PTSD in Virginia Workers’ Compensation: Diagnosis, Treatment, and Dilemmas

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PTSD is a Normal Reaction to Extreme Trauma—just as Bleeding is a Normal Reaction to Being Stabbed
Ambivalence in workers’ compensation in dealing with psychological injuries

“C’mon, c’mon – it’s either one or the other.”
Evolution of the Concept and Term

- In literature: Homer (The Iliad), Shakespeare (Henry IV), and Dickens (A Tale of Two Cities)
- Nostalgia late 1700s (Europe)
- Early European railroad accidents (nonmilitary)
- The Civil War: soldier’s heart and irritable heart
- WWI: shell shock and war neurosis
- WWII: Combat Stress Reaction, battle fatigue
- DSM I (1952): Gross Stress Reaction
- DSM II (1968): Adjustment Reaction to Adult Life
- DSM III (1980): PTSD (4% men; 10% women lifetime prev)
- DSM IIIR → DSM IV → DSM 5: Refinements based upon accumulation of research
Prevalence and Risk

- U.S. Lifetime: 8.7% (men: 4%, women 10%)
- 12 month prevalence: 3.5%
- Culture difference in both exposure and prevalence
- High risk vocations: Veterans, law enforcement, fire fighters, emergency medical personnel
- High risk exposures: military combat, sexual assault, captivity, genocide, terrorism
DSM-5 Diagnosis

- Criterion A (necessary event)
  - Exposure to actual or threatened death, serious injury, or threatened sexual violence (>1 required)
    - 1) Direct experiencing
    - 2) Actual witnessing
    - 3) Learning of a traumatic event occurring to a close family member or close friend; if involving actual or threatened death, must be violent or accidental
    - 4) Experiencing repeated or extreme exposure to aversive details of traumatic event(s) (first responders collecting human remains, police repeatedly exposed to details of child abuse); does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work related
DSM-5 Diagnosis

- Criterion B (intrusion symptoms, ≥1 required)
- Must be associated with the traumatic event(s) and beginning after the traumatic event(s)
  - 1) Recurrent, involuntary, and intrusive *distressing memories* of traumatic event(s)
  - 2) Recurrent *distressing dreams* with content and/or affect related to the traumatic event(s)
  - 3) *Dissociative reactions* (e.g., flashbacks) involving feeling and/or acting as if traumatic event(s) were recurring
  - 4) Intense or prolonged psychological *distress with exposure to cues* that symbolize traumatic event(s)
  - 5) Marked *physiological reactions to* internal or external cues that symbolize or resemble the traumatic event(s)
DSM-5 Diagnosis

- Criterion C (Persistent avoidance of stimuli associated with traumatic event(s), ≥1 required)

- Must begin after traumatic event(s)
  - 1) Efforts to avoid distressing memories, thoughts, or feelings associated with traumatic event(s)
  - 2) Efforts to avoid external reminders that arouse distressing memories, thoughts, or feelings associated with the traumatic event(s)
DSM-5 Diagnosis

- Criterion D (Negative alterations in cognitions and mood associated with traumatic event(s), ≥2 required)

- Must begin or worsen after traumatic event(s)
  - 1) Inability to remember an important aspect of traumatic event(s) (e.g., dissociative amnesia), not associated with head injury, substances, etc.
  - 2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," No one can be trusted)
  - 3) Persistent, distorted cognitions about the cause or consequences of traumatic event(s) leading individual to blame herself or others
  - 4) Persistent negative emotional state (e.g., fear, anger, guilt)
  - 5) Markedly diminished interest activities
  - 6) Feelings of detachment or estrangement from others
  - 7) Persistent inability to experience positive emotions
DSM-5 Diagnosis

- Criterion E (Marked alterations in arousal and reactivity associated with the traumatic event, >2 required)

- Must begin or worsen after traumatic event(s)
  - 1) *Irritable* behavior and *angry* outbursts with little or no provocation
  - 2) *Reckless or self-destructive* behavior
  - 3) *Hypervigilance*
  - 4) Exaggerated *startle response*
  - 5) *Problems with concentration*
  - 6) *Sleep disturbance*
You must clearly explain your problem
DSM-5 Diagnosis

- Criterion F: Duration of disturbance (above criteria > 1 month)
- Criterion G: Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Criterion H: Disturbance is not attributable to the physiological effects of a substance or another medical condition
DSM-5 Diagnosis

• Specify whether:

• With dissociative symptoms:
  ◦ 1) Depersonalization: persistently or recurrently feeling detached one's mental processes or body (e.g., feeling like an outside observer)
  ◦ 2) Derealization: persistent or recurrent experiences of unreality of surroundings (e.g., dream-like, distorted, distant)
  ◦ Must Not be attributable to the physiological effects of a substance or another medical condition

