PJP

CASE REPORT

THE SILENCED VICTIM: INTO THE NEUROLOGICAL INTRICACIES OF COMPLEX TRAUMA (BORDERLINE PERSONALITY DISORDER & COMPLEX POST-TRAUMATIC STRESS DISORDER)

MARIA LOURDES ROSANNA E. DE GUZMAN, MD, MS EPI, FPPA
TYRONE PAUL CAMMAYO, MD
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL MEDICINE
PHILIPPINE GENERAL HOSPITAL

This case is noteworthy and the problem that it addresses will definitely be of interest to all, given that this is frequently encountered not only in the clinics, but in social media, on-line platforms, in community and disaster work, and within the confines of the homes given the stigma of borderline personality disorder (BPD) and the lack of understanding of Post-Traumatic Stress Disorder (PTSD) and Complex Post-Traumatic Stress Disorder (cPTSD).

The objective of this case presentation is to look into the challenges that a mental health professional has to face when presented with a case of a patient with a chronic of history of sexual abuse, BPD and PTSD/cPTSD. First of all, given the case presentation, there is a need to determine the diagnosis and to work through the intricacies of symptomatology to be able to distinguish BPD, PTSD or CPTSD with a thorough discussion. Secondly, to present the neurobiology of early trauma and its impact on the developing brain, which often lead to adult symptomatology. Finally, to provide recommendations for treatment, both medical and psychological treatments, in order to find out what best fits the patient.

CASE PRESENTATION

Clara is a 20- year- old single mother, Methodist Christian from Malabon City. She recently returned to school as senior high school student last August. She was first seen on screening in the in-patient clinic on February until June 2021. Her chief complaint was: “I have been Doing self-harm. I want to understand myself better.”

At the age of 8, Clara was sexually abused by her godfather. Clara saw him as a father figure and felt that he was more affectionate to her than own father. She was confused about their sexual acts (fingering and penal insertion) but she was reassured that they were just playing games, which she learned to enjoy.

At times, Clara complained of vaginal pain to her mother, who would dismiss it as urinary tract infection. Whenever she experienced vaginal pain, she would refuse her godfather’s advances. Eventually she would have to give in because he would threaten her that he would stuff her inside a drum or shame her in church. She began to feel afraid and unsafe because he warned her that if she reported him, her mother would disown her. She regained her sense of safety when her mother was around, who was her refuge from the abuses of her godfather.

The sexual abuses happened almost weekly until Clara was about 10 years old. She vacillated between feelings of guilt (blaming herself for the

abuse) and pleasure. The sexual abuses ended when her godfather disappeared for reasons that was unknown to her. Somehow, she longed for his attention when he was gone. She remembered how he cared for her, giving her advices on school matters and how to behave properly, all the attention she needed that her parents were never able to give to her.

By the age of 12 years, while in school, Clara would allow two of her male classmates to fondle her genitalia. This happened about seven times within a few weeks, since it reminded her of the sexual games she played with her godfather. She could not confide to her parents for fear that they would only criticize her as they often did. She felt alone and distrustful of people in school. She thought that anyone who tried to befriend her would only take advantage of her.

Clara had also experienced sexual abuses on several occasions from her paternal uncle. When she tried telling her parents about it, they dismissed her complaints believing that she was just making up stories since her uncle had denied the accusations. She felt resentful and helpless, which led to her having suicidal ideations. To avoid the ire of her parents, she studied hard to garner academic honors, as a way of yearning for her parents' attention and love. Despite her efforts, she felt that her parents did not really care because of their own marital problems, often fighting about financial problems and her father's drinking problem. This lack of affirmation from her parents made her feel unappreciated, unloved, and inadequate.

A year after, Clara discovered that cutting her wrists lightened her feelings of resentment and helplessness. She lost her motivation to excel in school by skipping classes and neglecting her studies. She believed that cutting her wrists became an act of punishment, blaming herself for her parents' frequent marital arguments. Eventually, her parents separated when she was 15 years old. She was quite ambivalent about their separation, as much as she longed for her father's love, she felt relieved that he had left her mother for them to stop fighting. Clara frequently got into arguments with her own mother, Almira, when she could not provide for her needs.

It was at a church camp, when Clara met Erris, who became her boyfriend. Erris showered her the attention she was looking for. His presence would calm her down and reduce the episodes of self-harm, feeling relieve from her sense of helplessness and frustrations. Wanting to feel loved, she had started to engage in casual, unprotected sex with Erris. At the age of 16, Clara got pregnant and gave birth to a baby boy. Feeling a mixture of emotions, she was anxious because she believed that she was incapable of providing and caring for her child and worried that her parents would be disappointed at her since her pregnancy would disrupt her studies. Eventually, taking care of her son was physically and emotionally draining for her. Her mother would often criticize her and scold her for not taking good care of her son. She eventually broke up with her live-in partner, Erris, because he was remiss of his responsibilities as a father and husband. These intensified Clara's feeling of inadequacy, leaving her constantly depressed, isolated and unmotivated.

Left on her own, she started to experience nightmares, with intrusive memories of her early childhood sexual abuse at 8 years old by her godfather. She noted occasional hypervigilance especially when experiencing intense emotions of anger and sadness. At 19 years old and looking back at her past life, Clara perceived herself as "broken and vulnerable," and she tried coping by turning to smoking cigarettes and drinking alcohol. Unable to feel good about herself and confused about what she wanted for herself, she looked for friends through social media in order to ease her boredom. She persistently sought to make friends on social media, finding comfort and validation from men she met online and at times meeting up with men to have casual sex. While these activities gave Clara momentary gratification, her depressed mood persisted, with feelings of self-blame and hopelessness. Clara consistently turned to self-harm as the best method of relieving her overwhelming emotions of helplessness, pain sadness, and emptiness. Her mother eventually discovered Clara's self-harming behavior, which prompted consult at UP-PGH.

