Chapter

Perspective Chapter: Trauma and Depression – An Overview about Comorbidity

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Abstract

There are various types of trauma, some of which can cause post-traumatic stress disorder (PTSD): they are those involving death, or the threat of death, or serious injury, or the threat to the physical integrity of oneself or others. PTSD often appears associated with other disorders such as depression anxiety disorders and dissociation, and trauma can also increase the possibility that depression and anxiety become autonomous. However, it has long been observed that depression is the disorder that occurs most frequently associated with PTSD. This theme was also explored for the age groups under 18. The need to take into account the complexity of post-traumatic stress disorder and possible comorbidity was then underlined, therefore the use of multiple diagnoses is a valuable element. The diagnosis of PTSD, like that of depression, is a complex diagnosis, articulated on multiple phenomenological levels and it is therefore important in the diagnosis to have clear knowledge of the syndromic grouping of these disorders. The topic of psychodiagnostics was therefore introduced in this area. Finally, the therapeutic objectives common to the various orientations in the treatment of traumatized adults were exposed, and it was specified that the future of research in the field of pharmacotherapy and psychotherapy can no longer be represented by a sterile struggle for its affirmation but turns toward the study the best integration of the two approaches.

Keywords: trauma, PTSD, depression, pharmacotherapy, psychotherapy

1. Introduction

Already in 1994 Terr [1] distinguished between traumas of the "first type," that is, those due to a single traumatic experience, and traumas of the "second type," that is, those that occur several times over time, which can be, for example, abuse and mistreatment.

We must remember, upstream, that there are traumas of both the "first type" and the "second type" which can cause post-traumatic stress disorder (PTSD) according to the Diagnostic Statistical Manual of Mental Disorders. Explaining what we mean by PTSD we can remember that in 1980, following observations conducted on Vietnam veterans, a new diagnostic category was inserted, namely that of PTSD [2], which was recognized as a process of adaptation to adverse conditions, and this diagnostic

category clarifies how the procession of symptoms does not depend exclusively on the vulnerability of the traumatized subject but also on the characteristics of the event. Generally, people who have dealt with severe violence or stress have reported disturbing long-term symptoms, including memory distortion, punctuated by vivid flashbacks, emotional numbness, difficulty sleeping, elevated stress, and feelings of social isolation [3], but to make a precise diagnosis of PTSD it is necessary to meet some precise diagnostic criteria and, upstream, that the subject experiences an event which involves death, or the threat of death, or serious injuries or the threat to physical integrity of oneself or others. The person's response in that situation typically includes intense fear, feelings of helplessness or horror. To diagnose PTSD, some of these symptoms must be present for more than a month for each category listed below:

- *Intrusive symptoms*: Involuntary unpleasant memories, unpleasant trauma-related dreams, dissociative reactions, such as flashbacks, psychological distress, and physiological relationships when faced with trauma-related stimuli. One or more symptoms in this category must be present.

- *Symptoms related to avoidance of trauma-related stimuli*: Avoidance or attempt to avoid unpleasant memories and thoughts related to the trauma, and avoidance or attempt to avoid external factors (people, things, places, situations) that elicit unpleasant memories related to the trauma. One or two of the two criteria listed in this category must be present.

- *Negative changes in thoughts and emotions associated with the trauma*: Inability to remember some important aspect of the trauma, persistent and exaggerated negative beliefs or expectations about oneself and the world, and/or regarding the cause and/or consequences of the trauma, persistent emotional state negative, marked reduction in interest or participation in significant activities, feelings of detachment and/or alienation toward others, persistent inability to experience positive emotions. Two or more criteria from this symptom group in this category must be present.

- *Alteration of arousal and excessive reactivity to any stimulus related to the trauma*: Irritable behavior and/or explosions of anger, reckless and/or self-destructive behavior. Two or more criteria among those listed in this category must be present [2].

