PTSD: A Skeptic's View

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Behavioral Health –
Spring Professional Seminar

A Skeptic's View of PTSD
Jim Andrikopoulos, Ph.D., ABPP
Central DuPage Hospital

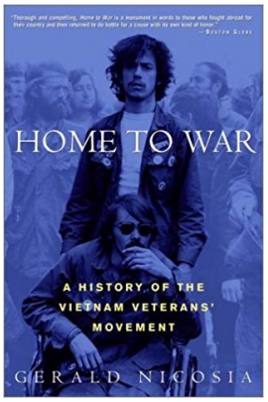
Friday, June 1, 2018; 1-4pm, 3 CE Units, Fee $20

How did I get into this line of work?

- Andrikopoulos, J & Greiffenstein, M. F. (2012). Something to talk about: The status on post-traumatic stress disorder in clinical neuropsychology. In Larrabee, G. J. (Ed.). *Forensic Neuropsychology. A Scientific Approach* (2nd Ed, pp. 365-400). New York: Oxford University Press.
- Andrikopoulos, J. (2018). The assessment of PTSD. In J.E. Morgan & J.H. Ricker, (Eds.), *Textbook of clinical neuropsychology* (2nd ed., pp. 757-791). New York: Psychology Press. University Press.
- Andrikopoulos, J. (In Preparation). Medicolegal aspects of PTSD. In K. B. Boone (Ed, 2nd ed), *Assessment of feigned cognitive impairment:* New York: Guiliford Press.

Political Science Creating Science

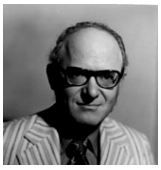
Part I: The History of PTSD



Inventing PTSD

"I will argue that this generally accepted picture of PTSD, and the traumatic memory that it underlies it, is mistaken. The disorder is not timeless, nor does it possess an intrinsic unity. Rather is it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources."

Young, A. (1995). *The Harmony of Illusions: Inventing PTSD,* p. 5.



Shatan

Lifton

Horowitz

Haley

Figely

Post-Vietnam Syndrome

- Lifton, R. J. (1973) *Home from the War, Vietnam Veterans. Neither Victims or Executioners.* New York, Simon & Schuster Inc.
- Haley, S. A. (1974). When the patient reports atrocities. Specific treatment considerations of the Vietnam Veteran. *Archives of General Psychiatry,* 191-196.
- Horowitz, M. J., et al. (1976). *Stress Response Syndromes* . New York: Aronson.
- Figley, C. R. (Ed). (1978) *Stress Disorders Among Vietnam Veterans: Theory, research and treatment*. New York: Brunner/Mazel

The New York Times

From Dak To to Detroit: The Life and Death of a Troubled Vietnam Hero

By Jon Nordheimer
May 26, 1971

The New York Times

Post-Vietnam Syndrome

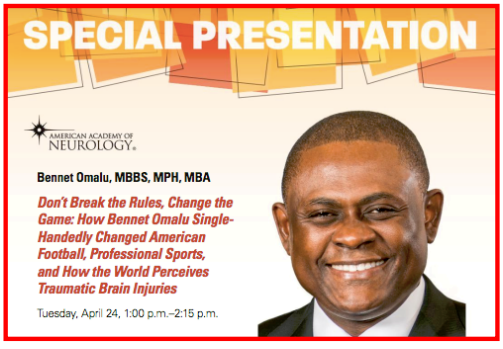
In the group raps, certain commonly shared concerns have emerged. Since they do not fit any standard diagnostic label, we refer to them loosely as the post-Vietnam syndrome.

