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Life Care Planning in a Country with For-Profit Medicine

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Overview of Life Care Planning Methodology

The multi-disciplined specialty in life care planning has thrived over the last several decades. The reasons for the growth include the demand in litigation and other venues, the formation of the International Academy of Life Care Planners (IALCP) with its established standards of practice and ethics, and the growing body of empirical research devoted to the profession. Since the 1993 *Daubert vs. Merrell Pharmaceuticals* decision that placed all experts on notice regarding the need for expert opinions to be based on generally accepted methodology and supported by one's peers, it is imperative that life care planners offer supported opinions (Field, 2000). Prior to the Daubert decision, expert witnesses could provide opinions based on their education, training and experience without necessarily having a consensus of professional opinions.

Through the years, the profession of life care planning has developed both an accepted methodology and scope of practice for life care planners. These have emerged from research included in textbooks, journal articles and from the multiple symposia held by the International Academy of Life Care Planners. The Academy has produced Consensus and Majority Statements with noteworthy statements related to standards and methodology including, life care planners shall: (#55) utilize research for recommendations; (#56) consider the integrity of the data; (#65) utilize adequate medical and other data for opinions; and, properly inject personal expertise (#73) (Johnson, 2015, p. 36-37). In preparing our plans, life care planners often walk a fine line regarding providing opinions based upon sound medical data yet remaining within our area of expertise to do so, which is also required by our guiding documents.

One area, however, that can be confusing to the trier of fact in litigation, is how two opposing life care planners assessing the same evaluee can at times be millions of dollars apart in their overall future care costs (Marini, 2012; Ysasi, Marini, Antol, Maxwell, & Kerwin, 2016). Marini (2012) offered one explanation for large differing (opposing) expert cost assessments being that some life care planners add in the costs of potential complications that are possible, but not medically probable within a degree of certainty. This article explores additional possible explanations for large cost differences, including the variation in costs found in the US healthcare system, particularly when compared to other countries. We also address the prevalence of healthcare goods and services in the US healthcare system and the issue of determining medical necessity of surgeries. Finally, implications to life care planning are addressed through presentation of an anonymous case scenario presented from the second author's life care planning experience.

Cost of Medical Care in the United States

Despite attempts to slow the costs of healthcare in the United States (US), costs topped over $2 trillion in 2005, $3 trillion by 2014, and are projected to top over $5 trillion by 2022 (Munro, 2014). Kane (2012) reported that the US spent an average of $8,233 per year per person on healthcare in 2010 and in 2014 approximately $9,086 per year per person (Squires & Anderson, 2015) making up approximately 18% of the Gross Domestic Product (GDP). In contrast, the Organization of Cooperation and Economic Development (OCED), which is made up of 34 developed countries, reported the average annual healthcare expenditure of $3,268 per person, almost two-thirds less the US average. Mahar (2006) compared healthcare cost differentials between the US and other countries, noting that the US spends 50% more than Switzerland, 85% more than Germany and Canada, and twice as much as the Netherlands, United Kingdom, and Australia, with approximately 30% of US healthcare dollars being paid to hospitals.

Kane (2012) noted that the average hospital stay cost in the US was $18,000, compared to the next highest countries of Canada, the Netherlands, and Japan whose hospital stays ranged from $4,000 – $6,000. Tokin (2012) also noted the drastic differences in the cost of the same surgery in different hospitals within one state, even some that were only miles away from each other. In his research, Tokin cited a California study of 19,000 patients who underwent uncomplicated appendicitis surgery with costs ranging from $1,529 to $182,955 across hospitals. Squires and Anderson (2015) reported that the average cost of a coronary bypass surgery in 2013 averaged $75,345 in the US, while Australia reported the second-highest cost for the same surgery at $42,130.

While the United States ranked the higher in healthcare costs than 195 other countries in the world, it ranked lowest in performance (among 11 industrialized countries) regarding health care quality, efficiency, access to care, equity, and healthy lives (The Commonwealth Fund, 2014). Among the 195 countries, the US ranks 37th in overall mortality rates. It does, however, rank fourth regarding quality healthcare (but only for those with insurance), but last in quality for those with poor or no health insurance. Mahar (2006) concludes that "while more healthcare equals more profits, it does not necessarily lead to better health." (p. xix).

The United States remains one of only a few industrialized countries without universal healthcare. Critics of universal health care argue that there will be the negative

financial implications for patients, the government, and businesses with universal healthcare and that the marketplace competition in the US system provides the highest quality healthcare (Mahar, 2006). Recent comments made by Warren Buffett to CEOs of American companies provide a different perspective. Sorkin (2017) cites Warren Buffett's May 2017 comments regarding rising healthcare costs where he cautioned CEOs that the major problem for retaining company profits is the financial burden of rising healthcare costs for employers. Buffett noted the alarming rise in healthcare costs related to HMOs, hospitals, doctor's visits, prescriptions, medical devices, and insurance companies that have driven the Gross Domestic Product from 5% over 50 years ago to its current 17%, with much of that cost being absorbed by employers. Corporate America pays more for healthcare than any other country's businesses, where American corporations spend over $12,500 annually to cover a family of four, up 54% from 2005 (Sorkin, 2017).

