COMPLEX POSTTRAUMATIC STRESS DISORDER: A CASE REPORT

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ABSTRACT
Purpose: Complex posttraumatic stress disorder (CPTSD) is a clinical syndrome associated with chronic and repeated trauma. Its diagnosis requires the core symptoms of posttraumatic stress disorder (PTSD), associated with a set of symptoms referring to affective dysregulation, negative self-concept and relationship problems. We present a case of a woman with CPTSD who was referred to psychiatric day hospital. Case Description: The patient was victim of long-term violence by her ex-husband and presented depressive and anxious symptoms, such as frequent complaints of nightmares and startle response to small stimuli as well as hypervigilance. Due to lack of clinical response after a psychopharmacological and psychotherapeutic approach, she was referred to psychiatric day hospital with the diagnosis of depressive disorder and borderline personality disorder (BPD). In day hospital, the maintenance of nightmares was verified, as well as the avoidance of situations of possible encounter with her ex-husband, verbalizations of guilt, uselessness and poor personal value, self-harming behaviors and inability to initiate relationships. Conclusions: The need for greater exposure of CPTSD to mental health professionals needs to be highlighted in order to improve its diagnosis and its distinction from other disorders, such as BPD, so proper treatment can be provided.

Keywords: Post-traumatic Stress Disorders; Complex Posttraumatic Stress Disorder; Borderline Personality Disorder; Domestic Violence; Trauma and Stressor Related Disorders.

PERTURBAÇÃO DE STRESS PÓS-TRAUMÁTICO COMPLEXA: UM CASO CLÍNICO

RESUMO
Objetivo: A perturbação de stress pós-traumático complexa (CPTSD) é uma síndrome clínica associada a trauma crónico e repetido. Para o seu diagnóstico são necessários os sintomas nucleares da perturbação de stress pós-traumático (PTSD), associados a um conjunto de sintomas referentes a desregulação afetiva, autoconceito negativo e perturbação nas relações. Apresentamos um caso de CPTSD numa mulher em tratamento no hospital de dia de psiquiatria. Descrição do caso: Doente vítima de violência física e psicológica de longa duração por parte do ex-marido apresentava sintomatologia depressiva e ansiosa, tal como pesadelos frequentes e fácil sobressalto perante pequenos estímulos, tal como hipervigilância. Devido à ausência de resposta clínica após abordagem psicofarmacológica e psicoterapêutica, foi referenciada a hospital de dia de psiquiatria com a hipótese diagnóstica de perturbação depressiva em doente com perturbação *borderline* da personalidade (BPD). Em hospital de dia, apurou-se a manutenção de pesadelos, tal como o evitamento de situações de possível encontro com o ex-marido, verbalizações de culpa, inutilidade e menos-valia, comportamentos auto-lesivos, incapacidade em iniciar relações afetivas. Conclusão: Destaca-se a necessidade de uma maior exposição da CPTSD aos profissionais de saúde mental, com vista a melhorar o diagnóstico e a sua destrinça de outras patologias, como a BPD, com fim a um tratamento adequado.

Palavras-chave: Transtornos de Estresse Pós-Traumáticos; Transtorno de Estresse Pós-Traumático Complexo; Transtorno de Personalidade Borderline; Violência Doméstica; Transtornos Relacionados a Trauma e Fatores de Estresse.

INTRODUCTION

Originally proposed by Herman in 1992, complex posttraumatic stress disorder (CPTSD) is a clinical syndrome which emerged from the observed clinical heterogeneity of

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patients diagnosed with posttraumatic stress disorder (PTSD)(1). Since its proposal, there has been much controversy regarding the diagnostic validity of this new diagnosis, mainly due to the fact that its symptoms seem to overlap with other disorders (mainly PTSD and borderline personality disorder (BPD)). However, to date there are diverse studies supporting the validity of this diagnosis and its independence from PTSD and BPD(2,3).

