Is it bipolar disorder, or a complex form of PTSD?

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How would you handle this case?

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Mr. X, age 26, is chronically suicidal. He has multiple chronic medical illnesses and an extensive history of childhood trauma. Is bipolar II disorder the correct diagnosis?

CASE A long history of suicidality

Mr. X, age 26, who has a history of bipolar II disorder and multiple inpatient admissions, presents to a state hospital after a suicide attempt by gunshot. He reports that throughout his lifetime, he has had >20 suicide attempts, often by overdose.

Mr. X is admitted to the hospital under a temporary detention order. He is initially adherent and cooperative with his psychiatric evaluations.

HISTORY Chronic physical and emotional pain

Mr. X is single, unemployed, and lives with his mother and nephew. He was diagnosed with bipolar II disorder during adolescence and receives sertraline, 50 mg twice a day, and lamotrigine, 100 mg twice a day, to which he reports adherence. He also was taking clonazepam and zolpidem, dosages unknown.

His medical history is significant for severe childhood liver disease and inflammatory bowel disease. He dropped out of school during high school due to his multiple medical conditions, which resulted in a significantly diminished overall childhood experience, interrupted developmental trajectory, and chronic physical and emotional pain. He has never been employed and receives financial support through disability benefits. He spends his days on the internet or watching television. He reports daily cigarette and marijuana use and occasional alcohol use, but no other substance use. His mother helps manage his medical conditions and is his main support. His biological father was abusive towards his mother and absent for most of Mr. X's life.

Beyond his mother and therapist, Mr. X has minimal other interpersonal interactions, and reports feeling isolated, lonely, and frustrated.

EVALUATION Agitated and aggressive while hospitalized

Upon learning that he is being involuntarily committed, Mr. X becomes physically aggressive, makes verbal threats, and throws objects across his room. He is given diphenhydramine, 50 mg, haloperidol, 5 mg, and lorazepam, 2 mg, all of which are ordered on an as-needed basis. Mr. X is placed in an emergency restraint chair and put in seclusion. The

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episode resolves within an hour with reassurance and attention from the treatment team; the rapid escalation from and return to a calmer state is indicative of situational, stress-induced mood lability and impulsivity. Mr. X is counseled on maintaining safety and appropriate behavior, and is advised to ask for medication if he feels agitated or unable to control his behaviors. To maintain safe and appropriate behavior, he requires daily counseling and expectation management regarding his treatment timeline. No further aggressive incidents are noted throughout his hospitalization, and he requires only minimal use of the as-needed medications.

Which of the following therapies might be *least* appropriate for Mr. X?

a) trauma-focused cognitive-behavioral therapy (CBT)
b) dialectical behavior therapy (DBT)
c) motivational interviewing
d) exposure and response prevention

The authors' observations

The least appropriate therapy for Mr. X would be exposure and response prevention, which allows patients to face their fears without the need to soothe or relieve related feelings with a compulsive act. It is designed to improve specific behavioral deficits most often associated with obsessive-compulsive disorder, a diagnosis inconsistent with Mr. X's history and presentation. Trauma-focused CBT could facilitate healing from Mr. X's childhood trauma/adverse childhood experiences, and DBT might help with his anger, maladaptive coping strategies, and chronic suicidality. Motivational interviewing might help with his substance use and his apparent lack of motivation for other forms of social engagement, including seeking employment.

Based on Mr. X's history of trauma and chronic physical and emotional pain, the treatment team reevaluated him and reconsidered his original diagnosis.

EVALUATION A closer look at the diagnosis

After meeting with Mr. X, the treatment team begins to piece together a more robust picture of him. They review his childhood trauma involving his biological father, his chronic and limiting medical illnesses, and his restricted and somewhat regressive level of functioning. Further, they consider his >20 suicide attempts, numerous psychiatric hospitalizations, and mood and behavioral lability and reactivity. Based on its review, the treatment team concludes that a diagnosis of bipolar disorder II or major depressive disorder is not fully adequate to describe Mr. X's clinical picture.

