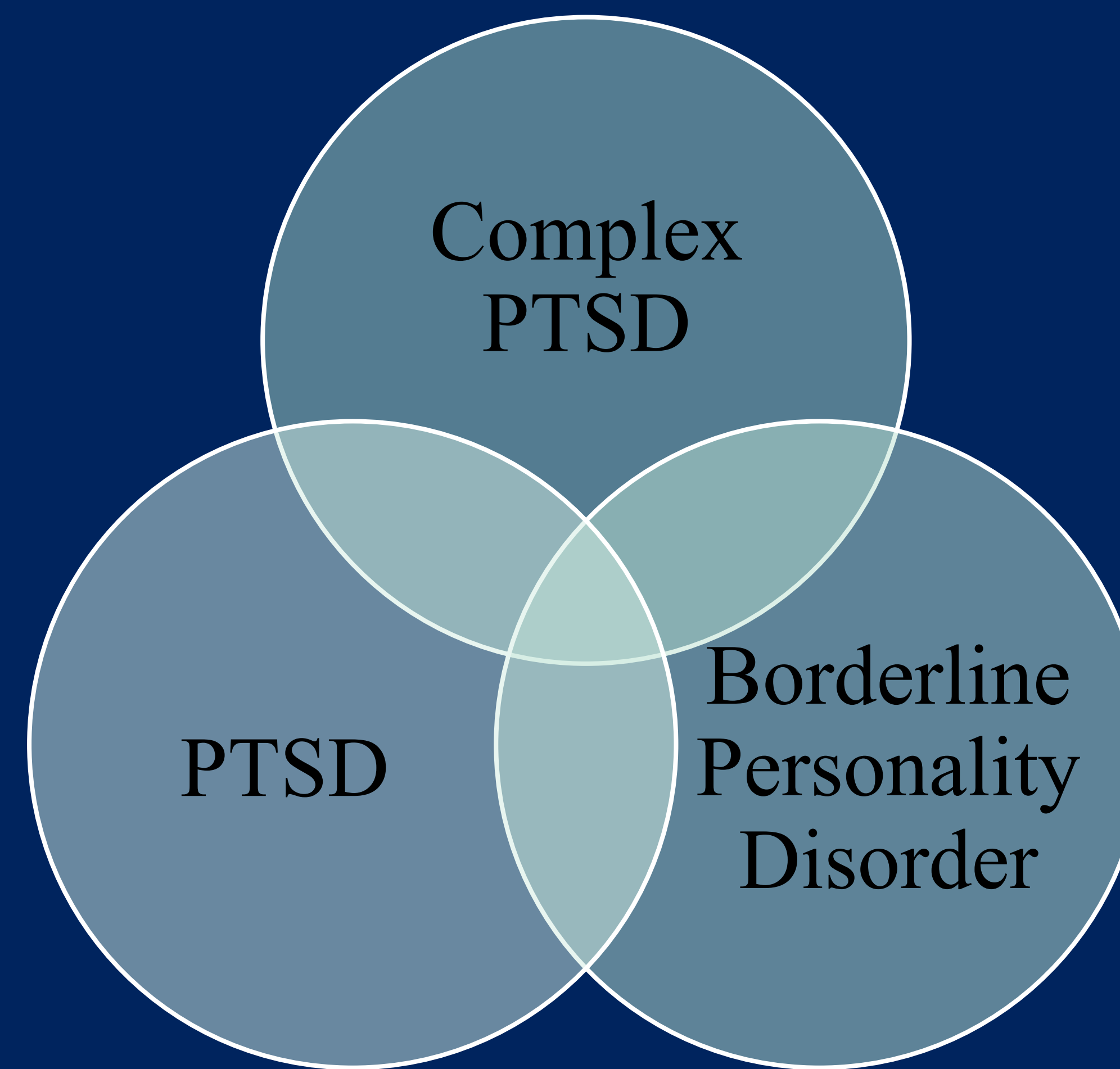