The primary working impression for Clara were the following:

•Persistent Depressive Disorder, early onset, with persistent major depressive episode
•Borderline personality disorder

The following are the V codes:
•Personal history of sexual abuse in childhood
•Parent-Child Relational Problem
•Child Affected by Parental Relationship Distress
•Personal history of self-harm

CASE DISCUSSION

This is a case of Clara who had suffered childhood sexual abuse that was fueled by a culture of a dysfunctional family environment i.e. marital discord of her parents and the chronic alcoholism of her own father, and the silence and neglect by her own parents, particularly her mother who was very critical of her. All were significant risks factors in developing mental health problems in children, which can extend to adulthood. This silence remains one of the biggest enablers for the many wrongdoings that impact children (Bandelow B. et al, 2005) (1).

Added to the fact that Clara did not have the adequate support systems to develop good coping strategies. Having developed borderline personality disorder, she manifested with serious problems of pervasive instability in many areas of functioning that included managing her emotions, controlling her behavior, relating to others and building a sense of self. She eventually became more prone to developing Persistent Depression given her feelings of worthlessness, hopelessness and thinking herself as unlovable to the point that she hated herself.

The main objectives of this case discussion is to apply the Biopsychosocial Paradigm in the treatment and management of childhood sexual abuse, BPD, PTSD and cPTSD. Given the presenting symptomatology of the patient, the psychiatric diagnosis will be discussed to determine if this is a case of BPD, PTSD or CPTSD. Present updates on the understanding the similarities, differences and treatment between the diagnostic entities: BPD, PTSD and cPTSD will be presented. This will be followed by the presentation of a psychodynamic formulation and supported by an understanding of the neurobiology of trauma. Finally, evidence-based pharmacological treatment and the different psychosocial interventions for BPD and PTSD/cPTSD will be presented.

This is often a dilemma of what one uncovers in one's own clinical practice, that besides the presenting clinical psychopathology of BPD, one suspects the presence of PTSD due to the exposure to childhood sexual abuse, associated with self-harm behavior, and depression, all of which may complicate the clinical picture. A good clinical history will be the basis of the diagnosis, which will be an important guide for management. It is necessary to understand what the patient is going through and to guide the patient towards a pathway of getting better.

Can complex trauma cause BPD? Prolonged and repeated traumas, particularly in early life, promote a chronic inability to modulate emotions, that can result in behavioral patterns characteristic of BPD, such as disturbed relationships, substance abuse, and self-injuries behaviors, in which precocious traumatic events are re-enacted over time.

No matter what the developmental stage of a child, the periods of neglect, psychological and sexual abuse had definitely made an impact on Claire's character and personality development. The anxiety and post-traumatic stress among children is expressed by developmental regression, aggression and distress. Growing up, Clara started to avoid social situations that were distressing or would shut down emotionally, and eventually started to engage in self-harm as a way of coping with stress.

The most common form of childhood trauma reported by people with Borderline Personality Disorder (BPD) were the ff: physical neglect (48.9%), followed by emotional abuse (42.5%), physical abuse (36.4%), sexual abuse (32.1%) and emotional neglect (25.3%). (Cattane N. et al, 2017) (2). In Clara's case, Childhood Sexual Abuse (CSA) is a risk factor for most psychiatric disorders, it is damaging to the person's psyche.Childhood abuse and neglect increases the risk for personality disorders in early adulthood fourfold. The risk is highest for cluster B personality disorders: Histrionic, Narcissistic, Borderline and Anti-social Disorders. And when other PD symptoms have been accounted for, sexual abuse is associated with increase BPD symptoms.

The effects of childhood trauma (both

childhood sexual abuse and neglect) can last well into adulthood affecting their future relationships. Childhood abuse and neglect interferes with personality development and increases risk for personality problems in general. BPD being a more severe type of PD may also be associated with other psychiatric disorders. Often these lead to other issues like depression and low self-esteem. CSA and neglect are cause psychiatric disorders in many cases but it is important to remember that trauma is neither necessary nor sufficient to lead to the development of BPD. There is some genetic and environmental contribution, including trauma that contributes to the risk for developing BPD. But, not all BPDs have experienced trauma. Many families have done the best they can to help them grow up in healthy ways, and that the BPD may be anchored on may other things aside from trauma and parenting.

Are there other diagnoses being missed out in Clara's case? What will explain the presence of nightmares and occasional hypervigilance, especially when experiencing intense emotions of anger and sadness? More importantly her impaired relationships with others, transient, stress related paranoid ideation and self-harm behavior? Besides BPD, does Clara have Post-traumatic stress disorder (PTSD)? If this were PTSD what kind? PTSD or complex Post-Traumatic Stress Disorder (cPTSD)? Can Clara have BPD and cPTSD? Can cPTSD be misdiagnosed as BPD?

Some of the symptoms of complex PTSD are very similar to those of borderline personality disorder (BPD), and not all professionals are aware of cPTSD. As a result, some people are given a diagnosis of BPD or another personality disorder when cPTSD fits their experiences more closely. The cPTSD can cause similar symptoms to PTSD and may not develop until years after the event. It's often more severe if the trauma was experienced early in life, as this can affect a child's development. As it may take years for the symptoms of complex PTSD to be recognized, a child's development, including their behavior and self-confidence, can be altered as they get older.

