

**AN IN-DEPTH EXPLORATION OF THE PERSONALITY STRUCTURE OF ADULT FEMALE PSYCHIATRIC PATIENTS
WITH A HISTORY OF CHILDHOOD TRAUMA BY UTILISING PERSONALITY ASSESSMENT**

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I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



SIGNATURE

22/02/2019

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Summary

The experience of complex childhood trauma produces a ripple-effect that psychologically impacts trauma survivors' functioning in multiple areas. The aim of the current study was to investigate and describe the interplay between complex trauma, subsequent personality development and later psychopathology by means of the multiple case study method of six female psychiatric patients attending treatment at a tertiary psychiatric hospital within Gauteng, South Africa. This was accomplished by assessing and qualitatively analysing the results of a carefully selected battery of personality and other psychometric assessments presented to study participants. The results indicated that the experience of complex childhood trauma impacted the study participants' personality in predictable ways, which further influenced the psychopathology they displayed as psychiatric patients. These findings aid in describing the psychological impact of complex trauma on the research participants, and also offers support for reconnecting past traumas to the current psychopathologies of psychiatric patients.

Key terms: Complex childhood trauma; Personality structure; Psychopathology; Borderline Personality Disorder; 16 PF; MCMI-IV; The Rorschach Inkblot Test; The Childhood Trauma Questionnaire; Trauma-saturated personality.

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Finally, I would like to say how thankful I am for having had the opportunity to conduct this research. It has aided me in developing as a clinical psychologist, and shaped my approach to understanding, diagnosing and treating the psychiatric patients I work with. My hope is that the knowledge this study produced also assists in shaping other developing clinicians' understanding of trauma, personality and psychopathology, as I regard this as crucial to being a better clinician.

Not only do I hope that the efforts of this study will aid other clinicians in their daily practice, but I also hope that it will assist trauma survivors in acknowledging the impact that their past trauma has had in shaping their current realities. It is my

belief that without the acknowledgement of the significance of these traumas, healing cannot truly begin.

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Chapter 1. Introduction

According to Bessel van der Kolk, a pioneer in research on psychological trauma, the rediscovery of trauma as an aetiological factor in mental disorders goes back 38 years (van der Kolk, 2000). During this time, there has been a significant expansion of knowledge regarding the manner in which life experiences shape the central nervous system, and the formation of ‘the self’. Developments in neuroscience have significantly enriched our understanding of how the brain is shaped by experience, and how life itself continues to form and transform the ways in which our biology is ordered (van der Kolk, 2000). van der Kolk (2000) further adds that the study of trauma may very well be the most productive area, within the disciplines of psychiatry and psychology, in aiding the development of a deeper understanding of the inter-relationships between emotional, cognitive, social, and biological forces that shape human development and behaviour.

In particular, the fields of psychiatry and psychology have discovered how certain life experiences can determine psychological expectations and biological selectivity. Research in these areas has thus revealed entirely new insights on how extreme life experiences, throughout the life cycle, can have profound effects on memory, affect regulation, biological stress modulation, and interpersonal relatedness (van der Kolk, 2000). Since all these components are severely impacted in psychopathology, it can therefore be reasoned the data produced by researching the impact of trauma on human functioning can thus assist in better understanding the pathological behaviour of individuals.

The association between trauma and psychopathology is not new, however, it is surprising that despite the vast amount of research advocating for an acknowledgement of past trauma in the clinical treatment of patients (Herman, 1992a; Jangam, Muralidharan, Tansa, & Raj, 2015; Terr, 1991; van der Kolk, 2000) little is done to assess past trauma or address it as part of the diagnosis and treatment of psychiatric patients. What is seen in the profession of clinical psychology and psychiatry today is that all too often past traumas are disconnected from the current

psychiatric symptoms they create, and most of the focus is on treating the symptoms of the past trauma rather than the actual trauma itself (Terr, 1991). It is the position of this researcher that various clinical diagnoses can be linked back to past traumas and the personality patterns or behaviour created. Many other research studies also support this preposition (Cole & Putnam, 1992; Herman, 1992a; Matthews, Deary, & Whiteman, 2003; Terr, 1991; Van der Kolk, 1987; Van der Kolk & Fisler, 1994). The diagnosis of Borderline Personality Disorder (BPD) is a case in point. This diagnosis is well known for its aetiological association with childhood trauma; yet even in the clinical treatment of this diagnosis is the past childhood trauma rarely addressed, other than a superficial recognition of its aetiological significance. It is the position of this researcher the past trauma experienced by BPD patients is actually central to the development of their pathological personalities and all their pathological behaviour and co-morbid diagnoses. A reconceptualisation of the centrality of trauma in the diagnoses and treatment of BPD is thus recommended. In essence, it is the belief of this researcher that it is necessary to reconnect the trauma to the observed psychopathology to truly help psychiatric patients. In addition, it is proposed the study of personality, as an organising principle for life experiences, such as trauma and the accompanying psychopathology, could aid in achieving this goal.

More specifically, this study maintains that a golden thread connects the experience of complex trauma, personality development, and the later expression of psychopathology. Part of achieving such an investigation includes a recognition of the continuity between normal personality characteristics and pathological personality characteristics with extreme life experiences, such as trauma, significantly disrupting the balance between normality and pathology. It is thus suggested the personality structure, which is composed of normal and abnormal traits, of individuals can be regarded as a crucial interconnection between trauma and its impact on the development of psychopathology. However, it is also the researcher's experience, as a clinical psychologist, this interconnection is often overlooked in clinical practice.

The topics of childhood trauma, personality and psychopathology have been studied extensively throughout the history of psychology. However, the question of how these three concepts are interlinked needs to be posed. It seems most research on these topics have been conducted in isolation or with a simplistic recognition of this inter-relationship. A review of relevant literature indicated that research on the inter-relationship between trauma and certain types of psychopathology (Cole & Putnam, 1992; Hengartner, Ajdacic-Gross, Rodgers, Muller, & Rossler, 2013; Herman, 1992a; Matthews, Deary, & Whiteman, 2003; Van der Kolk, 1987; Van der Kolk & Fisler, 1994), and on the link between personality and psychopathology (Akiskal et al., 1983; Blatt, 1974, 1995; Blatt & Blass, 1990; Blatt & Levy, 2003; Blatt & Shichman, 1983; Duggan et al., 2003; Millon & Francis, 1987; Mulder, Joyce & Sullivan, 1999; Widiger, Trull & Clarkin, 1994) have been conducted. A comprehensive description of such studies can be found in Chapter Two of this study. A need thus clearly exists in the field of clinical psychology to better understand and describe the relationship between trauma, personality and psychopathology, as it is proposed such an investigation will deliver a more holistic picture of how psychopathology, and in particular BPD is formed and functions.

The current study thus aims to achieve this goal by studying the inter-relationship between complex childhood trauma, personality development and functioning, and the psychopathology seen in BPD. The method of investigation used in this study is the in-depth personality assessment of psychiatric patients with a diagnosis of BPD within the South African context. This should deliver a detailed and descriptive picture of the phenomena being studied.

The findings of this study will be useful in a number of ways. First, the study will aid in elucidating and describing the link between complex childhood trauma, personality functioning and psychopathology. Second, it will assist in better conceptualising the diagnosis of BPD and aid in offering clinical insights with regard to the treatment of psychiatric patients with such a diagnosis. Third, the value of investigating and understanding trauma histories and personality functioning, in the

conceptualisation and treatment of psychopathology, will also be supported by this study's findings. This understanding could in turn greatly influence the development of new clinical guidelines when treating trauma and BPD patients.

According to van der Kolk (2000), studies of the impact of trauma on patient functioning greatly assists with the development of a range of new psychotherapeutic approaches. They also aid clinicians to become aware of entirely new perspectives of how traumatised individuals can be helped to overcome their past. These contributions are significant, especially when considering the South African context, where complex childhood trauma is found in the majority of psychiatric patient' histories. It should also be noted that not only have limited studies of this kind been done internationally (de Carvalho, et al., 2015; Rademaker et al., 2008) but a need exists to conduct studies of this sort in the South African context as well. This will likely assist South African clinicians to better understand the contexts of their South African patients and enable clinicians not to rely solely on research generated in other, mostly European countries. Testing the application and efficacy of international theories and research findings on a South African population will assist in revealing whether these conceptualisations are applicable to the South African population and whether it can be consulted with confidence when treating South African psychiatric patients.

1.1. The structure of the study

This chapter has introduced the nature of this research and the reasons for this examination. In Chapter Two, the most prominent literature related to this topic will be expanded upon, as along with the theoretical underpinnings that guided this study. Chapter Three contains a detailed description of the manner in which this study was conducted. This includes the research questions, aims and objectives that guided the study, the research design employed in the study, and the research methodology which guided the research enquiry. In addition, a detailed description of the psychometric and projective assessments used as the method of enquiry is provided.

The method of data analysis and data description is also elaborated upon. Finally, the ethical guidelines the study adhered to is also set forth in Chapter Three. Chapter Four contains a detailed and comprehensive description of the most clinically significant findings of data obtained from the participants' assessment results. These results offer the researcher the opportunity to link each participants' history of past trauma with their current functioning, behaviour and psychiatric diagnoses. The various case profiles, including a description of their trauma history, is also provided in Chapter Four. Chapter Five includes the findings produced after qualitatively analysing the participants' results. A discussion of the various themes that arose throughout the data is provided, as well as a detailed description of the clinical relevance of these findings. Chapter Five concludes with an overview of the research questions answered. Chapter Six sets out the conclusion and reiterates the clinical relevance of this investigation. The perceived limitations of this study will also be discussed. In addition, recommendations based on the findings of the study, with regard to clinical practice and continued research, are also made in the concluding chapter.

Chapter 2. Literature Review

This chapter offers an overview of prominent literature which guided the research study and pertains to the interplay between complex childhood trauma, personality functioning and psychopathology. The chapter begins with a discussion of the various aspects of trauma and how it pertains to the study of psychology. More specifically, the impact of complex childhood trauma, on psychological functioning and personality development, will be discussed. Thereafter, the interplay between personality and mental health will be elaborated upon. Of specific interest to the researcher was the manner in which complex trauma shapes personality and, in turn, the impact of personality structure on the development and expression of psychopathology. Of additional interest was the relationship between normal personality functioning and pathological personality functioning. In order to more effectively study the interplay between childhood trauma, personality and psychopathology, a specific focus of the study was on the investigation of the BPD diagnosis. In this regard the literature reviewed will aid in cultivating a better clinical understanding of the dynamics inherent in this diagnosis. The study's focus on BPD is of particular importance due to the diagnosis' known aetiological association with childhood trauma, as well as the fact that it presents a unification between personality and pathological functioning. The chapter concludes with an overview of the theory that guided this investigation. In this regard, Theodore Millon's theory on personality and psychopathology will be discussed with an additional focus on his conceptualisation of BPD.

2.1. The Impact of Childhood Trauma on Psychological Functioning

Traumatic events are extraordinary, not because they occur rarely, but rather because they can overwhelm ordinary human development and adaptations to life. These traumatic events can overwhelm the usual systems of care that give people a sense of control, connection, and meaning (Herman, 1992a). The impact of these occurrences, arguably, become of greater significance when no action can be taken

to mitigate the traumatic event, such as in the case of childhood trauma (Herman, 1992a). Traumatic childhood experiences are typically derived from harmful actions or events inflicted on the child and from the lack of a supportive environment. It should also be noted that much childhood trauma usually occur in the context of significant family dysfunction. Many patients with psychological difficulties, such as BPD, report nuclear family dysfunction, which include high levels of parental psychopathology, emotional neglect and family breakdown (Paris, 1998; Herman, 1992a). It could, however, be reasoned that all these life experiences, stemming from family dysfunction, indirectly be classified as traumatic, as it impacts the psychological development of the child and does not provide the needed support a developing child needs. As such, a wider conceptualisation of what childhood trauma entails is needed in this regard. Accordingly, it will be necessary to first consider the various ways in which childhood trauma could be defined.

