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Summary of *Posttraumatic Stress Disorder: Diagnosis and Assessment*

The Commission examined the reports of two studies that the Institute of Medicine conducted for the Department of Veterans Affairs on posttraumatic stress disorder in service members and veterans. This appendix contains the summary from the first of those reports, *Posttraumatic Stress Disorder: Diagnosis and Assessment*. The full report is available from The National Academies Press at www.nap.edu.

SUMMARY

In response to growing national concern about the number of veterans who might be at risk for posttraumatic stress disorder (PTSD) as a result of their military service, the Department of Veterans Affairs (VA) asked the Institute of Medicine (IOM) to conduct a study on the diagnosis and assessment of, and treatment and compensation for PTSD. An existing IOM committee, the Committee on Gulf War and Health: Physiologic, Psychologic and Psychosocial Effects of Deployment-Related Stress, was asked to conduct the diagnosis, assessment, and treatment aspects of the study because its expertise was well-suited to the task. The committee was specifically tasked to "review the scientific and medical literature related to the diagnosis and assessment of PTSD, and to review PTSD treatments (including psychotherapy and pharmacotherapy) and their efficacy." In addition, the committee was given a series of specific questions from VA regarding diagnosis, assessment, treatment, and compensation. The questions pertaining to diagnosis and assessment and the committee's responses are provided in Appendix A. This report is a brief elaboration of the committee's responses to VA's questions, not a detailed discussion of the procedures and tools that might be used in the diagnosis and assessment of PTSD.

The committee decided to approach its task by separating diagnosis and assessment from treatment and preparing two reports. This first report focuses on diagnosis and assessment of PTSD. Given VA's request for the report to be completed within 6 months, the committee elected to rely primarily on reviews and other well-documented sources. A second report of this committee will focus on treatment for PTSD; it will be issued in December 2006. A separate committee, the Committee on Veterans' Compensation for Post Traumatic Stress Disorder, has been established to conduct the compensation study; its report is expected to be issued in December 2006.

CHARACTERISTICS OF POSTTRAUMATIC STRESS DISORDER

PTSD is a psychiatric disorder that can develop after the direct, personal experiencing or witnessing of a traumatic event, often life-threatening. The essential characteristic of PTSD is a cluster of symptoms that include:

- Re-experiencing—intrusive recollections of a traumatic event, often through flashbacks or nightmares,
- Avoidance or numbing—efforts to avoid anything associated with the trauma and numbing of emotions,
- Hyperarousal—often manifested by difficulty in sleeping and concentrating and by irritability.

If those symptoms last for a month or less, they might be indicative of acute stress disorder; however, for a diagnosis of PTSD to be made, the symptoms must be present for at least a month and must cause "clinically significant distress and/or impairment in social, occupational, and/or other important areas of functioning."

CURRENT DIAGNOSTIC CRITERIA

Although there is a long history of descriptions of posttraumatic syndromes, the modern era of diagnosing PTSD began in 1980 with the introduction of PTSD in the third edition of APA *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*). Formal recognition of PTSD led to a large body of systematic research on its features and research findings led to modification and refinement of the diagnostic criteria. But many of the diagnostic criteria from *DMS-III* are largely unchanged in the latest revision of the fourth edition of the diagnostic manual, *DSM-IV-TR* (hereafter referred to as the *DSM-IV*).

The evidence-based diagnosis of PTSD, according to *DSM-IV* (see Box 2.1) has several components: exposure to a traumatic event, intrusive re-experiencing of the event, avoidance and numbing, hyperarousal, duration of symptoms for at least a month, and clinically significant distress or impairment that was not present before the trauma.

CLINICAL DIAGNOSIS AND ASSESSMENT

Numerous traumatic events or stressors are known to influence the onset of PTSD; however, not everyone who experiences a traumatic event or stressor will develop PTSD. Its development depends on the intensity of the traumatic event or stressor and on a host of risk and protective factors occurring before, during, and after the trauma.