• Specify if:

• With delayed expression: i.e., If the full diagnostic criteria are not met until ≥6 months after the event
Important Differences: DSM-IV to DSM-5

- PTSD removed from Anxiety Disorders to Trauma and Stressor-Related Disorders: entails multiple emotions, not just anxiety
- *Criterion A2 removed: Response involves "fear, helplessness, or horror"*
- 3 symptom clusters are divided into 4 clusters (avoidance/numbing symptoms separated into separate groups: avoidance and negative alterations in cognitions and mood)
- 3 new symptoms added (persistent negative emotional state, persistent distorted cognitions about the cause or consequences of the trauma leading to blame of self or others, reckless or self-destructive behavior)
- All symptoms have to begin or worsen after trauma
- Separate diagnostic criteria for young children (we will not discuss)
- *New dissociative subtype added*
Criterion A Revisited Relative to DSM-5

- Exposure to a Traumatic Event: *Not all stressful events are traumatic and not all traumatic events result in PTSD*
- Stressful events failing to involve immediate and serious threat to life or serious physical injury (e.g., divorce, being fired) are not considered traumatic
- Ambiguous DSM-IV "threat to physical integrity" was removed
- Medical trauma now limited to sudden and catastrophic level events such as awakening during surgery. Cancer, therefore, no longer qualifies. Natural cause medical incidents (e.g., heart attack) no longer qualify.
- **A4 added:** Experiencing repeated or extreme exposure to aversive details of traumatic event(s) applies frequently to workers
- “Intense fear, horror, or helplessness” eliminated: felt to conflate subjective experience with objective level of stressor
Relevant Kin of PTSD

- **Acute Stress Disorder**: Basically PTSD of 3 to 30 days duration following trauma

- **Adjustment Disorder**: When PTSD criterion A met but not other criteria and when the symptom pattern of PTSD occurs in response to a stressor that does not meet PTSD criteria A (e.g., spouse leaves)

- **PTSD and Traumatic Brain Injury**: Can occur together. Even for patients amnestic for traumatic event. LOC may lessen the number and severity of intrusive symptoms (Turbull, 2001). Utilize non-overlapping symptoms (e.g., re-experiencing, avoidance).
Stress, even great stress at times, is ubiquitous in modern life. But that does not necessarily involve trauma.
Talk or Behavioral Type Treatments:
- Cognitive-Behavioral Therapies
- Cognitive Therapies
- Exposure Therapies
- Mindfulness Therapies
- Eye Movement Desensitization Therapy

Medication Type Treatments
- Largely SSRI and SNRI antidepressants
- Some novel agents such as Prozasin (alpha blocker anti-hypertensive medication) for nightmares
- Generally, avoid benzodiazepines
"Now relax. . . . Just like last week, I'm going to hold the cape up for the count of 10. . . . When you start getting angry, I'll put it down."
Three Theories by Which a PTSD Claim May Be Awarded in Virginia

1) PTSD that results from an accident with physical injury(s) (i.e., injury by accident)
   - DSM-5 PTSD diagnostic criteria suffice

2) PTSD that results from a sudden shock or fright, unaccompanied by physical injury(s) (i.e., the “sudden shock or fright” is the “injury by accident”)
   - DSM-5 PTSD diagnostic criteria do not suffice
   - Additionally requires “sudden shock or fright” and must be “unexpected” in the performance of employed duties (i.e., “PTSD plus”)
Three Theories by Which a PTSD Claim May Be Awarded in Virginia (cont.)

- 3) PTSD as an occupational disease (i.e., not injury by accident)
  - DSM-5 Diagnostic criteria suffice
  - 6 Requirements - See Va. Code § 65.2-400(B).
    - A direct causal connection between the conditions under which the work is performed and the occupational disease
    - It can be seen to have followed is a natural incident of the work as a result of the exposure occasioned by the nature of the employment
    - It can fairly traced to the employment as the proximate cause
    - It is neither a disease to which the employee may have had substantial exposure outside of the employment, nor any condition of the neck, back or spinal column
    - It is incidental to the character of the business and not independent of the relation of employer and employee; and
    - It had its origin in a risk connected with the employment and flowed from that source as a natural consequence, though it need not have been foreseen or expected before it's contraction
Virginia State Trooper Hess responded to a fatal accident scene in 2015. Involved MVA, driver ejected to opposite lane, hit by another vehicle, dragged almost a mile. Hess witnessed a “mutilated body beyond recognition.” Ten year history of working accidents with fatalities, but this one “unfamiliar to any in his experience.” Disturbed at the scene, distress continued through his shift. Sought psychological help. Brought claim for temporary total disability benefits. Initial Commission review favorable. Review by Full Commission reversed decision. “Events surrounding the accident were ‘not shocking or unexpected to an experienced state trooper and crash scene investigator.’”
“Hess’s traumatic experience was not a sudden or unexpected shock or fright for a State Trooper who received fatal accident and crash scene reconstruction training and had a decade of professional experience doing so.”

