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Case Report

Erotic Transference as a Presentation of cPTSD: A Case Report using TF-CBT

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ABSTRACT

The cumulative effect of recurring traumatic experiences in early childhood substantially increases the risk of adjustment problems later in life. Enduring these adverse circumstances can develop a complementary constellation of emotional and interpersonal symptoms currently understood as complex posttraumatic stress disorder (cPTSD). The present case study illustrates the narrative of a twenty-three-year-old woman with a history of repeated interpersonal trauma, which presents in the therapeutic setting as erotic transference. Provocative behaviour, asking personal questions, making repeated requests for closeness and constant contact outside of session timings were noted. In a clinical space, erotic transference, unlike other transference phenomena, presents as a wish for sexual contact as a duplication of past trauma, rupturing the therapeutic alliance. The case report highlights the clinical presentation, with the theoretical framework, management plan, and treatment details of TF-CBT used throughout the sessions.

Keywords: *Complex Trauma, CPTSD, Single-Case Study, Erotic Transference, Countertransference*

cPTSD (Complex posttraumatic stress disorder) was initially proposed as a clinical syndrome following precipitating traumatic events which are prolonged in duration and are of predominantly early life onset, significantly those with an interpersonal nature, explicitly consisting of trauma associated with the early stages in the form of child abuse and neglect (Herman et al., 1992). Furthermore, it was defined by symptom clusters that mimicked an enhanced PTSD, with symptoms of a threat, social withdrawal, shame, hostility, feeling of being permanently damaged and somatization, among others. cPTSD was also seen as a presentation of diversity from the previous personality. The clinical presentation was understood as a disturbed sense of self (self-perception with a negative self-concept, affective dysregulation and perception of penetrators) which was often the leading cause of interpersonal problems (Herman et al., 1992; Reed et al. et al. 2016; Cloitre, M. et al. 2011).

World Health Organisations ICD 11 reconceptualizes the previous diagnosis, "enduring personality change after catastrophic experience", which maintains characteristic clinical features of self-organization dysfunction and exposure to multiple and chronic or repeated and entrapping, for the individual traumatic events such as child abuse, domestic violence,

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imprisonment and torture. ICD-11 further suggests that cPTSD shares three core clusters of symptoms with PTSD, namely reexperiencing, avoidance and a sense of threat, additionally adding emotional dysregulation, relational disturbance and negative self-concept. Concepts suggest that cPTSD presents similar traits to BPD (Borderline Personality Disorder, now conceptualized as Emotionally Unstable Personality Disorder), with supporting literature indicating that chronic PTSD can lead to personality factor alterations (Ehlers et al., A. 2000). While a distinct personality change is not a diagnostic criterion for cPTSD, there is an unavoidable alteration of personality factors due to prolonged traumatic events.

Research in treatment for cPTSD is limited due to the novelty of the diagnostic criteria. However, due to its resemblance to a subtype of EUPD and similarity with PTSD, it is treated using trauma-focused and non-trauma-focused interventions. TF-CBT (Trauma-Focused Cognitive Behaviour Therapy), developed by Cohen, Mannarino, and Deblinger as a conjoint parent-child treatment, is seen to be used. Ehlers and Clark (2000) explained that clients with PTSD hold highly negative appraisals of the trauma and that their autobiographical memory of the traumatic events is marked by poor contextualization and strong perceptual priming, which leads to automatic reexperiencing of the trauma. Ehlers and Clark suggest that individuals with PTSD employ problematic behavioural and cognitive strategies that prevent them from changing these negative appraisals and memories.

De Arellano, M. A. et al. (2014) conducted an evidence-based review of TF-CBT and found that TF-CBT indicated positive outcomes in reducing symptoms of posttraumatic stress disorder. Additionally, Watkins, L. E., Sprang, K. R., & Rothbaum, B. O. (2018) note that according to the APA guidelines of 2017, TF-CBT is highly recommended for treating PTSD. Furthermore, they found that CBT is more effective than a waitlist (Power et al., 2002), supportive therapy (Blanchard et al., 2003) and a self-help booklet (Ehlers et al., 2003). Jensen et al. (2022) found that TF-CBT is a recommended treatment for youth with PTSD, and while ICD-11 introduced cPTSD, there have been no studies examining whether TF-CBT may be helpful for youth with CPTSD using a validated instrument. In this case report, parts of TF-CBT were used for a female client suffering from cPTSD and depression. In addition, this study illustrates explicitly how a presentation of cPTSD is seen through eroticized Transference through the material of the client.