2.1.1. Defining childhood trauma.

Terr (1991, p. 11) provides a wider definition of childhood trauma as: *the mental result of one sudden, external blow or a series of blows leaving the child temporarily helpless and surpassing ordinary coping and defensive processes.* This definition assists to include experiences not only traditionally included in definitions of trauma but also milder and prolonged experiences with a traumatic impact on child development. This is also more in line with the psychoanalytic views of trauma, in which Freud (1920) introduced the concept of psychic trauma to describe real or imagined instances which occurred during childhood, and that influenced the individual's subsequent life and his or her predisposition to cope with future stress. In addition to these early life incidents, the degree of traumatic impairment in adult life is further reliant on the interaction between the severity of the traumatic stimulus and the predisposition of the individual's personality to endure the shock of the external event. In essence, from a psychoanalytic view, any event that has intrapsychic repercussions and occurs when the psyche's protective barrier is either

immature or has been breached beyond its protective capacity, can be regarded as psychic trauma. (Walrond-Skinner, 2013).

Booth and Jernberg (2010) use the term *complex trauma* to designate the range of ongoing early trauma that includes abuse, neglect, deprivation, multiple placements, and institutionalisation. Of importance is that this type of chronic trauma within relationships results in damage to several areas of development, and hence the term complex trauma is used (Cook et al., 2003). Important to note, complex trauma is different from trauma due to a single catastrophic event such as a fire, a flood, or an auto-accident, as it tends to occur when those who should protect and nurture the child do the opposite and repeatedly harm the child physically and or emotionally over extended periods of time. This type of trauma is characterised by chronic patterns of neglect, abuse, humiliation, and emotional abandonment, which convey to the child there is no one who can provide emotional or physical protection (Booth & Jernberg, 2010). In particular, complex trauma can include physical, verbal or emotional abuse as well as physical and emotional neglect over the course of years.

In essence, complex trauma involves the loss of a secure base, the trauma itself, and being alone with the emotional dysregulation (Main and Hesse, 1990; Schore, 1994). These children have lived a life filled with fear and a primal shame that can make it very difficult for them to attach to others. It is also important to note these different types of complex trauma rarely occur in isolation, and that individuals tend to experience a combination of two or more types of maltreatment, which exacerbates the impact that complex childhood trauma has on survivors. Numerous studies have highlighted the accumulative effect childhood multi-type maltreatment can have on later symptom complexity and psychopathology. These aftereffects include internalising symptoms (Anda et al. 2007; Danielson et al. 2005; Ford et al. 2010; Sachs-Ericsson et al. 2007; Schumm et al. 2006; Widom et al. 2007), externalising symptoms (Brown & Anderson, 1991; Finkelhor et al. 2009; Ford et al. 2009, 2010; Herrenkohl et al. 1997; Shen, 2009), as well as other trauma

symptoms (Boney- McCoy & Finkelhor, 1996; Finkelhor et al. 2007, 2009; Ford et al. 2010; Mulder et al. 1998; Schaaf & McCanne, 1998; Shen, 2009; Vranceanu et al. 2007). This large amount of research succeeds in showing it is understandable that trauma may be referred, not only as a present-or-absent construct, but may also include dimensional aspects, considering the multiplicity of maltreatment forms observed and the frequency and duration of traumatic exposure.

Although many possible definitions exist for what constitutes a childhood trauma, trauma is generally defined as a violent shock, severe psychological wounding and the consequences of these on the individual's psychic functioning (Walrond-Skinner, 2013). The term *childhood trauma* could thus include various experiences that negatively impact the child's development and can be presented on a spectrum between sudden and isolated traumatic events to more persistent, chronic and complex type of trauma. For the scope of this study the term *complex childhood trauma* will be used to represent prolonged and interpersonal types of traumatic experience that resulted in psychological wounding and impacted the individual's psychic functioning. As mentioned, this can include, but is not limited to, child maltreatment, such as physical, sexual, and psychological abuse as well as physical and emotional neglect. Also included in this concept are negative life experiences, such as disruptions in the child's nuclear family system or wider ecological systems which traumatically impacted the child's psychic functioning. It should be reiterated that of importance in the use of the term *complex childhood trauma* is the prolonged nature of the trauma, as well as the fact that the trauma was interpersonal in nature. In essence, the trauma investigated in this study left the survivors without a secure base and without a sense of safety, protection and support. Their trust in interpersonal relationships will have been severely violated by their childhood experience of this complex trauma and their psychological coping mechanisms will have been completely overwhelmed.

2.1.2. The impact of complex trauma on child development.

The impact of *complex traumatic events* in early childhood have been widely recognised as a key factor in psychological adjustment which could compromise a child's development (Allen & Lauterbach, 2007; Rademaker, Vermetten, Geuze, Muilwijk, & Kleber, 2008). Usually, normal human development will follow a predictable, organised course, beginning with the child's mastery of physiological regulation and continuing throughout the development of higher skills, such as problem solving and peer relationships. However, when considering abnormal or unusual circumstances, such as childhood trauma or abuse, the predictability and organisation found in normal development are disrupted and thrown off-course. This is likely to result in developmental failures and limited adaptation for the affected individual. The environmental circumstances introduced when experiencing trauma are thus likely to pose developmental challenges, many of which are psychological (Mash & Wolfe, 2005).

A study conducted by Trickett, Kurtz and Pizzigati (2004) indicated that children who have experienced sexual abuse underwent significant interruptions in their developing view of themselves and their world. This, in turn, resulted in pronounced emotional and behavioural changes in an attempt to cope with the trauma they experienced. In essence, it was found these children would adapt in such a way that poses the least risk and offers maximum protection and opportunity for growth, in other words, employing protective factors that could have protected them from the initial trauma. In addition, it has also been shown that in the absence of adequate support, traumatised children's core developmental processes become impaired and ultimately lead to emotional and behavioural difficulties. This is increasingly likely if they do not possess protective personality characteristics such as a positive self-esteem and sense of self (Mash & Wolfe, 2005).

According to Heim et al. (2000) studies, have shown the consequences of early life stress may have severe and enduring effects on emotion, cognition and behaviour; the effects of which can span adulthood. *Complex childhood trauma*

leads to a number of mental adaptations that in time account for some adult character problems, such as certain kinds of psychotic thinking, violence, dissociation, and extremes of passivity, self-mutilation and a variety of anxiety disturbances (Terr, 1991). This view is supported by Cicchetti and Lynch (2005), who found that maltreated children are at an elevated risk of developing many forms of psychopathology across their life course.

The nature of the trauma, and the age during which the trauma occurs, also significantly impacts the effect of the trauma on the individual's adaptation and consequent psychological functioning. Furthermore, in addition to the nature of the trauma, and the number of protective factors present, it seems the duration of the trauma experienced by the child results in differences amongst individuals. According to Terr (1991), children who experience a single and sudden trauma differ, in terms of the psychological reactions they experience, to those who experience longstanding and repetitive exposure to trauma, that is, complex trauma. Individuals subjected to prolonged, repeated trauma have been shown to develop an insidious, progressive form of Post-Traumatic Stress Disorder (PTSD) that invades and erodes the personality structure. While the victims of a single acute trauma may feel after the event that they are "not themselves", the victim of chronic trauma may feel they are changed irrevocably, or they may lose the sense they have any self at all. Chronically traumatised individuals have also been found to be persistently hypervigilant, anxious, and agitated (Herman, 1992a).

Although the impact of childhood traumas on outcomes in later life have been well researched, it should, however, be mentioned that according to Paris (1998) the impact of life experiences on the development of mental illness is best understood as a gene-environment interaction. Negative childhood experiences can accordingly be regarded as only one of many risk factors for developing psychopathology in adulthood, and a long-term interaction between other risk and protective factors possibly offer a more holistic explanation of the development of psychopathology. This could provide some explanation as to why not all maltreated children develop

maladaptively, and that a resilient and positive outcome in the presence of adversity does occur and have been recorded in literature (Cicchetti & Rogosch, 1997).

According to Herman (1992a), the most powerful determinant of psychological harm is the character of the traumatic event itself. It can be reasoned that with severe enough traumatic exposure, no person is immune to the negative impact of such an experience. Though the likelihood that a person will develop symptoms of psychopathology depends on the nature of the traumatic event, individual differences also play an important part in determining the form the psychopathology will take. No two people have identical reactions, even to the same event.

Research conducted on the post-traumatic reactions of war veterans has shown that a particular individual's predominant symptom pattern was related to his/her individual childhood history, emotional conflicts, and adaptive style. According to Herman (1992a), this can be reasoned to be true for other types of traumatic experiences. Research has shown that with the occurrence of stressful events, highly resilient individuals are able to make use of opportunities for purposeful action in collaboration with others, while ordinary people on the other hand are more easily paralyzed or isolated by terror. The capacity to preserve social connection and active coping strategies, even in the face of extremity, thus has been shown to serve a protective function against the later development of post-traumatic syndromes. Individuals particularly predisposed to adverse psychological reactions to traumatic events, seem to be those who have less opportunities to access a supportive network of interpersonal relationships and might not have had the opportunity to develop adequate coping strategies that serve as protective factors when faced with traumatic events. This is supported by Herman (1992a), who indicated although resourceful individuals may be particularly resistant to the malignant psychological effects of trauma, individuals at the other end of the spectrum may be particularly vulnerable, such as those who are already disempowered or disconnected from others.

In considering factors that increase the vulnerability to the malignant psychological effects of a trauma, it should be emphasised that children and adolescents, who are relatively powerless in comparison to adults, are particularly susceptible to the harm of trauma. Studies of abused children demonstrate an inverse relationship between the degree of psychopathology and the age of onset of abuse. In addition, the experience of terror and disempowerment during adolescence effectively compromises the three normal adaptive tasks of this stage of life: the formation of identity, the gradual separation from the family of origin, and the exploration of a wider social world (Booth & Jernberg, 2010). When considering complex childhood trauma, it becomes apparent the trauma might not only be significant due to its early onset but also occurs at a crucial developmental period when many psychological structures are still in the process of formation. According to Herman (1992a), repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood deforms the personality, again reiterating the significant impact early traumatic experiences can have on psychological functioning and adaptation.

Accordingly, it can be said complex childhood trauma, ultimately, shapes the child's personality. It is also important to note these traumatic reactions tend to persist in an altered and exaggerated state long after the actual threat has passed, making the impact of exposure to traumatic events so clinically significant. Acknowledging the impact of childhood trauma on mental health could thus act as an organising principle to understanding many mental disorders as well as the accompanying personality structure that results due to the psychological adaptation that accompanies exposure to complex traumatic experiences.

2.1.3. Childhood trauma and psychopathology.

The ordinary response to an atrocity, such as a *complex childhood trauma*, is to banish it from consciousness. However, such an atrocity on most occasions refuses to be buried. It is thus likely the traumatic event resurfaces, not as a verbal

narrative of the events, but rather as a psychological symptom, especially if the response to such a trauma is secrecy and repression (Herman, 1992a). In general, traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory and may be expressed in the form of various psychological symptoms (Herman, 1992a). Childhood abuse has specifically been recognised as a precursor and maintaining factor for adult psychopathology in psychological literature (Jangam, Muralidharan, Tansa, & Raj, 2015). Due to the impact of childhood trauma on the development of a child, a number of critical areas could potentially be affected by the exposure to trauma (Mash & Wolfe, 2005).

According to Ross and O'Carroll (2004), experiencing childhood trauma does not produce a distinct identifiable syndrome but rather yields a variety of symptomatic and pathological behaviours. These behaviours are also in part likely due to the tendency of individuals who have experienced a childhood trauma to engage in multiple coping strategies to minimise or avoid the aversive emotions brought forth by the trauma (Write et al. 2007; Zwickl & Merriman, 2011). These maladaptive coping strategies often include a variety of symptomatic and pathological behaviours such as substance abuse, dissociative behaviours, suicidal or self-injurious behaviour, aggression, over and under sexualised behaviours, and poor self-esteem. These maladaptive coping responses to trauma may persist into adulthood and cause lifelong impairments including anxiety, depression, academic and occupational difficulties, unhealthy partner relationships, and sexual dysfunction, (Arreola et al., 2009; Black & DeBlassie, 1993; Cohen et al., 2000; Gilbert et al., 1997; Mimiaga et al., 2009; Loeb et al., 2000; Najman et al., 2005; Watkins & Bentovim, 1992). A discussion of the manner in which a childhood trauma impacts various areas of psychological functioning could thus offer valuable insights in this regard.

a) Attachment and emotional regulation.

