PJP

CASE REPORT

A CASE REPORT ON COMPLEX POSTTRAUMATIC STRESS DISORDER WITH COMORBID BIPOLAR II DISORDER

ANDREA NICHOLE D. BAUTISTA, MD
ENCARNITA RAYA-AMPIL, M.D., FPNA, FPPA
UNIVERSITY OF SANTO TOMAS

ABSTRACT

This is a case of a 22-year-old female who presented with labile mood, impulsivity and persistent suicidality. Despite numerous pharmacologic and psychotherapeutic regimens, she only had minimal improvement. Subsequently, she revealed traumatic events in younger years.She has been experiencing recurrent intrusive thoughts, low self-worth, guilt and avoidance behavior.

Pharmacotherapeutic management was revised as well as her psychotherapy, which resulted in a positive outcome. However, recurrence occurred after she encountered negative life events. Electroconvulsive therapy and revision of pharmacologic treatment eventually led to significant improvement. This case highlights the importance of underlying psychological trauma that caused persistent symptoms. The intensity of impact and the chronic recurrent negative effect of the trauma on the patient influenced the treatment outcome. It is important to optimize therapeutic management with the use of pharmacologic agents, psychotherapy and somatic therapies.

KEYWORDS: *Complex Post-traumatic Stress Disorder, Comorbid Bipolar Disorder*

INTRODUCTION

The patient presented with intrusive thoughts, avoidance, and nightmares after suffering from a significant sexual trauma at the hands of her own relative. This eventually led to persistent depression, from which she found no escape. She had previous psychiatric consultations and hospitalizations prior to her most recent admission on October 30, 2022. On the day of hospitalization, she became suicidal again and according to the patient, she never got better.

CASE REPORT

The patient, Sophie, is a 22-year- old Filipino female, single, right -handed, Roman Catholic, post-graduate student i.e. Master in Psychology, Major in Clinical Psychology, from Bulacan. She is the youngest in a brood of 3 siblings.

As an infant, Sophie was described to be well-behaved. She was breastfed and bottle-fed on demand for the first 1-2 months during her mother's maternity leave. Her diaper was regularly checked if soiled, and it was immediately changed. Whenever she cried, she was immediately carried and soothed. When her mother started working again, she was placed under the care of her maternal aunts and grandparents. Her father was barely home, and he was always out in the field working in his poultry business. Her speech and language, fine motor and gross motor milestones were reportedly at par with her sisters.

When Sophie was around 1.5 years old, her mother was promoted to office work so a distant maternal relative was hired as a caregiver for

her and her siblings. At 2-3 years old, her potty training was primarily supervised by her caregiver and maternal grandparents, since her mother was working. There were no known encountered difficulties in caring for her at this time.

At 3-4 years old, Sophie was enrolled in a Methodist school for preschool. There was no noted separation anxiety or uncooperativeness when being brought to school by her maternal grandmother. She was sociable and well-liked by her classmates and teacher. She also performed well in school.

During this time, Sophie's parents started having frequent verbal altercations because her father started using methamphetamine. Her mother took her and her siblings out of the house to stay with her maternal grandparents. Her mother claimed that the maternal grandparents and maternal aunts were her primary disciplinarians during this time, and that they were quite permissive. When she asked for a snack or a toy, it would be given to her more often than not. They employed a verbal mode of discipline.

At 4-5 years old, Sophie's mother quit her job as an office employee so that she can spend more time with her children. She was given a job as a manager/contractor in her brother in law's business. Her mother and maternal grandparents took care of her. She continued to do well in preschool.

In 2007, at 7 years old, Sophie was allegedly sexually assaulted twice by her adolescent maternal male cousin in their grandmother's house. She claimed that what her maternal cousin did to her was painful, and she did not know what it meant, but she knew that it was wrong. She did not tell anyone so as not to compromise family relations and the occupation of her mother who was working for the parent of the maternal cousin who allegedly raped her. Since then, she was observed to be more subdued, and aloof towards her mother and sisters.