Case Introduction

[Note: Personal/ Descriptive information has been altered to maintain client anonymity. Written and verbal Consent for a case report was taken from the client].

Ms X is a 23-year-old female presenting with chief complaints of anxiety attacks during work, suffocation in relationships and abrupt crying bouts. The index client has a history of sexual abuse at twelve by a man on public transport and by a family member at sixteen. The index client has a history of one lethal suicidal attempt at the age of fifteen through ingestion of poisonous substances and a history of recurrent physical and emotional abuse from the father. The client reports passive death wishes from the age of eight and an impulse to indulge in self-harm each year on her birthday. No current attempts at DSH(Deliberate Self Harm) have been reported.

Presenting Complaints

Ms X sought probono psychotherapy services from the author (psychotherapist) for her recurrent anxiety attacks, which she noticed started during working hours. Ms X could not identify the reason for the discomfort and frequently isolated herself from social settings

feeling suffocated from reciprocating interpersonal relations with past college friends, colleagues at work or family members.

History

Ms X was apparently fine until three months before seeking mental health services when she noticed feeling anxious in work meetings, taking calls from colleagues and answering emails. Ms X had frequent crying bouts throughout that period and would socially isolate herself from her peers. At the same time, she could not trace the origin of these anxiety attacks; Ms X notes feeling anxious throughout her childhood when her father would constantly threaten her and would repeatedly emotionally and physically abuse her. Through further probing, the client reported a history of one lethal suicidal attempt at fifteen through the ingestion of poisonous substances after an altercation with her father. Ms X reported a history of sexual abuse at the age of twelve by a man on public transport, by a family member at the age of sixteen and a few months before treatment sexual harassment online. Ms X notes that the presenting complaints are an exacerbated reaction to the anxiety that she has felt throughout her childhood.

The client has a history of psychiatric illness reported in a second-degree relative with epileptic seizures. No organic history of head trauma and associated illnesses is noted, and no previous history of physical or psychiatric illness exists.

Assessments

Two symptom measures were used to assess Ms X's symptom severity.

1. ***Anxiety***. The HAM-A was used to measure the severity of anxiety symptoms. The scale consists of 14 items, each defined by a series of symptoms, and measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). Maier et al. tested the scale's reliability and validity in samples of 97 anxious and 101 depressed individuals. They inferred that the reliability and concurrent validity of the HAM-A and its subscales were adequate. There is reasonable inter-rater reliability and good one-week retest reliability.
2. ***Depression.*** The Beck Depression Inventory-II (BDI-II) assessed depressive symptoms and their severity. The BDI-II is a 21-item self-report measure that taps significant depression symptoms according to diagnostic criteria in the DSM. In research from Segal et al. (2008), the internal reliability of the BDI-II was found to be good among older and younger adults.

Case Conceptualisation

Session 1-4: History

The client was seen in a bi-weekly setting online, and the first four sessions (two weeks) were spent eliciting history. The following interim case formulation was conducted and revised in the assessment phase. The family dynamics uncovered that Ms X was frequently intimidated by death threats by her father, with recurrent episodes of verbal and physical abuse throughout her childhood and adulthood, precipitating her lethal suicidal attempt at age fifteen. Furthermore, Ms X has a history of two counts of CSA (Child Sexual Abuse). These events can be categorized as a series of traumatic childhood events. Tarocchi et al. (2013) noted that the cumulative effect of recurring traumatic experiences in early childhood substantially increases the risk of adjustment problems later in life. Enduring these adverse circumstances can develop a complementary constellation of emotional and interpersonal symptoms currently understood as complex posttraumatic stress disorder (cPTSD).

Based on the symptoms presented during the first four sessions, the client was assessed for anxiety and depression using symptom measures HAM-A and BDI-II, where she scored 27 and 35, respectively. These scores indicated Moderate to Severe Anxiety and Severe Depression. During the assessment phase (Session 5), Ms X reported no significant stressors, which could aid as perpetuating factors for the anxiety and crying bouts. However, further probing mentioned recurring flashbacks to instances of DV (Domestic Violence) in her extended family, events she had witnessed since childhood.