Shatan, C. F. *The New York Times*, May 6, 1972

The New York Times

Expert Ties Ex-Player's Suicide to Brain Damage

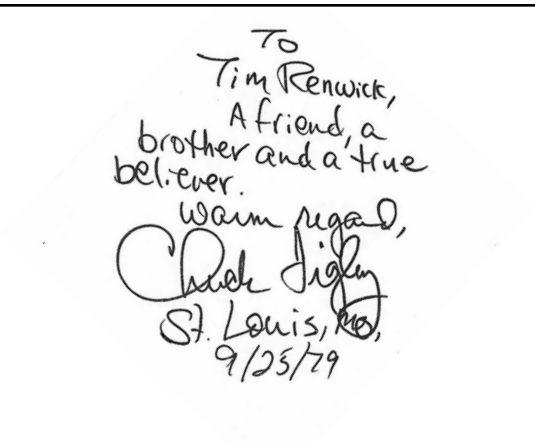
by Alan Schwartz
January 18, 2007



Skeptics and Enthusiasts in Neuropsychiatry

- Suspected partial seizures
- Mild Head Injury
- Attention problems in bright adults
- Pain disproportionate to physical signs
- Rehabilitative Therapies

Fogel, B., et al. (1992). *Journal of Neuropsychiatry & Clinical Neurosciences,* 4, 458-462.



The Washington University Experience

- Narcotic use in southeast Asia and afterward. An Interview study of 898 Vietnam returnees -1975
- Antecedents of narcotic use and addiction. A study of 898 Vietnam veterans -1976
- Depressive disorders in Vietnam returnees -1976
- The course of alcohol problems in Vietnam veterans -1979
- Depression in Vietnam veterans and civilian controls -1979

PTSD The General Population Epidemiologic Catchment Area Survey

- St. Louis in 1981, 3004 household residents interviewed
- "psychologically traumatic event that is generally outside the range of usual human experience"
- Vietnam Veterans
  - in combat but not wounded 4% met criteria
  - wounded combatants,20% met the criteria

Helzer, J. E., et al. (1987*). NEJM, 317,* 1630-1634.

St. Louis Study

"…it exists but is uncommon except among wounded Vietnam veterans. …the symptoms were usually few and seldom included the features that were claimed to be the hallmarks of the post-Vietnam syndrome: ***long-delayed onset, guilt***, belief that the traumatic experience is ***recurring***, and ***emotional numbing***. The common symptoms were hyperalertness, sleep problems, and nightmares.

Helzer, J. E., et al. (1987). *NEJM, 317,* p. 631

PTSD is not a *de novo* diagnosis

"..we believe that post-traumatic stress disorder is not a de novo diagnosis whose entrance into the DSM-III was politically motivated, but rather that it is a serious psychiatric condition affecting many men and women who have survived life-threatening events, including ***combat***, ***rape***, ***political torture***, and other ***disasters*** that often occur in the course of world events. Its effects should not be minimized."

Keane, T. M., et al. (1988). *NEJM, 318*, p. 1691.

National Vietnam Veterans Readjustment Study

Current PTSD
- 15.2% male veterans
- 8.5% female veterans

Partial PTSD
- 11.1% males veterans
- 7.8%female veterans

Lifetime PTSD
- 30.6% male veterans
- 26.9% female veterans

Kulka, R. A., et al. (1990). *Trauma and the Vietnam War Generation*. Brunner/Mazel.

Epilogue: "A self-guide for Vietnam Veterans."

HELP FOR PTSD

"The only report that should not be accepted at face value, although one may choose not to challenge it, is the patient's report that combat in Vietnam had no effect on him."

Sarah Haley, 1974

*Kulka, R. A., et al. (1990). *Trauma and the Vietnam War Generation, p.286.*

Editorial Note: Charles Figley

"… perhaps when next confronted with the prospect of sending citizens to fight a war - the purpose of which is questionable - policymakers will consider these findings. Perhaps they will be moved to acknowledge the vast and enduring costs of such a war to an entire generation of this country's children. Perhaps. "

Kulka, R. A., et al. (1990). *Trauma and the Vietnam War Generation. p. xxi*

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Part II: The History of DSM

DSM I Gross Stress Reaction

- overwhelming fear
- reversibility of reaction / its transient character
- temporary diagnosis until a more definite diagnosis is established
- justified only when exposed to severe physical demands or extreme emotional stress
- specified as combat or civilian catastrophe

