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IMPACT OF TRAUMA: INTERRELATIONSHIP BETWEEN PTSD AND DEPRESSION

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St. Louis Center for Family Development, LLC

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)

BECAUSE OF THE HIGH CO-MORBIDITY

80% of those with PTSD diagnosis will also be diagnosed with -Kessler, 1995

- ✓Depression
- ✓Another Anxiety Disorder
- ✓Substance Abuse/Dependence

COMORBIDITY OF PTSD AND DEPRESSION

STATS

- 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%

PTSD Diagnostic Criteria

- ✓ Exposure to a traumatic event
- ✓ Recurrent, involuntary and intrusive distressing memories, dreams, dissociative reactions (flashbacks), intense distress when exposed to internal and external cues of the event
- ✓ Avoidance of or efforts to avoid distressing memories, thoughts, or feelings related to event
- ✓ Avoidance of external reminders (people, places, conversations, activities, objects, situations) that arouse distressing thoughts or feelings
- ✓ Inability to remember important aspects of the event
- ✓ Negative beliefs or expectations about oneself, others, or the world
- ✓ Distorted cognitions about the cause or consequences of the event that lead to self-blame or other-blame
- ✓ Persistent negative emotional states
- ✓ Diminished interest or participation in significant activities
- ✓ Feelings of detachment or estrangement from others
- ✓ Inability to experience positive emotions
- ✓ Irritability and anger, reckless behavior,

Major Depressive Disorder

- ✓ Depressed mood most of the day, nearly every day for at least 2 weeks
- ✓ Diminished interest or pleasure in all or almost all activities most of the day, nearly every day
- ✓ Weight loss or increase
- ✓ Sleep disturbance
- ✓ Psychomotor agitation or retardation
- ✓ Fatigue or loss of energy
- ✓ Feelings of worthlessness or excessive guilt
- ✓ Diminished ability to concentrate or indecisiveness
- ✓ Recurrent thoughts of death

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*

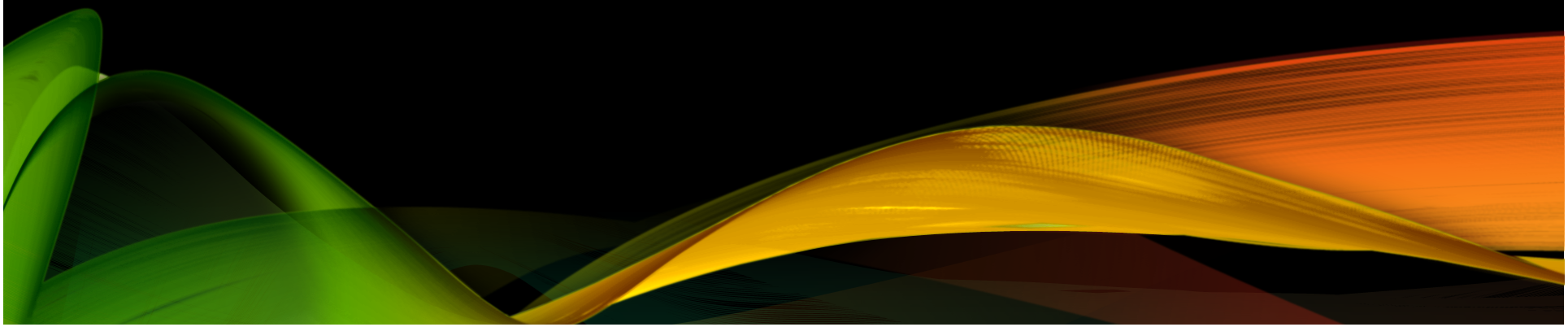
Finding 1: *Many treatments that target PTSD (CBT) also have positive outcomes for depression*

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)*

IMPACT ON TREATMENT



WHAT DO WE DO WITH TREATMENT?

- Do we integrate treatment?
  - DBT-PE
- Do we make treatment sequential?
  - DBT
  - Target PTSD then Depression; vice versa?
- Do we provide parallel treatments?
  - PE and SUD
- Do we just treat one and be done?
  - PE alone?

WHAT WE HAVE LEARNED FROM PROLONGED EXPOSURE

- PE is the most widely researched treatment for PTSD, across the widest array of trauma exposures and populations.
- PE is a CBT treatment that uses four components
  - Psychoeducation
  - Imaginal Exposure
  - *In-Vivo* Exposure
  - Emotional Processing

SUPPORT FOR SINGLE TREATMENT

Prolonged Exposure lends support for treating the single diagnosis of PTSD

PE doesn't target Depression Directly

Prolonged Exposure treatment not only treats PTSD, but consistently treats depression as well

What does this mean? Why does PE treat both? Why is symptom relief occurring?

SUPPORT FOR AN INTEGRATED TREATMENT

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders

Developed by David Barlow et. al.

Focuses on integrating a standard treatment that targets similar underlying pathways that are associated with psychopathology…emotional disorders involve themselves with problems in emotion regulation