The cPTSD may be diagnosed in adults or children who have repeatedly experienced traumatic events, such as violence, neglect or abuse. In Clara's childhood she had suffered a severe form cPTSD given the following traumatic events early in life:
1) having witnessed domestic violence due her parents' marital conflicts, poor parenting skills, parental disbelief and lack of emotional support, even blaming her for causing trouble to the family; 2)the "sexual games with her godfather, at 8 years old,a paternal uncle who sexually abused her at 12 years old , sexual harassment by her male classmates and "her flings" who would took advantage of her; and 3) emotional neglect, negative criticisms of her mother, and the separation of her parents, for which she blamed herself had deepened her sense of rejection, isolation, unworthiness and inadequacy that led her to self-harm herself as a means of coping as a cry for help. Self -harm was Clara's way of coping with the overwhelming and distressing thoughts and feelings of abandonment and rejection. It gave her temporary relief from the emotional pain she was feeling. Soon after, feelings of guilt and shame followed, which then made her hurt herself again. Eventually it became her normal way of dealing with life's difficulties.

The diagnostic criteria for BPD and PTSD are found in the DSM-5 TR 3, while BPD, PTSD and cPTSD diagnostic criteria are found in ICD 113 . Why is cPTSD not in the DSM? The cPTSD did not make it to the different DSM criteria since there was still a need to clarify the validity of the diagnosis i.e. Complex PTSD/DESNOS was not added as a separate diagnosis to DSM-5 because results from the DSM-IV Field Trials indicated that 92% of individuals with complex PTSD/DESNOS also met diagnostic criteria for PTSD.

On the other hand, in 2020, the WHO's International Classification of Diseases, 11th Edition (ICD11) (4), introduced cPTSD as a new diagnostic category. It included two distinct sibling conditions, post-traumatic stress disorder (PTSD) (code 6B40) and complex PTSD (CPTSD) (code 6B41), under a general parent category of 'Disorders specifically associated with stress (4).

The key difference between BPD and cPTSD is that symptoms of BPD stem from an inconsistent self-concept and cPTSD symptoms are provoked by external triggers. A person with

cPTSD may react to or avoid potential triggers with behaviors similar to those that are symptomatic of BPD. Sufferers of cPTSD tend to have a stronger sense of self than those with BPD, but they struggle with intense feelings of being "damaged," which is common among shame-based mental disorders. On the other hand, one can have a dual diagnosis of cPTSD and BPD. Consistent with this analysis, person-centered research studies have provided evidence that BPD and cPTSD constitute somewhat distinct but often overlapping symptom profiles that also often overlap with PTSD symptoms.

A good psychiatric clinical history is important since many different forms of mental illness share similar symptoms. One example of this is borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD). A person with symptoms of either disorder may be misdiagnosed with the other, and it's also possible to have both at the same time. Not that BPD is worse than PTSD, but when someone has both conditions, the symptoms tend to be worse than if they had BPD or PTSD alone. PTSD can increase the likelihood of dissociative, intrusive and suicidal thoughts in people with BPD; thus, the need to arrive at the correct diagnosis.

The criteria for PTSD include, first, direct or indirect exposure to a traumatic event, followed by symptoms in four categories: intrusion, avoidance, negative changes in thoughts and mood, and changes in arousal and reactivity. The criteria also state that the symptoms must last for at least a month, cause considerable distress and/or interfere with life, and not be caused by another medical condition or by substance use. Common symptoms pf PTSD include: intrusive thoughts, flashbacks, and/or dreams of the traumatic event; physical reactions when reminded of the event; avoidance of people, places, situations, etc., that elicit memories of the event; pervasive negative emotional state, such as shame, anger, or fear; hypervigilance; irritability; impulsive behavior; and difficulty sleeping. Symptoms of PTSD can vary in severity and not everyone with PTSD will have the same symptoms.

On the other hand, complex post-traumatic stress disorder (complex PTSD or cPTSD) refers to PTSD resulting from prolonged, repeated trauma—usually, childhood trauma, especially early onset(< 12 years of age). It is a serious mental health condition that can take some time to treat, and for many people, it's a lifelong condition (5). Complex PTSD has the same symptoms as PTSD, along with additional symptoms including: difficulty controlling emotions; negative self-view; difficulty with relationships; detachment from the trauma; and loss of a system of meanings (5).

Similarities, differences and treatment between the two diagnostic entities: BPD and cPTSD

There is a divide between BPD and PTSD. Eventually, it has come to the reconciliation that a lot of people who have BPD have PTSD and those who have PTSD have BPD. There is something that is not captured by the DSM V diagnostic system that has to do with people who have suffered chronic child abuse to develop cPTSD in the ICD. The comparison of BPD, PTSD and cPTSD in the DSM V/ ICD-11 are presented in Table 16. (Ford JD et al, 2014)

The major domains for PTSD are distinct symptoms, a distinct experience that is a result of a traumatic experience such as a life-threatening experience e.g. re-experiencing (flashbacks or nightmares); avoidance (numbing/ dissociation); and sense of threat (hypervigilance). For BPD, the most common symptoms that are the main reasons why patients seek acute treatment include the following: suicidal behavior, gestures or threats and deliberate self-harm, which is a response to emotional dysregulation, feeling out of control, or having either life or interpersonal stressors. These could also be frantic efforts to avoid abandonment and due to shifting self-identity.

