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IMPACT OF TRAUMA: INTERRELATIONSHIP BETWEEN PTSD AND DEPRESSION

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What draws you to working with those who have been traumatized?

What do I hope to learn and how will this impact the work that I do?
Why a training on the intersection between PTSD and Depression?
45% of individuals diagnosed with one mental disorder meet criteria for a second mental disorder

- U.S. National Comorbidity Survey Replication (NCS-R)
80% of those with PTSD diagnosis will also be diagnosed with —Kessler, 1995

✔ Depression
✔ Another Anxiety Disorder
✔ Substance Abuse/Dependence

BECAUSE OF THE HIGH CO-MORBIDITY
COMORBIDITY OF PTSD AND DEPRESSION
PTSD has **highest** psychiatric comorbidity rates of any disorder but depression

Among people with current PTSD as primary diagnosis:
- Any current anxiety or mood disorder (80-92%)
- Current Major Depression Disorder (69%)
- Lifetime alcohol abuse or dependence (31%)
- Current panic disorder (23%)
- Current obsessive compulsive disorder (23%)

Stats provided by Foa slide Prolonged Intensive 2012
Those with PTSD who also have MDD 69%

Those with MDD who also have PTSD 37% to 48%
The empirical question: How are they related?

Does disorder $x$ cause disorder $y$?

Does disorder $y$ cause disorder $x$?

Both $x$ and $y$ are caused by some other factor

Each disorder arises independently, without any relation between them

Each disorder may impact the course of the other, even if not caused by it
The empirical question: How are they related?

Does PTSD cause disorder MDD?

Does disorder MDD cause disorder PTSD?

Both PTSD and MDD are caused by some other factor.

Each disorder arises independently, without any relation between them.

Each disorder may impact the course of the other, even if not caused by it.
What research is showing...

- The overlap of symptoms indicate shared pathways
- Having one increases the likelihood of the other
- Severity of one negatively impacts the severity of the other
- Comorbid conditions are associated with poorer outcomes
Implications of diagnostic relationships

✓ Changes how we think about risk factors
✓ Changes how we think about prevention
✓ Changes how we think about treatment
  ✓ Do we provide sequential treatment?
  ✓ Do we provide integrated treatment?
  ✓ Do we provide parallel treatment?
  ✓ Do we provide single diagnosis treatment?
Problem 1: Comorbidity is the norm yet treatment studies routinely exclude people with co-morbid conditions

Problem 2: Not all comorbid conditions are a like

Problem 3: Treatments are not necessarily ONLY treating a specific disorder

Problem 4: Treatments are not specifically designed to target more than one disorder
Finding 1: Many treatments that target PTSD (CBT) also have positive outcomes for depression

Finding 2: Integrated treatments for SUD, BPD, Panic have shown positive outcomes

Finding 3: Treatments (CBT) tend to address common problems (problematic cognitions and avoidance behavior): GAD, MDD, PTSD, SP,

Finding 4: Treatments for OCD may increase PTSD symptoms (as one got better the other got worse)
Transdiagnostic Approaches
“EMOTIONAL DISORDERS”

- Social anxiety
- Depression
- Panic disorder
- Agoraphobia
- Generalized Anxiety
- OCD
- Etc…

In all of these disorders people:

Experience strong, intense, and/or uncomfortable emotions

These emotions get in the way of one’s Quality of Life
“emerging conceptualizations of the major emotional disorders emphasize their commonalities rather than their differences”  - Barlow 2011
There is considerable overlap across diagnoses as evidenced by the significant rate of co-morbidity – Barlow 2011

Response rates of treatments that target a specific disorder tend to influence and impact the level of the comorbid disorder – Barlow 2011
“Emotion regulation is a process by which individuals influence the occurrence, intensity, expression, and experience of emotions”

- from Gross & Thompson 2007 in Barlow et al, 2011

It appears that deficits in ER skills play an important role in the development and maintenance of anxiety and mood disorders.
The role of emotion regulation

Individuals experiencing anxiety, mood and other emotional disorders tend to share common difficulties in emotion regulation:

- Heightened Emotional *Reactivity*
- Heightened *Sensitivity* to Emotional Experiences
- Heightened Appraisal of Emotional Experiences as *Aversive*
- Involves attempts to *Alter, Avoid, or Control* Emotional Responding
“distilling and incorporating the common principles found in existing empirically supported psychological treatments—namely, reevaluating maladaptive cognitive appraisals, changing action tendencies associated with the disordered emotions, preventing emotion avoidance, and utilizing emotion exposure procedures” - Barlow 2011
POST-TRAUMATIC STRESS DISORDER
Types of Trauma:
- Combat Related
- War Experience
- Natural Disaster
- Interpersonal Violence
- Accidents
- Childhood Abuse/Neglect
- Community Violence
WHAT DEFINES TRAUMA?