As we can observe, what is now called in scientific terms post-traumatic stress disorder is represented by a constellation of symptoms, both psychological and physical, whose identification within a single clinical picture is not always easy; in fact, even if on the one hand we are facilitated in identifying PTSD as the triggering cause is generally evident, on the other hand we find ourselves faced with a very complex phenomenon, both for the variety of symptoms and the numerous biological and psychological processes involved. This disorder also often appears associated with other disorders, in fact, after exposure to a traumatic experience PTSD is not the only psychiatric condition that can develop: anxiety and depression can also arise and comorbidity is the norm rather than the exception [4]. It should be emphasized in this regard that depression has been found to be one of the most serious and prevalent conditions that occur in conjunction with PTSD [5] and it has long been observed that depression is the disorder that occurs most frequently associated with post-traumatic stress disorder [4], in fact, even from

studies carried out already in the 90s following natural and technological disasters, a clear high frequency of depressive symptoms [6].

Having observed the frequency of comorbidity, various studies were therefore carried out in the following years to determine more precisely the relationship between depression and post-traumatic stress disorder, and it was therefore observed that, if before the trauma a subject already had PTSD or episodes of depressive disorders the individual was more predisposed to developing the pathology of the two not yet experienced before, since it seems that each of the two disorders predisposes one to vulnerability to the other [4].

Scientific studies have also suggested over time that depressive symptoms are often an integral part of PTSD and that identifying depression as a distinct PTSD disorder sometimes appears to be a daunting task; however, there is also evidence to suggest that depression can also exist as a separate and independent entity [4]. In summary, after exposure to trauma, it has therefore been found that PTSD and depression can frequently manifest themselves both as separate disorders and as concomitant disorders, and we recall again that some scholars have raised the question of whether PTSD and depression are really separate disorders after trauma or whether they are part of a single overarching construct, also suggesting that when PTSD and depression co-occur they reflect a shared vulnerability with similar predictive variables [4]. Regarding the relationship between trauma and depression, it was finally found that for women who face pregnancy in adulthood, previous traumatic events represent a risk factor for later developing postpartum depression [7] and it has been noted, regarding the relationship between trauma and postpartum depression, which in particular traumatic events experienced in the military can increase the risk of postpartum depression among women veterans (who in fact are more likely to have suffered trauma during the course of military service) [8]. This leads us to consider, as mentioned previously, that both depression can make us more vulnerable to PTSD and PTSD can over time make us more vulnerable to depression because the two disorders appear to be related to each other.

2. Trauma and depression in developmental age

We must specify that although the diagnosis of PTSD, when it was first formulated in 1980, was not considered relevant for children and adolescents, Leonore's studies Terr on a group of children kidnapped and held hostage demonstrated the opposite [9, 10]. Unfortunately, it is known that adults often commonly underestimate the severity of children's reactions to trauma, that is, they may therefore not be aware of children's need to process their experience [11], but in the scientific community, it is now clear that even minors can develop PTSD (and also other disorders) following traumatic events [9–11].

The diagnosis of PTSD in children over 6 years of age and adolescents is almost isomorphic to the diagnosis for adults, whereas the diagnosis of PTSD for children under 6 years of age has its own specific criteria. Post-traumatic stress disorder in children under 6 years of age be diagnosed must fall within the following criteria: 1) exposure to actual death or threat of death, serious injury, or sexual violence in one of the following ways: directly experiencing the traumatic event, directly witnessing a trauma that happened to others, coming to knowledge of the trauma that occurred a family member or caregiver. The trauma must have occurred in one or more of the above ways. 2) presence of one or more of the following intrusive symptoms:

recurrent, involuntary, and intrusive unpleasant memories of the trauma. Recurring unpleasant dreams related to trauma. Dissociative reactions, for example, flashbacks, where the child feels or acts as if the trauma is recurring, this can happen during play. Intense or prolonged psychological distress upon exposure to internal or external triggers that symbolize or resemble some aspect of trauma. Marked physiological reactions in response to factors reminiscent of the trauma. 3) One or more of the following symptoms, representing persistent avoidance of trauma-related stimuli or negative changes in emotions and thoughts associated with the trauma: persistent avoidance of trauma-related stimuli. Negative alterations in connectivity, such as increased frequency of negative emotional states, marked decrease in interest or participation in meaningful activities, withdrawn social behavior, and persistent reduction in expression of positive emotions. 4) Alteration of reactivity associated with the trauma: irritable behavior and explosions of anger, hypervigilance, exaggerated alarm responses, concentration problems, and sleep difficulties. 5) The duration of the alterations is more than 1 month. 6) The alteration causes clinically significant clinical distress, impairment in relationships with parents, siblings, peers or others, or in school behavior [2].