In addition to differences in costs of services among US healthcare providers, there are also noteworthy differences in consumption of healthcare services between US residents and residents of other countries. Kane (2012) notes that the US spends significantly more on diagnostic testing and prescription medications than any of the 34 developed countries, a finding similarly reported by Squires and Anderson (2015). Squires and Anderson (2015) found that Americans consume more prescription drugs (average 2.2 each), nearly twice the amount of prescription medication than citizens of other industrialized countries. This rate of medication of prescription has been linked to the epidemic in opioid related overdoses and deaths in the US, with the Center for Disease Control (2016) reporting approximately 33,000 annual American deaths from prescriptions. At this rate of 78-91 deaths per day, this is a 72% increase in opioid related overdose deaths from 2014 to 2015 (CDC, 2016; Leonard, 2016).

Mahar (2006) in her book *Money Driven Medicine: The Real Reason Health Care Costs So Much*, suggests several reasons for the high cost of medicine in the United States including unnecessary diagnostic testing and/or surgeries, entanglement with pharmaceutical companies and device makers, and the differences between for-profit and not-for-profit hospitals. Overall, noteworthy healthcare differences between the US and other countries begs the question; are Americans simply more unhealthy than other nations or is the American free-market healthcare system a factor in our outcomes?

Determining Medical Necessity

Waddell (1987), over 30 years ago, noted that lumbar disc surgeries have a medical basis in only 1% of patients seen by surgeons, yet he noted in 1987 approximately 400,000 such surgeries were performed. Weber (1983) found that patients who are recommended for a second similar surgery are twice as likely to have that surgery fail, and if a third or more lumbar surgery is required, the likelihood of it failing to relieve the patient's pain four to 10 times higher. Waddell (1987, p. 636) adds "In an extensive review of the treatment outcomes data, there is no evidence that any treatment for low back pain is better than a combination of the natural history and the placebo effect." Weber (1983) similarly reported that patients who underwent a lumbar surgery, were no better off in having their pain reduced than a control group with the same lumbar diagnosis/symptoms who were treated conservatively, at a four and 10-year follow-up.

Similar to Weber's (1983) findings regarding lumbar surgery, Harris, Mulford, Solomon, van Gelder, and Young (2005, as cited in Franklin, Wickizer, Coe, & Fulton-Kehoe, 2015) found that patient recovery from lumbar surgery was far worse when compared to those with similar lumbar issues who did not have surgery. In a sample of patients with chronic low back pain who underwent lumbar surgery, 66% were still disabled while 23% underwent a second lumbar surgery (Chou et al., 2009). The success of thoracic outlet syndrome surgeries was also studied with 21% of those who underwent surgery complaining of greater neurological problems after the surgery (Franklin, Fulton-Kehoe, Bradley, & Smith-Weller, 2000). The authors reported poor outcomes for those who had the surgery versus those who did not have surgery (Franklin, Fulton-Kehoe, Bradley, & Smith-Weller, 2000).

Case Scenario

The second author is a certified life care planner with 17 years of life care planning experience who was asked by defense counsel to review a case involving an individual who reported cervical and lumbar disc herniations as a result of a motor vehicle crash. The life care planner was asked about the reasonableness of a plaintiff physician life care plan (PLCP). A review of records revealed that the individual participated in 6 to 12 months of typical conservative treatment (e.g. chiropractic care, physical therapy, ultrasound) then received epidural steroid injections to the cervical and lumbar spine. Finally, one treating surgeon performed a cervical laminectomy, discectomy and fusion, and a second treating surgeon performed the same surgery for the lumbar herniation. Neither treating surgeon indicated in any medical records that their respective surgery failed, nor did they note the need for ongoing treatment.

After the plaintiff's physician life care planner performed an IME, a life care plan was developed without the individual consulting treating or other related professionals for future medical care recommendations. The PLCP recommended: a) lifelong or almost lifelong related physician visits; b) periodic MRI, x-ray, CT scans; c) the cost of second-level cervical and lumbar surgery as medically probable; d) ancillary physical therapy; e) lifelong or near lifelong NSAIDs, antidepressants, opiates and analgesics; f) continued epidural steroid injections; and, g) lifelong maid

services, and other minor items.

During this assignment, the second author consulted with defendant's retained orthopedic surgeon. The surgeon indicated that when these surgeries are successful (as the medical records in this case appeared to indicate), the patient will require a short-term comprehensive physical and/or occupational therapy to be followed by a home exercise program. The surgeon opined that there would be no justification for lifelong care unless some other intervening event had occurred.

Case Analysis

In opining about the reasonableness of the plaintiff physician life care plan, this life care planner consulted life care planning standards of practice. The 2015 Standards of Practice for Life Care Planners (International Association of Rehabilitation Professionals [IARP], 2015, p. 6) states that "the life care plan is a collaborative document among various parties, when possible" and that life care planners evaluate literature and use appropriate research findings when developing a life care plan.