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

The role of emotion regulation

"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

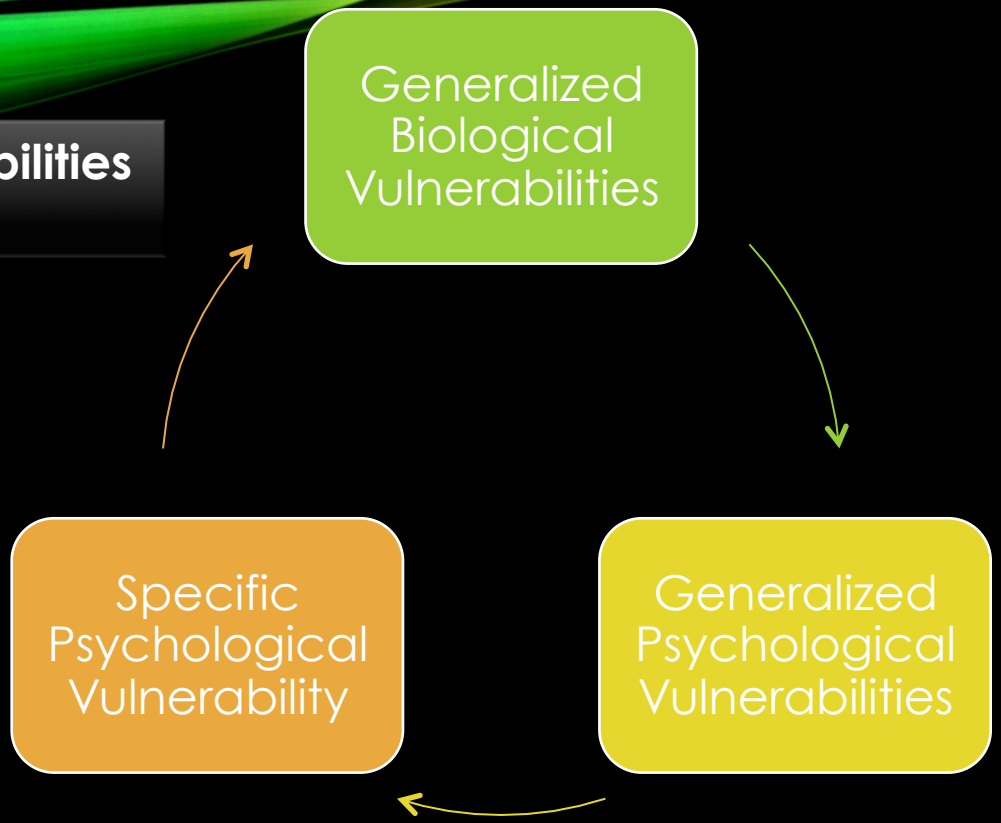
The role of emotion regulation

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

Triple Vulnerabilities Theory



GBV: genetic basis of temperaments (anxiety, neuroticism, negative affect, or behavioral inhibition)

GPV: early life experiences contributing to a sense of uncontrollability and unpredictability

SPV: learning a particular focus of anxiety or learning that some situations, objects, internal somatic states are dangerous

"its particular emphasis on the way individuals with emotional disorders *experience* and *respond* to their emotions is unique" - Barlow 2011

"The main premise of the treatment is that individuals with emotional disorders use *maladaptive emotion regulation strategies*---namely, attempts to avoid or dampen the intensity of uncomfortable emotions---which ultimately backfire and contribute to the maintenance of their symptoms" – Barlow et al. 2011

The goal is not elimination, the goal is experience of emotion in adaptive ways

Core Treatment Modules Target

- Present-focused emotion awareness
- Cognitive Flexibility
- Emotion avoidance and emotion-driven behaviors
- Awareness and tolerance of physical sensations
- Interoceptive and situation-based emotion exposure

UP Treatment Modules

- Motivation Enhancement for Treatment Engagement
- Psychoeduction and Tracking of Emotional Experiences
- Emotion Awareness Training
- Cognitive Appraisal and Reappraisal
- Emotion Avoidance and Emotion-Driven Behaviors
- Awareness and Tolerance of Physical Sensations
- Interoceptive and Situation-Based Exposures
- Relapse Prevention

Extras!

POST-TRAUMATIC STRESS DISORDER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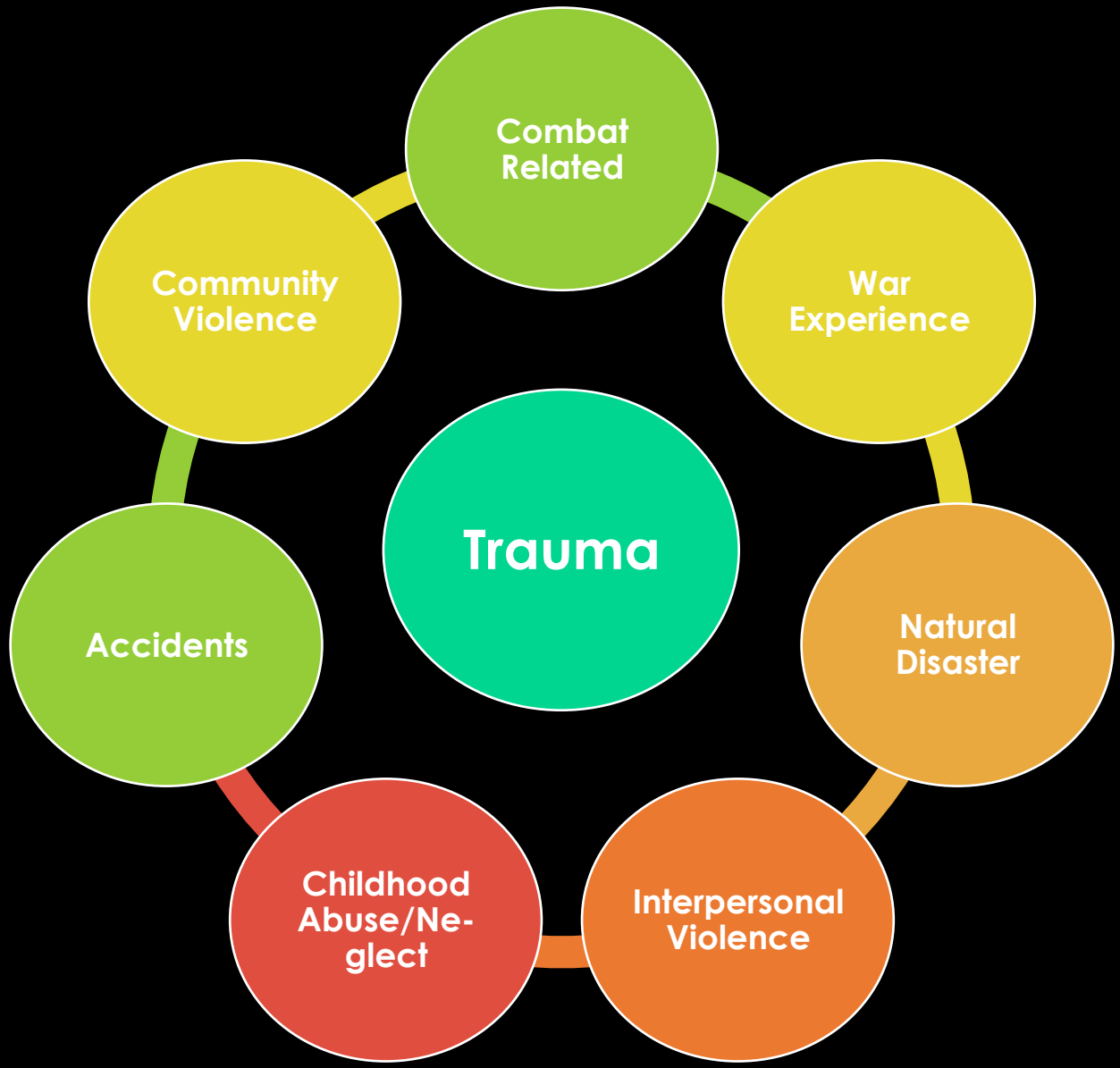
TYPES OF TRAUMA