We must point out that after the 90s several studies were carried out regarding PTSD in children and adolescents but most of the epidemiological studies on post-traumatic stress disorder have mostly been conducted on adolescents and older adults [11]; it has been observed that young children after a trauma show less emotional numbness and also have more problems reporting avoidance reactions, since they are not relevant or too complicated to express in words, since they require rather complex cognitive introspection and this can make it more difficult for young children to meet the DSM criterion of avoidance [11].

As we have already mentioned, following exposure to traumatic stressors, children show a wide range of stress reactions and we must specify that these vary with age and to some extent by gender. It has been noted that younger children after a trauma show more evident aggression and destructiveness and may also show more repetitive playing (and drawings) about the traumatic event, as well as behavioral reenactments. For preschool children, there is less agreement on the extent and severity of their reactions to stress, and for this age group the reactions appear more determined by the parents' reactions to the event: if the parents respond calmly the child may feel more protected and safe. Above the age of 8–10 years, children's reactions become more similar to those expressed by adults: the school-age child is better able to understand the situation, is able to see the long-term consequences to a greater extent end of the traumatic event(s) and can reflect more on their role in what happened. Gender differences often appear in the reaction of children and adolescents: more girls than boys qualify for the diagnosis of PTSD, while boys show higher rates of behavioral symptoms [12].

At the same time, there are also numerous studies regarding childhood traumas and the development of depression, highlighting in this case too a strong correlation between traumas and depression.

In this regard, several studies have been carried out on young subjects in which it has been found that the physiological disturbance immediately after exposure to trauma has proven to be a factor that can predict anxiety and depression [13], and has been observed and confirmed that childhood traumas are considered associated with the onset of depression in adulthood [14]; in this regard, it seems that there is also a specific relationship between childhood traumas and the subsequent development of depression: one study found an increase of four times of the risk of depression

in adults who had experienced multiple traumas during childhood [15] and the role of childhood trauma in the development of depression has also been confirmed in studies on twins [16], and finally it seems that individuals who have experienced early traumas also appear to be particularly sensitized to the depressive effects of acute stress in adulthood [17]. It should be specified that regardless of age, children exposed to chronic and repeated stressors, such as victims of physical and sexual abuse, war, or harassment, may develop personality changes, various self-harming and suicidal behaviors, depression, or other psychiatric disorders. Exposure to trauma in these formative years can also influence the maturation of the central nervous system and neuroendocrine systems. A review of the neurobiological sequelae can be found in van der's research Kolk [18], while the clinical implications of these aspects for PTSD were explained in research by Cohen et al. [19]

In conclusion, we can state that it is important that the traumatized child can talk to adults about the trauma because in this way he can: a) restore the experience in memory and prevent forgetting; b) help the child interpret the experience; c) correct misunderstandings; d) help the child manage and regulate his emotions; and e) provide information on coping strategies and facilitate their implementation [20].

3. Post-traumatic stress disorder and other comorbid situations

Finally, with respect to comorbidity, we can state that it is also known that people who are victims of serious trauma can also undergo permanent changes in their personality (e.g., develop personality disorders), or on the contrary, if the personality disorders were already existing, they can make in turn the subject most vulnerable to PTSD [21]. Other studies have also found the following to be associated with PTSD: eating disorders, dissociative episodes of varying degrees, antisocial, and aggressive manifestations [22].

It is also important to specify with regard to dissociation that trauma can modify a person's brain structure and functions [23], and individuals under severe stress can also initiate dissociation, which is an autohypnotic process that anaesthetizes and isolates pain [24].