In school, Sophie had a fixed set of friends, consisting of 2-3 females. She was described as a quiet, obedient student. She rarely initiated conversations with her classmates, but she claimed she was approachable. She had average grades and rarely joined any extracurricular activities in school.

In 2012, at 6th grade, Sophie learned about what the [sexual]"act" meant and that it could have resulted in pregnancy. She began to punch herself in the stomach because she knew that the "act" can result in pregnancy; and she hated the possibility of being pregnant. She became angry with herself, because she saw herself as impure and disgusting. She had nightmares about the incident and actively avoided any interaction with that cousin. During this time, her mother and sisters noticed that she became more quiet and withdrawn but they attributed it to puberty, and just let her be. She started feeling attracted to the opposite sex, but she did not act on these feelings since she was afraid of experiencing what she went through previously. She felt frustrated with herself and her situation. She used swimming as an outlet to release her frustrations.

In 2013, at 13 years old, a male classmate bullied Sophie verbally during the first two years of high school by calling her demeaning names. She mentioned that she did not mind the bullying as she considered it as harmless since she was not the only one in class who was teased. During this time, the intrusive thoughts and nightmares about her cousin reportedly lessened since his family moved away from their area.

In 2015, at 15 years old (3rd year high school), Sophie attended a parade as part of a school activity and rode at the back of a truck with her classmates. The person who had been bullying her allegedly touched her genitals. She froze and kept quiet but noticed afterwards that the friends of the bully were looking and laughing at her. She felt ashamed and started avoiding these individuals at school. The act reminded her of what happened to her before. She then had recurrent, intrusive, or persistent thoughts about her cousin assaulting her in the past. She had repeated nightmares about the incident, as well as the previous incident of sexual assault. During this time, her family reported that she became more distant and had frequent blank stares. Whenever they would ask her about it, she refused to open up. She felt guilty for not telling her family and felt like a burden to them.

In 2017, when Sophie was in college; she decided to rent an apartment with 2 of her female friends. An employee in their school lived next door to them, with his wife and child. He was friendly with Sophie and her friends and they would often throw jokes at each other. Whenever he found Sophie alone either in the apartment or the school, he often said sexual and intimate things to her. This made her very uncomfortable. She did not avoid him but did not initiate conversation with him and did not allow herself to be alone with him. She had a suitor in college, but she was afraid of being touched and she felt impure because of what happened to her. The relationship did not blossom. Sophie was also unhappy with her chosen course in college but did not want to shift courses because of the financial burden it would cause to her family. At this time, she already felt as if she did not deserve any happiness and she could not see a good future ahead of her anymore. She felt depressed and she could not enjoy things she previously appreciated.

There was difficulty initiating sleep, poor appetite, fatigue and suicidality. Sophie started cutting her wrists with the intent to end her life. She even punched the wall out of frustration at times. Her classmates noticed this change in her mood, as well as the wounds on her wrist. They notified their guidance counselor about it and she was advised to seek consult with a psychiatrist. She consulted a psychologist at first, and she had regular psychotherapy sessions with her, thrice a week for 3 months.

In June 2019, Sophie was brought to a psychiatrist due to the persistently low mood. She was prescribed escitalopram 10 mg/tab and aripiprazole 5 mg/tab daily. She did not report any improvement in her symptoms. She was supposed to work in her school for two years as a return service as part of her scholarship contract. However, she was not allowed until she was given fit to work by her psychiatrist. She wanted to go into a masteral program in psychology but the school did not allow her as well. She felt a sense of hopelessness.

In August 2019, neuropsychological evaluation was done and it revealed a diagnostic impression of rule out bipolar II mood disorder and borderline personality disorder.

In the subsequent follow up with the therapist, Sophie briefly opened up about her sexual trauma. However, she quickly bottled up because she felt ashamed and she was afraid to be judged. She was also afraid that her family would find out about it. After the session, she cut her left wrist using a blade that she always brought with her. She was brought by her therapist to the hospital where she was admitted for 3 weeks.