In personality disorders such as BPD, there are two main areas of disturbances i.e. in relationship functioning and in the sense of self. In the area of relationship functioning, those with BPD have the following problems: very unstable relationships (oscillate between thinking of people as all good or all bad; idealizing or devaluing them); and also, frantic kind of avoiding abandonment, "intolerance of loneliness" (7).

In addition, there is the problem of the sense of

self i.e. people who feel out of control all the time, vacillate with their relationships, get confused about themselves e.g. who they are, what they want, what they are doing, and have a lot of problems regarding their identity. Those with BPD, do not have a stable sense of self - personality or identity - so they have difficulty in reliably navigating the world; they cannot project in terms of what will happen to them, so there is a great degree of mistrust with themselves and towards others.

Overlapping and closer to PTSD, are the problems with emotional dysregulation or imbalance, feeling badly about themselves and the others is also present in BPD. Shifting to more clinical features, Figure 1 presents a diagram of the overlap between PTSD, cPTSD, BPD and MDD (8).

There are lot of different features that belong to others and not to some while other clinical features overlap. The cPTSD have some symptoms of PTS, BPD and MDD, DESNOS. There are some symptoms that are related to PTSD such as increased vulnerability to depression while some are similar to BPD: identity disturbance, interpersonal and impulsivity. There is an overlap, which are reactions to severe stress - fatigue, sleep disturbance, affective instability. They are shared, not in one domain over the other.

According to Choi-Kain, director of the Gunderson Personality Disorders Institute, there are symptoms that are related to PTSD, MDD and BPD as reactions to severe stress. For example, one experiences irritability, aggression, risky or destructive behavior, with depressed,

Table 1. Comparison of PTSD, cPTSD and BPD based on DSM 5 / ICD-11

PTSD	cPTSD	BPD
Re-experiencing (flashbacks/nightmares)	Self-harm	Suicidal behavior, gestures or threats
Avoidance of memories (numbing/dissociation)	Unstable sense of self	Frantic efforts to avoid abandonment
Sense of Threat – symptoms related to sense of danger everywhere – maintain that (hypervigilance/startle)	Emotional regulation difficulties (anger/mood shifts/ impulsivity)	Shifting self-identity
	Interpersonal problems cPTSD: disconnected/ lack of closeness BPD: intense and unstable	
	Negative self-concept (worthless/guilt)	

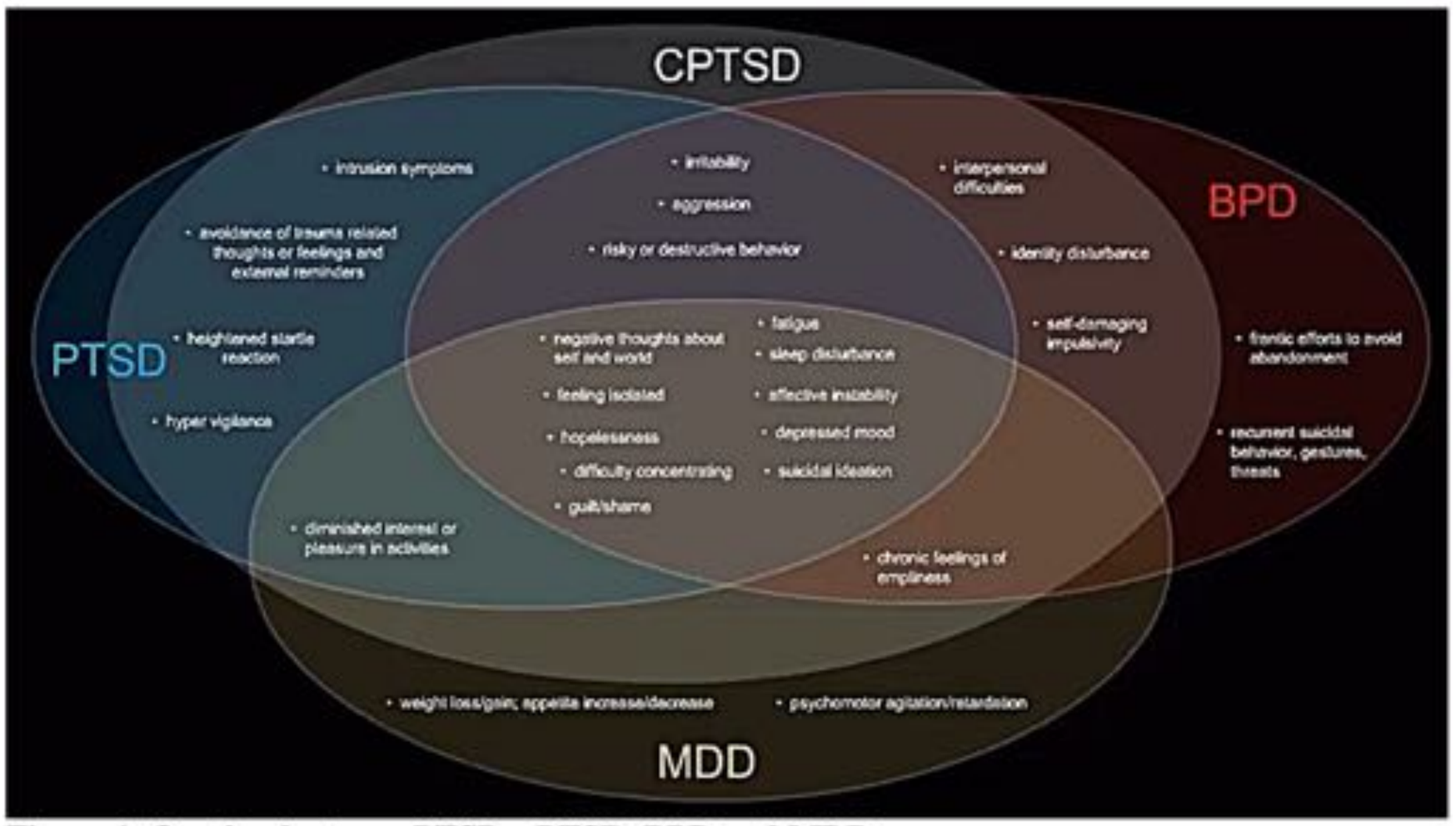

Figure 1. Overlap between PTSD, cPTSD, BPD and MDD.

with some suicidal ideation, not necessarily being suicidal (9).

