at higher risk of exposure to trauma. One other possible explanation is that individuals with substance use are more likely to develop PTSD due to poor coping strategies. Whatever the exact nature of this relationship between PTSD and substance abuse, assessment of the individual's overall functional capacities is necessary in the disability setting.

PTSD in the Workplace

Given the prevalence of PTSD in the general population it is not uncommon for people with PTSD to report symptoms that have an impact on workplace performance. Symptoms often include changes in mood, elevated anxiety, traumatic reminders, difficulties with focus and concentration, and dissociative episodes. The Social Security Administration considers PTSD as a disabling condition in some cases. The presence of PTSD symptoms or a PTSD diagnosis does not, in and of itself, preclude someone from engaging in work-related activities or being employed. Workplace conditions can influence and impact someone's ability to work with PTSD. The nature of someone's work, trauma-related symptoms, and co-morbid conditions play an important role in determining disability as a result of PTSD.

Typical workplace accommodations for PTSD include flexible scheduling (when possible), noise-canceling devices, allowing for phone calls to support persons throughout the workday, modifying break schedules, reduction of exposure to high-risk traumatic events (i.e. desk work vs being out in the field), and allowing for adequate time in the schedule for individuals to attend therapy and physician appointments. Additional accommodations may include reducing distractions, providing checklists and other organizational tools, and regular meetings with co-workers and management. A safety assessment of individuals who work in high-risk settings (police officers, firefighters, EMTs/paramedics, corrections officers, etc.) is also suggested to determine an individual's ability to make decisions under pressure and in high-stress situations.

The economic burden of PTSD is substantial. Davis et al. (2022) estimated the economic burden in the USA due to PTSD was $232.2 billion in 2018.

Total excess direct health care costs due to PTSD were estimated to be $76.1 billion ($66 billion in the civilian population). Of the 1.2 million individuals receiving disability due to PTSD, 86% were from the civilian population. PTSD accounted for an estimated $14.5 billion in excess costs of disability benefits. Unemployment due to PTSD was estimated to be $42.7 billion for the US general population. In the general US population, 9.7 and 33.1 excess days per year were lost due to PTSD-related absenteeism and presenteeism, respectively, among adults with PTSD. This translates into an excess cost of productivity loss at work due to PTSD of an estimated $29.2 billion in the US civilian population.

Evaluating PTSD-Related Disability

As with all psychiatric conditions, there are no clear, outward, physical manifestations of PTSD. People live with trauma-related symptoms and are able to function in many aspects of their lives. The majority of people exposed to trauma do not go on to develop PTSD, and the majority of people diagnosed with PTSD are not considered disabled or unable to engage in work-related activities. Given the "silent" nature of trauma symptoms, as well as the preserved functioning in most people with PTSD, there needs to be medical documentation to support trauma-related symptoms resulting in impairment in occupation functioning.

In addition, impairment in occupational functioning may be specific to certain occupations and is not necessarily global in nature. Trauma-related symptoms and impairment may be limited to specific circumstances or situations, and not global in nature. Accommodations to limit exposure or decrease the risk of re-traumatization can assist in returning someone with PTSD to the workforce. Alternative work environments or new occupations are also effective interventions to reduce the burden of trauma symptoms and improve functioning.

Like all psychiatric conditions, the diagnosis of PTSD relies heavily on the clinical interview and the self-report of the individual being evaluated. A comprehensive medical and psychiatric history, reviewing childhood and social history is essential to any psychiatric evaluation. Assessment and reporting of an

individual's complaints and reports of traumatic events, onset of symptoms, and nature of symptoms is also a part of any psychiatric evaluation. Work history should be included and [is/may be] a helpful guide.

Structured psychological screening tests and diagnostic tests can be of benefit to better describe an individual's symptoms, personality style, tendency, and reliability of reporting symptoms, and to assess for malingering.

Diagnostic testing/rating scales include the PCL-5 (which is specific for PTSD), PHQ-9 (for depression), GAD-7 (for Generalized Anxiety Disorder), and other clinical screening tests. These tests are useful as they are self-rated and provide insight into an individual's report of symptoms. There are limitations to self-reported scales such as these, including the potential for over-reporting symptoms and distress. In a disability setting, the presence of symptoms, and even high scores on self-rated scales such as these do not necessarily translate into disability or impairment. It is useful to explore what functional capacities an individual has when assessing for disability. The above-cited rating scales are often useful in a diagnostic setting to help establish a diagnosis and/or to track symptoms. The presence of symptoms/complaints does not necessarily impact one's ability to manage daily needs, interact with others, complete tasks, organize oneself, or result in cognitive impairment. Additionally, impairment may not be global in nature, affecting all areas of an individual's functioning, again necessitating assessment of functioning in all areas of life.

The MMPI-2 is a 567-item (true/false) self-report measure designed to assess personality and psychopathology, although it is also used extensively outside of mental health and medical settings. The MMPI-2 has several validity scales designed to evaluate the accuracy with which test takers respond to test items and to predict distorted presentations. These include scales to detect the under- or over-reporting of symptoms. On average this assessment takes 90-120 minutes to complete, and a standardized report is generated from the individual's answers. This test can be very helpful in assessing for exaggerating impairment.

Millon Clinical Multiaxial Inventory (MCMI-III) is a 175-item self-report scale (true/false items) that takes about 30 min to complete. With a focus on personality disorders, its 28 subscales comprise the following categories:

- ✓ Modifying Indices (including validity items)
- ✓ Clinical Personality Patterns
- ✓ Severe Personality Pathology
- ✓ Severe Syndrome
- ✓ Clinical Syndrome

Atypical patterns, extreme scores, or high invalidity can suggest malingering.

