PTSD
&
Personality Disorders

by

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TRAUMA AND PERSONALITY DISORDERS

INTRODUCTION

"Above all, do no harm."

- Since 1991, TRAUMA*TYS* has evaluated and treated thousands of persons presenting with PTSD, associated with co-morbidity and functional limitations.

  No selection criteria are applied, except for the presence of an acute psychotic episode requiring hospitalization.

  Many patients present with both PTSD and PD according to Bowlby's and Masterson's models.

  The psychotherapy is conducted following Gaston's specialized and integrative model for treating PTSD (1995), including the components described in this document.

- According to an independent and retrospective study by the research team of Dr Brunet at McGill University, using 100 files randomly selected at TRAUMA*TYS* (2004),

  - This specialized and integrative psychotherapy for PTSD lasted naturalistically an average of 9 months, varying from few weeks to many months

  - Using the SCID structured diagnostic interview, PTSD remission rate was 96%:

    - 48% complete remission
    - 48% with residual symptoms

TRAUMA AND PERSONALITY DISORDERS

INTRODUCTION

- Unfortunately, diagnoses of personality disorder (PD) diagnoses are too often used as accusatory labels, while they are useful clinical identifiers of a condition.

- There is also a too frequent accusation of victims for being responsible for the crimes they have endured.

- It appears that both are at least partially defensive manoeuvers against our helplessness toward aiding these individuals and toward the message they carry at times.

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- Recent theoretical models of PD increase our understanding of these disorders, as well as the therapeutic effectiveness, rendering possible and useful a synthesis of these two clinical realities, that is, PD and PTSD.

- In this seminar, the emphasis is placed on the PD model of Masterson (1989), while the psychotherapeutic model derived from the attachment theory of Bowlby (1988) is also emphasized.

- With respect to PTSD, the dynamic model of Horowitz (1986) and the integrative model of Gaston (1995) are retained, with the addition of the cognitive-experiential models of McCann & Pearlman (1990) and Epstein (1991).

TRAUMA AND PERSONALITY DISORDERS

INTRODUCTION

- Besides the diagnoses of PD and PTSD, there is the concept of complex PTSD and the suggested diagnosis of DESNOS (Herman, 1992).

- These concepts recognize the distortions in the victim's self as they were enforced by the perpetrator in the context of a repeatedly abusive relationship, including an internalization of the perpetrator into the center stage of the psychic world of the victim. But, these concepts have important shortcomings:

    - They fail to explain the variations in damage to the self and in the defensive manoeuvers employed by victims;

    - They view personality disorders as a direct consequence of traumatic events in childhood, which is not supported empirically; not all abused children develop personality disorders while children who have not been victims of traumatic events may develop personality disorders.

    - They have interfered with the possible reconciliation of PTSD and PD.

- Traumatic events could be the cause for some PD but only if events are repetitious and severe, and PD is more likely to be a function of an interaction between the person (temperament-personality) and the environment (familial and extra-familial) (Paris, 1997).

- According to my clinical and knowledge, traumatic events reinforce a pre-existing PD, and PD is a predisposing factor to develop PTSD.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Experience during a Traumatic Event and PD Development

- Similarities of experiences leading to PTSD and PD:
    - In PTSD, the victim was made into an object

      = > in PD, as a child, the person was the object of significant caregivers

    - In PTSD, the victim experienced extreme loneliness

      = > in PD, as a child, the person experienced emotional abandonment

    - In PTSD, the victim experienced annihilation anxiety

      = > in PD, as a child, the person experienced abandonment anxiety/threats, which could have led to the death of the child

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PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Responses of Well-Structured Individuals

- Well-structured individuals have strong-enough ego capacities (i.e. defense mechanisms, cortical and limbic functioning, etc.) to contain and metabolize intense dysphoric affects and good-enough internalized objects.

* * *

- When they are victims of a traumatic event, well-structured individuals experience the dysphoric affects associated with the traumatic event in a somewhat contained way, and they experience dysphoric affects associated with relatively circumscribed conflicts.

- Their dysphoric affects are amenable to be addressed directly in psychotherapy.

* * *

- Across types of traumatic events, only 25% of victims develop PTSD, among which are:
    - well-structured individuals having experienced very violent traumatic events and
    - not-so-well-structured individuals having experienced traumatic events of varying intensity.

- In community samples, PTSD severity is found to be proportional to the intensity of the violence embedded in traumatic events (accounting for 25% of PTSD severity variance on average), emphasizing the contribution of the traumatic event *per se* to PTSD.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Responses of Individuals with PD

- Oftentimes, individuals with PD have reduced ego capacities to contain and metabolize intense dysphoric affects and they have malevolent internalized objects.

* * *

- When they are victims of a traumatic event, individuals with PD experience overwhelming affects associated with both the traumatic event and the core conflict surrounding the emotional abandonment experienced in childhood.

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- These patients are overwhelmed by these dysphoric affects due to their reduced ego capacities, and the dysphoric affects are maintained by the malevolent internalized objects (e.g. internalized perpetrator).

- The percentage of individuals with PD developing PTSD is unknown.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Responses of Individuals with PD

- At TRAUMA*TYS*, a clinic specialized in treating PTSD which I founded, over thousands of patients have been treated, and a majority presented with PD according to the Masterson (1989) approach, although most had moderate to high functioning levels.

- In 120 patients at TRAUMA*TYS*, no association was found between PTSD severity and the intensity of the violence in the traumatic events (r = .00), contrary to what is usually observed in community samples, suggesting the presence of pre-morbid factors (Gaston, unpublished).

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- So, in PD, traumatic events appear to act as stimuli reactivating the dysphoric affects and malevolent internalized objects associated with core abandonment experiences in childhood.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Attachment Patterns

- In the attachment literature, It has been shown that an insure attachment pattern at 1 year old has strong predictive validity for an insure attachment disorder in adulthood.

- At birth, infants have a genetic blueprint for a neuronal structure in the right pre-frontal cortex, connected with the amygdala, which can be built through soothing from a primary caregiver and therefore develop basic self-soothing capacities in infants (Shore, 1996).