During hospitalization there was frequent hair pulling and hitting of her head with her fists. Sophie was plagued by the intrusive thoughts of her cousin's assault as well as the other instances in her life that she experienced sexual trauma. At that time, she did not disclose this to any of her doctors because she did not want it to reach her family. She only mentioned her school and lack of work as her triggers for her mood and symptoms. Her medications of escitalopram and aripiprazole were continued. She underwent 20 sessions of repetitive Transcranial Magnetic Stimulation.

At this time, Sophie's previous school had been calling her regarding her return service. When they learned of her condition and hospitalization, the school decided not to push through with her return service. After discharge, she felt significantly better, but she felt numbness instead of sadness. Her nightmares decreased in frequency. She started sending out her resumes to call centers and companies that offered office work.

In December 2019, Sophie started buying things impulsively. She became impatient and irritable. She frequently bought clothes and shoes online in large quantities. She felt a decreased need for sleep and thought about a lot of things all at once. She also bought two dogs and two cats on a whim.

In February 2020, Sophie decided to seek consult with her current psychiatrist. She wanted a female physician with whom she was more comfortable. She was prescribed lithium 450 mg/tab twice daily along with escitalopram 10 mg/tab and aripiprazole 10 mg/tab daily. After starting this regimen, Sophie's intrusive thoughts lessened and her mood gradually improved. She was able to find work as a data analyst. She did

not regularly follow up with her psychiatrist and psychologist.

In early 2021, a male co-worker sent mixed signals to Sophie about liking her became physically demonstrative. He would squeeze her arm, touch her face and her hair. Although a part of her was flattered, she was still very uncomfortable with the attention. She tried not to actively avoid him, but she preferred not to be alone with him during work. The intrusive thoughts regarding her past started coming back, but she claimed she was still able to brush them off initially.

In December 2021, Sophie ingested a significant amount of her medications. She did not disclose this to anyone and did not seek consult. Due to the unsuccessful suicidal attempt at overdosing, she started cutting herself again. She did not see any purpose in living anymore; this all started because of her past trauma coming back to her and she felt as if she could not move forward anymore. At work, she requested for a band-aid at their clinic. The nurse saw the self-inflicted wound on her left forearm and the company immediately requested that she take a leave of absence. She did not tell her family about this, and still left the house, pretending to go to work.

On December 13, 2021, Sophie took 20 tablets of lithium and 4 tablets of pramipexole. She informed her psychologist by text and explained that she just wanted to escape from life. She did not expect the message to be read immediately; and she just wanted someone to explain the circumstances to her mother and sisters. She vomited and sought consult in a tertiary hospital in Pampanga, near where she worked. She was advised admission into a psychiatric facility.

Sophie's medications were changed to quetiapine, carbamazepine and duloxetine. She was initially hesitant to explain her triggers. She frequently pulled on her hair and punched her head or stomach after waking up from a nightmare. At times, she had to be physically and chemically restrained in order to prevent further harm towards herself. She would be extremely agitated when one of the male staff would go near her. She also refused to speak to her family. Medications were revised: quetiapine was increased and brexpiprazole was started.

Two weeks into hospitalization, Sophie finally disclosed the sexual trauma and how she felt that nothing in her life was in her control. She said that she was disgusted with herself. The intrusive symptoms, avoidance, negative alterations in cognition and mood, alteration in arousal and reactivity were all present, confirming the diagnosis of Posttraumatic Stress Disorder.

The treatment plan included reducing her trauma symptoms and depression, as well as improving Sophie's coping strategies and overall functioning. Considering that she was unable to tolerate considerable discussion about the traumatic event, particularly the first one, Eye Movement Desensitization and Reprocessing (EMDR) was planned. However, in the preparation of the patient for EMDR, she was not able to establish a safe place. For her, nothing felt safe, even an imaginary one. Progressive muscle relaxation was used as an alternative albeit temporary technique to address the distress.