Provisional Diagnosis. Based on the anxiety and depression symptom severity and preliminary trauma assessment, the client met all criteria for ***cPTSD***.

1. **Exposure to a series of highly threatening or horrific events**, most commonly prolonged or repetitive, from which escape is difficult or impossible. (two accounts of CSA, recurrent DW by father)
2. **Fulfils the criteria for PTSD**; (Presence of flashbacks of DV, social isolation and avoidance of public transport, enhanced startled reaction to traffic lights, car honking, and street lights).
3. **Dysregulated affect**, emotional numbing (blunted affect, depersonalization).
4. **Predominant feeling of worthlessness** (Self-defeating behaviour).
5. **Interpersonal Conflict** (Feeling suffocated in intimate relationships).
6. **Bio-Psycho-Socio-Occupational Dysfunction** (Present as seen in sleep/wake cycle, occupational distress).

However, the client also had symptoms of severe depression and anxiety, understood as a manifestation of the complex trauma history and are subsumed under this diagnosis.

Based on the clinical presentation, the intervention plan was created following TF-CBT, aimed at Psychoeducation and Relaxation: Short-term Goals were collaboratively decided in session with the client.

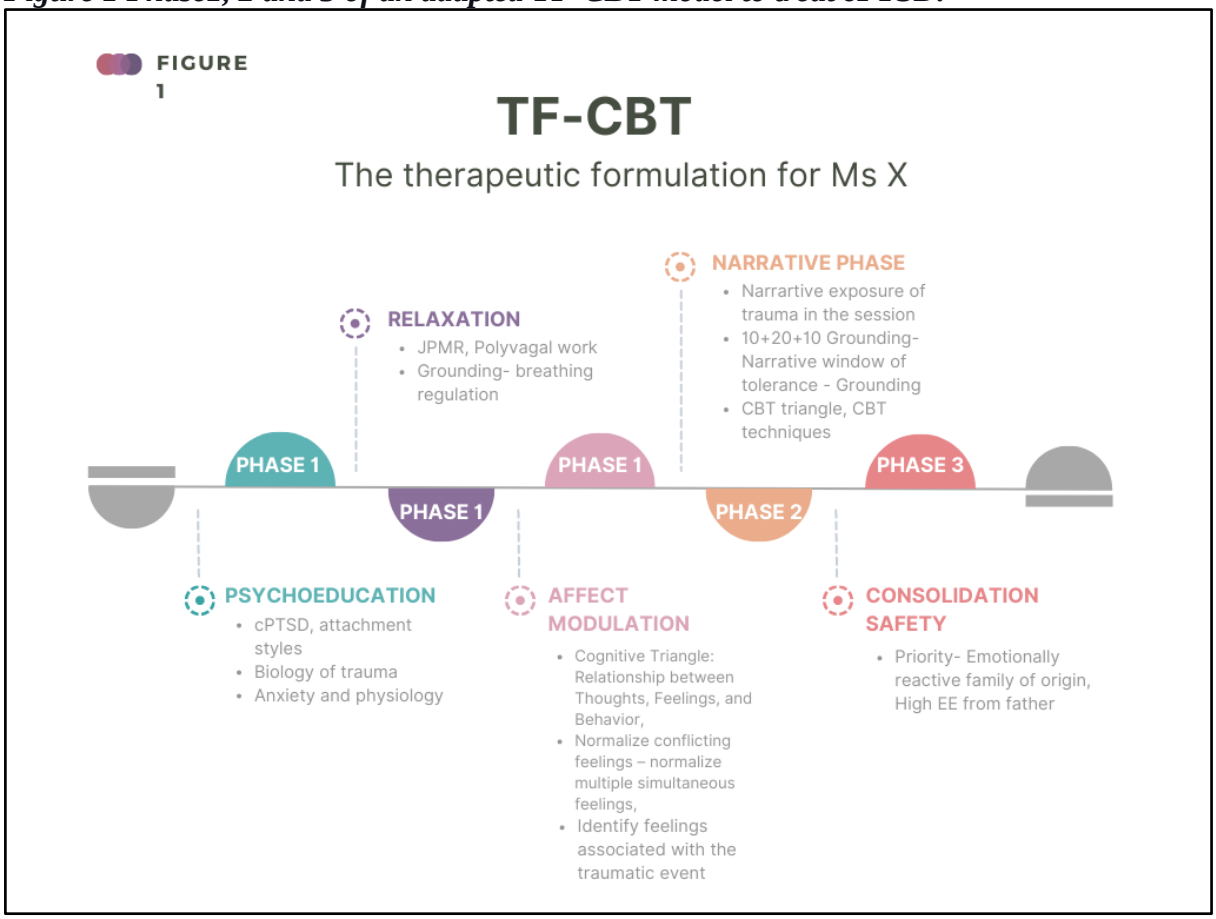
CRAFTS Assessment under TF-CBT

A trauma assessment was done following a CRAFTs approach of TF-CBT (Fleming & Waheed, 2014).

1. **Cognitive Dysfunctions:** The cognitive problems were assessed in the first four sessions. The client has a negative view of the world (Congruent to her unique life stressors and recurrent trauma accounts). Furthermore, the client has cognitive distortions of Mind reading and Fortune telling, congruent to literature about maladaptive cognitions of people with a trauma history (Ouhmad et al.).
2. **Relationship Problems:** The client reported severe IPR difficulties with intimate partners and conflict at the workspace.
3. **Affect Regulation:** The client had a blunted affect during the sessions and presented with constricted emotions throughout the assessment.
4. **Family Dysfunctions:** The client reported high expressed emotions of overinvolvement and hostility from the father, and there was a presence of Domestic Violence. The client reported an estranged relationship with the sibling because of high sibling rivalry.
5. **Traumatic Behaviour Problems:** The client reported recurrent passive death wishes, planned a detailed high-intensity self-harm plan to end her life on her twenty-fifth birthday and reported recurrent episodes of anxiety attacks. The client reported difficulty maintaining an intimate relationship with her partners and described her need to gain comfort from men significantly older than her.

6. **Somatic Problems:** The client reported difficulty sleeping and recurrent neck and shoulder pain, including recurring hypertension (No formal diagnosis was made for hypertension). Gupta M. A. (2013) reports medical co-morbidities with PTSD across various studies, including cardiovascular disease and hypertension. PTSD is associated with limbic instability and alterations in the hypothalamic-pituitary-adrenal and sympathoadrenal medullary axes resulting in autonomic nervous system dysregulation, making somatic symptoms a common trauma presentation.

