



PTSD 101 Course

Transcript for: Functional Impairment and PTSD

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Hi, I'm Dr. Brian Marx, and I'm a psychologist at the National Center for PTSD and VA Boston Healthcare System, and I'm a professor at the Boston University School of Medicine, and I'm going to be talking to you today about functional impairment and posttraumatic stress disorder.

What I'm hoping to do today for you is to provide you with an overview of several related topics that may be of particular relevance to you and your work with individuals who experience trauma and suffer from PTSD and other trauma-related disorders.

Certainly the extent to which one's PTSD is related to functional impairment has direct implications for both our assessment and treatment decisions.

So, briefly, what I hope to do during this talk is three things. First, I'll discuss how PTSD impacts quality of life and functioning, and I'll review some of the research findings in that area. Second, I'll identify and elaborate on the VA/DoD 2010 Clinical Practice Guidelines for assessing PTSD-related functional impairment, and finally, I will describe some of the measures that can be used to assess psycho-social functioning, and quality of life, for those with posttraumatic stress disorder.

However, before we do so, I'd like to start with a case example in order to bring to life some of the things that I'll be talking about today. The case is a 64-year-old divorced, white male who is a Veteran of the United States Marine Corps. He did two tours in Vietnam in the late 1960's and, during his time in Vietnam, he saw very heavy combat. He reportedly feared for his life on numerous occasions, and also reported that he saw friends get injured and die.

Since his return from Vietnam he reported that he has experienced many of the hallmark symptoms of posttraumatic stress disorder. For example, he reports having frequent nightmares; he frequently experiences intrusive thoughts and memories about his experiences; he is distressed when he encounters reminders of Vietnam, and he tries to avoid these reminders at all costs; he experiences emotional detachment from others; he reports emotional numbing; he is unable to experience pleasure; he also reports sleep problems frequently and severe hyper vigilance when in public.

But, perhaps the most important or significant symptom for him is his anger, which has gotten him into trouble on many occasions, both within his social life as well as from a legal point of view, too. He has assaulted people because he has gotten so angry at them and, obviously, this has been problematic. He

also reports a significant history of drug and alcohol use, and he reports his use being related to his attempt to distract himself from the distressing memories, to help him sleep, to not feel so distressed when he encounters reminders of his times in Vietnam.

As a consequence of many of these symptoms, he reported having a lot of difficulties across multiple facets of his life. For example, because of his need to use drugs and alcohol to numb himself, and reduce the frequency and severity of his memories and trauma-related distress, he had to retire early from his job as a truck driver.

He also reports significant social difficulties related to his anger, aggression, and emotional detachment. As I said, he was unable to sustain relationships. He had difficulties in his relationships with his children as well. He also reported being extremely distressed as a result of these problems at work and in his social life. He lamented them greatly and he really wished that his life was different, that things were, quote unquote, “back to normal” for him in the way that they were prior to him going to Vietnam.

And, in fact, I think it's safe to say that, probably the dysfunction that he was experiencing at work, and his social relationships, was really the motivating force for him to come into therapy. And, finally, as a function of his PTSD and the impairment that he was experiencing, as a function of his PTSD, he now receives disability benefits from VA for this service-connected PTSD.

Now, I wanted to bring up this case because I think that it illustrates three important things. The first thing that it illustrates, is that individuals with PTSD experience problems in functioning across a variety of domains, or parts, of their life. They experience problems in their social functioning. They experience problems in their occupational functioning, their academic functioning, and just their day-to-day stuff that goes on at home.

It also illustrates the importance of functioning for individuals with posttraumatic stress disorder. As I said, this person was extremely distraught by the fact that his symptoms were having such an impact on his life, and that was what brought him to therapy in the first place. And, thirdly, what I'd like to point out is that this case illustrates why what we do matters so much, because it's not necessarily the symptoms that matter a whole lot to these people but the impact that they have on their lives, and so, the work that we do not only reduces their symptoms but also helps them to get their lives back in order, which is what they care about most.

