DSM-V: Diagnosing PTSD in Military Veteran

Cora Gipson-Prude, CRNP
Coordinator

Judy Martorana, CRNP
Speaker
Outline

• Overview of PTSD
• Symptoms of PTSD
• Diagnosing PTSD
  • PCL
  • DSM-V (upgrade of DSM IV)
• Recognizing Military PTSD
• History
• Epidemiology
• Suicide Rate
• Cost
• Treatment
• Case Study
Overview

- Posttraumatic stress disorder (PTSD) is no longer categorized as an anxiety disorder but a trauma- and stressor-related disorder that a person may develop after exposure to actual or threatened death, serious injury or sexual violence.

- The symptoms include anxiety or fear-based symptoms, anhedonic and dysphoric symptoms, externalizing anger or aggressive symptoms, dissociative symptoms, or a combination (requiring fear, helplessness, or horror after the trauma is no longer required for DSM 5).

- A traumatic event is something terrible and scary that a person may witness, hear about, or experience, such as:
  - Combat exposure or war
  - Unexpected death of a love one
  - Terrorist attack
  - Sexual or physical assault
  - Serious accidents, like a car wreck
  - Natural disasters, like a fire, tornado, hurricane, flood, or earthquake

- It is normal to have stress reactions after a traumatic event or life-threatening event; however, a traumatic event resulting in overwhelming stress reactions that exceed a month is the hallmark of PTSD. The stress associated with PTSD may take several forms such as pathological anxiety, fears, phobias and nervous conditions that may come on suddenly or gradually over a period of several years, and may impair or prevent social interactions, capacity to work or other areas of functioning.
Symptoms of PTSD

There are four types of symptoms of PTSD:

- **Reliving the event (also called re-experiencing symptoms)**
  - Nightmares
  - Flashback
  - Triggers

- **Avoiding situations that remind you of the event**
  - Avoid crowds
  - Avoid driving
  - Avoid watching TV
  - Avoid seeking help

- **Negative changes in beliefs and feelings**
  - Reluctant to feel, love or have a relationship
  - Forget the traumatic event
  - Fail to trust

- **Feeling keyed up (also called hyper-arousal)**
  - Difficulty sleeping
  - Trouble concentrating
  - Easily startled
  - Hypervigilance

(National Center for Post-Traumatic Stress Disorder, 2014)
Detecting PTSD

- PTSD Screening and Referral: For Health Care Providers (PC-PTSD)
- Clinician-Administered PTSD Scale (CAPS)
- PTSD Check List (PCL)

Note: These are currently based on DSM-IV and is being revised in accordance with DSM-V.
PC-PTSD

- 4-item questionnaire designed for use in primary care and other medical settings.
- Brief and problem-focused.
- Used by VA to screen for PTSD in veterans
CAPS

- Gold standard for PTSD assessment
- Structured interview that provide categorical diagnosis, as well as a measure the severity of PTSD symptoms
- Administered by any trained person and takes 30-60 minutes.
PCL

- 17 item self-report scale for PTSD
- Different version: Military (M) and Civilian (C), as well as a version focused on a "specific stressful experience" (S).
- 5 to 7 minutes to complete
DSM-V

• DSM stands for Diagnostic and Statistical Manual of Mental Disorders.

• DSM provides standard criteria and common language for the classification of mental disorders. It is published by the American Psychiatric Association.

• DSM-V is the fifth revision that was released in May 2013. This revision is an upgrade of DSM-IV and, it includes changes to the diagnostic criteria for PTSD and Acute Stress Disorder.
DSM-V

Criterion A: stressor

• The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)
  • Direct exposure.
  • Witnessing, in person.
  • Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
  • Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

(American Psychiatric Association & American Psychiatric Association, 2013)
DSM-V

Criterion B: intrusion symptoms

- The traumatic event is persistently re-experienced in the following way(s): (one required)
  - Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
  - Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
  - Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
  - Intense or prolonged distress after exposure to traumatic reminders.
  - Marked physiologic reactivity after exposure to trauma-related stimuli.

(American Psychiatric Association & American Psychiatric Association, 2013)
**DSM-V**

Criterion C: avoidance

- Persistent effortful avoidance of distressing trauma-related stimuli after the event: *(one required)*
  - Trauma-related thoughts or feelings.
  - Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

(American Psychiatric Association & American Psychiatric Association, 2013)
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Criterion D: negative alterations in cognitions and mood

- Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)
  - Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
  - Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
  - Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
  - Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
  - Markedly diminished interest in (pre-traumatic) significant activities.
  - Feeling alienated from others (e.g., detachment or estrangement).
  - Constricted affect: persistent inability to experience positive emotions.

