



Medical Group

Archives of Depression and Anxiety

ISSN: 2455-5460

DOI

CC BY

Rachel Thomlinson¹, Steven Muncer^{2*} and Helen Dent³

¹Clinical Psychologist, Northumberland, Tyne and Wear, NHS Foundation Trust, UK

²Doctorate in Clinical Psychology, School of Health and Social Care, Teesside University, Middlesbrough, UK

³High Intensity Therapist, Northumberland Tyne and Wear NHS Foundation Trust, Newcastle, UK

Dates: Received: 06 March, 2017; Accepted: 29 May, 2017; Published: 30 May, 2017

***Corresponding author:** Steven Muncer, Doctorate in Clinical Psychology, School of Health and Social Care, Teesside University, 0, UK, E-mail: S.Muncer@tees.ac.uk

Keywords: Improving access to psychological therapies; Comorbidity; Anxiety; Depression; Posttraumatic stress disorder

<https://www.peertechz.com>

Research Article

Comorbidity between PTSD and Anxiety and Depression: Implications for IAPT Services

Abstract

Objective: The Improving Access to Psychological Therapies (IAPT) initiative was introduced in the UK to increase access to psychological therapies for those with mild to moderate anxiety and depression. Recent outcome figures suggest recovery rates of 42%. One potential reason for non-recovery is the experience of previous trauma and potential PTSD comorbidity, which has been found to negatively impact treatment for anxiety and depression. This study therefore aimed to investigate trauma levels in IAPT patients.

Method: A total of 54 participants were recruited at the beginning of therapy within an IAPT service. Participants completed outcome measures for anxiety, depression and trauma.

Results: Forty (76.9%) participants reported previous trauma. Of these, 15 (28.3%) met tentative diagnostic criteria for PTSD, with only 3 (14.2%) already having a diagnosis of PTSD. Significant positive correlations were found between trauma and anxiety and depression.

Conclusions: The findings suggest comorbidity between trauma/PTSD and anxiety and depression in IAPT services. The findings also show that PTSD is not always detected in patients referred for other reasons. It is proposed that careful screening for PTSD and an increased focus on trauma in supervision may increase recovery rates and reduce relapse.

Introduction

Anxiety and depression are common mental health problems that have been found to affect over 15% of adults in the general population of the United Kingdom (UK), the majority of which are not receiving any treatment [1]. To improve access to evidence-based psychological therapies the Improving Access to Psychological Therapies (IAPT) initiative was developed in the UK [2]. It aimed to introduce 10,000 new therapists by 2013, with the majority being trained in Cognitive Behavioral Therapy (CBT). It would have a stepped-care approach with low intensity therapists (also known as Psychological Wellbeing Practitioners (PWP)) for mild anxiety and depression cases, and high intensity therapists for more complex or moderate to severe cases. Outcome measures would be completed at each session to measure levels of anxiety (measured by the Generalized Anxiety Disorder Questionnaire, GAD-7) [3] and depression (measured by the Patient Health Questionnaire, PHQ-9) [4]. A recent summary of findings from the first year of IAPT found overall recovery rates (defined as scores of less than 10 on the PHQ-9 and less than 8 on the

GAD-7) of 42% for patients who received at least at least two sessions [5].

Whilst IAPT has shown successful outcomes, the level of recovery has varied across the 32 sites, from 27% to 58% [6,7]. IAPT sites that “stepped up” (i.e. moved to the next level of therapy) a greater number of patients had higher recovery rates, as did those with a greater number of high intensity therapists. One reason for this finding could be that patients are presenting with increasingly complex problems that do not respond to low intensity treatment. Complexity is increased when there is comorbidity between disorders [8]. One disorder that has been found to be comorbid with both anxiety and depression is Posttraumatic Stress Disorder (PTSD). A 20 year longitudinal study of Israeli war veterans found rates of triple comorbidity between PTSD, anxiety and depression, were higher than rates of PTSD either alone, or with comorbid anxiety or depression [9]. Similar findings were reported in an older adult population in the United States, with participants with PTSD being more likely than the comparison group, who had been exposed to trauma but did not meet the criteria for PTSD, to meet the

criteria for mood and anxiety disorders [10]. Interestingly, IAPT services were found to have an overrepresentation of patients with Depression or Mixed Anxiety and Depression, and an under representation of patients with persistent anxiety disorders, such as Posttraumatic Stress Disorder (PTSD) [5], based on general population estimates [1]. This could mean that patients with comorbid PTSD are being misdiagnosed as having pure depression. This has an implication on recovery rates, as research suggests greater improvement when PTSD is treated first when found to be comorbid with anxiety or depression [11].

