

Emerging Through Childhood Trauma: Complexities and Challenges

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Abstract

Post-Traumatic Stress Disorder (PTSD), in developmental age group, often manifests widely beyond the classical symptom triad of re-experience, autonomic arousal and avoidance, leading to diagnostic dilemma. Clinical research involving victims of chronic abuse recognises a distinct entity commonly known as complex PTSD, incorporating dissociative amnesia and dissociative personality in its fold. Index case, an adolescent boy, surviving repeated trauma perpetrated by his father, presented with a complex mix of symptoms suggestive of PTSD, along with episodes characterized by dissociative symptoms and aggression. His response to a complex pharmacological regime consisting of selective serotonergic receptor inhibitor, sodium valproate and benzodiazepine, along with behavioural intervention highlights the necessity of exploring different symptoms and individualizing treatment approach in similar cases.

Keywords: Childhood Trauma; Complex PTSD; Dissociation

Key Messages

PTSD in adolescence, following repeated abuse, might manifest in a complex way beyond classical form. Dissociation, aggression and other symptoms often create diagnostic confusion, necessitating careful exploration and individualization of treatment regime.

Introduction

Diagnosis of Post-Traumatic Stress Disorder (PTSD) is often difficult because of the heterogeneous nature of its presentation. The criterion mentioned in the classificatory system are experience of traumatic stress, re-experience, numbness/ avoidance, autonomic arousal [1]. However, a victim of prolonged trauma might present with features of personality disturbance, substance abuse and affective disorder often overshadowing obvious manifestation of PTSD [2]. For its innumerable presenting features PTSD is often compared to syphilis, known for its myriad presentation in the field of medicine [3]. Additionally, in case of children and adolescents, significant trauma, whether single episode or repeated, might be followed by a set of symptoms completely different from adults such as appearance of new aggression, oppositional behaviour, regression in developmental skills (toilet training and speech), new onset separation anxiety, and new fears with no apparent relation to the traumatic event [4]. Dissociation, whether in

form of dissociative amnesia or dissociative personality change presenting as a feature of PTSD has constantly been debated, until finally resulting in a dissociative subtype of PTSD in DSM-5 which is assumed to be seen in complex PTSD. This again, widely differs from classical PTSD in terms of the nature of stressor and psychopathological development. In light of this knowledge the following case is being discussed here, remarkable for its atypical and baffling presentation.

Case History

Master S, 14 yrs. old boy, 8th standard student from middle socio economic background was brought by his elder sister and mother with chief complains of avoiding school and episodes of behavioural disturbance for last three months. The onset could be dated back to an attempt of being kidnapped by his own father and his aides three months back in front of his school which he managed to escape with minor physical trauma.

Since then he has been refusing not only to go to school but also displaying aversion to studies. Soon after that traumatic event and over the past three months his family members have often seen the child behaving in unusual way for periods ranging from half an hour to six hours, episodes being noted to be precipitated mostly by seniors' request to continue schooling and studying. Behaviour during this period has been characterised by uncontrollable shouting, using slangs uncharacteristic of him, throwing tantrums, change in personality from being his usual self to authoritative

and domineering. He was also seen running out naked in one occasion. During these periods he would often behave like a spirit worshipper, with voice and gesture of an older person. After this period of agitation is over he would fall asleep generally. The boy never recalled about this episodes, generally consider them as a period of sleep but he recognises having excruciating headache preceding and following this period of "sleep". Although he has been staying away from studies he managed pursuing his other interests like painting, playing and computer tuitions. He maintained normal interaction with relatives and liked to visit their house occasionally.

There is past history of behavioural outburst although shorter in duration three years back which followed an eight-month period of isolated stay with his father during which he reportedly faced humiliation, neglect and sexual abuse by his father's close associates. It was during this time that his parents started seeking legal procedure of separation and he was brought back to his mother's custody.

He was the second among two siblings, there was no difficulty during birth and development. He was interested in his studies, also liked to read, play football, paint and learn computer during his leisure period. He was described as obedient, cheerful, well-mannered and sensitive by his sister, had good interaction with children of his age. There was significant disturbance of parent child relation, as in childhood he had witnessed his father's excessive drinking, impulsive behaviour and frequent quarrel among parents. After his parents started staying separated, he, along with his mother and sister, moved to a rented apartment four years back. The family depended on his sisters' earning through private tuition and financial help from maternal uncles.