• In terms of PTSD, a trauma is anything that **threatens life or one’s physical integrity**

• Difficult to define precisely

• Scientific debate around definition of traumatic events

• Many experiences may be traumatic for one person and not to others
HOW COMMON IS IT?

• 60% of the U.S. population will be exposed to at least 1 Traumatic Event in their lifetime – ACE Study

• Lifetime Prevalence Rate for PTSD
  • 8%-14% in the general population
  • MOST people recover naturally, on their own, and without treatment
Prevalence

1. 12-month Prevalence: 3.5% of U.S. adult population
2. Severe: 36.6% of these cases (e.g., 1.3% of U.S. adult population) are classified as "severe"

Demographics
(for lifetime prevalence)

1. Sex: Not Reported
2. Race: Not Reported
3. Age:

Average Age-of-Onset: 23 years old

http://www.nimh.nih.gov/statistics/1ad_ptsd_adult.shtml
Treatment/Services Use

12-month Healthcare Use: 49.9% of those with disorder are receiving treatment
- Percent Received Minimally Adequate Treatment: 42.0% of those receiving treatment are receiving minimally adequate treatment (21.0% of those with disorder)

12-month Any Service Use (including Healthcare): 57.4% of those with disorder are receiving treatment
- Percent Received Minimally Adequate Treatment: 40.4% of those receiving treatment are receiving minimally adequate treatment (23.2% of those with disorder)

2 Ibid
CHRONICITY AND SEVERITY

• Spectrum of Symptom Severity and Chronicity

• Excellent Prognosis with Intervention

• Most trauma symptoms resolve within 3 months without intervention

• If symptoms persist for 1 year; unlikely to resolve without treatment (Kessler, 1995)
GENDER

• Lifetime Prevalence Rates
  • 10.4% for Women
  • 5% for Men

• Some Evidence Suggests
  • Women 4x more likely to develop PTSD when exposed to same event than men

• Some Evidence Suggests
  • Women may be more responsive to treatment
Chronic PTSD

- Mood Disorders
- Substance Use Disorders
- Reduced Quality of Life
- Social/Occupation
- Other Anxiety Disorders
- Dissociative Disorder
- Psychosis
• Most people who experience a traumatic event recover naturally

• PTSD represents a failure of natural recovery

• If PTSD does not remit within a year, it is unlikely to remit on its own

• PTSD is highly distressing and debilitating disorder
Symptoms of PTSD
Exposure to a Traumatic Event

Symptom Clusters
1. Re-experiencing
2. Persistent Avoidance
3. Negative Mood and Cognitions
4. Increased Arousal

- 1 month in duration
- Causes significant distress
DEFINITION OF A TRAUMATIC EVENT

Exposure to actual or threatened death, serious injury or sexual violation

• Directly experiences the traumatic event
• Witnesses the traumatic event in person
• Learns that a traumatic event occurred to a close family member or friend
• Experiences first-hand repeated or extreme exposure to aversive details of a traumatic event
POSTTRAUMATIC STRESS DISORDER

Healthy Brain

PTSD
Brain Scan of Depression

Depressed

Not Depressed
**RE-EXPERIENCING (AT LEAST 1 SYMPTOM)**

- Distressing recollections of the trauma
- Distressing dreams of the event
- Reliving the experience (flashback)
- Psychological distress at exposure to trauma reminders (internal or external)
- Psychological reactivity to trauma reminders
PERSISTENT AVOIDANCE
(AT LEAST 3 SYMPTOMS)

Avoidance refers to distressing memories, thoughts, feelings, or external reminders of the event

- Efforts to avoid trauma-related thoughts or feelings
- Psychogenic amnesia
- Diminished interest in activities
- Detachment from others
- Restricted Range of affect
- Foreshortened future
NEGATIVE MOOD AND COGNITIONS

Includes a myriad of mood and cognitive symptoms that consistently show up in conjunction with PTSD symptoms.