PTSD develops following a traumatic experience, with 42.2% of the UK population having experienced a traumatic event at some point in their lifetime [1]. The experience of previous trauma has been found to be a predictor of anxiety and depression [12,13] and a risk factor for relapse in depression [14]. A study of primary care patients found that of those reporting trauma, 27.8% met the criteria for depression and 20% for current PTSD [13]. A further study of female primary care patients found that 93% reported having experienced a traumatic event, and that a history of emotional abuse and neglect in childhood was associated with increased anxiety and depression in adulthood [15]. IAPT services tend to use CBT to treat anxiety and depression, which focuses on symptom reduction by altering cognitive distortions and changing behaviors thought to maintain these disorders. CBT is therefore focused on the symptoms of anxiety and depression as opposed to factors that might have influenced the development of the disorders, such as the experience of traumatic life events. This means that if a patient has a history of trauma or underlying PTSD, it is likely that CBT will not address it, and they are therefore less likely to benefit from the therapy.

Due to the possibility that trauma history and potential underlying PTSD could be negatively impacting upon recovery rates in IAPT services, this study aimed to investigate the prevalence of trauma and PTSD in IAPT services, and investigate its relationship with anxiety and depression.

Method

Participants

Participants were recruited from an IAPT service in the UK at the beginning of their treatment within the service (less than two treatment sessions), and were aged between 18 and 65, in line with working-age adult services. They did not have to have experienced previous trauma to be eligible to take part in the study. Data from a total of 54 participants was collected. 20 participants were male and 34 were female, and had a mean age of 42 years. 72.2% of participants were attending low intensity (step 2) psycho-educational groups and the remaining 27.8% were receiving a mixture of low intensity (step 2) and high intensity (step 3) individual therapy.

Procedure

IAPT clinicians handed information packs to potential participants. The information packs contained: an information sheet providing further details about the study; a consent form;

a demographic information sheet to record their age, sex and employment status; and a trauma questionnaire.

The trauma questionnaire used was the Detailed Assessment of Posttraumatic Stress (DAPS) [16]. The DAPS is a self-report measure of 104 items and provides information on trauma specification, immediate trauma impacts, posttraumatic response, as well as supplementary scales measuring trauma-specific dissociation, substance abuse, and suicidality. The measure also includes a validity scale and allows for tentative diagnosis of PTSD and Acute Stress Disorder based on the DSM-IV criteria [17]. The DAPS has been found to have good sensitivity (.88) and specificity (.86) [16] and takes approximately 20 minutes to complete.

To measure anxiety and depression, participants' scores on the GAD-7 and PHQ-9, were recorded by their clinician on the demographic information sheet.

Participants completed the questionnaires at home and returned them at their next appointment.

Ethical considerations

Ethical considerations were taken into account when designing this research and the research was cleared by the University and NHS ethical panels

To ensure participants were fully aware of what would be involved in the research, they were provided with an information sheet prior to completing the research, detailing the reasons for conducting the research and the risks and benefits of taking part. They were made aware that they would be required to comment on any traumatic experiences they may have had, and were encouraged to discuss any issues raised with their IAPT clinician. Contact details for the research team were also provided. Clinicians were also encouraged not to hand out the packs to anyone they felt may be adversely affected by the questionnaire.

The responses to the questionnaires were anonymous, and participants were only identified by a unique participant number, to ensure the information provided remained confidential and secure.

Results

Frequency of trauma and PTSD

DAPS was found to be very reliable (Cronbach's alpha of .94). Forty (76.9%) participants reported previous trauma. Of these, 28.3% met the tentative diagnostic criteria for PTSD according to the DAPS manual. Of those meeting the tentative diagnostic criteria for PTSD on the DAPS, 42.9% were initially referred for mixed depression and anxiety, with only 14.2% initially referred for PTSD (Table 1).

Differences in group Vs. individual therapy

Participants attending the psycho-education groups were screened for PTSD by IAPT services prior to attendance, with those screening positive being referred on to individual therapy

Table 1: Frequency table for referral reason.

