PTSD in Workers' Compensation:
Accurate Diagnosis, Effective Treatment, and Meaningful Recovery

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IDAHO NEUROPSYCHOLOGY™ PLLC

Disclosures

The information presented in this educational offering reflects the opinion of the presenters. As with all science, there may be multiple explanations for the data and multiple reasonable conclusions.

Note: All cases have been de-identified.

Demographic characteristics of all patients have been altered and non-essential details regarding the patients' histories and courses of treatment have been changed.

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Learning Objectives

- What is posttraumatic stress disorder (PTSD) per DSM-5-TR, and how common is it?
- How do standard physical–mental injury claims differ from Idaho's PTSI statute for first responders?
- How do we evaluate PTSD?
- Is the distress real?
- What does the evidence say about effective treatments for PTSD?
- What happens when PTSD shows up alongside other conditions, like chronic pain or concussion?
- Myths about "being broken forever" and why treatment is time-limited.

PTSD Statistics

Most people who go through a traumatic event will not develop PTSD.

About 6 out of every 100 people (or 6% of the U.S. population) will have PTSD at some point in their lives.

About 5 out of every 100 adults (or 5%) in the U.S. has PTSD in any given year. In 2020, about 13 million Americans had PTSD.

Women are more likely to develop PTSD than men. About 8 of every 100 women (or 8%) and 4 of every 100 men (or 4%) will have PTSD at some point in their life.

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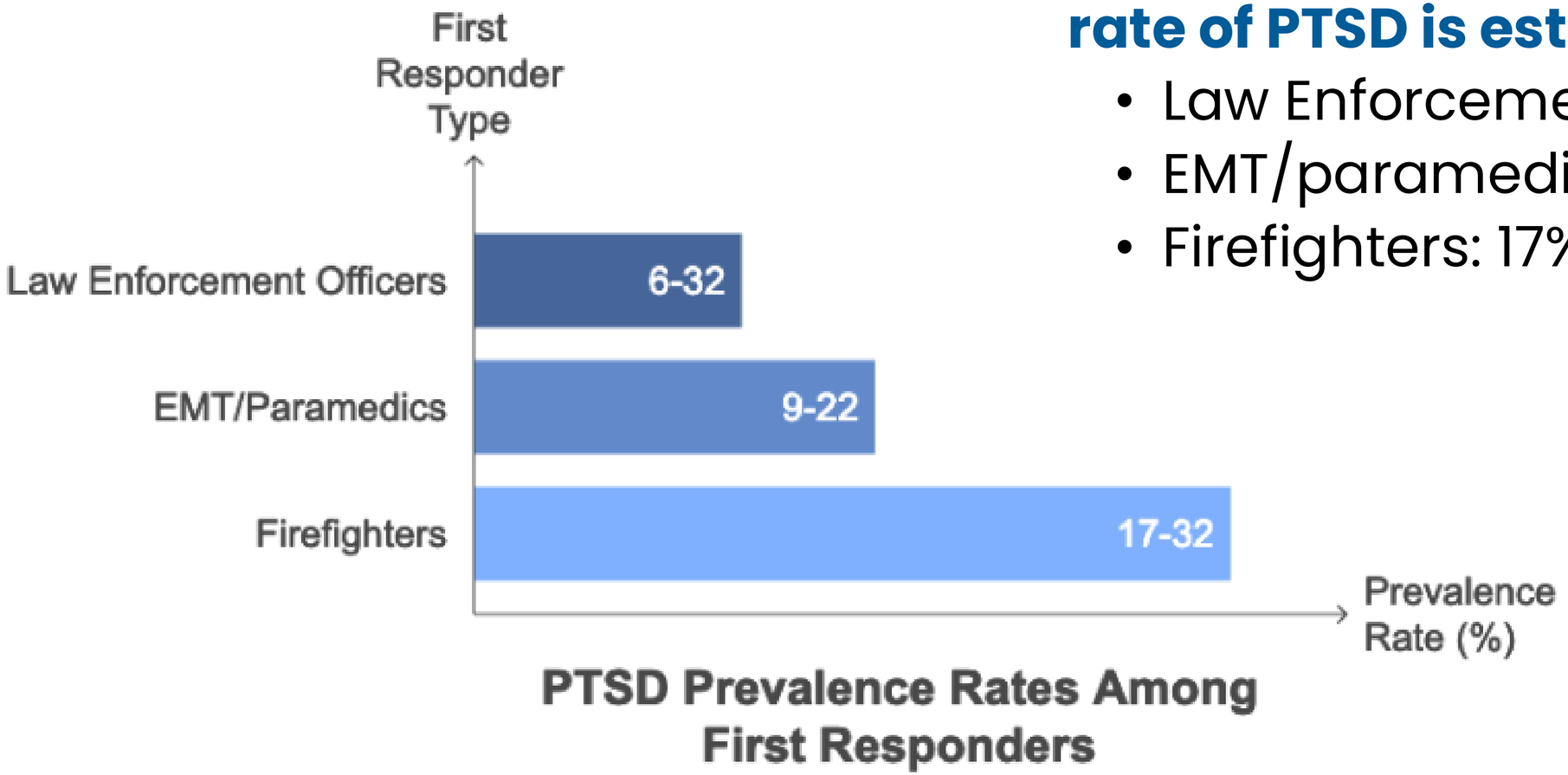
First Responder Specific Stats



