Analysis of the therapeutic impact on a patient suffering from a personality disorder with a possible perverse connotation and dissociation disorder in a traumatic context

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Abbreviations

DSM : American psychiatric association

OCD : Obsessive compulsive disorder

PTSD : Post-traumatic stress disorder

TBP : Borderline personality disorder of traumatic origin

DID : Dissociative identity disorder

ATDS-1Other : Aissociative disorder specified subtype

PAN : Apparently normal part of the personality

EP : Emotional part

DES : Dissociative experience scale

CBT : Cognitive behavioural therapy

Abstract

This work focuses on the treatment of people suffering from post-traumatic stress with identity dissociation and personality disorders and, possibly, a "perverse connotation" in the relationship with the other. It therefore seemed appropriate to ask whether it is possible to treat all these symptoms in the context of trauma psychotherapy. Should the personality disorder be treated before the trauma What elements should be taken into account when considering treatment Which approaches should be favoured What tools should be used in psycho-trauma techniques Or should we refuse this type of psychotherapy from the outset These questions and many others seem to be relevant, and the aim of the research will be to provide elements that can answer them concisely. The aim of this work will be to shed light on and reflect on the limits of the therapeutic work that can be envisaged, as well as the tools that can be used while accompanying the patient in his or her humanity and suffering, while respecting the limits of the therapeutic possibility.

Keywords: trauma, sexual abuse, maltreatment, perversity, dissociations, personality disorders, dissociative identity disorders, gender identity disorder, hypnosis, psychoeducation

Introduction

This study focuses on the care offered to people suffering from post-traumatic stress with identity dissociation and personality disorders with, possibly, a "perverse connotation". Indeed, it seems relevant to look into this theme because it may be present in the consultation and it is congruent to know how to accompany the patient in his humanity and suffering. Is it necessary to treat the personality disorder before treating the trauma? What are the important elements to take into consideration when considering treatment? Which approaches should be favoured? What tools should be used in psycho-trauma? These questions, and many others, seem to be relevant and the objective of this research is to provide elements that can be used to answer them in a clear and concise manner. Furthermore, in view of the abundant literature, it will remain complex to take into account all the elements that make up this theme, especially as some authors present contradictory opinions. Indeed, for some, it seems dangerous to take in charge people with personality disorders in trauma, especially if they present aspects of perverse behaviour in the relationship with the therapist. Thus, the objective of this work is to bring a point of light and reflections on the limits of the therapeutic work which can be envisaged, as well as the tools which one can use. To do this, we will first look at the personality, since this is where everything starts, before presenting the personality disorder. Next, we will look at trauma and dissociative identity disorders. In addition, the focus of this dissertation will be on the management of a clinical situation. Finally, this work highlights the various factors likely to make treatment optimal as well as the contributions of the multidimensional approach, which could, therefore, serve as a basis for the development of more targeted treatment.

Clinical situation

Introducing tom

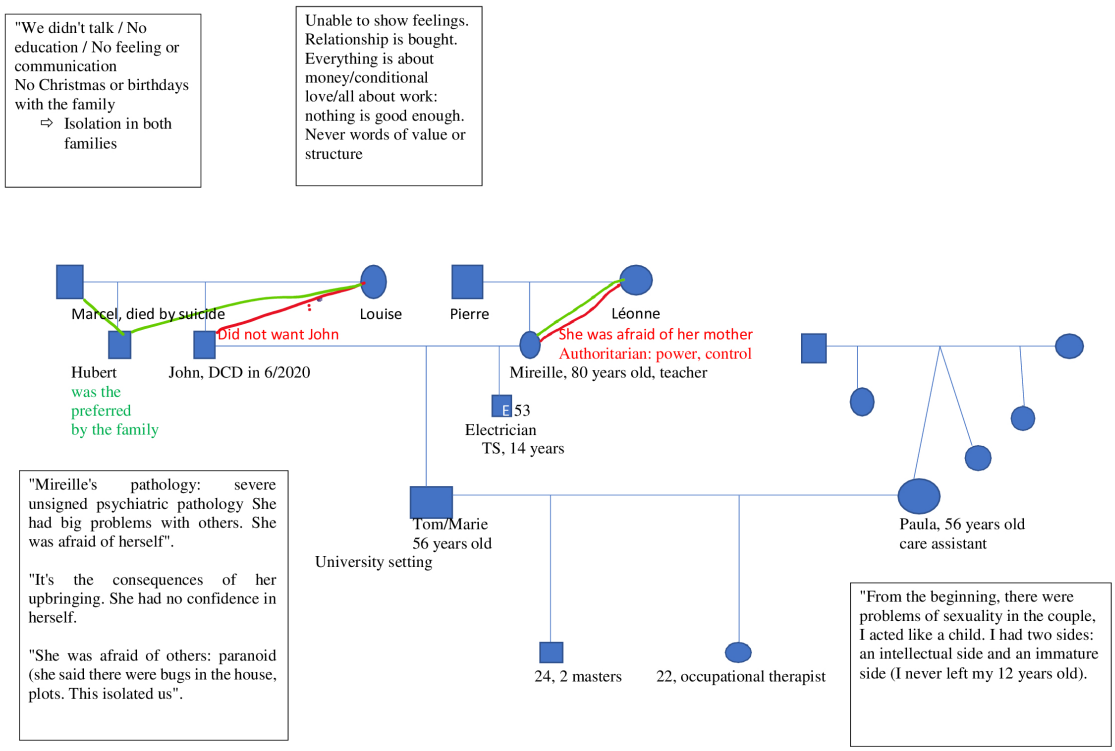
Tom is in his fifties and has been married for over 20years. He has two grown-up children: a 24-year-old boy and a 22-year-old girl. He works as a manager in an institution. He has been on sick leave for about 5years following hospitalisation due to burnout. Today, he is in early retirement due to his state of health. During the first meeting, the man explained that he was suffering from dissociation. In fact, he talks about Marie, his potential other identity. It is Mary who is present at the consultation, leaving little room for Tom's identity. He confides that he wears women's underwear under his suit and tie. We are surprised that we do not notice any "switch" of identity or change of voice when he talks about his female identity. He is also under the care of a psychiatrist and has already consulted several psychologists. The psychiatrist confirms that Tom suffers from a personality disorder. The patient says that the last psychologist was unable to continue the consultation with him because, according to him, she started crying when he verbalised the traumas he had suffered in childhood. During the consultation, he mentions recurrent flashbacks, nightmares that invade him at night. As regards his clinical treatment, he mentions a long list of psychotropic drugs. He also explains that he has a recurrent compulsive problem: he allegedly downloads large numbers of files that he does not even consult (music, films, and also, once, a child pornography site....). He would have at least a hundred hard drives at home. To conclude, he explains that he downloaded a child pornography site that he does not remember (amnesia), as he does for the rest, and today he was questioned by the police who are conducting an investigation. He is shocked by this discovery because he says that he is not attracted to children and even less to pornographic sites which he has absolutely no memory of having consulted. Could there be amnesia to these compulsions?

About his family history: Tom has a younger brother. This brother is an employee. We learn that this brother attempted suicide at the age of 14 (shot himself in the stomach). Tom's mother, Mireille, is 80years old. She was a former teacher. According to Tom, his mum had serious relationship problems. He talks about her suffering from paranoia (for example, she said that there were bugs in the house and looked for them). He explains that in Mireille's family, no one was demonstrative of emotions or feelings. Relationships were asymmetrical. The main values were work and everything is bought with money. On the side of the father, John (deceased in 2020) he remembers the coldness of this man. His grandfather, Marcel, committed suicide when Tom was still a baby. His paternal grandmother was, according to Tom, a cold person and dressed him as a girl until he was five. He describes a total isolation in both families: "we didn't celebrate Christmas or birthdays". Tom tells us that in his family "he was not given the codes" to interact with others. Yet he did well in his studies but regrets that his father never had any recognition (never any words of encouragement or structure) for his successes. On the other hand, his brother was valued despite his failures, according to the patient. He received rewards. But all this remains Tom's vision. At the couple level, there is no intimate relationship. The wife supports her husband. Her relationship with her children is cold and hard, in her words "I'm a demanding dad. I am very harsh in my judgements and my son has become very harsh on himself too. He has a parachute license. He is insensitive to pain. My daughter, on the other hand, is the opposite of her brother. She is like my wife. She likes life, she is fulfilled, she doesn't seek control, and she appreciates poetry, the arts. She is gentle. She likes to cuddle.

Background to the traumas: Tom was about ten years old when he went to visit his grandmother who owned a building and worked in the shop on the ground floor of the building.

At the back of the building there was a huge garden with garages and above the garages there was a flat. The tenants of the flat would have attracted Tom and one of his girlfriends, called Julie, who often came to play. Julie was 12 years old. Tom explains that it was in this garage that the two children were abused, humiliated and tortured by these adults on several occasions. Julie committed suicide as an adult as a result of these traumas. Tom will concentrate on his schooling and university studies to grow up. No one in his family will know, he says, about what happened in that garage. There too, he will say that his attackers disguised him as a girl. Today, he says that Marie, it is her identity that saved and comforted him during the abuse.