In addition to the IALCP Standards of Practice for life care planners, the American Academy of Physician Life Care Planners (AAPLCP) have their own Standards of Practice and ethics (AAPLCP, n.d.). Under Standard 2D, physician life care planners endeavor to discover and consider (among other things), documented opinions from the subject's treating physicians. Standard 3A notes that physician life care planners seek collaboration with other experts whenever necessary and practicable. Standard 3D notes that physician life care planners formulate medical opinions by considering all prospective, medically probable effects of a subject's impairments while 3E notes that physician life care planners formulate opinions regarding probable duration of care based upon published, peer-reviewed methods and standards.

In this case, there was divergence from life care planning standards of practice by not conducting consultation with treatment team members. Despite no treating surgeon recommending future lifelong treatment, the PLCP included this treatment, without citing relevant research or recommendation from a treating professional. In addition, prior life care planning research has noted less than half of physician life care planners surveyed reported consulting treating physicians for recommendations or utilizing empirically based research to develop their life care plans (Ysasi et al., 2016). Reliance upon published data assisted this life care planner in reaching conclusion about the reasonableness of the life care plan.

Implications for Life Care Planners

Life Care Planning Standards of Practice and Majority and Consensus Statements indicate that life care planners come from different disciplines and should remain within our scope of practice. Despite our background differences, there is a vast body of literature stating how life care plans should be developed (Deutsch & Raffa, 1981; International Academy of Life Care Planners, 2015; Weed & Berens, 2010). It is critical that life care planners adhere to these methods, which have been documented for 30 years, even as the healthcare systems in which we practice have become increasingly complex. Our practice recommends collaboration with various professionals in the development of our plans. When conducting this consultation/collaboration, our standards cite that we should be knowledgeable of the relevant literature including outcomes and evidence-based practices.

Life Care Planning Consensus and Majority Statements (2015) suggest that life care planners use research for recommendations, but that we also consider the integrity of data (Johnson, 2015). Perhaps understanding how the US healthcare system compares to other developed countries in terms of costs and number of procedures as well as the rate of medications and diagnostic studies prescribed, will help inform our base of information. We work in a system where there are opposing medical experts, psychologists, psychiatrists, etc. who are retained on either side who often proffer differing opinions about the same injured party (Marini, 2012; Ysasi et al., 2016). Yet our guiding documents, including Consensus and Majority Statements provide guidance for our professional practices in situations where we are confronted with divergent opinions (Johnson, 2015).

It behooves all life care planners to be familiar with evidence-based research, including understanding "optimal outcomes achievable for particular injuries" when collaborating with treating or IME physicians in life care plan development (Johnson, 2015, p. 35). Life care planners are not simply scribes to physicians, but a group of professionals with years of research and directives agreed upon by our profession, available for our use. We should not underestimate our value, skills, knowledge, and capabilities to assist physicians in providing their recommendations, particularly when we suspect their recommendations are not fully supported in the literature. If recommendations are inconsistent with our understanding of the literature, we should engage in a dialogue with the life care plan contributors. Our Consensus and Majority Statements address this issue stating, "Life Care Planners shall methodically handle divergent opinions" (Johnson, 2014, p. 37). The second author has observed in his practice that one way that life care planners handle discordant opinions is by creating different projection options or scenarios for the trier of fact to decide.

Overall, the United States has the costliest healthcare system of all industrialized countries, with few market regulations (Mahar, 2006; Squires & Anderson, 2015). It behooves all life care planners to do their research on specific disabilities, particularly prevalence statistics of secondary complications. The more knowledgeable life care planners are about specific disabilities, the more capable we are when

collaborating with the healthcare team regarding the future medical care needs of our clients.

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Trauma and Stress Related Disorders: Relevance to DSM-5 and Life Care Planning

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Abstract

Research posits that people with disabilities are at greater risk of experiencing events that could precipitate the development of trauma symptoms when compared to people without disabilities (Hassouneh-Phillips & Curry, 2002). This information places life care planners in a strategic position to assist this potentially vulnerable population. This article provides a definition of trauma, information about populations at risk for acquiring trauma- and stress-related disorders, and clinical features of disorders listed under the new DSM–5 trauma and stress- related disorders section. Psychosocial and vocational aspects of trauma-and stressor-related disorders are also presented. Finally, implications for life care planners are discussed. A review of six sexual trauma case studies with recommendations follow a discussion of the new DSM-5 definitions and criteria for trauma and stress- related disorders.

Since 2013, when the *Diagnostic and Statistical Manual of Mental Disorders-5* (DSM-5) recognized and listed trauma and stress-related disorders as a specific category, there has been heightened interest in trauma and trauma-related symptomatology (American Psychiatric Association, 2013; Jones & Cureton, 2014; Nemeroff et al., 2013). In 2015, individuals 12 years of age and older in the United States experienced an estimated 5 million violent victimizations (i.e., rape or sexual assault, robbery, aggravated assault, or simple assault) (United States Department of Justice, 2016). Between 2005 and 2010, the majority of these violent injuries were caused by loved ones or acquaintances with over 60 percent occurring within the home by assailants known to the victim (Harrell, 2012). While the current rate of violent victimization declined over previous years, these assaults still result in considerable physical, emotional, social, and economic consequences (Truman & Planty, 2012). Living through traumatic events can change the way individuals view themselves and the world around them because the traumatic event is outside the individual's normal realm of experience and overwhelms the individual's usual psychological defenses.

