Co-Occurring Disorder-Related Quick Facts:
TRAUMA/POSTTRAUMATIC STRESS DISORDER (PTSD)

Trauma/PTSD: More than half of the adults in the United States report one or more lifetime events outside of normal human experience; in some studies, rates have been estimated in the 70-90 percent range. An estimated 60 percent of reported traumatic events involve the sudden unexpected death of someone close or a trauma suffered by someone close.[1]

Clinically significant responses to trauma include Acute Stress Disorder (ASD), Posttraumatic Stress Disorder (PTSD), Major Depressive Disorder, Traumatic Grief, and Adjustment Disorders. These Quick Facts will concentrate only on PTSD, with an emphasis on facts related to PTSD and SUDs (Substance Use Disorders).

Epidemiology: The development of PTSD is dependent upon many factors, especially the type of trauma itself. For example, in one survey in Detroit, 9.2 percent of persons experiencing a trauma developed PTSD, but half of those who had been raped or held captive, tortured, or kidnapped developed PTSD compared with 2.2 percent of those who learned of the rape, attack, or injury of a close relative.[1] In a study of about 100,000 veterans in VA health facilities from 2001-2005, PTSD was the most common service-related mental health diagnosis (approximately 13,000 cases) and accounted for more than half of all mental health diagnoses and 13 percent of the study sample. During 2006 the VA reported providing treatment for 346,000 veterans diagnosed with PTSD.[2] In the National Comorbidity Survey Replication, 6.8 percent of respondents were found to have a lifetime PTSD diagnosis and 3.6 percent a 12-month prevalence rate (N=5692).[3]

The rates of rape and sexual assaults are disproportionately higher for women than men, while the reports of assaultive violence (being mugged, shot, stabbed, or threatened with a weapon) are higher for men, it is difficult to assess why women are about twice as likely to have a lifetime diagnosis of PTSD.[1] While increasing age throughout adulthood shows little sign of any associated increase in PTSD[1] and a considerable drop after the age of 60,[3] young adults experience more trauma events,[1] and runaway, homeless, and criminally involved youths and adults report high levels of traumatic situations. One study of incarcerated women found that one-third had PTSD.[4,5] McNamara et al. (2001) found that PTSD was the most common anxiety disorder among the 128 homeless persons they interviewed in a behavioral/contingency management treatment program, with 16 percent of the 128 meeting diagnostic criteria for PTSD.[6] Hein et al. (2000) found a similar rate (20%) of diagnosable PTSD among their sample of 96 substance abusing patients.[7] Both of these findings on substance use disorder clients are similar to a rigorous epidemiologic study of the homeless conducted by North and Smith (1992) of 900 homeless individuals. North and Smith found that 18 percent of the males and 34 percent of the females had lifetime PTSD, and of these two groups, 56 percent of the males and 43 percent of the females also had lifetime drug use disorder diagnoses.[8]

PTSD patients have repeatedly been found to have a high rate of substance-related disorders. Since clients with SUDs have a higher incidence of trauma in their lives, it is unclear to what extent having a SUD predisposes one to develop PTSD in response to trauma or to what extent it

is simply the greater rate of traumas that increases the association of having a lifetime SUD with that of having a lifetime PTSD. Even more difficult to discern are the relationships among increases in drinking following trauma (a common phenomenon) and the development of PTSD and/or a SUD.

Rates of PTSD among clients in SUD treatment have been found in various studies to range from 19 percent to 62 percent, with one national study of women reporting a 51.3 percent lifetime rate and a 35.7 percent current rate.[9] People with a PTSD-SUD co-occurring disorder are also prone to have additional mental health disorders, including mood, other anxiety, and personality disorders.[10]

Treatment: Based on a review of 90 randomized clinical trials of pharmacological and psychological treatments of PTSD, the Institute of Medicine (IOM) found they could endorse only exposure therapy as having demonstrated effectiveness.[2]. In a review of pharmacologic studies, Golier, Legge, and Yehuda (2007)[10] concluded that the selective serotonin reuptake inhibitors fluoxetine, sertraline, and paroxetine are effective for reducing symptoms and improving outcomes, and that imipramine and phenelzine have also been found efficacious.

Other recent reviews both of pharmacological and psychosocial treatments found support for a number of approaches. Najavits (2007) found that PTSD treatments work, and she concluded that overall the general effectiveness of any treatment did not differ significantly from that of other treatments for the well-known treatments she reviewed.[11] The National Trauma Consortium described four models tested in SAMHSA's Women with Co-Occurring Disorders and Violence Study (WCDVS) along with one other model. These approaches can be used to establish safety and stabilization in the first stage of treatment: *ATRIUM* (Miller & Guidry, 2001), *Helping Women Recover* (Covington, 1999), *Seeking Safety* (Najavits, 2002), *Trauma Recovery and Empowerment Model (TREM)* (Harris, 1998), and *Triad* (Clark & Fearday, 2003).[12]

Major SAMHSA Activities/Resources:

- Substance Abuse Treatment and Domestic Violence: Treatment Improvement Protocol (TIP) Series 25 and related KAP keys

- Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues: Treatment Improvement Protocol (TIP) Series 36 and related KAP keys

- Alcohol Screening and Brief Intervention of Trauma Patients: Treatment Improvement Protocol (TIP) Series 16 and related KAP keys

- Understanding Links between Adolescent Trauma and Substance Abuse: A Toolkit for providers (available from National Child Traumatic Stress Network)

- SAMHSA Web site link to the Disaster Technical Assistance Center: www.mentalhealth.samhsa.gov/datc/default/asp

- SAMHSA Web site link to Disaster Relief Information: www.mentalhealth.samhsa.gov/cmhs/traumaticevents/tips.asp

- SAMHSA Web site link to the National Center for Trauma-Informed Care: www.mentalhealth.samhsa.gov/nctic (produced "Trauma Matters," a newsletter)

- SAMHSA Web site link to the National Child Traumatic Stress Network: www.nctsnet.org

- SAMHSA Web site link to the Department of Veterans Affairs National Center for Posttraumatic Stress Disorder: www.ncptsd.va.gov

- CSAT's Disaster Recovery Resources for Substance Abuse Treatment Providers (CD and on the Web)

- Center for Mental Health Services (CMHS) grant programs on Child Traumatic Stress

- Journal publications from SAMHSA's Women and Violence program –Two special issues: *Journal of Substance Abuse Treatment*, Vol. 28 (2005), and *Journal of Community Psychology*, Vol. 35, No. 7 (2007)

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