After a traumatic event, there is substantial variation among patients with regard to both the timing of the onset of symptoms and the types of symptoms. Furthermore, there might be a delay between the onset of symptoms and when the patient seeks help. Patients also vary in how they present to a health professional. For example, a patient might present at a health facility with a physical or psychiatric complaint unrelated to PTSD, and it is only during the course of evaluating or treating the patient for the presenting complaint that symptoms of PTSD can be identified and a diagnosis made. In other cases, a patient might present to a mental health professional who is conversant with the diagnosis of PTSD and is better able to elicit a narrative of exposure and symptoms; or a family member or other person familiar with the veteran might seek advice from a health professional about coping with a veteran who might be suffering from PTSD. The presenting symptoms and initial diagnostic process are variable and might necessitate a brief or long assessment.

Optimally, a patient is evaluated in a confidential setting with a face-to-face interview by a health professional experienced in the diagnosis of psychiatric disorders, such as a psychiatrist, psychologist, clinical social worker, or psychiatric nurse. The interview should elicit the patient's symptoms, assess the history of potentially traumatic events, determine whether the patient meets the *DSM-IV* criteria for PTSD, determine the frequency and severity of symptoms and the associated disability, and determine whether there are comorbid psychiatric and medical conditions. It is critical that adequate time be allocated for this assessment. Depending on the mental and physical health of the veteran, the veteran's willingness and capacity to work with the health professional, and the presence of comorbid disorders, the process of diagnosis and assessment will likely take at least an hour and could take many hours to complete.

Unfortunately, many health professionals do not have the time or experience to assess psychiatric disorders adequately or are reluctant to attribute symptoms to a psychiatric disorder. Furthermore, veterans with PTSD might not present to a mental health professional, because they do not attribute their symptoms to a psychiatric disorder, they feel that a stigma is associated with psychiatric illness, they have limited access to such professionals, or for other reasons, such as cost. Therefore, health professionals should be aware that veterans, especially those who have

served in war theaters, are at risk for the development of PTSD, but might present with physical or psychiatric complaints that are symptomatic of substance use disorder or other psychiatric conditions. Health professionals should ask all veterans about possible exposure to potentially traumatic events.

A basic component in diagnosing PTSD is determining whether a person has experienced a traumatic event that has led to symptoms indicative of PTSD (see criterion A in Box 2.1). A war environment is rife with opportunities for exposure to traumatic events of many types. Types of traumatic stressors related to war include serving in dangerous military roles, such as driving a truck at risk for encountering roadside bombs, patrolling the streets, and searching homes for enemy combatants, suicide attacks, sexual assaults or severe sexual harassment, physical assault, duties involving graves registration, accidents causing serious injuries or death, friendly fire, serving in medical units, killing or injuring someone, seeing someone being killed, injured, or tortured, and being taken hostage.

ASSESSMENT INSTRUMENTS

The most important consideration in diagnosing PTSD is a systematic, comprehensive approach to obtaining a patient's clinical history in a face-to-face, confidential diagnostic interview. Structured and semi-structured approaches to diagnosing PTSD are also useful, especially in epidemiologic and treatment-outcomes research. Some of the most widely used interview instruments for diagnosing PTSD are the Clinician-Administered PTSD Scale (CAPS), the Structured Clinical Interview for DSM-IV, the PTSD Symptom Scale–Interview Version, the Structured Interview for PTSD, the Diagnostic Interview Schedule IV, and the Composite International Diagnostic Interview.

Structured interviews such as the CAPS, which were developed specifically for diagnosis of PTSD, might take an hour or more to administer, although others, such as the PSS-I, can take less time. There are also several self-report instruments that can be used to help document symptoms and traumatic exposures. These include the Posttraumatic Diagnostic Scale, the Davidson Trauma Scale, and the Detailed Assessment of Posttraumatic Stress (DAPS). Each of the instruments determines what symptoms of PTSD are present, as well as their frequency and intensity.

Although numerous instruments have been developed for the diagnosis and assessment of PTSD, the committee strongly concludes that the best way to determine whether a person is suffering from PTSD is with a thorough, face-to-face clinical interview by a health professional trained in diagnosing psychiatric disorders. Such a health professional will be familiar with the *DSM-IV* criteria for PTSD (which the committee finds are appropriate for diagnosing PTSD) and will use those criteria when diagnosing patients.