

PTSD: Diagnosis, Misdiagnosis, Treatment & Management in the Workplace

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Director



THE UNIVERSITY OF
MELBOURNE

About Phoenix Australia

- Not-for-profit organisation
- **Our mission:**
 - Improved mental health, wellbeing and quality of life for individuals, organisations and communities who experience trauma
 - Through research, policy and service development advice and training

Board of Directors

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Phoenix Australia

Leadership team & program streams



Director - Professor David Forbes



**Deputy Director and Policy & Service Development
- Dr Andrea Phelps**



**Research & Evaluation - Associate Professor Meaghan
O'Donnell**



Education & Training - Associate Professor Darryl Wade

Policy & Service Development

- Development of Australian NHMRC guidelines for the treatment of PTSD
- Trauma management frameworks, implementation of PFA, early interventions for high risk industries
- Development of Defence mental health screening framework
- Trauma informed care frameworks for service organisations
- Development and implementation of clinical standards and quality assurance processes across veteran and military mental health services
- Development of three-tiered service framework for post disaster mental health care (now included in the Attorney General's handbook for disaster response)

Research and evaluation

- Framework for the evaluation of mental health initiatives across defence
- Longitudinal study of resilience in the ADF
- Leading the development and trial of an international post disaster mental health response
- Evidence compass - rapid evidence reviews and summary website for Commonwealth Departments of Veterans Affairs and Defence
- Development of predictive screening for posttrauma mental health problems
- Intervention studies for posttraumatic mental health
- PhD Mental health and wellbeing in firefighters

Education & Training

- Workforce skills development programs in trauma management & trauma informed care
- Training program for post disaster health care providers
- Supervision & consultation services across a diverse range of clients
- E-health training programs for health professionals (e.g., gponline in trauma and disaster) and for the community (e.g., PTSD Coach Australia app)

Trauma and PTSD overview

Trauma and trauma response

PTSD diagnosis and current diagnostic challenges

Trauma in high risk workplaces

- Cumulative trauma
- Other operational and organisational stressors

Best practice approach to trauma management

Mental health, disability and compensation

Application to high risk workplaces

Potentially traumatic events (PTEs)

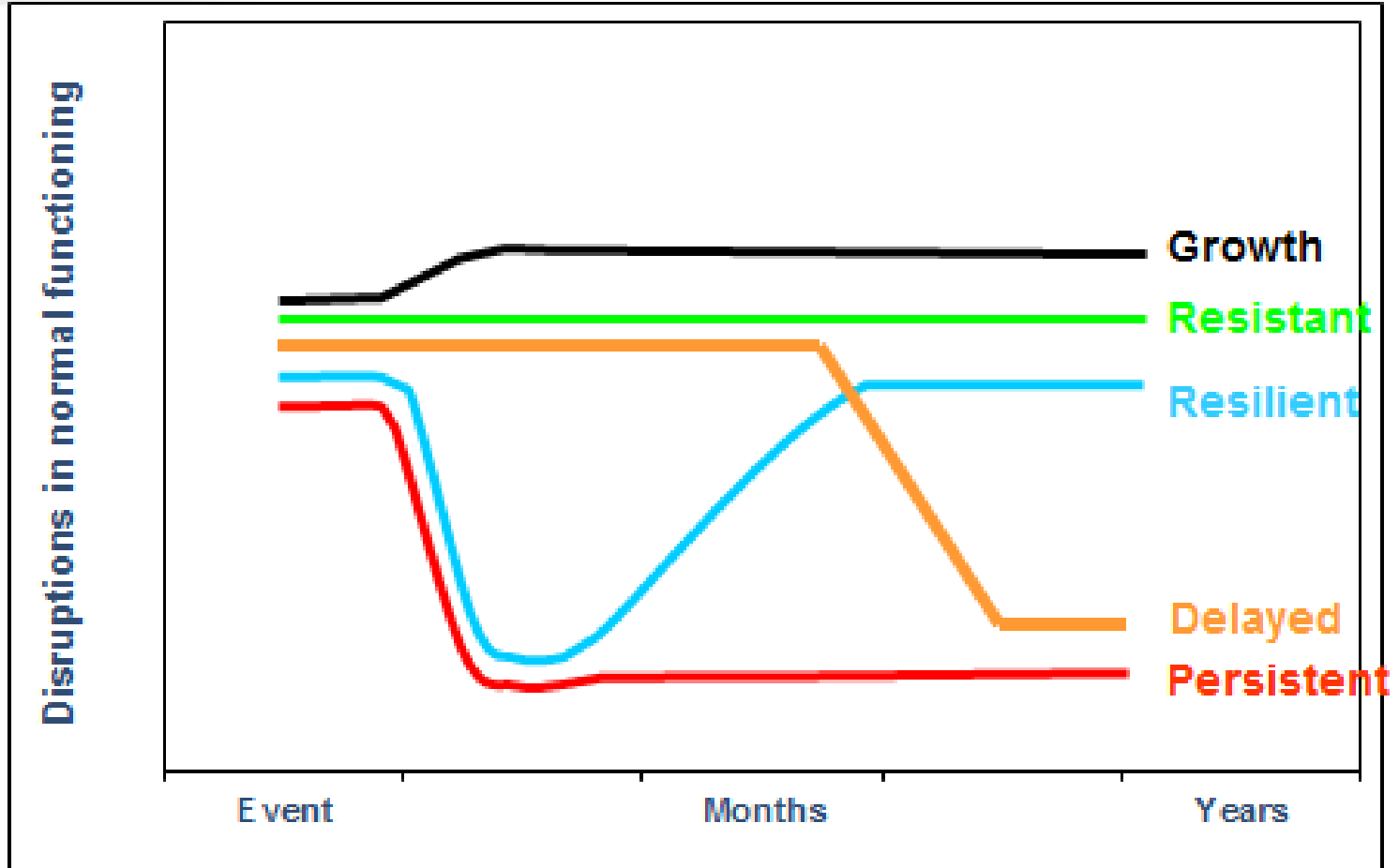
An event involving actual or threatened death, serious injury or sexual violation