So, with that now, I'd like to start talking about Objective One, which is understanding how PTSD affects our quality of life. The research is actually fairly extensive in this area, and so, I'm not going to go into a lot of detail in this discussion. Instead, what I'd like to do is really summarize the most important information that we have from this research

Before we get into the actual findings, what I'd like to do is, I'd like to take a step back and define what we mean when we talk about quality of life. The World Health Organization defines quality of life as our physical, mental, and social well-being. It's helpful in one sense, but it's kind of a vague description of what quality of life is, in another. And, there are some researchers who have suggested that quality of life has three components, the first component being our social, material conditions; things like what our employment status is, our annual income, what our marital status is. That's what they mean by our social material conditions. The second component of quality of life is our functioning. Functioning has been defined as our role performance.

So, in other words, how well one performs our duties on the job, how one performs his or her duties as a parent, as a spouse, as a caregiver and so on. So, when we talk about, if we think about functioning, in this regard, as our role performance, then impairment and functioning or functional impairment is really the difficulty that we experience in our role performance.

And, finally, the third component of quality of life is satisfaction. Satisfaction is typically defined as our subjective sense of well-being; how happy are we, generally speaking.

Why do we care about quality of life? Well, it used to be the case that we didn't really care about our quality of lives all that much, but it's really now viewed as a very important component of our health. And, in fact, one model of healthcare sees not just the quantity of our lives, or how long we live, but the quality of our lives as a very important outcome, and so, there's lots of attention being paid to it for that reason. And, in relation to what we're talking about today, it's been increasingly recognized that mental disorders play a very important role in our quality of life.

In general, we know from the research that PTSD is associated with reduced quality of life for both Veterans and civilians alike. And, in fact, there was a recent meta-analysis of this research and, specifically, this meta analysis looked at the associations between quality of life and all of the anxiety disorders: PTSD, panic disorders, social anxiety disorder, obsessive compulsive disorder and so on.

And, Olatunji, and colleagues, found in this meta analysis that PTSD actually had a very large effect on multiple dimensions of quality of life. And, in fact, the associations between PTSD and quality of life were among the strongest of all of the anxiety disorders. It appears that PTSD exerts an incredibly important effect on our quality of life.

If we break down quality of life into the three components that I discussed earlier we see that research has looked at each of those components, respectively, and what we know from the research is that, with respect to social and material component of quality of life, we know that PTSD is associated with greater unemployment, greater likelihood of homelessness, greater likelihood of divorce and marital difficulties. We know that PTSD is strongly associated with financial loss and legal difficulties as well.

With respect to the second component of quality of life, that is functioning, we know that there is a strong relationship there as well. Most of the studies that have looked at the association between PTSD and quality of life have focused on functioning, so there's a lot of research that has really examined this question.

We know that PTSD, as you saw from the case example that I mentioned earlier, PTSD exerts a powerful effect on social functioning. It can play a serious role in impairing social relationships. It also can impair occupational and academic performance, as well as performance among other domains as well.

The research, interestingly enough, also shows that people who don't meet the full criteria for PTSD, also display significant impairments across multiple domains of functioning. So, the important thing there to recognize is that, you can have some symptoms of PTSD, or partial PTSD, and still be significantly affected by those symptoms.

An important point to mention here is that a lot of the research in this area that's looked at the association between PTSD and functional impairment is cross sectional, meaning that these associations have been looked at simultaneously within the same time point, and that's problematic from the standpoint of knowing which came first and what's effecting what. But, now, there's more and more research coming out that has been longitudinal in nature, which shows that PTSD symptoms actually predict future impairments, so we can see that, over time, PTSD does have a deleterious effect on one's functioning.

With respect to satisfaction, we see a similar trend in the findings. We know that PTSD is related to lower overall life satisfaction. We also see, more specifically, that it's related to reduced satisfaction in relationships.

There's been some research to show that it reduces satisfaction in parenting. And interestingly, the reductions in satisfaction that we see are on par with the reductions in satisfaction that we see among those who are depressed or have symptoms of depression.

Following up on this more global examination of PTSD and quality of life and functioning, there's been some research that has examined exactly which PTSD symptoms are related to decreases in quality of life and functional impairment. And, what that research shows us, is that it's more of the avoidance and numbing symptoms of PTSD that are most strongly associated with decreases in quality of life and increases in functional impairment.

I think it's easy to see why that may be, and the research does suggest that these symptoms lead to problems in functioning and quality of life, because they may lead to the individual withdrawing or having some difficulty in expressing themselves, emotionally speaking. And, so you can see how that could get someone into trouble in their social relationships and in their occupational functioning. That was certainly the case for the client that I mentioned earlier.