Eventually, Sophie decided not to proceed since she was not ready to confront her past. Principles and techniques of Dialectical Behavior Therapy (DBT) were used to help her learn understand, label, and regulate her emotions. Acceptance-based strategies such as mindfulness and radical acceptance were used to help her learn to tolerate distress and accept herself instead of engaging in self-criticism. Sophie was also encouraged to follow the safety plan created with the therapist and practice these skills during crisis situations to prevent suicide attempts and self-harming behaviors.

Concomitantly, due to poor mood regulation, carbamazepine was tapered off and lithium was resumed since clinical response to the latter was better. The dose of brexpiprazole was further increased. Eventually, Sophie's mood improved and she started to accept online visits with her mother and sister. She became hopeful and expressed that she will try again to fulfill her dream of becoming a psychologist. The intrusive thoughts still occurred but she was much more in control of them. Her improvement was steady and this led to her discharge on February 26, 2022, with a diagnosis of Complex Post-traumatic Stress Disorder, Bipolar II Mood Disorder. She maintained regular follow up with her psychiatrist and psychologist.

In March 2022, Sophie tried to apply for a masteral program in Psychology in two private schools. One school did not accept her because

the administration was aware of her psychiatric history. She never heard from the other school. Her mother observed that her mood was low. Previously, she was the one who cared for her pets; but recently, her mother shouldered the responsibility. There were no disturbances in sleep and appetite, sense of hopelessness, suicidality, fatigue or difficulty with concentration.

In the interim, Sophie applied for office work. She reapplied in her previous work but was not accepted. She was visibly saddened by this, so her mother encouraged her to go out and spend time with her cousins. Sophie maintained her psychotherapy sessions and regularly followed up with her psychiatrist. Her medications during this time were: Duloxetine 60 mg daily, Lithium Carbonate 450 mg daily, Brexpiprazole 3 mg/tab daily and Quetiapine 300 mg/tab 1 tab daily.

In September 2022, Sophie attempted to apply for the Master's Program in Psychology, majoring in Clinical Psychology in a school in Bulacan. She attended online classes every Saturday. She also applied as a call center agent in two other companies, but she was also not accepted because she disclosed that she was a student. She was still visibly happy since she got into her master's program.

In October 2022, Sophie had her first face-to-face psychotherapy session with her psychologist. After the session, she was upset and agitated. Sophie claimed that her intrusive thoughts about suicide recurred, associated with nightmares. She did not disclose what transpired during her session with her psychologist. She was depressed, with anhedonia, difficulty initiating sleep, poor appetite, difficulty in concentration, and suicidal ideations.

A week later, Sophie attempted to harm herself using a cutter. She was stopped by her mother and she was immediately rushed to the hospital. During hospitalization, she refused to join most of the occupational therapy (OT) activities, did not want to socialize with the other patients and had suicidal ideation. Frequent self-harm was noted, with hair pulling, hitting her head with her fists and punching the wall.

Electroconvulsive therapy (ECT) was recommended.

Sophie underwent six sessions of ECT, and her Beck Depression Inventory score went from severe to moderate. Subsequently, medications were adjusted and after a few weeks she was discharged improved with Lithium, Brexpiprazole, Paroxetine and Chlorpromazine.