Genogram



Personality disorders

Definition

There are many definitions of personality. However, some points can be made. Overall, personality is an organisation, an active and dynamic process. According to Hansenne[1] personality is an internal force that determines how individuals will behave and is made up of recurrent and persistent patterns of response. Furthermore, it is reflected in several directions: behaviours, thoughts and feelings. Finally, personality is a psychological concept with a physiological basis. It is essential to emphasise this because no psychologist can deny the influence of biological factors in the broad sense on personality. In addition to the definitions of personality, there are many theories and general models, but if we wish to approach the field of personality pathologies, it is necessary to establish criteria of normality, whatever the chosen mode of approach. Indeed, according to Guelfy & Hardy[2] the study of personality disorders highlights the problem of choosing the criteria for establishing the boundary between normal and pathological on the one hand, and those for distinguishing personality disorder from mental illness on the other. This is further complicated by the fact that not all personality disorders isolated in modern classifications have the same relationship to normal personality as to the rest of mental pathology. Indeed, it is true that people with a personality disorder need to be treated. But the organisation of their personality clearly differentiates them from illnesses such as psychosis and mood disorders.[3] However, in order for patients to be given a diagnosis of personality disorder they must exhibit general maladaptive behaviour with regard to reactions to personal and social stress and which, in addition, is inflexible, stable and pervasive since early adulthood. Furthermore, this general behaviour leads to chronic and generalised difficulties which, in turn, impact on the individual's ability to work and cooperate with others. This is compounded by subjective distress that leads to complaints of anxiety, depression and worry about their physical health. Many patients with personality disorders have problems with impulse control: either too impulsive or too rigid, for example. They also suffer from difficulties in the way they perceive and interact with themselves, others and situations. For example, this may manifest itself in cognitive deficits in empathy, tendencies to blame others, and distrust of others' intentions. Finally, they also experience difficulties in maintaining healthy lifestyle choices with regard to diet and personal and professional activities, thus demonstrating that personality disorders can influence objective and subjective aspects of physical health. It is clear, therefore, that the altered outlook on life specific to personality disorders leads to impaired emotional regulation, impulse control, interpersonal relationships, cognition as well as physical health.

However, this is not all, as people with personality disorders usually do not question themselves and often delegate responsibility to others. Indeed, they often blame other people or external circumstances for their problems, be they physical, psychological and/or social. This is actually the result of two characteristics of personality disorders that no clinician should overlook: first, patients provoke strong emotional reactions in others (or in the therapist) without acknowledging the abnormality of their own behaviour, thoughts and feelings. Second, they do not try to change themselves, but to change others. These two characteristics, specific to personality disorders, illustrate an effort to reduce their distress and improve their subjective quality

of life. Finally, it is important to mention that the diagnosis of a personality disorder can be accurately established provided that the main characteristics have been assimilated in order to be able to recognise and understand them.[4] To conclude this chapter, there is a classification of personality disorders according to the DSM-V (American Psychiatric Association, 2013), for which personality disorder is presented as: "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, emerges in adolescence or early adulthood, is stable over time, and results in distress or impairment".[5] In addition to the classification of different personality disorders (paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive), as well as specified and unspecified personality change (according to the different clusters, which will not be discussed in detail in this chapter), patients rarely tend to present symptom patterns corresponding to a single personality disorder.[6]

Why treat the personality disorder before committing to treating the trauma?

Five years ago, after a burn out - a form of professional exhaustion that led to hospitalization for severe depression - our patient began to have disturbing dreams, even nightmares; the visions he then had of his childhood were painful flashbacks, punctuated by scenes of physical and psychological violence that he had experienced in the garage of his paternal grandmother's tenants. From these horrible experiences, the patient retains only what hurts him even more today: the lack of consideration his parents had for him. When he told his mother, now 80 years old, that he had been abused, she initially refused to believe him. It was at this point that the patient began to decompensate. Today, aged 56, Philip's regulation and control of emotions remain his biggest worries: when difficulties arise, he feels overwhelmed and he finds strategies that cause him serious problems: OCD (on the computer: compulsive downloading of programs, for example): indeed, Philip needs to download programs of music or anything to calm his anxieties, and also to wear women's underwear because he has difficulties with his own identity.

Post-traumatic stress disorder versus borderline personality disorder?

Following his hospitalization, a psychiatric follow-up was set up. It is important to treat the patient's personality disorder. Can we talk about a borderline disorder? The diagnosis is not clear enough. However, the drug treatments are quite extensive. It is obvious that we have to treat two pathologies: a so-called "complex" post-traumatic stress disorder (complex PTSD), which corresponds to a set of serious and persistent symptoms: nightmares, flashbacks, anxiety, etc., resulting from a childhood trauma; and a so-called "pathological" personality disorder marked by intense and unstable emotions that harm the self-image and relationships with others and are often accompanied by anxiety attacks and OCD. Personality disorder (borderline or otherwise) and complex PTSD share a number of characteristics and symptoms, such as difficulty in regulating emotions and an altered self-image. But there is a key difference: complex PTSD explicitly defines a person's condition as a reaction to trauma - old or recent, long or short term - whereas personality disorder does not. Many people meet the diagnostic criteria for both disorders at the same time. But the importance of trauma in the development of personality disorders has been, and still is, the subject of lively debate among psychiatrists and psychologists. Indeed, scientific studies reveal that between 30% and 80% (Cerveau et Psycho n°141, 07 February 2022) of people suffering from a personality disorder (borderline) also present the diagnostic criteria of a trauma-based disorder or report past experiences linked to trauma. Of course, most clinicians and physicians who have studied or treated people with personality disorders agree that not all of them have experienced trauma, at least as traditionally defined. But a growing body of work suggests that what constitutes 'trauma' is not as obvious as it might seem. Even when negative experiences do not fit the traditional definition of trauma, they can leave lasting 'scars' in the brain and increase the risk of developing mental disorders such as borderline personality disorders. This relatively new awareness is challenging the definition and treatment of personality disorders. Some clinicians and patients believe that the overlap between personality disorders and complex PTSD is significant enough to rule out the former diagnosis. However, it is clear that in order to treat the trauma, it is necessary to consider the differential diagnoses and treat the personality disorder first before dealing with the trauma. Indeed, it is wise to understand the subject's functioning and dysfunction before dealing with the trauma. This is all the more true because in our patient, Tom also presents us with another underlying differential diagnosis, that of Dissociative Identity Disorder, when he discusses, in consultation, the two entities that constitute him: Mary and Tom.[7]

Dissociative disorders

In this chapter, we will discuss the various existing dissociative disorders in order to better understand the ego states of our patient following the traumatic consequences that lead him to consult and in which category we could classify Tom's dissociative disorder. Indeed, on several occasions, Tom states that he lives with another entity that he calls Mary. Mary would be mainly present. Tom is the entity "hidden" behind Mary who does not want him to take her place. Mary is the entity that would have 'protected' our patient during the traumatic abuse he suffered as a 10year old boy.

Dissociation

Generally speaking, dissociation can be taken as an "auto-hypnotic phenomenon", i.e. an altered state of consciousness without internal induction that allows the subject to protect him/herself in situations of tension that he/she can no longer cope with. Such a process differs from "normal" functioning in terms of controllability while interfering with it. This so-called "normal" dissociation involves the ability to protect oneself from a perceived threatening situation by "cutting off" from painful sensations. This innate, natural ability, involving reflex and automatic behaviours, reflects the ability to internalise through recourse to the imaginary, the mind freeing itself from the constraints of reality. However, when a traumatic event occurs, some people will present dissociative symptoms: in this case we speak of traumatic dissociation. This is known as traumatic dissociation. It involves a disruption of normally integrated functions such as consciousness, memory, identity and perception of the environment. Therefore, in addition to the criteria for Post-Traumatic Stress Disorder, the subject presents, in response to a trauma-related stimulus, persistent or recurrent symptoms of one or other of the following states:

Depersonalisation: feeling of detachment from oneself (feeling of living in a dream, that one's body is not real or that everything is happening in slow motion)

Derealization: persistent or recurrent feeling that the environment is not real (the surrounding world does not seem real, the impression of being in a dream...)

Dissociation is thus defined in psychology as "a functional separation between psychic or mental elements that are usually united". Thus, the consideration of reality and experience is inhibited (thought, judgement, feeling), temporarily or permanently, in order to support the psychological trauma.[8]

In the context of trauma, three types of dissociations are classified:

Primary or peri-traumatic dissociation: dissociation becomes a survival strategy of the brain when certain thoughts or memories recall the traumatic event causing too much emotional or mental pain. The subject cannot integrate the experience as 'normal'. The experience or part of it is dissociated. In effect, it is an adaptive response to a stressful event: the individual maintains partial mental control while physical control is impaired. If dissociation is prolonged in daily life, it allows the individual to disconnect from his or her affects and to avoid the emergence of traumatic memories. The dissociative disorder allows the victim, during the traumatic impact, to avoid the fear resulting from the confrontation with death. On the neurophysiological level, the overactivity of the amygdala produces a short-circuiting of the nervous pathways that link the limbic system and the cortex, which can no longer modulate the emotional response. This physiological disjunction between the cortex and the emotional brain can be seen in medical imaging. Primary dissociation is clinically manifested by anxious inhibition, amnesia of the facts, denial but also by symptoms of depersonalisation or derealisation. Dissociation thus has the effect of compartmentalising the traumatic experience. However, because of the protection it offers, dissociation induces a disabling repetition syndrome that defines PTSD. According to Louboff[9] "dissociation represents a primordial process to explain all the symptoms of PTSD".

