

# Issues in the Assessment of PTSD

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# Objectives

- Causes of Combat Related PTSD
- Conceptual Model of PTSD
- Components of Quality Assessment
- Components of Quality Report
- Documents to be Reviewed
- Can Neuropsychological Assessment Help?
- Research Needs.

- *What causes combat related PTSD?*

# Diathesis – Stress Models

- Individual characteristics comprise diatheses
- Diatheses can be genetic, psychological, physiological, or contextual.
- Life and Death Exposures vary in frequency, intensity, and severity.
- Recovery environment varies considerably.
- Responses to the exposures are a function of the individual's diatheses, the events, the recovery environment.

# Meta-analysis of Risk Factors

- Severity of the Traumatic Event
- Absence of Social Support Post Event
- Additional Life Stressors
- Adverse Childhood Events
- Low SES, Intelligence, Education
- Prior Traumatic Exposure
- Gender

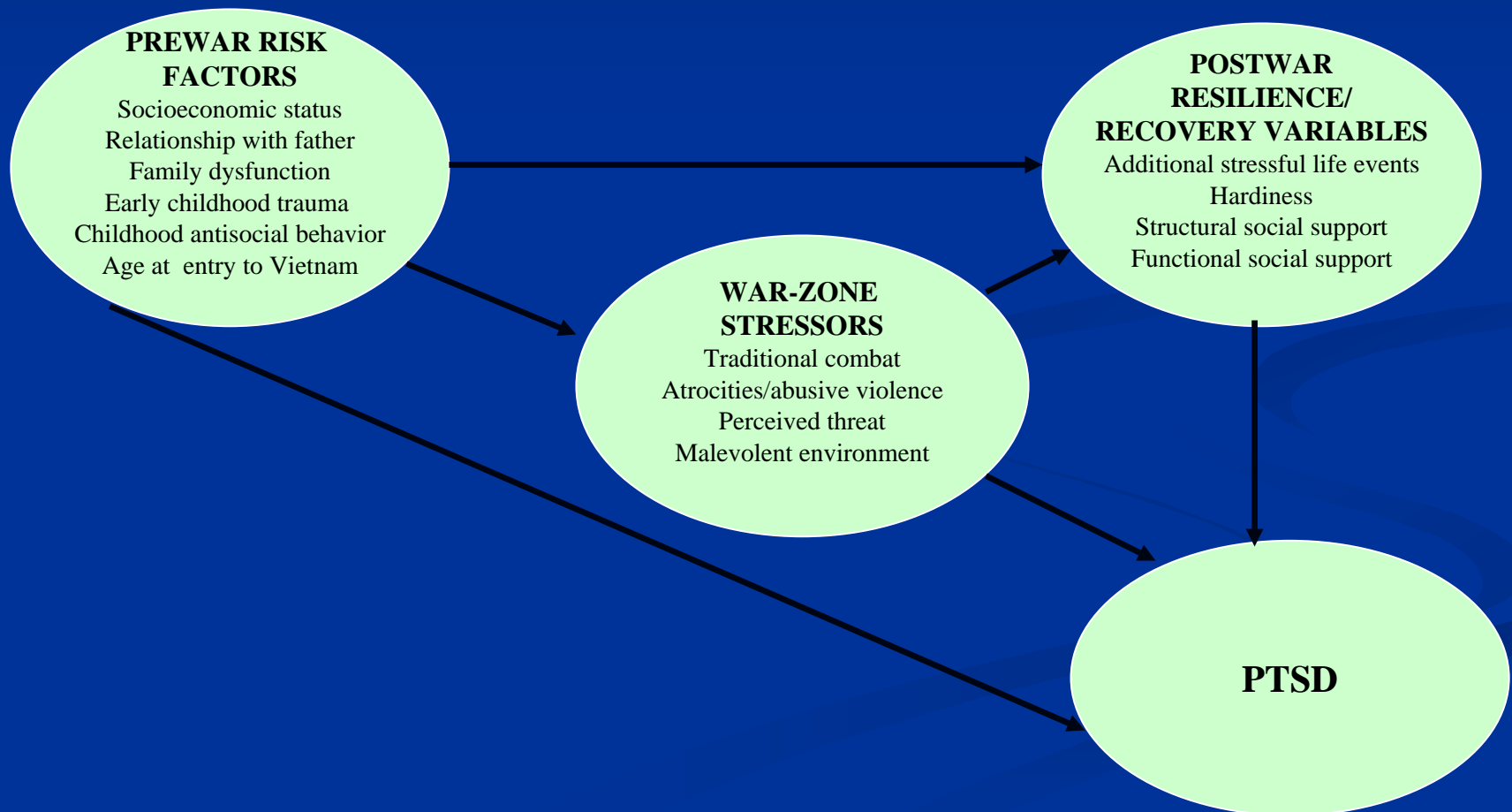
# Warzone Stressors

- Combat events
- Perceived life threat
- Malevolent environment
- Battle aftermath
- Family concerns
- Harassment: sexual, racial, ethnic
- Toxic exposure

*King, King, Keane, Foy, & Fairbank (1998)*

# Kings' NIMH Etiology Studies

GLOBAL PURPOSE: To specify and evaluate a fully integrated model that incorporates all categories of variables: prewar risk factors, war-zone stressors, postwar resilience/recovery variables, and PTSD.



# PTSD ETIOLOGY PROJECT

- For men, the most potent variable set accounting for PTSD was war-zone stressors, followed by postwar factors (e.g., social support), followed by prewar factors (e.g., early family life);
- For women, the postwar factors were most salient, followed by war-zone stressors, and then prewar factors.
- Current PTSD may be tied to multiple exposures to stressful events.
- Depletion of resources was a general theme in the models.
- Resilience/recovery variables are potent.
- In the final integrated model, about 70% of the variance in PTSD symptoms was accounted for, about 50% by war-zone stressors.