The research also shows that it's the PTSD symptoms of hyperarousal that are also very important here. So, symptoms of difficulty concentrating, difficulty with sleep, and anger. It's very easy to see how, if you're experiencing problems in those areas, that that could then translate into problems in functioning and quality of life.

A lot of this research that's been done has been done with Veterans, but it's not exclusively done with Veterans. It's certainly been done with civilians, too. And, most of the research, initially, was done with Veterans of the Vietnam era, and I think it's important to point out here that, as we have more folks coming back from Iraq and Afghanistan, this research is being replicated with those folks, too, and what we see is very similar findings. We're seeing that these associations with PTSD and decreases in quality of life and functional impairment are holding up among this younger cohort of Veterans.

So with that out of the way, let's now talk about the second objective of this talk, which is to go over the Clinical Practice Guidelines for assessing PTSD-related functional impairment.

The Clinical Practice Guidelines were published jointly in 2010 by the Departments of Veterans Affairs and the Department of Defense. And, the purpose of publishing these Clinical Practice Guidelines was to bring the evidence-based practice to clinicians, who provide care to trauma survivors and those with PTSD in need of services within VA and DoD.

Now, that being said, it's important to point out that these guidelines are not just pertinent to those who work within the VA or DoD. They certainly are relevant for those who work with civilians outside of VA and DoD. And, so, what I'd like to do now, is briefly describe the Clinical Practice Guidelines, and then provide some additional information that could be helpful to you when assessing PTSD-related functional impairment and decreases in quality of life.

So, what do the Clinical Practice Guidelines say? Generally speaking, what they do is they recommend a thorough, comprehensive approach to assessing PTSD-related functional impairment and quality of life. And, that's in order to do several things. The first thing is to assess PTSD-related functional impairment and quality of life in order to identify those who are at risk for endangerment to self or others. We know that those with serious problems in functioning, those who are experiencing real decrements in their quality of life, may be at risk for harming themselves and others, so, obviously, it's important to catch that ahead of time.

It's also important to conduct a thorough comprehensive assessment in order to promote an accurate diagnosis of PTSD. Obviously, this is important since a person can only be diagnosed with PTSD if they report significant distress, or impairment, related to their symptoms. Thirdly, a thorough assessment of

functional impairment is important from a treatment planning point of view. It's important to know what kinds of problems they're experiencing so we know whether or not to address them within the context of our treatment.

And, finally, it's important to have a sense of what kinds of problems they're experiencing so that we can see, hopefully, that those problems are improving over the course of our treatment.

The term comprehensive thorough assessment is pretty vague, I think, and so, it's important to really point out what is meant by thorough comprehensive assessment, and I think it really means two things. Number one, a comprehensive assessment of functioning and quality of life means thoroughly assessing all of the relevant domains.

So, for quality of life, what that means is assessing those three components that I talked about earlier. It means assessing the social material conditions. It means assessing one's functioning across a number of different domains, occupationally, academically, socially, day-to-day self-care; whatever is relevant for that individual. And, of course, getting a good sense of their satisfaction, their sense of well-being, how happy they are, currently speaking.

Doing a thorough assessment also means conducting an assessment using a multi-method approach that features the use of evidence-based assessment tools. And, as we'll see later on in this discussion, there are a variety of evidence-based tools from which to choose, and that I think can be, you know, perhaps confusing for some, and hopefully we'll clear that up a little bit later on.

But, the important point is to use evidence-based assessment methods within the context of a multi-method approach, which means that you should be using self report measures, interview measures, getting objective records of performance, whenever that's possible. If it's possible to do observer ratings, that would be great. If it's possible to get collateral reports from a spouse, or other significant others, of how one is functioning, that would also be important to do.

A multi-method approach of assessment is important because no single method of assessment is foolproof. If you use the single method there would be some error, and you wouldn't exactly know the extent to which your assessment results accurately reflected reality or whether or not there was some error or distortion in the measurement. When you use multiple methods of assessment, that hopefully corroborate one another, you can get a better sense of what the current problems are for the individual that's being treated by you. So, it's important to get multiple perspectives in order to understand one's current level of functioning and quality of life.