At no point during his hospitalization does Mr. X meet full criteria for a major depressive episode or display mania or hypomania. The treatment team considers posttraumatic stress disorder (PTSD) in the setting of chronic, repetitive trauma given Mr. X's nightmares, dissociative behavior, anger, negative cognitions, and intrusive symptoms. However, not all his symptoms fall within the diagnostic criteria of PTSD. There are also elements of borderline personality disorder in Mr. X's history, most notably his multiple suicide attempts, emotional lability, and disrupted interpersonal attachments. In this context, a diagnosis of complex PTSD (CPTSD) seems most appropriate in capturing the array of trauma-related symptoms with which he presents.

Complex PTSD

Since at least the early to mid-1990s, there has been recognition of a qualitatively distinct clinical picture that can emerge when an individual's exposure to trauma or adversity is chronic or repetitive, causing not only familiar PTSD symptomatology but also alterations in self-perception, interpersonal functioning, and affective instability. Complex PTSD was first described by Judith Herman, MD, in 1992 as a distinct entity from PTSD.[1] She theorized that PTSD derives primarily

Clinical Point

Complex PTSD may arise in situations with more chronicity, such as being held in captivity or subject to prolonged sexual abuse

from singular traumatic events, while a distinct clinical syndrome might arise after prolonged, repeated trauma.[1] A diagnosis of CPTSD might arise in situations with more chronicity than a classic single circumscribed traumatic event, such as being held in captivity, under the control of perpetrators for extended periods of time, imprisoned, or subject to prolonged sexual abuse. Herman's description of CPTSD identifies 3 areas of psychopathology that extend beyond PTSD[1]:

- symptomatic refers to the complex, diffuse, and tenacious symptom presentation
- characterological focuses on the personality changes in terms of dissociation, ego-fragmentation, and identity complications
- vulnerability describes characteristic repeated harm with respect to self-mutilation or other self-injurious behaviors, and suicidality.

Clinical Point

DSM-5 added several criteria to PTSD, including changes in self-perception, affective instability, and dysphoria, and a dissociative subtype

Taxometrics, official recognition, and controversy

Complex PTSD was proposed for inclusion in DSM-IV as "Disorders of Extreme Stress Not Otherwise Specified," or DESNOS. Reportedly, it was interpreted as a severe presentation of PTSD, and therefore not included in the manual as a separate diagnosis.[2] In contrast, ICD-10 included a CPTSD-like entity of "Enduring Personality Change After Catastrophic Event" (EPCACE). Although the existence of CPTSD as a categorically distinct diagnosis in the psychiatric mainstream has been debated and discussed for years, with many arguably unaware of its existence, clinicians and researchers specializing in trauma are well-versed in its clinical utility. As such, CPTSD was again discussed during the development of DSM-5. In an apparent attempt to balance this clinical utility with ongoing concerns about its validity as a diagnostically distinct syndrome, DSM-5 did not officially recognize CPTSD, but added several criteria to PTSD referencing changes in self-perception, affective instability, and dysphoria, as well as a dissociative subtype, effectively expanding the scope of a PTSD diagnosis to also include CPTSD symptoms when applicable. ICD-11 has taken a different direction, and officially recognizes CPTSD as a distinct diagnosis.