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

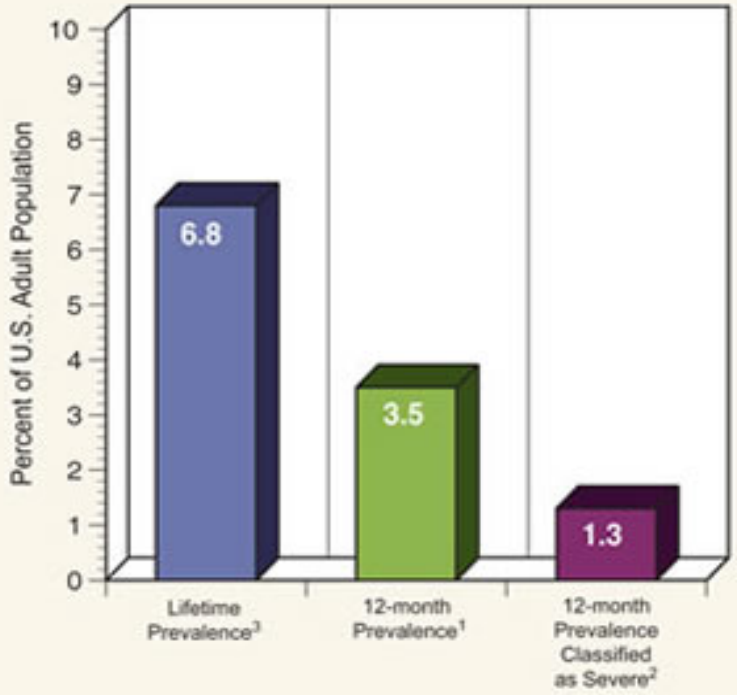
HOW COMMON IS IT?

- 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

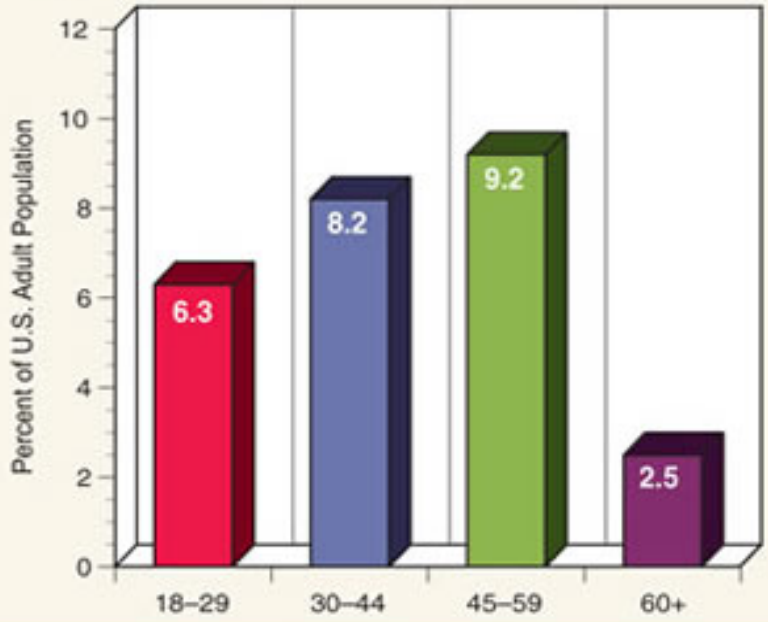
Prevalence

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



Demographics (for lifetime prevalence)[5]

- **Sex:** Not Reported
- **Race:** Not Reported
- **Age:**



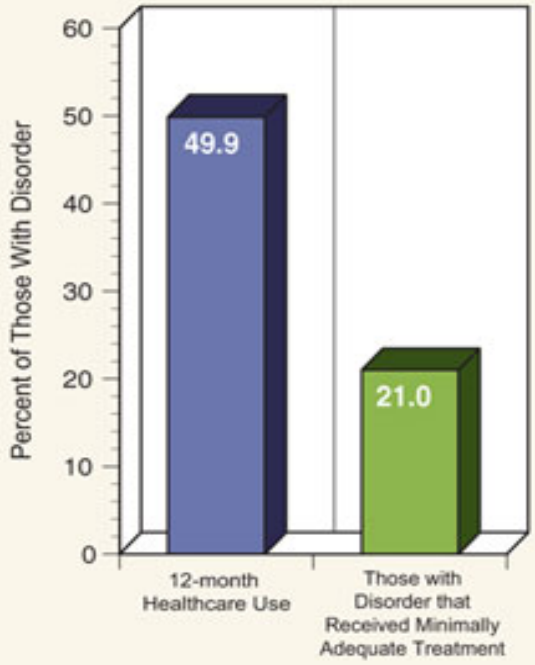
Average Age-of-Onset: 23 years old[4]