Based on the trauma assessment, a tentative therapeutic plan was created using TF-CBT. Figure 1 Phase1, 2 and 3 of an adapted TF-CBT model to treat cPTSD.



Session 6-10 (Phase 1 of TF-CBT)

The client was provided with psychoeducation on trauma responses and their physiological manifestations, following which relaxation techniques were taught. Jacobson's Progressive muscle relaxation (JPMR) was taught; however, the client entered a state of RIA (Relaxation-induced Anxiety), and JPMR was terminated. Instead, the client was taught alternate grounding techniques, and subsequently, the client noticed a reduction in the frequency of anxiety attacks, and spontaneous crying bouts were extinct. The reduction of the presenting complaints was followed by multiple boundary violations in the eighth session from the client to permeate the therapist's boundary. The client had a very low distress tolerance and threatened severe physical harm to elicit reactions from the therapist. The therapist maintained a trauma-informed approach and reflected the feelings of the client, leading to aggressive Transference in the session.

Session 11: (Self-Reported Erotic Transference)
The client reported writing a detailed account of the first ten sessions, emphasizing the therapist's appearance, behaviour and more. Unwilling to share the details in session, the client had a dysregulated affect. The client avoided eye contact in the session and was hypervigilant. On an objective assessment for risk, it was discovered that the client had recurrent suicidal ideations and was at active risk of self-harm. A three-step crisis management plan was initiated and administered to ensure client safety. The clinical supervisor was given a recording of session 11 with the client. Explicit Informed Consent was taken, and the client was debriefed about the nature of the information.

Supervision Notes: Continue regular sessions, ask the client to refrain from reading/self-diagnosing, and might need professional psychiatric support. Erotic Transference is present.

Session 12-16: (Psychiatric follow up)
The client was provided psychoeducation required to refrain from self-educating/ misinterpreting topics of trauma. The client shared an "ultimatum" in the session, explaining how they wanted to end their life in a planned suicide by the age of twenty-five as self-assurance for a life lived. The presentation was followed by the client describing aggressive egodystonic impulses to harm herself using household materials (the client has a history of suicide attempts using household materials). Based on a formal assessment, aggressive obsessions were suspected, and a psychiatric follow-up was recommended (The client was prescribed an antidepressant, mood stabilizer and an SOS pill). The client reported a decline in presenting complaints of anxiety and added that she is relocating for work to a different city. Adaptive work for relocation and relaxation was the focus of the sessions.