(American Psychiatric Association & American Psychiatric Association, 2013)
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Criterion E: alterations in arousal and reactivity

- Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)
  - Irritable or aggressive behavior
  - Self-destructive or reckless behavior
  - Hypervigilance
  - Exaggerated startle response
  - Problems in concentration
  - Sleep disturbance

(American Psychiatric Association & American Psychiatric Association, 2013)
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Criterion F: duration
- Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

Criterion G: functional significance
- Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion
- Disturbance is not due to medication, substance use, or other illness.

(American Psychiatric Association & American Psychiatric Association, 2013)
Specify if: With dissociative symptoms.

- In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
  - **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).
  - **Derealization**: experience of unreality, distance, or distortion (e.g., "things are not real").

Specify if: With delayed expression.

- Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

(American Psychiatric Association & American Psychiatric Association, 2013)
Recognizing Military PTSD

- One in five veterans suffer with combat-related post-traumatic Stress Disorder (PTSD)
- Victims of Military PTSD: Those who spent time overseas and experienced war, violence (torture), bloodshed and death, and sexual or physical assault.
- Commonly experienced symptoms of military PTSD include:
  - inappropriate anger or irritability
  - insomnia
  - problems on the job and at home
  - acting detached or distant;
  - having trouble with social events such as weddings, funerals and other family gatherings
  - being easily startled or hyper vigilant

(Croft, 2013)

- Video: [http://www.youtube.com/watch?v=SqjwV-lsVEs](http://www.youtube.com/watch?v=SqjwV-lsVEs)
History of Military PTSD

- Civil War: Irritable Heart
- World War I: Shell Shock or Effort Syndrome
- World War II: Combat Stress Syndrome
- Vietnam: Concept of PTSD derived
- Gulf War Syndrome
- PTSD entered DSM III in 1980
Epidemiology

- **Prevalence of PTSD in USA**
  - 5.2 million adult Americans or 3.6% adults ages 18 to 54 (NIMH); Approx. 1 in 52 or 1.91%
  - about 30% of war veterans.

- **WORLD WAR II, 1939-1946**
  - The NC PTSD: ~ 1 of 20 WWII veterans suffered sx of bad dreams, irritability & flashbacks.
  - Department of Veterans Affairs' statistics in 2004, 25,000 WWII vets were still receiving disability compensation for PTSD-related symptoms.
  - The most poorly treated prisoners of war < symptoms than front-line soldiers due to prisoners were no longer in a position where they had to kill.

- **KOREA, 1950-1955**
  - a Korean researcher: ~ 30 percent of U.S. troops who fought in Korea and present have symptoms of PTSD

- **Vietnam, 1960-1975**
  - 1986-1988 study by the National Vietnam Veterans Readjustment Survey (NVVRS): 15.2% of men (479,000 out of 3,140,000 ) and 8.1% of women (610 out of 7,200) with PTSD
  - Almost half of all male Vietnam veterans suffering from PTSD had been arrested or in jail at least once, 34.2 percent more than once and 11.5 percent had been convicted of a felony, according to the same survey.
  - VA statistics in 2004 showed that 161,000 veterans were still receiving disability compensation for PTSD.
  - A major VA study found that about 31 percent of men and 27 percent of women had suffered from PTSD at some point after their return from Vietnam.

(Epstein & Miller, 2005)
Epidemiology

- Persian Gulf War, 1991
  - 1996 study in the Journal of Traumatic Stress: Rates of PTSD: Gulf War vets < military personnel from prior wars due to lower levels of exposure to combat.
  - 1999 study by the Journal of Consulting and Clinical Psychology: Rates of PTSD: iGulf War veterans increased significantly over time, with a rate of 3 percent for men, 8 percent for women immediately upon return from the war, climbing to 7 percent for men and 16 percent for women followed up 18 to 24 months later. These rates are higher than what has been found among veterans not deployed to the Persian Gulf. Approximately 697,000 service members were deployed to the Persian Gulf.
- OIF/OEF, 2001 +
  - AFGHANISTAN:
    - A recent study showed that 18 percent of 45,880 veterans were diagnosed with psychological disorders, including 183 with PTSD.
  - IRAQ:
    - According to a 2005 VA study of 168,528 Iraqi veterans, 20 percent were diagnosed with psychological disorders, including 1,641 with PTSD.

(Epstein & Miller, 2005)

- General Population:
  - Women twice as likely as men to have a diagnosis of PTSD at some point in their lifetime.
  - Specifically, 10.4% of women and 5% of men have PTSD at one time or another in their lifetime.