- Attachment patterns are as follows:

    - Secure attachment is due to a contingent responding by the mother when the child cries and needs to be soothed, leading the child to demonstrate distress at the departure of the mother, to be able to soothe himself or herself during her absence, and to show distress momentarily upon the return of the mother.

    - Insecure ambivalent attachment is due to non contingent responding by mother when the child cries and needs soothing, leaving the child unsoothed and never certain that there will be a response; therefore, the child expect abandonment even when an adequate response by the mother is given.

    - - Insecure avoidant attachment due to non-responding by mother in a consistent fashion, leading the child to not express distress (or very little) and to pretend indifference when the mother leaves or comes back.

    - Disorganized insecure attachments are usually seen in the context the two insecure attachment patterns, and are due to early traumatic events, presenting dissociation (see Siegel, 1999).

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Attachment Patterns (continuation)

- Good-enough mothers soothe when their infant is in distress, and stimulate joyful play when the infant is bored or available to stimulation. The quality of voice of the mother is quite illustrative:
    - Mothers fostering a secure attachment in a child meets the child half way in terms of the distress shown in the voice, while
    - Mothers fostering an ambivalent attachment display a voice showing as much distress as the child, and
    - Mothers fostering an avoidant attachment display no distress in a voice in response to call of distress by their child.
    - So good-enough mothers fostering a secure attachment in their child display in their voice both their empathic recognition of the child's distress and their capacity to remain calm and, therefore, competent in soothing her child. Such mothers meet the child half-way in his or her distress, and bring their voice pitch down gradually, while verifying that the child's distress decreases along the way (Siegel, 1999).

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Attachment Patterns (continuation)

- If such attuned and sensitive attitude is consistently displayed by the therapist, it can play a major role in psychotherapy for patients presenting with insecure attachments, helping to build brain structures involved in affect modulation and to foster the internalization of a benevolent representation of a strong caregiver.

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- At TRAUMA*TYS*, some patients were recruited to participate in a neurological study of the fMRI activity of specific brain changes in association with changes in PTSD severity. It was found that, after 6 to 9 months of integrative psychotherapy specialized for treating PTSD, patients displayed a PTSD reduction which was correlated with decreased activity in the amygdala (center highly involved in the production of anxiety, emotions, and emotional memory), in the hippocampus (center involved in the integration of complex information, and in non-emotional memory) and in the right anterior cingulate cortex (center involved in the modulation of emotions and emotional behaviors) (Dickie et al., 2011).

  At moderate levels of stimulation, the amygdala, the hippocampus, and the anterior cingulate cortex function proportionally, if we refer to the Yerkes-Dobson law. If there was less activation of the amygdala provoked by images of fearful faces in those recovered from their PTSD, there was less need for the hippocampus and the anterior cingulate cortex to function. Therefore, it appears that the amygdala itself was calmed down, with a lessened baseline activation level and a heightened threshold of activation.

  These findings support the presence of neurological changes associated with psychotherapy.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Dynamic Models for PTSD

- Fenichel (1945): Traumatic events revive infantile conflicts which come to reflect ways of feeling and defending that were operative in childhood.

  = > considers childhood-based conflicts

  * * *

- Horowitz (1986): Traumatic events interact with the person's schemas of self and others to create dysphoric meanings which reactivate affect-laden conflicts and cannot be assimilated by the person developing PTSD.

- Catherall (1991): Primary trauma damages the ego, and secondary trauma damages the person's relationship to internalized objects.

  = > consider ego strength, conflicts, internalized objects, and their interaction with the traumatic material

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Horowitz's Model for PTSD

- Horowitz (1985) proposed a psychodynamic theory of PTSD, then labelled *Stress Response Syndrome*, including the principles of information theory and the notions of self-others internal representations or schemas:
    - Traumatic information is integrated by being assimilated into the pre-existing self, or the pre-trauma self accommodates to the traumatic information.
    - PTSD develops if the traumatic information is too incongruent with the pre-existing self (schemas of self and others, and associated affects).
    - In PTSD, the traumatic information cannot be assimilated, so, the self needs to accommodate itself to allow the integration of the traumatic information into the whole self, otherwise the self will be split into pre-existing self and traumatic self.
    - The involuntary oscillations observed in PTSD are driven by a tendency to completion (or self-actualization) to force the consideration of this new, significant material.
    - This integration through accommodation is achieved from conscious and voluntary oscillations between the traumatic and pre-existing selves, so that self-others schemas are altered to allow the traumatic self to become ego syntonic.
    - The meanings associated with the traumatic event are elaborated in interaction between the qualities of the traumatic event and the schemas of the pre-existing self.
    - Traumatic events fuel warded-off affect-laden conflicts.

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PHYSICAL VS PSYCHOLOGICAL INTEGRITY

PTSD in PD

- From a Masterson's perspective, Orcutt (1995) suggests that:
    - In PD, the traumatic information is too congruent with parts of the pre-existing self or self-others schemas and, therefore, evokes the dysphoric affects associated with these schemas.
    - These congruent aspects of the pre-existing self have been warded-off from consciousness and the associated affects are actively defended against.
    - The traumatic event fuels them so they strongly resurface.

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- Said otherwise, a traumatic event makes individuals with PD have an experience which is too much like the ones they have experienced with great pain in their early childhood and have tried to suppress thereafter, experiences which have become the cornerstone from which their psychological structure has been erected.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

PTSD in PD (continuation)

- Sometimes, individuals with PD can alter the traumatic information and thus assimilate it into their conscious ("The rape was nothing; I can handle that!") as suggested by Hollon and Garber, 1988). Such assimilation is maladaptive, although functional.

- Otherwise, they have to:

    - Accommodate their pre-existing structure to the traumatic information, and

    - Identify partly with their traumatized self, rather than rejecting it (Gaston, 1995).