Session 17-18: (Please/Appease -Fawn response)
The presenting complaints of anxiety were resolved, and a possible shift to a clinical psychologist for further assessment and advanced treatment was made. The client shifted into a fawn response, also called the please/appease model- quoting, *"I will come up with a lot more things don't worry since chief complaints have been addressed."* The client started a chain of emails violating therapeutic boundaries between sessions to get the therapist's attention, and a possible incident of physically meeting the therapist was initiated. Aigner (2022) reports that a person experiencing the please/appease survival response seems socially committed. However, this survival response is typically defined as opposing these relational qualities. They are triggered in response to danger, crisis, or perceived threat and are driven by the necessity for self-protection. Here the threat is understood as the possible termination of the therapy, which exacerbates the erotic transference to elicit a response from the therapist.
A psychiatric follow-up is requested when the client sends many emails post-session threatening suicide and to meet the therapist in other intimate settings.

Psychiatrist Follow-up: The client has been on medications for twenty days; personality pathology may be present (Cluster B, C compound). Client has histrionic traits, and clinical presentation may look like hypomania but primarily follows the depression theme under cPTSD, and a mood stabilizer may be prescribed. Micropsychotic Episodes and OC symptoms are present.

Supervision Notes: Despite definitive boundary setting, transference suggests a trauma response to the current clinical presentation, which implies a presentation of cPTSD. To be

terminated with referral post consultation for meds with a psychiatric follow-up. The therapist advised preponing the next session to discuss medication and termination.

Sessions 19-21 (Termination)
Termination started, given the imminent risk of self-harm and the current possibility, of a hypomanic episode client was referred to a clinical psychologist for further treatment and assessment. The client reported "feeling hurt" that the therapist is terminating the sessions. Erotic Transference was unaddressed due to high-risk pathology on the recommendation of the treating team.

Sessions 22-24 (Follow Up)
The follow-up psychotherapy sessions reviewed the client's transition to sessions with the clinical psychologist. The therapist initiated the session by acknowledging the end of the therapeutic relationship since the last session. The client demonstrated a willingness to engage in introspection and personal growth. She acknowledged the difficulty moving to a clinical space and the sessions were handed over to the clinical psychologist for further assessment and review.

Barriers to care: Countertransference
Beeber, A. (2016) notes that when transference occurs in the therapist during psychotherapy, it is called countertransference. In the discussed case, the therapist initially noticed high anxiety levels with tightening of the chest and dryness of the throat. The anxiety was related to the client repeatedly violating the boundaries of the therapeutic alliance, which was brought out in supervision regularly to limit the possible barriers to change during therapy. However, countertransference can be highly challenging. Training and supervision to deal with countertransference go a long way to enhance the opening of personal challenges in the therapist, which may create obstacles in their work (Kakar, 2019).

CONCLUSION

The current case report emphasizes the importance of training in transference-based therapies when working with individuals affected by complex trauma. The primary objective of this report was to explore Erotic Transference as a clinical manifestation of complex post-traumatic stress disorder (cPTSD). The client initially presented with symptoms of anxiety and a history of recurring complex interpersonal trauma. The therapist employed Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) as the therapeutic approach, and over the course of eighteen sessions, the development of erotic transference became evident.

During the therapy process, the therapist experienced negative countertransference, which was initially recognized and appropriately addressed through supervision. It is crucial to highlight that the findings of this case report cannot be generalized to every individual with a diagnosis of cPTSD. However, the observed pattern of repeated boundary violations and the emergence of erotic transference provide valuable insights into the role of transference and its connection to cPTSD.

To effectively navigate transference-based issues and address complex trauma in therapy, mental health professionals need to receive specialized training in this area. This training equips therapists with the necessary knowledge and skills to identify and manage transference reactions, including erotic transference, in a clinically appropriate and ethical manner. Such training enhances the therapist's ability to create a safe therapeutic environment, promote healing, and facilitate the resolution of complex trauma-related issues.

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Conflict of Interest

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