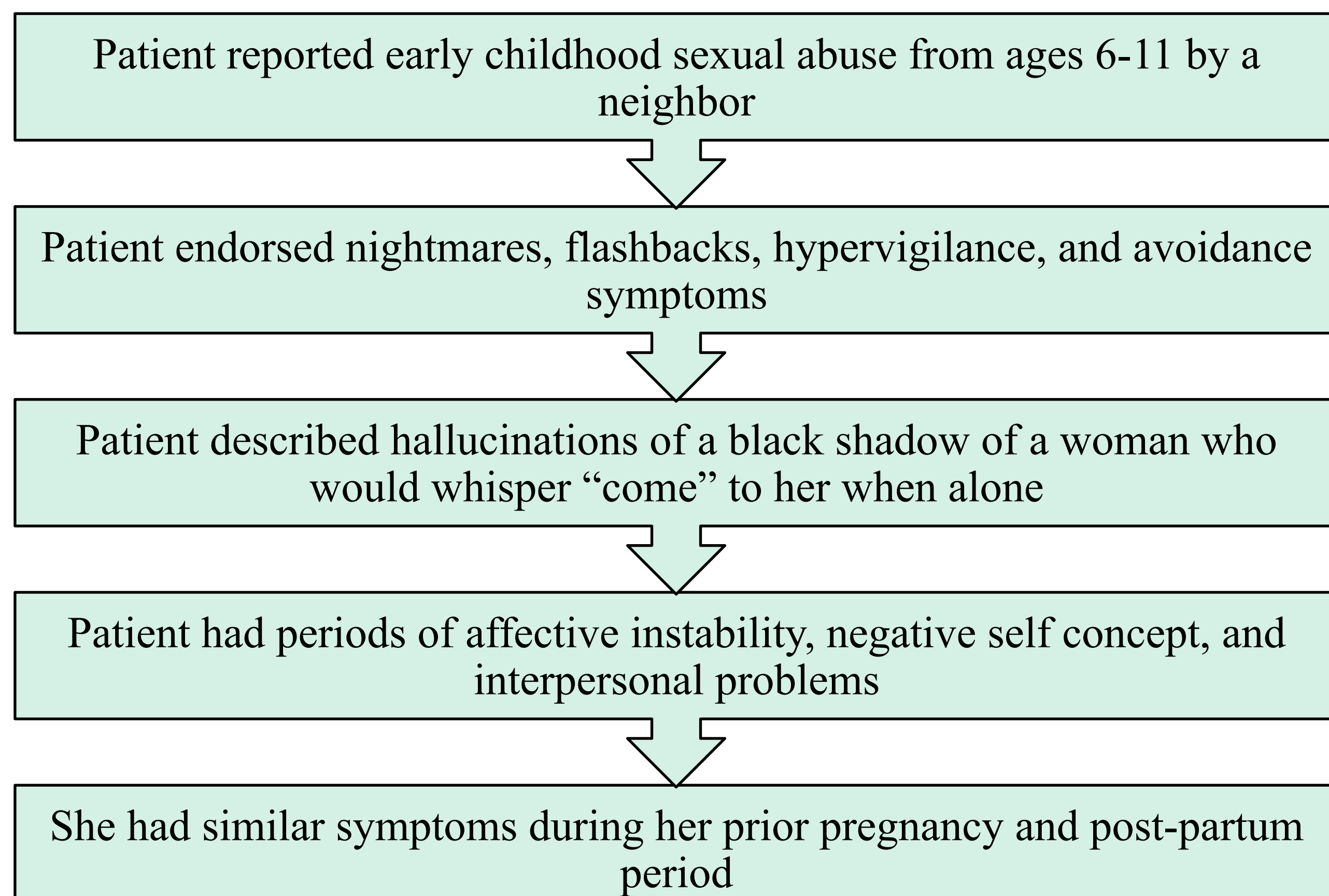