Secondary dissociation: when the person is already in a dissociated state, a disintegration at the level of personal experience may occur: there is a dissociation between the "observing self" and the "experiencing self". The subject distances him/herself from the event and experiences the event from the position of an observer. This definition is similar to depersonalisation disorder. In secondary dissociation, there are more fragile dissociated ego states than in primary dissociation. PTSD is complex. There may be extreme stress disorders not otherwise specified (cf. DESNOS) or Traumatic Borderline Personality Disorder (cf. TBP). Secondary structural dissociation differs from the former in that the symptoms continue to occur even though the threatening event is over. The stress system is continuously activated and causes the subject to oscillate between anaesthesia and amnesia (e.g. feeling less) and overwhelm (e.g. feeling too much). And this lasts as long as there is no integration of this traumatic event (sometimes a lifetime).[10]

Tertiary dissociation: As a result of ongoing trauma, the individual is able to create independent ego-states called 'ego-states' to store traumatic experiences. These ego-states are, in extreme cases, so distinct and developed that they present complex self-identities. This definition is similar to Dissociative Identity Disorder (DID).

This type of dissociation can be defined by the fragmentation of the self, classified as the so-called 'dissociative' disorders. Janet[11] refers to a breakdown of personal unity: "when too many sensations are isolated from conscious perception, a new type of perception is formed, and we can then speak of a secondary or subconscious personality, parallel to the main personality. The ego is thus divided, dissociated into two".[12]

Definition of Dissociative Identity Disorder (DID)

In Dissociative Identity Disorders, the subject is composed of several identities which take precedence over behavioural responses, depending on the time, the perception of the environment and the way they adapt. We therefore find alterations in perception such as the intrusion of anxious, angry or insulting voices or fleeting visual perceptions, but also in cognition such as the intrusion of thoughts that are not felt as personal thoughts, or in sensorimotor functioning such as involuntary movements, sensations of physical contact, pain, alterations in the perceived size of the body or part of the body. These three types of dissociations can either be perceived as having a different and distinct quality each or they can be imagined on a continuous scale and described as an increasingly strong expression of the basic phenomenon of dissociation.[13]

Dissociation: mary and tom

Like many traumatized individuals, our patient, Tom, also alternates, like them, between phases of re-experiencing or reliving their trauma and phases of detachment or even relative unawareness of their trauma and its effects. In the case of PTSD with delayed onset, since it was at the time of our patient's hospitalisation that the past traumas emerged, a small number of traumatised subjects develop dissociative amnesia as part of a disorder that involves gaps in the recall of memories related to the trauma, or of parts of their past life, or even of their entire life. These patients remain amnesic over a long period of time.

This was the case for our patient. Final recall of the trauma may resolve the disorder, but in some cases a pattern of alternating phases of amnesia and reliving of the trauma develops. However, closer observation suggests that in both cases a range of states are present, not just one. For example, being detached from the trauma does not in itself exclude being joyful, ashamed, sexually aroused, or curious at different times. The re-experience of trauma can also include states such as flight, fight, immobilisation, suffering or anaesthesia. In the clinical situation concerning our patient, Tom, we would tend (first hypothesis) to consider that he would suffer from a secondary structural dissociation disorder rather than a tertiary Dissociative Identity Disorder (D.I.D.), although the borderline between the two remains tenuous. If the trauma starts at a young age, lasts for a long time, is caused by a close relative or a third party in the relatives' relationship, or involves extreme insecure or disorganised attachment, it is as likely to cause secondary as tertiary structural dissociation. However, tertiary structural dissociation is usually the result of more extreme, long-lasting perceived traumas in a person with weaker psychic defences or a naturally greater tendency to dissociate. Tertiary structural dissociation is theoretically the equivalent of Dissociative Identity Disorder (DID). In practice, some individuals with Other Specific Dissociative Disorder subtype (OSDD-1) may meet some of the criteria for tertiary structural dissociation, while some individuals with IDD may not

meet the criterion related to numbers of units. Tertiary structural dissociation involves the presence of Apparently Normal Parts (ANPs) and several Emotional Parts (EPs) within the same subject. The NAPs of tertiary structural dissociation may deal with different aspects of daily life, which may intersect. For example, one NAP may be the host, which manages school, university, work and social relationships. Another NAP might be more suited to managing social relationships and help the first, consciously or unconsciously (some believe that NAPs always waste time when they exchange control and are not aware of each other; for subjects with IDD, this seems to be true), while another helps with certain individuals with study at school, or certain aspects of work. Another NAP might have to manage the family of origin or help care for the children.[14] Subjects with IDD would not have a NAP that reflects what the individual's self would be like if they had a fully integrated identity. In order to be aware of their condition, NAPs may be highly phobic of EPs. However, after becoming aware of the existence of EPs some NAPs may actively seek out those EPs that are perceived to be the least "threatening". Indeed, the "alters" (alternating identities) may be highly developed and separated by strong dissociative barriers. The NAP can often interact smoothly with some EPs, without necessarily being overwhelmed by traumatic memories, perceptions or impulses. Strategies used by NAPs to avoid activation of EPs may involve amnesia, anaesthesia, limiting the range of NAP emotions or numbing the intensity of emotions. These avoidance behaviours, combined with frequent intrusions of EPs, can drain mental energy and allow depression, anxiety, chronic feelings of hopelessness, shame, guilt or anger to take hold. The most desperate NAPs may initiate self-harming behaviours or substance use in order to force themselves into the present and prevent the EPs from intruding. It is likely that the most disconnected NAPs will find it difficult to form intimate interpersonal relationships or will have more difficulty perceiving their emotional and physical needs. However, most NAPs feel the need to appear as functional as possible and may find it easier to avoid all situations that could trigger EPs, including those that require attachment or trust in others, and then throw themselves into work or other activities that avoid self-reflection. As in secondary structural dissociation, tertiary structural dissociation EPs may deal with different aspects of trauma and contain different memories, behavioural patterns, internalised messages, strong emotions, attachment patterns or personal characteristics. The EPs of tertiary structural dissociation may resemble those found in ATDS-1. However, they are more likely to be complex and developed than those found in secondary structural dissociation, although some remain as simple containers of traumatic elements. On the other hand, the EPs of subjects with IDD may perceive themselves as being of various ages. They will not necessarily be children frozen in time. EPs may manage aspects of daily life such as exploration, play and socialisation. Some may greatly resemble NAPs, or completely disprove the idea of containing traumatic elements making them somehow less developed, rational or mature! Individualised EPs may focus more on defending themselves through confrontation, escape, freezing or submissive reactions to specific emotions or attachment types. It is then common for EPs to show up gradually, with a new EP revealing itself and its traumas when the previous EP and its traumas have been processed and integrated. Several EPs may come together depending on the types of trauma experienced, with some EPs containing a specific aspect (image of place, sounds, emotions) or specific actions to the same trauma and traumatic memories. Some traumas may have been recorded by a part that has stored images either directly or as a result of an 'out of body' experience caused by dissociation. The observing part may have no particular emotions, being detached. EPs and NAPs can manifest through both passive influence and full part changes.

Time loss and blackouts may or may not accompany these changes depending on the level of co-awareness of the system. Systems with a high level of co-awareness are more likely to deny the existence of other parts, or memories of other parts. Denial of other parts also occurs in systems with blackouts, which are blaming another disorder (mental or biological), therapist or peer influence, or a naturally weak memory. The denial of memories of other parts is common to all systems. At the same time, both NAPs and EPs may deny the appearance and present condition of the body, or dislike their current job, spouse, children or living arrangement. Both NAPs and EPs may avoid each other, internal groups may have been created and reject each other. And when faced with these alters, they may react with shame, guilt or hatred. However, friendships and alliances are also common and some systems may forge a group based on a kind of family unit. Alters may or may not be aware of each other or that they are parts of a whole. Alters may perceive themselves as unique or separate individuals, perceiving other alters in the system as a kind of 'me...without being me'. They may share the history and current situation of the subject on an intellectual level, but not feel they have any control over what is happening and over the other alters. And thus become irritable if forced to feel otherwise. It is therefore necessary for the system to accept responsibility for the actions of all its members, and most efforts to do so; but actions that are not dangerous and simply based on preferences may be completely rejected by alters who are not involved. While alters may be aware that they share the same body and brain, they may insist that they are still 'unique'. They are not clones of a subject who will eventually re-emerge. Some alters are so independent, differentiated and developed, sometimes referred to as 'emancipated' or 'developed' that it raises questions about what constitutes an individual's identity. It is clear that individuals with IDD may continue to form EPs and NAPs even in adulthood depending on their experiences and needs. While new EPs may emerge following new real or perceived traumas, new NAPs may be created after the birth of children, for the management of a new job or to replace a host who is too exhausted to continue managing daily life. New parts or alters are created when new actions, emotions, memories or perceptions cannot be integrated into the whole subject or into an existing alter. It is important to remember that an alter can only contain things that have been experienced by the subject. An alter cannot have the power to instantly heal the whole system or deal with all the current problems of the system if the necessary adaptive capacities and the desire to do so is not already present within the system.[15,16]

