WSCC MEDICAL BULLETIN – JULY 2021

POST-TRAUMATIC STRESS DISORDER (PTSD)

PTSD is a mental health condition that develops following a traumatic event. It can develop from exposure to traumatic, stressful and frightening event(s) and is categorized as an anxiety disorder.

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), a diagnosis of PTSD requires the following:

Diagnosis of PTSD requires exposure to actual or threatened death, serious injury, or sexual violence in one or more ways. Exposure can happen in one or more of the following:

- The person directly experienced the traumatic event.
- They witnessed, in person, the traumatic event occurring to others.
- They learned someone close to them experienced or was threatened by the traumatic event.
- They are repeatedly exposed to graphic details of traumatic events (for example, if they are a first responder to the scene of traumatic events).

Someone may have PTSD if the problems experienced after this exposure continue **for more than a month** and cause significant problems in the ability to function in social and work settings and negatively impact relationships.

TO DIAGNOSE PTSD:

- **Perform a physical exam** to check for medical problems that may be causing the symptoms
- **Do a psychological evaluation** that includes a discussion of the signs and symptoms and the event or events that led up to them
- **Use the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**, published by the American Psychiatric Association

Symptoms Include:

- Reliving - Flashbacks, hallucinations, nightmares of the incident
- Avoiding - Avoiding people, places, things, or memories that remind of the trauma
- Excessive arousal - Increased alertness, anger, fits of rage, irritability, or hatred, difficulty sleeping or concentrating
- Negative thoughts or feelings such as guilt
- Flat affect

The WSCC requires specific criteria to be met when diagnosing PTSD or other psychological injuries. For instance, PTSD is not typically seen as a Psychological Diagnosis within the first 30 days of an incident or injury. Some other criteria specific to PTSD include, but not limited to:

1. Exposure to actual or threatened death, serious injury, or sexual violence.

2. Presence of one or more intrusive symptoms related to the traumatic event beginning after the event occurred.
3. Persistent avoidance of stimuli associated with the traumatic event.
4. Negative alterations in cognition and mood associated with the traumatic event.*

** see page 271 of DSM-5 for more detailed information*

Some of these criteria overlap with other psychological conditions such as Acute Stress Disorder and Adjustment Disorder, among others.

- It is important to note these differences when offering a diagnosis to an injured worker for a psychological injury.
- For example, PTSD cannot be offered as a psychological diagnosis within the first 30 days of an injury or incident. The diagnosis may be better explained as another posttraumatic disorder.

Page 279 of the DSM-5 states:

> ***Other posttraumatic disorders and conditions.*** *Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to PTSD. The diagnosis requires that trauma exposure precede the onset or exacerbation of pertinent symptoms. Moreover, if the symptom response pattern to the extreme stressor meets criteria for another mental disorder, these diagnoses should be given instead of, or in addition to, PTSD...*

TREATMENTS:

All treatments should focus on a return to function and work.

Psychotherapy

The most recommended and approved forms of treatment are:

- **Cognitive therapy.** This type of "talk" therapy helps recognize the ways of thinking (cognitive patterns) that are preventing functioning and causing increased symptoms - for example, negative beliefs and the risk of traumatic things happening again. For PTSD, cognitive therapy often is used along with exposure therapy. A cognitive behavioural treatment program should incorporate a work component including planning and return to work.
- **Exposure therapy.** This behavioral therapy helps the worker safely face both situations and memories that are frightening to learn to cope with them effectively. Exposure therapy can be particularly helpful for flashbacks and nightmares. One approach uses virtual reality programs that allows a worker to re-enter the setting in which the trauma was experienced.
- **Eye movement desensitization and reprocessing (EMDR).** EMDR combines exposure therapy with a series of guided eye movements that help process traumatic memories and change how an individual reacts to them.

In a study that compared a standard Cognitive Behavioural Therapy (CBT) program to a combined CBT program that incorporated a work component, the combined CBT and work program reduced time to return to work (RTW) by nearly seven months. While both CBT programs reduced emotional symptoms, symptom reduction alone did **not** predict RTW. The authors speculated that the provision of graded activity and skills for managing critical work events provide workers with a sense of control and self-efficacy, challenge dysfunctional beliefs that maintain anxiety, and establish a daily working rhythm (Blonk et al, 2006). It is important that treatments remain work focused.

Medications

Several types of medications can improve symptoms of PTSD including antidepressants and prazosin and if recommended may be approved by the WSCC.

RETURN TO WORK

Return to work can happen in conjunction with treatment and recovery and ideally should be a component of the treatment plan

There are studies that suggest a rapid RTW reduces PTSD-related work impairment. Avoidance which is a common symptom is most effectively treated by early exposure to the work site and graduated approach to work activities. Those not exposed to the workplace within 3 months post trauma remained off work 2 years later. (Grunert et al. 1989; Grunert et al. 1992; Grunert et al. 1990). Unemployment has been found to predict persistence of PTSD symptoms (Nandi et al. 2004).

WSCC Assistance

It is important to work with the WSCC and Employer to identify work modifications that promote worker control over RTW and work activities, and convey acceptance and support for returning workers. The WSCC has a Return to Work Specialist that can assist in working with the employer to make appropriate work modifications:

Work modifications may involve:

- Modifying or removing the specific environment that triggers the memory or reaction
- Minimizing distractions in the workplace
- Flexible work schedule
- Workplace supports
- Guidelines for follow up and feedback
- Conflict resolution mechanisms

If you have any questions about how WSCC can assist you in treating patients with workplace injuries or illnesses, or would like to discuss the above information with WSCC's Medical Unit, contact them here.

REFERENCES

- Blonk, R. W. B., Brenninkmeijer, V., Lagerveld, S. E., & Houtman, I. L. D. (2006). Return to work: A comparison of two cognitive-behavioral interventions in cases of work-related psychological complaints among the self-employed. *Work & Stress, 20*, 129-144.

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