APA. (1952). *Diagnostic and Statistical Manual of Mental Disorders.*

DSM-III "PTSD"

A. Stressor that would evoke distress in almost anyone
B. Re-experiencing
1. Recollections of the event
2. Dreams
3. Act or feel it was happening again
C. Emotional numbing
4. Loss of interest in activities
5. Feeling detached or estranged
6. Constricted affect
D. Two of the following:
7. Hyper-alertness or startle response
8. Sleep disturbance
9. Guilt
10. Memory or concentration problems
11. Avoidance of activities
12. Intensification of symptoms worsen when exposed to reminder

APA. (1980). *Diagnostic and Statistical Manual of Mental Disorders.*

Nancy Andreasen

Outside the Range of Human Experience What does Andreasen have to say?

"In my view, this broadening should be reconsidered. Giving the same diagnosis to death camp survivors and someone who has been in a motor vehicle accident diminishes the magnitude of the stressor and the significance of PTSD."

Andreasen, N. C. (2004). *The American Journal of Psychiatry*, *161*, p. 1322

Can we fix PTSD in DSM-5?

NO

McNally, R. J. (2009). *Depression & Anxiety*, *26*, 597-600.

DSM-5

A. Exposure to actual or threatened death, serious injury, or sexual violence (4 symptoms)
B. Presence of one (or more) intrusion symptoms (5 symptoms)
C. Persistent avoidance of stimuli (2 symptoms)
D. Negative alterations in cognitions and mood (7 symptoms)
E) Marked alternations in arousal and reactivity (6 symptoms)
F) Duration of the disturbance is more than 1 month.
G) Distress or impairment in social, occupational,
H) Not due to a medical condition or substance abuse
Specify
- Depersonalization:
- Derealization:

Specify if: delayed expression:

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders.*

What else has changed?

- "DSM-5 : should PTSD be in a class of its own?"*
- "Malingering should be ruled out" is out
- "Traumatic Brain Injury" is in

Miller, M. W., et al. (2009). British Journal of Psychiatry*, 194, p.90

ICD-11 PTSD

Exposure to a stressor of *exceptionally threatening or catastrophic nature*.

Re-experiencing
- Distressing dreams
- Daytime images

Avoidance
- Thoughts
- People, places or activities

Hyperarousal
- Startle response
- Hypervigilance

Impact of Events Scale-Revised

A 22 Item self-report instrument

- Intrusions (8 items)
- Avoidance (7 items)
- Hyperarousal (7 items)

Horowitz et al. (1979). Impact of Event Scale: A measure of subjective stress. Psychosomatic Medicine, 41, 209-218.

Political Science creating Science

Part III: The History of Delayed PTSD

Post-Vietnam Syndrome Why Delayed PTSD?

"These meetings were initiated in 1970 by veterans themselves, either because of their distrust of "establishment" psychiatric services, or because their disturbances manifested themselves *too late to prove the "service connection"* required for Veterans Administration treatment."

Shatan, C. F. *The New York Times*, May 6, 1972

How did delayed PTSD stay in?

- 4 hospitals in Australia
- 3 & 12 months follow-up
- 834 randomly selected patients with severe injury (admit more than 24 hrs)
- 9% (n=73) PTSD at 12 months
- 53% (n=39) delayed PTSD

O'Donnell, M. L., et al. (2013). *Psychosomatic Medicine,* 75, p.68-75.

Implications for DSM 5

"These studies have implications for DSM 5. First, they suggest that delayed-onset PTSD is relatively common condition that needs to be adequately represented in the diagnostic nomenclature."

"As the focus turns to DSM 5 and as the implications of delayed onset become increasingly important for veteran and civilian health and ***compensation systems***, it is vital that research continues to better understand these complex trajectories of psychopathology after the trauma exposure.

O'Donnell , M. L., et al. (2013*). Psychosomatic Medicine, 75*, p. 74.

Jones vs. Clinton (1998)

What does Andreasen have to say?