PTSD Prevalence Rates Among First Responders

Nationally, the lifetime prevalence rate of PTSD is estimated at:

- Law Enforcement Officers: 6 –32%
- EMT/paramedics: 9% - 22%
- Firefighters: 17% - 32%

PTSD per the DSM-5-TR

Criterion A: Exposure to actual or threatened death, serious injury or sexual violence.

Criterion G: Clinically significant distress or impairment

Criterion F: Symptoms more than 30 days

Criterion H: Not due to another condition

4 symptom buckets

- Criterion B: Re-experiencing
- Criterion: C: Avoidance
- Criterion D: Negative Mood/Cognitions
- Criterion E: Hyperarousal

Idaho Code: 72-451 Psychological Injuries

Idaho Statutes

Idaho Statutes are updated to the web July 1 following the legislative session.

TITLE 72
WORKER'S COMPENSATION AND RELATED LAWS — INDUSTRIAL COMMISSION
CHAPTER 4
BENEFITS

72-451. PSYCHOLOGICAL ACCIDENTS AND INJURIES. (1) Psychological injuries, disorders or conditions shall not be compensated under this title, unless the following conditions are met:

(a) Such injuries of any kind or nature emanating from the workplace shall be compensated only if caused by accident and physical injury as defined in section 72-102(17)(a) through (17)(c), Idaho Code, or only if accompanying an occupational disease with resultant physical injury, except that a psychological mishap or event may constitute an accident where:

(i) It results in resultant physical injury as long as the psychological mishap or event meets the other criteria of this section;

(ii) It is readily recognized and identifiable as having occurred in the workplace; and

(iii) It must be the product of a sudden and extraordinary event;

(b) No compensation shall be paid for such injuries arising from conditions generally inherent in every working situation or from a personnel-related action including, but not limited to, disciplinary action, changes in duty, job evaluation or employment termination;

(c) Such accident and injury must be the predominant cause as compared to all other causes combined of any consequence for which benefits are claimed under this section;

(d) Where psychological causes or injuries are recognized by this section, such causes or injuries must exist in a real and objective sense;

(e) Any permanent impairment or permanent disability for psychological injury recognizable under the Idaho worker's compensation law must be based on a condition sufficient to constitute a diagnosis using the terminology and criteria of the American psychiatric association's diagnostic and statistical manual of mental disorders, third edition revised, or any successor manual promulgated by the American psychiatric association, and must be made by a psychologist or psychiatrist duly licensed to practice in the jurisdiction in which treatment is rendered; and

(f) Clear and convincing evidence that the psychological injuries arose out of and in the course of the employment from an accident or occupational disease as contemplated in this section is required.

(2) Nothing in subsection (1) of this section shall be construed as allowing compensation for psychological injuries from psychological causes without accompanying physical injury.

