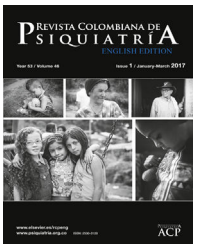
Asociación Colombiana de Psiquiatría ACP

Revista Colombiana de Psiquiatría

www.elsevier.es/rcp



Case Report

Adolescent patient with post traumatic stress disorder due atypical stressor: Case report

Jhonny Alejandro Muñoz Valencia[a,*], *Jose Ricardo MuñoZuñiga*[b], *Juan Carlos Rivas Nieto*[a,b]

[a] *Universidad del Valle, Colombia*
[b] *Universidad ICESI, Colombia*

ARTICLE INFO

Article history:
Received 10 May 2021
Accepted 7 November 2021
Available online 22 April 2024

Keywords:
Post-traumatic stress disorder
Paediatrics
Neuropsychiatry

ABSTRACT

Introduction: Post-traumatic stress disorder (PTSD) is characterised by intrusive, anxious, and avoidant symptoms that are triggered after a stressful experience and affect the mood. The definition of a stressor that generates PTSD has been debated in recent years, as a clinical picture compatible with the disorder can occur after exposure to stressors that do not meet the criteria A1 of the DSM V; these stressors have been defined in the literature as "of low magnitude, uncommon, unusual or atypical".
Clinical case: We present the clinical case of a paediatric patient who developed PTSD after being exposed to an atypical stressor.
Conclusions: The literature shows these stressors to be more frequently documented in the paediatric population. We therefore suggest that cases should be analysed as a complex interweaving of variables, where one of the most important is each patient's interpretation of the event according to their life history and social context, and not because of an inherent characteristic of the stressor itself.

Paciente adolescente con trastorno de estrés postraumático debido a estresor atípico. Reporte de caso

Palabras clave:
Trastorno de estrés postraumático
Pediatría
Neuropsiquiatría

RESUMEN

Introducción: El trastorno de estrés postraumático (TEPT) se caracteriza por síntomas intrusivos, ansiosos y evitativos que se desencadenan luego de una experiencia estresante y afectan a la esfera del ánimo. La definición de un estresor que genera un TEPT ha estado en controversia en los últimos años, ya que se puede presentar un cuadro clínico compatible con el trastorno tras la exposición a estresores que no cumplen el criterio A1 del DSM-V. Estos estresores se han definido en la literatura como «de baja magnitud, poco comunes, inusuales o atípicos».

DOI of original article: https://doi.org/10.1016/j.rcp.2021.11.004.
* *Corresponding author*.
E-mail address: retroturi@hotmail.com (J.A. Muñoz Valencia).

Caso clínico: Se presenta el caso clínico de un paciente en edad pediátrica en el que se desarrolló un TEPT luego de exponerse a un estresor atípico.
Conclusiones: Se evidencia en la literatura que estos estresores se han documentado más a menudo en la población pediátrica, por lo cual se propone analizar los casos como un complejo entrecruzamiento de variables, de las que una de las más importantes es la interpretación que cada paciente hace del evento según su historia de vida y su contexto social, y no por una característica inherente al estresor en sí.

Introduction

Post-traumatic stress disorder (PTSD) has a prevalence of approximately 3.5% in the United States, with lower rates in the rest of the world of approximately 0.5–1%.[1] Among the paediatric population, the prevalences of PTSD are more inconsistent due to geographical area, resilience, age and sex, but there are reports in Colombia of a prevalence of approximately 4.7%.[2] PTSD is characterised by symptoms of intrusion, anxiety and avoidance, which are triggered after a stressful experience and affect the mood. In DSM-5,[1] a stressor is defined as a situation perceived as threatening, with a risk of death, sexual violence or serious injury.[3] Some examples include kidnapping, torture, social adversity, natural disasters and road traffic accidents.[4] In Colombia, the internal armed conflict is an important factor.[2,5–7]

The definition of a stressor that generates PTSD has been debated in recent years, as a clinical picture compatible with the disorder can occur after exposure to stressors that do not meet criterion A1 of the DSM-5.[3,4,8–12] These stressors have been defined in the literature as "of low magnitude, uncommon, unusual or atypical". Some examples include movies, animated series, eating spoiled foods and other everyday experiences. There is evidence that atypical stressors can generate symptoms consistent with PTSD. To demonstrate this, we present the case report of a paediatric patient who developed PTSD after being exposed to an atypical stressor.