Referral Reason	Frequency	Percent
Depression	16	30.8
Anxiety	14	26.9
Depression and anxiety	16	30.8
PTSD	1	1.9
PTSD and depression	2	3.8
OCD	2	3.8
Stress	1	1.9

instead. Therefore the psycho-education group condition should have significantly fewer participants with potential PTSD. However, no significant differences in PTSD diagnosis were found between the group and individual therapy conditions ($\chi^2(1) = .62, p = .43$), with 33.3% of participants in the psycho-education groups meeting the criteria for PTSD on the DAPS.

Relationship between trauma/PTSD with anxiety and depression

Scores on the Posttraumatic Stress–Total (PTS–T) subscale (i.e. level of trauma) of the DAPS were found to be significantly positively correlated with scores on the GAD–7 (anxiety), $\tau = .25, p = .03$, and the PHQ–9 (depression), $\tau = .25, p = .03$.

Discussion

The results support previous research that has found comorbidity between trauma/PTSD with anxiety and depression. Furthermore, heightened trauma levels were associated with higher levels of anxiety and depression.

As hypothesized, potential PTSD was not detected by clinicians, even when previous screening had been conducted. It is possible that the screening technique used is not sensitive enough at detecting potential PTSD. Currently IAPT services ask about the presence of traumatic life events at initial assessment, and those with possible PTSD are screened using the Impact of Events Scale (IES–R), with those with high scores being referred into high intensity treatment. Another possibility, however, is that participants may not have wanted to disclose trauma to their clinician, but felt more comfortable reporting it in this study as the results were confidential. This is supported by research which has found inconsistencies in reporting trauma between time-points [13]. As well as being missed in the psycho-education group condition, PTSD diagnosis was also missed in the individual therapy condition. Overall, only three out of the 54 participants were initially referred for PTSD, despite 15 meeting the criteria for PTSD on the DAPS questionnaire.

Clinical implications

The findings suggest a need for completion of a screening tool for trauma/PTSD at initial assessment. This would help identify those with comorbid trauma or PTSD, so they can be given the most suitable therapy. By addressing the impact of traumatic life events and potential PTSD, patients are more

likely to meet the threshold for recovery [11] and maintain it [14]. Whilst the DAPS is lengthy, it would be possible to produce a short-form for screening purposes. This would include the 13 items on trauma specification, as well as 30 items that would provide information on re-experiencing, avoidance and hyper-arousal, which together form the Posttraumatic Stress–Total score, which was used as the measure of trauma in the analysis for this study.

Another implication relates to the training of clinicians. Psychological Wellbeing Practitioners (PWP) are not trained in recognizing trauma or PTSD, despite the findings suggesting they are evident in patients in low intensity treatment. Therefore better training in recognizing trauma and PTSD for these clinicians, alongside the introduction of a screening tool, may help them to pick it up earlier.

PTSD detection could also be improved by focusing on it in supervision and case formulation. Supervisors (who are trained in detecting PTSD) can ask the supervisee appropriate questions that will ensure that the impact of trauma is less likely to be missed. The introduction of a screening tool for PTSD and an increased emphasis on trauma/PTSD in supervision will create a trauma-informed service, which is widely recognized as being of value in the US [18] and likely to be beneficial in all mental health services.

Future Research

Conducting the study with a larger sample would be beneficial. This would allow a regression to be conducted to see whether trauma/PTSD predict anxiety and depression as previous research suggests. Data on whether this is the participant's first referral to services would also be useful, as this would allow analysis on re-referral in relation to trauma levels.

Conclusion

Despite limitations relating to sample size, this study has provided further support for the finding of comorbidity between trauma/PTSD with anxiety and depression. This has implications for IAPT services, which do not currently screen for trauma. Patients may have experienced previous trauma and may have underlying PTSD impacting upon their experience of anxiety and depression. This may result in less effective therapy and greater likelihood of relapse. Therefore the introduction of a trauma-focused service, with a PTSD screening tool and an increased focus on trauma in supervision, could help improve recovery rates in IAPT services.