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

Treatment/Services Use[6]

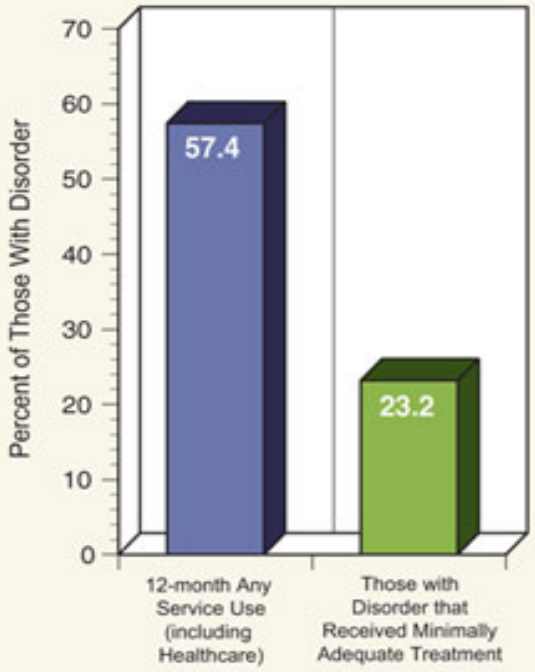
12-month Healthcare Use: 49.9% of those with disorder are receiving treatment

- **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)



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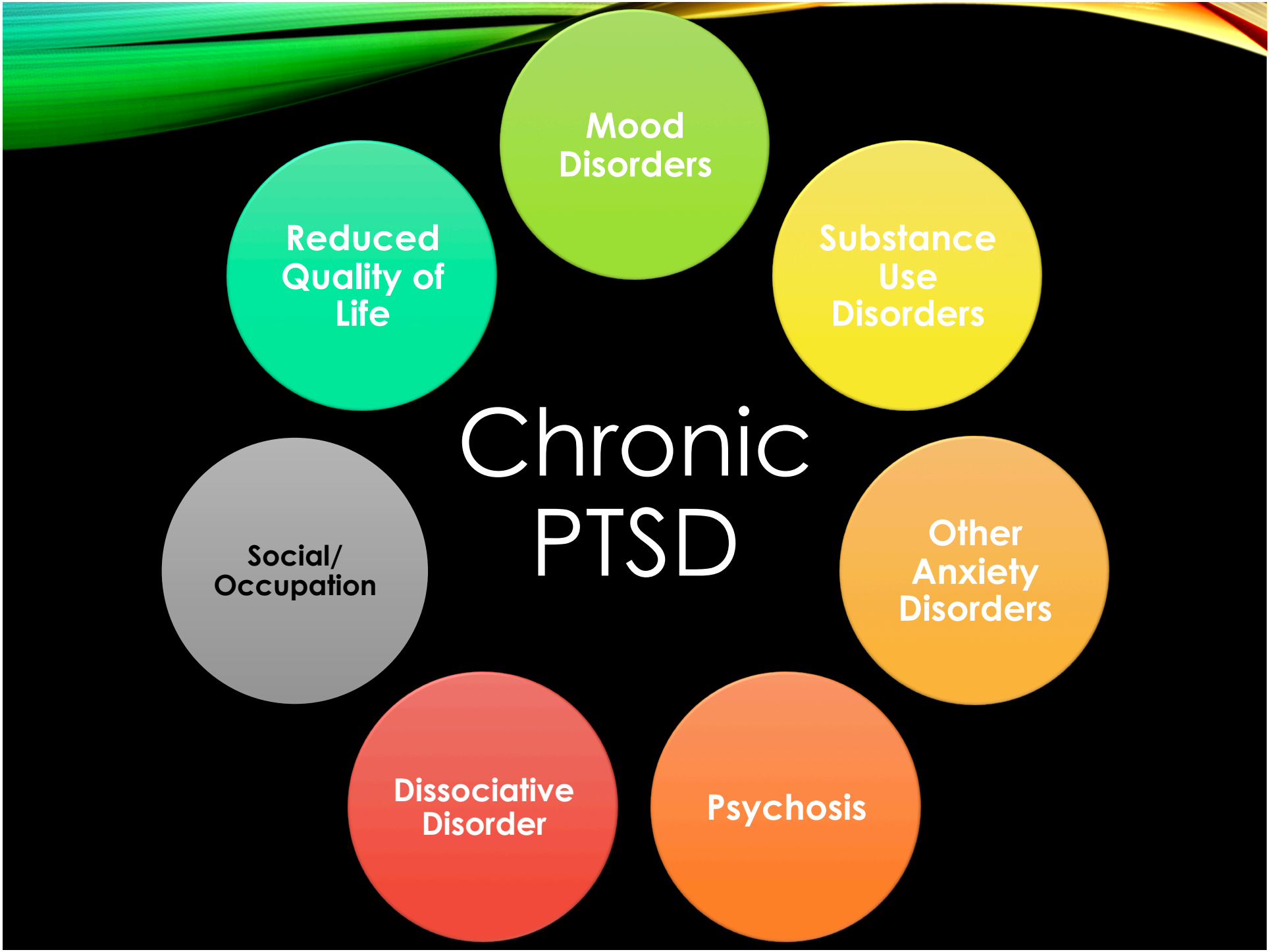
[1] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27.
[2] Ibid
[3] Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry. 2005 Jun;62(6):593-602.

