FDA Advisory Statement on PTSD

By Esther Giller and Elizabeth Vermilyea

Thank you for the opportunity to attend this meeting and to present to the FDA information about posttraumatic stress conditions and the need for increased understanding and treatment. The Sidran Institute is a national nonprofit organization exclusively dedicated to educating professionals and the public about traumatic stress conditions, including PTSD.

Prevalence

Kessler et al. (1995) found that 60% of men and 51% of women in the general population reported at least one traumatic event at some time in their lives. Almost 17% of men and 13% of women who had some trauma exposure had actually experienced more than three such events. These data are consistent with several prevalence studies on PTSD.

The NIH National Comorbidity Survey found that childhood sexual abuse was a very strong predictor of the lifetime likelihood of PTSD. The trauma most likely to produce PTSD was found to be rape, with 65% of men and 45.9% of women who had been raped developing PTSD (Kessler, et al, 1999). This study shows that PTSD is associated with nearly the highest rate of service use and possibly the highest per-capita cost of any mental illness.

Chronicity

Epidemiologic studies demonstrate that PTSD is a chronic problem for many people. Studies of chronicity demonstrate 33-47% of PTSD patients reporting experiencing symptoms more than a year after the traumatic event (Davidson, 1991 & Helzer, 1987).

In a focused study of severe PTSD, Ford (1999) demonstrated exceptionally high levels of service use among patients meeting criteria for DESNOS (Disorders of extreme stress not otherwise specified). Switzer et al. (1999) studied service use among clients with PTSD at an urban mental health center and found 94% of clients had a history of trauma and 42% had

PTSD. Switzer documented especially high levels of service use among those with PTSD as compared to others.

Leserman et al. (1998) and Freidman and Schnurr (1995) showed that PTSD is also associated with high levels of use of non-mental health services. An HMO study (Walker et. al., 1999) reported substantially increased healthcare costs among patients who reported childhood trauma. (Hidden costs include medical costs for suicidal and parasuicidal behaviors as well as other somatoform and psychophysiological disorders commonly reported by trauma survivors.) Child sexual and physical abuse may not only produce PTSD in some, but may increase PTSD susceptibility in response to later, adult stressors (Briere, Woo, McRae, Foltz, & Sitzman, 1997, Journal of Nervous and Mental Disease). People who have experienced assaultive violence (interpersonal victimization) at home or in the community, have also been shown to be at very high PTSD risk (21%) (Breslau, et. al., 1998, Archives of General Psychiatry).

Comorbidity

The moderating effects of PTSD can significantly complicate any other co-occurring disorder including developmental disorders. Persons with PTSD are likely to have at least one other mental health disorder. Even in the most conservative studies, people with PTSD were two to four times more likely than those without PTSD to have almost any other psychiatric diagnosis (Kessler et. al., 1995). Somatization was found to be 90 times more likely in those with PTSD than in those without PTSD. This shows an important but frequently overlooked connection between PTSD and physical complaints.

Many people with PTSD turn to alcohol or drugs in an attempt to escape their symptoms. Clients who are dually diagnosed with substance abuse and PTSD may benefit from trauma treatment instead of or in addition to traditional model substance abuse programs.

The Cost of Trauma

Early outcome studies showed that early diagnosis and appropriate treatment of trauma-related disorders are cost effective, especially when compared with the cost of incorrect or inadequate treatment occurring prior to a correct diagnosis (Loewenstein, 1994).
Ross and Dua (1993) studied women with trauma related dissociative disorders who were admitted to an inpatient service over four years. Prior to correct diagnosis, the patients had averaged 98.77 months in treatment. Following a correct diagnosis, they averaged 31.53 months in the system. Before diagnosis, about 2.8 million dollars (Canadian) had been spent on

treatment for this group. If the 98.77 months prior to correct diagnosis were reduced to 12 months, the estimated savings would be $250,000 per patient.

In a study of rape victims, Koss et. al. (1990) found that severely victimized female members in an HMO had outpatient medical expenses double those of control HMO members.
Findings suggest that from 3.1 to 4.7 million crime victims received mental health treatment in 1991, for an estimated total cost of $8.3 to $9.7 billion (Cohen & Miller, 1994). These recipients represent only a small portion of trauma victims in need of treatment, since those with PTSD are typically reluctant to seek professional help.

Recent outcome data has largely focused on veteran populations. Fontana & Rosenheck (1997) found that short-term specialized programs to treat PTSD were more cost effective and beneficial than either long-term specialized units or non-specialized programs. Although this study does not address those who suffer with chronic PTSD from childhood trauma, it does demonstrate the efficacy of specialized treatment delivered in an accessible, cost effective manner.

Marginalized Populations

There has been increasing attention paid to PTSD resulting from high-profile "single blow" traumas, such as school shootings, transportation disasters, etc. But PTSD resulting from chronic trauma (such as experiencing or witnessing childhood abuse, domestic violence, and interpersonal victimization in the community) is not well known in the general population, among primary health care providers, or even among mental health care providers in many settings. Also, male survivors of abuse (perhaps the most marginalized subgroup of all) are frequently overlooked, even within the trauma-focussed survivor empowerment movements and specialized trauma treatment units.

Misdiagnosis

Misdiagnosis and incorrect or inadequate treatment is not unusual for adults and children with PTSD. For example, refractory depression, substance abuse, and eating disorders, among others, often mask underlying but undiagnosed PTSD. Flashbacks and other dissociative episodes can frequently be mistaken for psychosis (especially schizophrenia), and unnecessary anti-psychotic medication can undermine treatment progress. Schools increasingly report disciplinary problems with no understanding that some children may be suffering from violence-related trauma disorders rather than ADHD or ADD. Consequently, they are improperly treated with Ritalin, while their real problems remain unaddressed.

Education

There is a dearth of treatment providers properly trained to recognize and treat PTSD, especially complex chronic types, and the topic is rarely addressed in universities and professional schools. Public education about PTSD is lacking as well, with lay people commonly associating PTSD with combat and little else.

Conclusion

These data clearly indicate the critical need for recognition of and appropriate treatment for survivors of traumatic experiences who develop traumatic stress-related mental health conditions. In addition to research and development of pharmaceutical and psychotherapeutic treatment approaches, successful intervention depends on a two-fold approach to education: in professional and treatment settings, as well as in the patient population and general public. Since primary care physicians and community mental health staffs are most likely to see people with PTSD, they must learn to ask about trauma exposure, recognize symptoms of PTSD, and refer patients appropriately.

Educating professionals first is paramount to managing the influx of clients that will certainly follow public awareness programming. The Sidran Foundation is actively involved in a variety of trauma education initiatives.

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