



Factors Associated with Occupational Impairment in People Seeking Treatment for Posttraumatic Stress Disorder

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Objectives

- To explore demographic and clinical correlates of occupational impairment in 60 people seeking treatment for posttraumatic stress disorder (PTSD).
- To investigate whether treatment-related reductions in symptoms are correlated with treatment-related functional improvements.



Background

- Posttraumatic stress disorder (PTSD) is an anxiety disorder that develops after exposure to a severe traumatic event that:
 - involves an actual or perceived threat of death or serious injury *and*
 - the person felt intense fear, horror, or helplessness (*DSM-IV*)



DSM-IV PTSD Symptoms

- Re-experiencing (e.g., intrusive recollections, nightmares, flashbacks, etc.)
- Avoidance (e.g., of feelings, thoughts, place, activities, & other reminders of event)
- Emotional numbing (e.g., loss of pleasure, feeling detached from others)
- Hyperarousal (e.g., sleep disturbance, irritability, poor concentration, hypervigilance)



Clinical Features of PTSD

- Lifetime prevalence in general population = 8%
- Typically follows a chronic course
- Frequently associated with:
 - an increased risk of other psychiatric disorders
 - elevated rates of physical health problems
 - significant functional impairment




Occupational Impairment in PTSD

- What do we know about it?




• PTSD is associated with impaired occupational functioning

- as reflected by absenteeism, unemployment, work disability (e.g., *Breslau, 2001; Hull et al., 2002*).
- e.g., in a community survey, *Breslau et al. (2004)* found that for people with PTSD, a mean of 11.4 days of work were lost over a 30 day period due to PTSD.




• PTSD symptom severity has been shown to be positively correlated with occupational impairment, even after controlling for the effects of comorbid disorders (e.g., *Breslau et al., 2004; Ciechanowski et al., 2004; Momartin et al., 2004; Stein et al., 1997; Zatzick et al., 1997*)



Research Questions

- What are the relationships between occupational impairment, PTSD, and their correlates?
- How do specific features of PTSD impact occupational functioning?
- What are the risk factors of occupational impairment in PTSD?
- Does PTSD treatment improve work functioning and vocational outcomes?



Method

- This study represents a secondary analysis of a treatment outcome study on chronic PTSD by Taylor et al. (2003)




- Dimensional measure of pretreatment work impairment (along with pretreatment measures of social/leisure and family/home impairment) was correlated with demographic and pretreatment clinical variables



- The relationship between impairment and treatment outcome was examined by computing residual gain scores on measures of PTSD symptoms.




- The sample was also divided into patients who were either full-time employed or on disability benefits at pretreatment. These groups were compared on demographic, pretreatment clinical, and treatment outcome variables.




Participants


- Recruited from physician referrals and advertisements
- Strict inclusion/exclusion criteria
- 60 met the inclusion/exclusion criteria and entered treatment, 45 completed therapy.
 - dropouts and completers did not differ in demographics or psychopathology




- For the 60 people entering the study:
 - Mean age = 37 years (SD = 10 years); 75% = female.
 - 77% = Caucasian; 78% completed some form of college education.
 - Employment:
 - 42% were employed full-time or part-time outside of the home
 - 15% were students
 - 5% were full-time homemakers
 - 13% were unemployed
 - 25% were supported by some form of disability assistance.



- Mean duration of PTSD was 8.7 years (SD = 10.8).
- 65% had experienced more than one type of traumatic event; The most common forms were:
 - sexual assault (e.g., childhood or adult rape), 45%
 - physical assault, 43%
 - transportation accidents, 43%
 - exposed to a sudden death (e.g., witnessing a homicide), 22%




- The most common coexisting mental disorders were major depression (42%), panic disorder (31%), social anxiety disorder (12%).
- 48% were taking psychotropic medication




Measures

- SCID-IV (SCID-IV: First et al., 1996) to assess DSM-IV Axis I disorders
 - also used to assess demographic variables (including occupational status) and PTSD duration.
- CAPS (CAPS: Blake et al., 1997 to assess PTSD symptom severity (past week)
 - divided into 4 factor-analytically distinct scales: reexperiencing, avoidance, numbing, and hyperarousal (Asmundson et al., 2004),




- Beck Depression Inventory (Beck & Steer, 1987)
- Sheehan Disability Scale (Sheehan, 1983); consists of 3 items, each assessing a domain of functioning
 - work
 - social life and leisure activities
 - family life and home responsibilities.