- Experienced directly
- Witnessed in person
- Learned about in the case of close friend or family
- Repeated or extreme exposure to aversive details (e.g., first responders, police having repeated exposed to details of child abuse)
- Includes participation through an electronic medium where part of occupation

Mental health response to trauma

- The mental health impact of experiencing a PTE may be:
 - **Valence:** Good, bad, mixed
 - **Severity:** Negligible, mild, moderate, severe
 - **Duration:** Brief, long-lasting, permanent
- The vast majority of people do not develop long term mental health problems

Prototypical patterns over time



Factors that increase the risk of event impact

Pre-incident factors

- Prior trauma or mental health problems

Incident related factors

- Nature, severity and duration of exposure

Post-incident factors

- Lack of social support – validation, opportunity to “process” the event
- Other stressful life events

Individual risk & protective factors

- Predictors based on two large meta-analyses (Brewin, 2000; Ozer, 2003)
 - Social support posttrauma (.40)
 - Other life stress posttrauma (.32)
 - Trauma severity (.23)
 - Childhood trauma (.19)

Diagnosis:

Changes to diagnostic criteria of PTSD

DSM-5

- Expand to include comprehensive profile of traumatic stress symptoms

ICD-11

- Reduce to identify symptoms unique to PTSD to avoid overlap with other disorders

First time DSM and ICD diagnostic criteria for PTSD have looked so different

DSM-5

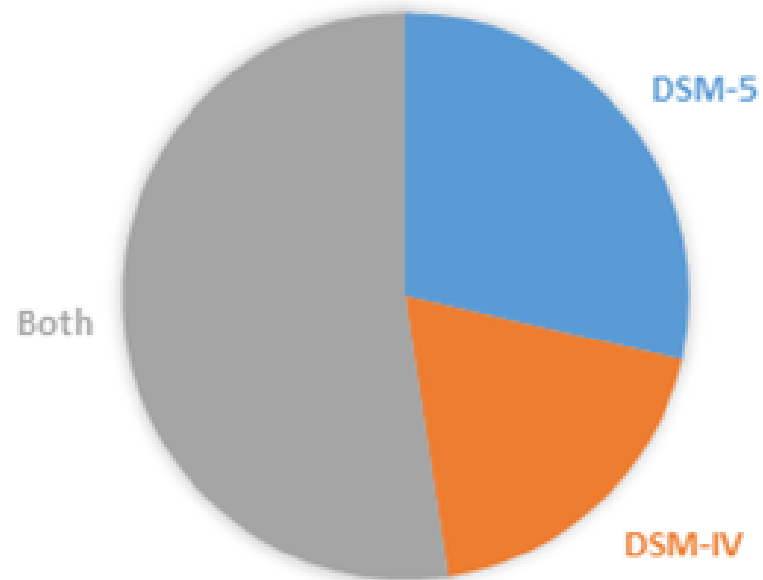
Published in 2013

- Removal of A2 (subjective response)
- Separation of active avoidance from passive avoidance
- Creation of new symptom cluster (D- negative alterations of cognitions and mood)
- Move from 3 to 4 symptom clusters
- Move from 17 to 20 symptoms

PTSD symptoms in DSM-5

1. **Intrusion symptoms (memory keeps coming back)**
 - sudden clear thoughts & images; nightmares; feeling “back there” (flashbacks) & distress on seeing reminders
2. **Avoidance symptoms (try to avoid or stay away)**
 - push away thoughts & feelings; avoid places or people which remind
3. **Negative alterations in cognitions and mood (persisting negative feelings or thoughts related to the event)**
 - feel anxious, angry, sad & depressed, guilt, or emotionally “shut down”
4. **Alterations in arousal and reactivity (keyed up and on edge)**
 - hyperalert; sleep & concentration problems; irritable & angry; easy startled