It should be specified here that the specificity of the trauma creates peculiar consequences, for example, those who suffer violence in childhood are more likely to suffer dissociative symptoms and amnesia, so it has been considered that violence suffered in childhood has different consequences from those, for example, of a cataclysm or other trauma circumscribed in adult life. It also turns out that those who dissociate at the time of trauma are more vulnerable to post-traumatic reactions [25].

As Bromgerg states, dissociation comes into play when a chaotic flow of unregulated affects takes place in the mind, threatening the stability of the self and sometimes mental health itself [26].

It also appears that subjects with PTSD present an increased risk of suicide, especially if they have a diagnosis that highlights comorbidity with depression [27].

Furthermore, after a post-traumatic experience, physical health can also be compromised in other ways, in general, there is a greater incidence of asthenia, headaches, chest pain, and gastrointestinal and cardiovascular disorders [28]. Undoubtedly, many of these physical signs are also common to depression.

However, it must be added in this regard that several depressive episodes begin as a consequence of an event, a loss, which can be mourning, but also the loss of a social position, of autonomy, the loss of a role, all the factors which were considered essential

for the subject and for maintaining his or her psychic balance and these events can be experienced as a trauma, regardless of whether they caused PTSD or not. We can assert that after a traumatic event, whatever it may be, it is not always an easy task to diagnose depression in a subject who requires psychological consultation due to suffering that has been dragging on for some time, which cannot be fully defined, since the depressive disorder, such as PTSD, presents with various signs and can be confused with other symptoms. It therefore seems very important to make a precise diagnosis both to start psychotherapy and to introduce pharmacological support [29].

4. Possible diagnostic pictures in adults

The need to take into account the complexity of post-traumatic stress disorder and possible comorbidity has been highlighted; therefore, the use of multiple diagnoses is a valuable element in the treatment of stress response syndromes, and PTSD in particular [21], therefore making an accurate diagnosis and taking into account the difficulties it entails is important for planning an adequate therapeutic intervention.

Great attention must therefore be paid to the clinical diagnosis, where it is necessary to distinguish whether the diagnosis of PTSD is secondary or primary to parallel co-diagnoses. Among the tests used to identify PTSD, we mention, for example, the MMPI-2- post-traumatic stress disorder scale and the post-traumatic stress disorder symptom scale PSS [30]. To evaluate PTSD in children, child PTSD symptom scale was developed. A 17-item scale developed by Edna Foa and collaborators [31], it was used both in initial diagnosis and in monitoring progress and contains a brief assessment of functional impairment.

To evaluate Instead more generally _ the impact of the trauma was created the adult scale "The Impact of Event Scale" [32] later adapted for use with children and adolescents [33].

It is necessary for PTSD assessment to be evaluated. Also, exposure to trauma and examine the etiology of the disorder, that happens in adults in general In the context of a retrospective self-report and during an interview clinical [34] in which the identification of clinical cases of PTSD is important, that is, establishing the threshold for detecting the presence of the disorder or not, a very complicated task due to the presence of subclinical diagnostic pictures or characterized by comorbidities.

The clinical interview, characterized by a systematic collection of information, is one of the most widespread tools for obtaining information for the purpose of diagnosis and the creation of a therapeutic project; to plan a therapeutic intervention, it is also desirable to also investigate the patient's history prior to the trauma and his levels of adaptation, integrating them, if possible, with the information provided by the person closest to the patient [35].

It should also be remembered that the onset of disorders following serious traumatic events can occur in a period of time distant from the traumatic episode, for this reason, it is often necessary to also carry out longitudinal observations of patients who have experienced traumatic events.