One area shown to be impacted by a childhood trauma, in particular child maltreatment, is *attachment* and its effect on an individual's *emotional regulation*.

Studies have found that episodes of child abuse and neglect can disrupt the important process of attachment and interfere with a child's ability to seek comfort and to regulate their own physiological and emotional processes (Lyons-Ruth, Yellin, Melnick, & Atwood, 2003). Particularly, early in life, social context plays a critical role in buffering an individual against stressful situations and assists in building psychological and biological capacities to deal with further stresses. Parents who serve as young children's primary social context, accordingly, teach the skills needed in order to modulate emotional regulation. A secure attachment bond with parents is thus a primary defence against the trauma-induced stress some children may experience as well as the resultant psychopathology that can ensue due to a lack of such defences against trauma-related stress (Booth & Jernberg, 2010). According to McFarlane (1988), the parent-child bond is thus likely the most important determinant of long-term damage as a consequence of a childhood trauma. This is confirmed by Cicchetti, Ganiban and Barnett (1990), who posited that parent-child attachment and the general climate in the childhood home, plays a critical role in the development of emotional regulation, which is the ability to modulate and control the intensity and the expression of feelings and impulses in an adaptive manner. This is of particular importance when considering the emotional impact a childhood trauma can have on the expression and regulation of emotions related to the trauma. This is especially true if the trauma occurs in the home environment. Studies by van der Kolk and Fisler (1994), indicate that traumatised adults with histories of childhood neglect have, as a result of the trauma, a particularly poor long-term prognosis when facing psychopathology.

Maltreated children generally live in a world of emotional turmoil and extremes, making it difficult for them to understand, label and regulate their internal states. Since expressions of affect, such as crying or signals of distress, may trigger disapproval or avoidance or abuse, maltreated children tend to inhibit their emotional expression and regulation and remain more fearful and on alert. They are also likely to show increased attention to anger and threat-related signals, like facial expressions and less attention to other emotional expressions. These difficulties in

regulating and expressing their own and interpreting other's emotions are then consequently expressed in numerous ways during childhood, and later life in the form of depressive reactions, anger outbursts, and fearfulness as well as other forms of psychopathology (Mash & Wolfe, 2005).

b) Brain development.

Also, it has been found that the emotional regulation difficulties experienced by maltreated children are linked to alterations in the development of children's brain structures. In general, traumatic experiences cause the child's neurophysiology to become hyper-aroused and the child to feel fearful and easily dysregulated (Booth & Jernberg, 2010). The experience of stressful life encounters, such as child maltreatment, has been said to negatively impact the neuroplasticity and structural composition of the brain (Teicher et al. 2004). Some of the brain areas indicated in the stress response related to a trauma include the hippocampus, the prefrontal cortex and the amygdala, which affect learning, memory and emotion (Bremner, 2003). Other studies have found incidents of childhood sexual abuse in particular, are linked to alterations in sections of the cerebral cortex, prefrontal cortex, hippocampus, amygdala, corpus callosum, cerebellum, and limbic system as well as the endocrinal Hypothalamic-Pituitary-Adrenal axis – *HPA* (De Bellis et al. 1999). Decreases in blood flow to the frontal lobe have been found in childhood trauma survivors, and impacts cognitive functioning, personality and social expression. Difficulty with executive functions, such as decision making and interpreting emotional meanings, have also been linked to reduced frontal lobe functioning (Booth & Jernberg, 2010; Wilson, 2003). Contrary to this, increased cerebral activity and blood flow has been found in the temporal lobes of childhood trauma survivors. This leads to a heightened perception of surroundings due to the temporal lobe's involvement in the processing of environmental stimuli (Shin et al. 1999).

Research has also indicated childhood trauma impacts the developing child's neuroendocrine system, which becomes highly sensitive to stress. Specifically, the

emotional-anger centre of the brain- the amygdala - is activated, triggering chemical responses associated with fear and anger (Gerhardt, 2004). This results in the release of the stress hormone cortisol, which acts on an emergency basis to draw energy away from the digestive and immune systems so that the body can protect itself by fighting or fleeing from perceived danger. However, as stress becomes chronic, various systems can begin to malfunction. An inability to regulate cortisol levels has been shown to correlate with depression, obstruction of neurons, and loss of response and inhibition of the HPA axis. This may result in higher levels of cortisol in the system and a decline in one's ability to manage stressors (Meyer & Quenzer, 2005). Chronic high levels of cortisol can cause receptors to malfunction and constantly remain activated, keeping the child in a constant state of vigilance, which results in them being overly suspicious of any sensations that might signal possible danger (Booth & Jernberg, 2010). High levels of cortisol has also been linked to the destruction of neurons in the hippocampus, (Booth & Jernberg, 2010).

Other studies have linked smaller hippocampal volume in trauma survivors, specifically of childhood sexual abuse, to impaired memory. A smaller hippocampal volume also correlates with higher instances of Major Depressive Disorder as well as dissociative symptoms and Post-Traumatic Stress Disorder (Stein et al. 1997; Vythilingam et al. 2002). Research has found the reduced hippocampal size could also be related to experiencing stronger emotional responses and also explain various psychological symptoms found in childhood trauma survivors (Matsuoka et al. 2007). In addition to the afore mentioned neurological changes, the thalamus, which plays a critical role in the conditioning of incoming stimuli, also malfunctions in such a way that sensory information becomes disconnected and fragmented, causing a fear response to unpredictable triggers (Booth & Jernberg, 2010). Increased activity was also noted in the cingulate gyrus and areas of the limbic system. This typically results in a higher level of sensitivity to emotional signals and individuals being more sensitive to situations which evoke sadness, anxiety and fear responses (Dubin, 2001). Research has shown a linear correlation between limbic system

dysfunction and various types of physical and sexual abuse. This in turn leads to higher levels of reported physical and psychiatric distress.

According to Heim et al. (2000) the association found between a history of childhood trauma, such as abuse, and irregular neuroendocrine functioning, significantly impacts the formation of psychological conditions in affected individuals. In this manner a traumatised child's nervous system can be described as engaging in an internal struggle, which wears down other functions and systems (Booth & Jernberg, 2010). These changes in the neurochemistry and structures of the brain ultimately result in a reorganisation of the brain into trauma pathways. The brain thus becomes "fear-driven" and conditioned to react reflexively at the slightest hint of the past trauma (Booth & Jernberg, 2010). These neurobiological changes could thus further account for developmental outcomes later in life, specifically, the emergence of psychiatric problems in childhood or later in adult life (Mash & Wolfe, 2005).

c) View of self and others.

As a part of the ordinary developmental process, children form complex mental representations of people, relationships and the world. These representational models are significant as they contain the experiences, knowledge and expectations that will be applied to new situations in the future (Cicchetti & Lynch, 2005). Trauma, however, affects the development of character and concepts of the self (Cole & Putnam, 1992; Herman, 1992a). Maltreated children often lack the positive core beliefs about themselves and their world due to the negative events they have experienced (Feiring, Taska, & Lewis, 2002). Instead, they are likely to develop negative representational models of themselves and others that result from a sense of blame and self-shame as well as rage toward others that further impair their ability to regulate their affective responses. The feelings of betrayal and powerlessness that often characterise maltreated children's life experiences, later become salient components of their self-identity (Mash & Wolfe, 2005). As a result, trauma-based

internal schemes come to occupy a place in the person's view of him/herself and the world. These schemes then serve as a guide for subsequent interactions and expectations (van der Kolk & Ducey, 1989).

According to Herman (1992a), a trauma, specifically interpersonal trauma, impacts the individual's autonomy, initiative, competence, identity, and intimacy. This is of significance since a secure sense of connection with caring people is the foundation of personality development. When this connection is shattered as is the case in interpersonal trauma, the traumatised person loses his/her basic sense of self (Herman, 1992a).

The aftermath of a trauma can thus have a significant impact on the personality development of the trauma survivor. This can include disturbances in the individual's sense of self; separateness and autonomy in relationships; disturbances in the view of body image; viewing the self as helpless, damaged and ineffective; and difficulties with trust, intimacy and self-assertion (Cole & Putnam, 1992; Herman, 1992a; van der Kolk, 1987). The traumatised individual's conception of him/herself and the outer world is permanently altered because the traumatised person continues to act as if the original traumatic situation is still occurring. As a defence he/she employs protective devices which failed on the original occasion. These defences are viewed as a means of survival and result in maladaptive changes made by the trauma survivor to protect themselves (Kardiner, 1941). Traumatic events, by definition, impede initiative and overwhelm individual competence, as the actions of the affected individual were insufficient to ward off the tragedy experienced. In the aftermath of these traumatic events, survivors may often review and judge their own conduct during the occurrence of the trauma, which often results in feelings of guilt and inferiority (Herman, 1992a). In this sense, they may feel that they failed in some manner during the maltreatment and as such are to blame in some way for the trauma they experienced. As a result, traumatised people often fail to maintain an interpersonal sense of significance, competence and inner worth. Although many of these individuals have learned to behave competently and

responsibly early in life, they tend to perceive themselves as unlovable, despicable and weak. They consequently experience their competence as a part of a façade with which they fake their way through life (van der Kolk, McFarlane, & Weisaeth, 2007).

Their traumatic experience not only impacts their view of themselves but also their interactions with others. Interpersonal trauma has a profound effect on their capacity to trust others. A traumatised individual in this regard tends to perceive all other relationships based on the negative experience they had during the interpersonal trauma. In a study done by Herman. et al. (1989), it was found that, on the one hand, traumatised patients tended to be dependent on others and, on the other, socially isolated and withdrawn, lacking rewarding social relationships. Due to their history of powerlessness in a trauma situation, these individuals struggle tremendously with issues of powerlessness, trust, helplessness and safety. Likewise, these feelings of powerlessness result in traumatised individuals developing excessive interpersonal sensitivity. Although this can lead to a remarkable ability to read the needs and feelings of others who may have power over them, this is merely done in an attempt to survive and, accordingly, they are likely to misinterpret other people's motives in most instances as malevolent, even in circumstances when no such intent is planned.

The difficulty in interpersonal relationships is further exacerbated by the fact that in the traumatised individuals' attempts to adapt to the traumatic experiences, they may experience hypervigilance and consistent feelings of fear, which then become the norm. These reactions are mainly an attempt to become highly responsive to threatening and dangerous situations in order to safeguard themselves from future danger. However, these strategies employed as protective factors, hamper the social and interpersonal functioning of these individuals. Some maltreated individuals might be more distracted by aggressive stimuli and misread the intentions of their peers and others they interact with as more hostile than they are in reality. In addition, it has also been shown that physically abused and

neglected children show less skill at recognising and responding to the distress that others might feel. As such, their ability to show empathy toward others is reduced. This can result in either withdrawal from relationships with their peers, or them becoming aggressive.

This inherently impacts their ability to form and maintain satisfying interpersonal relationships, which could serve as support that is much needed in order to heal from a past trauma (van der Kolk, McFarlane, & Weisaeth, 2007).

d) Emotional and behavioural problems.