Procedure

- Pretreatment assessment: telephone screen, SCID-IV, CAPS, self-report measures
- Treatment: compared exposure therapy, relaxation training, and EMDR:
 - participants randomized to 8-week treatment condition (n = 15 per group)
 - 2 therapists randomly assigned to patients
- Post-treatment assessment: CAPS & measures
 - 1-month after the last treatment session
- Follow-up assessment: CAPS & measures
 - 3 months later




Results

- PTSD-reexperiencing & hyperarousal symptoms, and depressive symptoms
 - were all significant correlates of work impairment
 - but were not significantly correlated with other forms of impairment
- Emotional numbing was
 - significantly correlated with family/home impairment
 - but not with work or social/leisure impairment
- Pre-treatment demographic variables largely unrelated to impairment




- The disability group (vs. full-time employed) had significantly more severe reexperiencing and hyperarousal symptoms at pretreatment
- The groups did not differ on other variables.




	Employed (n=17) M (SD) or %	Disability (n=15) M (SD) or %	t or χ^2	df	η^2
Demographics					
Age	37.3 (7.0)	39.7 (11.1)	0.75	30	.02
Women (%)	71	53	1.01	1	.18
Education level	4.9 (2.0)	4.3 (1.7)	0.94	30	.03
Caucasian (%)	88	80	0.41	1	.11
Married or cohabiting (%)	59	47	0.47	1	.12
Pretreatment Clinical Variables					
PTSD – re-experiencing	4.3 (1.3)	5.4 (1.3)	2.30*	30	.15
PTSD – avoidance	5.3 (1.9)	6.1 (1.5)	1.34	30	.06
PTSD – numbing	3.9 (1.2)	3.9 (1.7)	1.56	30	.00
PTSD – hyperarousal	4.7 (1.2)	5.7 (0.8)	2.73**	30	.20
PTSD duration (years)	4.9 (5.8)	6.6 (10.8)	0.57	30	.01
Depression	24.3 (8.3)	26.1 (12.3)	0.49	30	.01

*p < .05, **p < .011.




Discussion

- PTSD re-experiencing and hyperarousal symptoms, and depression were uniquely associated with occupational impairment
 - Why?



• These symptoms may interfere with a broader range of occupational tasks


- Whereas other symptoms, e.g., avoidance, may be related to work impairment in more specific circumstances
 - e.g., person reluctant to return to their job after work-related trauma




Discussion

• Occupational impairment differed from other forms of functional impairment.


- Why?



• Work functioning (vs. other areas of functioning) often involve higher levels of cognitive processes (e.g., concentration, memory), which may be more negatively impacted by hyperarousal and re-experiencing symptoms



• Patients receiving disability benefits at pretreatment endorsed more severe reexperiencing and hyperarousal symptoms than patients those who were employed full-time.




• Treatment-related symptom reductions were associated with treatment-related improvements in work functioning.
– people on disability assistance benefited as much as employed people.



Limitations

• Small N, treatment-seeking sample
– Needs replication with larger community samples (vs. treatment sample used in this study), and specific trauma groups (e.g. work-related trauma)

• Other potential factors related to occupational impairment not examined (e.g., work satisfaction, workplace social support)



Implications & Future Directions

- Advancing our understanding (and measurement) of the nature of the relationships between PTSD, occupational impairment, and other correlates
- Developing new interventions for reducing occupational impairment
 - e.g., strategies to directly target specific PTSD symptoms
 - e.g., integrated treatment strategies to address both PTSD symptoms & work difficulties, such as cognitive behavioural therapy return-to-work programs.