- Persistent or distorted sense of blame of self or others
- Estrangement from others
- Markedly diminished interest in activities
- Inability to remember key aspects of the event

Added to the DSM-V in response to the further observation and research showing this to be the norm.
INCREASED AROUSAL (AT LEAST 2)

• Sleep disturbances
• Irritability or outburst of anger
• Difficulty concentrating
• Hypervigilance
• Exaggerated startle response
IMPACT OF PTSD
VIDEO

https://www.youtube.com/watch?v=4DF5caucKjl
https://www.youtube.com/watch?v=gDCX8NqRnto
PROBLEMS IN FUNCTIONING

- Family
- Mood
- Relationships
- Somatic
- Cognitions
- Behavior
Cognitive Distortions

- Inaccurate Thoughts
- Self-Blame
- Unhelpful Thoughts

Behavior

- Avoidance Behaviors
- Aggressive
- Sexualized
- Oppositional
- Unsafe

Affective

- Sadness
- Anxiety
- Fear
- Anger
- Emotion Dysregulation
- Inability to Self-Soothe
Somatic

- Sleep Problems
- Physiological Hyper-arousal
- Hyper-vigilance
- Physical Tension
- Headaches
- Stomachaches

Relationships

- Poor Problem Solving
- Poor Social Skills
- Hypersensitivity in Relationships
- Impaired Trust

Family

- Parenting Skill Deficit
- Impaired communication
- Impaired bonding
- Dysfunctional interactions
IMPLICATIONS ON TREATMENT
• Treatments are interventions whose aim are to reduce or alleviate symptoms of a particular disorder

• We have around 20 years of research on treatment efficacy

• Treatments range from structured and manualized treatments to unstructured and non-directive
EFFICACY

• **Efficacy Data:**
  data used to support whether a particular treatment results in the **intended outcomes** or changes

• **Treatment Efficacy:**
  the ability to **predict a treatment will produce the desired outcome** of the amelioration or reduction of symptoms associated with a particular disorder
EVIDENCE-BASED TREATMENTS

• EBT’s are treatments that have been well studied, through a rigorous scientific process, that have shown predictive reduction in and/or amelioration of symptoms of a disorder

• Treatments without evidence does not mean they are not effective treatment; only that they have not been studied in a way showing efficacy

• There are treatments that have been shown to do harm
TREATMENTS

1. Cognitive Behavior Therapies
2. Eye Movement Desensitization Reprocessing
3. Psychodynamic Therapies
4. Psychopharmacologic Therapy
5. Group Therapy
6. Creative Arts Therapy
## Cognitive Behavior Therapies (Level A)

<table>
<thead>
<tr>
<th>Exposure Therapy</th>
<th>Cognitive Processing Therapy</th>
<th>Cognitive Therapy</th>
<th>Dialectical Behavior Therapy</th>
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<tbody>
<tr>
<td>• Level A</td>
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<tr>
<td>• 24 RCT</td>
<td>• 4 RCT's</td>
<td>• 2 RCT's with civilian traumas</td>
<td>• 2 RCT's</td>
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<tr>
<td>• Imaginal Exposure</td>
<td>• Female rape survivors, survivors of childhood sexual abuse</td>
<td>• Post-trauma symptom reduction</td>
<td>• Support for sequential application of skills training first</td>
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<tr>
<td>• In-Vivo Exposure</td>
<td>• combat veterans</td>
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<tr>
<td>• Combo of Imaginal and in-vivo most effective</td>
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<td>• Most Efficacy of all CBT treatments</td>
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<td>• Superior to Control</td>
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<td>• Range of trauma exposure</td>
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<td>• Additional Techniques do not yield better outcomes</td>
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EYE MOVEMENT DESENSITIZATION REPROCESSING (LEVEL A)

- Level A for Adults with PTSD
- Level B for Children with PTSD
- 7 Meta-Analyses of EMDR
- Equally as effective as Exposure Based Therapies
- Dismantling Research shows no support for saccadic eye movement or alternating movements (does not add to the treatment)
OVERVIEW

- International Society for Traumatic Stress Studies recommends the following treatments for PTSD as first line treatments
  - TF-CBT
  - EMDR
  - Pharmacotherapy

- Levels of evidence are based on the current availability of research

- Lack of evidence does not mean a treatment is not effective

- Some treatments have been found to be counter-productive and harmful


National Comorbidity Survey
http://www.hcp.med.harvard.edu/ncs/

The World Mental Health Survey Initiative
http://www.hcp.med.harvard.edu/wmh/

The Adverse Childhood Experiences Study
http://www.acestudy.org/