- Accident AND physical injury ›› psychological injury
  - Sole exception: PTSI for First Responders
  - Cannot arise of HR actions, general work conditions
- Accident must be "predominant cause compared to all other causes combined" of psych injury
- Psychological injury must be "real and objective" (i.e., measurable and meet DSM-5-TR criteria)
  - First Responders must meet for Post-Traumatic Stress Disorder (PTSD) AND "clear and convincing evidence" related to occupational duties

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How is PTSD Evaluated?

- Review of available records
- Comprehensive diagnostic interview
- Broadband measures vs. targeted, in-depth measures of PTSD
  - Example broadband measures:
    - MMPI-3, PAI
  - Targeted PTSD-specific measures:
    - TSI-2, PCL-5, DAPS, CAPS-5, etc.
- Based on interview, assessing differential diagnoses

Differential Dx

- **First responders will almost always meet criterion A**
  - Question is whether they meet the other criteria
  - Example: Criterion H regarding rule-out for other mental health is the piece that appears to be missed at a lot of clinics and inpatient facilities people focus on the Criterion A exposure and do not complete the full differential workup.

- **PTSD has a complex differential with other conditions, which is why over-reliance on PCL is problematic:**
  - Bipolar Disorder (hypomanic/manic episode)
  - Major Depression
  - Substance Use Disorder

Symptom Validity Tests

- Old terminology (e.g., “effort tests”) has been replaced with:
  - Performance validity tests (PVTs): assess potential non-credible performance on cognitive tests
  - Symptom validity tests (SVTs): assess unlikely or non-credible reports on questionnaires *(e.g., Larrabee, 2012; Sweet et al., 2021)*
- Standalone vs embedded
- Research has exploded over last 30 years

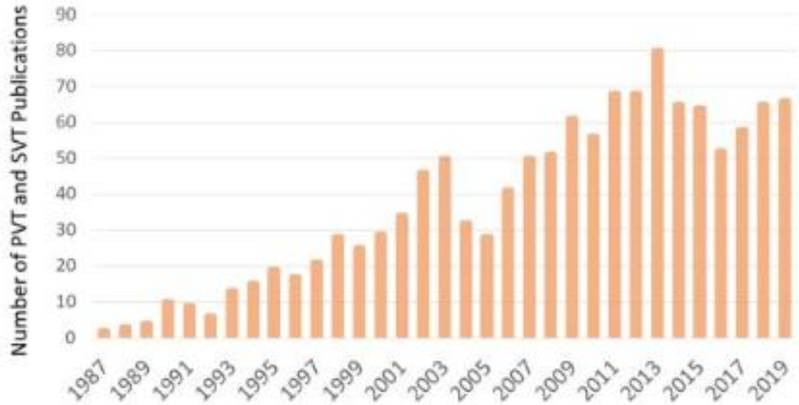

Figure reproduced from Sweet et al. (2021)

Challenges in Assessing PTSD

- PCL-5 does not contain SVTs and has high face validity (easily manipulated)
  - Significant amount of social media coaching online for people for how to ‘present’ with PTSD and game the system
- Need for using higher SVT cut-offs in trauma population on certain tests (e.g., SIMS)
- Evaluation of marked discrepancies

Key Definitions

Malingering

Per DSM-5-TR (APA, 2022): "Intentional production of false or grossly exaggerated physical or psychological symptoms for external incentives…"

Per consensus criteria (Sherman et al., 2020): "…is volitional feigning or exaggeration of neurocognitive, somatic, or psychiatric symptoms for the purpose of obtaining material gain and services OR avoiding formal duty, responsibility, or undesirable outcome." (emphasis added)

Can occur in the context of a real injury and bona fide symptoms

Examples of External Incentive:

- Compensation (e.g., settlement, disability payment, wage replacement)
- Avoidance of work duties
- Attempts to gain access to desired treatments, medications, surgeries

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Key Definitions

Factitious Disorder

Intentional symptom production for internal psychological benefit (APA, 2022).