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

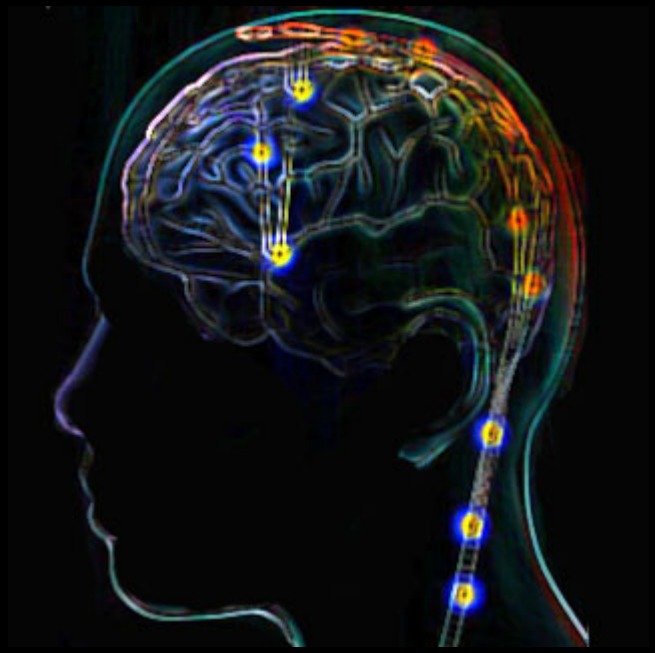
- Lifetime Prevalence Rates
  - 10.4% for Women
  - 5% for Men
- Some Evidence Suggests
  - Women 4x more likely to develop PTSD when exposed to same event than men
- Some Evidence Suggests
  - Women may be more responsive to treatment


Chronic PTSD
Mood Disorders
Substance Use Disorders
Other Anxiety Disorders
Psychosis
Dissociative Disorder
Social/ Occupation
Reduced Quality of Life

- 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

DSM V



Exposure to a Traumatic Event

Symptom Clusters

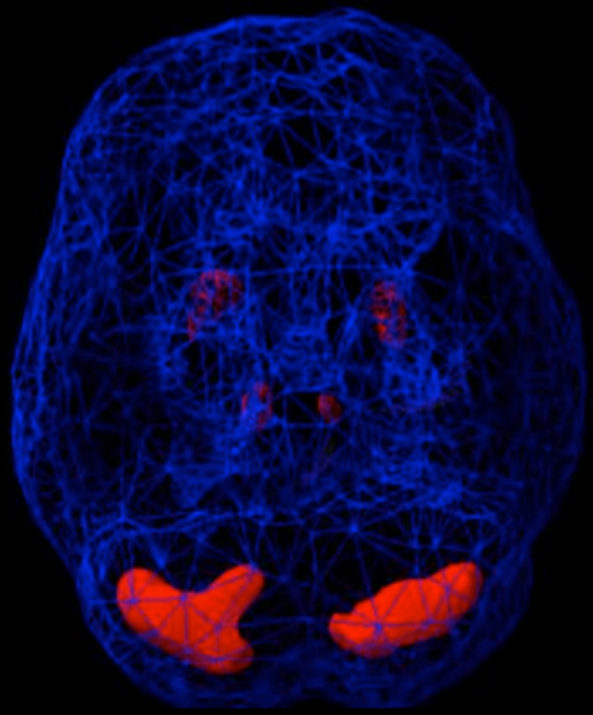
1. Re-experiencing
2. Persistent Avoidance
3. Negative Mood and Cognitions
4. Increased Arousal