Integration of dissociative parts

The integration of the dissociative parts is a fundamental achievement of any psychotherapy. This complete integration of the two dissociative parts of the patient into a coherent whole is called unification. The integration should never be forced by the therapist but should be discussed with the patient. Most dissociative patients are phobic, as is the case with Mary/Tom in our vignette illustration above, about the idea of parts coming

together in some way and become extremely stressed when the therapist brings up the subject. It is through psychoeducational work that the therapist will bring up the idea of integration of the parts, gently reassuring the patient and respecting the patient's journey through the therapeutic work as well as their journey. The patient can be reassured that it is a choice that is completely in his hands (which is the case in Tom's clinical situation). He is not forced to integrate the two parts immediately. This will happen in due course. The therapist may remind the patient during the interviews that it is difficult to imagine, but that many people have found that it is quite natural and good for all parties to come together when it is the right time for them. The patient then experiences this as something comfortable and helpful. Integrative work with the dissociative parts already starts in phase 1 when the therapist supports the patient to accept and understand the dissociative parts. This is actually a step with the patient, Tom, who has already accepted the idea of this unification, even though it is still far from being integrated into the therapeutic work. Regularly, the therapist checks with the patient the reasons for maintaining the separation of the two parts: Mary and Tom. A focus on the need for dissociation is ongoing and can target specific issues that maintain the dissociative parts, such as phobia, anger or a lack of realisation of having been sexually abused.[17,18]

Complex trauma

Taking the Dissociative Experience Scale (DES)

We decided to administer the Dissociative Experience Scale to our patient. The DES is a self-reporting tool that estimates the patient's degree of general dissociation. It measures both common dissociative experiences (daydreaming, road hypnosis) and pathological dissociative experiences. The results of the DES do not constitute a diagnosis because they only give an average of the degree of dissociation and do not allow to discriminate a potential disorder with precision. However, they can be used as a basis for an interview in order to make a diagnosis at a later stage. People with post-traumatic stress disorder usually score high on this test. In the case of our patient, Tom, the score after taking the DES is: total item scores divided by the number of items, i.e. score of 1550:28 = 55.35 (well above 25). We have the presence of a "dissociation". What can we observe about the item categories?

Tom's results

Amnesia	Item 3,4,5,6,8,10,25,26	Score : 140
Absorption/ imagination	Item 2,14,15,16,17,18,20,22,23	Score : 610
Depersonalisation/derealization	Item 7,11,12,13,27,28	Score : 530

The main items that reacted were the Absorption and Imagination items followed by Depersonalisation/Derealisation. It will be interesting to investigate a little further: what comes out of the interview and the sensations the therapist encountered during the interview (notion of transference and counter-transference that we will mention in the discussion in one of the chapters)? What about when the person has personality disorders? As far as identity disorders are concerned, we find them in dissociative disorder as well as in personality disorder. We would probably need more in-depth questionnaires to find out more. What we have chosen to do first is to ask about the most important points. We cannot do everything at once because we do not have the time. It is interesting to ask about dissociative disorder, where it is not easy to answer questions because they are revealed. If we want to go deeper, we can take a piece of the questionnaire to exclude certain diagnoses. In case the consultation gets stuck, we could ask ourselves what is going on in the transference and counter-transference. If we look at the window of tolerance, everything above it shows us that there are too many symptoms: flashbacks, ruminations, nightmares... In dissociation, there are avoidances. The patient is often phobic.

In the case of our patient, Mary takes up all the space erasing the Tom ego which generates a fear of the reunification of the two parts.

Indications and contraindications of trauma confrontation work

Some authors believe that it is necessary to work on the trauma as quickly as possible, even in cases of severe trauma sequelae and without particular stabilisation.[19] Others[20] consider that what can be applied with simple PTSD cannot be applied as such to complex PTSD and even less to complex trauma sequelae. These are guidelines from the International Society for Study of Traumatic Stress which emphasise the need for a consistent stabilisation phase. We fully agree with this last point of view because we consider that stabilisation work should be done as a priority. In the clinical situation presented above, we cannot 'dive' directly into the patient's trauma for several reasons: firstly, because Tom's psychic and emotional structure is severely damaged. We need to ascertain from the patient's family history whether the family environment was able to support and console the child that the patient was at the time. If there is a lack of security for the parents when the traumas took place, there is a risk of immediate and/or later psychic after-effects in adulthood. In order for resilience to develop favorably, significant adults must be able to regulate the child's affects following the trauma. The lack of support, reassurance and consolation in our patient, Tom, led him, as a child, to cut himself off from his emotions or to express them in an inappropriate way, particularly in the trauma he experienced. In this case, we are faced with severe difficulties in regulating emotions. To start with trauma work would have been, in our opinion, an aberration close to medical maltreatment. Trauma work is also not indicated when the therapist knows that the patient has dissociative problems (in this case, dissociative identity disorders, the first hypothesis), as this is a clear sign of a lack of emotional regulation capacity. Another condition for confronting the trauma is that the patient has sufficient security, especially in the relationship or relationships to the outside world, in the relationship with the therapist, and in the relationship with oneself.[21]

Working on the LINK with personality disorder before working with trauma: why?

The issue of attachment in the patient

Attachment disorders influence the therapist-patient relationship, especially in people with borderline personality disorders, in

whom ambivalent insecure (or disorganised) attachment disorders are particularly common. These patients need to find a good relational distance during treatment. Motivational interviewing techniques are particularly suitable because of the dialectical approach in which the psychotherapist intervenes actively and patients are encouraged to retain their autonomy and freedom of decision. They are also encouraged to participate in the processes of change in their therapeutic work.[22] In the clinical situation presented, our patient, Tom, would have an ambivalent insecure attachment disorder. We note that early injuries in the adult child can create difficulties in the integration of sensory perceptions. Tom shows various symptoms related to his insecure attachment: low self-esteem, weaker engagement with previous therapists, slowed cognitive functioning, need for control, hyper-vigilance, high vulnerability to stress and fragility to traumas that resurface through nightmares and sensory flashbacks as well as anxiety disorders (learned helplessness). Questions about the connotations of so-called "perverse" behaviour emerged during the first interviews without the patient seeming to be aware of them. In fact, on several occasions during the first interviews, the patient wanted at all costs to put down the personal details of the content of the abuse suffered (verbalisation of the traumas in their context and in sordid detail). He explains that the previous psychologist had listened to him talk about what he had experienced as a child and that she had ended up crying during these interviews. She was unable to continue the therapeutic process with Tom and had to stop the consultations. Tom was referred to our Psychotherapy Centre. From the beginning, a clear framework was defined so that these outbursts would not transfer to the therapist's potential sounding board. We will talk about this framework later on. These attempts at outbursts by the patient made us fear that the patient would replay in the session the abusive perversity of the aggressors by the patient himself in an unconscious way. We would then be victims of another form of perversity left to the patient. Therefore, it was also important for the therapist to talk about these behaviours in supervision and to reframe the patient. In the case of the present clinical situation, these reframings allowed the patient to accept to stop his attempts to enter into the (verbal) traumatic experience during the sessions. The work could continue. We believe that we have introduced a sufficiently secure framework for the patient to continue the therapeutic work.

Psycho-education (framework)

Sufficient psychoeducation, based on theoretical and well-conducted models, promotes patient engagement and motivation. There are different models, the characteristics of which we will briefly describe:

Horowitz's model (1986, 1993):[23] progressive assimilation of the event and accommodation of existing patterns

Brewin's model (1996, 2003):[24] integration of traumatic experience into the VAM system or SAM system

Van der Kolk's model (1996):[25] favouring non-speech approaches to integrate stimuli that have not been stored in declarative memory

Bottom up and top-down methods:[26] allowing the body to have experiences that deeply and viscerally contradict the helplessness, rage and collapse that results from trauma.