CPTSD is typically associated with chronic and repeated trauma, which takes place mainly during early life stages, although these events can also occur during adulthood(4), leading to profound personality changes(1). In this way, its diagnosis includes not only the core symptoms of PTSD (from the clusters of reexperiencing, avoidance and sense of threat), as well as an additional set of disturbances in self-organization (DSO) symptoms. DSO symptoms are distributed across three clusters: affective dysregulation (heightened emotional reactivity, violent outbursts, self-destructive behavior, dissociative states), negative self-concept (persistent beliefs about oneself as diminished, defeated or worthless, with feelings of shame, guilt or failure) and disturbances in relationships (difficulties in maintaining relationships because of tendency to either avoid relationships or because of experiencing difficulty in sustaining emotional engagement)(5,6).

Released in 2018, the 11th version of the *International Classification of Diseases and Related Health Problems (ICD-11)*, includes the diagnosis of CPTSD, alongside with the PTSD diagnosis, in the group of "Disorders specifically associated with stress"(7). Regarding the 5th edition of the *Diagnosis and Statistical Manual for Mental Disorders (DSM-5)*, it doesn't contemplate the diagnosis of CPTSD, though the PTSD concept was re-evaluated, with the addition of a new cluster of symptoms including altering in mood and cognition following the traumatic experience, as well as a dissociative PTSD subtype(8). A comparative view between the different diagnostic criteria of DSM and ICD classification systems is present in Figure 1.

Figure 1 – Diagnostic criteria of DSM-5 for PTSD and ICD-11 for PTSD and CPTSD

DSM-5 PTSD	ICD-11 PTSD	ICD-11 CPTSD
Intrusions (B)	Re-experiencing	Re-experiencing
Memories	Memories	Memories
Flashbacks	Flashbacks	Flashbacks
Nightmares	Nightmares	Nightmares
Avoidance (C)	Avoidance	Avoidance
Thoughts	Thoughts	Thoughts
People, places, situations	People, places, situations	People, places, situations
Arousal (E)	Sense of threat	Sense of threat
Hypervigilance	Hypervigilance	Hypervigilance
Startle	Startle	Startle
Irritable behavior		
Self-destructive behavior		
Negative alterations in cognition & mood (D)		Emotion regulation
Inability to remember		Anger
Negative beliefs of self or others		Hurt feelings
Distorted cognitions		Negative self-concept
Negative emotional state (guilt, shame)		Worthless
Diminished interest		Guilt
Feelings of detachment		Interpersonal problems
Inability to experience positive emotions		Avoid
		Feel disconnected

We present a case of a 42-year-old woman who was admitted to the psychiatric day hospital due to depressive symptoms refractory to medication and apparent presence of maladaptive personality traits which were believed to interfere with treatment.

CASE REPORT

A 42-year-old Portuguese woman was referred to psychiatric consultation due to complaints of sadness, anxiety and self-harming. The onset of depressive symptoms dates from about fifteen years ago, being reactive to the discovery of infidelity by her husband, who was her partner since she was eighteen years old. By that time, the relationship was already marked by domestic violence (psychological and physical), which gradually intensified until the divorce (four years after the discovery of the extramarital case). At the time of the divorce, the shared custody of the only daughter was amicably agreed upon, which led to regular contact with the ex-husband. This contact maintained characteristics of conflict, with physical and verbal violence, which led to the intensification of complaints of sadness, anhedonia, social isolation and ideas of less value, motivating the beginning of antidepressant medication five years after the divorce. This medication was prescribed by the general practitioner, and was only maintained for one year. Gradually, the ex-husband begun to fail to comply with his