* * *

- As suggested by McCann & Pearlman (1988), prior negative schemas can be seemingly confirmed by victimization, while Beck & Emery (1985) put it in terms of confirming prior negative beliefs.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

PTSD in PD (continuation)

- Epstein (1991) suggested that individuals elaborate a self-theory which should fulfil four basic functions. Each function is associated with particular self-others schemas:
    - Maintaining favorable pain-pleasure balance (Freud)

      = > benevolent others versus malevolent others
    - Maintaining a coherent self-theory (Rogers)

      = > world is meaningful (predictable, controllable, just) versus the world is meaningless
    - Maintaining self-esteem (Adler & Allport)

      = > self is worthy (competent, lovable, good, attractive, etc.) versus unworthy
    - Maintaining relatedness (Bowlby)

      = > others are worthy relating to versus unworthy

***

- In PD, these negative schemas are likely to have developed in childhood and to have been reactivated by a traumatic event if there is a PTSD.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

PTSD in PD (continuation)

- Brain imaging studies have also found decreased function of the anterior cingulate cortex in abuse related-PTSD during recall of traumatic memories (Bremner et al., 2005).

- Repeated traumatized individuals in childhood were also found to display smaller pre-frontal cortical and hippocampal areas than controls. They also display memory deficits and failure to activate the hippocampus during memory tasks (Bremner et al., 2005).

***

- Like in PTSD, individuals with PD are clinically known to have structural deficits in modulating emotions and emotional behaviors.

- From a neurodevelopmental assessment of subjects with borderline personality disorder, it was found that neurodevelopmental vulnerability is a stronger predictor than childhood history of abuse (Kimble et al., 1997).

- Horowitz and colleagues (1986) found, in 52 bereaved patients given brief dynamic psychotherapy for PTSD, that more exploratory actions were more suitable for highly motivated and/or better-organized patients and less suitable for patients with lower levels of motivation or organization of self-concept.

  Conversely, more supportive actions were more suitable for patients at lower dispositional levels and less therapeutic for patients at higher levels.

From clinical experience, I hypothesize that persons presenting with narcissistic and schizoid disorders of the self also have neurodevelopmental vulnerability and deficits, although these individuals do not overtly display the associated overwhelming distress, as persons with a borderline disorder of the self.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

PTSD in PD (continuation)

- With patients treated at TRAUMA*TYS*, Dickie and colleagues (2013) conducted a neurological study. Functional and structural Magnetic Resonance Imaging (fMRI) was employed to examine brain activity and structure in severely symptomatic PTSD patients at the beginning of psychotherapy and 6 to 9 months later, when the majority of patients no longer met diagnostic criteria for the disorder.
    - The thickness of the right anterior cingulate cortex (center involved in the modulation of emotions and emotional behaviors) before treatment predicted PTSD severity 6 to 9 months later. Initial patients' capacity to modulate affects thus influenced psychotherapy outcome in the short-term.
- Thin or small key cortical areas may indicate, in the long term, a structural deficit due to damages to neurons by glucocorticoids (large stress hormones).

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Masterson's Approach to PD

- Masterson (1985) proposed a synthesis of developmental, object relations, self and ego psychology theories for understanding PD.

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- PD develops if there is a mother-child misattunement, based on oversensitivity on the part of the child and/or an unavailability of the mother.

- In PD, the child meets an unempathic wall against dependency and/or autonomy needs (depending on the developmental age and, therefore, the possible personality disorder to be developed), which renders him/her helpless to get what is needed emotionally.

- The child's strides toward need fulfilment lead to threats, explicit or implicit, of being abandoned, which is experienced as emotional abandonment.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Masterson's Approach to PD (continuation)

- These children erect a defensive structure to avoid experiencing the emotional abandonment (or sometimes real abandonment), labelled as abandonment depression by Masterson:
    - The real self, with associated overwhelming affects, is suppressed.
    - Self-activation, which resides in the real self, is kept in check, preventing self-actualization.
    - A false self is created in an attempt to answer the needs of the caretaker and, therefore, prevent further abandonment.
- Therefore, in PD, the self is composed of a false, defensive self, erected to defend against the dysphoric affects of abandonment anxiety and depression, and of an impaired self, which is the rudimentary core of the real self.

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PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Masterson's Approach to PD (continuation)

- Masterson's description of PD is analytical rather than phenomenological as in the DSM.

- For Masterson, individuals with PD present low to high functioning levels.

  As for temperaments, although they are genetically determined, they can be modified by the environment when the temperaments are not extreme (Chess and Thomas, 1986).

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Masterson's Approach to PD (continuation)

- Four types of PD, or disorders of the self, are proposed by Masterson:
    - Psychopathic = No object relation (not considered here)
    - Schizoid = Forbidden to have needs, emotions, wishes
      Inner Model = Master vs Slave/Sadistic Other vs Self-in-exile
        - "Is anybody there?"
        - (Secret or Manifest)
    - Narcissist = Forbidden to be dependent, vulnerable
      Inner model = Admiring vs Admired/Admired vs Admiring
        - "Does anyone see what I see?"
        - (Closet or Manifest)
    - Borderline = Forbidden to become capable/independent
      Inner model = Rewarding/Withdrawing vs Good/Bad
        - "Does anyone care?"
        - (Compliant or Hostile)

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- Hare's (1993) research supports Masterson's notion of psychopathy, showing a lack of neurological reactivity in psychopaths to affect-laden words, while other inmates present reactivity to affect-laden words.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Temperament

- Level of functionality can largely depend on temperament.
- Temperaments play a role (Chess & Thomas). There are three basic temperaments:
    - Easy infants and children (can be easily soothed, and adapt to change)
    - Slow-to-warm-up, or fearful infants and children; 25% of them remain pathologically shy throughout their lives even if adequate parenting is provided in terms of soothing, patience, and encouragement toward participating in fearful situations such as groups (they take longer to be soothed and often present difficulties with change)
    - Difficult, or feisty infants or children; 70% of them develop behavioral problems later in life (they are hard to soothed, reacting with intense anger and rage at times, are anger-prone, and tolerate little frustration)

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- It seems to me that temperaments can counterbalance or reinforce PD.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

Similarities between PTSD and PD

- For each type of PD, the experience of a traumatic event will be specifically based on the interaction between the traumatic information and the person's internalized self-others schemas.