DSM-IV and DSM-5 agreement (disagreement)

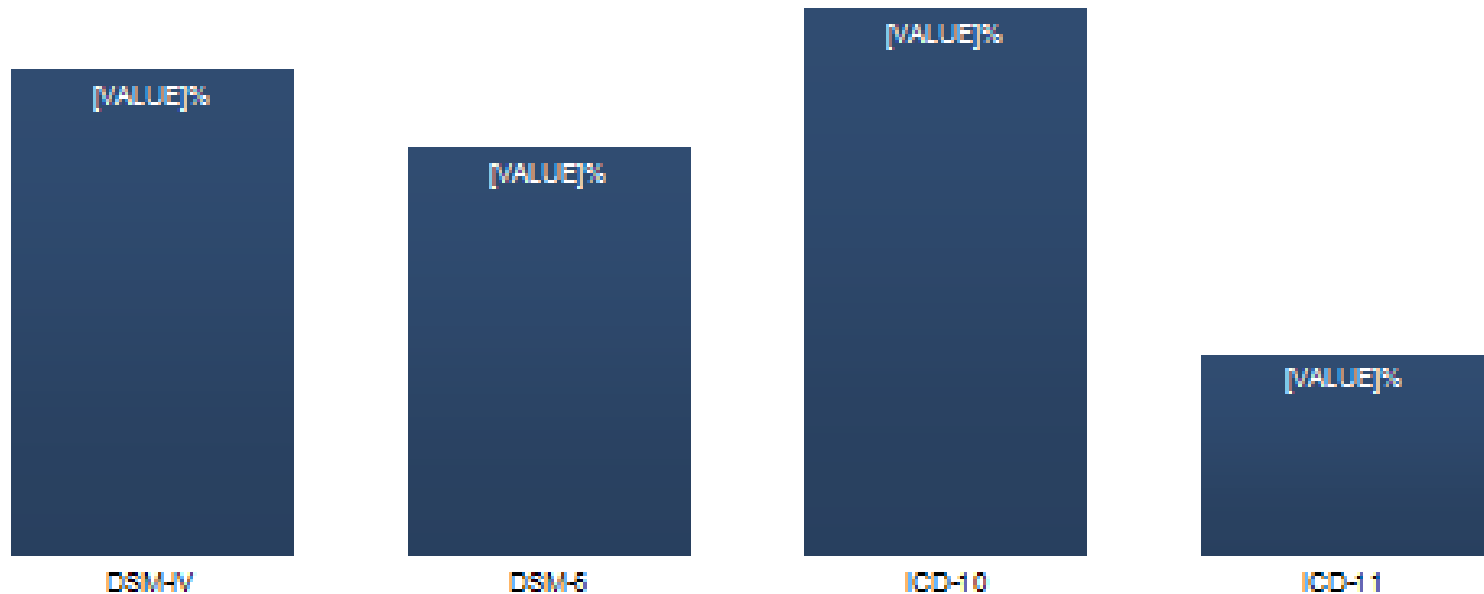


ICD-11 proposed changes to PTSD

- Due for publication in 2017 – field trials underway
- Key principles for ICD-11 include an emphasis on clinical utility of diagnosis and accessibility to front line workers
- Clinical utility encourages simplicity
- Three clusters of two symptoms each
 - Re-experiencing – flashbacks and nightmares
 - Avoidance – external and internal avoidance
 - Hyperarousal – exaggerated startle and hypervigilance

