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A CHALLENGE TO BORDERLINE PERSONALITY DIAGNOSIS: INVESTIGATING POST-TRAUMATIC PERSONALITY DISORDERS. CONNECTING PERSONALITY TRAITS TO DEVELOPMENT IN FAMILY.[1]

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Systemic model and attachment theory

The pioneers of family therapy didn't consider personality disorders. The first experiences in the fifties-seventies only point out psychopathology, that is the first axis of DSM IV: Bateson with schizophrenia and double bind, Cancrini with drug addictions, Selvini Palazzoli with anorexia. Therapy is focused on the dissipation of illness through the systemic work of "depathologising", prescriptions, rituals, provocation and so on.

The first systemic manual written in 1967 by Paul Watzlawick *Pragmatics of human communication* , an edit of the complex and subtle thought of Gregory Bateson, strongly leans on the here and now. In contrast to psychoanalysis, it asserts that the focus of the clinical work has to be shifted from past to present, with the observation of the dynamics and communications within the families that for the first time in the history of psychiatry/psychoanalysis are called to participate all together. Therefore the systemic model rises ignoring the models of developmental psychology (see the opposition to the attachment theory since dyadic), focusing on disruptive interventions that can change families in short term (see the structural interventions of Minuchin, the strategic ones of Haley, the paradoxes of Selvini Palazzoli).

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The generation successive to the pioneers, since the eighties, will realize the systemic extremism limits: a too simple theory that risks feeding mechanical, provocative and executive attitudes in the therapists.

A renewal is produced by the division of the family therapy movement in two currents: post-modern constructivism draws the attention on the therapist and his creativity, where the development of the personality focus is replaced with the badly defined theme of “narration”. Selvini Palazzoli lead remains instead focused on psychopathology and families, but is open to the concepts of evolutionary psychology: the attachment theory becomes crucial.

It is the systemic trend that could be called "integrative of suffering" because talking mainly of homeostatic function of the symptom, "power tactics", "failed release", the dimension of pain was to be partially blurred or forgotten.

Cirillo and his research group start to deal with trauma and personality in T*he addict's family*; immediately after the last work of Mara Selvini Palazzoli *Anorexic and bulimic girls*(Selvini Palazzoli, Cirillo, Selvini, Sorrentino, 1998) in which the authors theorize four types of personalities of the anorexic-bulimic patients: dependent, borderline obsessive-compulsive and narcissistic (p. 175-195) which today we prefer to rename as post-traumatic personality (subject-parentified, seductive, autarkic and punitive-tyrannical) in reference to the reorganizations of attachment which I will discuss in the next paragraph.

There is a transition from a pure relational model to an individual-familiar pattern, where the dimension of trauma has to be recovered, both as specific trauma and traumatic development (also in the sense of deficiency).

The development contexts as learning matrix of individual functioning?

In dealing with the causes of personality disorders the same dilemma that arises in relation to psychopathology recurs: is the search for the family/relational "causes" correct? The dominant biological psychiatry replies adversely to this question, referring to genetic and biochemical factors. The second axis of the DSM IV only describes personality disorders, without any reference to their etiopathogenesis.

In the literature of psychotherapy you can find instead hypothesis linking a personality disorder to a matrix or a relational context, for example a reference author such as Lorna Benjamin (1993) speaks of the chaotic family, "a disaster a day" of the borderline.

On the other hand scholars of personality (Oldham et al. 2008) strongly emphasize that family can "mould" only part of the infant, who always has an active role and brings its genetic (beauty, health, etc.) and temperamental specificity.

Personality disorder is the result of a complex path of development, an interactive path where both specific trauma and developmental trauma, linked to family difficulties, can have a very considerable impact.

Especially the moment of birth seems to leave an outstanding *imprinting* to the character: for example, a very good mother can fall, for reasons often not easy to decipher, in a post-partum depression that inevitably has consequences on the baby, in the sense of a disorganized attachment.