It is important for life care planners to recognize when a client is experiencing symptoms of a psychiatric disorder following a traumatic experience. Such recognition is critical for developing a treatment plan that addresses the trauma, and the resulting mental health symptoms. Understanding the changes in the current *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)* will assist life care planners with proper identification, referral, and treatment options for their clients.

Definition of Trauma

Trauma is now defined as exposure to actual or threatened death, serious injury, or sexual violence in one or more of four ways: (a) directly experiencing the event; (b) witnessing, in person, the event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders (APA, 2013). This definition differs from the previous versions of the DSM, by specifying examples of experiencing or witnessing a traumatic event and by being explicit about if the event was experienced directly or indirectly. The new definition also eliminated such events as the unexpected death of a family member or close friend due to natural causes, as well as indirect non-professional "… exposure through electronic media, television, movies, or pictures" (APA, 2013). Consequences of the changes in definition include an individual losing a claim for damages based solely upon indirect involvement in the traumatic event, for example, watching a traumatic event on television.

Trauma can occur in a single incident or become a chronic presence. Violent acts and trauma cause millions of people to suffer injuries that lead to long-term disabilities with a significant proportion of disabilities being caused by injuries resulting from traffic crashes, falls, acts of violence, and war and conflict (World Health Organization, 2014). Estimates propose that up to one quarter of disabilities around the world may be the product of injuries and violence (WHO, 2014). Individuals for whom life care plans are developed may have incurred physical injuries as a result of a traumatic event. Conversely, injuries may be psychological in nature and these injuries may co-exist with physical injuries or in the case of sexual assault or similar trauma, the psychological injuries may persist long after the physical injuries have healed. An individual's ability to cope with violence or trauma is moderated by individual and contextual factors, including social support, cognitive functioning, personality variables, behavioral capacities, preexisting psychological conditions, and the duration and intensity of the trauma (Coursol, Lewis & Garrity, 2001; Strauser, Lustig, Cogdak & Uruk, 2006). When life care planners become involved in a case, they will likely learn, through reviewing medical records, interviewing the evaluee or through interviewing family members, the effects that trauma may continue to have on the individual as a result of the disabling event.

Populations at Risk

Research has consistently reported that individuals with

disabilities, women and children, and elderly individuals are at a much greater risk of overall physical, sexual, and emotional abuse (Hines, Malley-Morrison, & Dutton, 2013; Jones et al., 2012; Plummer & Findley, 2012; Stalker & McArthur, 2012). In regard to domestic violence, 1 in 15 children are exposed each year, and 1 in 3 women have been victims of physical violence by an intimate partner in their lifetime (National Coalition Against Domestic Violence, 2015). A recent study reported that 7.6%-10% of elderly individuals experienced abuse within the past year (Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University & New York City Department for the Aging, 2011). It is also reported that individuals with developmental disabilities are 4 to 10 times more likely to become victims of crimes than individuals without a disability (Tyiska, 1998). While individuals with disabilities cannot be viewed as a monolithic group, this population in general may have characteristics that lead to increased victimization of domestic abuse and bullying, such as dependency on others for caregiving, limited mobility or communication, and possible social isolation (Blake et al. 2014; Hines, Malley-Morrison, &Dutton, 2013; Jones et al., 2012; Plummer & Findley, 2012; Stalker & McArthur, 2012). This is certainly something that life care planners should consider when developing plans for individuals with limitations in cognition. When developing facility care options in a life care plan, this fact should be strongly considered to ensure that such placement does not lead to further injury.

Many times, individuals with severe disabilities are placed in long-term care settings that make them particularly vulnerable to violent victimization (Iversen, Kilvik, Malmedal, 2015). Unfortunately, advocates report that crimes against these populations often go unreported (Frohmader & Didi, 2015; National Research Council, 2003; Office for Victims of Crime, n.d). Many reasons explain this underreporting: mobility or communication barriers, fear of losing needed services, feelings of shame and self-blame, ignorance of the justice system, or if the perpetrator is a family member or primary caregiver. The high incidences of abuse by caregivers have prompted some researchers to promote the expansion of the definition of domestic violence to include paid caregivers (Lightfoot & Williams, 2009).

DSM-5 Trauma and Stress- Related Disorders

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) is the standard classification of mental disorders used by mental health providers in the United States (APA, 2013). It contains a listing of diagnostic criteria for every psychiatric disorder recognized by the United States healthcare system. The DSM-5 is the most contemporary system available in the United States to rehabilitation counselors and other clinicians in making distinctions between normal life variations and more serious psychiatric symptoms. A DSM-5 diagnosis also assists with accountability, record keeping, treatment planning, and communication with other helping professionals.