ICD-11 presents CPTSD as a "sibling" disorder, which it distinguishes from PTSD with high levels of dissociation, depression, and borderline personality disorder traits.[3] Within this framework, the diagnosis of CPTSD requires that the PTSD criteria be met in addition to symptoms that fall into a "disturbances of self-organization" category. When parsing the symptoms of the "disturbances of self-organization" category, the overlap with borderline personality disorder symptoms is apparent.[4] This overlap has given rise to yet another controversy regarding CPTSD's categorical validity; in addition to its distinctness from PTSD, its distinctness from borderline personality disorder has also been debated. In a study examining the similarity between CPTSD and borderline personality disorder, Jowett et al[5] concluded that CPTSD was associated with greater exposure to multiple traumas earlier in life and resulted in higher functional impairment than borderline personality disorder, ultimately supporting CPTSD as a separate entity with features that overlap borderline personality disorder.[5] According to Ford and Courtois[6] "the evidence ... suggests that a sub-group of BPD patients—who often but not always have comorbid PTSD—may be best understood and treated if CPTSD is explicitly addressed as well—and in some cases, in lieu of—BPD."

PTSD and CPTSD may therefore both be understood to fall within a spectrum of trauma diagnoses; this paradigm postulates that there exists a wide variety of posttraumatic patient presentations, perhaps on a continuum. On the less severe

Table 1

Diagnostic criteria of PTSD (DSM-5[12])

A. Exposure to actual or threatened death, serious injury, or sexual violence 1. directly experiencing the traumatic event(s) 2. witnessing, in person, the event(s) as it occurred to others 3. learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental 4. experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (eg, first responders collecting human remains, police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related
B. Presence of ≥1 of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1. recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children >6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed 2. recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content 3. dissociative reactions (eg, flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. Note: In children, trauma-specific reenactment may occur in play 4. intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s) 5. marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: 1. avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s) 2. avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by ≥2 of the following: 1. inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or illicit drugs) 2. persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (eg, "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined") 3. persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others 4. persistent negative emotional state (eg, fear, horror, anger, guilt, or shame) 5. markedly diminished interest or participation in significant activities 6. feelings of detachment or estrangement from others 7. persistent inability to experience positive emotions (eg, inability to experience happiness, satisfaction, or loving feelings).
E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by ≥2 of the following: 1. irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects 2. reckless or self-destructive behavior 3. hypervigilance 4. exaggerated startle response 5. problems with concentration 6. sleep disturbance (eg, difficulty falling or staying asleep or restless sleep).
F. Duration of the disturbance (Criteria B, C, D, and E) is >1 month
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
H. The disturbance is not attributable to the physiological effects of a substance (eg, medication, alcohol) or another medical condition

PTSD: posttraumatic stress disorder

Clinical Point

PTSD and complex PTSD may be understood to fall within a spectrum of trauma diagnoses

side of the trauma spectrum, the symptoms traditionally seen and characterized as PTSD (such as hypervigilance, nightmares, and flashbacks) may be found, while, with increasingly severe or prolonged trauma, there may be a tendency to see more complex elements (such as dissociation, personality changes mimicking borderline personality disorder, depression, anxiety, self-injurious behavior, and suicidality).[7]

Nevertheless, controversy about discriminant validity still exists. A review article by Resnick et al[8] argued that the existing evidence is not strong enough to support CPTSD as a standalone entity. However, Resnick et al[8] agreed that a singular PTSD diagnosis has limitations, and that there is a need for more research in the field of trauma psychiatry.

Clinical Point

The addition of CPTSD as a diagnosis is helpful in determining the etiology of a patient's presentation

Utility of the diagnostic conceptualization

Although the controversy surrounding the distinction of CPTSD demands categorical clarity with respect to PTSD and borderline personality disorder as a means of resolution, the diagnosis has practical applications that should not limit its use in clinical formulation or treatment planning. Comorbid diagnoses do not prevent clinicians from diagnosing and treating patients who present with complicated manifestations of trauma.[9] In fact, having overlapping diagnoses would highlight the array of patient presentations that can be seen in the posttraumatic condition. Furthermore, in the pursuit of individualized care approaches, the addition of CPTSD as a diagnostic conception would allow for more integrated treatment options using a multi-modular approach.[10]

The addition of CPTSD as a diagnosis is helpful in determining the etiology of a patient's presentation and therefore formulating the most appropriate treatment plan. While the 2-pronged approach of psychopharmacology and therapy is the central dogma of psychiatric care, there are many specific options to consider for each. By viewing such patients through the lens of trauma as opposed to depression and anxiety, there is a clear shift in treatment that has the potential to make more lasting impacts and progress.[11]

CPTSD may coexist with PTSD, but it extends beyond it to include a pleomorphic symptom picture encompassing personality changes and a high risk for repeated harm. Failure to correctly classify a patient's presentation as a response to repetitive, prolonged trauma may result in discrimination and inappropriate or ineffective treatment recommendations.