Later this woman will recover, her husband will be a good father and husband, but their son, who we may meet in adolescence, will carry the memory of that original drama in his body (Van der Kolk, 2014).

For this reason it would be a mistake to think that in the family that we meet today, we can always find that the relational dysfunction that caused the symptom or the dysfunctional personality trait is still active and unchanged. This was one of the major limitations of systemic purism. That child could have also been a difficult child and the family could have activated responses either not at all or only partially reparative.

See in our recent *Entrare in terapia* (Cirillo, Selvini, Sorrentino, 2016, p. 145) the reflection on the developmental systemic dimension: it is often severely incorrect to connect a symptom to the way in which the system acts in the present.

Our work has to be both individual and relational: we don't focus primarily on the families but on the development of our patients, trying to understand if their reference figures have been adequate in the past and if they are in the present.

We know that families can be dysfunctional: distorted reality (Selvini, 1993) first of all means that a parent sees his child in a unrealistic/deformed way. We have to be careful not to take for granted that families are always dysfunctional. The emblematic conception of Framo (1965) that "When there is some disorder in children there is always some trouble in the marriage, even if not all troubled marriages produce disturbed children" granted as an axiom of truth by the pioneers of family therapy has favored judgmental and hypercritical attitudes: our goodwill towards families is a crucial therapeutic factor, whereas blaming and demonizing families, typical of the Freudian culture, is dangerously toxic and harmful.

When in a first session with a teenager and his parents (Selvini, 2014) I see a chillingly sadistic father in action, I observe a helpless mother and I am perturbed by the fury of their son's reactions, I can certainly speculate that this type of system has worked in this way since the birth of the child, and surely I will have to try to understand the causes of the drama (cross-generational reflections on father's story, story of the couple, etc.,) but the clinician must also wonder what may have been the active role of the child, for what reasons and in what stage of its growth.

Even a relationship or a non familiar event could have had a negative impact, especially if none of the family have been aware of it. The acknowledgment of the trauma is the first phase of resilience (Selvini, Sorrentino, Gritti, 2012).

The individual/systemic model has to be a procedural and circular pattern of reciprocal influences between the specificity of child development and family relations.

The five reorganization strategies

In the study of personality disorders, that is, the most unsuccessful developmental paths, the concept of disorganized attachment is crucial: the child is subject to an impact with a reference adult that is frightened, frightening, hostile or helpless (Lyons-Ruth et al., 2009). Recent research on non-clinical populations calculate approximately 15-20% are subjects with a disorganized attachment; this percentage rises to 50-80% in populations of patients in treatment. It is therefore highly likely that a large portion of our patients present this matrix in their development history.

Liotti e Monticelli (2008), then Lyons-Ruth et al. (2009) conceive disorganization as a fracture, that is a high anxiety subjective state of in the dilemma of fear/need of the reference figures: a type of distressed ambivalence impossible to bear. The historic concepts of defense can be reinterpreted as the need to find a way out from unbearable live experiences. Lyons-Ruth and other attachment researchers identified two key strategies to regain control, that is to reorganize the disorganization:

Protective: the savior. This is the classic role reversal, where the child becomes grandfather of himself, acting as the parent of his parent/reference figure. It is evident that the prevalence of this existential choice will lead to the identity (or sub identity in typical disorganized patterns) of the parentified type.

Punitive-tyrannical: the tormentor/executioner The child becomes tyrannical/dominant towards the reference figure. We find this reorganization especially in the border types (the "persecuter/rescuer" vertex of the dramatic triangle) but is also likely to be one of the matrices of antisocial, paranoid and narcissistic personalities.