Table 1. Timeline

2007 (7 years old)	Event: Sexual Assault Patient Status: Low mood, did not disclose to her family Intervention: None
2012 (12 years old)	Event: Sophie realized what was done to her Patient Status: Low mood, angry with herself, she sees herself as impure/disgusting, with self-harm, nightmares, avoidance behavior, quieter and more withdrawn, she still did not disclose to her family Intervention: None
2015 (15 years old)	Event: Sexual harassment from high school bully Patient Status: Ashamed, felt like a burden to her family, with nightmares, avoidance behavior, intrusive thoughts about previous assault, more distant, blank staring, did not disclose to her family Intervention: None
2017 (17 years old)	Event: Male neighbor saying sexual/intimate things Patient Status: uncomfortable, did not initiate conversation, no avoidance behavior Intervention: None Event: presence of college suitor Patient Status: afraid of being touched, felt impure Intervention: None Event: College Patient Status: unhappy with career choice, felt like she did not deserve happiness, no good future for her, poor sleep and appetite, fatigue, suicidal, self-harm, cutting, punching walls Intervention: Guidance counselor, psychologist, psychotherapy 3x/week for 3 months
2019 (19 years old)	Event: Hospitalization Patient Status: self-harm, hair pulling, hitting head with fists, intrusive thoughts Intervention: Escitalopram, aripiprazole, TMS x 20 sessions Outcome: felt better, felt numb rather than sad Event: Post discharge Patient Status: impulsive buying: clothes, shoes, 2 cats, 2 dogs; irritable; decreased need for sleep, racing thoughts
2020 (20 years old)	Event: Consulted a female psychiatrist Intervention: lithium 450 mg/tab BID, escitalopram 10 mg/tab OD, aripiprazole 10 mg/tab OD Outcome: intrusive thoughts lessened, but persisted, mood improved, Sophie was able to find work, irregular follow up with psychiatrist
2021 (21 years old)	Event: Hospitalization Patient Status: initially, Sophie did not disclose, with self-harm, agitated when male staff approached her; later, she disclosed, felt out of control, intrusion symptoms, avoidance behavior, negative alterations in cognition & mood, alteration in arousal & reactivity Intervention: quetiapine, carbamazepine, duloxetine, brexpiprazole then revised regimen from carbamazepine to lithium, brexpiprazole increased, improved coping strategies, EMDR did not push through, progressive muscle relaxation, DBT principles and techniques Revised diagnosis: Complex PTSD, Bipolar II mood disorder Outcome: improved mood, accepted family televisits, hopefulness, able to make future plans, persistent intrusive thoughts, but with better control of them
March 2022 (22 years old)	Event: Not accepted into masteral program, not accepted in her previous job Patient: low mood, stopped looking after her pets Intervention: regular psychotherapy and follow up with psychologist and psychiatrist; duloxetine 60 mg/cap OD, Lithium 450 mg/tab OD, brexpiprazole 3 mg/tab OD, quetiapine 300 mg/tab OD Outcome: eventually accepted into a masteral program in September 2022
October 2022 (22 years old)	Event: First face-to-face psychotherapy with psychologist Patient: agitated, with intrusive thoughts, suicidality recurred, depressed mood, anhedonia, poor sleep, poor appetite, poor concentration, self-harm: cutting Intervention: Hospitalized: ECT x 6 sessions, on Lithium carbonate, brexpiprazole, paroxetine, chlorpromazine Outcome: Improved

The diagnostic impression was Complex Post-traumatic Stress Disorder and Bipolar II Mood Disorder. The therapeutic interventions were combinations of pharmacologic management, psychotherapeutic strategies and somatic therapy.

DISCUSSION

Trauma is an external event that can overwhelm one's defenses, causing the traumatized person to regress to earlier, more primitive modes of functioning (1). Freud's theory of personality describes the psyche as structured into three parts, with the ego being the realistic part that mediates between the instinctual id and the superego (2). The ego typically develops between 3-5 years of age (2). The rational, realistic thinking that develops and solidifies in adulthood is possible with proper ego function, enabling the person to solve problems in a reasonable manner (2). If this function fails due to an overwhelming effect of a traumatic event, unconscious defense mechanisms are employed to help ward off unpleasant feelings or to make the situation feel better for the individual1.

The atypical upbringing of Sophie and permissive care she had may have resulted in a weak and fragile ego, not strong enough to withstand her traumatic experiences. While she found a way to deal with her reality, the immature defense mechanisms led to patterns of behavior and thinking that promoted the development and reinforcement of learned helplessness. Pathologic and immature defenses were employed which permitted Sophie to rearrange her external experiences so that she does not have to deal with her reality. She was faced with memories that were too distressing to her, and she developed denial in order to reject that reality. She repressed her trauma for so long, to cope with her life, reshaping her own external reality to meet her internal needs. This led to a life of misery filled with persistent need to escape from her situation, one in which suicide was seen as the only way out.

