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## CLINICAL PRESENTATION OF COMORBID DEPRESSION AND POST-TRAUMATIC STRESS DISORDER

### SUMMARY

Comorbidity of post-traumatic stress disorder (PTSD) and depression offers the possibility to explore a broad spectrum of interactions of mood and anxiety disorders in several domains: in the domain of clinical presentation as well as in the treatment effectiveness and in the domain of pathophysiology of the two disorders.

The aim of the paper was to determine characteristics of the clinical presentation of comorbid PTSD and depression.

The investigation included 60 patients assessed by means of the following instruments: The Structured Clinical Interview for DSM-IV AXIS I Disorders, Investigator Version (SCID-I (modified), (SCID for DSM-IV), Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX), Montgomery-Asberg Depression Rating Scale (MADRS) and 17-item Hamilton Rating Scale for Depression (HAMD). The data were analyzed using the methods of descriptive statistics. Differences between groups were evaluated using the t-test.

The results obtained indicated that comorbidity of depression and PTSD is associated with higher intensity of intrusive symptoms' cluster, especially with flash-backs and intrusive thoughts distinctive to either PTSD or to depression, with broader spectrum of emotional and mood experiences and with more patient's suffering.

The analysis of the clinical presentation and complex spectrum of interactions of depression and PTSD inclusively enabled better understanding of symptoms presented by the patients, choice of the more effective treatment strategies and shed some light onto possible mechanisms of the human reactivity to extreme traumatic experiences.

**Key words:** comorbidity, depression, PTSD

### INTRODUCTION

The category of post-traumatic stress disorder provided an extraordinary potential to understand the human reactivity to extreme traumatic events. The symptoms of this nozological

entity – intrusive, numbing and hyperarousal symptoms comprise a broad range of mental phenomena and conceptualize them into a unitary whole.

The destiny of the sensory input and altered information processing that lead to the change of the

process of perception, reactivity and reasoning, and to the formation of the post-traumatic stress disorder symptoms have been perfectly conceptualized so far. There was not sufficient effort invested in order to investigate the affects encompassing traumatization, and investigate persistent consequences of the traumatic events on emotional states or mood.

The epidemiological data in our country indicate an increasing number of the cases diagnosed as post-traumatic stress disorder and depressive reactions (1).

Psychiatrists in clinical practice are faced with the following problem: precise diagnosis of the complaints presented by a patient is needed in the shortest possible time. Only precise diagnosis completed on time enables the implementation of the efficacious therapeutic programme which is of the utmost importance in the treatment of reactive states (2).

A well-known fact is that diagnostics in the initial stages of illness is always difficult. Traumatized persons develop a broad range of complaints – they present global and broad picture of disturbance reflecting many different symptoms (3-5). The group of registered symptoms refers most often to post-traumatic stress disorder as well as to depression. The problem in differential diagnosis of those entities is due to the facts that there are significant symptoms overlapping between two disorders, and due to the fact that post-traumatic stress disorder and depression most often are developed as comorbid disorders (6).

Our motive was to analyze delineated psychiatric entities and their interaction. Using the standard methodological inventory for characterization of depression and post-traumatic stress disorder, we analyzed the elements of the clinical presentation which indicate that the person suffers from comorbid post-traumatic stress disorder and depression. The results of the investigation will enable better diagnosis and therapy of traumatized persons. The interpretation of results in the light of patophysiological mechanisms underlying the symptoms enables the insight in the possible mechanisms of interaction of two disorders whose occurrence in comorbidity is common.

The aim of the paper was to determine the characteristics of clinical presentation of the comorbid complex of symptoms of post-traumatic stress disorder and of depression and to determine whether the use of the clinical instruments for measuring the presence and intensity of disorders enables valid diagnosis of the comorbidity of delineated disorders.