Liotti suggests to study other three reorganization strategies:

Submission: the victim. The child may learn that to control the figure of reference, and therefore to make it less threatening and more predictable, being completely "under his command", in a state of utter complacency/subjugation works well. This idea struck me because it solves a big contradiction that had tormented me in the description of the "dependent-symbiotic" type. In the mentioned book (Palazzoli et al., 1998) describing the dependent type we put together symbiotic traits (the difficulty to act independently and to think with one's own head) with reversal of roles traits (protective). As we will see later, it is the frequent combination of two reorganizations, but it appeared a confused type when looking for matches in the development history. In fact, in dealing with subjects that in the DSM IV could be classified as "dependent", the clinical experience didn't confirm at all the presence of a hyper-protective learning environment. On the contrary we encountered case stories with severe deficiencies, almost abusive stories; in parallel, in literature we can also find reference to an authoritarian style in parenthood (Bornstein, 1998). I can therefore assume the existence of two types of dependent personalities, so different from each other as to rise the doubt whether it is a good idea to apply the identical term. In fact, this submissive child seems more easily led to the genesis of a masochist tract or a passive aggressive one, that is precisely to an identity based on the submission to the will of the reference figure. We must therefore distinguish carefully between the inability to think and do only on the basis of an infantilism caused by a caregiver being anxiously overprotective and the same inability built on the strategy of submission to a reference that is unreliable/threatening.

Seductive: the manipulator. We come here to a classic theme of the history of psychotherapy: the famous Freud's hysterical subjects now renamed histrionic: girls scared by not being acknowledged who try to exist with active hyper caregiver involvement strategies (using precisely seduction and discomfort and illness). These children run the greatest risk of sexual abuse. Putting into focus this type of reorganization helps us to hypothesize their active part, precisely on the grounds of excessive attention seeking.

Autarkic: the self-sufficient. Liotti calls this reorganization "unplug the attachment plug", that is, the highly avoidant attachments that lead to the origins of the obsessive, schizoid or paranoid personalities, but that we often meet as precariously present in border and psychotic outlines: if my caregiver frightens me, I will delete it, I'll manage without this person.

The connection between these strategies and many trust disorders appears obvious. The attachment phobia that requires activation of other motivational systems, matrices of reorganizations.

This simple reorganization model is very useful to rethink in the light of development psychology the classical concept of defense and to understand the development pathways that lead to personality disorders.

Abolishing stigmatizing borderline and masochistic diagnosis

Unlikely our patients will show a single reorganization: the divided self of post-traumatic patients is precisely characterized by different parts of the same person that swing from one to the other (see the historical concept of dramatic triangle Karpman, 1968). To set up a treatment program it's important to identify first the insecure attachment area (ambivalent or avoidant) and subsequently the prevailing reorganization: this gives direction the approach and the prognosis.

We start from the protective reorganization (ambivalent attachment area), which is the one that presents the best prognosis, to the point of not being considered in the II ° axis of the DSM IV. They require a more directive approach, a guide, as does the entire area of ambivalent attachment. They struggle to accept the therapy because they have difficulties in taking care of their needs, since they are tuned to those of the other. We find traces of this functioning in the psychodynamic diagnosis of oral dependent (Johnson, 1994). These people are particularly exposed to the risk of overload (hyper-responsibility), with the consequent anxious and depressive symptoms. These people will very easily choose the helping professions. Miller (1996) has defined these personalities neurotic narcissistic, others, including the author, have called it parentified personality (Selvini, 2008).

With the punitive reorganization, in the avoidant attachment area, we move to the opposite pole of the worst prognosis: the tyrant child will trigger a lot of negativity in his reference figures that can reach actual abuse. Development paths open that start with a *fight* reaction to stress/trauma and lead to the diagnosis of narcissistic, antisocial and paranoid personality disorders. Here the approach should be welcoming, as throughout all the avoidance area, but with important initial cautions: the narcissist confuse empathy with commiseration and often respond more positively to a good-natured challenge seen as being more respectful.

The submission (in the ambivalent attachment area) is instead connected to a post-traumatic *frozen* (freezing/dulling/depression) reaction that has a bad prognosis, although better than the tyrannical one. Indeed, we have a "good boy", although a bit '"detached." The trajectory towards personality disorders leads to masochist, border dependent subtype, passive-aggressive diagnosis. The key point of therapy is to lead the patient to the changing experience of having an active, effective and fulfilling role.