In addition to these methods, the Clinical Practice Guidelines recommends including an idiographic assessment of functioning. And, what they mean by that is, asking the person to sit down and write a narrative description of the changes in their lives that they have experienced. Hearing that, getting a narrative account in the person's own words, is very important. It's important that the person describe these changes as thoroughly as possible across all of the different domains of functioning and quality of life, so that we can thoroughly see, as much as possible, how this person has been effected by their PTSD, or their substance use, or other kinds of difficulties that they may be experiencing.

It's also important to get a sense, in this narrative description, about the subjective importance of each of these domains. As you recall from our discussion of the case example, earlier, I had said that that person was extremely distraught by the fact that he was, he had to retire early, that he had lost some relationships. And, I think it's understanding those things that's incredibly important, from a therapeutic point of view, because we know, then, that these are items that need to be addressed.

On the other hand, for example, if a person reports that they lost their job, but they're not necessarily distressed by that, or if they lost their marriage, but they're not necessarily distressed by that fact, then

maybe that's not something that should be a focus of therapy. But, if they are distressed by the fact that their marriage broke up because of their PTSD, then yes, that would be something that we would like to hopefully focus on within the course of treatment.

It's also important to get a sense, from this narrative, whether or not the impairments in functioning are related to the exposure, as well as to specific PTSD symptoms. And, so in that respect, it's important to get a sense from the individual if these difficulties pre-dated the trauma exposure and the PTSD, or if they've now occurred after the onset of the PTSD symptoms that the person is experiencing.

When conducting the assessment, it's important to keep some important points in mind. The first thing that I think is important to recognize is that the current diagnostic system has some important limitations with respect to functional impairment. As I said before, the only way that someone can be diagnosed with PTSD, currently, is if they do report experiencing significant distress or impairment as a function of their symptoms. And, I suppose, that it's possible to have one without the other. It's possible to experience distress without impairment, although that's probably not likely to happen.

And, the second point, that I think is important to keep in mind, is, as I said earlier, that even people who do not meet full criteria for PTSD, who may be sub-threshold or only experiencing some of the symptoms of posttraumatic stress disorder, may, in fact, experience significant impairments, or decreases in quality of life, as a function of those symptoms.

Another important point to keep in mind is that the DSM doesn't make it clear how symptoms should effect functioning. It doesn't make it clear how, or what it means, by, when we talk about clinically significant impairment, the DSM does not define what it means by clinically significant. That's a judgment call on the part of the clinician, and what it may mean is that you might need to collect additional information in order to determine whether or not, in fact, someone's impairment is "clinically significant".

Other important considerations: it's not surprising that the research shows that PTSD is related to functional impairment and decreases in quality of life. In fact, these concepts are intertwined, as I just mentioned before, at the diagnostic level. In order to be diagnosed with PTSD in the first place, the individual has to report either clinically significant distress or impairment, and likely, they will report both.

At the symptom level, were a condition or a symptom not causing some sort of difficulty for the individual, it's difficult to imagine that that phenomenon would be called or labeled a symptom at all. So, both at the symptom level, and at the diagnostic level, the line is, in fact, blurred between diagnosis and functioning and symptoms and functioning, respectively.

It's also important, I think, to not judge an individual against others in terms of whether or not they're functioning well. What could be good functioning for one, may not be good functioning for another and vice versa. Instead, it might be more appropriate to compare someone against him or herself using a baseline assessment at the beginning of treatment and following someone over time to see how those things change, with respect to, perhaps, changes in their lives, situational characteristics changing or personal characteristics changing, like changes in symptoms and so on.

What I'd like to also do now is, I'd like to say a few things in regards to assessing functional impairment in the context of disability exams. Obviously, it's important to determine the extent of functional impairment and how it relates to PTSD, within the context of a disability examination, because those things will, in fact, determine the level of disability and the level of compensation, perhaps, that people receive.

It's also important to use evidence-based assessment methods, within the context of a PTSD disability examination, precisely for those reasons, because it's important to determine the extent of impairment and how it relates to one's PTSD. What's particularly interesting, is that the research shows that many

examiners who conduct these disability examinations do not necessarily use evidence-based assessment methods.