In an attempt to address the difficulties traumatised individuals might face with emotional regulation, they may engage in a number of problematic behaviours. These typically include self-mutilation, unusual sexual practices, bingeing and purging behaviour as well as substance abuse (van der Kolk & Fisler, 1994). Specifically, suicide attempts, self-cutting and other self-injurious behaviours may serve multiple functions in regulating affective states. In general, self-mutilation is a common reaction to social isolation and fear, which could be attributed to the impact of a trauma. Many patients that engage in self-mutilation report dissociative symptoms, which are a common occurrence after experiencing a significant trauma, and include feelings of numbness prior to harming themselves as well as a sense of relief after self-mutilation (van der Kolk, McFarlane, & Weisaeth, 2007). Childhood trauma, such as abuse occurring during early childhood and latency periods, have been strongly correlated with suicide attempts, self-mutilation and other self-injurious behaviour. On the other hand, abuse that occurred during adolescent years have been linked to *anorexia nervosa* and increased risk-taking behaviours. Overall, a link has been found between the age of onset of the trauma and the severity of self-destructive behaviours, with earlier onsets of trauma related to more severe self-destructive behaviours (van der Kolk, et. al, 1991). Research has also specifically indicated a link between separation and neglect histories and increased self-destructive behaviours (van der Kolk, McFarlane, & Weisaeth, 2007).

Other behavioural difficulties such as anxiety, inattention, lack of autonomy and self-guidance, negative attention seeking, and academic difficulties have been noted in maltreated children (Mash & Wolfe, 2005). Traumatized children also experience difficulty in verbally expressing their feelings. This is likely attributable to a manifestation of neuroanatomical changes, such as decreased oxygen supply to Broca's area in the brain, attributable to abusive and neglectful treatment. This lack of verbal expression further contributes to impaired impulse control and psychosomatic symptoms (van der Kolk, 1987).

Not only does the trauma affect childhood development, but it also has long-term consequences for adult mental health. Developmental impairments that stem from childhood maltreatment can lead to pervasive and chronic psychiatric disorders, depression, eating disorders, sexual problems and personality disturbances (Mash and Wolfe, 2005). In addition, childhood abuse has been linked with a variety of psychological as well as physical health difficulties among adult females. The range of psychological difficulties linked to childhood abuse include anxiety difficulties and phobias as well as difficulties such as schizophrenia, affective disorders and depression. Childhood abuse has also been associated with Post-Traumatic Stress Disorder (PTSD) and substance abuse (Windom, Dunmont, & Czaja, 2007). Various studies have focused on the different types of childhood abuse, more specifically, sexual abuse, physical abuse, emotional abuse and neglect, and their association to specific psychiatric disorders. These studies have found an association between childhood sexual abuse and psychiatric disorders such as depression, suicidal ideation, substance abuse, PTSD, borderline personality disorder, dissociative identity disorder, pain disorder and *bulimia nervosa* (Beitchman, et al. 1992; Briere & Runtz, 1990; Dube, et al. 2005; Putnam, 2003). Research on childhood physical abuse has also indicated an increased risk in the development of adult psychopathology, which has been shown to include depression, substance abuse and attachment difficulties (Afifi, Brownridge, Cox, & Sareen, 2006; Miller-Perin, Perrin, & Kocur, 2009; Springer, Sheridan, Kuo, & Carnes, 2007). In addition, past experiences of multiple forms of abuse, which

includes neglect, has been associated with a lifetime prevalence of personality disorders, PTSD, dissociative disorders, depression, anxiety disorders and psychosis (Afifi, Bowman, Fleisher, & Sareen, 2009; Chapman, et al. 2004).

In a study done by Jangam, Muralidharan, Tansa, and Raj (2015) it was found that childhood abuse was reportedly higher in women with severe mental disorders than compared to healthy women. In particular, emotional abuse was found to be significantly related to a predisposition toward psychiatric disorders. A history of childhood abuse was also found to have a significant influence on the relapse and recovery of women with mental disorders. Other studies have also found that child abuse experiences not only impacted individuals' mental health, but also affected the course and outcome of their psychological and psychiatric treatment, in that more treatment resistance and increased symptomatology have been reported in individuals with histories of childhood abuse (Kendall-Tackett & Becker-Blease, 2004). When considering the clinical manifestations of trauma, a multitude of disorders could possibly be diagnosed, such as Conduct Disorder, Borderline Personality Disorder, Depressive Disorders, Attention Deficit Hyperactivity Disorder, specific phobias, Dissociative Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Adjustment Disorder and Post-Traumatic Stress Disorder, all of which could be regarded as technically correct. Arguably, what is needed is a more organised investigation of childhood trauma and a recognition of its aetiological effects on mental health (Terr, 1991).

2.1.4. The value of understanding the impact of childhood trauma on psychological functioning.

According to Jangam, Muralidharan, Tansa, and Raj (2015), it is important to assess the presence and severity of physical, emotional and sexual abuse when considering mental health evaluations in inpatient settings. They also posit that it is equally surprising that despite the impact of childhood abuse on psychiatric symptomatology, prognosis and treatment resistance, inquiry into childhood trauma

in clinical settings is rarely done. This could partially be attributed to the tendency of traumatic symptoms to become disconnected from their source and to take on a life of their own. In this manner a traumatised individual might find him- or herself experiencing a multitude of psychological symptoms, such as a constant state of vigilance, irritability or anxiety, for unknown reasons (Herman, 1992a).

According to Terr (1991), clinicians run the risk of amplifying the diagnostic particulars of trauma to such an extent they disregard the external forces which initially created the internal changes and contributed to the formation of the disorder. Terr (1991), urges clinicians to guard against overlooking the trauma condition and to reorganise their thinking about childhood trauma and abuse. Trauma survivors challenge us to reconnect fragments, to reconstruct history, to make meaning of their present symptoms in the light of past events (Herman, 1992a). It is in this regard that the role of the clinician and researcher is of upmost importance in uncovering the golden thread running through a patient's traumatic past, the manner in which they have adapted to these traumatic events, and the behavioural manifestations of these interconnected aspects in the patient's present. This is exactly what the current study aims to achieve – to cultivate a deeper understanding of the interconnection between complex childhood trauma, patient behaviour and clinical diagnoses.

2.1.5. Childhood trauma and personality.

Due to the impact of life experiences on the formation of personality, life experiences that can be regarded as beyond the range of what is normatively encountered-such as the experience of childhood trauma and abuse-could be reasoned to have significant implications for developmental outcomes in later life (Rogosch & Cicchetti, 2004). Maladaptive personality types in adulthood have been shown to constitute an important and modifiable risk factor for prolonged and severe psychological distress (Spinhoven, Elzinga, Hemert, de Rooij, & Penninx, 2016). In addition, the development of less flexible personality patterns during childhood and adolescence has been identified as an underlying mechanism in explaining the

association between childhood maltreatment and subsequent psychopathology (Kim, Cicchetti, Rogosch, & Manly, 2009)

According to van der Kolk (2007), traumatic experiences can accelerate or retard critical developmental transitions in childhood. This is in part attributable to the neurophysiological alterations that traumatised children go through following a traumatic experience, which may disrupt normal biological maturation and, in turn, have a significant impact on a variety of childhood developmental outcomes. Accordingly, it is likely these traumatic experiences have an impact on the development of the emerging personality of that child. More specifically, studies have implicated childhood trauma in the formation of adult personality and other complex disorders (Hengartner, Ajdacic-Gross, Rodgers, Muller, & Rossler, 2013). This again reiterates the long-term effects childhood trauma can have on the adult personality and mental health of an affected individual. In addition, as mentioned previously, traumatic experiences in childhood have been linked to difficulties in the development of mature emotional regulation, which is a crucial part of personality development and an important aspect in interpersonal relationships.

Research has shown that chronic dissociation, physical problems with no known medical cause, as well as a lack of adequate self-regulatory processes, are all common outcomes of childhood traumatic experiences. It can further be reasoned these outcomes of childhood trauma further impact on the development of personality (van der Kolk, McFarlane, & Weisaeth, 2007). Literature indicates the impact on personality development could include a disturbed sense of self, a disturbed body image as well as viewing the self as helpless, ineffective and damaged. Difficulties with trust, intimacy and self-assertion have also been noted (Cole & Putnam, 1992; Herman, 1992a; van der Kolk, 1987; van der Kolk & Fislser, 1994). Of importance, when considering the impact a trauma has on personality development, is that the individual acts as if the original traumatic event is still occurring and as such continually engages the protective devices that failed on the original occasion. In essence, this results in the individual's conception of his or her

outer or inner world to be permanently altered, with previous conceptions being replaced by a trauma-based internal schema of the self and the external environment (van der Kolk, McFarlane, & Weisaeth, 2007).

The importance of personality in determining the impact of childhood trauma on developing psychopathology is further emphasised by Paris (1998), who offers a succinct summary of the developmental relationship between negative life experiences, personality and psychopathology. According to Paris (1998), the impact of life experiences have been found to differ between individuals; that children exposed to negative life experiences can develop higher levels of resilience than their peers; and that only the accumulative effects of multiple risks overcome an individual's level of acquired resilience. In addition, he states that individuals show varying levels of sensitivity to their environments and that this level of sensitivity is determined by their personality traits. It, thus, seems that not only does childhood trauma impact personality development, but that premorbid personality and level of resiliency also effects the impact of childhood trauma on resultant behaviour.

Despite the importance of this link between childhood trauma and personality, the association between childhood trauma and personality traits have been poorly described and reported (de Carvalho, et al., 2015). This view is supported by Rademaker, et al. (2008) who also reported that there is a scarcity of studies which focus on the association between childhood trauma and psychological traits. Thus far, research has mainly focused on the relationship between childhood trauma and certain types of psychopathology. This could be attributed to the number of patients who suffer from various psychological disorders who also report a history of childhood abuse, and thus leading to the inherent association between childhood trauma and psychopathology (Matthews, Deary, & Whiteman, 2003).

However, there is significant evidence from a number of related studies suggesting that traumatic events in general influence not only psychopathology but also personality traits. One such study found individuals with traumatic lifetime

experiences display higher scores on neuroticism and low scores on openness to experience scales on personality assessments (Allen & Lauterbach, 2007). Another study by Rademaker, et al. (2008) found a negative relationship between traumatic events and personality traits of self-directedness and cooperativeness. Cole and Putnam (1992), found early trauma can have detrimental effects on personality-related outcomes, such as identity development and socialisation. Other studies have also found a negative impact of traumatic experiences on self-esteem and coping behaviours (Toker, Tiryaki, Ozcurumez, & Iskender, 2011), as well as impulse control, defensive styles, affect regulation and the formation of stable attachments (Cicchetti & Toth, 2005; Rademaker, et al., 2008). Due to the lack of studies that focus specifically on childhood trauma and personality traits, de Carvalho et al. (2015) using a general population sample in Brazil, focused on exploring the severity of various reported childhood traumas, the corresponding personality profiles that were related to these traumas, as well as how these aspects influenced the participant's general levels of maladjustment. Their study found that specific temperament and character traits were associated with certain types of childhood trauma. The personality dimensions of harm avoidance and self-directedness were strongly associated with childhood trauma of emotional abuse and neglect. High levels of harm avoidance combined with low levels of self-directedness have also been found to be related to various forms of psychopathology such as depression, eating disorders, personality disorders and alcohol abuse. In addition, significant associations were found between emotional neglect and reduced reward dependence as well as between emotional abuse and reduced cooperativeness. de Carvalho et al. (2015) also found that dysfunctional personality traits showed stronger associations with events of emotional abuse than with physical or sexual abuse during childhood years.

Evidence has also been provided for the intermediating effect of personality in the intercession between exposure to childhood trauma or maltreatment and resultant psychopathology. In a study conducted by Spinhoven, Elzinga, Hemert, de Rooij and Penninx (2016), it was found that the severity of childhood maltreatment

predicted higher levels of initial psychological distress and that this effect was mediated by certain maladaptive personality types. In particular, the study evidenced that participants who reported more severe childhood maltreatment, specifically emotional neglect and emotional abuse, showed the most maladaptive personality types in terms of Five Factor Model clusters of personality traits, that is, high neuroticism combined with low extraversion, agreeableness and conscientiousness. Emotional neglect and emotional abuse were also found to be associated with an increased risk for personality disorders, anxiety and depression when compared to other forms of maltreatment such as physical or sexual abuse. Although this study offers promising results in relating childhood trauma and the corresponding psychopathology to the mediating effect of particular personality traits, the authors of the study do, however, argue a need exists to conduct further and more in-depth research that focuses on the use of more extensive questionnaires and assessment measures that tap personality traits and personality organisation. They also advocate for a stronger focus in related research on personality trait clusters, or groupings of personality traits, rather than a sole focus on isolated personality traits.