The seductive reorganization (in the ambivalent attachment area) seems to be more clearly linked to a relational context where the experience of invisibility feeds fear. Hence two major subtypes: the seducer-resuscitator (with better prognosis) and that of the sick patient (eg hysterical paralysis cured by Freud). Here too, the post-traumatic reaction seems predominantly "fight" but more mixed with dissociative/flight aspects, therefore the risk that the body speaks instead of the person itself. The DSM IV diagnosis will be that of the histrionic personality. In therapies we will work to understand and satisfy that need of visibility and to prevent acting-out and self-injurious behaviors (fatuous exhibitionism, promiscuity, etc.).

Finally the autarkic reorganization (in the avoidant attachment area) is engaged on post traumatic dissociative/flight. It presents an intermediate prognosis gravity similar to the seductive one, and leads, in order of severity, towards schizoid, obsessive and avoidant personality disorder diagnosis. The challenge of these treatments is entering in a truly authentic contact with these patients, helping them to do the same it with the other (enlargements).

As correctly suggested by Herman (1992), the diagnosis of borderline and masochistic personality have become severely stigmatizing for patients. Diagnosis of personality that favor the recognition of the distortions of the development path and then help an empath/positive attitude towards patients are much more useful. My proposal is to abolish the borderline and masochistic labels and replace them with definitions related to the reorganizations:

1) Submissive/parentified post traumatic personality
2) Seductive post traumatic personality
3) Punitive- tyrannical post traumatic personality
4) Autarkic post traumatic personality

I suggest to integrate two of the reorganizations because clinical experience shows that they are almost always combined together, although with different specific gravities, as we anticipated in Anorexic and bulimic girls (Palazzoli et al., 1998) even only intuitively.

Clinical research has demonstrated the presence of severe trauma in almost all patients receiving psychiatric diagnoses in general, and especially in subjects with borderline and masochistic diagnosis. The diagnosis of borderline is however still used for too many people, even greatly different among themselves. Hence the need for clinical research to identify more homogeneous groups of patients to assess the major/minor effectiveness of different treatment strategies.

Organizing a classification of personality disorders

I followed the criterion of continuity between normality and pathology: the same trait can be classified as a style, a neurosis or a disorder (Johnson, 1994). If we take as an example narcissism we have the benign narcissism style of the basically well-functioning person, aware of the risk of his tendency to feel superior, his being contemptuous, his difficulty in seeing his limitations, sometimes insensitive to the feelings of others. Then we have the neuroses of those who are only partially aware of their narcissistic functioning, and finally the real disorder, that is the malignant narcissism of the person entirely ego syntonic with its dysfunctions.

The diagnosis of personality has no clinical utility without a simultaneous assessment of the severity of the disorder.

As an ordering criteria of the whole range of the personalities we have used the attachment theory and, therefore, the range of ambivalent/disorganized/avoidant attachment.

Even Solomon (1989) proposed a similar contribution that Cirillo (2013) adopted as a starting point for a classification of personality disorders, ranging from excess of dependency to excess of autonomy.

Therefore, the following 14 personalities types:

Ambivalent area

1) dependent
2) parentified
3) histrionic
4) passive-aggressive

Ambivalent versus disorganized area (that is borderline personality disorder)

5) protective-submissive post traumatic
6) seductive post traumatic

Avoidant versus disorganized area (that is narcissist, antisocial, paranoid, schizoid and schizotypal disorders)

7) tyrannical-punitive post traumatic
8) autarkic post traumatic

Avoidant area

9) avoidant
10) obsessive
11) narcissistic
12) antisocial
13) paranoid
14) schizoid

This vertical classification has nothing to do with severity assessments which are preferably to be read horizontally on all types (style-neuroses-disorder). In my article of 2008 I placed the borderline disorder in the area of disorganized ambivalent attachment. If instead we cancel the borderline diagnosis to replace it with that of post-traumatic personality, they should be placed in the avoidant disorganized area.