There was a recent study that was conducted, in fact, showing that, overwhelmingly, most of the disability examiners, in a sample of folks who do these assessments for the VA, do not use evidence-based methods for assessing PTSD, nor do they use evidence-based methods to assess functional impairment, which is a bit problematic when, in fact, decisions are being made based on how well someone is functioning. It's important to get a good standardized sense of how well, or how poorly, someone is functioning and how that functioning may, or may not, be related to one's PTSD.

Within VA, the current ratings criteria for determining level of disability considers both one's occupational and social impairment. And, the range of disability ranges from 100% disabled, or totally disabled, both socially and/or occupationally speaking, to not at all being disabled by one's PTSD. What's interesting about the current ratings criteria, though, is that they do not explicitly link the PTSD symptoms, that someone is experiencing, to their disability or impairment.

Instead, what the current ratings criteria do is, it considers other symptoms of mental disorders more broadly. So, it takes into consideration symptoms of anxiety and depression, psychosis, more broadly when making a determination of how much someone is disabled and the extent to which that disability is connected to their psychological symptoms. You might be asking yourself why that is the case. It was certainly confusing to me when I realized this.

But, I think it's just simply a function of the fact that it simply is not practical to have different ratings criteria for each possible disorder in the DSM, so what they tried to do is, they sort of tried to make it a conglomeration of all the different kinds of symptoms that potentially could be impairing to someone. So, it's certainly not ideal. It certainly doesn't fit what you may think about, you know, how someone is going to be considered, in terms of their PTSD symptoms, and how those symptoms then relate to their impairment, but that's simply the way that things are right now.

The good news is that these ratings criteria are in the process of being revised. And, there are a few principles that are driving these new ratings criteria. Number one, the focus will be on functional impairment associated with mental disorder disability as it impacts average lost earnings. So, the ratings criteria will change such that social impairment won't be considered any more; it will be mostly a focus, or completely a focus, on occupational impairments, more specifically on average lost earnings, because that, then, plays obviously an important role in how much to know how much a person should be compensated for their PTSD and their associated impairment.

The second principle is that the emphasis will be on functional impairment rather than symptoms, and this is good because it will avoid needing a separate criteria for PTSD, or other disorders, for that matter. And, the third principle is that it's expected that these revised ratings criteria will be expected to correlate better with average lost earnings than the current symptom-based criteria.

Let's talk a little bit about treatment planning. As I said to you before, and as you noted in the case that we discussed at the top of the talk, poor quality of life and functioning certainly can serve as a motivator for individuals to seek treatment. It's not necessarily the symptoms that they experience, but the fall out of those symptoms is what drives people to come into therapy. Their lives are much different, they're less satisfied, they're feeling like they're not living a life that they want to live, that they're not being able to achieve their goals and dreams as they had hoped for, and that is really what serves to drive people to come into therapy.

Of course, this, then, underscores a need for careful evaluation at the top of therapy and all along the course of treatment, and to review the results, intermittently, both with yourself and, perhaps, even the client. It's important to be mindful of the course and progress of PTSD symptoms and indicators of quality

of life and functioning, because that, then, will have importance for, maybe perhaps, making changes or modifications to the treatment plan along the way.

While we do have some evidence-based treatments for PTSD already, there has been some discussion of developing more specific interventions for PTSD-related functional impairment. And, the folks who have thought about this, and have written about this, have taken a page from the book of the psycho-social rehab professionals and have talked about adapting some of those treatment techniques for use with individuals who experience problems related to posttraumatic stress disorder. And, there are a variety of different kinds of psycho-social rehab techniques that could be used: patient education techniques, supported education, self-care and independent living, supported housing, supported family services, social skills training, supported employment and case management.

These techniques are really heavy, as you can see, on support and skills training with the goal being to get the individual not to ignore the problems that they may be experiencing within the context of their occupational functioning or their social functioning; to take a more proactive approach, not to just simply assume that changes in symptoms will translate into changes in functioning but to really do that proactively, with the hope being that you will see that and, perhaps, those changes in functioning will then translate into changes in symptoms, perhaps.

Moving on, the next objective of our discussion is to take a look at some of the available measures for assessing functional impairment. As I mentioned previously, there are many different measures to choose from.

Probably the measure that everyone knows the best is the Global Assessment of Functioning, or the GAF. The GAF is a rating scale from 0 to 100, with higher scores meaning better functioning. The GAF is a part of the DSM, which means that it gets used a lot. But, there are some important limitations of the GAF.