  My clinical experience informs me that the abandonment anxiety, announcing the abandonment depression, is activated at an unconscious level by a traumatic event in all individuals with both PD and PTSD, although some are better at defending against it.

- Similarities of experience between PD and PTSD are as follows:

PTSD	**PD**
Threat to physical integrity	Threat to psychological integrity (= > physical for infants)
Perpetrators as malevolent	Caregivers as malevolent
Fear Helplessness Extreme loneliness	Fear Helplessness Feelings of abandonment

* * *

- By association, during traumatic events, individuals with PD experience exactly what they have erected a whole defensive structure against, that is, abandonment, along with the associated dysphoric affects and negative schemas of self-others.

TRAUMA AND PERSONALITY DISORDERS

PHYSICAL VS PSYCHOLOGICAL INTEGRITY

PD Vulnerabilities Toward PTSD

- PD comprises many predisposing factors for developing PTSD:
    - Ego-related vulnerabilities reside in the fact that individuals with PD have not developed defenses which provide perspective on internal realities, but they rather employ defenses which push their internal realities out of consciousness. Their limbic system may also be hypersensitive; therefore, they are not so capable of containing intense dysphoric affects once their defenses collapse.
    - Object-related vulnerabilities reside in highly negative self-others schemas which have developed through their experiences in early childhood, and tend to be confirmed later on in life.
    - Conflict-related vulnerabilities reside mostly in the core conflict between abandonment depression and self-activation.
- Nonetheless, not all individuals with PD will develop PTSD after a traumatic event; an interactive fit is required between the traumatic information and the pre-existing real self, as proposed by Horowitz. Borderlines tend to be more reactive to traumatic events than narcissists and schizoids.

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

Masterson's PD Triad

- Self-activation => anxiety/depression => defense

  but, in time

  = > the pull to self-activate may resurface

- For PD, Masterson postulates a core conflict between a:
  - Need to avoid abandonment depression
  - Need to self-activate/self-actualize
- Abandonment depression = depression, anger, fear, guilt, passivity, helplessness, emptiness, and void
- Self-activation = doing things according to one's real needs/wishes
- During a traumatic event :

  forced self-activation = > abandonment anxiety = > defenses intensify

  but, in time

  = > the pull to self-activate may resurface

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

PD Triad in PTSD

- Traumatic event = > self-activation:
  - Feelings at the core
  - Doing things for oneself
  - Wishes from real self
- Traumatic event = > annihilation and abandonment anxiety in PD

  = > intensification of defenses and regression
- PD patients with PTSD may come into therapy in states of avoidance, abandonment and/or annihilation anxiety, or abandonment depression. They may also fluctuate from state to state.
- Traumatic events may also be unconsciously perceived as impediments imposed by life (i.e. others), such as a punishment, toward self-activating when traumatic events occur right after an individual has successfully self-activated. Such situation renders it harder to treat such an individual because the basic negative schema of self-others has been forcefully reinforced.

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

PD Defenses

- In addition to usual PD defenses,
    - Schizoids = >
        - Distancing
        - Intellectualization
    - Narcissists = >
        - Idealizing and devaluating
        - No conscious clinging
    - Borderlines = >
        - Clinging (dependent or hostile)
- Usual PD defenses are:
    - Projective identification
    - Projection
    - Splitting
    - Acting out
    - Denial
    - Avoidance

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

Transferential Defenses

- Transference needs to be distinguished from the therapeutic alliance which stems from the attachment need and is a necessary process ingredient to obtain significant changes in psychotherapy.

- Transference may serve the function of:

    - Defending against experiencing abandonment depression
    - (abandonment-based, defensive transference)

    - Protecting against future pain (trauma-based transference)

    - Anticipating reality from one's schemas which were elaborated from multiple and similar past experiences (schema-based transference)

- In individuals with PD and PTSD, there are thus three types of transferential reactions to consider.

- Each type of transference reaction needs to be managed differently:

    - Abandonment-based transference needs to be either managed through the therapeutic relationship or interpreted.

    - Trauma-based transference needs to be identified and responded to in a deactivating way.

    - Schema-based transference needs to be addressed mostly cognitively by contrasting past and present realities.

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

Transferential Defenses (continuation)

- PD-related transference can be specific to the types of PD:
    - Schizoids will tend to hide their feelings from the therapist, and/or to subjugate themselves to external demands (including the therapist's explicit, implicit, or projected demands).
    - Narcissists will tend to idealize or devalue the therapist, and present themselves in an excessively unfavorable or favorable light.
    - Borderlines will tend to expect that the therapist will take charge of them; otherwise, they will become hostile.
- Individuals with PD will also have therapists pass a test:
    - Schizoids will test whether a therapist will try to become intimate.
    - Narcissists will test whether a therapist will accept them with their deficiencies, or expect them to be perfect.
    - Borderlines will test whether a therapist will treat them as being incapable of managing their lives, or invade their boundaries.
- These manoeuvers could be viewed as transference reactions embedded in the hope that someone will react differently from previous caregivers, as suggested by Weiss and Sampson (1986).

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

Transferential Defenses (continuation)

- Trauma-based transference reactions may be based on experiences at the hands of the perpetrator, and from interacting with immediate helpers and significant others in the aftermath of a traumatic event.

- McCann & Pearlman (1990) suggest that victims can come to perceive their therapists as:

    - aggressors
    - violators
    - betrayers
    - interrogators
    - controllers
    - indifferent witnesses
    - potential victims of the patient's aggressiveness
    - helpless bystanders
    - saviors

- Of course, these trauma-based transferential reactions can be fuelled by specific self-others schemas embedded in PD.

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

Counter-transferential Defenses

- Counter-transferential reactions may be based on:
    - Projective identification by the patient
    - Trauma-related material
    - Therapist's own issues

* * *

- It is interesting to note that both PTSD and PD patients often employ projective identification as a defense against overwhelming affects (Masterson & Klein, 1989; Catherall, 1991).

- Projective identification involves putting overwhelming affects and unacceptable attitudes onto the therapist, and then seeing how the therapist handles them.

- Counter-transferential feelings based on projective identification can be quite therapeutic in that they provide important information about the patient's inner world, representing either how the patient feels or how significant others have felt and acted toward the patient.