- E.g., Benefits within a family system for playing the sick role; gaining sympathy from doctors

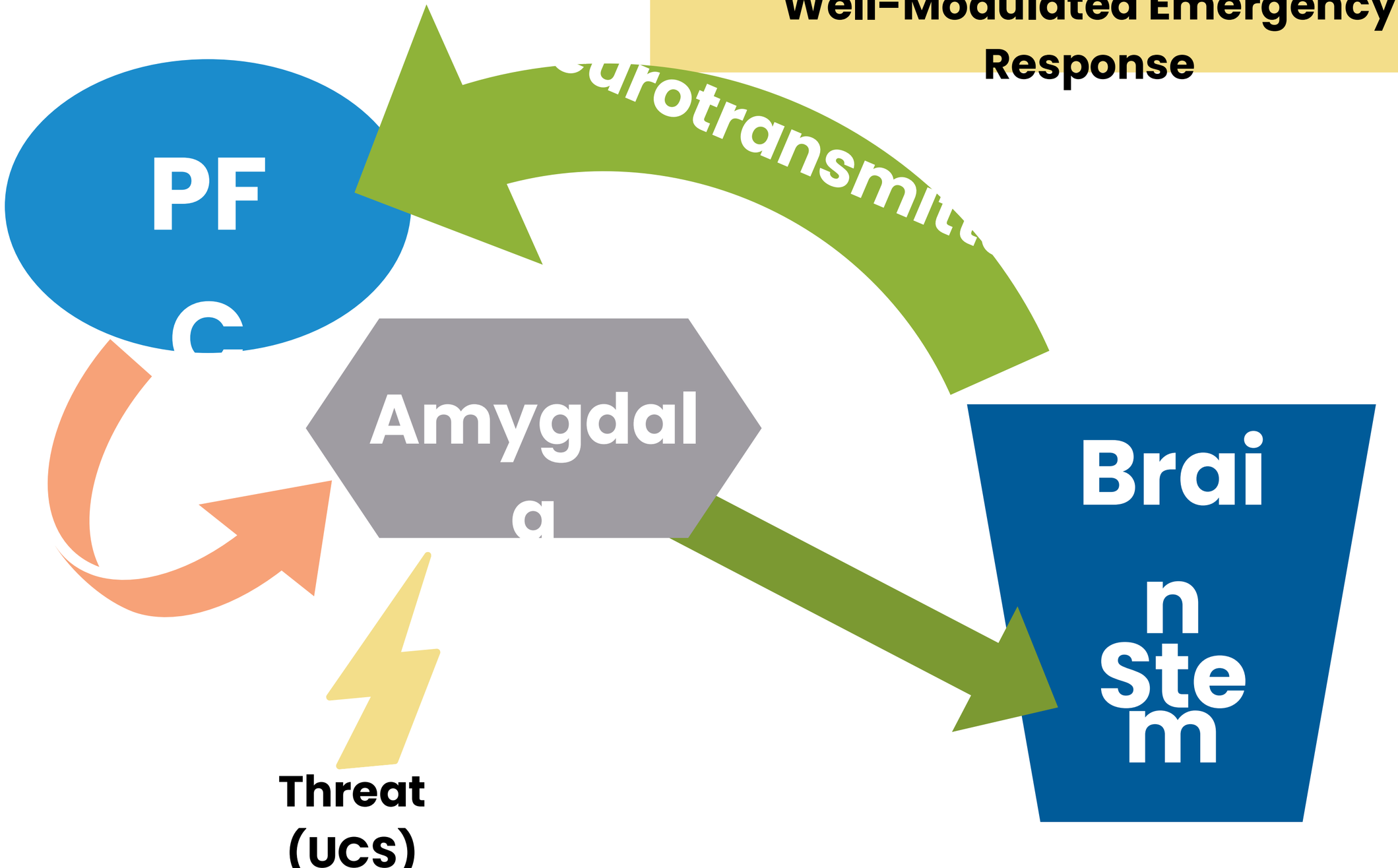
Symptom Exaggeration

Amplification of real symptoms, consciously or unconsciously (e.g., Sherman et al., 2020).