- 1 month in duration
- Causes significant distress

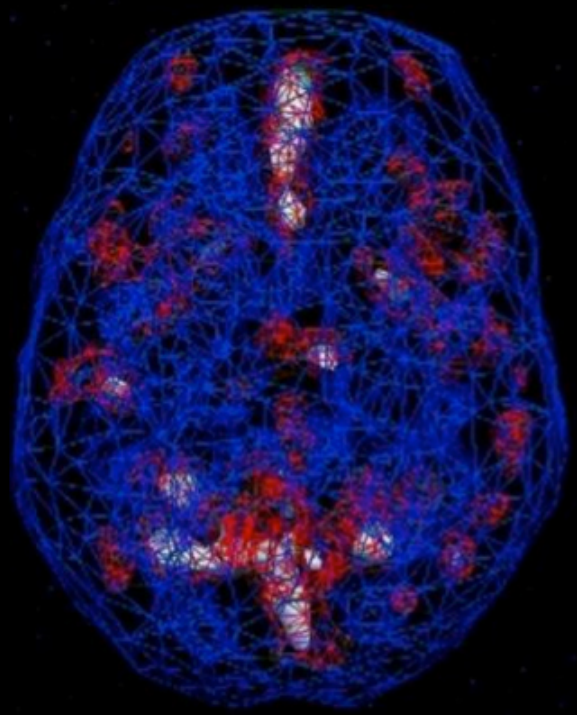
DEFINITION OF A TRAUMATIC EVENT

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



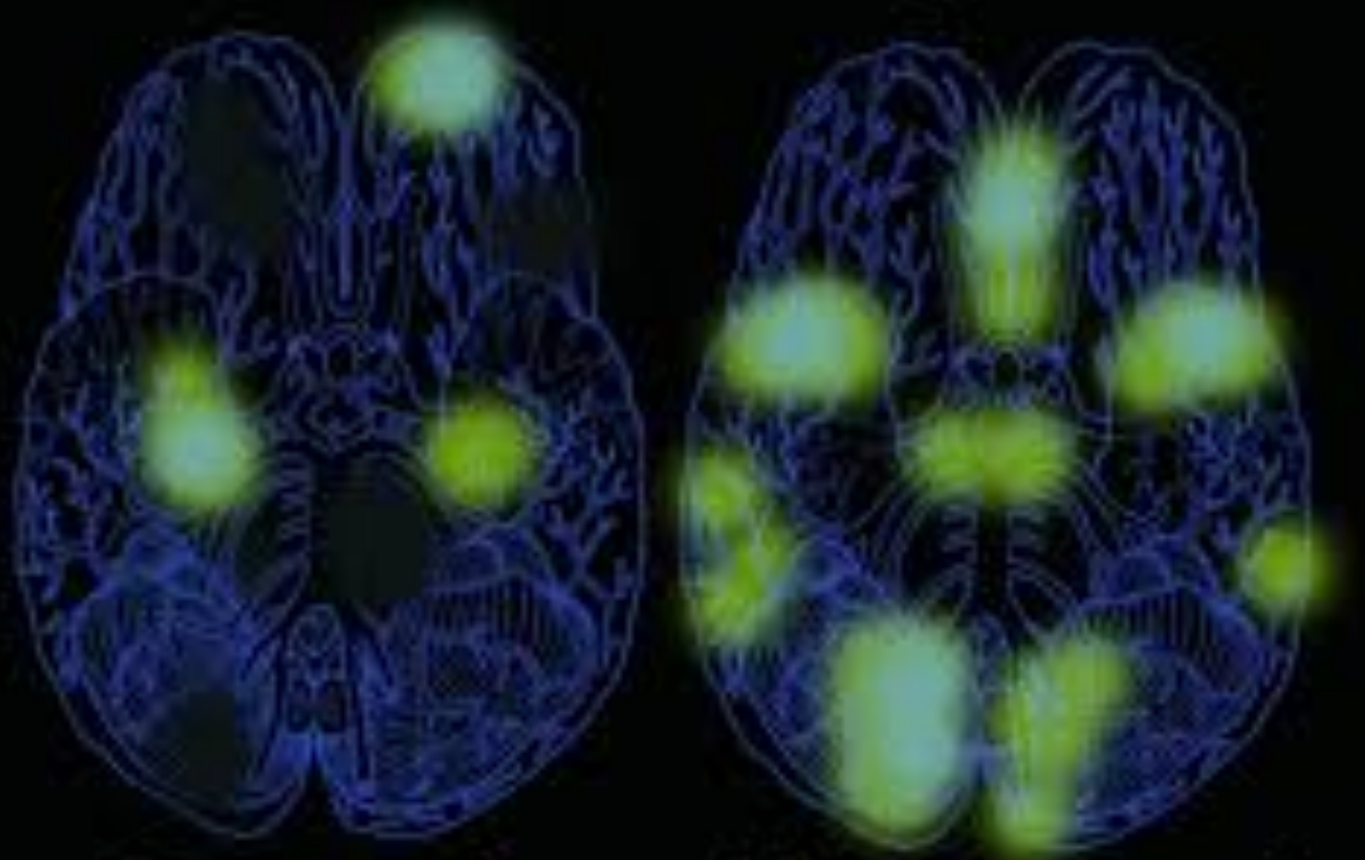
Healthy Brain



PTSD

POSTTRAUMATIC STRESS DISORDER

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-relate thoughts or feelings
- Psychogenic amnesia
- Diminished interest in activitie
- Detachment from others
- Restricted Range of affect
- Foreshortened future

NEGATIVE MOOD AND COGNITIONS

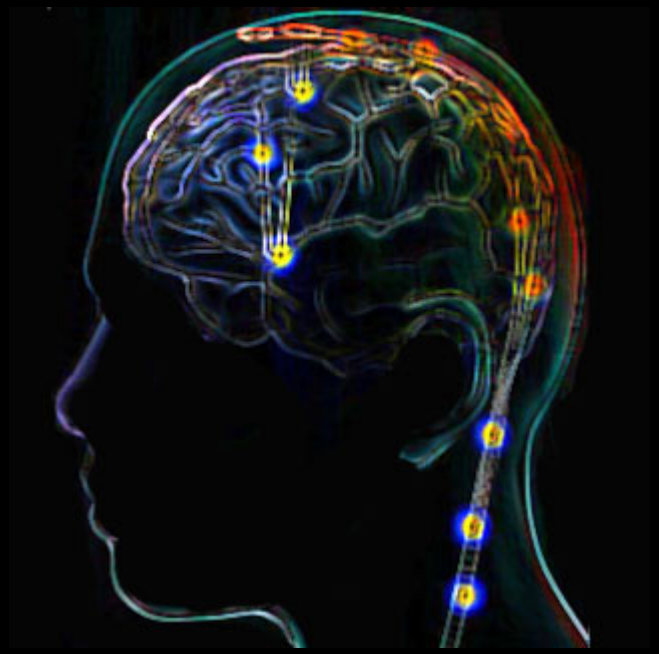
Includes a myriad of mood and cognitive symptoms that consistently show up in conjunction with PTSD symptoms.