Case report

A 13-year-old male patient, who was in year six of basic education, was brought in for an appointment 1 year after watching a video at night-time in the company of his mother. The video was about the history of the animated series *Kick Buttowski*. During the video, the protagonist enters into a Faustian pact with Lucifer and sells his soul for some of Lucifer's clothing. The patient's symptoms began with recurrent episodes of anxiety, feelings of impending doom, depersonalisation, derealisation, shaking, palpitations, dyspnoea, tachycardia and crying, which lasted for approximately 15 min and occurred 3–4 times a day. In addition to dysautonomia symptoms, this caused the patient to feel terror and anguish between crises and he was unable to stay at home on his own, to sleep alone or to turn off the lights. This was associated with insomnia, nightmares, flashbacks and avoidance related to the content of the video, evidenced in acts such as no longer watching television, getting rid of video games, and avoiding any conversation regarding the situation or related content, to the point of not being able to say the title of this video. He stated: T̈hat video is demonic; I should never have watched it:̈

The patient is an only child and was the result of a preterm pregnancy during which the mother suffered from depression, with no other complications. He was born by caesarean section due to the cord being wrapped around his neck and non-reassuring foetal status, with a normal Apgar score. He had normal psychomotor development with normal performance at school. His interpersonal relationships were described as good. The patient lived with his parents and the family dynamic was adequate. The father has obsessive personality traits. There is a history of type I bipolar affective disorder, alcoholism and dementia in the uncles and grandparents.

The patient's physical examination, lab tests, cognitive assessment and brain CT scan were normal. A mental examination showed a non-cooperative attitude during the interview, that he was fearful, with phobias and flashbacks of the video. There were no hallucinations or hallucinatory behaviours. Consequently, the patient's condition was diagnosed as a specific phobia and treatment with fluvoxamine 100 mg/day was prescribed for 3 months.

After 6 months of treatment, when the authors became aware of the case, the patient showed a partial improvement with greater tolerance for being alone, resolution of the fear of the dark and a better capacity to cope with the event. The same treatment was continued and psychotherapy was added but the patient did not continue to attend check-ups.

Due to the presence of symptoms triggered by exposure to a specific event that was perceived in an aberrant way and the associated symptoms of anxiety and dissociation, intrusive ideas and avoidant behaviours, together with deterioration of the patient's social and family circles, the diagnosis was changed to PTSD.

Discussion

We have presented the case of a patient diagnosed with PTSD secondary to an atypical stressor. Initially, the patient was diagnosed with phobic anxiety disorder with agoraphobia, generalised anxiety disorder and panic disorder, but his clinical symptoms indicated the possibility of PTSD.

There is currently controversy surrounding the definition of a stressful event in PTSD. In DSM-4 and DSM-5, substantial changes were made to the definition of Criterion A, which is less specific in the latest version, but the stressor concept

did not change.[13–16] Today, it excludes the possibility that there is a group of stressors that do not comply with the historical definition, omitting to take into account reports of cases of PTSD secondary to so-called l̈ow magnitude, unusual, uncommon or atypicalstressors, little studied in the paediatric population,[17,18] thus revealing the need for a discussion, at least with respect to this group of patients.