There are cognitive vulnerabilities that predispose an individual to the syndrome of PTSD. This would partially explain why there are select individuals exposed to trauma who develop this condition. Elwood et al defined these as rumination, attributional style, anxiety sensitivity and looming maladaptive style (3).

Notably, Sophie possesses all these vulnerabilities. She kept telling herself that she will never improve and that she will be depressed her whole life. She overgeneralized that men are all the same, and are out to harm her. She blamed herself for her situation, even if she knew she had no control over it. In turn, she deemed herself hopeless and unlovable. She often acted out her impulses, like repeatedly hitting her head, in order to drive out her intrusive thoughts. She frequently resorted to suicidal attempts in order to escape her reality, without thinking of the consequences of her actions, and without ever finding another way out. What is very evident in the case of Sophie is the development of cognitive distortions. There is no sense of control over external events and this was repeatedly triggered by situations that somehow reminded her of the past. This lack of control over life events and the learned helplessness made the PTSD persistent and recalcitrant to treatment.

The past traumatic events in Sophie's life were deeply ingrained in her thoughts, much as how the learning theory proposed. The Pavlovian fear conditioning makes the person live with irrational fear which becomes generalized (4). After a trauma, normal extinction of the fear memories occurs and there is good discrimination of what is fearful or not (4,5). The process of extinction is not evident with Sophie and the generalized fear was further consolidated with the recurrent traumatic events in early life. The successive traumatic events made her feel helpless, a recurrent reaction reactivated by reminders of the past. There are underlying changes in the brain that cause such dysfunctional response. The prefrontal cortex, hippocampus and amygdala are consistently implicated. The amygdala mediates conditioned fear and associative emotional learning (4, 5). In this condition, the reduced activity of the prefrontal cortex and hippocampus leads to their impaired top-down control on the amygdala, leading to the hyperresponsiveness of the latter (4). The reduction in hippocampal volume and activity alters stress responses and extinction (6). The HPA axis is also involved. The abnormal activation of the CRH seen in PTSD results in over-consolidation of fear memories and hinders fear memory extinction, evoking conditioned responses to trauma-related stimuli (7). Additionally, it contributes to the excitability of the basolateral amygdala (7).

The complex interaction of all the factors contributing to the emergence of PTSD in Sophie is clearly seen in the diathesis-stress model (8) .The premorbid risk factors, situational stressors, physiologic changes and cognitive distortions are evident in Sophie. The severity of the trauma is a strong predictor of the development of PTSD. Sophie's experience of the first traumatic event was enough to trigger the cascade of changes that led to her condition. She was very vulnerable at a very young age when this happened and it was allegedly committed by a person she trusted, with other trusted relatives passively looking on. This event was the critical catalyst in the development of PTSD in Sophie's case. The other traumatic events further solidified her pathologic state.

Neurochemical changes in the brain among patients with PTSD include increase in levels of dopamine and norepinephrine and decreased concentration of serotonin (9). The heightened activity of catecholamines cause the arousal and startle response, with promotion of encoding of fear memories (9). Alteration in serotonergic activity likewise promotes pathologic manifestations, such as vigilance, startle, impulsivity and intrusive memories (9). This also increases symptoms of anxiety. Pharmacologic treatment of PTSD is anchored on neurotransmitter changes.

A recent publication in the Cochrane database of systematic reviews revealed that SSRIs are first line agents in the treatment of PTSD (10). Among the SSRIs fluoxetine, paroxetine and sertraline are strongly recommended (11). Paroxetine and sertraline have received FDA approval for the treatment of PTSD (7). Additional pharmacologic agents may be needed to address the intensity of symptoms in this condition. The hyperdopaminergic state can be ameliorated with the use of antipsychotic agents. Brexpiprazole is a serotonin dopamine activity modulator, being a partial agonist in both D2 and D3 receptors and a 5HT1A agonist (12). In an animal study, it was able to promote normal fear memory instead of PTSD-like memory (13). It also improved patients in published case studies with complex PTSD who were not responding to treatment (14). Studies are necessary to further support the use of Brexpiprazole as an adjunctive treatment in PTSD. With Sophie, however, Brexpiprazole produced a significantly positive effect. Sophie had prominent intrusive thoughts, cognitive distortions and impulsive behavior. Psychotherapy cannot be fully applied due to her reaction whenever the session was carried out. It was when Brexpiprazole was introduced that these symptoms became controlled. This is likely due to Brexpiprazole's effect on amygdala's activity, reducing the conditioned-fear response (7).