PTSD diagnostic criteria DSM-5 vs ICD-11

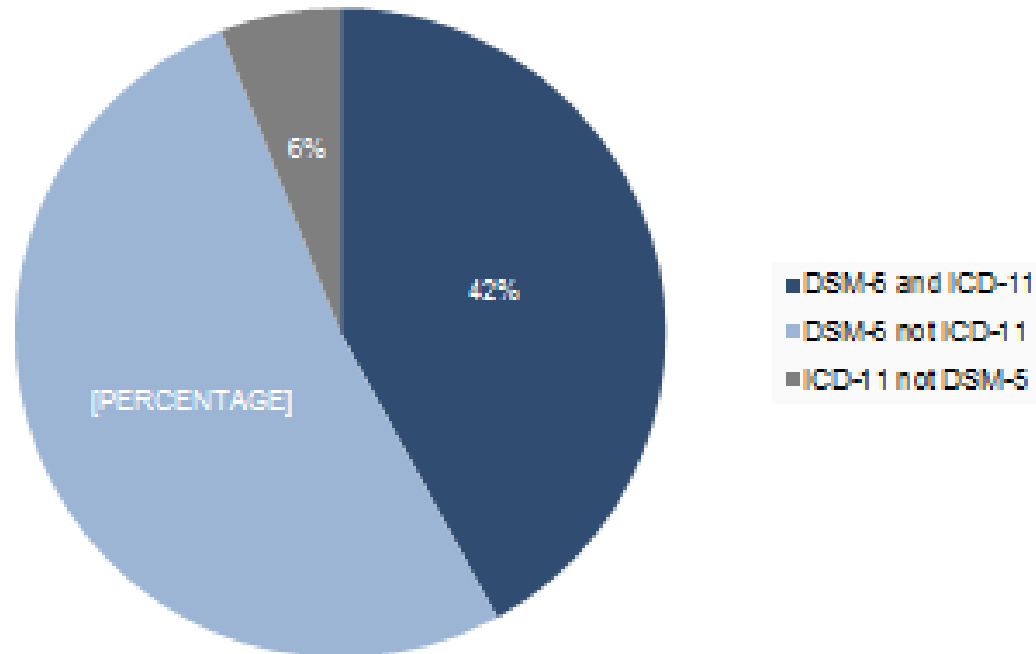
Prevalence of PTSD



O'Donnell, M.L., Alkemade, N., Nickerson, A., Creamer, M., McFarlane, A., Silove, D., Bryant, R.A., & Forbes, D. (2014). The impact of the diagnostic changes to posttraumatic stress disorder for DSM-5 and the proposed changes to ICD-11. *British Journal of Psychiatry*. doi:10.1192/bjp.bp.113.135285

Are they the same people?

ICD-11 and DSM-5



Diagnostic algorithms are identifying predominantly different people

PTSD: often goes with....

- Guilt; Depression; Anxiety; Anger
- Substance use problems
 - alcohol; more recently others
 - to try & cope with sleep, nightmares, anxiety & memories
- Relationship problems
 - family: withdrawn, irritable & angry; trouble feeling loving feelings
 - friends: often hard to feel understood; withdraw
- Impact on work functioning
 - concentration and attention
 - can be hard to stay well enough to maintain a job

PTSD diagnosis and comorbid depression : DSM-5 vs ICD-11

Table 1 Post-traumatic stress disorder (PTSD) 'caseness', comorbidity with depression and disability caseness as scored by different PTSD algorithms (n = 510)

| | % (n/N) | | | |
|-------------------|-------------------------|--|---|---|
| | PTSD caseness (n = 510) | Proportion of participants with PTSD comorbid with a depression diagnosis ^a (n = 507) | Proportion of participants with PTSD meeting disability caseness ^b (n = 450) | Proportion of participants with PTSD meeting poor psychological quality of life caseness ^c (n = 452) |
| DSM-IV with A2 | 5.9 (30) | 69 (20/29) | 92 (24/26) | 81 (21/26) |
| DSM-IV without A2 | 8.0 (41) | 63 (25/40) | 83 (30/36) | 72 (26/36) |
| DSM-5 | 6.7 (34) | 67 (22/33) | 86 (24/28) | 75 (21/28) |
| ICD-10 | 9.0 (46) | 56 (25/45) | 85 (34/40) | 65 (26/40) |
| ICD-11 | 3.3 (17) | 56 (9/16) | 77 (10/13) | 69 (9/13) |

a. Using the Mini International Neuropsychiatric Interview version.
 b. Using the World Health Organization Disability Assessment Schedule II.
 c. Using the World Health Organization Quality of Life – BREF.

O'Donnell, ML., Alkemade, N., Nickerson, A., Creamer, M., McFarlane, A., Silove, D., Bryant, RA., & Forbes, D. (2014). The impact of the diagnostic changes to posttraumatic stress disorder for DSM-5 and the proposed changes to ICD-11. *British Journal of Psychiatry*. doi:10.1192/bjp.bp.113.135285

The course of PTSD

- Untreated - in 50% of cases it will subside over the course of 1-2 years
- Just as commonly: chronic and ongoing
- Fluctuates in intensity and severity

How common is it?

Prevalence

- Over 1 million Australians have PTSD (4.4%)
- Rates vary by trauma type
 - 5-10% following natural disasters or severe motor vehicle accidents
 - 50% following sexual assault
- Military populations
 - General range 10-20% but higher after particular experiences e.g. kidnapping (78%) killing someone (28%)
- Emergency service personnel
 - Reports are inconsistent
 - Estimated 10%

Trauma in High Risk Organisations

Foreseeable and predictable risk of repeated exposure to trauma

And these occur in the context of:

- Routine operational stressors – shift work, fatigue, time critical responses, job control and autonomy
- Organisational stressors – management, supervision, leadership, collegiate environment, role clarity, adequacy of resources

Impact of repeated exposure to PTEs

- No “rule of thumb” about how many events are too many
- Effects of trauma may be contained by camaraderie & support of unit or workgroup
- May be growing signs along the way, work or home
- A particular event can trigger symptoms
 - Event or victim “strikes a cord”
 - The “straw that broke the camel’s back”

Interactions between operational and organisational stress, support and PTSD

Link between routine operational and organisational stress (e.g., co-worker conflict, management practices, job insecurity, safety concerns) and PTSD