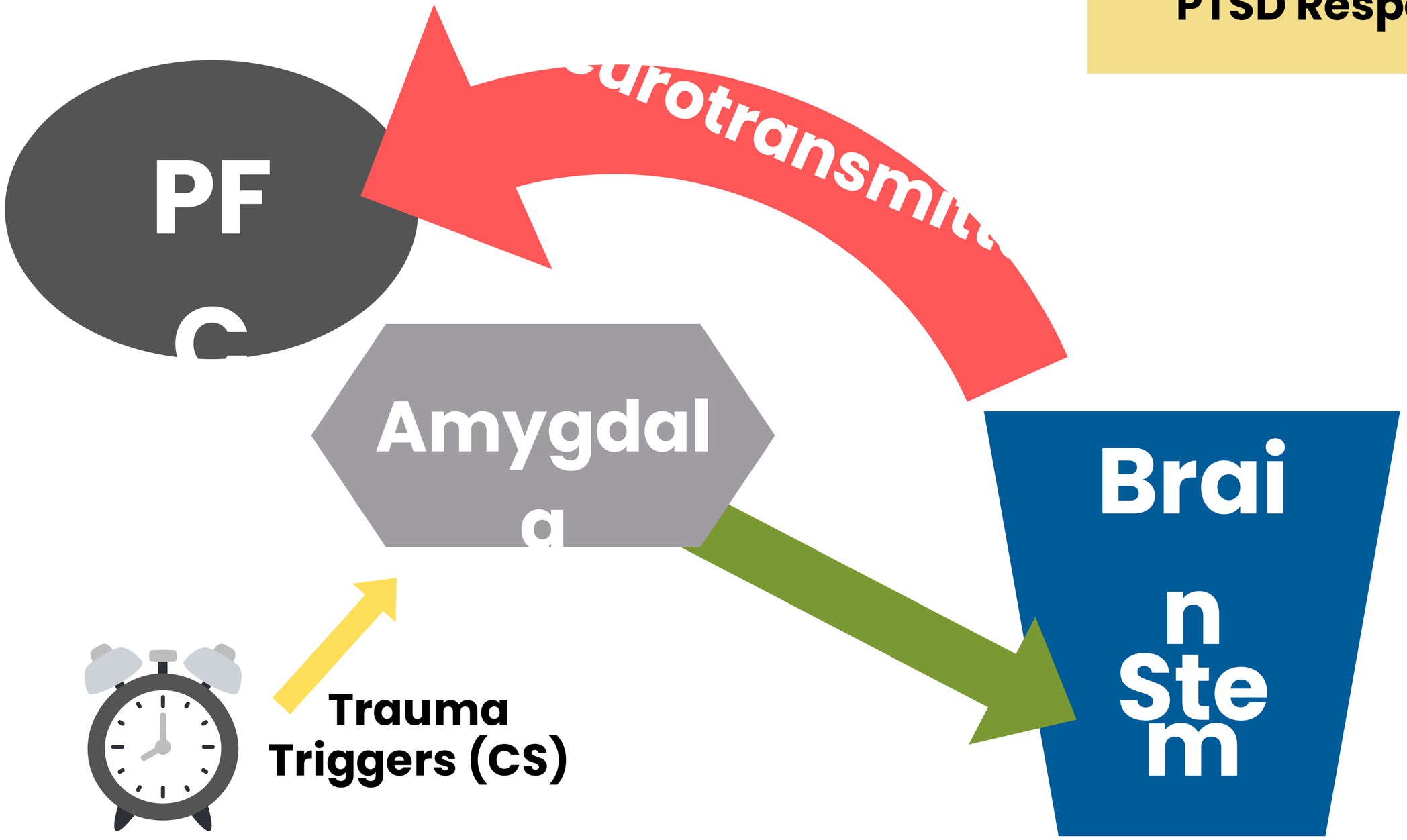
How Does Treatment Work?

Let’s talk about how trauma impacts the brain and how we look at treatment.

Well-Modulated Emergency Response



PTSD Response



How Trauma Therapy May Work

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Trauma Focused Therapy

CT forces the frontal lobe on-line which inhibits the amygdala and prevents extreme emotional responses, even while the trauma circuit is simultaneously & sufficiently activated.

Tale of Two Traumas

Case #1

- Early adult female
- Law enforcement officer
- Combined MVA and response to critical incident
- Referred over 6 months after injury

Case #2

- Middle aged male
- Truck driver
- MVA-both physical and psychological injuries
- Referred within 3 weeks after injury

Treatment Options

Evidence Based Treatment should be the gold standard for PTSD

- Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), Eye Movement Desensitization and Reprocessing (EMDR)
- Other adjunctive treatments, such as mindfulness, hypnosis

Incorporating Treatment with Other Injuries

- Specifically with concussion/TBI
  - Cog rehab
- Collaborating with providers on pain, treatment adherence issues, etc.