In the DSM-5, disorders which are precipitated by specific stressful and potentially traumatic events are included in a new diagnostic category, "Trauma and Stress-Related Disorders" (APA, 2013). Friedman et al., (2015) assert that there is heuristic value in grouping this set of disorders in a specific stress-related category because it enables clinicians to differentiate among normal (non-pathological) distress, from acute, diffuse clinically elevated stress reactions indicative of Adjustment Disorders, as well as more severe and chronic psychopathology (including Posttraumatic Stress Disorder). Disorders listed under the new trauma and stress- related disorders section include Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, Other Specified Trauma- and Stressor-Related Disorder, Unspecified Trauma- and Stressor-Related Disorder, Adjustment Disorders, Acute Stress Disorder, and Posttraumatic Stress Disorder (APA, 2013). The definition, common causes, treatment, and psychosocial/vocational aspects of each disorder are provided.

Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

The DSM-5 eliminated the diagnostic group, "Disorders Usually First Diagnosed In Infancy, Childhood, or Adolescence", in which Reactive Attachment Disorder had been placed. Unlike other stress disorders, which may arise at any age and may originate from a single event, Reactive Attachment Disorder and Disinhibited Social Engagement Disorders must originate during the early developmental period (i.e., prior to the age of 5) and must involve a pattern of social neglect, rather than a single traumatic incident (APA, 2013). Like the trauma associated with Posttraumatic Stress Disorder (PTSD) the stressors that precipitate Reactive Attachment Disorder and Disinhibited Social Engagement Disorder must be serious and extreme. The earliest time period both disorders can be diagnosed is "a developmental level of at least 9 months" (APA, 2013, p. 266, 269).

Reactive Attachment Disorder is defined as a lack of ability to form affectional bonds with other people and a pattern of markedly disturbed social relationships (Broderick & Blewitt, 2010). There are two types of Reactive Attachment Disorder: inhibited and disinhibited. Follan and McNamara (2013) characterized inhibited type as being withdrawn, hypervigilant, or having contradictory responses, and disinhibited type as indiscriminate sociability, over-friendliness, diffuse attachments, aggression, and problems with peers.

Disinhibited Social Engagement Disorder is an alternative diagnosis for children who manifest symptoms, prior to the age of two, that are mainly associated with the disinhibited type of Reactive Attachment Disorder. The American Psychiatric Association reports that Disinhibited Social Engagement Disorder closely resembles Attention

Deficit Hyperactivity Disorder (ADHD). However, the two disorders differ in important ways, including correlates, course, and response to intervention. The *DSM-5* cautions that the indiscriminate sociability of youngsters who meet the criteria for Disinhibited Social Engagement Disorder is not due primarily to impulsiveness (as is the case in attention deficit hyperactivity disorder), but is mainly a function of the child's socially disinhibited behavior.

Other Specified Trauma- and Stressor-Related Disorder and Unspecified Trauma- and Stressor-Related Disorder

The *DSM-5* description states that symptoms that cause clinically significant distress or impaired functioning predominate, but do not fully meet the criteria for another disorder go into the Other Specified Trauma- and Stressor-Related Disorder category. Unspecified Trauma- and Stressor-Related Disorder is a temporary diagnosis for settings such as an emergency room where there is insufficient information to give a complete diagnosis.

Adjustment Disorders

Adjustment Disorder is a stress-related, short-term, non-psychotic disturbance with symptoms including low mood, sadness, worry, anxiety, insomnia, and poor concentration. The definition of Adjustment Disorder is emotional or behavioral symptoms developing within three months of the onset of the stressor(s) plus either or both of: (1) marked distress that is out of proportion to the severity or intensity of the stressor, even when external context and cultural factors that might influence symptom severity and presentation are taken into account and/or (2) significant impairment in social, occupational, or other areas of functioning (APA, 2013). After the termination of the stressor (or its consequences), the symptoms persist for no longer than an additional six months. As the term Adjustment Disorder implies, symptoms develop when the person is responding to a particular event or situation, for example a loss, a problem in a close relationship, an unwanted move, a disappointment, or a failure. Medical illness or injury may also be a trigger for a diagnosis of adjustment disorder.

Acute Stress Disorder

Acute Stress Disorder, is a psychiatric condition that is characterized by acute stress responses that could last anywhere from two days to four weeks following the traumatizing life event. A diagnosis of Acute Stress Disorder requires that a person experience a traumatizing life event, experience an intense emotional reaction to this event, and also experience a specific constellation of symptoms that cause impairment or distress (Shelvin, Hyland, & Elklit, 2014). For a diagnosis of Acute Stress Disorder in the DSM-5, qualifying events must now be explicit as to whether they were experienced directly, witnessed, or experienced indirectly. Also, the DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (i.e., "the person's response involved intense fear, helplessness, or horror" (APA, 1994 pp.427-8) has been eliminated. Based upon evidence that acute posttraumatic reactions are heterogeneous and that the DSM-IV's emphasis on dissociative symptoms was overly restrictive, individuals may meet diagnostic criteria in DSM-5 for acute stress disorder if they exhibit any 9 of 14 listed symptoms within the following five categories: intrusion, negative mood, dissociation, avoidance, and arousal.