daughter's shared custody agreement, preventing the patient from having regular contact with her. In this context, a further exacerbation of depressive complaints occurred, with the appearance of self-harming behaviors, which led to the referral for psychiatric consultation. In the first consultation, depressive symptoms were present, with complaints of anhedonia, sadness, terminal insomnia, anorexia (with weight loss of about 11kg in three months), neglect of self-care, anxiety and passive ideas of death. The patient complained of frequent nightmares and it was observed that she was easily startled by small stimuli, and presented hypervigilance towards the surrounding environment. There was no evidence of substance use or other psychiatric history. In terms of professional activity, the patient worked in an electronics store, but was on a sick leave. Medication was started, with paroxetine 20 mg/day, clonazepam 0,5 mg twice daily and quetiapine 50 mg (prolonged release) at night and psychotherapeutic treatment was also initiated. After one year of follow-up, the patient hadn't improved, presenting total functional disability as well as the same complaints, so she was referred to the psychiatric day hospital for clinical stabilization and functional rehabilitation. The diagnostic hypothesis was of a depressive disorder in a patient with potential borderline personality disorder.

During her follow-up at the psychiatric day hospital, it was possible to ascertain the long suffering of physical and verbal abuse perpetrated by the former partner (both during marriage and up to the present), of whom the patient was afraid. A traumatic episode in her adolescence was also found, in which she was the victim of attempted sexual assault by a neighbor. The patient referred to frequent nightmares related to both events, and an enormous fear of her ex-partner, with whom she avoided any contact, no longer frequenting places in which she believe she could find him or acquaintances of him. She verbalized feelings of guilt, uselessness and poor personal value, feeling powerless in the face of any frustration, which led her several times to be angry at herself, scratching herself and pulling her own hair. She also described being unable to maintain any kind of relationship, because she felt incapable of loving someone again.

A multidisciplinary approach was initiated, focusing on emotional self-regulation and improving social skills through participation in groups. She also maintained an individual psychotherapeutic approach focusing on trauma, and at a later stage, began an occupational therapy. Improvement of symptoms was gradually observed.

DISCUSSION

In this clinical report we describe the case of a woman who was victim of prolonged trauma during adulthood, as well as victimized during adolescence. The patient presents symptoms of re-experience of trauma, avoidance and sense of threat or arousal, as well as DSO symptoms, exhibiting emotional dysregulation, negative self-concept and problems with relationships. In our view it is a probable case of CPTSD.

It is interesting to note that the patient was firstly hypothesized as having a possible personality disorder, which is one of the diagnosis that seems to show some symptom (mostly DSO) overlap with CPTSD, particularly BPD. Nonetheless there are important phenomenological differences on how these symptoms manifest in both disorders. In BDP, self-concept difficulties reflect an unstable sense of self, whereas in CPTSD, they reflect a persistent negative sense of self instead of shifting. When it comes to relational problems, in BPD relations are intense, with a volatile pattern, and with extremes of idealization and devaluation, whereas in CPTSD, they reflect a tendency to avoid relationships. Affect dysregulation in BPD manifests the fears of abandonment, whereas in CPTSD it reflects difficulties in maintaining emotional balance, with emotional sensitivity, reactive anger and poor coping responses(3,9). Most importantly, CPTSD requires trauma exposure for the diagnosis, while BPD does not, although a vast number of BDP patients has a history of traumatic victimization(3). Also of relevance, in our clinical case the patient only manifests these symptoms in full adulthood, being known that personality disorders tend to manifest during adolescence or early adulthood, and in many cases experience some level of stability in middle age(7).

Given these differences, treatments for CPTSD should focus on reduction of social and interpersonal avoidance, development of a more positive self-concept and should approach traumatic memories. This is different from BPD treatment, which focuses in the reduction of disruptive behaviors such as suicidality and self-harm, as well as the reduction in the dependency on others and an increase in a stable sense of self(9).

Almost three decades after it was first conceptualized, CPTSD still seems to need further clinical recognition as an independent and valid diagnosis. There has been crescent research about this disorder, and its inclusion in ICD-11 is a step forward towards its vaster recognition, which is vital for a greater knowledge about its management.

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