- High level of ongoing stress may mean less able to cope with psychological demands of attending PTEs

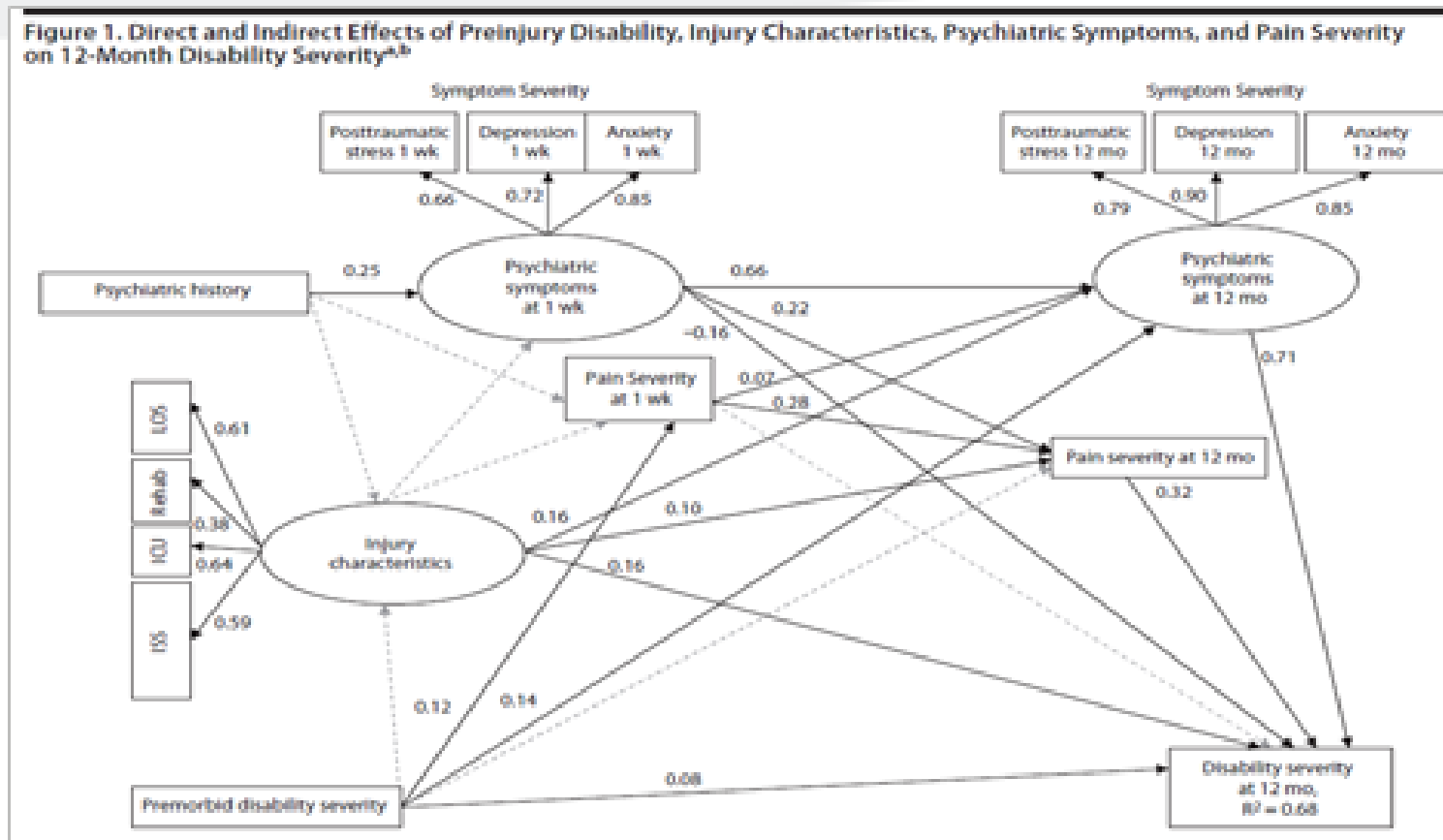
Link between organisational support after a PTE and PTSD

- Organisational support may buffer the impact of PTEs

Impact of mental health on disability

- Disability
 - WHO definition - Inability to conduct activities at a level considered normal and may occur in a range of domains including self care, employment and participation in society.
- Traditionally, focus has been on contribution of physical injury to disability
- Investigating the relative contribution of psychological and physical factors in determining disability after injury (our 6 year longitudinal study of 1100 traumatic injury patients)

Mental health and disability



O'Donnell, M.L., Varker, T., Holmes, A.C., Ellen, S., Wade, D., Creamer, M., Silove, D., McFarlane, A., Bryant, R.A., & Forbes, D. (2013). Disability after injury: The cumulative burden of physical and mental health. *Journal of Clinical Psychiatry*, 72, 2, 137 – 143.

