

An Alternative Approach to the Effects of Multiple Traumas: Complex Post-Traumatic Stress Disorder

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ABSTRACT

Exposure to multiple traumatic events, particularly in childhood, has been shown to result in more complex symptoms than those seen after exposure to a single traumatic event. In case of overlooking the link between trauma and psychopathology, patients with multiple traumatic experiences receive a variety of different diagnoses that are unable to completely cover the clinical picture. Misdiagnoses of genuine cases inevitably lead to mistreatment. A diagnosis of complex post-traumatic

stress disorder has been proposed to cover the emerging psychopathology in survivors of multiple traumas. This present report aimed to discuss the construct and to increase the awareness of complex post-traumatic stress disorder diagnosis among mental health professionals.

Keywords: Psychological trauma, childhood trauma, complex post-traumatic stress disorder

INTRODUCTION

Post-traumatic stress disorder (PTSD), by definition, captures a limited psychopathology that develops after a single or certain traumatic event (1). Psychopathologies or symptoms that develop after complex and repeated traumatic events such as captivity, prisoners of war status, being a victim/refugee of human trafficking, domestic violence, physical or sexual abuse/neglect in childhood, or exposure to organized sexual exploitation are reported to be much more complex (1). The multitude of diagnoses in victims of multiple traumas, along with the presence of a wide range of symptoms (2) and the need for different treatment strategies other than therapies for PTSD (3,4) have created a need for a new diagnostic category (5). For example, the traumatic stresses that occur in individuals after a natural disaster or a traffic accident are reported to show different characteristics and different treatment approaches in comparison to those that occur in individuals exposed to chronic abuse or neglect since childhood (6). "Complex post-traumatic stress disorder" (CPTSD) diagnosis was proposed by Herman in 1992 (5). The proposed diagnostic criteria for CPTSD were: 1) difficulty in organization of feelings and impulses; 2) alterations in attention and consciousness; 3) negative self-perception; 4) dysregulation of relationships with others; 5) somatization; and 6) alterations in systems of meaning (4,7). There are the studies that reporting its clinical benefits to be valid and reliable (1,4,8,9,10,11); however, there are also studies reporting that it is not a definite diagnosis, there is insufficient evidence and that its clinical benefits are uncertain (12,13). Many symptoms that were recommended for CPTSD were added to the new PTSD diagnostic criteria in DSM-5, as a result of the studies conducted on the CPTSD concept. Additionally, a subtype of PTSD that shows dissociative symptoms was defined (14). In spite of these developments, which have made major contributions to our understanding of traumatic stress, we believe that the new PTSD definition of DSM-5 and the dissociative subtype are insufficient to define the clinical picture in some patients, due to a wide range of complex symptoms in CPTSD that develops after exposure to multiple traumas and the presence of multi-dimensional personality changes that affect identity organization. The members of the ICD-11 working group have considered these and similar opinions regarding the classification of disorders specifically associated with stress and have recommended in their recent article that the diagnostic criteria of CPTSD should include the following: 1) persistent and pervasive impairment in the regulation of feelings and impulses; 2) negative self-perception with a dominant ideation of insignificance, insufficiency and shame; 3) in addition to PTSD core symptoms, inability to build or maintain long-term, permanent relationships and this should be considered as a different diagnostic category in ICD-11, which is proposed to be completed in 2015 (15). It is claimed that, if accepted, this may play an important role for more effective therapies in future by increasing awareness in understanding and recognizing the clinical picture in patients who are victims of chronic traumatic events (1,10).

The aim of this report is to discuss the concept of CPTSD with the aid of a case presentation and increase awareness on it, which is lacking among mental health care professionals.