"…many soldiers do not develop stress symptoms until they return home, since a stress reaction in the midst of combat is not adaptive, and so the impact of their traumatic experiences is delayed. Therefore, we also identified a delayed form.

Andreasen, N. C. (2004). *The American Journal of Psychiatry*, *161*, p.1321-1323.

Nancy Andreasen receiving the National Medal of Science

Epidemiology: Populations Studies

What does true trauma look like?

September 11, 2001 (Schlenger, W. E., et al., 2002, JAMA)	11.2%
Ugandan & Congolese Child Soldiers (Bayer, C. P., et al., 2007, JAMA)	34.9%
1995-1996 Paris bombings (Verger, P., et al., 2004, Am J Psychiatry)	31%
Oklahoma City bombing (North, C. S., et al., 1999, JAMA)	34.3%
Rwanda (Pham, P. N., et al., 2004, JAMA)	24.8%
	Mean 27.4%

Blanchard & Hickling Studies

- 161 subjects seeking treatment
- Seen 11 months post MVA
- 60% in litigation

- Mean CAPS score 72
- 68% PTSD
- 57% Major Depression

Blanchard, E. B., et al. (2004). *After the Crash.* Washington, D.C.: APA.

"After the Crash" & PTSD

- "..participants were asked if they contacted a lawyer; if they answered affirmatively, they were scored as involved in litigation." p.186
- "We made no effort to check the veracity of participants' reports but found no obvious reason to doubt them…We had no instances for which we felt we had been misled" p. 197
- "In our larger sample of more than 400 participants, only two participants had been identified as having faked or exaggerated their symptoms." p. 243
- "We do not routinely use the MMPI-2 or other tests that might add validity measures or tests of malingering to the assessment." p. 246
- "We did not collect medical records on our patients." p.247

Blanchard, E. B., et al. (2004). *After the Crash.* Washington D.C.: APA.

Epidemiology
Head Injury & PTSD

MVA & PTSD: The true prevalence?

N=107 Norway (Malt, U.,1988)	28 mths	.009%
N=106 Japan (Nishi, P., et al., 2013)	6 mths	7.5%
N=106 Switzerland (Schnyder, U., et al., 2001)	1 yr	1.9%
N=163 Germany (Wrenger, M., et al., 2008))	1 yr	2.5%
N=60 (mom) Germany	1yr	5.7
N= 53 (dad) (Landolt, M. A., et al., 2005)	1yr	0%
	Mean	2.9%

Synonyms for Malingering

Profession	Term
• Medical	➡ Malingering
• Law	➡ Perjury
• Insurance	➡ Fraud
• Layperson	➡ Lying

The Context is the Same: Clinical vs. Legal Referrals

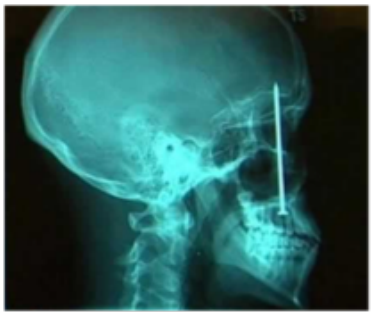
	Clinical N=52	Legal N=50	CHI N=24
Age	38.85	41.52	33.16
Education	12.71	13.41	11.96
Male	44 %	47%	8.58
Female	56 %	53%	72
# of Tests	29.64	28.14	28.63
Imp. Tests	6.08	7.63	8.17

Results By Diagnosis Presenile Presentation (N=40)

Alzheimer's -	14.3% (n = 6)
Normal -	38.1% (n = 16)
Vascular dementia -	4.8 % (n = 2)
Parkinson's disease -	4.8 % (n = 2)
UKN Cognitive Impairment	4.8 % (n = 2)
Cognitive Impairment -	4.8 % (n = 2)
Known Dementia -	2.4% (n = 1)
Malingering -	11.9% (n = 5)