References

- McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (2009) Adult psychiatric morbidity in England, 2007: Results of a household survey. Leicester: The NHS Information Centre for health and social care.
- Layard R, Bell S (2006) The depression report: A new deal for depression and anxiety disorders. London: London School of Economics. [Link: https://goo.gl/Bmp44j](https://goo.gl/Bmp44j)
- Spitzer R, Kroenke K, Williams J, Lowe B (2006) A brief measure for assessing generalized anxiety disorder: The GAD-7. Arch Intern Med 166: 1092-1097. [Link: https://goo.gl/PkAMhl](https://goo.gl/PkAMhl)

4. Kroenke K, Spitzer R, Williams J (2001) The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med* 16: 606-613. [Link: https://goo.gl/ece8Eb](https://goo.gl/ece8Eb)
5. Gyani A, Shafran R, Layard R, Clark D (2013) Enhancing recovery rates: Lessons from year one of IAPT *Behav Res Ther* 51: 597-606. [Link: https://goo.gl/KyKkOn](https://goo.gl/KyKkOn)
6. Bastiampillai T, Jones G, Furber G, Moreau M, Healey D, et al. (2014) The IAPT@Flinders Service: adapting the Improving Access to Psychological Therapies model to the emergency department setting in Australia. *Australasian Psychiatry* 22: 277-280. [Link: https://goo.gl/M9Df56](https://goo.gl/M9Df56)
7. Gros D, Price M, Magruder K, Frueh B (2012) Symptom overlap in posttraumatic stress disorder and major depression. *Psychiatry Res* 196: 267-270. [Link: https://goo.gl/5AhTZW](https://goo.gl/5AhTZW)
8. Kessler R, Chiu W, Demler O, Walters E (2005) Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Arch Gen Psychiatry* 62: 617-627. [Link: https://goo.gl/1f2iTX](https://goo.gl/1f2iTX)
9. Ginzburg K, Ein-Dor T, Solomon Z (2010) Comorbidity of posttraumatic stress disorder, anxiety and depression: A 20-year longitudinal study of war veterans. *J Affect Disord* 123: 249-257. [Link: https://goo.gl/MDC7gJ](https://goo.gl/MDC7gJ)
10. Pietrzak R, Goldstein R, Southwick S, Grant B (2012) Psychiatric comorbidity of full and partial posttraumatic stress disorder among older adults in the United States: Results from wave 2 of the national epidemiologic survey on alcohol and related conditions. *Am J Geriatr Psychiatry* 20: 380-390. [Link: https://goo.gl/489znx](https://goo.gl/489znx)
11. Nickerson A, Steenkamp M, Aderka I, Salters-Pedneault K, Carper T, et al. (2013) Prospective investigation of mental health following sexual assault. *Depression and Anxiety* 30: 444-450. [Link: https://goo.gl/VGUz1l](https://goo.gl/VGUz1l)
12. Spinhoven P, Penninx B, van Hemert A, de Rooij M, Elzinga B (2014) Comorbidity of PTSD in anxiety and depressive disorders: Prevalence and shared risk factors. *Child Abuse Negl* 38: 1320-1330. [Link: https://goo.gl/aJIXBK](https://goo.gl/aJIXBK)
13. McQuaid JR, Pedrelli P, McCahill ME, Stein MB (2001) Reported trauma, post-traumatic stress disorder and major depression among primary care patients. *Psychological Medicine* 31: 1249-1257. [Link: https://goo.gl/ZXPOBA](https://goo.gl/ZXPOBA)
14. Gopinath S, Katon W, Russo J, Ludman E (2007) Clinical factors associated with relapse in primary care patients with chronic or recurrent depression. *J Affect Disord* 101: 57-63. [Link: https://goo.gl/u8x5eq](https://goo.gl/u8x5eq)
15. Spertus I, Yehuda R, Wong C, Halligan S, Seremetis S (2003) Childhood emotional abuse and neglect as predictors of psychological and physical symptoms in women presenting to a primary care practice. *Child Abuse and Neglect* 27: 1247-1258. [Link: https://goo.gl/pVu1ly](https://goo.gl/pVu1ly)
16. Briere J (2001) Detailed assessment of posttraumatic stress (DAPS). Odessa, Florida: Psychological Assessment Resources. [Link: https://goo.gl/K6SQvg](https://goo.gl/K6SQvg)
17. American Psychiatric Association (1994) Diagnostic and statistical manual of mental disorders: DSM-IV. (4th Ed.). Washington DC: American Psychiatric Association. [Link: https://goo.gl/6nWz0A](https://goo.gl/6nWz0A)
18. Rose S, Freeman C, Proudlock S (2012) Despite the evidence – why are we still not creating more trauma informed mental health services? *Journal of Public Mental Health* 11: 5-9. [Link: https://goo.gl/VgK6rG](https://goo.gl/VgK6rG)