In accordance with this, the current study similarly assumes that continued research into the interrelated dynamics of childhood trauma, personality structure, and experienced psychopathology could aid in illuminating the manner in which personality adaptations could act as an organising principle in understanding the various mental disorders that ensue upon exposure to childhood trauma. In fact, it can be argued that personality can be regarded as a modulating factor between complex childhood trauma and the expression and development of other forms of psychopathology.

2.2. Personality and Mental Health

As afore mentioned, it can be reasoned an individual's personality plays an important modulating role between the experience of complex childhood trauma and the development of mental health difficulties. The importance of personality can

accordingly not be overlooked in the field of clinical psychology as it impacts the expression of various mental health difficulties and significantly influences the patient's prognosis and treatment. It should, however, be mentioned that the importance of personality should always be considered when conceptualising psychiatric treatment of patients, however, it is the researcher's experience that this is an oversight sometimes made by clinical professionals. A deeper understanding of the interaction between personality and mental health is thus needed to better inform the clinical management of psychiatric patients. In order to truly appreciate the importance of individual personality in everyday functioning and mental health, an overview of the history of personality in psychology, as well as a description of some key concepts in the field of personality psychology, will be beneficial and is accordingly provided.

2.2.1. History of personality psychology.

The history of the field of personality psychology is rich and comprehensive, and parallels the complexity and magnitude of the knowledge accumulated in the field. In order to truly understand and appreciate the accomplishments of this discipline, the current study will provide an overview of the main stages of the development of modern personality psychology.

The importance of personality in the study of psychopathology has been recognised since the early beginnings of medicine. The science of personality can be traced back to Hippocrates and his study of humours in an attempt to understand individual differences. He distinguished between a sanguine (cheerful and enthusiastic), choleric (angry and irritable), phlegmatic (stolid and apathetic) and melancholic (depressive) temperament (Maher & Maher, 1994; Mcadams, 2000). Some of his terminology is still used in modern psychology where the term melancholic is used as a specifier in the depressive disorders category of the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, (DSM-5; American Psychological Association, 2013).

Various other theorists followed in Hippocrates' direction positing that personality is rooted in bodily differences. It was only in the 19th century scientists developed methods for formally assessing individual differences. Personality assessment developed based on advances made in mental testing and intelligence testing, such as seen in the work of Francis Galton and Alfred Binet respectively (Caprara, 1992). The occurrence of both World War I and World War II resulted in a greater need to identify individual personality differences as a method by which to select civilians fit for military duty. The assessments used to evaluate military-fit personnel later became integral to the development of the Minnesota Multiphasic Personality Inventory, widely used today as a measure of personality and psychopathology (Caprara, 1992; McAdams, 2000).

According to Capara (1992), the study of personality was not formalised until the 1930s. This formalisation of personality psychology was greatly assisted by discoveries made in the 20th century with regard to human behaviour, science, medicine and psychology, which permitted the development of modern personality research.

During this period, prominent theorists such as Freud, Allport and Murray, laid the groundwork for further developments in personality psychology. As the interest in studying personality grew, divergent theories of personality developed and resulted in tension between competing viewpoints with regard to the correct manner through which to study personality (McAdams, 2000). It is important to note when personality psychology began to emerge as a science it found itself caught between a theory of drives and a theory of learning. With the split between behaviourism and psychoanalysis as the two primary paradigms governing the study of psychology at the time, personality psychology became defined by researchers attempting to identify with neither behaviourism nor psychoanalysis but instead trying to solve the apparent irreconcilability of these two dominant viewpoints. Personality psychology thus became a sub-discipline that could potentially be seen as a link between research on human processes and clinical practice. In essence, the

main goal of personality psychology became the integration and unification of the psychology discipline. In an attempt to unite the large theories that dominated the psychology field, a myriad of mini-theories, research topics and personality measures emerged, and were continuously invented and reinvented in an attempt to gain academic legitimacy; the scope of which is too large to mention here. As a result, personality psychologists became increasingly involved in academia where it would ultimately succeed in legitimising itself as a science. Although personality psychology retained a wide focus, Cattell's psychometric tradition (Caprara, 1992) was mostly responsible for solidifying personality psychology's scientific credibility. Cattell was supported in his scientific contribution by other researchers such as Guilford and Eysenck which marked the beginning of personality trait research and assessment (Caprara, 1992).

The history of personality psychology is as exhaustive as the amount of personality theories and research findings produced to date. Accordingly, the study of personality continues to expand as new research is conducted and personality assessment measures are continuously developed. Despite the diversity of views found within the study of personality, one aspect that is continuously reiterated is the complex nature of personality. According to Caprara (1992, p. 351) this calls for an "*emphasis on complexity rather than simplicity, diversity rather than similarity, on specificity rather than generality and on uniqueness rather than commonality, and has led to a redefinition of what personality theory should be*". The words of Pervin (1990, p. 726) offers an adequate summary of a more modern view of personality:

What is distinctive about personality is the focus on the person as a system, thereby involving the interplay between consistency and diversity, stability and change, and integration and conflict, as well as the study of people in a variety of contexts and over a long enough period for patterns to emerge in their private world of thought and feelings as well as their public behaviours.

2.2.2. Overview of personality structure and key concepts.

The study of personality is subject to a wide array of concepts that are essential to understanding the complex nature of personality psychology. A knowledge of the basic concepts found within the literature as well as their place in the psychological sciences thus forms the foundation of an exploration of personality psychology.

Due to the concept of *personality* and its terminology being used more freely today, a precise definition becomes increasingly difficult to ascertain. Reber (1995), has suggested there are an indeterminate number of definitions of personality in the field, with each author's meaning coloured by his or her theoretical bias. Widiger, Verheul, and van den Brink (1999), define personality as the characteristic manner in which one thinks, feels, behaves and relates to others. Other definitions of personality view personality as the collective perceptions, emotions, cognitions, motivations and actions of the individual, that interact with various environmental situations (Patrick & León-Carrión, 2001). A variety of definitions of personality have been offered which, upon examination, illustrate the importance of cognitive processes (thinking), emotional processes (feeling) and behavioural processes (actions), whether explicit or implicit, in defining personality. It is thus fitting that, for the scope of this study, the term personality will be defined as a person's characteristic style of behaving, thinking and feeling (Schacter, Gilbert & Wegner, 2009).

According to the DSM-5, a *personality disorder* is defined as:

...an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (APA, 2013, p.645).

The criteria for diagnosis of a general personality disorder, according to the fifth edition of the DSM (DSM-5), is set forth in Appendix A. According to these

criteria, personality disorders represent dysfunction in two or more of the following life areas: cognition, affectivity, interpersonal functioning and impulse control.

The DSM-5 further defines a personality trait as a tendency to feel, perceive, behave and think in relatively consistent ways, across time and across situations in which the trait may manifest. Personality traits can be divided into two hierarchical levels consisting of personality trait *domains* and personality *facets*. Personality *domains* refer to the broader dimensions of personality traits and can further be broken down into the detailed personality *facets* that make up each of these broader domains. Accordingly, both personality trait domains and facets tend to occur together and represent different levels of the same personality phenomena (APA, 2013).

2.2.3. Personality development.

An overview of the basic developmental pathways an individual's personality undertakes is important to better understanding the manner in which the development of personality and the development of mental illness can mirror each other and are intertwined in the development of the person as a whole. Personality development can be seen as commencing early in life where basic temperaments of infants and young children are modified by environmental experiences and result in an individual's personality evolving over time (Rogosch & Cicchetti, 2004). Due to the important role of childhood in the development of personality, much personality development literature focusses on early life experiences such as attachment experiences and the object relations of the individual. These writings have indicated that attachment patterns are related to personality development as well as various types of psychopathology in adults (Blatt & Levy, 2003). Blatt and Levy (2003), together with other colleagues (e.g., Blatt, 1974, 1995; Blatt & Blass, 1990; Blatt & Schichman, 1983), have attempted to bridge the two configurations of personality and psychopathology through an examination of attachment theory in their research conducted over the past 25 years. These research findings are quite extensive and,

in summary, have found that personality, attachment, and psychopathology tend to centre around two basic developmental lines, which include interpersonal-relatedness and self-definition. The importance of these two core variables have been supported throughout personality literature findings by many other theoretical perspectives both psychoanalytical and non-psychoanalytic (e.g. Balint, 1959; McAdams, 1980; Spiegel & Spiegel, 1978).

These theorists believe that personality development throughout an individual's lifespan from infancy to late adulthood occurs as a complex interplay between these two developmental forces of the self and other. Due to the large role that interpersonal relationships play in human development, Blatt and Levy (2003) further emphasise the value of early interpersonal relationships and object relations in the formation of attachment styles and personality. Their work builds on the attachment theory of Bowlby (1977) which stressed the significance of attachment in the understanding of both normal and psychopathological development.

Bowlby (1977) maintained various forms of emotional distress and personality disturbances can be explained by the role of attachment in human development. He further believed that childhood attachment underlies an individual's later capability to form affectional bonds with others and could account for certain adult dysfunctions, such as marital problems and parent-child related problems. In essence, Bowlby postulated that early attachment experiences have long-lasting effects that tend to persist across the lifespan and in part determine personality organisation and psychological disturbances. Likewise, Blatt and Levy (2003), utilise the connection between attachment and personality development, as well as attachment and psychopathology to build a more holistic representation of the relation between early attachment experiences, personality structure, and the experience of psychological difficulty.

Another important aspect to bear in mind when considering personality development is the continuity and discontinuity in personality development throughout an individual's life span, which has received a considerable amount of

debate over the years (McAdams & Olson, 2010). Some theorists and researchers argue that personality crystallises at quite a young age and remains stable throughout that individual's lifespan. In particular, Sigmund Freud believed that personality crystallises by the age of five years and remains the same throughout life (Caspi & Roberts, 2016).

Many research studies have attempted to shed more light on this matter and in some cases have offered confirmation personality constellations related to individual differences cluster at age nine, however, seem to be maintained from an age of six years (Cicchetti & Cohen, 1995). Although the influence of childhood experiences are of importance to understanding how personality unfolds, recent research supports the notion of personality development as a lifelong process (Caspi & Roberts, 2016). The concept of development as extending well into adulthood is not new. Theorists such as Erikson have long proposed a model of lifelong human development (Erikson, 1950). More recently research, however, focuses on an individual's personality as experiencing a developmental spurt in early adulthood between the ages of 18 years to 40 years (Roberts, Walton, & Viechtbauer, 2006). Although personality is generally seen as a set of stable and unchanging traits, findings of recent personality studies succeed in illustrating that personality can and does change throughout the lifespan and is confirmed by other research findings (Roberts, Wood & Caspi, 2008). This offers new insight into how personality and psychopathology can alter its presentation throughout an individual's lifespan and could indicate important areas for future research that can aid in optimising treatment conceptualisation and understanding prognosis of these disorders.

The matter of nature and nurture in the formation of human personality is another important aspect to consider in personality development. Currently, there is a degree of consensus among personality theorists with regard to the influence of both genetic and environmental factors in the formation of an individual's personality. However, there is still much debate regarding the importance of these factors in the contribution to an individual's personality composition. Different

theories of personality development support different positions with regard to this debate.

Costa and McCrae (1990), introduced the Five Factor Model of personality development that includes basic tendencies, of inherited dispositions or traits and characteristic adaptations, which are fluid and produced by the interaction of these basic tendencies with the environment. These characteristic adaptations are of significance to mental health professionals in understanding how individuals relate to their environment and how personality is formed and reformed by this interaction. Although both genetic and environmental influences are acknowledged, the Five Factor theory argues personality trait development is mostly determined by biological and genetic influences, with the influence of environmental factors accounting for a small fraction of the variance found between individuals (McCrae & Costa, 2008).