First of all, it's been shown to be unreliable across raters. The GAF was never meant to assess functioning for individuals with posttraumatic stress disorder, and thirdly, it's a single-item measure, which means that from a psychometric point of view, it may not necessarily be reliable or valid. So, as you can see from this slide, there are lots of different measures to choose from that could potentially replace the GAF. So, for example, you could instead use the SF-36. You could use the World Health Organization Disability Assessment Scale, or the WHO DAS. The Social Adjustment Scale is another widely used measure of psycho-social functioning.

The Sheehan Disability Scale is another measure that's also a good one to consider, particularly because it's very short and could be used in primary care contexts. So, there are lots of different measures that could be used to substitute for the GAF.

However, like the Global Assessment of Functioning, these measures all have limitations as well. So, for example, some are more resource-intensive or require training prior to use. The WHO DAS, the GAF, the PROMIS, the Disability Profile, all require some training prior to use. You can't just take it off the shelf and use it. At least that's not recommended.

Some measures are difficult to score. For example, with respect to the WHODAS, there are different ways to score the WHODAS. It's hard to find consistent information on how best to score it, and that may be confusing to clinicians, in terms of deciding which one to use.

The SF-36 is problematic, from a scoring perspective, because it's actually quite complex. It's not just simply add up the total and you have a measure of how someone is functioning. Different items have different weights, and it's much more complex, and, in fact, most people use a computer program to score the SF-36 because it's just simply not straight forward.

There are some measures that require permission to use, either from the authors or from a publishing company or from another organization. The SF-36, the Social Adjustment Scale, the WHODAS, all require permission prior to use.

Another issue, for many measures, is that they may be too narrow, as far as the content goes. For example, there are many measures that just simply focus on social functioning, or there are other measures that focus on occupational functioning exclusively.

And, that may be fine if that's all you want to assess, but if you're looking for a more complete assessment of how one is functioning, you may have to string many measures together in order to really get a more comprehensive view of how one is functioning or get a sense of their quality of life.

There are some measures who focus on impairment related to physical problems, and while, again, that may be relevant in some cases, that makes these measures less relevant for assessing PTSD-related impairment, or impairment related to other psychological disorders like, other anxiety disorders or depression.

So, the WHODAS, the SF-36, the SIP, or Sickness Impact Profile, the Sheehan Disability Scale, the Quality of Well-Being Scale, the PROMIS, all of these measures have some connection to functioning related to physical problems, which then complicates the interpretation of knowing whether or not the functioning difficulties are related to PTSD or other difficulties.

There are some measures that require an attribution on the part of the individual, and what I mean by that, is that these measures ask the individual to assess, or give a sense of their functioning or well-being, with respect to the problems that they are experiencing; their psychological symptoms or their physical symptoms.

And, that may be difficult for someone to make that kind of an attribution, to know exactly what the cause of their functioning problems are. And, that's the case for someone with PTSD, because, as we know, that PTSD doesn't occur in a vacuum, that, often times, someone with PTSD has other psychological difficulties, they have other physical difficulties. And so, in that kind of a context, it will be hard for someone to know, well, the cause of my social impairment is because of my PTSD and not my depression and so on and so forth. So, it can be confusing in that respect.

And, also, we just know from the research that people make all kinds of attributional biases all the time. There are memory biases, for example, in terms of understanding what happened, and when, and where, and why. And so, these measures that require an attribution on the part of the individual may be artificially either inflating or deflating the estimate of functional impairment for the individual.

The observation that not one measure was ideal to assess PTSD-related functional impairment led me, and my group, to begin a project to develop such a measure. And, we decided that what was needed was a measure that sufficiently assessed multiple domains of functioning and forms of impairment; distinguish between the symptoms and the impairment by not confounding the two. The measure, ideally, would not require an individual to make an attribution regarding the cause of their impairment. We wanted a measure that could be used flexibly by clinicians.

We also thought it would be important to have a measure that would be easy to use and score; a measure that would certainly be relevant to PTSD, but not necessarily exclusive to PTSD. So, we wanted to have a measure that was not disorder-specific but could be used for a variety of different psychiatric disorders. We wanted a measure that could be used across various contexts and a measure that could be used for Veterans, active duty personnel, as well as civilians.