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

Counter-transferential Defenses (continuation)

- With PTSD, McCann & Pearlman (1990) propose that, therapists can become:
    - Hostile or indifferent toward the victim
    - Angry or enraged at the perpetrator and/or society while losing sight of the patient
    - Helpless or overwhelmed
    - Oriented to save the patient from further pain
- Similar counter-transferential reactions can be experienced with individuals with PD, and they should be kept in check.

* * *

- Counter-transferential reactions based on the therapist's own conflicts should be restrained from influencing the psychotherapeutic process, and the therapist should attend to their resolution outside of the therapeutic context.

* * *

- Counter-transference "acting in" may be viewed as a therapist's collusion with a patient's projective identification or as a therapist's own issues, most likely leading to a reinforcement of the patient's self-others schemas.
- Unless the therapist recognizes the "acting in" and its source, genuinely feels sorry for it, and uses the associated knowledge to better understand the patient, such "acting in" is anti-therapeutic.

TRAUMA AND PERSONALITY DISORDERS

DEFENSES AGAINST TRAUMA INTEGRATION

Dissociative Defenses

- Contemporary traumatic events may elicit dysphoric affects and negative schemas of self-others related to:
    - PD
    - Early traumatic events ("I thought I had resolved that!")

* * *

- If traumatic events occurred during the formative years (0-3), there may be dissociative defenses involved (Orcutt, 1995).
- Implementation of dissociative defenses may vary according to the age at which traumatic events have occurred and their violence.

* * *

- If traumatic events occurred during the formative years, Orcutt (1995) suggests that:
    - Experiential components of traumatic events are put in storage; part of self is left behind, unable to grow.
    - Development of PD reinforces the ensuing PTSD through its rigid patterning of defenses.
    - Dyadic experience in traumatic events intrudes on the interpersonal space where mother and child are creating the child's inner models.
    - Repression barrier around 3 years old may seal the processing and structuring of the formative years, reinforcing the internalized model of self-others.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Trauma-Focused Work?

- Intense dysphoric affects associated with PTSD and PD can lead to an intensification of defenses which, when they are unsuccessful, brings the individuals to be overwhelmed and dysfunctional, and often bring them in psychotherapy despite themselves.

- The wish for consulting is usually to be helped successfully to avoid experiencing painful affects. It is also geared paradoxically toward self-activation but in a more unconscious manner.

* * *

- When PTSD develops in PD, the traumatic event was experienced by the real self, thus forcing self-activation.

- So, experientially reviewing a traumatic event is thus intolerable for individuals with PD because it reactivates the real self and its associated pain.

* * *

- Therapists need to be aware of pulls from patients to review or address traumatic events too early in therapy; it may represent a transferential acting out, or testing of the therapist.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Trauma-Focused Work? (continuation)

- When PTSD happens in PD, there is:
    - Trauma-related pain
    - Abandonment-related pain
- Any experiential review of a traumatic event, or trauma-focused work, evokes intense dysphoric affects for everybody but, in PD, these affects are related to both the traumatic event and the emotional abandonment experienced in early childhood.
- So, when an experiential review of a traumatic event is undergone with an individual with PD, as the ego is not able to contain and metabolize intense dysphoric affects, such review creates unmodulated arousal and a consequent intensification of defenses (especially if PD is associated with low to moderate functioning).
- Such review in PD can thus be anti-therapeutic and may even harm the therapeutic alliance, as well as further hypersensitize the limbic system.
- Experientially reviewing a traumatic event with a PD patient should thus:
    - Remain at a cognitive level, while providing empathic comments about the traumatic experience to enhance recognition of the traumatized self
    - Be conducted in the context of personality-focused work

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Trauma-Focused Work? (continuation)

- Therefore, as suggested by Orcutt of the Masterson Institute, when someone presents with PTSD in PE,

  Personality-Focused Work Before Trauma-Focused Work

  Restructuring Before Reviewing

***

- However, when patients present only with PD and no actual PTSD, although there is a history of past traumas, the therapists must attend to PD only, unless memories of traumatic events resurface if ever.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Integrative Psychotherapy for PTSD

- Dynamic psychotherapy for PTSD is geared toward ego functioning, conflict resolution and object relations, as well as the interaction between the traumatic material and the pre-existing schemas.

- It is phase-oriented.

* * *

- Horowitz's (1986) model, with Gaston' additions (1995):

    - Phase A:
        - Regain control over one's worlds
        - Recognize one's traumatized self (parallels Masterson's testing phase)

    - Phase B:
        - Integrate the traumatic information (parallels Masterson's working-through phase)

    - Phase C:
        - Stabilize the new self
        - Reappraise traumatic events as challenges (parallels Masterson's separation phase)

- As it is restructuring, Phase A could be sufficient for some traumatized individuals with PD because it can help them regain control over their lives while recognizing their traumatized self and paying more attention to it in a benevolent way.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Techniques For Regaining Control in PTSD

- Regaining control over one's internal and external world is necessary to counter the feelings of helplessness elicited in both PTSD and PD.
- Regaining control allows one to contain one's PTSD symptoms and to foster one's psychosocial functioning.
- Techniques:
    - Explain PTSD phenomenon
    - Reframe one's contributions to the traumatic event
    - Identify and reinforce adaptive coping strategies
    - Alter problematic defenses
    - Encourage patients to :
        - reduce trauma-related exposure
        - limit internal and external demands
        - seek appropriate help from environment
        - reduce criticism toward oneself
        - take medication
        - seek affective support
        - use strategies to counter memory difficulties
        - address & solve external stressors
        - enhance self-care
        - augment pleasurable events

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

- Most individuals with PD have different reactions to the majority of these standard techniques employed with PTSD.

- Regaining control may involve self-activation, which is likely to be met with varying defenses by individuals with PD.

- As the control over their lives is managed by the false self of schizoids and narcissists, it may be easier for them to apply these techniques aiming at regaining control, but conflicts surrounding the use of these techniques can nonetheless emerge:

    - Schizoids may view these techniques as dangerous because they often involve focusing on one's inner world or promote proximity with others (including the therapist).