An alternative view of personality development is provided by the social investment theory, which purports that age-related life transitions, such as life-cycle changes of marriage, parenthood, retirement and the like, stimulate personality maturation as new social roles need to be negotiated. This view is similar to those of other theorists, who view personality development as an interplay between order and disorder, as a psychological repertoire that is derived from an interaction with the environment. In line with this view, personality development can be understood as a succession of crises, where the order achieved is immediately challenged by new forms of disorder, which leads to a different, sometimes higher level of order. These crises represent the various stages individuals pass through in their lives and reflect the unstable equilibrium that characterises living systems through which new structures, processes, and behaviours persistently emerge and transform (Caprara, 1992).

In essence, many divergent views, with regard to the process of personality formation, can be found in personality literature. New findings from behavioural-genetic, cross-cultural research and other longitudinal studies have succeeded in

offering insights with regard to 20 years of research on personality development and could add to more clarity with regard to the important factors in the formation of personality.

These studies have found genetic influences definitely guide much of personality trait make-up, however, environmental influences seem to become more important and increasingly stable during the stage of early adulthood. In addition, it was found that social-role transitions are related to personality trait change and result in a greater level of social maturity (Bleidorn, 2015). These insights offer recent information on the interplay between genetics and the environment in personality development and act as a useful reference for future research endeavours. Based on the literature reviewed thus far, it is the view of this researcher that the role of environmental influences, such as complex childhood trauma, are of the utmost importance when considering personality development. These experiences play a crucial role in shaping a developing personality as well as in explaining psychopathology developed later in life.

2.2.4. Personality and psychopathology.

For many years the study of personality and psychopathology have developed separately, with the exception of the focus on personality pathology in terms of personality disorders found in the various editions of the DSM. However, it is the premise of this study that the concepts of personality and psychopathology share various similarities that are often overlooked.

The relationship between personality and mental disorders, or psychopathology, is clearly seen in the definition of these two concepts. A mental disorder is defined as clinically significant impairments in an individual's thinking, feeling and behaving (APA, 2013). This definition bears a remarkable resemblance to the definition of personality, where personality is defined as a person's characteristic style of behaving, thinking and feeling (Schacter, Gilbert, & Wegner, 2009). It can thus be reasoned that personality, which affects our thinking, feeling

and behaviour, plays a vital role in determining our level of mental health attained and maintained. Research has shown some individuals are more prone to mental illness and psychopathology, due to their characteristics and personality traits, whereas the opposite may also be found in individuals who experience higher levels of mental health due to their personality characteristics that serve a protective function (Salehinezhad, 2012). The relationship between personality and psychopathology has been of specific interest to many researchers (e.g., Akiskal et al. 1983; Duggan et al. 2003; Millon & Francis, 1987; Mulder, Joyce & Sullivan, 1999; Widiger, Trull & Clarkin, 1994). It has been argued a focus on personality will enrich one's understanding of mental illness and that it should be regarded as fundamental to the understanding and interpretation not only of personality disorders, but also other psychopathologies (Millon & Francis, 1987). To date, several meta-analyses have emphasised the importance of personality traits in understanding individual differences in psychopathology (Kotov, Gamez, Schmidt, & Watson, 2010; Malouff, Thorsteinsson, & Schutte, 2005) and well-being (DeNeve & Cooper, 1998; Steel, Schmidt, & Shultz, 2008), and further emphasise the significance of studying these two aspects concurrently. In order to gain a better understanding of how personality and psychopathology are related, an exploration of some of the theoretical orientations, which dominate in personality/psychopathology literature, should prove useful.

2.2.5. Personality theory and psychopathology.

According to Akiskal et al. (1983), personality vulnerability may be related to mental illness in various ways. A vulnerable personality might be aetiologically related to a mental disorder, may affect the discourse and outcome of a mental disorder, be the consequence of repeated episodes of mental illness or be viewed on a continuum where a personality vulnerability is seen as an attenuated form of a previously categorised Axis I condition, also known as syndromal psychopathology. Various types of personality-psychopathology relationships have been identified in

personality literature, which includes a *pathoplastic relationship*, a *spectrum relationship* and a *causal relationship* (Salehinezhad, 2012).

A *pathoplastic relationship* refers to the bi-directional nature of the relationship between personality and psychopathology. In this regard, personality traits can impact or exacerbate the appearance of psychopathology and, in turn, the presence of any psychopathology can affect the presentation of an individual's personality (Widiger & Smith, 2008). In summary, an individual's characteristic manner of thinking, feeling and behaving can alter the development and appearance of a certain mental disorder. However, mental disorders may also alter the presentation of an individual's characteristic personality traits, in that, individuals who are experiencing mental disorders, such as depression and anxiety, may be unlikely to provide an accurate description of their premorbid personality traits. In addition, psychological problems can predispose individuals to develop morbid personality traits, which in turn can intensify their psychological problems (Salehinezhad, 2012). Although, in general, the notion of personality is regarded as a stable phenomenon, many research findings support the bi-directional relationship between personality and psychopathology (Clark & Harrison, 2001; Farmer, 2000; Vitousek & Stumpf, 2005; Widiger & Samuel, 2005).

A *causal relationship* between personality and psychopathology implies that personality and mental disorders play a causal role in the development of one another. It follows that an individual's characteristic manner of thinking, feeling, behaving and relating to others can result in or contribute to the formation of a mental disorder in a predisposing manner. In turn, a severe or chronic mental disorder can contribute to fundamental changes in personality, where the mental disorder complicates or scars the individual's personality at the trait level (Krueger & Tackett, 2003; Widiger & Smith, 2008).

For many years it was assumed that personality and psychopathology are distinct and separate. This is seen in the treatment of personality disorders as a

distinct diagnostic category separate from other mental disorders in the DSM-5 (Salehinezhad, 2012).

A different view is purported by the *spectrum relationship* view of personality and psychopathology, which reasons personality and psychopathology exist along a shared continuum of functioning. According to this view, personality disorders exist on a spectrum with syndromal psychopathology (previous Axis I disorders) and syndromal pathology on a spectrum with personality (Widiger & Smith, 2008). Accordingly, personality and psychopathology are not seen as distinct but instead, personality, psychopathology and syndromal psychopathology are seen as ranging on a continuum from sub-clinical traits to full-scale psychopathology (Krueger & Tackett, 2003). Therefore, a common spectrum of functioning between personality and psychopathology is suggested (Widiger & Smith, 2008). The spectrum model of the personality-psychopathology relationship is continuously gaining influence, as seen in the addition of an alternative dimensional explanation of personality disorders as presented in the DSM-5 (APA, 2013). An integration of personality characteristics and psychiatric symptoms are thus suggested by supporters of this model (such as Krueger, 1999; Krueger, McGue & Iacono, 2001; Markon, 2010). Accordingly, continued research is encouraged in order to gain further insight into the spectrum relation between personality and psychopathology. Authors such as Krueger and Tackett (2003) have underscored the need for studies to focus on the broader personality-psychopathology domain and in particular with regard to the joint structure of personality and psychopathology. Krueger et al. (2011), specifically argue for the importance of research investigating relations between normal personality and psychopathology.

The current study supports this view of a spectrum relationship between personality and psychopathology. In accordance with this view, the current study will aim to investigate the relation between normal personality as conceptualised by the 16 Personality Factor Questionnaire 5th Edition (16PF-5) and psychopathology as conceptualised by the Millon Clinical Multiaxial Inventory 4th Edition (MCMI-

IV). In order to obtain a more in-depth understanding of the personality organisation of inpatients, objective assessments will be supplemented with a projective assessment, such as the Rorschach Inkblot Test in order to gain insight into the unconscious dynamics and defences that also make up the personality of the whole person being studied, and how these are related to other patterns of personality structure at the trait *domain* level and the deeper *facet* level.

2.2.6. The joint structure of psychopathology and normal personality.

A study conducted by Blais (2010) aimed to investigate the joint structure of normal personality and psychopathology. By using assessment measures that measure both normal personality (NEO-PI-R) as well as psychopathology (Personality Assessment Inventory-PAI), the study results indicated normal personality and psychopathology share a common latent structure. In particular, it was found that Neuroticism, found in constellations of normal personality, was positively related to Anxiety, Anxiety-related disorders and Borderline Personality Disorder. Neuroticism was also positively related to Paranoia and Schizophrenia. Agreeableness and Conscientiousness which are also components of normal personality were negatively related to drug abuse and Antisocial Personality Disorder. Lastly, the personality dimensions of Extraversion and Openness were positively related to Mania and negatively related to Depression (Blais, 2010).

Slobodskaya (2014), conducted a study examining the hierarchical structure of personality and psychopathology in childhood. This study proposed both personality and psychopathology are hierarchical in nature and that these two fields are closely related. In particular, she posited that knowledge of the joint factor structure of normal personality and psychopathology may be particularly important in understanding the development of specific patterns of psychiatric problems and the high rates of comorbidity among different psychiatric disorders. She also suggested normal personality traits and problem behaviours coexist from early childhood years into adulthood. Using two assessment measures, that measured

childhood personality and child mental health respectively, the study succeeded in indicating that normal patterns of behaviour and psychopathology in children can be integrated by including a focus on personality traits. In general, it was found that specific constellations of personality traits and problem behaviours were hierarchically related. The interaction between normal personality traits and pathological traits and disorder can accordingly not be overlooked, and will form an additional focus in this research study.

2.2.7. Unifying syndromal (Axis I) and personality (Axis II) psychopathology with normal personality.

Research by Luyten and Blatt (2011) proposed there is a fundamental continuity between normal personality features and psychopathology or a disrupted personality. In particular, they found both personality and psychopathology development converge around two central polarities, namely interpersonal *relatedness* and *self-definition*. *Relatedness* in this regard is defined as the development of increasingly mature, intimate, mutually satisfying, reciprocal, interpersonal relationships. *Self-definition* on the other hand is defined as the development of an increasingly differentiated, integrated, realistic, essentially positive sense of self or identity.

Luyten & Blatt (2011), also regarded these two concepts as intertwined, in that progress in both the *relatedness*, or anaclitic, and *self-definition*, or introjective, developmental line facilitates progress in the other. In this regard, an increasingly differentiated, integrated, and mature sense of self emerges out of constructive interpersonal relationships and, conversely, the continued development of increasingly mature interpersonal relationships is contingent on the development of a more differentiated and integrated self-definition and identity. An individual thus needs both these aspects to develop holistically.

This two polarities model provides a powerful theoretical model of psychopathology that suggests many syndromal (Axis I) and Personality (Axis II)

Disorders can be localised around the two personality polarities of *relatedness* and *self-definition*. As such, psychopathology can be organised in two clusters or configurations of psychopathology, based on the view that different forms of psychopathology involve exaggerated distortions of one developmental line, either *relatedness* or *self-definition*, to the neglect of the other. This is mainly a result of compensatory or defensive manoeuvres in response to developmental disruptions. In this regard, it is worth mentioning that, as previously shown, childhood maltreatment poses a significant disruption to normal developmental outcomes specifically related to the view of the self and other, making this perspective specifically useful to this study. Luyten and Blatt (2011) also posited that different forms of psychopathology are not static entities resulting only from developmental deficits, but dynamic, conflict-defence constellations that attempt to maintain a balance between the personality dimensions of *relatedness* and *self-definition*, yet in a non-adaptive and disturbed manner.

Luyten & Blatt (2011) also argued many of the personality traits described by other personality theories (e.g., Attachment Theory, Beck's Personality Theory, the Five Factor Model and the Interpersonal Circumplex Model of Personality) could be linked back to these two concepts of *relatedness* and *self-definition*. It seems as if these two domains then present higher-order personality *domains* under which many other, more detailed, personality *facets* could be organised. This view is in line with the alternative conceptualisation of personality disorders in section three of the DSM-5.

In this regard, this alternative conceptualisation regards disturbances in self and interpersonal functioning as constituting the core of personality psychopathology, which can be evaluated on a continuum. Self-functioning in this regard involves *Identity* (experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate a range of emotional experience) and *Self-Direction* (pursuit of coherent and meaningful short-term and life goals; utilisation

of constructive and prosocial internal standards of behaviour; ability to self-reflect productively), whereas Interpersonal-functioning involves *Empathy* (comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of one's own behaviour on others) and *Intimacy* (depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behaviour; APA, 2013).