Upon review, the diagnosis of cPTSD is able to encompass almost all of them. Not to undermine the fact that people really suffer from them, but they suffer from a cluster of different outcomes that are related to being chronically traumatized and how much it interferes in their personality development and their capacity to endure life stress, which leads to a vulnerability for developing MDD. The question is whether it is useful to diagnose cPTSD or more useful to diagnose the 3 disorders; MDD, PTSD and BPD that exist.

Is cPTSD an amalgam of BPD and PTSD? Is BPD with comorbid PTSD distinguishable from cPTSD? There is evidence that they are three distinct entities: cPTSD, BPD and PTSD are valid independent constructs, valid entities that overlap or exist to some degree in patients (5).. (

Four types:

1.Low symptom type: decrease all symptoms - people with Child Sexual Abuse (CSA) have factors in their life situation or in their biological endowment that help them no to develop symptoms even if they have had a history of CSA
2.PTSD type: increase PTSD symptoms, decrease cPTSD symptoms and BPD
3.cPTSD type: increase PTSD & cPTSD, decrease BPD
4.BPD type: increase BPD

There are four symptoms for clinicians that increase the odds of being BPD type vs cPTSD type: frantic efforts to avoid abandonment; unstable sense of self; unstable and intense interpersonal relationships; and impulsiveness. A lot of disorders have emotional dysregulation and unstable sense of self including BPD, but interpersonal relationship functioning is the distinguishing factor in BPD, that differentiates from the others. BPD have a lot of personality problems in the thinking and emotionally. What symptom particularly rates high in PTSD and cPTSD is the feeling of emptiness.

The Neurobiology of PTSD
Research shows that people with borderline personality disorder may have structural and functional changes in the brain, especially in areas that control impulses and emotion regulation. The most impaired brain structures in PTSD are the prefrontal cortex, amygdala, hippocampus, locus coeruleus, periaqueductal gray, and the HPA axis: hypothalamus & pituitary gland.

According to Alexander (2012) (10), the neurobiology of trauma i.e. the effects of trauma on the brain--is important to understand because it helps break down common misconceptions and victim-blaming about gender-based violence and it helps survivors to understand their experience and the aftermath in a new way.

The stress-response system called the hypothalamus-pituitary-adrenal (HPA) axis is initiated by an actual or perceived threat. The amygdala, as the first responder, receives information from the thalamus, (gatekeeper of incoming sensory information) which is rapidly screened for danger, with the potential of activating the pituitary (gland that releases hormones). The hippocampal memory system assists in this assessment by providing the amygdala with information from its database of past threats. In tandem with the prefrontal cortex (PFC), (critical for emotional regulation and decision-making), the hippocampi (memory storage structures) are also essential in deactivating the HPA axis when threat subsides10.

Once the amygdala sounds the alarm, the HPA axis releases a cascade of chemicals and hormones, mobilizing the individual to survive the threat by fighting or fleeing. When mobilizing is not possible, then survival through immobilizing kicks on, significantly slowing the individual's life sustaining systems e.g. heart rate, breathing. These reactions are immediate, bypassing any thoughtful decision-making. Typically, when the real or perceived danger passes, the HPA axis returns to its pre-threat status10.

However, when trauma is ongoing, such as chronic abuse or neglect in childhood, the HPA axis continues to flood the body with the stress hormone cortisol from the adrenal glands (producer of several key hormones). This over-production creates a state of toxic stress within the body that changes the physical structure and

function of the amygdala, hippocampi and Pre - Frontal Cortex (PFC). Although the brain's intention is to promote a higher possibility of survival through a state of constant vigilance, other capacities are compromised, such as thinking clearly and managing feelings.

The high levels of cortisol, and inability to emotionally regulate heighten the probability of the youth engaging in risky behaviors and of the onset of physical health issues. Youth who have experienced childhood adversity, or have current toxic stress, are often stuck in fight or flight mode, feeling jumpy, anxious, or hyper-vigilant; some can be stuck in shutdown, feeling disconnected, foggy, numb, or unfocused. These feelings, the behaviors that coincide, and the reactions of others are confusing and disrupt functioning in daily activities and relationships.

The hypothalamic-pituitary-adrenal (HPA) axis is commonly studied in BPD for its role in coordinating the body's physiological response to stress. Many individuals with BPD exhibit stress-related paranoid ideation or dissociative symptoms, and dysfunctions in the HPA axis are associated with mental disorders that frequently co-occur with BPD, e.g. MDD and PTSD (10).

Treatment Options and Recovery

Arriving at the correct diagnosis is important as a guide in properly managing cases such as Clara with the goal of improving her functioning both in terms of work as well as social relationships.