Evidence Based Treatment

Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), Eye Movement Desensitization and Reprocessing (EMDR)

CPT
CPT focuses on the five main areas wh see the most change after trauma: saf trust, power/control, esteem and intir Very effective when there is guilt, sha blame or responsibility stuck points.
Hands on/written; daily worksheets or points

Tale of Two Traumas

Case #1

- Cognitive Processing Therapy
- Chosen because of stuck points and responsibility/blame
- 12 total sessions total; PCL drop of 26 points-highly statistically significant

Case #2

- Prolonged Exposure
- Chosen because avoidance of getting back into truck; resurgence of symptoms upon getting back to driving
- 9 total sessions; PCL drop of 27 points-highly statistically significant

When PTSD Isn’t The Only Issue

- Co-morbid with pain
  - Additional resources like ACT and Clinical Hypnosis
- Co-morbid with head injury
  - Cog Rehab
  - Coordination with additional brain rehab services
    - OT
    - PT
    - Speech
- Acknowledgment of other co-morbidities

Does Recovery Mean “I’m Over It” Forever?

- Differences in treatment goals for WC treatment versus “regular therapy”
- Myths about “brokenness”
- Potential harm of “supportive therapy”
- Why time limited treatment is key to return to work
    - What is the status of their relationship with work?
- Massed treatment approach

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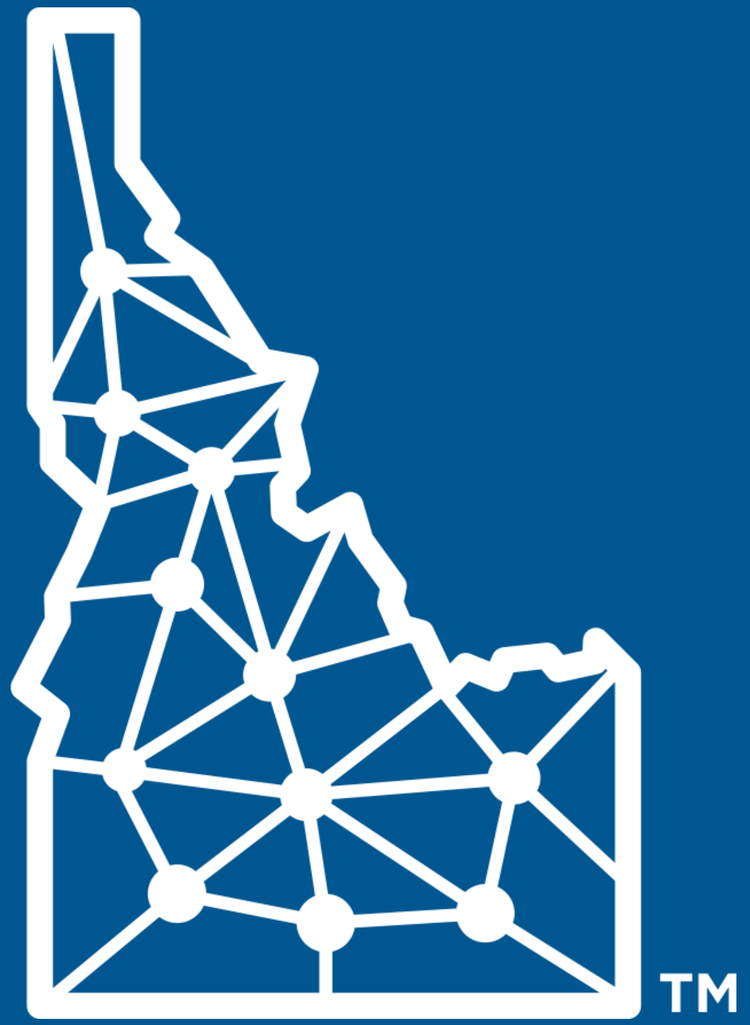

We're here to help

For Additional Questions

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