This classification is similar to that of Benjamin's regarding the belonging-detachment axis, but it is detached from the three clusters of DSM IV because these gather areas of opposite attachment: for example, the dependent of the ambivalent area and the obsessive of the avoidant area, are joint in the anxious cluster. It is inevitable that following a development criterion a purely descriptive classification will clash. Our diagnosis will be both categorical and dimensional. They will be categorical because in a minority of cases we will meet people who embody the prototype of a certain type or personality trait. But they will especially be dimensional because more often we will see people who embody and combine different traits.

The more complex and decisive differential diagnosis is therefore that between a primary or organized personality disorder and a disorganized personality disorder as post-traumatic. For example, a child who grows up with a stable avoidant attachment and is simultaneously exalted for exceptional natural gifts, may develop an organized narcissistic disorder, which has similarities with the traits of people with a post-traumatic story of punitive reorganization. The two personality structures, and therefore treatments and prognosis, however, will be completely different. The same problem arises for other differential diagnosis: for example, a paranoid will be so structurally perched in response to a negative environment or will he be presenting a main reorganization that conceals others, more accessible to the therapeutic relationship?

Connecting personality traits to stories of development in the family

In the mid-nineties, while preparing our book Anorexic and bulimic girls (Palazzoli et al. 1998) we started to research these correlations and to study the related literature.

In the clinical work it was important to verify that the expected links overlapped: for example, with a narcissistic trait we expected that that child had been exalted/obeyed and very often it was just what we found in the family history. However when the hypothesis was not confirmed, this was still very interesting, because it brought to light other subtypes of personality, such as revenge narcissism (Di Maggio, Semerari, 2003). Similarly it was very interesting to study the cases where the dependent trait did not fit a family history of infantilism/overprotection. This made it possible to better identify the submission reorganization.

I'll try now to synthesize in a table the main correlations.

PERSONALITY TRAITS	**DEVELOPMENT STORY OF THE FAMILY**
Dependent/Infantile/Symbiotic	Overprotection
Parentified	Role reversal
Histrionic	Only seen if ill or seductive
Passive aggressive	Humbled and overwhelmed
Protective-submissive post traumatic	Neglect, abuse, parental fragility in emotional context
Seductive post traumatic	Unpredictable alternation of acceptance/ abandonment in an emotional context, but a lack of visibility
Punitive-tyrannical post traumatic	Alternation of exultation/aggression in an unpredictable/hostile environment, lack of affection
Autarkic post traumatic	Unpredictable alternation of presence/absence of fragile parents in a rejecting and cold context
Avoidant	Aloofness and hypercriticism in a formally adequate context
Obsessive	Aloofness and hyper responsibility in a formally adequate context
Narcissistic	Lack of caregiving and quality magnification unrelated to the merits
Antisocial	Lack of caregiving and manipulation in a stress context
Paranoid	Deficiency and aggression in a lack of affection context

Schizoid	Inaccessibility to attachment figures

With this scheme I suggest a distinction between trauma and lack of caregiving. Deficiency leads to developmental deficits linked to organized insecure attachment, ambivalent or avoidant. Development trauma refers to attachment disorganization.

Treatment strategies

The existing literature, both on personality disorders and on post traumatic disorders, two fields that tend to overlap a lot, tends to ignore the work with families, only focusing on individual psychotherapy.

The clinical experience of my group, tested mainly on the restrictive anorexia ground (Cirillo, Selvini, Sorrentino, 2011) where girls with post traumatic personality, dominated by autarkic, submissive and protective reorganizations, but all five are present, although with different prevalence, showed the effectiveness of a multimodal teamwork that integrates individual therapy with family therapy.

Family therapy is crucial both in the first phase of the personality disorders treatment: the impact of the acknowledgment of the trauma (Selvini, Sorrentino, Gritti, 2012) or of the lack of caregiving, but also in the next phase in which the family is prepared to share the trauma that the patient has never revealed and is willing to support him in the elaboration process.

