alongside formulation-based case conceptualization and risk management for self-harm, suicidality, and re-traumatization. Emphasis is placed on transdiagnostic mechanisms, including threat processing, avoidance, and emotion dysregulation, and on trauma-informed communication to enhance engagement and retention.
Clinical Implications: A phased, personalized care pathway is proposed. Initial stabilization focuses on safety, psychoeducation, sleep and arousal regulation, and management of comorbid depression, anxiety, and substance use. Readiness for trauma-focused therapy is addressed through selection and sequencing of first-line psychotherapies, including trauma-focused CBT, EMDR, prolonged exposure, and cognitive processing therapy, with adaptations for dissociation, complex presentations, and ongoing stress. Pharmacological strategies are discussed as adjuncts targeting specific symptoms such as hyperarousal, nightmares, and comorbid mood and anxiety disorders, with caution regarding polypharmacy and agents with dependence potential. Special considerations are outlined for developmental trauma, perinatal contexts, migration-related trauma, and culturally sensitive assessment.
Conclusions: A structured yet flexible clinical approach is required for trauma-related disorders, balancing diagnostic precision with formulation, prioritizing safety and engagement, and applying stepped, evidence-based interventions. Trauma-informed, mechanism-focused pathways may improve outcomes, reduce chronicity, and support integrated care across psychiatric services.

Disclosure of Interest: None Declared

ECP009

Case presentation-1

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Abstract: This Clinical Perspectives presentation describes an anonymised case of an adult patient with complex PTSD following prolonged interpersonal trauma, complicated by substance use and problematic benzodiazepine intake. The patient presented with persistent affect dysregulation, hyperarousal, intrusive symptoms, dissociation, sleep disturbance and severe functional impairment, alongside escalating use of alcohol/cannabis and intermittent high-dose benzodiazepine self-medication to manage anxiety and insomnia. The case highlights key clinical dilemmas frequently encountered in trauma-related care: differential diagnosis (complex PTSD vs borderline personality disorder vs major depression), risk assessment including self-harm, and treatment sequencing when trauma symptoms coexist with addiction-related behaviours. Management is discussed using a phased, recovery-oriented approach, integrating stabilisation and psychoeducation, careful psychopharmacological planning (including benzodiazepine harm reduction and tapering strategy), and referral to evidence-based psychotherapy (trauma-focused therapy when clinically safe), combined with addiction-focused interventions and relapse prevention. The presentation emphasises multidisciplinary collaboration and practical decision-making applicable to outpatient psychiatry, particularly when ongoing stressors and limited resources affect continuity of care.

Disclosure of Interest: None Declared

ECP010

A case of C-PTSD: building trust and safety in the therapeutic relationship

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Background: Complex Post-Traumatic Stress Disorder (C-PTSD), recognized in the ICD-11, is a mental disorder resulting from chronic and prolonged interpersonal trauma, such as physical or sexual abuse or neglect. In addition to the core symptoms of PTSD (re-experiencing, avoidance, and a persistent sense of threat), C-PTSD is characterized by disturbances in emotional regulation, a negative self-concept, and persistent difficulties in interpersonal interactions, including relationship avoidance and distrust of others. These features can be detrimental to the therapeutic relationship.
Methods: We present the case of a 25-year-old woman who came to an outpatient psychiatric clinic with depressive mood, anhedonia, high levels of anxiety, insomnia, and pervasive feelings of shame and worthlessness. Her history included physical abuse within her family of origin and prolonged bullying during childhood and adolescence. She was diagnosed with C-PTSD and major depressive disorder and was started on antidepressant medication and referred for psychotherapy.
Results: During the first nine months of treatment, the patient showed improvement in depressive mood; however, feelings of worthlessness, marked anxiety, and hyperarousal persisted. She subsequently missed two consecutive monthly appointments. At the following visit, she disclosed having recently exited an abusive intimate relationship. She reported feeling too ashamed to discuss the situation earlier but decided to leave her boyfriend after experiencing physical assault. At that time, she presented with panic attacks, emotional lability, flashbacks, hyperarousal, insomnia. Pharmacological treatment was resumed, and psychotherapy was re-initiated.
Discussion: Leaving the abusive relationship and finding the capacity to disclose her experience and ask for help represented a significant therapeutic turning point. The gradual establishment of trust and perceived safety within the therapeutic relationship enabled the patient to address ongoing trauma-related difficulties.
Conclusion: C-PTSD is a condition associated with high vulnerability, which requires a careful approach. Patients with C-PTSD often struggle with trust and may delay disclosure of ongoing abuse. Providing a consistent sense of safety, emotional attunement, and non-intrusive support is essential to fostering engagement and facilitating recovery.

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