In the case of an assessment with children, it is possible that it is useful to focus on the child's traumatic experience already in the first session; the use of systematic assessment of both the child's exposure to trauma and its effects should be incorporated into a clinical interview in which the child or adolescent can describe their experience with a wealth of clinical information that can determine the choice of therapy. For single traumas, it is advisable to provide the child with help from the first session

(i.e., a simple method to reduce intrusive thoughts) that helps him with his most annoying symptom, this will increase the patient's optimism and motivation to return. When meeting and evaluating a child, drawing can also be used as a communication tool. If children are given the opportunity to draw about an emotionally charged event while talking about it, children between 3 and 9 years of age report more detailed verbal accounts than when asked to provide an account without drawing [11].

As already specified, the diagnosis of PTSD, like that of depression, both in the case of adults and in the case of children and adolescents, is a complex diagnosis, articulated on several phenomenological levels and it is therefore important in the diagnosis to have a clear knowledge of the syndromic grouping of disorders; in this regard, already in the 90s, various studies appeared relating to the procedures and criteria for diagnostic differentiation between PTSD and other psychopathological forms [22].

5. Common therapeutic goals in the treatment of traumatized adults

In the last three decades, more and more attention has been paid to mental health pathways to address PTSD [36] and despite a diversity of techniques and approaches in the treatment of PTSD, some similar psychotherapeutic objectives are envisaged. Meichenbaum [37], illustrating the most important psychotherapeutic "judes -lines," states that the objectives can be:

- Help the patient to rework their story, reliving and recounting the trauma in the "here and now," modifying the way in which it is narrated, in order to achieve integration and a "sense of control" of the experience. A possibility to "find meaning" to the events experienced must also be provided. A feeling of dominion over intrusive memories and the ability to tolerate discomfort is therefore obtained, making the patient capable of reliving traumatic memories, but with a relatively high degree of voluntary control.

- Reexpose the patient to stimuli and signals related to the trauma, but in a structured way and with psychological support (e.g., using "direct exposure," various guided imagery, hypnosis, support, and gradual reexposure techniques to stress).

- Focus on beliefs, ideas, and opinions that have been "destroyed" in the patient and have caused intrapersonal and interpersonal difficulties; through cognitive restructuring, problem-solving and creative writing techniques; they are therefore faced with feelings of guilt, anger, fear, sadness, desperation, victimization, and disorientation.

- Starting from the traumatic event itself, the personal resources that could be the basis of growth are examined, to move, for example, from the position of victim to that of survivor; to achieve this goal it is important to help change the patient's temporal orientation (from a focus on the past to a perspective centered on the present and future); the development of more satisfying lifestyles and closer and stronger social supports is thus encouraged.

- Encourage the patient to activate his resources connected with the belief system (e.g., religious and philosophical convictions and beliefs).

- The therapist must not provide meanings to the patient, but they must be found by the patient himself, for example by attending groups of people who have been exposed to the same trauma; it is important to help him reconstruct his past experience, increasing the feeling of having future goals [38].

It is also important to remember that Otto Kerberg states that in order to process trauma in a psychotherapy process, it is important that stability, security, and empathy are present [38].

Finally, it is necessary to know that although there are main "guidelines," similar for the different therapies, patients suffering from PTSD may differ regarding the number, intensity, type, and duration of the traumatic events suffered, and also the individual variables and coping strategies can change from subject to subject; therefore, the assessment strategies, the criteria for diagnostic decisions, and the different approaches to the treatment of this disorder must be chosen based on the specificity of each individual case, for example, it is not advisable to approach "combat-related PTSD" and "civilian-related PTSD" [39].

6. Conclusions

We have specified what are the psychotherapeutic objectives common to the various approaches in the treatment of a traumatized adult but it must be remembered up front that for the majority of psychopathologies today the scientific community has moved the debate from the search for the best treatment between psychology and psychotropic drugs, in a logical in contrast, to a logic of integration of both approaches starting from the assumption that both treatment philosophies have scientifically demonstrated their usefulness [40]. In fact, in scientific studies, it has been proven that the effects of the antidepressant and psychotherapy alone were equal and significantly less effective than the combined treatment [41]. In conclusion, we must underline from the outset how there is a need for patients to be able to speak and be listened to by a mental health professional capable of taking charge and understanding the problems that are brought forward, regardless of the fact that a more pharmacological or psychotherapeutic [40]. The future of research in the field of pharmacotherapy and psychotherapy nowadays can no longer be represented by a sterile struggle for one's emancipation and affirmation but is aimed at studying the best integration of the two therapeutic approaches, that is, psychotherapy and pharmacotherapy, with contemporary use or sequential and this point of view is now accredited and recognized (and regarding sequential use the improvement induced by pharmacological therapy can allow the inclusion of psychotherapy in difficult patients, who without any form of help can degenerate into chronicity).