Various studies link PTSD to events such as kidnapping, rape, terrorist attacks, wars and catastrophic events in both the adult and paediatric population.[19–23] Regarding atypical stressors in the adult population, there are case reports of a neurosis associated with watching the movie *The Exorcist* in 1975[24] and the case of a 47-year-old man who was diagnosed with this disorder with the stressor of having eaten a bar of chocolate infested with worms.[4]

Reports of atypical stressors among the paediatric population are less common. Two articles were found regarding atypical stressors that caused this disorder in children. One study, conducted in Iran in 2013, studied 84 patients aged 6–11 years. The study found that 33% of the patients had symptoms consistent with PTSD related to watching violent or catastrophic events on television, including movies, news programmes and cartoons.[17] In a 2010 study involving a sample of 1420 children aged 9–13 years, the Adolescent Psychiatric Assessment (CAPA) was applied to screen and classify exposure to high and low-magnitude stressors. Fifteen items were used to assess low-magnitude stressors, including the loss of a loved one, parental separation, moving house, moving to a new school, and breaking up with a friend or a boyfriend or girlfriend. Children were then assessed for symptoms such as painful recall or avoidance and for autonomic symptoms related to the exposure. It was found that l̈ow-magnitudestressors were more prevalent, even though the proportion of symptoms in both groups was similar.[18]

In addition, a 2013 study found that the DSM-4 Criterion A2 had greater sensitivity, with a high negative predictive value, for the onset of post-traumatic stress in children, and assigns importance to the emotional perspective of each stressor in the paediatric population.[25] On considering this case, the authors believe that a stressor should not be classified only from a historical perspective, since one can fall into a reductionist perspective,[26] but should also take into account other variables, such as social context, age, sex, resilience, one's own perspective, and even nationality.[27–32] We therefore suggest that paediatric cases should be analysed as a complex interweaving of variables, where one of the most important is each patient's interpretation of the event according to their life history and social context, and not because of a characteristic inherent to the stressor itself.[33]

Conflicts of interest

The authors have no conflicts of interest to declare.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub; 2013.
2. Pérez-Olmos I, Fernández-Piñeres PE, Rodado-Fuentes S. Prevalencia del trastorno por estrés postraumático por la guerra, en niños de Cundinamarca, Colombia. Rev Salud Publica. 2005;7:268–80.
3. Gil-Iñiguez A. Intervención en un caso de trastorno de estrés postraumático por violencia sexual. Psicol Clin Niños Adolesc. 2016;3:75–80.
4. Christensen RC. The development of posttraumatic stress disorder following an unusual life event: a case report. Innovat Clin Neurosci. 2012;9:26.
5. Alejo EG, Rueda G, Ortega M, Orozco LC. Estudio epidemiológico del trastorno por estrés postraumático en población desplazada por la violencia política en Colombia. Universitas Psychologica. 2007;6:623–35.
6. Sinisterra M, Figueroa F, Moreno V, Robayo M, Sanguino J. Prevalencia del trastorno de estrés postraumático en población en situación de desplazamiento en la localidad de Ciudad Bolívar Bogotá, Colombia 2007. Psychologia. 2010;4:83–97.
7. Suárez RS. Trastorno de estrés postraumático, ansiedad y depresión en adolescentes y adultos expuestos al conflicto armado en Colombia 2005–2008. Medicina. 2016;38:134–56.
8. Mol SS, Arntz A, Metsemakers JF, Dinant GJ, Vilters-Van Montfort PA, Knottnerus JA. Symptoms of post-traumatic stress disorder after non-traumatic events: evidence from an open population study. Br J Psychiatry. 2005;186:494–9.
9. Willard VW, Long A, Phipps S. Life stress versus traumatic stress: the impact of life events on psychological functioning in children with and without serious illness. Psychol Trauma Theory Res Pract Policy. 2016;8:63.
10. Lancaster SL, Melka SE, Rodriguez BF. An examination of the differential effects of the experience of DSM-IV defined traumatic events and life stressors. J Anxiety Disord. 2009;23:711–7.
11. Weathers FW, Keane TM. The Criterion A problem revisited: controversies and challenges in defining and measuring psychological trauma. J Traum Stress. 2007;20:107–21.
12. Long ME, Elhai JD, Schweinle A, Gray MJ, Grubaugh AL, Frueh BC. Differences in posttraumatic stress disorder diagnostic rates and symptom severity between Criterion A1 and non-Criterion A1 stressors. J Anxiety Disord. 2008;22:1255–63.
13. Larsen SE, Pacella ML. Comparing the effect of DSM-congruent traumas vs. DSM-incongruent stressors on PTSD symptoms: a meta-analytic review. J Anxiety Disord. 2016;38:37–46.
14. Gold SD, Marx BP, Soler-Baillo JM, Sloan DM. Is life stress more traumatic than traumatic stress? J Anxiety Disord. 2005;19:687–98.
15. Larsen SE, Berenbaum H. Did the DSM-5 improve the traumatic stressor criterion? Association of DSM-IV and DSM-5 criterion a with posttraumatic stress disorder symptoms. Psychopathology. 2017;50:373–8.
16. Roberts AL, Dohrenwend BP, Aiello AE, et al. The stressor criterion for posttraumatic stress disorder: does it matter? J Clin Psychiatry. 2012;73:264–70.
17. Kousha M, Tehrani SM. Normative life events and PTSD in children: how easy stress can affect children's brain. Acta Medica Iranica. 2013:47–51.
18. Copeland WE, Keeler G, Angold A, Costello EJ. Posttraumatic stress without trauma in children. Am J Psychiatry. 2010;167:1059–65.
19. Hinojos-Gallardo LC, Ruiz-Escalona L, Cisneros-Castolo M, Mireles-Vega E, Pando-Tarín GA, Bejarano-Marín JM. Estrés postraumático en la población pediátrica atendida en el Hospital Infantil del estado de Chihuahua, México. Bol Med Hosp Infantil México. 2011;68:290–5.
20. Pérez-Olmos I, Ibáñez-Pinilla M, Penaranda LAJ. Follow-up of child war-related post-traumatic stress disorder and other