- 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



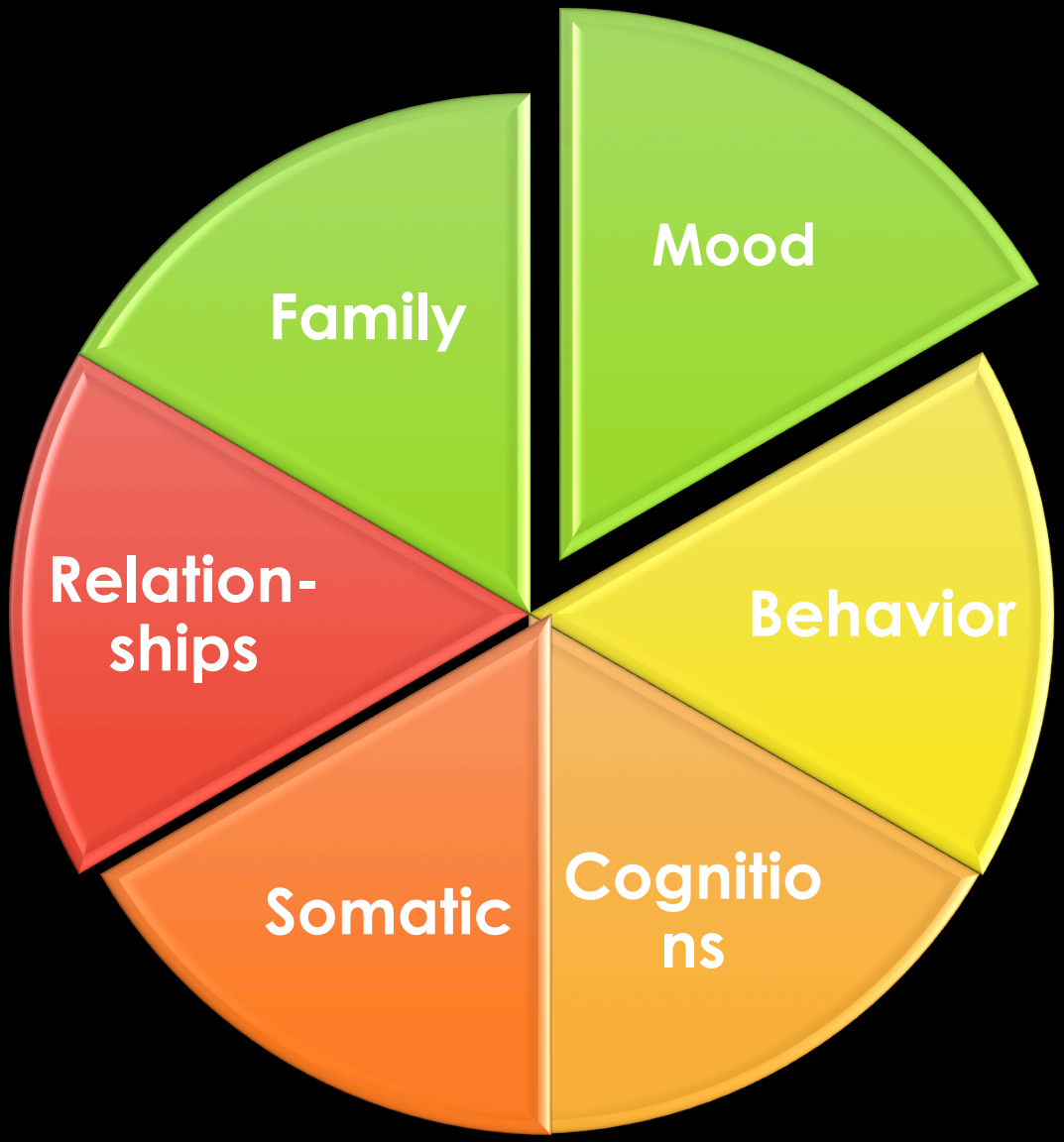
IMPACT OF PTSD

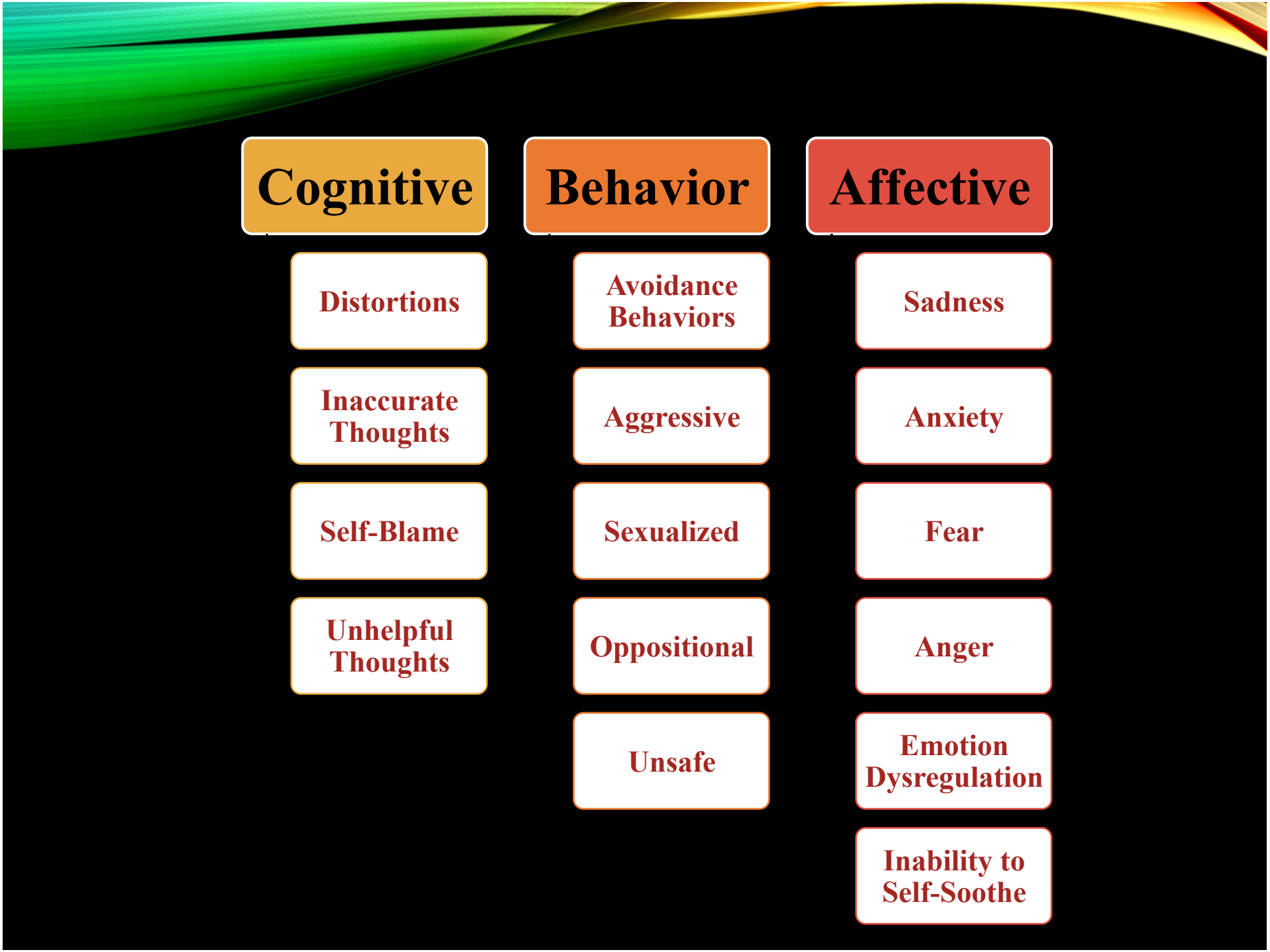
VIDEO

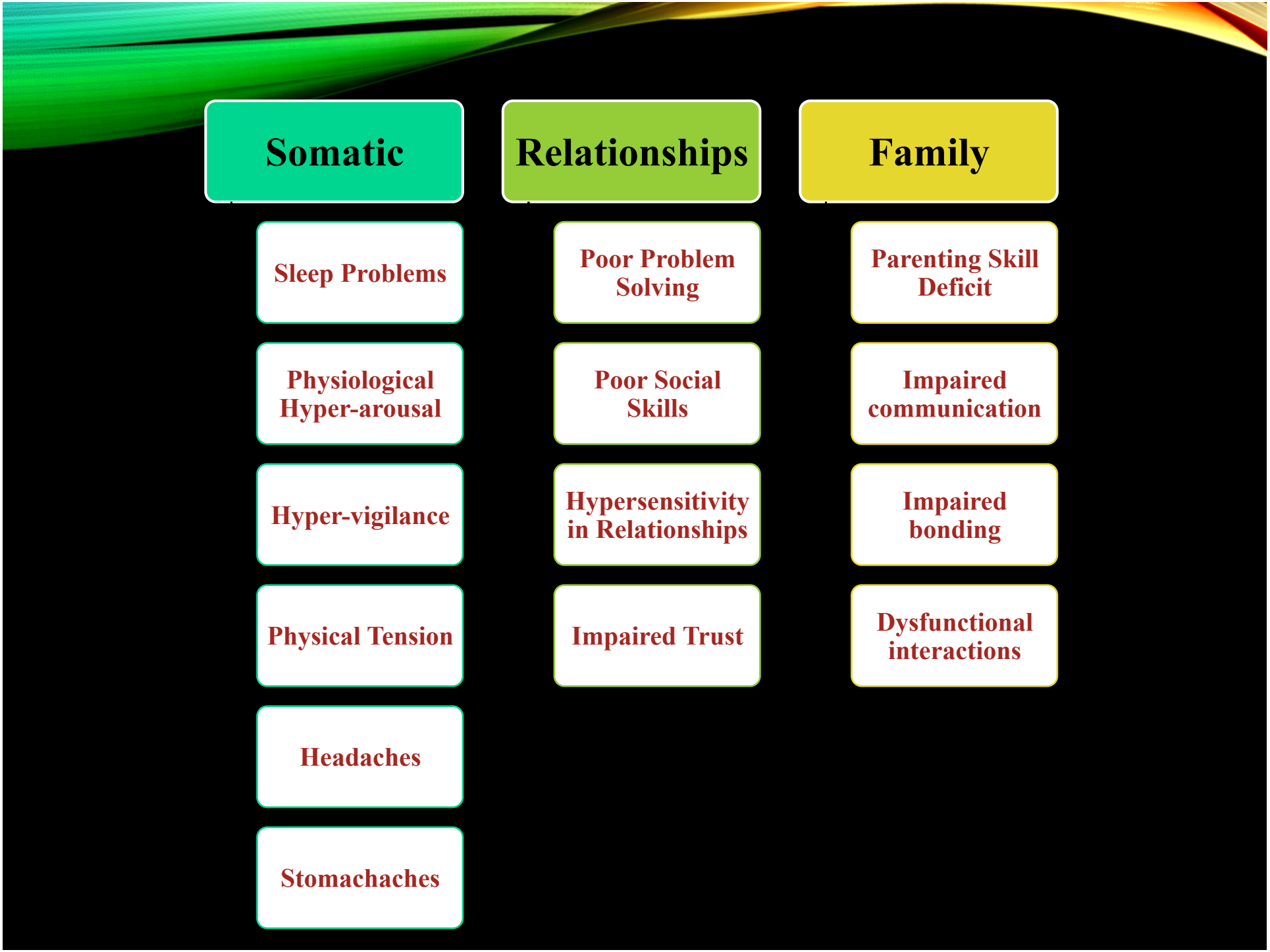
https://www.youtube.com/watch?v=4DF5caucKjI

https://www.youtube.com/watch?v=gDCX8NqRnto

PROBLEMS IN FUNCTIONING




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
Relationships
Family
Sleep Problems
Physiological Hyper-arousal
Hyper-vigilance
Physical Tension
Headaches
Stomachaches
Poor Problem Solving
Poor Social Skills
Hypersensitivity in Relationships
Impaired Trust
Parenting Skill Deficit
Impaired communication
Impaired bonding
Dysfunctional interactions

IMPLICATIONS ON TREATMENT

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)

Exposure Therapy	Cognitive Processing Therapy	Cognitive Therapy	Dialectical Behavior Therapy
•Level A •24 RCT •Imaginal Exposure •In-Vivo Exposure •Combo of Imaginal and in-vivo most effective •Most Efficacy of all CBT treatments •Superior to Control •Range of trauma exposure •Additional Techniques do not yield better outcomes	•Level A •4 RCT's •Female rape survivors, survivors of childhood sexual abuse •combat veterans •Second most support	•Level A •2 RCT's with civilian traumas •Post-trauma symptom reduction	•Level A •2 RCT's •Support for sequential application of skills training first

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

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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/