## INTRODUCTION

- Complex Post-Traumatic Stress Disorder (CPTSD) is characterized by classic PTSD symptoms as well as disturbances of self-organization, which can include mood symptoms, psychotic symptoms, and maladaptive personality traits
- CPTSD during the perinatal period is poorly understood, but like PTSD is comorbid with other psychiatric disorders and may increase the risk for adverse birth outcomes
- CPTSD risk factors are highly prevalent during the peripartum period, and the disorder can be precipitated or worsening in these periods of stress and mimic other diagnoses
- We highlight aspects of CPTSD that are relevant to Consultation-Liaison (C-L) psychiatrists by discussing a case of CPTSD with perinatal exacerbation to underline diagnostic nuances, assessment, and treatment strategies.

## CASE REPORT

RY is a 35yo G3P1011 partnered mother with a 3-year-old child with a past medical history of obesity and gestational diabetes and a self-reported past psychiatric history of bipolar disorder who presented to an outpatient psychiatry clinic with symptoms of worsening dysphoria and insomnia during her second trimester of an unplanned yet desired pregnancy.



## Differentiating Complex Post-Traumatic Stress Disorder

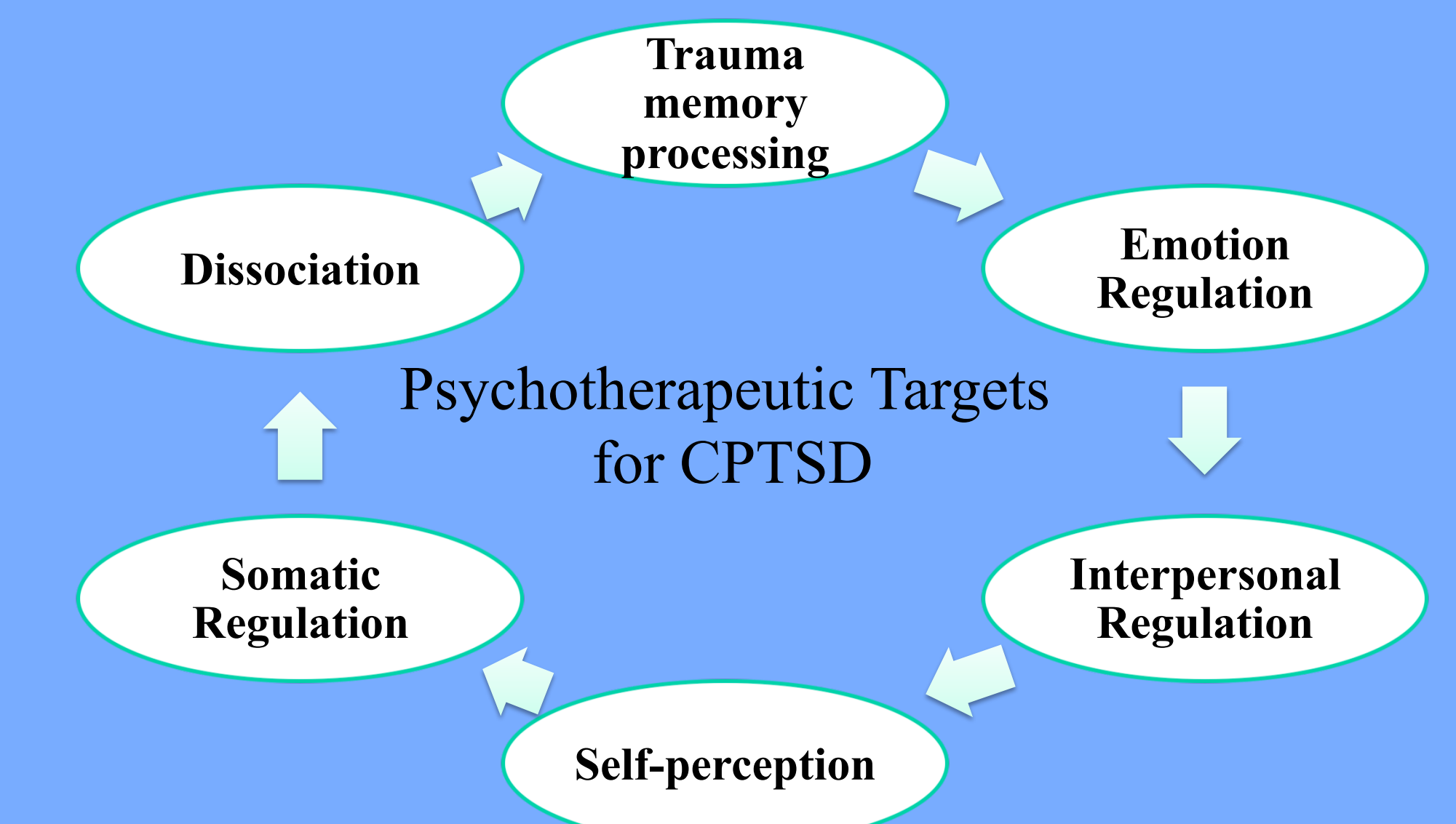
	CPTSD	Borderline Personality Disorder	PTSD
<b>Traumatic Event</b>	Prolonged, repeated trauma with loss of control	Emotional invalidation	Isolated traumatic event
<b>Interpersonal Style</b>	Fluctuates with predominant avoidance	Pervasive unstable relationships	Relative Stability
<b>Defenses</b>	Oscillates depending on threat	Immature	Mature
<b>Psychotic Symptom Trigger</b>	Threat of trauma or betrayal	Threat of abandonment	Treat of trauma
<b>Sense of Self</b>	Negative Self-Perception	Alternating	Intact
<b>Emotion Dysregulation</b>	Trigger for anger or substance use	Trigger for self harm	Relative stability