The Miller Forensic Assessment of Symptoms (M-FAST) is a brief screening measure designed to detect malingered mental illness in forensic settings by assessing individual response styles.

There are many other rating scales and tests that can be administered to assess symptoms as well as the potential for symptom exaggeration or malingering. Standardized testing can assist in confirming the presence of symptoms and a diagnosis, as well as an individual self-reported level of distress at the time of administering the testing.

Additional areas of assessment may need to be considered when assessing individuals who work in the public safety arena (i.e. Police/Fire/EMS/Prison Guard). Assessing an individual's ability to be safe in high-stress situations, make decisions when under duress, maintain their own and other's safety, interact with others in an appropriate manner, and manage high emotions, is essential when reviewing the impact of PTSD symptoms and the capacity to work in this population. Individuals who have suffered a traumatic event while in the workplace may require a gradual return to work, initially with accommodations that minimize the

risk of re-exposure and/or re-traumatization. Supporting an individual with PTSD to pursue treatment that minimizes the impact of trauma on their level of functioning is also highly encouraged.

The presence of symptoms and/or a diagnosis of PTSD does not in and of itself translate into disability. In the course of a clinical interview, it is essential to also explore and discuss an individual's daily life, activities, and engagement in life. Trauma-related symptoms may impact an individual in a specific area(s) of life and may not be global in nature. Additionally, the nature of psychiatric disorders (including PTSD) is that symptom intensity typically waxes and wanes. Given that PTSD is typically not globally impairing, individuals are able to work within limitations and/or restrictions that minimize re-exposure to trauma or in alternative fields of employment. When applicable, efforts to reduce/eliminate risks or re-exposure and/or re-traumatization are appropriate if impairment is present.

Treatment for PTSD

PTSD is a readily treatable disorder that can involve multiple types of interventions. Treatment includes medications, as well as psychosocial/therapy interventions aimed at symptom reduction and improvement in functional capacities. As stated above, the majority of individuals exposed to trauma recover within several weeks (studies suggest upwards of 90% recovery). Treatment to address subsyndromal PTSD as well as individuals with PTSD is noted to improve functioning. Specifically, treatment goals include maintaining the safety of the individual and others around the individual (when applicable), decreasing distress related to re-experiencing symptoms, decreasing hyperarousal, reducing avoidant behaviors, reducing the risk of relapse, and addressing comorbid/co-occurring disorders.

The mainstay of medication treatment includes the use of a class of medications known as selective serotonin reuptake inhibitors, or SSRIs (Prozac, Zoloft, Celexa, and others), as well as the other antidepressant/anti-anxiety medications commonly prescribed for mental health conditions. SSRIs have been shown to be the most effective medication intervention to reduce the symptom burden associated with PTSD; other classes of antidepressants are also noted to be effective, although not as robust.

Sleep disturbances are often difficult to treat in PTSD. PTSD-related nightmares are the most common symptom targeted with medication. Prazosin is often used as an augmenting agent to antidepressants. There is mixed evidence of the efficacy of this medication.

Second-generation antipsychotics are often used as adjunctive medications in the treatment of PTSD. While these medications are frequently prescribed to address residual symptoms of anxiety and distress, the current medical literature is mixed regarding the efficacy of these medications for PTSD.

Non-pharmacologic interventions have been shown to be highly effective in reducing symptoms of PTSD and improving function. Trauma-focused therapy includes cognitive-behavioral therapy, exposure-based therapy, eye movement desensitization and reprocessing (EMDR), as well as more traditional psychotherapy. PTSD is not necessarily a permanent condition. Studies have shown that 95% of individuals diagnosed with PTSD recover within 1 year. The goals of therapy are not always at the total elimination of symptoms but at the reduction of the impact of symptoms on functioning. Exact data on remission rates is not available, and studies have repeatedly shown that therapy is highly effective in improving functioning and reducing symptom burden. The benefits of treatment have been demonstrated to last at least 12 months (or longer) after treatment. The goals of treatment may not be complete remission and may be better framed as reduction of symptoms such that an individual can be engaged in all aspects of life.

In individuals with more intense symptoms and impairment, there are various higher levels of care that can be of benefit in reducing symptoms. When acute care is needed due to safety concerns, suicidal or homicidal thinking, extreme dissociation, or an inability to care for oneself, an individual may need inpatient

psychiatric treatment. Residential treatment for PTSD may be an option for an individual who requires 24-hour care. There are a number of specialized residential treatment settings for individuals with PTSD in specific occupations such as former military/veterans, first responders, and other occupations. These settings provide comprehensive treatment with a focus on all aspects of the individual's condition.

Other treatment settings include partial hospitalization programs and intensive outpatient programs. All of the above higher levels of care typically include group treatment, individual therapy, as well as assessment and management of an individual's psychiatric conditions and needs with medications by a psychiatrist (or psychiatric provider).

Conclusion

As noted, PTSD is a highly treatable condition, which responds to therapy as well as medications. Upwards of 95% of individuals diagnosed with PTSD recover within 1 year, however, the goals of treatment and recovery are not always at the total elimination of symptoms but are shown to be highly effective in improving functioning and reducing symptom burden. Treatment goals include maintaining the safety of the individual and others around the individual (when applicable), decreasing distress related to re-experiencing symptoms, decreasing hyperarousal, reducing avoidant behaviors, reducing the risk of relapse, and addressing comorbid/co-occurring disorders. These treatment goals will also have an impact on occupational functioning such that such workplace restrictions or limitations may be necessary given the nature of reducing symptoms and improving overall functioning. The presence of symptoms of PTSD symptoms is not, in and of itself, a disabling condition and speaks to the need for a more in-depth assessment of functional capacities. Such evaluations, which take into account all aspects of an individual's life and functioning allow for a more nuanced approach to disability due to PTSD.

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