Due to the involvement of these concepts of the self and other on the development of normal and abnormal personality, as well as other forms of psychopathology, Luyten and Blatt (2011), advocated continued research should focus on exploring the manner in which genetics, temperament and personality dimensions interact with environmental factors. This, of course ultimately, leads to the development of cognitive-affective schemas of the self and other.

2.2.8. Disorders of personality. The continuity between normal and disrupted personality development.

Although many writers, as mentioned, have indicated the importance of acknowledging personality organisation when considering all forms of psychopathology, it still remains that the most apparent manner in which personality is related to mental disorders is in the fundamental features of personality disorders as classified in the DSM-5 (Krueger & Eaton, 2010). Accordingly, this relation should not be overlooked and could, ultimately, assist in better understanding the interrelated phenomena of personality and psychopathology in general.

Personality disorders have a powerful impact on an individual's thought processes, affect and behaviour and, accordingly, influence work functioning, interpersonal relationships and many other aspects of an individual's life (Clarkin, Cain, & Livesley, 2015). There has been a lot of debate concerning the definition of a personality disorder. According to Clarke and Watson (1999), abnormal personality is best regarded as an extreme variation of underlying personality traits.

This is supported by other authors (e.g., Duggan et al., 2003; Paris, 1996; Trull et al., 2003), who view personality pathology as derived from an amplification of normal traits. As indicated by Krueger et al. (2011), increasing focus is being given to the relationship between normal personality and disrupted or abnormal personality. According to (Walton & Pavlos, 2015) models of disordered personality resemble models of normal personality at the broader trait level. Specifically, various researchers have argued abnormal personality represents extreme variants of normal range traits (Markon et.al, 2005; Watson et al. 2008; Widiger, 1998).

Furthermore, it is assumed personality can only be regarded as pathological when traits are exaggerated to dysfunctional levels (Paris, 1998). An increasing amount of research is recognising abnormal and normal personality as continuous due to similarities found in clinical and non-clinical samples with regards to personality structure. Although this idea is gaining more support in the personality research field, the connection between normal personality and personality disorders, as classified in the DSM-5, have been limited in the past (Krueger & Tackett, 2003). More recently research has begun to identify profiles of normal personality traits for specific personality disorders. These studies have mostly focused on the Five Factor Model of personality (McCrae & Costa, 2008).

Research linking the Five Factor Model to personality disorders is quite extensive and have established a noteworthy relationship between personality disorders and the higher order factors of the Five Factor Model (e.g., Ball et al., 1997; Costa & Mc-Crae, 1990; Trull, 1992; Wiggins & Pincus, 1989). Other research studies have focused on the facets of the Five Factor Model which allows for a more detailed analysis of and greater discrimination among personality disorders (e.g., Axelrod et al, 1997; Dyce & O'Connor, 1998; Morey et al., 2002; Trull et al., 1998).

According to Krueger and Tackett (2003), facet-level analysis of personality disorders have contributed to a more accurate conceptualisation of personality disorders that offer a comprehensive understanding of certain personality disorders in relation to normal personality. Those studies that have succeeded in showing a

relationship exists between general personality functioning and the DSM personality disorders (Mulder et al. 1999; Widiger et al. 1994), have obtained promising results. Mulder et al. (1999) specifically found that Cluster B personality disorders were associated with high novelty-seeking; Cluster C personality disorders with high harm avoidance; and Cluster A personality disorders with low reward dependence and high harm avoidance.

Despite the vast amount of research that attempts to shift the focus from categories of disorders to a more dimensional approach to understanding disorders of the personality, the traditional categorical approach is still the favoured approach in classifying and diagnosing mental disorders.

This is seen in the latest DSM 5th edition, in which an alternative dimensional approach to classifying personality disorders is added as an additional explanation of these psychopathologies, yet the original categorical approach is still regarded as the chief approach in classification and diagnosis (APA, 2013). Although this addition to the DSM does present growth in the manner in which personality disorders are conceptualised, it seems a need still exists to further elaborate on the notion of a normal-abnormal personality continuum. If the conceptualisation of various mental disorders are to evolve, it will be necessary for continued research to clarify the direction of this evolution.

Further research on the dynamics of personality disorders and general personality functioning could aid in elucidating the relationship that exists between personality and psychopathology in general, and aid in generating new information in the field of psychology. Since the aim of this study is to examine, describe and better understand the dynamics of personality, specifically how it is influenced by life stressors, such as *complex childhood trauma*, and how personality in turn influences the development and expression of psychopathology, it was decided that a study of disordered personality would best accomplish these aims. A specific personality disorder, that is BPD, was chosen as the focus of investigation due to its aetiological association with *complex childhood trauma* as well as its high

prevalence of other co-morbid psychopathologies. It is, accordingly, assumed a better understanding of BPD will not only be beneficial in itself to the profession of clinical psychology, but also assist in elucidating the interrelationship between *complex childhood trauma*, personality development and subsequent psychopathology.

2.2.9. Borderline Personality Disorder. An investigation into the dynamics of pathological personality.

The diagnosis of BPD has elicited many debates in the professions of psychology and psychiatry, with regard to the clinical utility of this diagnosis. Many researchers and clinicians are of the opinion that BPD presents nothing more than a wastepaper basket category, merely covering a range of symptoms, and that this diagnostic category is most likely the sum of multiple (previously Axis I) disorders (Cauwels, 1992; Gabbard, 2005; Tyrer, 1999). Despite the large amount of research conducted to clarify this diagnostic category, it still seems to remain vague and highly criticised (Cartwright, 2008). In general, BPD reflects multiple combinations of symptomology in impulse control, affect regulation and cognitive as well as interpersonal functioning, all of which are areas which have been shown to be significantly impacted by *complex childhood trauma*. The investigation of this diagnosis thus presents researchers with the ideal opportunity to study the complex trauma-psychopathology interaction.

In general, BPD is described as a pervasive pattern of instability in interpersonal relationships, self-image, and affect, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts (APA, 2013). The exact diagnostic criteria for BPD, as presented in the DSM-5, can be found in Appendix B. Although the categorical outline of diagnostic criteria in the DSM provides clinicians with a uniform manner by which to diagnose and conceptualise mental disorders, it does, however, overlook the complex nature of such a diagnosis. According to the DSM-5, five of the nine presented diagnostic criteria need to be

met for a diagnosis of BPD to be made (APA, 2013). This, however, results in 256 various combinations of criteria and accompanying symptomology, which complicates a homogeneous understanding and conceptualisation of this disorder (Skodol et al., 2002). This is not only true for BPD but holds true for any other DSM disorder diagnostic criteria. Numerous combinations of criteria and symptoms can be found for each DSM disorder which impacts case conceptualisation and treatment planning. With regards to the borderline personality diagnosis in particular, this variability in symptom combination has resulted in the validity of this diagnosis being questioned (Gabbard, 2005).

In addition, the disorder's high level of comorbidity with other disorders has also led to the accuracy of a BPD diagnosis being further questioned (Cartwright, 2008). Although the BPD diagnostic category has resulted in more questions than certainty, ongoing research continually assists in clarifying the nature of this diagnosis as well as its relationship with other frequent co-morbid diagnoses. A need, however, still exists to further enhance the amount of research with regard to BPD's relationship with other mental health conditions. It is due to BPD's complex nature and relation to various other phenomena, such as other psychopathologies and certain aetiological factors (such as a history of childhood trauma; Herman, 1992a), that further research in this area might yield interesting results in better understanding the relationship between personality, life experiences and mental illness.

Many quantitative studies have also focused on studying BPD from the perspective of general personality (Costa & Mcrae, 1990; Reynolds & Clark, 2001; Trull, 1992). These studies have found BPD can be understood as a maladaptive variant of certain personality traits, in particular, Five Factor Model traits. Although these studies have succeeded in a correlation exists between BPD and certain personality traits, such as high levels of neuroticism and low levels of agreeableness and conscientiousness (Clarkin et al., 1993), these studies do not succeed in capturing the full essence of BPD. It is, accordingly, proposed that a more in-depth

examination of BPD could also offer a richer description of the relationship between general personality functioning and pathological personality functioning. By identifying overarching patterns of personality organisation that go beyond those examined by the Five Factor Model in patients diagnosed with BPD, a more detailed and holistic account of borderline dynamics and symptomology could be obtained, and is thus proposed in this study. This is especially beneficial to clinical conceptualisation and treatment of this diagnosis; specifically, in creating a clinical understanding of the manner in which *complex childhood trauma* is related to personality development and subsequent psychopathology.

2.3. A Spectrum Approach to Understanding the Environment – Personality – Psychopathology Interaction

American clinical psychologist Theodore Millon's theory on personality and psychopathology offers a unifying approach to understanding the interplay between lifetime experiences, such as childhood trauma, the adaptations that take place in the individual's personality structure as a result of such a trauma and the resultant psychopathology as a result of the interplay of these two factors. His theory also supports the view that personality and psychopathology follow a spectrum, as such, falling on a continuum from normal to abnormal functioning.

Millon conceptualises personality as an integrated system, with the focus on understanding the person holistically (Jankowski, 2002). Over the past four decades, Millon has contributed to the field of psychology and offers a rich and detailed theory of human personality and psychopathology in an attempt to unify the two, once separate, sciences (Davies, 1999). Due to this study's focus on the interconnected relationship between personality, mental health and illness, as well as a history of child abuse, it is thus fitting that Millon's theoretical contributions guide this study's examination.

Overall Millon views personality as:

... a complex pattern of deeply embedded psychological characteristics that are largely nonconscious and not easily altered, expressing themselves automatically in almost every facet of functioning. Intrinsic and pervasive, these traits emerge from a complicated matrix of biological dispositions and experiential learnings, and ultimately comprise the individual's distinctive pattern of perceiving, feeling, thinking, coping and behaving (Millon & Davies, 1996, p. 4).

Millon argues that two principal determinants of an individual's personality style are biophysical constitution and past experiences, or more specifically, genetic and environmental influences which contribute to the formation of an individual's personality. The combination of these two formative factors resulted in the development of a biosocial-learning theory of personality development (Davies, 1999; Millon & Everly, 1985).

Central to this view is Millon's reliance on the concept of reinforcement (Jankowski, 2002). As an individual grows and develops through the stages of childhood, the individual's perception and responses are guided by his or her biological make up (temperament, intelligence, physical strength, vulnerabilities and so forth). The child thus relates to his or her environment in a manner suitable to his or her biological characteristics (Millon & Everly, 1985). However, environmental pressures, beginning in childhood, that exceed normal environmental circumstances, inevitably force the individual to find alternative strategies of relating to the world that differ from that individual's natural inclinations. In essence, Millon believes individuals are inclined to adopt behaviours related to a reward, a positive outcome and feeling, that is, positive reinforcement. The individual learns through a series of life experiences, such as parenting practices and interactions with siblings and peers, which behaviours are linked to a reward and learn which instrumental actions must be employed to achieve these rewards in the future (Davies, 1999; Millon & Everly, 1985).

According to Millon, this biosocial learning model explains the development of troublesome lifestyles, in that the individual has become accustomed to certain types of reinforcement, the sources that potentially provide the sought-after reinforcement, as well as the displayed behaviours coupled to these reinforcements. Millon views the concept of reinforcement as crucial to understanding pathological behaviour. By focusing on the types of reinforcement the individual seeks, and the accompanying behaviours employed to elicit these reinforcements, Millon believes clinicians could more clearly understand the essential personality styles and disorders that guide an individual's coping behaviour (Davies, 1999).

Millon provided many revisions of his initial theory of personality. In 1990, he reconceptualised his personality model to include the principles and processes of evolution and the accompanying laws of nature (Jankowski, 2002). He holds the principles of evolution are universal and can be found in a variety of subject fields, including psychology. Millon observed the genetic composition of a species followed a similar pattern of evolution as the developmental strategies of adaptation in individuals. In essence, individuals will adapt and display behaviour fitting to their environment and ultimate survival. Individuals learn from experience which genetic traits are best suited to the interaction with their environment. This gene-environment interaction thus acts to shape the individual's characteristic style of thinking, feeling and behaving, in other words, personality style. Personality is, thus, seen as a distinctive style of adaptive functioning that an organism of a particular species exhibits as it relates to a range of environments experienced (Jankowski, 2002).