## MATERIAL AND METHODS

The investigation was performed at the Department for Post-traumatic Stress Disorder at the Clinic for Mental Health Protection in Nis, from July 1999 to December 2000, according to recommendation of the expert team recommended for the investigation of post-traumatic stress disorder (7). There were 60 subjects divided in two groups: the experimental group consisted of the subjects meeting DSM-IV criteria for post-traumatic stress disorder and for comorbid depressive episode. The control group comprised subjects meeting criteria for Post-traumatic Stress Disorder only. The initial diagnosis was performed using the Structured Clinical Interview for DSM-IV AXIS I Disorders, Investigator Version (SCID-I) (modified) to establish the diagnosis of Post-traumatic Stress Disorder (PTSD) and major depressive episode (MDE) (8). After initial assessment, we administrated the following instruments for measuring the presence and intensity of disorders: Clinician-Administrated PTSD Scale for DSM-IV (CAPS-DX), Montgomery-Asberg Depression Rating Scale (MADRS) and 17-item Hamilton Rating Scale for Depression (HAM-D) (9-11). The data analysis was performed using the t-test.

## RESULTS

Comparison of the results in experimental and in control groups on CAPS instrument (Tables 1-4) showed that the two groups differed most significantly ( $p < 0,001$ ) in the following symptoms: flash-backs and acting or feeling as events were recurring, diminished interest in activities, detachment or estrangement, restricted range of affect, in the level of total score of the avoidance and restriction of affect symptom cluster and the level of total CAPS score. Differences of less significant levels ( $p < 0,01$ ) were found in the following symptoms: intrusive recollections, the level of total score of the intrusive cluster symptoms and the level of total score of the hyperarousal cluster (Table 1 – 4). The symptoms: psychological distress, avoidance of thoughts, sense of forshortened future, sleep disturbance, difficulty concentrating, exaggerated startle response differed in the least level of significance ( $p < 0,05$ ) in experimental and in control group (Tables 1 – 4). The symptoms on the CAPS instrument: distressing dreams, physiological reactivity, irritability or outburst of anger did not differ significantly.

**Presentation of results on CAPS instrument in experimental and control group**

*Table 1. Values of intrusive symptoms in subjects with PTSD and PTSD-D*

INTRUSIVE SYMPTOMS		PTSD (1)			PTSD-D (1)			T	p
		X	SD	Cv	X	SD	Cv		
B1	Intrusive thoughts	5.63	1.56	27.77	6.73	1.05	15.57	3.20	0.0022
B2	Nightmares	5.33	2.38	44.68	6.10	2.04	33.44	1.34	0.1859
B3	Re-experiences and flash-backs	4.70	2.12	45.10	6.20	1.03	16.62	3.49	0.0009
B4	Psychological reactivity	6.23	1.01	16.14	6.83	1.05	15.41	2.26	0.0279
B5	Psychological reactivity	6.23	1.25	20.07	6.40	1.10	17.21	0.55	0.5860
Btot		28.13	5.85	20.78	32.27	4.62	14.31	3.04	0.0036

*Table 2. Values of symptoms of avoidance and constrictions of affect in subjects with PTSD and PTSD-D*

AVOIDANCE AND AFFECT CONSTRICTION SYMPTOMS		PTSD (1)			PTSD-D (1)			T	p
		X	SD	Cv	X	SD	Cv		
C1	Avoidance of thoughts	5.23	1.74	33.17	6.13	1.22	19.96	2.32	0.0238
C2	Avoidance of activities	4.43	2.06	46.52	5.33	2.23	41.88	1.62	0.1103
C3	Amnesia	0.97	1.96	202.36	0.63	1.50	236.33	0.74	0.4615
C4	Diminished interest in activities	5.13	1.04	20.29	6.57	1.19	18.19	4.95	0.0000
C5	Detachment and estrangements	5.03	1.13	22.43	6.30	1.12	17.76	4.36	0.0001
C6	Restriction of affect	4.67	1.49	32.00	6.07	1.62	26.66	3.48	0.0009
C7	Sense of forshortened future	4.83	1.37	28.28	5.77	1.63	28.32	2.40	0.0196
Ctot		30.30	6.13	20.24	36.80	5.47	14.86	4.33	0.0001

*Table 3. Values of hyperarousal symptoms in subjects with PTSD and PTSD-D*

HYPERAROUSAL SYMPTOMS		PTSD (1)			PTSD-D (1)			T	p
		X	SD	Cv	X	SD	Cv		
D1	Sleep disturbances	6.37	1.30	20.41	7.13	1.22	17.16	2.35	0.0221
D2	Irritability	6.20	1.16	18.66	6.43	1.28	19.87	0.74	0.4614
D3	Difficulty concentrating	3.73	1.80	48.19	4.50	0.97	21.64	2.05	0.0446
D4	Hypervigility	4.67	1.54	32.97	5.60	1.35	24.19	2.49	0.0155
D5	Exaggerated startle response	4.97	1.67	33.64	5.73	1.23	21.45	2.02	0.0476
Dtot		25.93	4.39	16.94	29.40	3.97	13.51	3.21	0.0022