    - Narcissists may view them as humiliating as they emphasize their wounded, vulnerable self; so they may devalue them.

        Resistances toward such techniques may also arise from the schizoids' and narcissists' pull toward self-activation, which requests the recognition of the traumatized and abandoned selves rather than an enhancement of the defensive, competent self.

    - Borderlines may avoid collaborating at reducing PTSD symptoms and, therefore, enhancing their level of functioning. Borderlines may even alter the adaptive function of some of the coping strategies (e.g. seeking affective support to further regress into dependency).

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

- Therefore, beyond technique, therapists need to:

    - Schizoids need to be provided with control and be helped them feel safe within the therapeutic relationship (safety first, avoid emotions).

    - Narcissists need to be provided with realistic admiration and assistance (to promote some and healthy idealizing transference, rather than a negative one).

* * *

- From a different perspective, therapists need to provide:

    - Borderlines:

        - Structure and encourage their autonomy
        - Be astonished at their regression tendencies and encourage them to be concerned about themselves
        - Use confrontations as suggested by Masterson (address internal struggle between regressing vs. taking charge of one's life, along with their respective consequences)

"I wonder why you keep going back to the shelter because
it interferes with your self-confidence,
especially given that you have shown that you want and
are able to take charge of your life,
but this would involves bearing painful emotions."

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Techniques For Recognizing Traumatized Self in PTSD

- Techniques:
    - Empathy for:
        - Patient's distress, traumatized self
        - Patient's reactions during the traumatic event, while putting them in the context of abandonment anxiety
    - Validation of:
        - External dangers
        - Illegitimacy of perpetrator's actions
        - Helplessness forced onto the patient during event
        - Psychological damage beyond one's control
        - Limited appropriate control during the traumatic event
    - Exploration of:
        - Events and states of mind before traumatic event
        - Self and others' responses after the traumatic event
        - Traumatic events; past and present (cognitively; if possible, to make links)
        - Significant relationships; past and present
        - Interpretation of defenses, and their related material, along with making links with the emerging material

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Techniques For Recognizing Traumatized Self in PTSD

- Therapist need to intervene by addressing defenses employed toward the traumatized self and the abandoned self:

  - Schizoid = > Interpretation of schizoid dilemma & compromise
    (as suggested by the Masterson approach)
    The pain is acknowledged, and the defense against feeling in danger is pointed out.

    "Given what happened, I understand that you retreat within yourself in order to avoid terrible feelings of insecurity."

  - Narcissist = > Mirroring interpretation of narcissistic vulnerability
    (as suggested by the Masterson approach)
    The disappointment is recognized, and the defense against feelings of vulnerability is pointed out.

    "I understand that you protect yourself by finding justifications for the aggressors' actions, because it prevents you from feeling angry, as well as vulnerable."

    * * *

- With borderlines, therapists should restrain from interpreting the traumatized self outside of confrontations until the individual has mostly undone the conflict about dependency/self-activation, because it fosters their regressive tendencies as borderlines tend to overly identify with their traumatized self.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Techniques For Recognizing Traumatized Self in PTSD

- For individuals with PD, recognizing their traumatized self may lead to intense dysphoric affects associated with both abandonment and annihilation anxieties.

- To render those anxieties somehow tolerable, a therapist can cognitively put those anxieties within their spatio-temporal context, along with the associated figures, and handle the therapeutic relationship in accordance with the respective PD anxieties.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Techniques For Recognizing Traumatized Self in PTSD

- With schizoids and narcissists, the emphasis is put on empathically recognizing their traumatized self and the abandoned self, directly or indirectly, because they usually defend against it and, by doing so, they can emerge and be addressed.
    - Schizoids = >
        - Recognize feelings of insecurity and the reality of past dangers (if tolerable)
        - Provide a sense of safety and control
        - Become an empathic and patient witness (take an approach resembling the taming of a wild wounded animal)

          “I understand; it does not feel safe.”
    - Narcissists = >
        - Recognize feelings of vulnerability and the patient's realistic limits in a non-shaming way.

          "You were not as strong as you wished you could have been."
        - Provide some sense of togetherness through the support offered toward the patient's distress and somehow promote an idealizing transference.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Techniques For Recognizing Traumatized Self in PTSD

- With borderlines, the emphasis is put on empathically recognizing the competent self, without denying the traumatized and abandoned selves.
    - Borderlines = >
        - Recognize the reality of the traumatic event and its associated dysphoric affects
        - Cognitively differentiate the realities of the traumatic event and the patient's capacities to handle life stressors most of the time
        - Confront a tendency to identify with the dysfunctional traumatized self in order to avoid taking charge of their lives
        - Remain confident in the patient's capacities
        - Succeed in not owning one side of their conflict by attempting to take control over them

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Integrating Trauma with Personality-Focused Work

- In PD, the Phase B of the dynamic therapy for PTSD should be replaced with personality-focused work, i.e. revising the relationships with significant others and the internalized objects (self-others schemas), both cognitively and emotionally.

- By this restructuring work, the schemas associated with the traumatic event should be accommodated (i.e. transformed and rendered more flexible) so that they no longer destabilize the system.

- As suggested by Bowlby (1988), the focus needs to be placed on:

    - Internalizing the therapist's strong, benevolent figure

    - Identifying the patient's relationships with significant figures
    - (past and present)

    - Differentiating from these significant figures

    - Tackling one's abandonment anxiety

    - Linking one's schemas with one's experience at the hands of perpetrators, so one can come to understand some of the reasons for which PTSD developed

    So, one can alter one's relation to oneself and others, and view oneself as competent (less vulnerable) most of the time, and others as benevolent (or less malevolent) most of the time.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Personality-Focused Work in PD

- With respect to the therapeutic alliance, personality-focused work aims to:
    - Provide a new benevolent figure through the therapist, so patients can attach themselves to the therapist, so the benevolent figure can be internalized, through the therapist being reliable, sensitive, attentive and empathic (just as an adequate mother is with her child who will become a securely attached person).
    - So, it provides a secure base from which patients can explore their past and present experiences (including abandonment depression and helplessness), as well as their internalized objects.
    - So, it provides a secure base from which the patient can contrast past and present experiences with significant others.
    - So, it counterbalances the workings of the patients' malevolent internalized objects and, therefore, assists patients in differentiating themselves.
    - So, it allows individuals with PD to fundamentally regain control over both their internal and external worlds.