- DSM-5 has no “sudden shock or fright” criterion.

- DSM-5 has no “unexpected” criterion. Being in a normally stressful “high risk” job, does inoculate one from PTSD, it increases the risk of such.

- DSM-5 made more specific trauma specifiers seemingly to spotlight worker risk and allow also for cumulative stress to qualify:
  - Experiencing repeated or extreme exposure to aversive details of traumatic event(s) (first responders collecting human remains, police repeatedly exposed to details of child abuse)
“The types of precipitating events that give rise to purely psychological compensable injuries are consistently described as shocking, frightening, traumatic, catastrophic and unexpected.”

“This case centers on whether the injury was causally related to a ‘sudden shock or fright.’”

Again, DSM-5 does not have as part of Criterion A any particular initial emotional response to the trauma; nor does DSM-5 have any “unexpected” criterion.
Hess v. State Police – Law v. Medicine

- The pathology and severity of low back pain complaints are not judged based on how loudly an injured worker says “ouch” or even their functioning immediately after the physical injury. Why ought a psychological trauma be determined to have occurred or not based upon how loudly the claimant cries or how deep their furrowed brow at the time of the trauma? Actually, quiet dissociation (“shut down”) may be the most ominous initial response for the development of PTSD.

- Sudden shock or fright may manifest itself in more than one way.
  - The “high road”
  - The “low road”
  - Delayed
Hess v. State Police – Law v. Medicine

- On what objective basis does the issue of whether a stress or trauma is expected have anything to do with whether or not PTSD will develop?

- Preparing to see death and mangled bodies in military training hardly inoculates soldiers from PTSD.

- A miner who daily lifts/moves objects from 25 -150 lbs., injures their back lifting/moving a 75 lb. object; that expected occurrence of lifting does not preclude qualifying for benefits for the physical injury.
The same First Responder at higher risk for both physical and mental injuries than many other occupations may have a presumption for a physical claim (e.g., hypertension, heart disease), but not for their PTSD claim.

On what reasonable basis is there a difference in awarding benefits, particularly for those that put themselves in harm’s way to help others in situations of physical and mental danger? For First Responders, it amounts to exposure to greater risk equals a higher the threshold for establishing a claim at least for a mental injury.
General Issues for the Examining Clinician

- Taking the claimant as they are and the “fragile egg”
- Parsing out the predominant causal factors; occupational and nonoccupational
- Misattribution
- Malingering
The Department of Veterans Affairs

The Veterans Administration takes a very different approach with soldiers (requiring no apparent initial response of “sudden shock or fright” nor does it preclude expected or cumulative trauma) or whether the trauma is expected or not because these issues are irrelevant to whether or not PTSD develops or whether it is related to military occupational engagements.

The Veterans Administrations takes the same presumptive approach for mental injury such as PTSD as Virginia Workers’ Compensation takes for physical injuries.
Things are not always as they seem...
CHILDHOOD
A part of life that creates beautiful memories.
So, Regarding Hess v. Virginia State Police

- Is this endemic of the general societal devaluation of mental or emotional health over physical health? For physical injuries, there is no additional diagnostic burden to overcome. A first responder may even get a presumption to assist their claim for certain physical conditions. See Va. Code § 65.2-402.

- But for PTSD, there is an additional burden over and above meeting current diagnostic criteria (“PTSD plus”).

- Back and other physical injuries are common and expected in the mines. On what basis, ought the criteria for compensability be different with regard to expectation or level of risk for mental injuries vs. physical injuries?
For First Responder types: Is Theory 2 (PTSD that results from a sudden shock or fright, unaccompanied by physical injury(s)) ultimately “catch 22” if this path for benefits is pursued?

For professions trained to encounter sudden, shocking, and unexpected events, what circumstances could meet the threshold for Theory 2? Can a claimant realistically meet the burden of establishing “PTSD plus”?

Does the system now encourage false or exaggerated physical injury claims to lower the burden of establishing a legitimate psychological injury claim?

Does the system now encourage padding of prior psychological stressors to dodge Theory 2 to pursue Theory 3 (occupational disease claim) for one actual traumatic injury?
SO, HE/SHE CAN'T BE SUFFERING FROM PTSD BECAUSE THEY SEEM 'FINE'?

BUCK UP AND BORROW THEIR 'REALITY SHOES' FOR A DAY, WHY DON'T YOU?
For more information:

U.S. Department of Veterans Affairs website

https://www.ptsd.va.gov/index.asp
Thank you.
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