*Table 4. Values of total CAPS score in subjects with PTSD and PTSD-D*

CAPS	PTSD (1)			PTSD-D (1)			t	p
	X	SD	Cv	X	SD	Cv		
Btot	28.13	5.85	20.78	32.27	4.62	14.31	3.04	0.0036
Ctot	30.30	6.13	20.24	36.80	5.47	14.86	4.33	0.0001
Dtot	25.93	4.39	16.94	29.40	3.97	13.51	3.21	0.0022
CAPSot	84.37	11.87	14.07	98.47	10.13	10.29	4.95	0.0000

Comparison of the results on MADRS instrument showed that all the symptoms differed on MADRS instrument (Table 5).

*Table 5. Values of MADRS score in subjects with PTSD and PTSD-D*

MADRS		PTSD (1)			PTSD-D (1)			t	p
		X	SD	Cv	X	SD	Cv		
M1	Apparent sadness	1.70	0.75	44.10	3.70	0.60	16.11	11.44	0.0000
M2	Reported sadness	2.07	0.64	30.95	3.57	0.63	17.55	9.18	0.0000
M3	Inner tension	2.90	0.66	22.82	3.50	0.63	17.99	3.60	0.0007
M4	Sleep disturbances	3.33	0.88	26.52	4.70	1.06	22.45	5.44	0.0000
M5	Reduced appetite	0.70	0.92	130.77	1.53	1.31	85.18	2.86	0.0058
M6	Concentration difficulties	1.40	0.86	61.07	2.20	0.71	32.47	3.93	0.0002
M7	Lassitude	1.53	0.82	53.43	3.13	0.82	26.15	7.56	0.0000
M8	Inability to feel	2.43	0.50	20.71	3.47	0.57	16.48	7.43	0.0000
M9	Pessimistic thoughts	0.73	0.83	112.87	2.93	1.01	34.60	9.20	0.0000
M10	Suicidal thoughts	0.17	0.38	227.43	1.70	1.12	65.81	7.11	0.0000
MADRStot		16.97	2.58	15.20	30.43	3.74	12.29	16.24	0.0000

The most significant difference ( $p < 0,001$ ) found using MADRS instrument was in the following symptoms: apparent sadness, reported sadness, reduced sleep, lassitude, inability to feel, pessimistic thoughts, suicidal thoughts and in the total MADRS score. The difference at the lower level of significance was found in the following symptoms ( $p < 0,01$ ): inner tension, reduced appetite and concentration difficulties.

Comparison of the HAMD scores of the experimental and control group showed that the two groups differed most significantly ( $p < 0,001$ ) in the symptoms: depressed mood, guilt, suicide, work and interests, retardation, agitation, psychic anxiety, somatic anxiety, gastrointestinal somatic symptoms, general somatic symptoms, genital symptoms, loss of weight and in the level of total HAMD score (Table 6).

diagnosis of disturbances presented by a patient. Application of the aforementioned instruments makes possible identification and estimation of the severity of the comorbid depressive episode despite the existence of the overlapping symptoms of post-traumatic stress disorder and depression, by which the danger in everyday clinical work is eliminated, cited by Blank, and which we experienced ourselves that depressive episode can be omitted and undiagnosed because it is overshadowed by the flamboyant picture of the reactive state (12).

Our results are in accordance with the results of the study of Blanshard, which states that post-traumatic stress and depression are not manifestations of the same unitary response to trauma. They are different disorders and not slightly different manifestations of the same disorders, which confirmed