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CASE

A 31-year-old female was admitted to the outpatient clinic with complaints of increased speech, anxiety, restlessness, forgetfulness and voices in her head. She was hospitalized because symptoms resembling a manic episode with suicidal ideation were considered. Her mother had divorced her father when she was 3 months pregnant and remarried someone 30 years older than her when the patient was a 1-year-old. She was exposed to multiple physical and psychological abuse/neglect from her step father until she was 5 years old, when she was institutionalized at an orphanage. The physical and psychological abuse/neglect from her teachers and orderlies of the orphanage continued until she was 14. She attempted to frequently escape from the orphanage till she was 14 years old; she then finally left and started living on the streets. She was raped when she was 15, following which she had given birth to a son. She has not seen him since he was institutionalized at the orphanage. She had moved to Istanbul after a major earthquake in 1999 and continued living on the streets. She had encountered multiple physical and sexual abuses and was raped twice until she met and married her husband at the age of 19. She gave birth to another child one year back, but a foster family was assigned and the child is now living with them. She had multiple and complex complaints involving mood fluctuations; suicidal and homicidal ideation from time to time; bursts of anger; periods of memory loss, following which she could not remember what she had done or where she was; inappropriate sexual relationships; risky behavior; various somatic complaints; and hearing voices in her head, for which she was treated 5 times on an outpatient or inpatient basis. She was found to have been treated for major depression, bipolar mood disorder, borderline personality disorder and dissociative disorder; however, she had only partial benefit from these treatments. Her affect was hypomanic and her mood was labile during the psychiatric examination. She complained of anxiety attacks that repeated 3–4 times in a day, which particularly reminded her of the past traumatic events she had experienced. She had passive suicidal ideation; however, a prominent perception disorder was not observed. She had multiple somatic complaints and seemed to have bipolar mood disorder, dissociative personality disorder, PTSD, somatization disorder and borderline personality disorder; according to the results of SCID-I, Borderline Personality Inventory, Dissociative Disorders Interview Schedule and Dissociative Experiences Scale (mean score: 31.7 points). A treatment including pharmacotherapy with 900 mg/day lithium, 20 mg/day paroxetine and quetiapine 200 mg/day was instituted after considering her passive suicidal ideation, mood fluctuation, impulsiveness, anxiety and various behavioral problems, with the addition of supportive psychotherapy that focused on her traumatic experiences. She was treated for 40 days at the hospital and she was followed-up on an outpatient basis with continued psychotherapy, while the dose of lithium was gradually decreased and subsequently altogether stopped. The aims of trauma-focused supportive psychotherapy were to define the link between the post-traumatic experiences and present complaints and the negative effects of those experiences at individual level. The awareness of the patient, who has started feeling more perceptive about her condition and about her experiences, was aimed to be increased. Although we are at the beginning of a long-term treatment, we observed a partial improvement in her functioning and a general decrease in her complaints.

DISCUSSION

Multidimensional personality changes including alterations in relationship and identity seemed to have developed in our patient, who was exposed to multiple recurrent traumatic events for a long time since childhood. Studies have shown that a surprising number of psychiatric symptoms occur particularly in patients who were exposed to multiple traumas since early childhood (7,9,16). These patients who have a complex symptomatology

are frequently defined with multiple and different diagnosis. Most frequent ones among those diagnoses are “borderline personality disorder;” “somatization disorder;” and “dissociative identity disorder” (5,17). Our patient fulfills the diagnostic criteria of five different diagnostic categories at the same time, according to the results of structured clinical interviews. The prominent fluctuations in the mood lead to a diagnosis of bipolar mood disorder at a cross-sectional view. On the other hand, persistent disturbances in functioning even during periods when she is not thought to be experiencing an episode, relatively mild fluctuations in her mood and the presence of many symptoms that are not in accordance with a diagnosis of bipolar mood disorder direct us away from such a diagnosis. PTSD was reported to accompany CPTSD frequently in various studies; however, both were also reported to have different clinical characteristics (8,18). PTSD, which sufficiently covers a clinical picture that occur as a result of single or limited traumatic events, such as natural disasters, war, or rape, does not sufficiently describe the psychopathology characterized by different symptoms that occur as a result of chronic traumatic stress and affects functioning in a more intense way and it does not seem to sufficiently cover all the symptoms shown by our patient (1,7,18). When our patient was evaluated for current psychiatric nosology, co-existence of borderline personality disorder and dissociative personality disorder may have been considered. However, as an alternative approach, we suggest a CPTSD diagnoses, with its more comprehensive structure, would have the potential to resolve the nosological fragmentation, requiring different diagnosis of borderline personality and dissociative personality disorders due to the presence of discordant symptoms in our patient (7). According to Herman, who had reported that the absence of a correct and comprehensive diagnostic category in the psychiatric classification system for patients with multiple traumas may create serious consequences, the inability to detect the link between symptoms of the patient and traumatic experience by the clinician may result, at best, in an insufficient understanding and eclectic approach to treatment (19). These patients use many medications that do not contribute to their treatment and ultimately become unwanted patients by tiring their physicians as a result of inadequate progress in their treatment (7). We believe that multiple diagnosis of the presenting symptom cluster, originating from the current structured interview scales, may have caused an incomplete understanding by covering the association between the traumatic experience and the psychopathology and eclectic therapy may have caused chronicity of the condition instead of complete cure.

In conclusion, in order to understand the multilayered psychopathology that develops in victims of chronic trauma and also overcome the problems while treating these patients, we believe that CPTSD diagnosis with its comprehensive structure may provide a different clinical approach and treatment opportunities for clinicians instead of providing multiple diagnoses for individual symptoms. Just like the inclusion of PTSD in DSM III pioneered a better understanding and recognition of the importance and effects of traumatic experiences on mental health, the inclusion of CPTSD in diagnostic guidelines may help clinicians visualize the underlying psychopathology with a more comprehensive approach and undertaking more effective therapies for increasing the understanding of the effects of multiple traumas.

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