Key points for consideration

- Psychiatric factors contributed more to the variance in disability at 12 months than either pain or physical factors
 - Yet where physical injuries are severe, psychological wellbeing might be overlooked
- *Persistence* of acute psychiatric symptoms through to 12 months associated with disability
 - Highlights importance of early intervention to prevent longer term disability

What drives what?

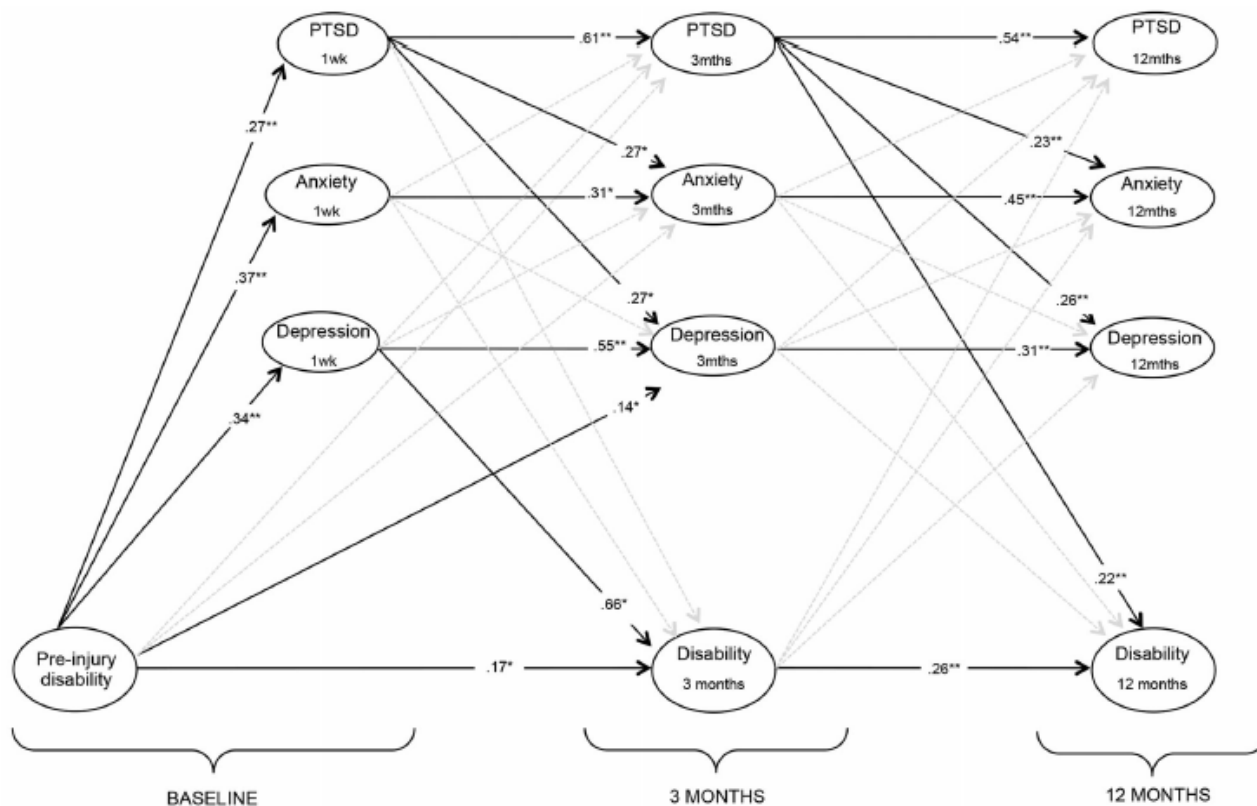


Figure 1. The cross-lag relationships between posttraumatic stress disorder severity, depression severity, anxiety severity, and disability severity over the first 12 months after serious injury.

Schweininger S., Forbes, D., Creamer, M., Silove, D., McFarlane, A., Bryant, RA., & O'Donnell, ML. (2014). The temporal relationship between mental health and disability after injury. *Depression and Anxiety*. DOI: 10.1002/da.22288

Key points for consideration

- PTSD has a unique role in driving other disorders over time as well as long term disability
 - Again, highlights importance of early intervention
 - And low uptake of mental health care highlights the importance of screening to increase early detection
- This research highlights the important interaction between physical and mental health impacts
- It calls for integrated treatment services

Impact of Compensation Seeking

Table 2. Claim Experience Survey: Stressor Questions and Results

| Claim Experience Stressors | Stressed Group ^a | |
|--|-----------------------------|------------------------|
| | Claimants, % | Score, Mean (SD) |
| <i>Was this aspect of your claim a source of stress? If so, how stressful was it (scale, 1-5)?</i> | | |
| 1. Understanding what you needed to do for your claim | 33.9 | 3.9 (0.8) |
| 2. The amount of time the compensation organization took to deal with your claim | 30.4 | 4.1 (0.9) |
| 3. The number of medical assessments or examinations you went through for your claim | 26.9 | 3.9 (0.8) |
| 4. The amount of compensation you received | 26.1 | 4.0 (0.9) |
| 5. The fairness with which the compensation organization dealt with your claim | 24.8 | 4.0 (0.9) |
| 6. Getting the compensation organization to listen to what you had to say | 22.1 | 4.3 (0.8) |
| 7. The level of respect and dignity the compensation organization treated you with as a person | 18.3 | 3.8 (0.9) |
| 8. Negative attitudes from doctors or other health professionals because of your claim | 7.9 | 3.7 (0.8) |
| 9. Negative attitudes from friends, family or colleagues because of your claim | 6.9 | 4.0 (0.8) |