Psychotherapy remains an integral component in the treatment of PTSD. The result of a network meta-analysis (15) emphasized that the long-term benefits of psychotherapeutic and combined treatment with medications were superior to just pharmacologic management. A review of current guidelines in the treatment of PTSD revealed Cognitive Behavioral Therapy (CBT) as the first-line psychological treatment for PTSD (11). Eye Movement Desensitization and Reprocessing or EMDR is a trauma-focused psychotherapy that is very effective in PTSD and is recommended together with CBT11. Sophie was not able to tolerate discussions that trigger traumatic memories so that EMDR was attempted. The latter intervention seemed to be a good alternative since this would not require extensive discussions (16) about Sophie's past. However, the establishment of the safe place which is necessary during the preparation of the patient (16) cannot be achieved.

Electroconvulsive therapy can benefit patients with severe, treatment-refractory PTSD especially if depression is concomitantly present (17,18). This somatic treatment was resorted to due to the strong suicidal behavior of Sophie, persistent symptoms despite pharmacologic management and difficulty in applying psychologic therapies. The intervention adequately controlled Sophie's symptoms.

This case highlights the intense effect of childhood trauma, reinforced by subsequent traumatic events that influenced treatment outcome. It is important to optimize therapeutic management with the use of pharmacologic agents, psychotherapy and somatic therapies. Equal consideration should also be given on comorbid conditions which can make management challenging.