On examination he was found to be calm and cooperative. He showed distress and anxiety on mention of his school and fear of similar traumatic incidence. He recalled having re-experiencing the event in the form of nightmare often awakening him from sleep. He also stated about vivid imagery consisting of fire, his father approaching to hurt him and a spirit worshipper he once came across. On most occasions he held himself detailing about the kidnapping episode as well as other previous occurrences of humiliation and abuse caused by his father. He avoided talking about his feeling on that matter at length, became irritable if insisted and refused to talk further at all when confronted. Provisional diagnosis in this case was PTSD, Dissociative Subtype (DSM 5) with differential diagnosis of dissociative disorder, intermittent explosive disorder and complex partial seizure.

An awake EEG showed no abnormality. By the time patient reached our OPD he was already on fluoxetine 60 mg and clonazepam 1mg. Although symptoms partially improved on this regime, he continued having frequent outbursts even after three months of treatment and he complained of excessive drowsiness.

Treatment was planned keeping in mind his flashbacks, autonomic arousals and associated violent outbursts. Tab. divalproex was started at 250 mg/day increased to eventually 1000 mg /day over 2 weeks resulting in less frequent number of such episodes. This was combined with a trial of an alternative SSRI: sertraline 50 mg and diazepam 5mg. Simultaneously, supportive psychotherapy was introduced. Focus of psychotherapy was on issues of day to day safety, relationship with family members and peers, providing scope for ventilation of inner horror, anxiety, pain and also management of overwhelming emotions, rather than on cognitive behavioural aspect. Patient was seen on weekly basis. After two months of combined pharmacotherapy and psychotherapy improvement was noticeable in terms of remarkable decrease in flashbacks, nightmares and autonomic arousals being. However, he still avoided school and lacked motivation to join classes.

Discussion

Initial presentation of the case was not typical of PTSD. While there was h/o significant traumatic stressor, episodic nature of behavioural outbursts had drawn the most attention of both care givers and physicians suggesting a widely different spectrum of disorders ranging from complex partial seizure to intermittent explosive disorder. Again, on a different perspective, patient's unawareness of his behaviour and precipitation on cue indicated towards dissociative disorder. It was through the process of careful interviewing that extent of his horror and helplessness into the kidnapping incidence and re-experience phenomena were disclosed. Key psychopathology also lies in his troubled parental relationship as well as in being a victim of repeated childhood physical and sexual abuse. He even described an eight-month long confinement episode spent with his abusive father which was very much similar to captivity induced PTSD [5].

Research by Herman [6] and Van der Kolk [6,7] appears relevant in this context. These authors delineated a syndrome of psychological problems associated with histories of sever interpersonal abuse known as complex PTSD or DESNOS (Disorder of Extreme Stress Not Otherwise Specified). Among the six mentioned features, 'alteration in affective impulses' and 'Dissociative amnesia and depersonalisation episodes' could be observed in the current case. Implication of a diagnosis of DESNOS is that it is frequently refractory to conventional PTSD treatment protocol such as combined prolonged exposure and cognitive restructuring [2]. Stein et al pointed out its association with male sex, childhood onset PTSD, higher levels of trauma exposure, higher functional impairment, suicidality and co morbid anxiety [8].

The diagnosis of PTSD was also challenging in this case because of the lack of evidence for exact magnitude of trauma exposure in this case as patient himself wilfully avoided talking about their occurrence during interview while he had been lone

witness of these events. Importance of a correct diagnosis not only lies in following a correct treatment protocol addressing the traumatic event but also in predicting caution regarding other possible consequences like personality disorder, suicidality and substance abuse.

The ordeal of this child points out towards the devastation ushered by childhood physical and sexual abuse. The repetitive nature of abuse in hands of one parent, disturbed parent child relation and broken home, as noted in the index case, seems enormous to a child. The intriguing feature of this case is complexity of presentation and varied differentials that come in clinician's mind. Beyond the traditional flashback and related autonomic arousal, other notable features were episodic nature and amnesia of the event that hint toward ictal phenomenon. Again, the dissociative spells and occurrence of violent outbursts spoke of the urgency of situation. A practical challenge was meaningful engagement of the child in academics. High level of anxiety was yet another issue.

The tell-tale signs of PTSD like flash back and avoidance kept this diagnosis in precedence to all others. Yet features like prominent violence and dissociation and marginal change with SSRI raised question about the conventional approach to manage a prototypical case of PTSD. Thus, strategies to address aggression and anxiety, in this case divalproex and diazepam, respectively, had to be incorporated, apart from SSRI and behavioural approaches. Interestingly, the response to those measures calls for exploring the associated features in cases of PTSD, as well as, the need to tailor made the approach for individual situation. The treating team is

still working with the child and his family members to address his academic needs.

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