For a comparison of the diagnostic criteria of PTSD, CPTSD, and borderline personality disorder, see ***Table 1***[12] ***(page 45), Table 2,***[13,14] ***(page 47),*** and ***Table 3***[12] ***(page 48).***

Patients with CPTSD

One of the authors (NR) has cared for several similar individuals presenting for treatment with vague diagnoses of "chronic depression and anxiety" for years, sometimes with a speculative bipolar disorder diagnosis due to situational mood swings or reactivity, and a generally poor response to both medications and psychotherapy. These patients were frustrated because none of the diagnoses seemed to fully "fit" with their pattern of symptoms or subjective experience, and treatment seemed minimally helpful. Very often, their social history revealed a variety of adversities or traumatic events, such as childhood sexual or physical abuse, a home environment plagued by domestic violence, or being raised by one or both parents with their own history of trauma, or perhaps a personality or substance use disorder. Although many of these patients' symptom profiles aligned only partially with "typical" PTSD, they were often better captured by CPTSD, with a focus on negative self-perception and impact on close relationships. Helping the patient "connect the dots" to create a more continuous narrative, and consequently

Table 2

Diagnostic criteria of PTSD and CPTSD (ICD-11[13])

Posttraumatic stress disorder

PTSD may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all of the following:

1. re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. Re-experiencing may occur via one or multiple sensory modalities and is typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations
2. avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event(s)
3. persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises.

The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

Complex posttraumatic stress disorder

CPTSD is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (eg, torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met.

In addition, CPTSD is characterized by severe and persistent:

1. problems in affect regulation
2. beliefs about oneself as diminished, defeated, or worthless, accompanied by feelings of shame, guilt, or failure related to the traumatic event
3. difficulties in sustaining relationships and in feeling close to others.

These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Note: Dr. Judith Herman's original conceptualization and definition are broader than the above ICD-11 criteria and may better demonstrate diagnostic overlap with borderline personality disorder. Dr. Herman describes the symptomatic difficulty in the following areas[14]:

- emotional regulation. May include persistent sadness, suicidal thoughts, explosive anger, or inhibited anger
- consciousness. Includes forgetting traumatic events, reliving traumatic events, or having episodes in which one feels detached from one's mental processes or body (dissociation)
- self-perception. May include helplessness, shame, guilt, stigma, and a sense of being completely different from other human beings
- distorted perceptions of the perpetrator. Examples include attributing total power to the perpetrator, becoming preoccupied with the relationship to the perpetrator, or becoming preoccupied with revenge
- relations with others. Examples include isolation, distrust, or a repeated search for a rescuer
- one's system of meanings. May include a loss of sustaining faith or a sense of hopelessness and despair.

CPTSD: complex posttraumatic stress disorder; PTSD: posttraumatic stress disorder

reconceptualizing the diagnosis as a complex trauma disorder, has proven effective in a number of these cases, allowing the patient to make sense of their symptoms in the context of their personal history, reducing stigma, and allowing for different avenues with medication, therapy, and self-understanding. It can also help to validate the impact of a patient's adverse experiences and encourage a patient to view their symptoms as an understandable or even once-adaptive response to traumatic stress, rather than a sign of personal weakness or defectiveness.