Minnesota Personality Inventory-2

	SCI	HA	HI	SZ	PZ	MHI	PSY
N	42	52	44	100	24	230	59
Hs-1	66	67	58	60	77	76	64
D-2	55	59	59	62	68	72	69
Hy-3	61	64	57	57	76	74	67
Pt-7	52	57	57	59	61	69	67
Sc-8	58	54	60	61	64	74	66



Workers' Compensation Status & Surgery Outcome

- Surgical intervention in which compensation status was reported
- 211 studies identified
- 175 stated compensation was associated with worse outcome
- 35 found no difference or did not describe one
- 1 described a benefit to compensation

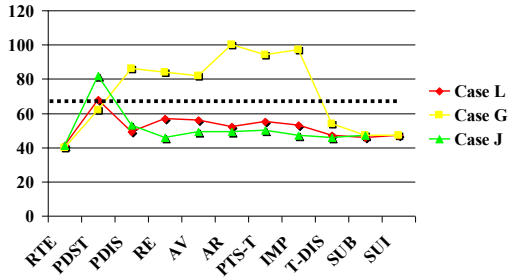
Harris et al. (2005) Association between compensation status and outcome after surgery: a meta-analysis. JAMA, 293.1644-52.

Malingered PTSD What does Andreasen say?

It is rare to find a psychiatric disorder that anyone wants to have, but PTSD is one of them.

Andreasen, N. (1995) American Journal of Psychiatry, p.964

PTSD: A Dose-Dependent Relationship



Practice Guidelines from the International Society for Traumatic Stress Studies

9. *Evaluate response bias*. Response bias, particularly malingering, should be assessed routinely in all clinical and research assessments of PTSD.

This crucial assessment domain has been given insufficient attention in the field of traumatic stress in particular, and in the assessment of mental health disorders more broadly (Rosen, 2004; Rosen & Taylor, 2007)

Foa, E. B., et al. (2008). *Effective Treatments of PTSD*. NY: Guilford Press, pp. 52-53

"I don't know about this PTSD but they did bomb SVT"

"There appears to be an inverse relationship between the enthusiasm an individual has for SVT and their knowledge of the syndrome they are trying to refute with SVT. When there is diagnostic uncertainty about a case, the rapidity with which the neuropsychologist asks the obligatory "What were their SVT scores?" can be embarrassing at times. One has to question if SVT has led to the 'dumbing down' of neuropsychology."

Andrikopoulos & Greiffenstein. (2005) In *Forensic Neuropsychology*, p. 393

Case Consultation

Managing the PTSD Claim

- The patient should choose mental health treater
- Medication can be started by primary care doctor
- If no improvement, refer to a psychiatrist
- Request approximate timeline for treatment
- Request monthly updates
- Do not ask the treater to do impairment rating
- Do not ask the treater if the patient is malingering

Managing the PTSD Claim

- Standard treatment for PTSD is time-limited trauma-focused therapy.
- If PTSD symptoms appear after a delay (> 1 month), get an IME before treatment.
- If symptoms are mild and less than 1 month, "watchful waiting" is recommended.
- If present for more than a month, treatment should commence.
- Patients should not be treated by multiple therapists.
- Evaluate carefully request for switch of treaters

When to Recommend an IME

- IME is best done by a psychologist
- Event not outside the range of usual human experience
- If one course of time-limited therapy failed
- If PTSD symptoms appear after a delay (> 1 month)
- If patient is not compliant with treatment
- If patient not back to work after one cycle of treatment
- If no improvement after 3 months of treatment
- Treater unwilling to commit to treatment timeline
- Treater assuming the role of expert witness

PTSD Assessment Mistakes

- The event was not of sufficient severity
- Relying solely on patient self-report
- Not giving personality testing
- Failure to provide examples of symptoms
- When asked, "bean counting approach" used
- Lacking knowledge of the PTSD literature
- Assuming an advocacy vs. a scientific role
- Failure to ask about all PTSD symptoms
- Not relying on multiple methods for diagnosis

E-mail me for the slides, thoughts, comments or questions.

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