Grant, G., O'Donnell, ML., Spittal, M., Studdert, D. . (2014). Relationship between stressfulness of claiming for injury compensation and long-term recovery. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2013.4023

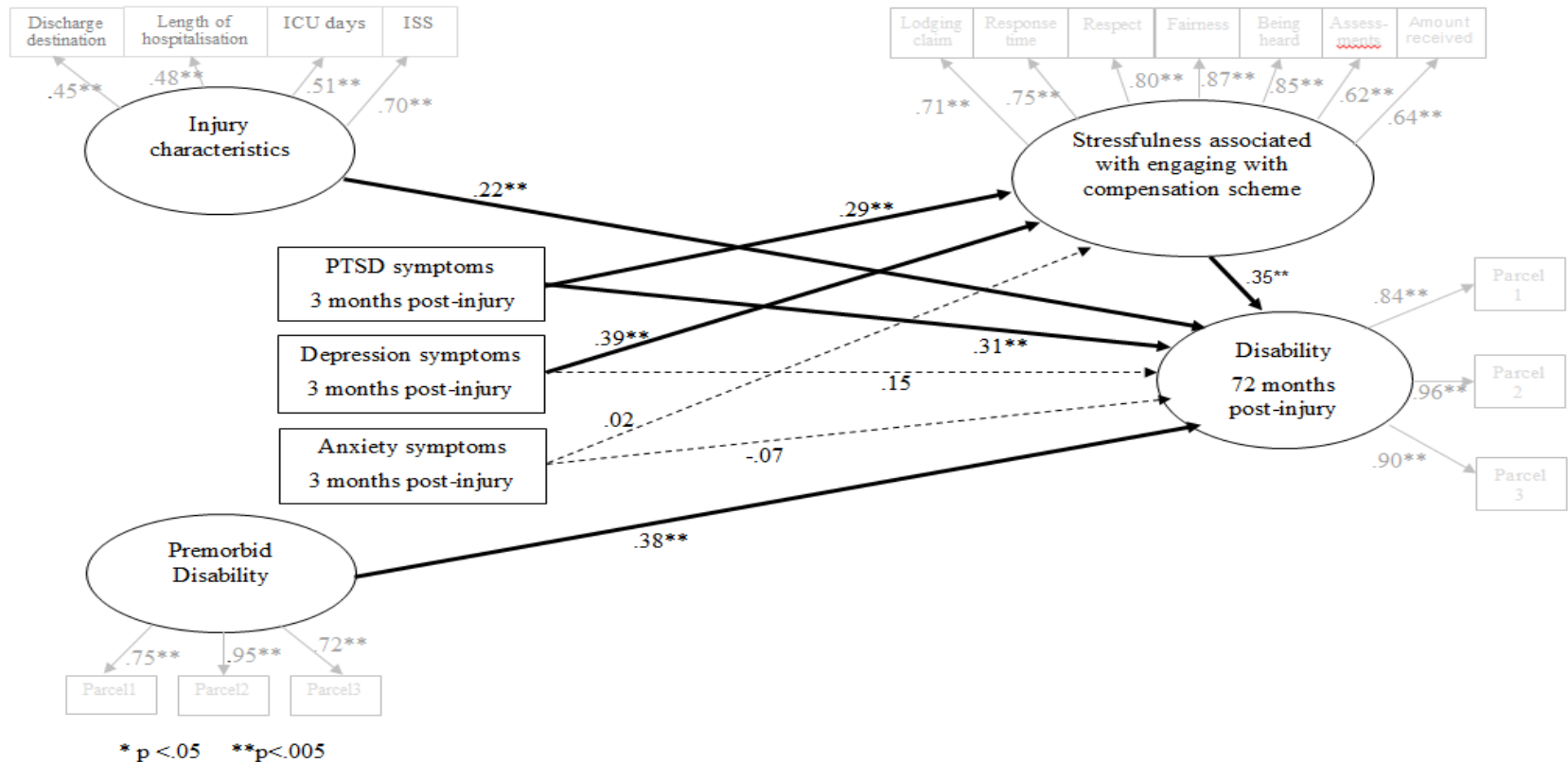
Impact of Compensation Seeking

- Study investigated the relationship between each source of stress and health outcomes
- Found that stress associated with seeking compensation was associated with:
 - higher levels of anxiety and depression
 - higher levels of disability
 - lower levels of quality of life.