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References

[1] Terr L. Unchained Memories: True Stories of Traumatic Memories, Lost and Found. New York: Basic Books; 1994

[2] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Publishing; 2013

[3] Lerner AB. The Politics of Trauma and Victimhood, Handbook on the Politics of Memory. Cheltenham: Edwar Edgar Publishing; 2023. pp. 147-162

[4] O'Donnell ML, Creamer M, Pattison P. Posttraumatic stress disorder and depression following trauma: Understanding comorbidity. The American Journal of Psychiatry. 2004;**161**:1390-1396

[5] Creamer M, Burgess P, McFarlane AC. Post-traumatic stress disorder: Findings from the Australian National Survey of Mental Health and Well-Being. Psychological Medicine. 2001;**31**:1237-1247

[6] Green BL. Traumatic Stress and Disaster, mental health effects and factors influencing adaptation. In: Liehmac F, Nadelson C, editors. International Review of Psychiatry. Vol. 2. Washington, DC: American Psychiatric Press; 1994

[7] Alvarez-Segura M, Garcia-Esteve L, Torres A, Plaza A, Imaz ML, Hermida-Barros L, et al. Are women with a history of abuse more vulnerable to perinatal depressive symptoms ? A systematic review. Archives of Women's Mental Health. 2014;**17**(5):343-357

[8] Combellick JL, Gaffey AE, Driscoll MA, Foley T, Ronzitti S, Dziura J, et al. Postpartum Depression in a Cohort of Post-9/11 Women Veterans: The Role of Military Stress and Trauma, Military Behavioral Health. 2020

[9] Terr LC. Children of Chowchilla. A study of psychic terror. The Psychoanalytic Study of the Child. 1979;**34**:547-623

[10] Terr LC. Chowchilla revisited: The effect of psychic trauma four years after a school-bus kidnapping. American Journal of Psychiatry. 1983;**140**:1543-1550

[11] Dyregrov A, Yule W. A review of PTSD in children. Child and Adolescent Mental Health. 2006;**11**(4):176-184

[12] Yule W, Perrin S, Smith P. Post–traumatic stress reactions in children and adolescents. In: Yule W, editor. Posttraumatic Stress Disorders: Concepts and Therapy. Chichester: John Wiley & Sons; 1999

[13] Barber BA, Kohl KL, Kassam-Adams N, Gold JI. Acute stress, depression, and anxiety symptoms among English and Spanish speaking children with recent trauma exposure. Journal of Clinical Psychology in Medical Settings. 2014;**21**(1):66-71

[14] Gladstone GL, Parker GB, Mitchell PB, Malhi GS, et al. Implications of childhood trauma for depressed women: An analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization. The American Journal of Psychiatry. 2004;**161**:1417-1425

[15] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998;**14**:245-258

[16] Nelson EC, Heath AC, Madden PA, Cooper ML, Dinwiddie SH, Bucholz KK, et al. Association between selfreported childhood sexual abuse and adverse psychosocial outcomes: Results from a twin study. Archives of General Psychiatry. 2002;**59**:139-145

[17] Kendler KS, Kuhn JW, Prescott CA. Childhood sexual abuse, stressful life events and risk for major depression in women. Psychological Medicine. 2004;**34**:1475-1482

[18] van der Kolk B. The neurobiology of childhood trauma and abuse. Child and Adolescent Psychiatric Clinics of North America. 2003;**12**:293-317