A combination of therapy and medication can help manage her symptoms and significantly improve her quality of life. According to Judith Lewis Herman11,from her book, Trauma and Recovery, "recovery can only take place within the context of relationships; it cannot occur in isolation". The book is about "restoring connections" between individuals and communities and reconstructing history in the face of a public discourse that did not want to address the horrors of sexual and domestic violence.

According to Herman, recovery is trying to find new ways to cope. The Recovery process Phase may be conceptualized in three stages: establishing safety, retelling the story of the traumatic event, and reconnecting with others. Treatment of posttraumatic disorders must be appropriate to the survivor's stage of recovery (11).

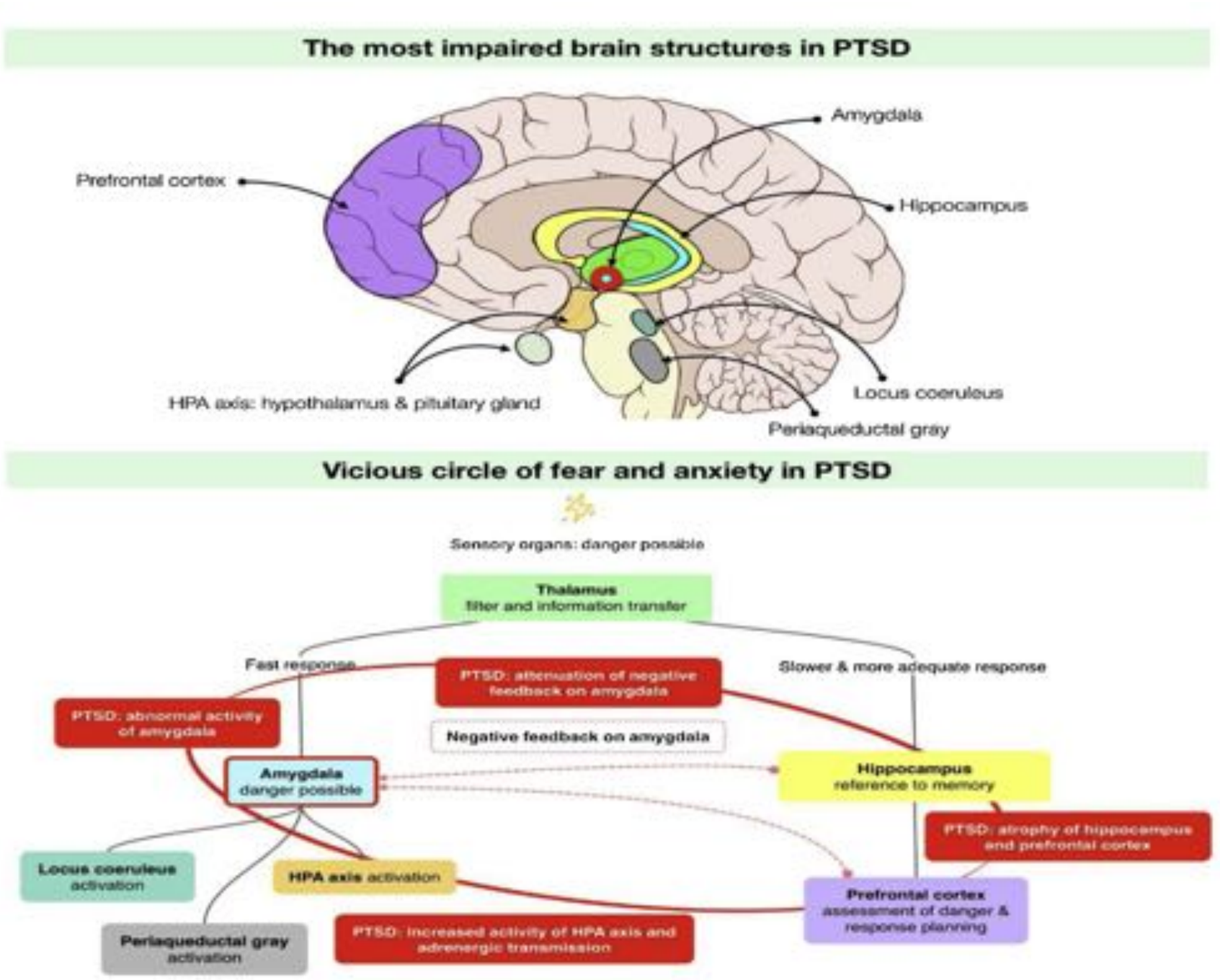

Figure 2. The Neurobiology of PTSD

Role of SSRIs

SSRIs affect the neurotransmitter serotonin primarily, which is important in regulating mood, anxiety, appetite, sleep, and other bodily functions. Although SSRIs are associated with an overall response rate of approximately 60% in patients with PTSD, only 20% to 30% of patients achieve complete remission (8).

SSRIs (selective serotonin reuptake inhibitors) and SNRIs (serotonin-norepinephrine reuptake inhibitors) are types of antidepressant medication. While no single pharmacological agent has emerged as the best treatment for PTSD, research and testimonials strongly recommend serotonin reuptake inhibitors (SRIs).

The FDA has only approved two SSRIs for the treatment of PTSD: sertraline and paroxetine. There are four SSRIs/SNRIs that are recommended for PTSD: sertraline; paroxetine; fluoxetine; and venlafaxine (7). The PTSD recommended and contraindicated treatment according to Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder 2017 (12) suggests that both traditional and rapid-acting antidepressant medications induce a biochemical fingerprint of resilience in brain regions associated with the regulation of emotion. Reality is the anchor. The goal of treatment is to help patients to survive their memories and see their memories as past and not live their memories in the present. It is important to get them beyond the nightmares and flashbacks and learn acceptance, not to blame themselves, just learning to accept what they have experienced.