We must stop the multigenerational chain: it can often be noted that a post traumatic patient has at least one post traumatic parent.

Here a dramatic example of tyrannical reorganization.

> *We are contacted by the father of Marco, a fifteen years old boy, very concerned about his eldest son's poor school performance of, the violent tensions at home with his mother, the physical ill treatment towards his sister. In the first meeting we invite Marco with his parents: he appears very challenging, provocative and very intelligent. The mother worries us even more than him: her hostility towards the boy is fierce, unstoppable. We are immediately forced to split the formats: Cirillo sees the parents, with me behind the mirror, and I see in parallel the boy alone. The parents tell a typical chaotic history, one of "a disaster a day". The mother comes from a very wealthy family, her father died in an accident when she was a teenager, she became the black sheep of the family, in perpetual conflict with her mother who takes over her late husband's well established activity, the favorite daughter seems to be her sister. She has no professional achievements and an unstable love life until her marriage to an employee of the family study. They go and live in a luxury apartment in the center of Milan. But also, this union is plagued by continuous conflicts: the woman has severed relations even with her*

husband's family. When asked about her relationship with Marco she leaves us shocked: "He has always hated me, from birth, he refused my milk, he has never noticed me." The father very feebly tries to mediate, overwhelmed by the incitement/intolerance of his wife and the provocation of the boy, he loses his temper and hits his son. Marco, in individual therapy, with a typical but nevertheless surprising change, stops despising me and starts an overflow of revelations and thoughts. On WhatsApp, he sends me at least forty hyper distressing pictures of bleeding wounds, he hands me a series of cutters. The parents are totally unaware of the self-harm problem, which has been going on periodically for several years. Marco in a dramatic individual session reveals, with a cold and detached attitude, his projects to exterminate of his family, his experiments, his enjoyment when he sees them suffer...

Through a complicated negotiation with the boy we manage to relocate the boy (relatives foster family) and this safety measure produces immediate improvements. We manage to convince his mother to start a personal therapy and we discuss with the parents how to contact the social services (we are in the private context). In separated parallel sessions with Marco and his parents we agree to resume contacts between the mother and the boy, that had been interrupted for a few weeks.

This case very clearly shows the unavoidable need of simultaneous family and individual therapy in taking charge of personality disorders. In fact, this child and then boy had been sent to various psychotherapists, and had always been seen individually, with insignificant results, most likely iatrogenic.

In the first sessions with a patient with a personality disorder the recognition of trauma is crucial: "We need to understand what has terribly frightened Marco when he was very young. Marco defended himself from the fear by becoming very domineering: being a bad boy gives him security for a while, until the consequences of his bad behavior turn upon him, frightening him to death! We have to get out of this tragic vicious circle".

The psychoeducation on the causes of personality disorders, through the theory of reorganization, is a decisive tool for family and individual personality disorders therapy. At a later stage of processing, family support installs a sense of security in the patient who can consequently remember and elaborate: the best part of family therapy is that of sharing the suffering, to allow a reconciliation that is prerequisite to a healthy sense of belonging.

Conclusions

The work of classification of personality disorders is very important, especially in the still not well defined area of post traumatic personality, just to be able to set up a systematic research in which treatment protocols can be more effective. In this area where psychiatry reveals its utter helplessness, systemic psychotherapy can really prove its social utility: a scientific challenge taking its first steps.

ABSTRACT

Systemic therapy theories should highlight the development patterns that lead to personality disorders. It is often mistaken to connect a symptom to the way in which the family acts here and now. Researches on family deficiency, on traumatic development, on attachment disorganization and on the five reorganization are the fundamentals for family and individual treatments of personality disorders.

"Borderline" stigmatizing diagnostic labels should be replaced by words that emphasize trauma and family deficiency.

Key words: *identification of the trauma, development family deficiency, attachment disorganization, attachment reorganization, simultaneous family and individual therapy.*

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