# Summary

- NVVRS is only nationwide probability sample of Vietnam Veterans.
- Data collection by experts outside VA.
- Minimal personal gain for participants.
- A priori validation of measures of PTSD.
- Clinical re-examination of cases & non cases.
- Employed multiple measures of PTSD construct
- Established a statistical algorithm for caseness.

*Conceptual Model....*

# A Model of the Etiology of Posttraumatic Stress Disorder (PTSD)

Generalized Psychological Vulnerability

Generalized Biological Vulnerability

Experience of Trauma

True Alarm  
(or alternative intense basic emotion, such as anger or distress)

Learned Alarm (or strong mixed emotions)

Anxious Apprehension  
(focused on re-experienced emotions)

Avoidance or Numbing of Emotional Response

PTSD

Moderated by Social Support and Ability to Cope

*Assessing &  
Diagnosing.....*

- *Classification Issues...*

# Psychiatric DSM

- Classification Systems are optimal when one element in the scheme is distinguished from the other elements using the fewest features possible.
- PTSD does not and should not describe all possible symptoms of the condition.
  - Complex PTSD is unnecessary addition to nomenclature.

# Conditions Following Traumatic Event

- PTSD
- Depression
- Substance Abuse (esp. Alcohol)
- Panic Disorder
- Phobias
- Transient Psychotic Reactions

# Utility Analysis

	PTSD (+)	PTSD (-)	Total
Assess (+)	True Positive	False Positive	<b>PPP Test</b>
Assess (-)	False Negative	True Negative	<b>PPN Test</b>
Total	<b>Sensitivity</b>	<b>Specificity</b>	Total N

- *What constitutes optimal evaluation of a patient for PTSD?*

# Multimethod Assessment of PTSD

- Clinical Diagnostic Interviews
- Psychological Testing
- Neurobiological Testing (Reactivity Measures)

*“All are imperfect and require clinical judgment in their use.”*

*Keane & Barlow (2002)*

# Diagnosing PTSD

- Clinician-Administered PTSD Scale(CAPS)
- PTSD Symptom Scale
- Structured Interview for PTSD
- PTSD Interview
- PTSD Module of SCID