Psychosocial Treatments for BPD

There are many treatments that work for BPD that may require time and a bit challenging and sophisticated (13).

1.Dialectical Behavior Therapy (DBT)
2.Mentalization Based Treatment (MBT) - simplistic in its approach
3.Transference Focused Psychotherapy (TFP) - using a psychodynamic outpatient approach to help people overcome their black and white thinking, and the vacillations of how they think in their relationship
4.General Psychiatric Management (GPM)
5.Trauma-informed therapy care
6.Eye Movement Desensitization Reprocessing (EMDR)
7. Trauma-Focused CBT
8. cPTSD Treatments Phased Based

It is very hard for patients with cPTSD, who were chronically abused to relearn that there are people they can eventually trust, so as not to feel victimized or controlled in every relationship. UKPTS Guidelines 2017 developed by UK on Skills Training in Affect & Interpersonal Regulation was developed in response to traditional PTSD treatment and not accounting for complex and affective symptoms of CSA-related PTSD (14). These are the following: Phase 1 with skills training in interpersonal regulation and Phase 2 with prolonged exposure. The results are: sustained with full PTSD remission; increased emotion regulation, decrease in interpersonal problems; and decrease drop-out rate for 8 sessions in skills training

Moving Forward

Clara was started on SSRIs on standard dose to address her depressive symptoms. Quetiapine was added as an adjunct to address episodes of difficulty sleeping and augment in managing her depressive symptoms. Currently no medications are indicated as first-line treatment for BPD as psychotherapy remains to be the primary treatment. Besides medications, a supportive approach is paramount in starting the therapeutic journey with Clara, it is important to establish the therapeutic alliance. With the diagnosis of BPD formulated with attachment as the organizing theory, the therapy sessions with techniques hinged on concepts of mentalization.

Clara was a person who developed a disorganized attachment in the context of the early years of development growing up with a distant, unavailable, neglectful and dismissive father coupled with a punitive, overbearing, hypercritical and inconsistent mother. This attachment pattern led to the patient having difficulty in affect regulation, identity diffusion and a tendency to use unhealthy coping strategies as well as interpersonal problems. The disorganized attachment was also perpetuated with the history of sexual abuse on several occasions.

Mentalization-based therapy has been found to be effective among patients diagnosed with BPD yet there was still a need to supplement the sessions with approaches of trauma-focused therapy (15). Prior to the mentalization based therapy, there was modest improvement in how Clara faces her

difficulties. The previous therapy sessions commonly centered on her disputes and arguments with her mother and how these would result in her having episodes of crying episodes and self-harm. Through mentalization, Clara developed the capacity to reflect and explore the mental states of other people as well as herself. The change afforded her some improvement, which was reflected by less frequent breakdowns and slight improvement in her mood, but it seemed that the improvement was rather blunted. Despite the initial noted decrease in frequency of her breakdowns, from approximately 4 – 6 x per week during the time the therapy sessions were started to 1-3 times per week by the 3rd month, Clara still noted having frequent arguments with her mother, often started and stirred by her and still causing feelings of distress.

The discussion of the possibility of the patient experiencing complex trauma from the history of childhood sexual abuse led to the inclusion of trauma-focused approach in the sessions. While the present problems of the patient were still discussed during sessions, time was devoted in the session to revisit the experience of childhood abuse and explore the associated feelings and thoughts about them. The goals of trauma-informed therapy were: to avoid re-victimization; appreciate that many problem were actually attempts to cope; strive to maximize choices for the survivor and control over the healing process and to seek to be competent in any skill or ability. These go hand in hand with the understanding of each survivor in the context of their personal life experiences and cultural background.

The prior approach of attachment theory-informed therapy with mentalization based techniques may have helped Clara develop the capacity to better handle the much -needed emotional processing of her traumatic experiences.

Patients who undergo trauma- informed therapy need to have a broad therapeutic window to accommodate the emotional distress that the processing may bring. Since then, Clara noted further improvement of her condition – she felt more determined and motivated with her school work while at the same time engaged in taking care of Enrico.

There were also less instances of breakdown and self-harm; at one point, Clara was even proud to share how she was able to avoid self-harming behavior for several weeks. She became more understanding of her mother, Almira and accepted her responsibilities as a daughter to her mother. While these improvements were most welcome, admittedly, treatment with Clara still has a long way to go and hopeful that with the supplementation of other therapeutic modalities, now incorporating and duly recognizing the role of trauma in the development of her difficulties, Clara will be able to navigate into her adulthood years with more confidence and optimism.

The goal is resiliency. Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands. A number of factors contribute to how well people adapt to adversities, predominant among them are the ways, in which individuals view and engage with the world; the availability and quality of social resource; and, specific coping strategies.

Psychological research demonstrates that the resources and skills associated with more positive adaptation i.e., greater resilience can be cultivated and practiced (16). There are behaviors, characteristics and qualities inherent in some personalities that will facilitate recovery after exposure to a traumatic event, such as protective factors e.g. good self- care i.e. sleeping at least eight hours a night; exercise, eating nutritious food, enforcing good boundaries and use of positive coping mechanisms rather than negative coping mechanisms.

To end, as health workers, we think about the future health of the people we care about. Along with
many other disciplines and services, we hope that someday we can change this problem of society to make all homes healthy, safe and free.