Table 6. Values of HAMD score in subjects with PTSD and PTSD-D

HAMD	PTSD (1)			PTSD-D (1)			t	p
	X	SD	Cv	X	SD	Cv		
H1 Depressed mood	1.53	0.57	37.26	3.07	0.45	14.67	11.55	0.0000
H2 Guilt	1.03	0.41	40.05	2.03	0.41	20.35	9.36	0.0000
H3 Suicide	0.00	0.00	–	1.17	0.87	74.94	7.31	0.0000
H4 Insomnia (initial)	1.77	0.57	32.17	1.97	0.18	9.28	1.84	0.0716
H5 Insomnia (middle)	1.90	0.31	16.06	1.97	0.18	9.28	1.03	0.3087
H6 Insomnia (late)	1.83	0.46	25.15	1.93	0.25	13.12	1.04	0.3023
H7 Work and activity	1.50	0.68	45.49	3.10	0.96	30.95	7.44	0.0000
H8 Retardation	0.47	0.51	108.73	1.23	0.68	55.05	4.95	0.0000
H9 Agitation	1.20	0.55	45.91	2.17	0.75	34.46	5.71	0.0000
H10 Anxiety-psychic	1.37	0.49	35.86	2.27	0.58	25.73	6.47	0.0000
H11 Anxiety-somatic	1.60	0.50	31.14	2.73	0.52	19.05	8.61	0.0000
H12 Somatic symptoms-gastrointestinal	0.20	0.41	203.42	1.63	0.49	30.01	12.32	0.0000
H13 Somatic symptoms-general	0.90	0.71	79.11	2.00	0.00	0.00	8.46	0.0000
H14 Genital symptoms	0.17	0.38	227.43	1.80	0.48	26.90	14.55	0.0000
H15 Hypochondriasis	0.53	0.78	145.51	0.83	0.79	94.98	1.48	0.1437
H16 Loss of weight	0.03	0.18	547.72	1.13	0.82	72.29	7.18	0.0000
H17 Insight	0.00	0.00	–	0.17	0.53	318.40	1.72	0.0907
HAMDtot	16.03	2.43	15.14	31.20	3.52	11.27	19.44	0.0000

The experimental and control group did not differ in the following symptoms: initial insomnia, middle insomnia, late insomnia, hypochondriasis and insight.

DISCUSSION

The results obtained indicate that clinical presentation of the comorbid complex of symptoms of post-traumatic stress disorder and depression differ significantly from the presentation of post-traumatic stress disorders without depression, which enabled making conclusions important for clinical work.

In this way, it was confirmed that the use of delineated clinical instruments permits precise

the validity of clinical construct of post-traumatic stress disorder and confirmed that neither the correlation is the illusion, as Yehuda doubted, nor the epiphenomenon of the imperfect diagnostic criteria used for those disorders (13-15).

Further analyses of the results showed that clinical presentation of the comorbid complex of symptoms of post-traumatic stress disorders and depression differs significantly from the presentation of post-traumatic stress disorder with no depression in certain symptom clusters. Delineated symptom clusters can be used as an indicator for the immediate orientation of a clinician that a patient suffers from both post-traumatic stress disorder and depression, so there is no danger that depressive episode can be overshadowed, undiagnosed and not cured.

The result showed that clinical presentation of comorbid complex symptoms of post-traumatic stress disorder and depression is characterized by more intense intrusive symptom cluster, more intense affective disturbances, but probably with growing tendency of the patients to report the symptomatology of affects and by the greater global disturbance and subjective suffering.

The first characteristic of comorbidity of post-traumatic stress disorder and depression is more intense intrusive symptom cluster.

At first glance, the greatest difference in B3 symptom – flash backs and reexperience of events between experimental and control group was surprising. Symptom B3, dissociative by its genesis, correlated by its significance with the symptoms of affective cluster that indicated its importance and that it is strengthened by the comorbid depressive reactivity. The explanation for this elevation was found in the literature that the visual cortex stimulation, where flash-backs phenomena are generated, is an automatic consequence of the stimulation of amigdala, which is phylogenetically originated and is present disregarding the physical properties of the stimuli. More intense visual cortex stimulation upon exposure of disturbing stimuli occurs more often in depressive subjects than in control ones, which was also found in this investigation (16).

The intrusive symptomatology regarding B2 symptom – intrusive thoughts and recollections refers, perhaps, to the increased cognitive activity which depression brings into post-traumatic stress disorder. Current understanding does not permit one to take the standpoint if it were a manifestation of an interaction mechanism—of an affect-based activation of the contents of traumatic memory or of intensified efforts to integrate fragmented elements of traumatic event. The data in traditional psychiatric literature point to the fact that formation of traumatic script, creation of narrative, telling the story of event is a reliable and well-known process of semantic memory activation, enabling mastering the traumatic event and putting the event into the past (17).