(Nebraska, 2007)
Epidemiology

- In an earlier VA study this year, almost 12,500 of nearly 245,000 veterans visited VA counseling centers for readjustment problems and symptoms of PTSD.

- The Marines and Army were nearly four times more likely to report PTSD than Navy or Air Force because of their greater exposure to combat situations.

- Enlisted men were twice as likely as officers to report PTSD.

- 8 percent to 10 percent of active-duty women and retired military women who served in Iraq suffer from PTSD.

- Studies show that U.S. women serving in Iraq suffer from more pronounced and debilitating forms of PTSD than their male counterparts.

- A Defense Department study of combat troops returning from Iraq found 1 in 6 soldiers and Marines acknowledged symptoms of severe depression and PTSD, and 6 in 10 of these same veterans were unlikely to seek help out of fear their commanders and fellow troops would treat them differently.

- A 2003 study published in the New England Journal of Medicine said about 1 in 6 soldiers returning from Iraq suffered from PTSD. Interviews with those at risk showed that only 23 percent to 40 percent sought professional help, most typically because they feared it would hurt their military careers.

(Epstein & Miller, 2005)
PTSD and Common Comorbidities

People with PTSD may also have other problems. Research suggests the following comorbid prevalence rates:

- Lifetime PTSD and...
  - 1 or more psychiatric disorder(s): 88.3% of men and 79.0% of women
  - 3 or more psychiatric disorders: 59% of men and 44% of women

- Common comorbid conditions include:
  - Major Depressive Disorder (MDD) 47.9% Men, 48.5% Women
  (means that 47.9% of PTSD male sufferers also had MDD during PTSD's course)
  - Social Phobia 27.6% Men, 28.4% Women
  - Simple Phobia 31.4% Men, 29.0% Women
  - Alcohol Abuse/Dependence 51.9% Men, 27.9% Women
  - Drug Abuse/Dependence 34.5% Men, 26.9% Women
  - Dysthymia 21.4% Men, 23.3% Women

(Grinage, 2003)
Military Suicide Rate

- Suicides among active-duty military personnel averaged one per day in 2012.
- Veterans now account for 20 percent of all suicides in the U.S.
- Greatest among the youngest veterans, age 17-24 yo and primarily those returning from Iraq and Afghanistan, taking their lives at four times the rate compared to other veteran age groups.

(Face The Facts USA, 2013)
Money Spent in Treatment

• Health care for veteran with PTSD costs 3.5 times as much as care for those without the disorder
• Average cost per veteran: $8,300 in the first year
• Treatment for Iraq and Afghanistan vets suffering PTSD has cost more than $2 billion so far.

(Face The Facts USA, 2013)
Basic Management of PTSD

- Comorbid depression – treat PTSD first.
- Substance dependence should be addressed first before treating PTSD.
- Support, guide veteran in confronting the trauma, and educate about coping skills.
- Sedatives and hypnotics can be helpful.
Pharmacology Treatment

- **SSRI**: Sertraline and paroxetine are considered first-line treatments for PTSD.
- **TCA**: Imipramine and amitriptyline
  - Dosages same as those used to treat depressive disorders,
  - Trial should last at least 8 weeks and maintenance for at least 1 year if respond well
- **MAOI**: Phenelzine and trazodone are effective in reducing re-experiencing symptoms and insomnia
- **Alpha-1-Adrenergic Receptor Antagonists**: Prazosin for PTSD associated nightmares
- **Anticonvulsants**: Carbamazepine and valproate
- **Benzodiazepines**: Do not appear to be effective although they may show some effects on insomnia, irritability, and general anxiety and arousal symptoms.

(Beck & Sloan, 2012)
Cognitive Behavior Therapy

CBT provides

- Education
  - Inform about the symptoms of PTSD
  - Inform about treatment rationales
  - Inform about common reactions to trauma
  - Make veteran aware and discourage behaviors that drive issues, such as avoidance and safety behaviors.
    - Avoidance is one of the main symptoms of PTSD, and it can thus take years for the patient to seek help for this condition.