REFERENCES

1.Bandelow B, Krause J, Wedekind D, Broocks A, Hajak G, Rüther E. Early traumatic life events, parental attitudes, family history, and birth risk factors in patients with borderline personality disorder and healthy controls. Psychiatry Res. 2005 Apr 15;134(2):169-79. doi: 10.1016/j.psychres.2003.07.008. PMID: 15840418.

2.Cattane N, Rossi R, Lanfredi M, Cattaneo A. Borderline personality disorder and childhood trauma: exploring the affected biological systems and mechanisms. BMC Psychiatry. 2017 Jun 15;17(1):221. doi: 10.1186/s12888-017-1383-2. PMID: 28619017; PMCID: PMC5472954.

3.American Psychiatric Association. DSM 5 TR. Washington DC: American Psychiatric Association; 2023.

4.World Health Organization. ICD-11: International classification of diseases. 11th revision. 2022. Available from: https://icd.who.int/en

5.Cloitre M, Garvert DW, Brewin CR, Bryant RA, Maercker A. Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. Eur J Psychotraumatol. 2013 May 15;4. doi:10.3402/ejpt.v4i0.20706. PMID: 23687563; PMCID:PMC3656217

6.Ford JD, Courtois CA. Complex PTSD, affect dysregulation, and borderline personality disorder. Borderline Personal Disord Emot Dysregul. 2014 Jul 9;1:9. doi: 10.1186/2051-6673-1-9. PMID: 26401293; PMCID: PMC4579513.

7.Gunderson JG, Hoffman PD, Eds. Understanding and treating borderline personality disorder: A guide for professionals and families. 1st edition. Washington DC: American Psychiatric Publishing Inc; 2005.

8.Resick PA, Bovin MJ, Calloway AL, Dick AM, King MW, Mitchell KS, et al. A critical evaluation of the complex PTSD literature: implications for DSM-5. J Trauma Stress. 2012 Jun;25(3):241-51. doi: 10.1002/jts.21699. PMID: 22729974.

9.Choi-Kain LW, Murray GE, Goldblatt MJ, Wilks CR, Vahia IV, Coppersmith DD, et al. Unremitting Suicidality in Borderline Personality Disorder: A Single Case Study and Discussion of Technology in Clinical Care. Harvard Review of Psychiatry 30(6):350-360, 11/12 2022. doi: 10.1097/HRP.0000000000000351

10. Alexander W. Pharmacotherapy for Post-traumatic stress disorder in combat Veterans: Focus on antidepressants and typical antipsychotic agents. P T. [Internet] 2012 Jan;37(1):32-8. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3956711/

11. Herman JL. Trauma and Recovery: The aftermath of violence – from domestic abuse to political terror [Internet]1997. Available from: https://archive.org/details/traumarecovery00herm_0/mode/1up

12. PTSD: National Center for PTSD [Internet]. Available from: https://www.ptsd.va.gov/professional/treat/essentials/complex_ptsd.asp

13.Reeves-Dudley B. Borderline Personality Disorder Psychological Treatment: An Integrative Review. Arch Psychiatr Nurs. 2017 Feb;31(1):83-87. doi: 10.1016/j.apnu.2016.08.009. Epub 2016 Aug 24. PMID: 28104065.

14. McFetridge M, Swan A, Heke S, Karatzias T, Greenberg N, Kitchiner N, et al. UK Psychological Trauma Society (UKPTS) Guideline for the treatment and planning of services for Complex Post-Traumatic Stress Disorder in adults. March 2017. doi:10.13140/RG.2.2.14906.39365.

15. Choi-Kain LW, Gunderson JG. Mentalization: ontogeny, assessment, and application in the treatment of borderline personality disorder. Am J Psychiatry. 2008 Sep;165(9):1127-35. doi: 10.1176/appi.ajp.2008.07081360. Epub 2008 Aug 1. PMID: 18676591.

16 .American Psychological Association [Internet] 2023. Available from: https://r.search.yahoo.com/_ylt=AwrKBzYiMHRkh6UMXq6zRwx.;_ylu=Y29sbwNzZzMEcG9zAzMEdnRpZAMEc2VjA3Ny/RV=2/RE=1685364899/RO=10/RU=https%3a%2f%2fwww.apa.org%2ftopics%2fresilience%2f/RK=2/RS=97qr7AJ5u3iwHHtCwH7llNAAqN8-

THE SILENCED VICTIM:
INTO THE NEUROPSYCHOLOGICAL INTRICACIES OF COMPLEX TRAUMA

KIMBERLY P. YU, MD

This piece represents the harrowing struggles of a woman as she attempts to make sense of her past trauma. The complexity of this piece is meant to represent the challenge of piecing together parts of her story that are discovered by the patient and the therapist through the course of therapy. The elements from the periphery of the page moving towards the center represent the layers that the therapist must endeavor to gently peel through each interaction.

The process of psychotherapy is both challenging and humbling. We must be able to see the patient as a whole person, with the constant push and pull of her inner and outer world.

We see here a woman, troubled and hurting, who in many ways is still a child, looking for love and healing from neglect and abuse. Her inner child is seen in red, shattered like fragile glass by the numerous physical, psychological and sexual abuses she endured during childhood.

The dark hand on the child's body represents the various abuses she suffered in the hands of her abuser. She remains hidden, tucked away from the world, silenced.

The dark shadows of her past, depicted as the dark amorphous figures behind her, represent the various people in her life who have failed her and who now constitute her inner world.

These figures continue to accompany her through the intricate stages of life, as she transitions from child to woman and from woman to mother. Through therapy, her inner child finds a voice to speak of the abuses of the past. She looks ahead to a hopefully brighter and more peaceful future, with the help of an attuned psychiatrist.