Psychoeducation gradually increases the patient's understanding of the processes underlying his or her symptoms and justifies the use of specific techniques, all of which are as necessary and effective as they are daunting and frightening. These psychoeducational techniques therefore need to be carefully described, explained and discussed to ensure that they are understood. It is necessary to emphasise that everything will be done in collaboration and at the patient's pace. When the subject has had an unfortunate or even traumatic history, psychoeducation should also address the psychological effects of the repetition of these events, in terms of global functioning, traumatic memory and cognitive patterns. Finally, psychoeducation already allows for cognitive restructuring: the aim is to move from a false vision "I am a person vulnerable to danger" to a more rational and constructive perspective "I suffer from PTSD, it is a known disorder, which can be treated, and I can act to get better".[27] With our patient, it was after several interviews, when the framework and the therapeutic alliance had been well established, that we were able to begin to put in place cognitive therapeutic tools, the exercises of which we will detail later in the following chapter. Tom has mobilised himself and is slowly adhering to the techniques proposed. We take care to respect the patient's window of tolerance, a window that allows us to understand and describe the normal reactions of the brain, to understand the fluctuation of emotions and to find strategies to maintain himself within this window. The window of tolerance is a safe zone where the patient can see how they can tolerate and reflect on what they are experiencing. When the patient is overwhelmed by the emotions, he/she leaves the window of tolerance and it becomes unbearable for him/her. We have to be vigilant. Porges[28] teaches us that, on a physiological level, survival reactions no longer allow us to relate to others, regardless of whether it is hyperactivation, corresponding to a strong sympathetic reaction, provoking an uncontrollable flight or fight reaction, or hypoactivation, corresponding to a dorsal parasympathetic reaction, showing itself above all by confusion, loss of muscular tone and even total collapse. Later, when working on the trauma, these elements are found and relived in an accelerated way, so as to transform an overcoming reaction into a controllable emotional reaction. This also allows the brain to transform a traumatic neural network, which is only subcortical, into a total experience, a network involving the whole brain and thus allowing, without being emotionally overwhelmed, that at the time, this difficult experience happened, but that today, after all this time, "I have learnt things and it no longer prevents me from doing what I want to do". Thus, the main changes after integration work are that the patient wants to move on, no longer feels caught up in the difficult experience, can access it without avoidance, can talk about it or not. She regains her ability to make choices and to do things consistent with her goals. Insomnia ceases. Anxiety levels drop. People move on and are more interested in prevention than avoidance.[29]

Safety with the patient and daily life (stabilisation profile)

If our patient is not safe, we cannot do anything. Stabilisation consists of getting to know the person, finding out what they want and what their goals are, and also sharing our knowledge with them so that they can make choices according to their possibilities and do preparatory exercises for the next phase: confronting the traumas. If all these tasks are carried out in the right conditions, it naturally follows that a supportive therapeutic relationship is built. It is clear that any encounter between a therapist and a patient is first and foremost a human encounter where a particular alchemy

will blossom. However, we believe that certain elements favour a supportive therapeutic relationship with traumatised people more than others. There are three primary needs for an individual to be able to stabilise, namely: to feel safe with the therapist in the here and now, to create a secure attachment (let us not forget that the patient often comes with an insecure attachment that is avoidant or ambivalent (and sometimes disorganised), and to have hope.[30] In order for the patient to access a sense of security in the here and now, it is essential that they are connected to their bodily senses. This is especially true for people with dissociative disorders who have developed a habit of distancing themselves. The first stabilisation exercises consist of calming the body in order to allow this connection, and then calming the mind. We offer techniques that focus on the body directly, through muscle and breathing exercises, anchoring and proprioceptive perception exercises, and orientation exercises in space and time, with the aim of bringing awareness into the body of the here and now. These "Bottom Up" techniques have the merit of allowing integrated mind-body work from the beginning of the therapy. When a sense of security is not yet established, or when something unusual happens, these are the most useful techniques for regaining stability. The feeling of safety can be assessed: "on a scale between 1, meaning "I don't feel safe at all", and 10 "I feel completely safe here in this room with the therapist", where are you now? The second need, that of attachment, is immediately consecutive to the feeling of safety: let us remember that the lack of social support after a terrifying event is one of the factors that aggravate the post-traumatic reaction and the recourse to dissociation.[24] We also know that when we are connected to a significant and supportive other, negative events can be experienced more easily: the secure connection to the other is stabilising. How then can we build a secure attachment with patients who have a phobia of attachment, and at the same time may show inappropriate attachment tendencies, driven by the fear of losing the attachment? Thus, in a majority of individuals with complex trauma, attachment disorders emerge at the point of trusting and remaining in a secure bond, when it comes to dealing with things that may create activation, whether voluntary or incidental. We used to say that as long as people are alive, their capacity to connect is present. We also believe that, whatever the person's primary attachment style, the ability to build a secure attachment relationship with a therapist is possible, provided that the therapist has a calm and composed attitude, makes himself/herself predictable and is consistent. Michel Delage (2007) .[31] teaches us that if in a family (a group, a couple or at least a therapeutic device) emotion can be felt, without it spilling over, then this produces attachment. If we want traumatised people who come to our practice to agree to create a secure attachment relationship with us, it is in our interest that emotions can be experienced, allowing people to remain within their window of tolerance, i.e. without spilling over either downwards (physiological under-activation) or upwards (physiological overactivation).

The therapist's sounding board

Any therapeutic worker faced with a situation of abuse, sexual abuse or rape cannot remain emotionally indifferent. Indeed, as Y-H. Haesevoets,[32] "anxiety is inscribed in the depths of human experience. The feeling of anxiety is also a motor of reflection that allows the therapist to become aware of his or her being, desire and existence. However, when anxiety is induced by abuse, the therapist, in a particular, singularly intense and difficult to manage personal and emotional situation, can disrupt the mental processes of decision making, reasoning, observation and understanding. Despite the therapist's level of skill and mastery, anxiety can become an attitude or visceral reaction. Irrationally, feelings of annihilation or powerlessness erupt and telescope the intervention system. If the therapist dramatises the situation of abuse, he/she runs the risk of fostering many anxious feelings and in this way, by rushing and exaggerating what has just been entrusted to him/her, induces truncated and erroneous evaluations that prevent any discernment. If the therapist minimises or is afraid of apprehending an abusive situation, he or she may not be aware of the suffering of the person who has been sexually abused or mistreated. Trivialising or accepting acts of abuse is sometimes a way for the carer to protect themselves from their own anxieties. Errors in assessment can keep a situation at risk. Every therapist has the right to doubt. Even when confronted with traces of blows, it is still possible to have doubts. The therapist's psychological defences are all the more reinforced when the family system is different or marginal and disrupts external transactions. These situations are sometimes confused, chaotic, dysfunctional at different levels. If he is made vulnerable because he is inexperienced or ambivalent, the therapist will allow himself to be dragged along by the patient's family or individual marasmus and its particular, often aberrant and sometimes perverse rules. He will then find pseudo-rational or cultural justifications for all these confusions. By trying to make an alliance with a family with abusive transactions, the practitioner may find himself alone in having to manage too many irrational elements that end up contaminating his own value system and destabilising his institutional reference points. These distortions of reality can be avoided if the worker can evolve within a stable multidisciplinary team or if he/she relies on a coherent intervention network.[33] If the worker dramatises the situation of abuse, he or she risks fostering many distressing feelings and in this way, by rushing and exaggerating what has just been entrusted to him or her, inducing truncated and erroneous assessments, preventing any discernment. If the worker minimises or fears to apprehend a situation of abuse, he or she risks not being aware of the suffering of a child or adult who has been abused. Trivialising or accepting acts of abuse is sometimes a way for the carer to protect themselves from their own anxieties. Errors in assessment can keep a situation at risk.

How can the therapist listen to the patient without hurting them? How can the therapist not brutalise the patient by helping him/her to understand him/herself better?

In Tom's clinical situation, we recall that the previous psychologist was crying with our patient as he laid down in session the verbal details of his account of sexual abuse and torture. When Tom arrived at our consultation, he tried several times to repeat in detail what he had already verbalized to other therapists. Without bullying him, we put a clear framework and tools in place so that Tom would not "perversely" replay his story and the scenes he had experienced to the therapist. Although he tried several times to do this again, the therapist's firm attitude finally stopped Tom from verbalising his story again in detail. We prevented the therapist from being unconsciously abused by the patient. The therapist's role is important because he or she is dealing with a person who is suffering and this suffering goes back many years. The therapy can have the function of being a kind of appeal, which would mean that the victim wants to and can finally deliver himself or herself or his or her suffering to a third party, a person outside his or her circle.

How can we listen to the patient without hurting them, without having to end the consultation?

It is important to deal with the patient's shame, guilt and fear. Indeed, shame is very low self-esteem. It is something ineffable, unspeakable. When the therapist can work with the patient on this feeling, he or she has already created a very strong bond and can move forward in helping the patient to rebuild his or her trauma. He can then listen to his suffering and help him to express his hatred and rage in his heart. Finally, he can work on the death anxiety and thus enable the patient to rebuild a positive image of himself. Then, when this first part of the work is done, it is important to take into account the social system in which the patient evolves: friends, love relationships outside the family. The therapist will be able to work with the social skills of the damaged patient, to bring him/her to be able to be with others in his/her environment. Also help the patient to express their emotions and feel what they sometimes no longer feel. Elucidate the meaning that the adult gives, see, in his family history, what meaning he can give now to these abusive situations that he has suffered. Work on the secret, everything that could not be said. Discover the function of secrecy in the family history of adults and children. If the patient (child, adolescent) has siblings, work on the reaction of their brothers and sisters. When all these stages have been completed, we can then begin prevention work, which would essentially consist of teaching the victim to take care of herself. To be stronger in order to get out of the repetition which sometimes risks leading to unconscious perverse behaviour in the patient (which we have observed and which is a risk in Philippe, our patient). And finally, to work on the image of the man or woman that the victim can become. Work on his creativity, his imagination that he can project onto the future. For the patient, the victim (whether a child, an adolescent or an adult), therapy is a kind of call. Calling and treating what speaks in the victim (who no longer speaks, no longer symbolises) helps to avoid forgetting, trivialisation and can open up a process of memory work so that the trauma becomes a memory. This can allow the victim to imagine his or her destiny as being different from that of the aggressor(s).[32]

Tools (phase 1)

In this chapter, we will present the different techniques we have discussed with the patient. We are still in phase 1 of the work. We decided to move forward very slowly for several reasons: Tom's mental health status (with a differential diagnosis of personality disorders), to establish a relationship of therapeutic trust, to be sure that he is secure enough to use the therapeutic tools. Avoid any overflow in the verbalization of the abuse story. Check the situations that can be "perverse" in the therapeutic work: the patient can replay with the therapist situations that belong to the aggressor.

