

## Estimating PTSD Prevalence Requires Precise Exposure Details

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The intensity and type of exposure to trauma should be carefully evaluated when estimating the magnitude of the posttraumatic stress disorder burden in the aftermath of a terrorist attack, findings from a study of 379 surviving employees from eight companies affected by the September 11, 2001 attack on the World Trade Center suggest.

The findings call into question prior estimates of PTSD prevalence after 9/11. Several studies provided such estimates for broadly affected populations following the 9/11 terrorist attacks (people throughout New York City, for example), but none sufficiently addressed the details of the exposure in order to link cases of PTSD to the terrorist attacks, the investigators noted.

More than a third of the subjects in the study who experienced direct exposure to danger during the tragic events of 9/11 met the [Diagnostic and Statistical Manual, Fourth Edition](#), Text Revision (DSM-IV-TR) criteria for posttraumatic stress disorder at any time following the disaster. Furthermore, 20% of those who were exposed to danger through witnessed experiences only, and 35% who were exposed through a close associate's direct exposure only also met the criteria for PTSD at any time after the events, Dr. Carol S. North of the University of Texas Southwestern Medical Center, Dallas, and her colleagues reported in the Sept. 7 Disaster Medicine and Public Health Preparedness.

Outside of these exposed groups, "few other possible sources of exposure were evident among the few individuals who were symptomatic, most of whom had preexisting psychiatric illness," the investigators wrote ([Disaster Med. Public Health Prep. 2011 \[doi: 10.1001/dmp.2011.50\]](#)).

The assumption that the New York City population was exposed and was therefore at risk for PTSD "has important implications for both prevalence estimates and service provision; it has not, however, been tested with respect to the DSM-IV-TR criteria for PTSD," they wrote. "Although the 9/11 terrorist attacks constituted an undeniable traumatic event, this is not sufficient for the diagnosis of PTSD; a qualifying exposure to the traumatic event is also necessary for consideration of this diagnosis."

That is, symptom scales applied without assessment of trauma exposure may count symptoms unrelated to trauma exposure and cannot accurately estimate PTSD incidence, they explained.

The problem is magnified in low-exposure – and thus low PTSD risk – populations such as geographically broad 9/11-affected populations. The result is a gross overestimate of PTSD prevalence, which could result in inaccurate diagnosis, unnecessary interventions, and missed opportunities for appropriate treatment.

Indeed, the findings indicate that it is unlikely that widespread PTSD-qualifying trauma exposure occurred in populations geographically distant from the attack sites. The findings have implications for disaster mental health planning and response. "Effective disaster mental health planning and response depend on accurate information about the numbers of people who will need distinct types of services," they wrote.

For the current study, investigators interviewed 102 individuals with direct exposure to danger following the attacks, including 65 who were in the World Trade Center towers at the time of the attack, and 277 with various other types of exposure. Subjects were interviewed about 3 years after the attack using the Diagnostic Interview Schedule/Disaster Supplement, and reassessment was performed at 6 years following the attack.

"This study uniquely combined assessment of PTSD according to full DMS-IV-TR criteria with detailed data about geographical

proximity and specific experiences of the 9/11 attacks for determination of qualifying trauma exposure," they noted.

While the data can't be presumed to represent an accurate estimate of PTSD prevalence (because the sample cannot be assumed to be representative of New York City or affected populations), the "major value of these data are, rather, in the opportunity to study the occurrence of PTSD in relation to objective 9/11 trauma exposures," they wrote.

The findings underscore the need for differentiating distress from PTSD and other psychiatric disorders to help prevent "inappropriate pathologizing of normal responses."

"This study has clarified the value of fully considering exposures to terrorist attacks when estimating PTSD prevalence, and it has demonstrated these considerations to be especially pertinent in populations outside close geographic proximity to the incident."

They also noted that the importance of examining trauma exposures with precision is relevant for other trauma-exposed populations as well, such as military combat veterans.

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