Through this work we came up with a new scale that's called the Inventory of Psychosocial Functioning. Just to give you some initial information about the IPF, or Inventory of Psychosocial Functioning, it's an 80-item self-report measure, and it assesses current functioning across multiple domains. We think that it is easy to use and score. There are no complicated scoring algorithms.

But, there are various scoring possibility indices that are built into the measure itself. It's flexible in that clinicians can use only the parts of the measure that are pertinent to their clients, at that point in time. It does not require any attributions on the part of the individual who is responding to the questions. It's not disorder-specific, and it is useable within both clinical and research settings. It is a measure that we developed with Veterans and active duty service personnel, but we also believe it is not exclusively useable for these groups. It could be used for civilians as well.

This slide shows you what one part of this measure looks like. As you can see from this slide, this is the section that asks about functioning within the context of romantic relationships. And, we asked the individual to answer the questions as they pertain to them within the past 30 days. We do that to, hopefully, reduce bias and recall.

And, if this section, or any section of the IPF, wasn't relevant for the individual, then they are just simply told to skip this section of the questionnaire and move on to the next one that might be relevant for them. As you can see from this slide, respondents are asked to answer all of the questions on a seven point scale, ranging from never to always, with higher scores on this measure being indicative of greater, or more, functional impairment.

This next slide shows just one of our findings from our research, which we see that individuals with PTSD report significantly greater functional impairment on this scale relative to those who are not diagnosed with posttraumatic stress disorder. The individuals with PTSD, on an overall scale of 1 to 7, have an average score of about just over 4, whereas those without PTSD have an average score of just over 3.

What this should tell you is two things. Number one, that individuals with PTSD do exhibit greater functional impairment; at least they report greater functional impairment. But, as I said to you before, folks who do not meet criteria for PTSD are not devoid of functional impairment. These individuals also can experience functional impairment. So, their average score is not zero on this scale. It's lower significantly than individuals with PTSD, but it's not zero or close to zero. They, too, might experience functional impairment and that's indicated on this slide.

We also thought it was important to develop a brief version of the IPF, and so that's in development as well. We've had several ideas about how to construct this brief measure that could be used very quickly to ascertain how well someone's functioning or could be used within the context of a primary care setting. There were three options that we considered.

One, is just to develop some more global items that could be used to sort of serve as a proxy for the more intricate scales that we developed for the full version. We also thought about using the items from the full version of the IPF, that most strongly correlated with the grand mean, for the scale. We also thought of using the items that most strongly correlated with the total scores for each domain on the IPF.

What we ultimately decided to do was to develop global items that essentially served as a proxy for each of the scales that we developed. So, for example, as you see on this slide, the romantic relationship section is assessed by the single item, "overall over the past 30 days I had trouble in my romantic relationship with my spouse or partner".

Respondents are asked to answer this item on a scale of 1 to 7, 1 being not at all to 7 being very much. Our research has shown that these single items correlate with scores on the full scales pretty highly.

Scales correlate on a range from 0.5 to 0.65 with these global items. So, that's good news for using these global items to assess the domains of relevance.

Okay, so we're at the end of the discussion here, and just to summarize a few of the points that I've gone over with you today, we know from the research that PTSD is associated with significant impairment across numerous domains of functioning, as well as overall quality of life. This suggests that it's important for clinicians to be aware of this, for their clients, and to assess functioning and quality of life, and, perhaps, even address it in treatment.

The VA/DoD Clinical Practice Guidelines suggest a comprehensive assessment of functioning and quality of life. It suggests that we use a multi-method approach to assessment using evidence-based assessment procedures. The guidelines suggest that we obtain a written narrative from the individual, getting a detailed assessment of their functioning and quality of life. It's important to keep a number of different points in mind when conducting this assessment about the DSM and the limitations of the DSM, and how symptoms sometimes get confounded with treatment and how it's important to kind of tease these things apart from one another.

And, finally, I think it's important to remember that there are numerous available measures of functional impairment and quality of life to choose from in your practice, that the GAF may not be the best measure to use, that there are other measures. Each of them have their blemishes. Each of them have their strengths. The important point, I think, is to choose one of these measures that have good psychometrics, that are shown to be reliable and valid measures of quality of life and functioning, so that we can get a very good sense of how someone is living his or her life.

With that, thank you very much, and I hope this has been helpful to you.