REFERENCES

1. Boland R, Verduin M, Ruiz P, Shah A, Sadock B. Kaplan and Sadock's Synopsis of Psychiatry. 12th ed. Wolters Kluwer; 2022. p 1396-1397.
2. Chertoff J. Psychodynamic assessment and treatment of traumatized patients. The Journal of Psychotherapy Practice and Research. 1998;7(1): 35.
3. Elwood LS, Hahn KS, Olatunji BO, Williams NL. Cognitive vulnerabilities to the development of PTSD: a review of four vulnerabilities and the proposal of an integrative vulnerability model. Clinical Psychology Review 2009; 29(1): 87–100. https://doi.org/10.1016/j.cpr.2008.10.002
4. Mahan AL, Ressler KJ. Fear conditioning, synaptic plasticity and the amygdala: implications for posttraumatic stress disorder. Trends in neurosciences 2012; 35(1):24–35. https://doi.org/10.1016/j.tins.2011.06.007
5. Norrholm SD, Jovanovic T. Fear processing, psychophysiology, and PTSD. Harvard Review of Psychiatry 2018; 26(3):129–141. https://doi.org/10.1097/HRP.0000000000000189
6. Bremner JD. Traumatic stress: effects on the brain. Dialogues in Clinical Neuroscience 2006; 8(4): 445–461. https://doi.org/10.31887/DCNS.2006.8.4/jbremner
7. Malikowska-Racia N, Salat K. Recent advances in the neurobiology of posttraumatic stress disorder: A review of possible mechanisms underlying an effective pharmacotherapy. Pharmacological Research 2019;142: 30–49. https://doi.org/10.1016/j.phrs.2019.02.001
8. McKeever VM, Huff ME. A diathesis-stress model of posttraumatic stress disorder: Ecological, biological, and residual stress pathways. Review of General Psychology 2003;7(3): 237–250. https://doi.org/10.1037/1089-2680.7.3.237
9. Sherin JE, Nemeroff C.B. Post-traumatic stress disorder: the neurobiological impact of psychological trauma, Dialogues in Clinical Neuroscience 2011;13(3): 263-278, DOI: 10.31887/DCNS.2011.13.2/jsherin. PMID: 22034143; PMCID: PMC3182008.
10. Williams T, Phillips NJ, Stein DJ, Ipser JC. Pharmacotherapy for post traumatic stress disorder (PTSD). The Cochrane database of systematic reviews. 2022; 3(3):CD002795. John Wiley & Sons, Ltd. Available from: https://doi.org/10.1002/14651858.CD002795.pub3
11. Ehret M. Treatment of posttraumatic stress disorder: Focus on pharmacotherapy. Mental Health Clinician. 2019; 9:373-82. [PMID: 31857933 DOI: 10.9740/mhc.2019.11.373]
12. Diefenderfer LA, Iuppa C. Brexpiprazole: A review of a new treatment option for schizophrenia and major depressive disorder. The Mental Health Clinician. 2018;7(5):207-212. doi: 10.9740/mhc.2017.09.207. PMID: 29955525; PMCID: PMC6007711
13. Ducourneau, EG, Guette C, Perrot D, Mondesir M, Mombereau C, Arnt J, Desmedt A, Piazza PV. Brexpiprazole blocks post-traumatic stress disorder-like memory while promoting normal fear memory. Molecular Psychiatry. 2021;26(7):3018–3033. Available from:https://doi.org/10.1038/s41380-020-0852-z
14. O'Connor M. Adjunctive therapy with brexpiprazole improves treatment resistant complex post traumatic stress disorder in domestic family violence victims. Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrist. 2020; 28(3): 264–266. https://doi.org/10.1177/1039856219889303
15. Merz J, Schwarzer G, Gerger H. Comparative Efficacy and Acceptability of Pharmacological, Psychotherapeutic, and Combination Treatments in Adults With Posttraumatic Stress Disorder: A Network Meta-analysis. JAMA Psychiatry. 2019;76(9):904–913. Available from: https://doi.org/10.1001/jamapsychiatry.2019.0951
16. Shapiro F, Maxfield L. Eye Movement Desensitization and Reprocessing (EMDR): information processing in the treatment of trauma. Journal of clinical psychology. 2002; 58(8): 933–946. https://doi.org/10.1002/jclp.10068
17. Margoob MA, Ali Z, Andrade C. Efficacy of ECT in chronic, severe, antidepressant- and CBT-refractory PTSD: an open, prospective study. Brain Stimulation. 2010 Jan; 3(1):28–35. doi: 10.1016/j.brs.2009.04.005. Epub 2009 May 27. PMID: 20633428.
18. Youssef NA, McCall WV, Andrade C. The role of ECT in posttraumatic stress disorder: a systematic review. Annals of Clinical Psychiatry. 2017 Feb; 29 (1):62–70. PMID: 28207917

SEEKING SAFETY IN THE MIDST OF A SCREAMING SILENCE

ANDREA NICHOLE D. BAUTISTA, MD

The silence was slowly killing her.

And that's all there ever was. Silence. It was all she knew. Keep quiet. Pretend nothing had happened, that nothing was wrong. Abuse is a parasite that feeds off hate and shame, growing in size and strength with silence.

Throughout her life, she experienced different scenarios of sexual trauma, and these are represented by the multiple pairs of hands touching her and hovering in the background. A hand covers her eyes, implying that she turn a blind eye to it all. A hand covers her mouth to her keep quiet. A pair of hands restrains her, telling her that she has no control over these events.

Trauma wounds are invisible. All we see are her steady flow of tears. We cannot see visible bruises, cuts, or scars. Yet, if we don’t tend to them, we can carry them throughout our lives. We may relive our trauma over and over, again.

But no matter how much evil we see, it is important for everyone to understand that there is much more light than darkness. We see the uncovered eye looking up towards the light. This symbolizes hope, that help is available to victims of trauma. All she has to do is look up, and know that help is there, that we are there for her and the other victims.