psychiatric disorders in two exposed towns in Cundinamarca, Colombia. Mind Brain. 2012;3.
21. Gómez-Restrepo C, Cruz-Ramírez V, Medina-Rico M, Rincón CJ. Salud mental en niños desplazados por conflicto armado — Encuesta Nacional de Salud Mental Colombia 2015. Acta Esp Psiquiatr. 2018;46.
22. Andrades Tobar M. Trastorno de estrés postraumático y crecimiento postraumático en niños y adolescentes afectados por el terremoto del año 2016 en Chile; 2016.
23. Castro Sáez M, Martínez Pérez A, López-Soler C, López-García JJ, Alcántara-López M. Trastorno por estrés postraumático en niños españoles maltratados. Ciencias Psicológicas. 2019;13:378–89.
24. Bozzuto JC. Cinematic neurosis following "The Exorcist": report of four cases. J Nerv Mental Dis. 1975.
25. Verlinden E, Schippers M, Van Meijel EP, et al. What makes a life event traumatic for a child? The predictive values of DSM-Criteria A1 and A2. Eur J Psychotraumatol. 2013;4:20436.
26. Maristan Scayola S. Locura, enfermedad y salud mental: significaciones y contextos socio-históricos en los procesos de reformas; 2016.
27. Zapardiel Fernández A. Estrés postraumático, depresión y ansiedad a largo plazo en víctimas de atentados terroristas; 2016.
28. Cova F, Valdivia M, Rincón P, et al. Estrés postraumático en población infantojuvenil post 27F. Rev Chile Pediatr. 2013;84:32–41.
29. Arenas MC, Puigcerver A. Diferencias entre hombres y mujeres en los trastornos de ansiedad: una aproximación psicobiológica. Escritos de Psicología. 2009;3:20–9.
30. van den Berg LJ, Tollenaar MS, Spinhoven P, Penninx BW, Elzinga BM. A new perspective on PTSD symptoms after traumatic vs stressful life events and the role of gender. Eur J Psychotraumatol. 2017;8:1380470.
31. Bensimon M, Solomon Z, Horesh D. The utility of Criterion A under chronic national terror. Israel J Psychiatr Relat Sci. 2013;50:81–3.
32. Bridgland VM, Moeck EK, Green DM, et al. Why the COVID-19 pandemic is a traumatic stressor. PLoS One. 2021;16:e0240146.
33. Reavell J, Fazil Q. The epidemiology of PTSD and depression in refugee minors who have resettled in developed countries. J Mental Health. 2017;26:74–83.