Anchoring

During phase 1 of the treatment, a harmonious and calm working relationship should be established. Anchoring is very important, especially with dissociated patients. With our patient, we worked several times on the here and now. We invited Tom to come back to the present time by proposing to him to feel the sensations which are good during the session. Our aim is to help Tom find an experience of well-being and security. This then establishes the associative anchor so that he can re-experience, at home, the exercise carried out in the consulting room. How did we proceed? We used a mindfulness technique that could be a positive experience and retain it afterwards. We asked Tom to get comfortable in the chair he was sitting in. We asked him to pay attention to all the details of this experience and to describe them, paying particular attention to the visuals, the sounds, the sensations only in the consulting room in which he is sitting. We asked him to "feel" his body by detailing each part (head, back, arms, legs, feet) and to let them sink into the floor, into the chair. To feel the body anchored to the surfaces. Then we invited the patient to enjoy the experience. At first, this was not easy for Tom because it was the first time he had been in the present using his body to feel the sensations. We asked him to describe what he could also feel in the room. We took advantage of the fact that our colleague had placed some very fragrant flowers on the table. We were able to take advantage of the opportunity to work with Tom's different senses so that he could become aware of his different senses in the here and now. As there are other doctors' surgeries, we also asked him to describe the sounds he heard. At the end of the exercise, we discussed with Tom what he had experienced and felt during the experiment. It is important to help the patient who has suffered trauma and dissociation to relearn this awareness of self in the here and now, which can be done through mindfulness exercises. Mindfulness means being in the present (hic at nunc). When the patient is in the present, fears about the past and the future are less likely to affect him/her. He can become aware of the uniqueness of a moment, allowing himself to be in a way that is not dissociative, so we can help the patient to become aware of himself, and through this we can help him to become aware of other people. One bias in this exercise is the fact that Tom talked about Mary, the entity that is most present at the consultation leaving his self, Tom, in the background. We have already discussed, above, the idea of unifying Tom's two dissociated entities: Mary/Tom. However, we keep in mind that this work will take place in its own time, with the progress of the patient's therapeutic process. At present, we think it is important that the patient learns to anchor himself with the body in reality. The perception of the body's limits and the body's points of contact are important aspects for stabilisation.

Since many traumatised people are not really "in their body", they have a distant contact with their body, which is a form of dissociation, it is very important to do this kind of simple exercise so that the patient becomes aware of his or her own body. The simpler something is, the more likely it is to be used, even if this simplicity surprises the patient. We explained to the patient that even though the exercise looks simple, it is just as difficult because it is completely new and anything unusual is also scary. We can lure the reason a little bit by suggesting to the patient that we try something once, experience it and decide later if it is really beneficial. This exercise therefore consists of getting in touch with one's body and senses in a benevolent way to avoid traumatic memories being reactivated by a neutral observation of body sensations. Our patient, who suffers from the after-effects of childhood trauma, has learned not to feel his body and is often overwhelmed by bodily symptoms. It is therefore necessary to be cautious and progressive.[34]

The safe

As the anchoring exercise was congruent, we were able to use a new exercise to help our patient manage his anxieties. The safe exercise allows the patient to control the traumatic material or his invasive anxieties or fears. It therefore helps to deliberately

repress, at least for a while. It allows the patient to lock up traumatic material and to decide for himself when he wants to take out parts of it in order to work on it. Before using the safe, it is necessary to create a safe place for the patient. We do this exercise in the stabilisation phase. It is about having these good inner images in situations of distress so that we can help the patient to regulate himself and calm his emotions.

With this exercise, we are looking for a feeling of emotional security or comfort, which corresponds to the child's feeling of security; but also, we are looking for a good experience to help the patient to anchor himself. Later on, the patient will be able to regulate his or her emotions a little more easily by calling on this image. Since we have already done mindfulness exercises (anchoring), this means that the body can relax as much as it wants to without the conscious ego giving it the command "relax". This is why this form of exercise is particularly enjoyable for trauma patients. Mindfulness exercises are a relaxation induction that can also be presented as an introduction to imagination.[35] Once the "safe place" is integrated, we can move on to the next step, using other techniques such as the safe, in this clinical case. The safe place exercise is also a container exercise, it is about the patient putting away something that is weighing them down or disturbing them. In our patient, these are anxieties and intrusive symptoms (nightmares and flashbacks). By putting these things in the safe, the patient knows that they are safe and can breathe for a while. Together with the patient, we imagine a safe in which we can first put intrusive images, inner films, emotions symbolised by an object, a colour or a character. Everything that is unpleasant and everything that the patient cannot get rid of at the moment. Sometimes the patient is unable to put something in the safe for a long period of time, so the exercise must be repeated. This exercise is mainly aimed at the adult ego state. It is used with patients suffering from the aftermath of trauma. The injured ego states that carry the traumatic experience are ignored. It is recommended that, after the safe exercise, the patient is taken back to the safe room of his or her imagination so that the experience ends with positive emotional connotations. Given the psychological state of our patient, Tom, we were surprised at how quickly he adhered to this exercise.

He continues to use it regularly in and out of session. Since then, we can observe a change in the consultation. The patient is calmer and less anxious, although he still talks about his nightmares and compulsive behaviours. However, he often repeats that these exercises are good for him and that the daily flashbacks have decreased significantly.[36]

Link marie + tom

Working with the dissociative parts, Mary/Tom, is a unique challenge that is important to carry out in therapeutic work in order to help the patient stabilise, mentalise and pursue integration, whilst recognising that they are singular individuals with a fragmented sense of self. In the present clinical case, Mary appears as the entity that calms the crisis. She takes precedence over Tom. We could associate her with a fruit of our patient's fantasy: "with Mary, I am totally dissociated". It is a way for the patient to cut himself off from his emotions. Mary is the product of this perverse couple who abused Tom. The patient, then 10years old, found sweetness when his friend, 12years old, dressed him as a girl at the request of the abusive couple, leaving the little boy disappointed and unable to exist. We could say that there was a kind of "castration" of the male part of Tom. The Tom part had to remain hidden. It is still hidden today. Remaining Mary prevents the realisation of the trauma. The more the patient pushes Tom away, the more the trauma will remain contained. There is an internal fragmentation with the trauma because the child had to grow up, despite what happened to him. It is a normal consequence of something abnormal. All these fragments of him are part of a unified whole: so, once this is worked out, we can reintegrate the different personalities, Mary/Tom into a unity.

The aim of the therapeutic work is to come out of dissociation and return to unification and recognise Tom in his entirety. If the patient is not ready for unification, if he persists in staying on the Mary track, then we might worry that he has not also been abused. All parts of him are respectable. It is important to identify which parts are identified with the abuser, what are the reasons why they remain predominant, keeping the victim part away. This is perhaps a way of dissociating oneself from the victim state in order to live the aggressor state. Integrative work with the dissociative parts already starts in Phase 1 when the therapist supports the patient to accept and understand the different dissociative parts. When we discussed this, the patient understood the purpose of the unification work and accepted the idea that we would do this slowly during the therapeutic process. The first step is to propose to the patient to bring the two entities together: to be together. The aim is to give Tom back his place. If the patient gives a positive response to the question of bringing the parts together, the therapist can ask if it is tolerable to take another small step by reminding the patient that he or she can stop the process at any time. If we encounter resistance, we should stop the exercise momentarily and try again later. It takes time to achieve the fusion and integration of the two parts. We keep this in mind by respecting the patient's rhythm.[37]

OCD work: mail and also the envelope

Previously, we raised the fact that our patient, Tom, was experiencing compulsive disorders when downloading sites from the internet. This led to the patient being spotted by the Police and being interviewed regarding a download or downloads of child pornography. He does not deny the downloads because he is aware that he has more than a hundred hard drives. On the other hand, he realises that he does not remember these downloads, especially as he confirms that he does not exploit them: listening to the music he downloads, for example. We wonder about a possible amnesia of his compulsions. To counteract these compulsions, we suggested that he should displace the compulsion by writing an email to the therapist explaining what he was feeling emotionally before the crisis. The aim is to defuse the impulse that comes and become aware of it. In addition, as it often happened that the patient came back with verbal traumatic contents to explain in detail the abuse he had experienced, we suggested to him to write down these traumatic contents in a letter and to put it in an envelope that would remain in a box with his name on it in the consulting room. The aim was to stimulate the imagination in order to contain him (who he is) and the traumatic content. It is interesting to know how far the therapist can go with such heavy traumatic contents with a part somewhere, too, that could be perverse.