TREATMENT A trauma-focused approach

Once the treatment team considers Mr. X's significant childhood trauma and

Clinical Point

Failure to correctly classify a patient's presentation as a response to prolonged trauma may result in inappropriate or ineffective treatment

Table 3

Diagnostic criteria of borderline personality disorder (DSM-5[12])

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by ≥5 of the following:

1. frantic efforts to avoid real or imagined abandonment (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5)
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. identity disturbance: markedly and persistently unstable self-image or sense of self
4. impulsivity in at least 2 areas that are potentially self-damaging (eg, spending, sex, substance abuse, reckless driving, binge eating) (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5)
5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. affective instability due to a marked reactivity of mood (eg, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. chronic feelings of emptiness
8. inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, recurrent physical fights)
9. transient, stress-related paranoid ideation or severe dissociative symptoms.

Clinical Point

For some patients, the reformulation from a primary mood disorder to a trauma disorder might lead to a change in pharmacotherapy

reconceptualizes his behaviors through this lens, treatment is adjusted accordingly. His significant reactivity, dissociative symptoms, social impairment, and repeated suicide attempts are better understood and have more significance through a trauma lens, which provides a better explanation than a primary mood disorder.

Therapeutic interventions in the hospital are tailored according to the treatment team's new insight. Specific DBT skills are practiced, insight-oriented therapy and motivational interviewing are used, and Mr. X and his therapist begin to explore his trauma, both from his biological father and from his intense stressors experienced because of his medical issues.

Mr. X's mother, who is very involved in his care, is provided with education on this conceptualization and given instruction on trauma-focused therapies in the outpatient setting. While Mr. X's medication regimen is not changed significantly, for some patients, the reformulation from a primary mood or anxiety disorder to a trauma disorder might require a change in the pharmacotherapy regimen to address behavioral symptoms such as mood reactivity or issues with sleep.

OUTCOME Decreased intensity of suicidal thoughts

By the time of discharge, Mr. X has maintained safety, with no further outbursts, and subjectively reports feeling more understood and validated. Although chronic suicidal ideation can take months or years of treatment to resolve, at the time of discharge Mr. X reports a decreased intensity of these thoughts, and no acute suicidal ideation, plan, or intent. His discharge planning emphasizes ongoing work specifically related to coping with symptoms of traumatic stress, and the involvement of his main social support in facilitating this work.

The authors' observations

As a caveat, it may be in some cases that chronic negative affect, dysphoria, and self-perception are better understood as a comorbid depressive disorder rather than subsumed into a PTSD/ CPTSD diagnosis. Also, because situational mood instability and impulsivity are often interpreted as bipolar disorder, a history of hypomania and mania should be ruled out. In Mr. X's case, the diagnostic reformulation

did not significantly impact pharmacotherapy because the target symptoms of mood instability, irritability, anxiety, and depression remained, despite the change in diagnosis.

Although the DSM-5 PTSD criteria effectively incorporate many CPTSD elements, we argue that this inclusivity comes at the expense of appreciating CPTSD as a qualitatively distinct condition, and we prefer ICD-11's recognition of CPTSD as a separate diagnosis that incorporates PTSD criteria but extends the definition to include negative self-concept, affect dysregulation, and interpersonal difficulties.

Related Resources

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Drug Brand Names

Clonazepam • Klonopin	Lorazepam • Ativan
Haloperidol • Haldol	Sertraline • Zoloft
Lamotrigine • Lamictal	Zolpidem • Ambien

Clinical Point

ICD-11's complex PTSD diagnosis includes negative self-concept, affect dysregulation, and interpersonal difficulties

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Bottom Line

Consider a diagnosis of complex posttraumatic stress disorder (CPTSD) when providing care for patients with chronic depression and suicidality with a history of trauma or childhood adversity. This reformulation can allow clinicians to understand the contributing factors more holistically; align with the patient more effectively; appreciate past and present interpersonal, psychological, and psychosocial factors that may precipitate and perpetuate symptoms; and allow for treatment recommendations beyond those of mood and anxiety disorders.