Posttraumatic Stress Disorder (PTSD)

Previously grouped under anxiety disorders, Posttraumatic Stress Disorder was reclassified in the DSM-5 to a trauma- and stressor-related disorder based on a common etiology (i.e. exposure to a traumatic event), rather than symptoms (Friedman et al., 2011). The *DSM-5* specifies examples of experiencing or witnessing a traumatic event, such as sexual assault or a recurring exposure that could apply to police officers or first responders. It also requires being explicit about how the event was experienced (i.e., directly or indirectly). The DSM-5 definition rules out such events as the unexpected death of a family or close friend due to natural causes, as well as indirect non-professional exposure through media sources (i.e., television, movies, or pictures).

Post-traumatic stress disorder (PTSD) can develop after a very stressful, frightening event, or after a prolonged traumatic experience. Types of events that can lead to PTSD include combat exposure, childhood neglect, physical abuse, sexual assault, physical attack, being threatened with a weapon, natural disaster, mugging, robbery, car accident, plane crash, torture, kidnapping, life-threatening medical diagnosis, terrorist attack, and other extreme or life-threatening events (Brown, Burnette, & Cerulli, 2015; Frame & Morrison, 2001; Mayo, 2017; National Institute of Mental Health, 2017)). While both genders can experience traumatic events, statistically the traumatic events most often associated with PTSD in men are rape, combat exposure, childhood neglect, and childhood physical abuse (Nebraska Department of Veterans' Affairs, 2007). For women, the traumatic events are most likely to be rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse (NDVA, 2007).

Two subtypes of PTSD have also been added: the preschool subtype (PTSD in children younger than six) and the dissociative subtype (PTSD with prominent dissociative symptoms). The most common causes of PTSD in young children are maltreatment and witnessing intimate partner violence (IPV). If the trauma involves the primary caregiver as either the perpetrator, (as in maltreatment cases), or the victim, (as in IPV), it can be particularly damaging to the mental health of the child, likely because of the central role of the caregiver in the child's early development (Scheeringa & Zeanah, 2001). The second PTSD subtype, Dissociative subtype, is diagnosed when PTSD is seen with prominent

dissociative symptoms including be either experiences of feeling detached from one's own mind or body, or experiences in which the world seems unreal, dreamlike, or distorted. The dissociative subtype is applicable to individuals who meet the criteria for PTSD and experience additional depersonalization and derealization symptoms.

Psychosocial and Vocational Aspects of Trauma

A traumatic event may impact an individual's life and can result in significant impairment in social, occupational or academic functioning (APA, 2013). Individuals often cannot function as well as they could before the traumatic event occurred (Friedman, 2015). As a result of trauma, survivors may experience difficulties with self-esteem, assertiveness, anxiety, trust, guilt, and decision making (Strauser, Lustig, Cogdal, & Uruk, 2005).

Traumatic events that occur in childhood can have a lasting impact on their future. For example, while Reactive Attachment Disorder is a major psychosocial disorder of childhood, it is increasingly understood to produce short- and long-term relationship, health, and social consequences for children (Follan & McNamara, 2013). The complications of Reactive Attachment Disorder can continue into adolescence and later adulthood, causing a number of long-term negative effects. Some of these effects may include: poor self-esteem, academic problems, delinquent or antisocial behavior, anger problems, anxiety, inappropriate sexual behaviors, depression, constant problems with coworkers or peers, substance and alcohol addiction, unemployment or frequent job changes (Allen, 2015; Kenny, Blacker, & Allerton, 2014; Millward, Kennedy, Towlson, & Minnis, 2006; Minnis, 2003; Zelechoski et al., 2013).

One aspect of the individual's function that may be affected by trauma is one's ability to engage in vocational/ work activities with PTSD being linked with lower income, lower educational success and absenteeism from work (APA, 2013). Over time, untreated and undertreated individuals who have developed psychological disorders due to a traumatic event are especially susceptible to a deterioration of personal and work relationships and to the development of substance abuse or dependence. Some examples of problems associated with the workplace for those who have experienced traumatic events are: memory problems, lack of concentration, difficulty retaining information, feelings of fear or anxiety, physical problems, poor interactions with coworkers, unreasonable reactions to situations that trigger memories, absenteeism, interruptions if the employee is still in an abusive relationship, trouble staying awake, and panic attacks (Flannery, 1995; Pagotto et. al, 2015; Schnyder, Moergeli, Klaghofer, & Buddeberg, 2014). In a 2005 study of trauma survivors, Strauser et al. (2005) found a significant relationship between higher levels of trauma symptoms and higher levels of dysfunctional career thoughts and lower levels of work personality, and vocational identity. A correlation was found between trauma symptoms and career thoughts, indicating that as trauma symptoms increase, so does the level of dysfunctional career thoughts (Strauser, et al., 2005). As a result, the trauma survivor's career goals, interests, personality, and talents become unclear and unstable. The authors propose that this finding supports the notion that trauma symptoms inhibit cognitive functions related to the development of a solid vocational identity (such as possessing clear vocational values, interests, and awareness of one's basic needs) and may interfere with the implementation of career goals (Strauser, et al., 2005).