# Assessment of Other Conditions

- **Structured Clinical Interview for DSM-IV**
  - One Hour to Complete
  - Covers Broad Array of Diagnoses
  - Provides Information on Past & Current
  - Uses Branching Strategy
  - Provides Clinician Flexibility
  - Comfortable for Patient

# Dimensional Measures of PTSD

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- Mississippi Scale for Combat Related PTSD
- PTSD Checklist (PCL)
- PTSD Diagnostic Scale (PDS)
- Davidson Trauma Inventory

# Functioning & QOL

- SF-36 from Veterans MOS
- Examine WHO's Disability Tools
  - Adopt for US Veterans
  - Consider modifications for physically disabled.
  - Utility for Polytrauma Blast Injuries
  - Incorporate TBI survivors.
- Distinguish QOL from Disability & Functioning

# Personality Assessment

- Minnesota Multiphasic Personality Inventory-2
  - One Hour Self Report Measure
  - Widely Used Measure of Personality/Pathology
  - Keane PTSD Scale (PK)
  - Validity Indices:
    - F, F-K, F-Back, F(p)
    - VRIN, TRIN
    - Lie, Defensive, Malingering
  - Measures of Approach to Assessment.

# Limitations of Psychological Assessment

- Self Report can yield inaccuracies.
- Sensitivity and Specificity at .90 yields false positives and false negatives.
- Limits of Skills/Experience of Evaluators.
- Best Practices Not Adopted.
- Negative attitudes to evidence base practice.

# Report Preparation

- Military History & Documentation of Exposure
- Other Lifetime Stressors (Death of Parent, etc.)
- Assessment Results:
  - Structured Diagnostics
  - Specification of Symptoms Meeting Criteria
  - Psychometric Findings
  - MMPI-2 Results
  - Psychophysiological Assessment Results
- Integration, Summary, & Recommendations

# Exaggeration for Compensation?

- 1982-86: Keane, Fairbank & Malloy:
  - Symptom Elevation
- 1987-91: Hyer & Boudewyns:
  - Symptom Over-reporting
- 1996-present: Frueh, et al.:
  - Symptom Exaggeration (Extreme Exaggeration).

# Symptom Exaggeration?

- *“It is important to note, however, that the validity profile of CS veterans is not, by itself, indicative of malingering.”*
- *“This caveat regarding the interpretation of validity scales is supported by the diagnostic data from clinical interviews which indicated that 92% of the CS veterans had PTSD.”*

*Frueh, et al., (1996)*

*How should stressful events be documented?*

# Document Review

- C-File for Exposure to Combat, Medals, Honors
- DD-214
- Unit Reports (Expensive, when available).
- Medical Records (Examine for gaps, esp. MH)
- Occupational Records when available.
- Family Reports (e.g., Spouse Mississippi Scale)
- Forensic Records.

***All are fallible sources of information.***

# Self Report Indicators

- Vietnam Era:
  - Combat Exposure Scale (Keane, et al. 1989)
  - War Zone Stress Exposure (Kulka, Schlenger, et al. 1988).
- Persian Gulf War I:
  - War Zone Exposure (Wolfe, et al. 1993, 1994)
- Persian Gulf War II:
  - Deployment Risk & Resilience Inventory (King, King, & Vogt, 2005)

# Criticisms of Self Report

- Memory is viewed as an active process.
  - Cross Lagged Analysis shows trivial changes in time.

“Actual number of changes with a 31 item inventory are relatively unremarkable...Some change should be expected.”

*King, King, et al. (2000)*

- *Can neuropsychological assessment help?*

# Neuropsychological Assessment

- Cognition
- Memory
- Attention
- Information Processing
- *Neuroimaging?*

*Future Scientific Work....*

# Directions for Research

- Cross-Cultural Assessment Studies
- Enhancement of Psychophysiological Assess.
- Generalization of Tools to OEF-OIF
- Further Development of Combat Exposure Tools
- Item-Response Theory/Methods to Shorten
- Adopt WHO Functioning/QOL Measures for VA Pop.
- *VA Cooperative Studies Program: Clinical v. Actuarial.*

# National Center Website

For Further Information:

[www.ncptsd.va.gov](http://www.ncptsd.va.gov)