(After controlling for age, income, ISS, duration of hospitalisation, gender, psychiatric history, compensation scheme, and disability levels prior to injury)

Impact of compensation seeking

Figure 1 – Structural relationship between 3-month PTSD severity, depression severity, anxiety severity, compensation stress and disability at 72 months after injury.



O'Donnell, ML., Grant, G., Studdert, D., Alkemade, N., Creamer, M., Silove, D., McFarlane, A., Bryant, RA., & Forbes, D. (in press). The role of compensation stress in driving disability after injury: A longitudinal study. *Journal of Clinical Psychology*

Key points for consideration

- Claims process can contribute to disability
 - Can the claims process be modified to address the main sources of stress e.g., increase understanding of the claims process, reduce duration?
- Mental health problems predispose people to experiencing the claims process as stressful
 - These people may benefit from additional support during the claims process

Managing trauma in emergency service organisations

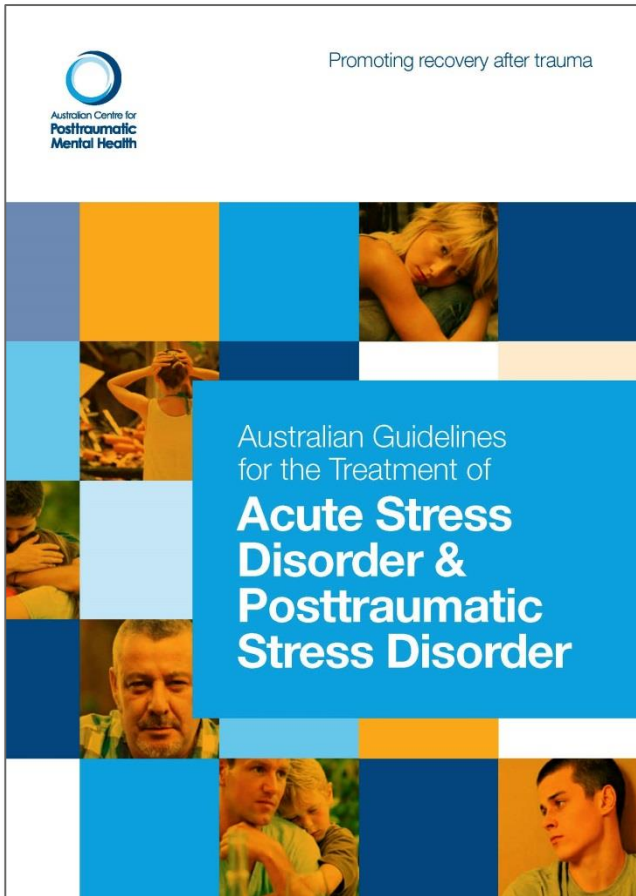
Increasing recognition of responsibility for workers in these industries.

Policy and procedures for:

- preparation for traumatic incidents
- responding to an incident to minimise harm
- ensuring best practice interventions for those affected
- attention to psychological factors even in physical injury

Key challenge is the absence of high level evidence to guide practice

Australian PTSD Guidelines



NHMRC approved



Supported by the Australian Government



Endorsed by professional associations (APS, RACGP, RANZCP)



Used for the PTSD Guidelines for emergency service workers

Key recommendations

Graded A-D, consensus point (CP), good practice point (GPP)

Pre-incident preparedness (e.g., resilience training)

May help psychological adaptation following the event (CP)

Post-incident interventions for all

Structured psychological debriefing is not recommended
(Grade B)

Key recommendations

Post-incident interventions for all (GPP)

- Provide practical and emotional support, access social supports, promote positive expectations
- Support people to talk about it if they choose to but don't insist
- Monitor and step up the level of support if needed

For the treatment of posttraumatic stress disorder

Trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing **(Grade A)**

Application to emergency service organisations

1. Workplace culture
2. Pre-incident preparedness
3. Incident response
4. Post-incident response

Trauma management framework

1. Build a supportive workplace culture

- Recognition of importance of staff morale
- Support for individuals impacted by trauma across all levels of the organisation

Trauma management framework

2. Pre-incident preparedness

At the organisational level

- Policies and procedures for managing PTEs, staff education and training to provide appropriate support

At the individual level

- No proven resilience training but briefings about what to expect, information about potential reactions and strategies to manage those reactions

Trauma management framework

3. Incident response

Policies and procedures to:

- Minimise exposure (number of people, length of exposure, exposure to grotesque elements)
- Minimise cumulative exposure (access to information about past exposures for individuals)
- Support affected workers in fulfilling operational requirements (expectation of resilience)

Trauma management framework

4. Post incident response

- Monitoring, information, emotional and practical support (e.g., psychological first aid)
- Given the variations in responses, the interventions also require flexibility
- Stepped care approach
- Access to evidence based treatment

Comments and questions?