Implications for Life Care Planners

It is important for life care planners to recognize when a client is experiencing a trauma induced disorder and assist them with seeking treatment. As a life care planner, it is imperative to address these symptoms in the life care plan to ensure adequate treatment of trauma and stress related disorders. Weed and Berens (2010), in the section entitled life care planning for mental illness (p.584), provide a life care plan checklist for mental illness that can serve as a guide for developing life care plans for individuals with mental health diagnoses. The American Psychiatric Association (APA) has also published practice guidelines for diagnoses including Major Depressive Disorder (APA, 2010c), PTSD/ Acute Stress Disorder (APA, 2010a), Bipolar Disorder (APA, 2010b) and Substance Use Disorders (APA, 2010d). Each of these can be consulted both for treatment planning purposes and may serve as a foundation for collaborating with professionals in the life care plan development process. The most common traumatic stress diagnoses seen by life care planners are likely Adjustment Disorders and Post-Traumatic Stress Disorder. These may be the primary presenting diagnoses or they may be co-morbid conditions existing with a physical injury/ illness. The DSM-5 notes, "Adjustment disorders are common accompaniments of medical illness and may be the major psychological response to a medical disorder (APA, 2013, p. 289).

Adjustment disorders are reported to be the most common diagnoses in a hospital consultation setting (APA, 2013). Adjustment disorders necessitate treatment, likely in areas of counseling, anti-depressant or anxiolytic medications, with necessary medical management. Areas of the life care plan most relevant to treatment for an adjustment disorder include: Projected evaluations, projected therapeutic modalities, future medical care, medications and potentially hospitalizations. Due to the nature of an adjustment disorder, once the stress has been terminated, symptoms would not be expected to persist for more than six months (APA, 2013).

By contrast, a client with a diagnosis of PTSD may have longer-term healthcare needs. Again, areas of the life care plan that would likely be considered include: Projected evaluations, projected therapeutic modalities, future medical care, medications and potentially hospitalizations. A review of the Practice Guidelines for PTSD was conducted with the authors concluding that psychotherapy was found to have a

significant beneficial effect on PTSD diagnosed in veterans, female assault victims and victims of other traumatic events (APA, 2010). Additional cognitive-behavioral interventions including systematic desensitization, progressive muscle relaxation, breathing exercises, as well as modalities including biofeedback, group therapy, imagery rehearsal, eye movement desensitization and reprocessing (EMDR) and exposure therapy are all discussed in the Practice Guidelines. For each modality, accompanying research findings are provided, some of which report treatment frequency and duration. This review of relevant research may be helpful in developing or supporting life care plan recommendations. For PTSD, Practice Guidelines also discuss the use of antidepressant medication including SSRIs, noting that they are the "most extensively studied medications in PTSD treatment research" (APA, 2010a, p. 63) with both sertraline (Zoloft) and paroxetine (Paxil) receiving approval of the United States Food and Drug Administration for PTSD symptom treatment. They report that SSRIs have been found more effective than placebo in multiple studies, reducing PTSD symptoms and improving social and occupational functioning. The Guidelines note that patients will generally need to continue the medication for symptom control. Discussion of other medications including benzodiazepines, monoamine oxidase inhibitors (MAOIs), tricyclic and other antidepressants, as well as effectiveness research regarding each class of medication is included in the Guidelines.

Life Care Planning Case Study

For demonstration of developing life care plans for trauma-related diagnoses, a review of six (6) cases from the second author's case load was made. In these cases, diagnoses found in the medical records included PTSD, adjustment disorder, depression, anxiety, and in one case, bipolar disorder following trauma. In these cases, the cause of the trauma was sexual abuse/ assault with two subjects reporting both sexual and physical abuse. Ages of the individuals ranges from 15 to 51 with two male victims and four female victims. Each of the individuals had achieved less than a high school diploma at the time of referral. Two were employed after the assault and three reported psychological symptoms and/ or treatment prior to the alleged abuse. Demographic data is summarized in Table 1 below.

Table 1: Case Study Demographics

Age	Gender	Education	Employment	Pre-Event Diagnosis
21	Female	<HS	No	No
21	Female	<HS	Post Only	No
21	Male	<HS	Pre/Post	Yes
19	Male	<HS	Pre/Post	Yes
15	Female	<HS	No	Yes
51	Female	<HS	Pre only	No

Consistent with life care planning methodology (Johnson, 2015; Preston & Johnson, 2012; Weed & Berens, 2010) a review of medical records was conducted that revealed DSM-IV diagnoses of adjustment disorder with anxiety and depression, post-traumatic stress disorder, depression, substance abuse and bipolar disorder. In terms of the DSM-5, PTSD and adjustment disorder would both be classified in the DSM-5 in the chapter entitled Trauma and Stressor Related Disorders (APA, 2013, 265-290). Bipolar disorder would be classified in the DSM-5 in the chapter entitled Bipolar and Related Disorders (APA, 2013, 123-154). Substance abuse would be classified in section II of the DSM-5 in the chapter entitled Substance-Related and Addictive Disorders (APA, 2013, 481-590). Anxiety would be classified in the DSM-5 in the chapter entitled Anxiety Disorders (APA, 2013, 189-233). Depression would be classified in section II of the DSM-5 in the chapter entitled Depressive Disorders (APA, 2013, 155-188).