Confronting trauma (Phase 2)

The work of confrontation, in Tom's case, has been approached but not yet really started. Indeed, we are moving slowly to be sure to remain benevolent in the consultation. In CBT (Cognitive Behavioural Therapy) techniques, we could consider working

in identification by using the intrusive images (Tom's daily flashbacks) as a route to personal and implicit meaning as a psychological assessment tool. How the mental images produced by our patient will guide us on the reading of a personal meaning in relation to the person's identity (his norms, his goals, his self): self-defining memories. We could focus on a particular technique, the imaging descriptor.[38] De facto, it is a cognitive restructuring called Socratic imagery that works on the verbal modality. However, this technique is not without difficulty since our patient presents complicated attitude approaches that risk leading the therapist to be absorbed in the traumatic content for which either the patient takes pleasure in observing the therapist's reaction and becomes himself intrusive and abusive in the consultation, or, we could work by succeeding in getting out of the "perverse" content of the trauma.

Another hypno-therapeutic technique would seem to be more appropriate, in our opinion. Indeed, when the trauma is being contracted, the subject automatically goes into a state of self-hypnosis (negative trance, in the sense that it is not well experienced). From then on, using hypnosis in the case of trauma becomes interesting because one arrives at the right level of consciousness where this event is registered (positive trance). Everything we have already put in place during stabilisation with our patient will be useful. Indeed, after having used the stabilisation techniques, we can work with the hypnotic confrontation techniques to the trauma.

We should approach this confrontation stage slowly and stabilising interventions should be applied according to the available mental energy of our patient. We should feel the patient's capacity to enter the confrontation. If his or her capacity is low, we will have to repeat the stabilisation methods (phase 1). We will check which techniques would be more appropriate for our patient when we go further in the therapeutic work.

CBT techniques with tom

Our patient cannot show the film in his head. He only transcribes it at the verbal level and we will transcribe it into images. We have to make sure that we work in a structured way. We will visit the trauma together. The general principle is the exposure to the imagery of reliving the trauma. How do we go about this? We leave via the front door: this is the hotspot, which means, the hot spot 39 . The hotspot is not the most dangerous piece, it is the eyes of our patient entering the room before he was abused and tortured and perhaps, when he himself would have been forced to abuse the other little girl in the perverse games imposed by the adults at that time. The hotspot can be an intrusive image, a detail, a smell,...An intrusive image is a small film. We could go looking for clues to recovery. The hotspot can also become the clue to recovery. We already know from this technique in conversational exchanges that for our patient, Tom, the hotspot could be the sweetness his 14 year old friend, Julie, had when she dressed him as a girl before the sexual abuse. The clue to recovery on this day may be the patient's pleasure in making himself feel good by putting on women's underwear underneath his costume. In this way, the anxiety glimpsed through the OCD here compensates for the activated recovery cue.

Indeed, when he goes to look for women's clothes, does he make a link with this little girl's disguise that becomes Mary? Has Mary become the safe part for our patient? Is she a resource person in his impulses? Is there an emotional part in our patient that makes him have sexual impulses and a traumatic abusive experience for which he feels ashamed, and another part that protects him from this?

Obstacles encountered with our patient for the work in confrontation with the CBT?

In situations of abuse, the patient integrates the information of his traumatic experience into his identity, from the moment we work in the imagery of compassion with himself. But it will be difficult to construct images of people who are compassionate with the suffering party. We notice that our patient immediately rejects the abused boy. Could this little boy have been active in the abuse of his friend, leading him to feel shame and guilt? The question remains open, although it is a hypothesis. In this technique, the danger is the "perverse" side that could resurface in reactivation and resistance in the sense that the description of the invasive images, the content of the flashbacks could "toxify" the consultation. The technique is certainly interesting, but the content itself could then be an obstacle to the work of confrontation.

Hypnosis techniques with tom

The hypno-therapeutic technique allows the patient to put the confrontation of the traumatic experience at a distance and thus to feel secure. We will therefore use the techniques of the screen to encourage the patient's double attention which allows him to be in the present with the therapist and at the same time in the past to digest the trauma. The patient will thus have a "connection" with the therapist to keep his or her feet in the present and thus develop a secure anchoring possibility.

We can ask: "How safe do you feel now on a scale of 1 to 10? In this exercise, we will use the safe place and put the trauma on hold first before entering into the confrontation.

How do we introduce hypnosis to our patient who does not know the tool?

It is important to make it clear to our patient that we are working in the here and now, even with the traumatic history of the past, and above all that we remain in the consulting room. For our patient, his traumatic memory is still in revivification, i.e. it is as if his memory is outside the time line. Our patient, in the present, still has the impression that it is still happening. That's why he comes back with the flashbacks. In the therapy, we will integrate these traumatic cellular memories so that the patient no longer experiences them in the present and that these traumas are classified in history. We will therefore work on the pathogenic nuclei (hotspots) that recall the trauma in their entirety. We will keep in mind that stabilisation work is very important, especially when the patient is very dissociated. We are thinking of using the screen technique with Tom. We would start with the simple screen where Tom could project (as in the cinema) the scene that traumatized him. He could see again the little boy he was at the time of the abuse, but with some distance, as he is now the adult observing the scene from a distance. We could investigate the emotional state of our patient. We could see what resources the patient could put in place at the scene to help the little boy in difficulty. Then we could move on to the double screen depending on the person's capacity for resistance. The double dissociation would have an interest in going to see the NAP and the EP of the child.

Our patient could meet the self, Tom, who is the child who has been abused. We could then interrogate Mary's role and ask the patient how he defines Mary's role (Tom's part transformed by a post-traumatic conversion). We could access the Mary/Tom double dissociation in another way. We could ask the patient what Mary would need? What would he have wanted to do as a child? We can suggest turning off the screen if the patient starts to relive the sordid history of abuse. We can work without entering these scenes. This is a better way to protect the patient from severe anxiety. For the therapist, it allows him to be more comfortable with his emotional resonance chamber. We can then work with the patient without removing their protection. Then we could ask our patient how he feels when he sees Mary helping Tom who is being abused. How can she do that? In double dissociation, we can go and see, when the patient is both victim and perpetrator. How can he have compassion for Tom? This active repressed part in him is repressed by Tom's identity conversion into Mary. Let us remember that our patient was 10years old when the traumas took place. Today, in the patient's identity construction, we can assume that there is certainly a part of Tom that he fears.

What difficulties/challenges might we encounter during the confrontation?

We can't really say anything yet because the technique has not yet been used in real sessions with our patient. But we could presuppose that it is the one that will best correspond to the progress of the therapeutic work with Tom. This technique would allow us to work in co-construction with the patient in the session. We could also use humour, in certain cases to bring lightness to the drama experienced by the patient, such as self-mockery of the atypical underwear.

This technique also allows us to use the safe place (stabilisation) with the safe (discussed earlier) or any other container that keeps the patient safe. For example, the patient can use an imaginary remote control to turn off the screen if the scene becomes unbearable. One can imagine a psychic safety net such as an electric cable to be disconnected if the images become unbearable. This allows the patient to protect himself and regain control where he has lost it (transformation of a pathogenic element). It is also important for us, as therapists, to use anchoring techniques in order to avoid being caught up in what the patient is saying or dissociating.

Discussion

Our work focused on a particular clinical case study with our patient, Tom, 56 years old, who came to the consultation with several clinical problems: dissociative disorders (Mary/Tom), a personality disorder confirmed by psychiatric follow-up, obsessive-compulsive disorders (OCD, e.g., compulsion to download all kinds of computer files and to wear women's underwear) and this, to calm internal tensions on a picture of a complex trauma experienced in childhood. In the course of this work, we put forward various hypotheses, some of which proved to be conclusive and others not.

On the other hand, several reflections have emerged during this work because, after 8 months of consultations, the avenues taken following our hypotheses have led us to other avenues that were not identified in the previous chapters. These hypotheses deserve to be updated because they also prove the limits that we may encounter during therapeutic work with the patient. Indeed, it is a whole holistic approach that is put in place between the therapist(s) and the patient concerned. We do not treat a single disorder but a set of symptoms around the same problem: the complex and specific trauma.

Our attention was first focused on dissociative identity disorders: Tom tells us about two parts that are present: Tom and Mary. Tom is, according to him, the part that remains hidden from Mary, who seems to be the one who is well and watching. But are we really in an IDD and/or a secondary structural dissociation (even if the border remains tenuous)? With hindsight, we think that we are neither in one nor the other. Indeed, the further we work with Tom, the more we observe symptoms of depersonalisation, amnesia in relation to the abuse that lasted several decades with disorientation when the patient has flashbacks linked to the trauma and which appeared during his hospitalisations (triggering of flashbacks and nightmares). Our hypothesis is therefore a diagnosis of complex dissociative disorder (complex PDD) with dissociative symptoms. The literature tells us that during depersonalisation, this syndrome or condition can arise at any time when the ego-coordinated defences change. During the depersonalisation of the patient, we do not witness a period of lack, but of rupture brought about by a process of identity dissociation. It provokes the caesura, emptiness, even a blank, during which the ego untied from the other instances feels threatened, but at the same time, it becomes aware of itself, of its individuality. The feelings of strangeness felt by our patient, which are often instantaneous or of short duration, risk provoking the syndrome of depersonalization, until the moment when the self, overcoming the fright of its excitations, addresses or lets itself be linked to the other instances and systems in order to carry out the necessary connections for new defenses, delirious or "hallucinatory" neoreality by way of dysfunctional response as traumatic protection. Sometimes, according to the structure of the subject, the self is satisfied with reinforcing or rigidifying the operation of these limits and its disorders, keeping a minimum of connections with the authorities and the systems, as shown by the organization of the limit states in people with personality disorders or character neuroses.[40]