(Bowlby, 1988)

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Personality-Focused Work in PD (continuation)

- With respect to transference, personality-focused work aims to:
    - Examine the patient's relationship to the therapist, only whenever it interferes with psychotherapeutic progress
    - View most of the patients' reactions toward the therapist's absences as natural whenever attachment is involved, rather than viewing them as defenses toward remembering and interpreting them.
    - Differentiate transference reactions based on past experiences with perpetrators (trauma-based transference) and/or significant caretakers (schema-based transference), from transference reactions based on defensive wishes toward avoiding abandonment depression (abandonment-based transference).
    - Encourage patients to recognize their traumatic transference and allow them to test the actual reality
    - Empathically interpret the patients' abandonment-based transference which prevents them from gaining control over the defended material

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Personality-Focused Work in PD (continuation)

- With respect to schemas, personality-focused work aims to:
    - Encourage patients to consider the ways in which they engage in relationships with significant figures in their current lives
    - Encourage patients to consider how their current perceptions, expectations, feelings and actions may be a product of childhood events or situations, or what they may have been repeatedly told
    - Enable patients to recognize their schemas derived from past experiences and misleading messages emanating from parents (mistakenly labelled as "fantasies")
    - Enable patients to recognize that these internal models have molded their relationship to themselves (self-self-object relations)
    - Interpret or confront defenses against abandonment depression
    - Encourage patients to let go of their internalized pathological relationships with malevolent internalized objects, and accept the associated feelings of abandonment coming up with bereavement
    - Encourage patients to recognize and let go of their idealized representations of neglectful and/or abusive parents, as a defense against feelings of emotional abandonment based on reality
    - Encourage patients to transform their relation to the self so they do not abandon themselves and develop self-caring attitudes
    - Encourage patients to recognize their own needs, limits, wishes, affects, and to differentiate them from those of others

(Bowlby, 1988)

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Trauma-Focused Work in PD

- After restructuring traumatized patients with PD, it may be constructive to experientially review the traumatic material with them if there is a persistence of symptoms or some dysfunctioning.
- Although Phase B of trauma therapy is often bypassed with traumatized individuals with PD, it may be useful to:
    - Counter dissociated self schemas
    - Confront the idealized parental objects with the abusive and/or neglectful parents
    - Address conflict about self-activation
- Techniques for experientially reviewing traumatic events should be adapted to patients' ego capacities, so therapists choose between:
    - Full re-experiencing through hypnosis
    - Counterbalanced re-experiencing with split-screen hypnosis
- The use of experiential reviewing techniques requires that:
    - Working-through and therapeutic alliances are established
    - The review in an usual state of consciousness is at an impasse
    - Both goals of phase A were sufficiently attained
    - Personality-focused work is well under way

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Terminating Psychotherapy for PTSD in PD

- Phase C is performed as usual.
- Goals of Phase C can usually be reached, at least partially, even with individuals with PD and PTSD.
- Working from a PTSD model versus a PD model should vary:
    - Within sessions
    - From phase to phase
    - Across patients

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Early Traumatic Events in PD

- According to Orcutt (1995), when early traumatic events are co-morbid with PD, they may re-emerge in adult life as psychotherapy starts dissolving PD:
    - Defenses are more adaptive
    - The therapeutic alliance is mostly established
    - Working through of abandonment depression is well under way
    - But, patients become disoriented, both psychically and somatically
- Therefore, working on early traumatic experiences needs to be included in the working-through phase.
- In psychotherapy, personality work may thus not be sufficient. An experiential review of traumatic events may be necessary to resolve the primitive dissociation based on trauma, allowing the integration of those lost parts of the self so they can become part of the whole self.

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

Efficacy of integrative Psychotherapy for PTSD in PD

- There are no controlled studies of its efficacy of psychotherapy for PTSD in PD, but some studies give us favorable indications.

- An independent and retrospective study found the integrative psychotherapy for PTSD according to Gaston (1995) had a 96% PTSD remission rate, with an average length of 9 months, varying from few months top few years (Brunet, 2004). Many patients at TRAUMA*TYS* present with both PTSD and PD.

- Furthermore, a prospective neurobiological study of patients treated at TRAUMA*TYS* found :

    - a 65% PTSD remission rate and

    - a significant association between changes in PTSD symptoms and changes in fMRI activity in key neurological sites: the amygdala (emotional memory, affect, and drive center), the hippocampus (contextual memory and cool system), and the right anterior cingulate cortex (modulation of affects and behaviors), after 6 to 9 months of integrative psychotherapy, although some had not yet terminated (Dickie et al., 2011).

TRAUMA AND PERSONALITY DISORDERS

TRAUMA VS PERSONALITY WORK

- From clinical observations, expectable results are that:
    - Goals of phase A to C can be attained within 1 to 3 years
    - Functional limitations may remain to varying degrees (e.g. not working anymore in high-risk jobs; mostly when patients have been abused in childhood)
    - Pre-morbid functioning is usually re-established or enhanced
    - Separation-individuation conflict may be softened depending on the:
        - pre-morbid level of functioning
        - PTSD severity
        - duration and repetition of the traumatic events

      Therefore, there is usually progress toward self-activation.
- These results can be expected only if the individual with PD has not been repeatedly and severely traumatized over long periods of time, which is likely to have created functional deficits in the limbic system.

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Efficacy of integrative Psychotherapy For PTSD in PD

- Flexibility between personality-related and trauma-related work is required to successfully help traumatized individuals with PD.
- Ideally, a therapist should know to:
    - Differentiate PTSD versus PD issues
    - Move fluidly between them

* * *

Differentiating Self-Schemas

- A therapist should differentiate between self-schemas as follows:
    - Traumatized self versus real self

      (when, during self-activation, the traumatized self appears, along with the real self)
    - Traumatized self versus defensive self

      (especially for borderlines)
    - True functional self versus defensive self

      (especially for schizoids and narcissists)
- Therapists should address them accordingly.