- Self-monitoring of symptoms
  - self-monitoring may in itself be therapeutic
Exposure Therapy

- Exposure therapy aims to help clients overcome the natural tendency to avoid stimuli related to the trauma and involves having the client repeatedly expose themselves to:
  - The memory of the traumatic event(s) (imaginal exposure)
  - Real-world stimuli (people, places, things) that are reminders of the traumatic event (in vivo exposure).
- Exposure is repeated until the patient no longer responds with high levels of distress.
- Helps in correcting dysfunctional beliefs about danger.
Cognitive Therapy

- For anxiety disorder, it focuses on identification and modification of misinterpretations that lead to overestimation of threat and underestimation of their coping abilities.
- But in PTSD, the perceived threat arise from the interpretation of trauma and its consequences.
- The patient is encouraged to drop behavior and cognitive strategies that leads to negative interpretation.
- Negative thoughts are replaced with more accurate and less disturbing thoughts.
Eye-movement desensitization reprocessing

- Patient is instructed to focus on a trauma-related image and its accompanying feelings, sensations, and thoughts, while visually tracking the therapists fingers as they move back and forth in front of the patients eyes.
- For example, patient talks about memories while focusing on distractions like eye movements, hand taps, and sounds.
- After a set of approximately 24 eye movements, cognitive and emotional reactions are discussed with the therapist.
- Once the distress to traumatic image is reduced coping statements are also introduced while the scene is being imagined.
Psychodynamic therapy

- The goal of the treatment is to work through and resolve an unconscious conflict which the traumatic event is thought to have provoked.
Stress Inoculation Therapy (SIT)

- Provide education about anxiety as well as training in coping or anxiety management skills (i.e., deep muscle relaxation, breathing control, thought-stopping, assertiveness training, reassuring self-talk).
- Goal of SIT is to “inoculate” individuals with PTSD from experiencing an increased stress response by utilizing anxiety management skills.
Other: Hypnotherapy

- The goal of this treatment is to enhance control over trauma-related emotional distress and hyper-arousal symptoms and to facilitate the recollection of details of the traumatic event.
- The effect is below trauma focused CBT or EMDR.
Case Study 1

Joe a 36 yo single, no children OEF/OIF veteran reported for his PCP visit and a summary revealed the following:

- Joe saw a good deal of active combat during his time in the military. Some incidents in particular had never left his mind – like the horrifying sight of Gary, a close comrade and friend, being blown-up by a land-mine. Even when he returned to civilian life, these images haunted him. Scenes from battle would run repeatedly through his mind and disrupt his focus on work. Filing up at the gas station, for example, the smell of diesel immediately rekindled certain horrific memories. At other times, he had difficulty remembering the past as if some events were too painful to allow back in his mind. He found himself avoiding socializing with old military buddies, as this would inevitably trigger a new round of memories. His girlfriend complained that he was always pent-up and irritable – as if he were on guard, and Joe noticed that at night he had difficulty relaxing and falling asleep. When he heard loud noises, such as a truck back-firing he literally jumped, as if he was readying himself for combat. He also stopped caring about his relationship and isolated himself from friends. He began to drink heavily to ease his mind.

- PC-PTSD revealed the following: Yes to 3 of the 4 questions.

(Cohen, 2006)
Questions and Answer

Should Joe receive referral for PTSD?
YES

List 4 indications.

- Re-experiencing
  - Filing up at the gas station, for example, the smell of diesel immediately rekindled certain horrific memories.
  - When he heard loud noises, such as a truck back-firing he literally jumped, as if he were readying himself for combat.

- Avoiding situations
  - He found himself avoiding socializing with old military buddies, as this would inevitably trigger a new round of memories.

- Negative changes in feelings
  - He also stopped caring about his relationship and isolated himself from friends.

- Hyper-arousal
  - pent-up and irritable
  - difficulty relaxing and falling asleep
Case Study 2

- Cindy is a married 26-year-old Army Reservist who is seeing you 6 months post-deployment after serving in Iraq for 12 months. Cindy sustained a mild injury when the vehicle ahead of hers in a convoy hit an IED killing 2 members of her unit and seriously injury 2 more. Cindy assisted in caring for the wounded until they were medically evacuated from the scene. Prior to serving in Iraq, she sought treatment for a rape that had occurred when she was a teenager. She reported feeling alternately numb, hyper-aroused, and depressed. She indicated having flashbacks to being wounded and to being raped, noting that she was avoiding others, having nightmares, and regrets her service in the Army. She also indicated that she sometimes feels like “just checking out.”

(Essential Learning, 2014)
Questions and Answers

What do you think are some of the issues that should be addressed further?

- Previous experiences of abuse and current comorbid conditions such as alcohol/substance abuse and depression.
- Anger and PTSD symptoms (numbness, arousal, re-experiencing the event).
- Potential suicidality also require careful assessment and documentation.
- Evaluation of potential loss of consciousness due to blast related injury.
- PTSD screening. If Cindy meets criteria for PTSD, moving forward with an empirically-based treatment seems to be indicated.
The End

Forum open.
Reference