In this case, memory and identity are indeed central to the pathology of PTSD in our patient. However, at the neurological level, the description of PTSD in our patient could also be well established and would thus reveal a particular pattern of neurological alterations in brain regions involved in memory and emotional regulation (hippocampus, amygdala, medial prefrontal and anterior cingulate cortex) underlying the patient's memory and emotional dysfunctions. Nevertheless, further investigations are needed to refine the descriptive models of the condition, including a more precise characterisation of the different types of PTSD. The frequent comorbidities of PTSD will also be an important aspect to consider in future investigations. Furthermore, it appears that some studies do not find the brain alterations generally described in PTSD and therefore suggest that heterogeneous differences could be induced by the type of trauma, related to the severity of the symptoms and to the typ.[41] As for dissociative disorders, it is not negligible to think that in our patient, other, more aggressive parts of himself may exist without this necessarily being Dissociative Identity Disorder. More specifically, on the basis of the different disorders around the patient's personality, we wonder about the reason and intrapsychic function of this protective part of Mary? This part that does not want and prevents the emergence of the Tom part? Each patient shows a unique set of dissociative self-states. In our patient's case, we establish various confirmed diagnoses: personality disorder, complex PTSD with dissociation

and, in the course of the clinic, we will also learn that our patient encounters periods of self-harm and OCD. Gender identity disorder is an emerging issue in our minds that remains unresolved. We recall that Tom was "disguised" as a girl when he was sexually abused when he was 10-12years old. The patient also reminds us that his grandmother, wanting a little girl, dressed Tom as a girl until he was five years old. What is happening to his sexuality and sexual orientation? During the consultation, Tom explains to us that he self-harms with a knife on his inner thighs, not far from his male sexual parts. Could this be an unconscious way of self-castrating and psychically eliminating the male sex? His sexual life as a couple appears to be very poor. The patient also informs us that he wears women's underwear under his suit and tie. These different elements lead us to question the sexual identity of the patient's self. When we asked about the possibility of changing sex and gender, the patient expressed his fear of losing his wife if he accepted this possibility (feeling of shame). There are many indications that the internal conflict may lie elsewhere.

Secondly, with regard to the aspect of transference/counter-transference previously discussed in our work, it seems important to us to go into it in greater depth at this stage. During this encounter, the psychotherapist and the patient learn at the same time but do not learn the same thing. The counter-transference is constructed with regard to the patient's first intention defences which will, in one way or another, be re-actualised. What would be transmitted would therefore be the immediate solutions of survival, which come under processes that are not new and are describable in the usual terms of psychology and psychopathology. What may be impossible to transmit gives rise to the trauma narrative on the patient's side and to the emergent scenario on the therapist's side. Indeed, the feelings of the therapist who followed the patient were expressed on two levels: firstly, the fear of a certain 'perverse provocation of the patient' regarding the fact that he wanted to verbalise the 'sordid' traumatic contents at all costs. Knowing that he had already verbalized them several times to other therapists during previous follow-ups, it was clear that a possible 'perverse' behaviour (of the aggressor) could be replayed in the session and thus give a feeling of rejection on the part of the carer.

Secondly, the feeling that the patient 'is touching' makes the therapist feel ambivalent about empathy. Similarly, psychotherapeutic work with trauma sufferers leads to reactions that can be relatively strong in the therapists and clinicians who work with them. These reactions reflect a sharing of the traumatic experiences of our patients as aspects of countertransference when in therapeutic care. In this case, they are found in all those who deal with people who have had traumatic experiences, and it is possible to apply the term countertransference to a wider range of situations. They develop in a variety of ways in response to this transmission of the 'traumatic' from the other. In situations of sexual violence or war, our reactions are even more marked and complex. However, countertransference can also inform us about a number of things and be a valuable clinical tool in terms of intuitive resonance.[42] Thus the different aspects of countertransference are complex and specific to each situation, which arises from a unique form of transmission between traumatised people and those who care for them. So what can be anxiety-provoking for the therapist and risk undermining the therapeutic alliance? According to G. Devereux,[43] the therapist may feel destabilised and may experience anxiety. Indeed, he may feel confronted with phenomena, practices, which are contrary to his values, which seem transgressive, disgusting, repulsive. But these practices may correspond, in his unconscious, to fantasies that we repress. For this reason, there is a kind of fascination, named by Devereux as a kind of "seduction", and "anguish" (due to the anguishing reactivation of repressed desires). These two reactions will therefore be found in therapists confronted with traumatised people. In our clinical situation, when the patient, Tom, presented himself in consultation, the first sessions aroused quite a few reactions: a feeling of discomfort, repulsion, rejection and incomprehension on our part in the face of certain attitudes: intrusive attitudes on his arrival at the place of consultation, attitudes that made us fear that he was replaying in session the perverse games of his aggressors by also detailing, in a precise and scabrous manner, his abuse. In spite of everything, we still felt the desire to accompany him and also the desire to go further (our benevolent curiosity, our humanity). Although we were concerned about the "perverse" aspect of some of our patient's (undoubtedly unconscious) behaviours, our ethics of assistance and psychological care did not waver. However, several limits had to be thought of in the shared benevolence for the therapeutic relational dynamic. Can we accept to conceive the continuation of the care under such conditions, or do we have to stop the follow-up directly because of the stories of abuse that our patient wanted to share with us? The clinical supervision enlightened us and allowed us to suggest a reframing, through the definition of clear limits, instructions not to evoke precise and scabrous details relating to the traumatic memories shared in sessions. This benevolent reframing aims at and allows the patient to bring him a secure container defined by a balancing structure, which was accepted by the patient. At the end of this discussion, the question of sexual identity remains predominant and would undoubtedly be the continuation of our investigation. Indeed, we have not yet sufficiently questioned and investigated this subject. It seems that there is little emotional expression in our patient. If this is related to the trauma, is the patient replaying the abuse and manipulating it in a dysfunctional way as an attempt to reassure himself by traumatic conversion of these personality disorders (Mary/Tom) or are we dealing with something else that would be related to a patient with a transgender gender identity disorder...?

Conclusion

In our work, we addressed the issue of caring for a person suffering from complex post-traumatic stress disorder with identity dissociation and personality disorders. The aim was to gain a better understanding of clinical approaches and methods. At the same time we discovered other pathologies and underlying mechanisms. The patient showed us a florid symptomatology (IDD, OCD, "Perversion", PTSD, sexual identity problems, borderline disorders (downloading), amnesia, attentional difficulties, chronic suffering). More precisely, it seemed relevant to us to ask whether it is possible to treat all these symptoms within the framework of a systemic and clinical psychotherapy in psycho-traumatology. Indeed, the patient seemed ready and motivated to enter into a more in-depth work after several attempts with other therapists. To do this, we first tried to understand what personality disorders were and how they differed from the various identity disorders. We also analysed different behavioural and relationship disorders presented by the patient. We observed many problems according to the grids of systemic psychology but also of traumatic psychology. After a thorough analysis, in our clinical case, a complex PTSD came to the fore. We used psychotherapy and psycho-trauma techniques with clearly positive effects.

More specifically, the transfer and counter-transfer mechanisms were called upon, particularly because of the patient's relational mode: aggressive, imposing difficult, almost "perverted" images, "playing" with the relationship (reliving his own history).

This warranted supervision. The techniques of reassurance of the patient were particularly productive in addition to the techniques learned during the training in psycho-trauma (Bottom Up, anchoring in the present, the safe, hypnosis techniques, etc.). We avoided the pitfalls of the "saviour" or "executioner" therapist: we felt provoked, the patient is ambivalent in the relationship and goes back and forth. It should be noted that this type of countertransference is quite common in the psychotrauma clinic and should be considered. We had reached a stage where hypnosis makes sense. Finally, hypnosis and mental imagery thus appear, in our clinical situation, as effective, relevant and versatile tools in the treatment of PTSD. Its psychopathological interest lies, in fact, in the use of the mechanism at the heart of PTSD. The dissociation, with the patient himself taking over the traumatic situation in the setting, allows him to exploit the resources instead of being the paradoxical victim of their power. Thus, hypnosis, as a dissociative technique, used in a structured, controlled and secure setting, allows the patient with complex PTSD to benefit from its know-how in a therapeutic way, and even to access dissociated elements that would have been closed to any other approach. Of course, hypnosis is not an effective therapy for everyone. We proceeded with trial and error given the clinical context presented by our patient. This tool is above all a singular way of communicating and being present to oneself, which we, therapists, have used by adapting ourselves to our patient, to his singularity, to his request, and according to the dynamics of the therapy. At the end of our work, the question of sexual identity appeared to us as important and would undoubtedly be the continuation of our research. It seems that there is little emotional expression in our patient. If this is related to the trauma, is the patient replaying the abuse or manipulating it in a dysfunctional way as an attempt to reassure himself by traumatic conversion of these personality disorders: Mary/Tom; or are we dealing with something else that would be related to a patient with gender dysphoria emerging from his trauma?

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