[19] Cohen JA, Perel JM, DeBellis MD, Friedman MJ, Putnam FW. Treating traumatized children. Trauma, Violence & Abuse. 2002;**3**:91-108

[20] Salmon K, Bryant RA. Posttraumatic stress disorder in children: The influence of developmental factors. Clinical Psychological Review. 2002;**22**:163-188

[21] Horowitz MJ. Stress Response Syndromes, valutazione e trattamento. Milan: Raffaello Cortina; 2004

[22] Sgarro M. Post Traumatic Stress Disorder, Aspetti clinici e psicoterapie. Rome: Kappa; 1998

[23] Mucci C. Trauma e perdono, una prospettiva psicoanalitica intergenerazionale. Milano: Raffaello Cortina Editore; 2014

[24] Schwaryz HL. From dissociation to negotiation: A relational psychoanalytic perspective on multiple personality disorder. In: Psychoanalytic Psychology. Vol. 11. Washington, DC, USA: American Psychological Association (APA); 1994. pp. 189-231. p. 191

[25] Williams R. Trauma e relazioni, le prospettive scientifiche e cliniche contemporanee. Milano: Raffaello Cortina Editore; 2009

[26] Bromberg PM. L'ombra dello tsunami. Raffaello Cortina, Milano: La crescita della mente relazionale. Tr. it; 2012. p. 49

[27] Oquendo MA, Friend JM, Batsheva Halberstam BA, Brodsky BS. Association of comorbid posttraumatic stress disorder and major depression with greater risk for suicidal behavior. American Journal of Psychiatry. 2003;**160**:580-582

[28] Sutker PB, Uddo-Crane M, Allain A. Clinical and research assessment of post-traumatic stress disorder: A conceptual overview. A Journal of Consulting and Clinical Psychology. 1991;**3**(4):520-530

[29] Zacchetti E, Castelnuovo G. La Cura Della Depressione. Milano: Franco Angeli; 2021

[30] Alder J, Staldmayr W, Tschdin S, Bitzerb J. Post-traumatic symptoms stress after childbirth: What should we offer? Journal of Psychosomatic Obstetrics and Gynecology. 2006;**27**(2):107-112

[31] Foa EB, Johnson KM, Feeny NC, Treadwell KRH. The child PTSD symptom scale: A preliminary examination of its psychometric properties. Journal of Community Psychology. 2001;**30**:376-384

[32] Horowitz M, Wilner N, Alvarez W. Impact of event scale: A measure of subjective stress. Psychosomatic Medicine. 1979;**41**:209-218

[33] Yule W. Anxiety, Depression and Post–Traumatic Stress in Childhood:

Child Psychology Portfolio. London: NFER-NELSON; 1997

[34] Wilson JP, Keane TM. Assessing Psychological Trauma and PTSD. New York London: Guilford Press; 1997

[35] Yule W. Disturbo Post-Traumatico da Stress, Aspetti Clinici E Terapia. Milano: MacGrow-Hill; 2000

[36] Booysen DD, Kagee D. Trauma survivors' perceptions and experiences of prolonged exposure for PTSD at a psychology clinic. South African Journal of Psychiatry. 2023;**29**:1-7

[37] Meichenbaum D. A Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Post Traumatic Stress Disorder. Ontario, Canada: Institute Press, University of Waterloo; 1994

[38] Kernberg O. Prefazione in Mucci C. Trauma e Perdono. Milano: Raffaello Cortina Editore; 2014

[39] Penk WE. Post-traumatic stress disorder: Selected issues. Journal of Clinical Psychology, XLV. 1989;**5**:688-832

[40] Angermeyer MC, van der Auwera S, Carta MG, Schomerus G. Public attitudes towards Psychiatry and psychiatric treatment at the beginning of the 21st century: A systematic review and metà-analysis of population surveys. World Psychiatry. 2017;**16**(1):50-61

[41] Keller MB, McCullough JP, Klein DN, Arnow B, Dunner DL, Gelenberg AJ, et al. A comparison ofnefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. The New England Journal of Medicine. 2000;**342**:1462-1470