Following review of medical records and client interviews, collaboration meetings were held with individuals involved in evaluation and/ or treatment of the individual. These professionals were most often psychiatrists, with one subject receiving care from both a psychiatrist and licensed clinical social worker (LCSW) and one from a psychologist and general practitioner. Based upon consultation with mental health professionals, life care plans were developed outlining treatment recommendations. A summary of treatment recommendations is below in Table 2.

Table 2. Life Care Planning Treatment Recommendations – Sexual Trauma

Client	Traumatic Event	Diagnosis	Life Care Plan Contributor	Recommendations
21 yo female	Sexual/ Physical Abuse	Adjustment disorder with anxiety/ depression; Post Traumatic Stress Disorder (PTSD)	Psychiatrist	One psychiatric eval through LE; Cognitive-Behavioral therapy (CBT) 48 sessions for 6 years; SSRI daily for 2 years; Psychiatrist visit 4/year for 2 years
21 yo female	Sexual/ Physical Abuse	PTSD, Depression, Anxiety	Psychiatrist	Psychiatric eval (1); CBT 48 sessions for 6 years; SSRI daily for 2 years; Psychiatrist visit 4/year for 2 years
21 yo male	Sexual Abuse	PTSD, Depression, Substance Abuse	Psychiatrist	Psychiatrist 4/yr for 5 years; 5 CBT evals through LE; Vocational rehabilitation services; SSRI for 5 years; 1 inpatient psychiatric hospitalization through LE
19 yo male	Sexual Abuse	PTSD, Bipolar Disorder	Psychiatrist	Psychiatrist visits 4 year for LE; 5 CBT evals through LE; Vocational rehabilitation services Assault Survivor group; CBT sessions 12-20 sessions/ year for 5 years; Family counseling 12-20 sessions for 5 years; SSRI for 5 years; Lithium or similar medication through LE; Laboratory monitoring yearly through LE; Inpatient psychiatric hospitalizations every 5 years through LE
15 yo female	Sexual Abuse	PTSD, Depression	Psychiatrist Social Worker (LCSW)	Psychiatrist 4/yr through LE; CBT weekly for 3 years then 10 occurrences of 27 sessions; SSRI LE; 1 Inpatient psychiatric hospitalization; Assault Survivor group; Art/Music therapy 4/mo for 8 years; Family therapy 24 sessions/ yr for 2 years; Vocational rehabilitation services
51 yo female	Sexual Assault	PTSD, Depression	General Practitioner Psychologist	GP visits 2/yr through LE; CBT weekly for one year/then 2 per month through LE; Support Group; SNRI through LE; Benzodiazepine through LE; Antidepressant through LE; Inpatient psychiatric hospitalizations PRN

The most common recommendations for future treatment of trauma-related injuries included use of anti-depressant medication and cognitive behavioral therapy, which were recommended in every case. It is noted that the frequency and duration of these services, varied, depending upon the symptomatology of the individual. Six of the seven cases included follow-up with a psychiatrist and in one case, this was performed by a general practitioner. The most common schedule of psychiatric follow up was four (4) visits per year for a period of 2-5 years in three cases and through life expectancy (LE) in two cases. Recommendations seen in three of the six cases included vocational rehabilitation services and inpatient psychiatric hospitalizations. Recommendations seen less frequently included family therapy (2 of 6 cases) and sexual assault survivor group (2 of 6 cases), art/ music therapy, use of lithium and laboratory monitoring seen in only one (1) of six (6) cases.

As can be seen, many of the future treatment recommendations were consistent with the American Psychiatric Association's Practice Guidelines. These included SSRIs and cognitive-behavioral treatment. Due to the holistic nature of the life care plan, additional recommendations including vocational rehabilitation services, family therapy and art/music therapy were found in this group of life care plans. These types of recommendations find support based upon the vocational disruption noted by Strauser et. al (2005) and also in the DSM-5 itself (APA, 2013). Because the life care plan is a comprehensive document designed to address facets of care that are not strictly medical, review of all relevant research should be made to inform the plan of care for individuals who have sustained trauma-related injuries.

Summary

Understanding the specifics of trauma disorders is important for the life care planner, as trauma is a leading cause of disability both in the United States and abroad. Prior to the DSM-5, previous versions of the *Diagnostic and Statistical Manuals* did not provide a trauma-specific diagnostic category. The most recent version, however, includes a trauma and stressor-related disorders section where PTSD and adjustment disorders can be found. A review of DSM-5 diagnostic criteria will provide the life care planner guidance in the individual's diagnosis and prognostic factors and help the practitioner better understand the impact of the disorder on a person's functioning.

In preparation of the life care plan, various sources of research should be consulted. Research is available addressing the impact on both psychosocial and vocational outcomes for individuals with these trauma-related disorders. Review of the American Psychiatric Association's *Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder* is one source of information for life care planners to obtain research-based practice recommendations. These may serve as a basis for recommendations when preparing life care plans for individuals who have experienced traumatic events or they may help inform the life care planner about treatment options to be discussed when collaborating with professionals in life care plan development. This important element in the life care plan should be addressed whether it is the presenting problem or a comorbid diagnosis.

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