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Differentiating Transference Reactions

- Various types of patient reactions toward the therapist may need to be differentiated as either:
    - Attachment or therapeutic alliance, which is a non-transferential issue
    - Schema-based transference as a displacement of perceptions attached to past experiences with significant caretakers
    - Abandonment-based transference as a defense against experiencing abandonment feelings
    - Trauma-based transference as a displacement of feelings attached to the traumatic event
- Therapists should address them accordingly:
    - Promote the therapeutic alliance
    - Cognitively address schema-based transference
    - Interpret abandonment-based defensive transference
    - Provide experiential counter-learning to trauma-based transference while addressing it cognitively in parallel

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Neutral Versus Supportive Stance

- Masterson suggests to adopt a neutral stance with PD to:
    - Avoid counter-transferential reactions
    - Facilitate individuation
    - Allow the experience of abandonment depression
- Neutrality should not equate distancing because the blank screen hypothesis is a fantasy, and traumatized individuals tend to project more fear and anger than others.
- Unfortunately, distortion of neutrality too often leads some therapists to be distanced, abandoning, disengaged, rude, or plainly sadistic.
- Neutrality should equate a non-judgemental attunement, evenly hovering attention, and acceptance of contradictory aspects of a patient's self and experience (in Pearlman & Saakvitne, 1997); that is, being at equal distance from both sides of the conflict (Kernberg).

* * *

- Trauma-related techniques require a supportive stance to:
    - Allow the experience of dysphoric affects
    - Allow the experiential revision of the traumatic material
    - Foster the experience of abandonment depression
- Support should not equate protecting patients from pain

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Neutral Versus Supportive Stance (continuation)

- The therapist's stance should vary according to the:
    - Material at hand
    - Type of PD at hand:
        - narcissists require more empathic support more than schizoids,
        - borderlines require less empathic support and more support in terms of encouragement

* Trauma-related material requires support at first, than neutrality is titrated to allow patients to fully experience dysphoric affects and meanings, as long as it is tolerable and therapeutic.

* Patients can tolerate abandonment and annihilation anxieties only if they do not feel abandoned by their therapist and feel safe in the psychotherapy.

* Supportive and encouraging attitudes of the therapist should help patients contrast their feelings emanating from the past with their actual realities.

* Besides the techniques described earlier for Phase A and those suggested by Bowlby (1988), support can also consist of bearing pain with patients.

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Active Versus Contemplative Stance

- With PTSD: An active stance is required throughout therapy, although less at the end of therapy.

- With PD: An active stance is required during testing phase, But whenever self-activation arises, a more contemplative stance is recommended (Masterson & Klein, 1989).

* * *

- With PTSD in PD: As self-activation arises during the working-through phase, it may evoke traumatic issues, so an active stance is required throughout therapy.

* * *

- Active stance prevents feelings of abandonment in the here-and-now, which have been acutely activated by the traumatic event.

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Giving Control to Patients

- With PTSD, control should be "given back" to patients as it was taken away from them during the traumatic event to:
    - Counter feelings of helplessness
    - Prevent unnecessary displacement of feelings from the perpetrator onto the therapist
- Same with PTSD in PD

* * *

- Frame issues should be enforced only if digressions dilute the therapy efficacy; otherwise, the therapist should respect them as legitimate attempts to regain control over one's life.
- In giving control to patients, the implicit message is that they are adults capable of making decisions whenever they are informed properly, and that they are an ally in psychotherapy rather than an object of the therapist's authority.

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Preserving Self-Esteem

- During a traumatic event, humiliation is experienced from:
    - Having to submit to perpetrators
    - Being rendered helpless by perpetrators
    - Being treated as insignificant by perpetrators
- Awareness of the patients' damaged self-esteem is required by the therapist and it must be countered whenever possible by:
    - Reinforcing patients' constructive actions toward their real selves
    - Reinforcing patients' accurate perceptions of reality

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Proceeding at Tolerable Dosage

- With both PD and PTSD, addressing problematic affect-laden issues should always proceed at tolerable dosage to not :
    - Overwhelm the patient and hypersensitize the amygdala
    - Disrupt patient's functioning unnecessarily
    - Protect the therapeutic relationship
- Otherwise, the therapist may be realistically perceived by patients as intrusive and potentially malevolent.

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Countering Helplessness

- With PTSD, helplessness during a traumatic event needs to become part of the self schema of victims, coming to view themselves as:
    - Helpless but within limits (Epstein, 1991), or
    - In control but within limits
- With PTSD in PD, helplessness during a traumatic event may evoke:
    - Helplessness in childhood
    - Helplessness in actual reality
- So, for traumatized individuals with PD, traumatic helplessness can become overwhelming and/or generalized to many facets of life because helplessness is at the core of the experiences with significant others, and it should be linked to its spatio-temporal context in therapy (i.e. the traumatic event and relationships with significant caregivers).
- Helplessness becomes acceptable only if patients have an increased sense of control over their lives; therefore, the therapist should assist traumatized patients, and especially those with PD, to regain such control.
- To do so, therapists must be aware of the very frequent counter-transferential reaction of feeling helpless about aiding a traumatized patient with PD, due to a projective identification of the patient's overwhelming sense of helplessness. However, sometimes, therapists need to "simply" hold and contain the helplessness for a long time.

TRAUMA AND PERSONALITY DISORDERS

ADAPTING RELATIONSHIP & TECHNIQUES

Countering Helplessness (continuation)

- In addition to previously mentioned techniques, therapists should:
    - Differentiate actual areas of helplessness vs. possible actions
    - Encourage to act despite overwhelming feelings of helplessness
    - Encourage to accept any reality of helplessness which cannot be countered
    - Develop with patients action strategies
    - Act for patients at times, but only in a very limited fashion
    - Differentiate moments of helplessness and power during:
        - traumatic events
        - childhood relationships
    - Contrast these feelings of helplessness with actual significant relationships where a sense of control can now be achieved

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