## Perinatal risk factors for CPTSD

<b>Perinatal Depression</b>	<b>Coronavirus-related stress</b>
<b>Sleep Deprivation</b>	<b>Boundary violations</b>
<b>Role Transitions/Disputes</b>	<b>Loss of structure and control</b>
<b>Attachment Difficulties</b>	<b>Hormonal Changes</b>
<b>Impulse to protect offspring</b>	<b>Obstetrical Trauma</b>
<b>Isolation</b>	<b>Uncontrollable sexual organ sensations</b>

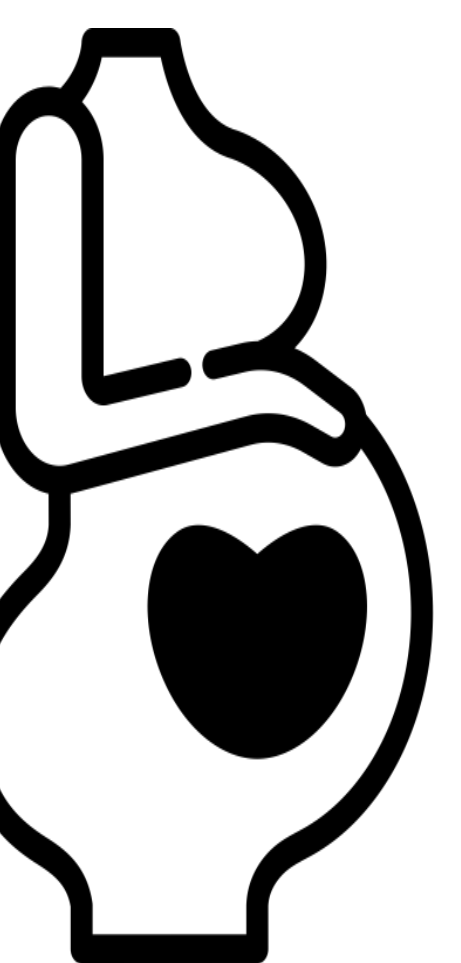
## CASE DISCUSSION

The psychiatrist administered a PTSD Checklist (PCL-5) and International Trauma Questionnaire (ITQ) to gather more information and diagnosed the patient with CPTSD. Her chronic auditory and visual hallucinations were attributed to a trauma-reaction as she had no other positive or negative psychotic symptoms. The psychiatrist consulted with the patient's obstetrician and recommended quetiapine to treat the patient's anxiety, insomnia, mood, and psychotic symptoms in addition to psychotherapy. The patient had an uncomplicated vaginal delivery and immediate success with breastfeeding. Quetiapine was discontinued as it led to excessive sedation and she was initiated on sertraline until she was lost to follow up at 10 months postpartum.



## LESSONS LEARNED

- CPTSD can be exacerbated during the perinatal period secondary to the physical, emotional, and social demands of pregnancy and caregiving
- C-L psychiatrists should be aware of the symptoms of CPTSD, how it differs from personality disorders and PTSD, and the importance of treatment during the perinatal period
- Further research is warranted to better identify mothers at risk for CPTSD, barriers to care, and evidence-based interventions



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