The conclusion indicates that depression in post-traumatic stress disorder brings intensified cognitive activity – higher frequency and intensity of intrusive thoughts. The consequences of this phenomenon have not been analyzed so far, but this area, together with the nature and complexity of mental intrusions deserves further investigation.

Another characteristic of comorbidity of post-traumatic stress disorder and depression is higher intensity of symptoms associated with affecti-

ve symptomatology within post-traumatic stress disorder associated with symptomatology of depression.

Conclusively, the patients with post-traumatic stress disorder and comorbid depressive episode demonstrate more intense emotional experiences and broader range of emotional manifestations: diminished interest in activities, detachment or estrangement, restricted range of effects, sadness, lassitude, pessimistic thoughts, suicidal thoughts, depressed mood, guilt, retardation, agitation, anxiety and genital symptoms, regarding those suffering of post-traumatic stress disorder only.

The third feature of comorbidity of post-traumatic stress disorder and depression is greater subjective suffering. The repetition of intrusive contents, tragic evaluation of outcome, sadness, anhedonia and guilt, together with non-modulated emotional manifestations, together with the decrease in control over impulses and behaviour, loss of self-regulatory capacities and social dissolution produce more intense subjective suffering and higher suicide risk. (18-23)

## CONCLUSION

The results pointed out that comorbidity of post-traumatic stress disorder and depression is characterized by the existence of a particular group of symptoms. Defining of the aforementioned group of symptoms is important for clinical work. Identification of those symptoms lead the clinician, faced with traumatized patient presenting broad and undifferentiated picture of global disturbance which represent many versatile symptoms and is based on real tragic events, to establish directly the diagnosis of post-traumatic stress disorder and depression.

The obtained results showed that the application of the above quoted clinical instruments enables thorough diagnostics of the trauma-related psychopathology. The importance of recognition the comorbidity of post-traumatic stress disorder and depression lies in the fact that the patient identified in that way develops more severe form of disorder and is more subjectively disturbed and more functionally disabled. Diagnostics of the comorbid depression leads the clinician to think about the suicidality that presents a great problem in post-traumatic stress disorder and has a higher rate in the cases of comorbidity of post-traumatic stress disorder and depression, keeping in mind that the patients with comorbid disorders manifest higher chronicity of illness and lesser rate of spontaneous remission and to adapt the applied methods of medicamentous and individual psychotherapy.

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## KLINIČKA PREZENTACIJA KOMORBIDITETA DEPRESIJE I POSTTRAUMATSKOG STRESNOG POREMEĆAJA

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### SAŽETAK

**Komorbiditet posttraumatskog stresnog poremećaja (PTSP) i depresije pružio je mogućnost sagladavanja širokog niza interakcija anksioznih i poremećaja raspoloženja i to u više domena: u domenu kliničke prezentacije, kao i u domenu procene efikasnosti tretmana i psihofiziologije ovih poremećaja.**

**Cilj rada bio je određivanje karakteristika kliničke prezentacije komorbiditeta PTSP i depresije.**

Evaluirano je 60 pacijenata uz korišćenje sledećih instrumenata: Strukturisani klinički dijagnostički instrument za Axis I poremećaje (SCID za DSM.IV), Skala za kliničku procenu PTSP (CAPS.DX), Montgomeri-Osberg skala za depresiju (MADRS) i Hamiltonova skala za depresiju (HAMD). Podaci su analizirani korišćenjem metoda deskriptivne statistike. Statističke značajnosti razlika između grupa su utvrđene korišćenjem T testa.

Rezultati su pokazali da je komorbiditet depresije i PTSP povezan sa višim intenzitetom intruzivnih simptoma, posebno sa fleš bekovima i intruzivnim mislima koje su ukazivale ili na PTSP ili na depresiju, sa širim spektrom emocionalnih doživljavanja i raspoloženja i sa većom subjektivnom patnjom pacijenta.

Analiza kliničke prezentacije i kompleksnog spektra interakcija depresije i PTSP omogućava bolje razumevanje simptoma prezentovanih od strane pacijenta, izbor efikasnijih terapijskih strategija i baca svetlo na moguće mehanizme ljudske reaktivnosti na ekstremne traumatske doživljaje.

*Ključne reči:* komorbiditet, depresija, PTSP