In line with Millon's view regarding personality, he further proposed that pathology results from similar forces as those responsible for the development of normal functioning. Of importance in the distinction between normal and pathological development is the timing and intensity of these environmental influences. This results in character differences as well as the development of

pathological traits in some individuals and the development of adaptive traits in others (Jankowski, 2002).

Millon goes on to identify three criteria that characterise the development of a pathological condition. First, *adaptive inflexibility* refers to an inappropriately rigid strategy an individual relies on to relate to the environment. In this regard, the individual is unable to effectively adapt to life circumstances and accordingly attempts to arrange the environment in such a manner as to avoid events perceived as stressful. This preference for rigidity could limit the individual's future opportunities for developing new, more adaptive behaviours and ultimately acts to amplify the individual's degree of rigidity due to a scarcity of effective coping mechanisms. (Jankowski, 2002).

Second, *tenuous stability* denotes a lack of resilience and a degree of fragility experienced by certain individuals under conditions of subjective stress. Incidentally, these individuals are likely to revert to former pathological methods of coping since effective coping strategies have not been developed. Their lack of effective coping methods leaves these individuals susceptible to further difficulties and disruptions, which only act to reinforce the use of preferred pathological styles of coping. The above-mentioned pattern of interacting with the environment results in the third criterion, *vicious circles*, in which the preferred rigidity and inflexibility result in a tendency toward a negative circular causality. In this regard protective manoeuvres, such as protective constriction, cognitive distortion and behavioural overgeneralisation, employed limit opportunities for new learning, and could result in benign events being misconstrued. This in turn elicits an accompanying provocation of reactions from others and the interpersonal exchange being regarded as negative. These reoccurring negative interactions with others reinforce and reactivate earlier difficulties experienced, and negatively impacts future interactions with others (Jankowski, 2002).

In essence, Millon viewed healthy and disordered personalities as similar at their core foundation, with disordered personalities displaying inflexible,

maladaptive and rigid variations of normal personality traits (Strack & Millon, 2012). Accordingly, the differentiation between normal and disordered thus produces a continuum of functioning (Jankowski, 2002).

Millon's view on personality is reflected in his development of multiple personality measures designed to assess a range of personality functioning from normal to maladaptive. Millon developed the Millon Index of Personality Styles (MIPS, 2003) devised for use with normally functioning adults and describes individual functioning on motivating, thinking and behaving scales (Millon & Bloom, 2008). The development of the Millon Clinical Multiaxial Inventory (MCMI, 1977), the Millon Adolescent Clinical Inventory (MACI, 1993; 2006) and the Millon Pre-Adolescent Clinical Inventory (M-PACI, 2005), alternatively, is designed to measure personality disorders and pathological syndromes within a psychiatric population (Jankowski, 2002) .

With regards to the areas in which personality were thought to evolve and personality disorders potentially could develop from, Millon identified four stages, namely *existence, adaptation, replication and abstraction*, as well as three accompanying polarity dimensions; pleasure-pain, active-passive, and self-other. *Existence* relates to an individual's orientation toward life and is characterised by the transformation of less organised states into states that possess the needed and durable structures that result in greater survivability (Davies, 1999). This domain is thus concerned with enhancement and preservation. Fundamental to the later development of the child in this stage is the level of attachment obtained between the child and the caregiver (Jankowski, 2002). Developed during this stage is the child's orientation toward *pleasure and pain*, whether oriented toward enhancing pleasure or avoiding pain (Jankowski, 2002). In this regard, the enhancement of pleasure is characterised by recognising and pursuing positive sensations and emotions, and the avoidance of pain by recognising and avoiding negative sensations and emotions. An intertwining and ever-changing balance between these two aims

comprises the pleasure-pain bipolarity and characterises normality. Both aims must be met in varying degrees as life circumstances require (Davies, 1999).

The second stage of *adaptation* entails the individual's adaption to the environment and the manner in which existence is maintained. The individual develops a level of adaptive confidence and a tendency to either engage the environment *actively or passively* (Jankowski, 2002). The manner in which the individual adapts to his or her environment becomes significant. Individuals either tend to passively engage their environment with a preference for blending in and accommodating the environment, or alternatively actively engage and modify the environment as a means of survival. According to Millon, optimal functioning requires a flexible balance between both adaptive polarities as the context requires it (Davies, 1999). Also, the individual's ability to differentiate from the larger ecosystem he/she is a part of and maintain his/her own unique structure is of importance. The presence of effective coping mechanisms is, accordingly, essential in order to achieve the necessary developmental goals (Jankowski, 2002).

Replication refers to the third stage where individuals either develop a self-propagating strategy, in which they develop an inclination to produce multiple offspring, but offer minimal effort in ensuring the survival of these offspring, or develop an other-nurturing strategy, where few offspring are likely to be produced but considerable effort is made to ensure the survival of descendants. Of importance to the formation of personality in this regard is the development of gender-role orientation and identity, as well as an individual's orientation toward the *self* or the *other* (Jankowski, 2002). In this regard, individual's will be inclined to develop a tendency toward being predominantly self-actualising or other-enhancing, which forms an important part of the individual's personality and character (Davies, 1999).

The final stage, *abstraction* is concerned with the development of competencies that cultivate anticipatory planning and reasoned decision making (Davies, 1999). In this stage, reason and emotion are balanced, and concrete thought is surpassed by symbolic integration of experiences that are internalised (Jankowski,

2002). In essence, the individual's ability to symbolise their world is developed, as well as their preference for thinking or feeling when decision making is concerned (Jung, 1971; Davies, 1999).

Ultimately, healthy individuals can be viewed as being balanced on three polarities, pleasure-pain, active-passive and self-other, whereas pathological individuals are notably unbalanced in this regard (Strack & Millon, 2012).

Based on this view of personality development, personality disorders are accordingly viewed as styles of maladaptive functioning that are related to deficiencies, imbalances, conflicts and structural defects that arise during the above mentioned evolutionary stages, resulting in the capacity of the individual to relate to the environment he/she faces to be compromised (Davies, 1999). In addition, Millon views the clinical signs of personality disorders as reflecting a deeply embedded and pervasive pattern of characteristics, that can be regarded as a system of traits, wherein a trait is systematically supported by each and every other trait in order to manifest in all facets of a person's life (Jankowski, 2002).

It thus becomes apparent the holistic and integrated nature of personality is central to Millon's view, in which he regards an individual's thoughts, feelings and behaviours, as interconnected. For Millon, the whole of a person's existence is greater than the sum of its parts. Accordingly, personality components, such as emotionality, self-image, defence mechanisms and cognitive schemas, are seen as interlinked and interact to produce a cohesive individual (Strack & Millon, 2012). Due to Millon's appreciation of the whole individual, he emphasises all personality elements should be examined together in order to fully understand individual functioning. He is of the opinion personality traits should not be separated from the rest of the person, nor considered in isolation for intervention. Rather, all personality elements should be explored cohesively, as an integrated set, in order to preserve the whole of the phenomena being examined (Strack & Millon, 2012).

In conceptualising human personality as an interlinked system, Strack and Millon (2012) urge clinicians to acknowledge the various parts of the personality

system that are dysfunctional will differ for each individual, even in individuals who share the same clinical diagnosis. In this regard, in order to develop a holistic understanding of the person, an assessment of the personality features primarily contributing to the individual's maladaptive functioning is recommended. Personality assessment also allows clinicians to develop a specified intervention plan aimed at targeting those personality traits associated with the presenting symptoms, and guide the treatment to enable the patient to gain a variety of beneficial adaptive behaviours better suited to his/her life circumstances (Strack & Millon, 2012).

Millon's theoretical contributions in the field of personology has, accordingly, made many beneficial contributions to the manner in which psychopathology can be conceptualised and treated. His proposed treatment strategy of personalised psychotherapy is aimed at targeting those underlying personality features thought to be at the root of the problematic behaviour as opposed to simply treating the emerging symptoms of a wider reaching problem. Millon's theory acknowledges each mental health patient has a unique personality that must be considered in order to fully understand the nature of their clinical conditions, and to provide the necessary treatment that delivers optimal results in the shortest amount of time.

Although Millon offers a rich and integrated theory of personality and psychopathology, there still exists a need for further research to study the interrelationship between normal and abnormal personality, as well as its link to psychopathology. According to Strack and Millon (2012), there has been a limited amount of empirical work that examines Millon's theory or his model of treatment, despite the tremendous influence Millon has had on the development of personality psychology and clinical psychology over four decades. The proposed study will thus aim to address this need by offering an in-depth examination of life experiences, personality and psychopathology based on the theory proposed by Millon and other relevant and supporting literature. In accordance with Millon's holistic conceptualisation of the person, and his views on personology and psychopathology,

this study proposes a multi-levelled exploration of the personality; psychopathology relationship comprising of a comprehensive assessment of personality traits, motivation, needs, defence mechanisms as well as cognitive schemas regarding the self and other within the South African context.

2.3.1. Millon's conceptualisation of Borderline Personality Disorder.

Millon described individuals with BPD as notable for their labile affect. They typically experience intense endogenous moods, with recurring periods of dejection and apathy, often interspersed with spells of anger, anxiety and euphoria. He further notes that individuals with BPD frequently have thoughts about suicide and self-mutilation. They are also typically preoccupied with securing the affection of others and experience much difficulty in maintaining a clear sense of identity. Cognitive-affective ambivalences are also frequently present, which is evidenced by their conflicting feelings of rage, love and guilt toward others (Millon, Grossman, & Millon, 2015).

He further explains that patients with BPD experience conflict between all three polarities identified in his evolutionary theory - pleasure and pain, active and passive, as well as self and other. These patients are unable to take a consistent and balanced position on the polar extremes and tend to fluctuate from one end to the other, struggling to stabilise themselves. In addition, these patients' typical manner of behaving and interacting cause immense difficulties for themselves (Millon, 2011). According to Millon, patients with BPD possess little character traits that guard against further deterioration. In fact, he posits it is their character traits which likely intensify their troubles. This indicates the interaction of their personality traits is circular in nature and their difficulties experienced are thus self-sustained (Millon, 2011).

Millon further describes patients with BPD as typically experiencing difficulty in three areas of functioning, which he summarises as an uncertain self-image, a split architecture, and being temperamentally labile (Millon et al., 2015).

a. Uncertain self-image

According to Millon, a BPD patient's uncertain self-image results in them experiencing confusion, characterised by an immature, unclear and wavering sense of identity, often accompanied by underlying feelings of emptiness. These individuals seem to be unable to settle on a life direction or role which might provide them with some basis for moulding an integrated and stable sense of self. In addition, they may seek to redeem their hasty actions and fluctuating self-presentations through expressions of remorse and self-punitive behaviour (Millon et al., 2015).

b. Split architecture

Millon describes patients with BPD as possessing an inconsistent and incongruent inner psychic structure. Their level of consciousness may shift suddenly, and they may be prone to experiencing contrasting perceptions, memories and affects. This may ultimately result in difficulties with reality testing and leave them prone to experiencing stress-related mini-psychotic episodes (Millon et al., 2015).

c. Temperamentally labile

Individuals with a BPD diagnosis are prone to be emotionally unstable with mood levels that frequently fail to reflect their extremal reality. Chronic feelings of dejection and apathy may be frequently experienced, along with periods of anxiety, anger and euphoria. These individuals can be expected to typically exhibit a dominant outlook or temperament, such as depression, however, may periodically experience anxious agitation or impulsive outbursts of anger or resentment, making them extremely unpredictable and difficult to interact with (Millon et al., 2015).

Millon (2011) also differentiates between different subtypes of BPD patients and suggests four different BPD profiles exist:

i. The impulsive borderline type.

Millon describes this BPD sub-type as evasive, superficial and seductive, akin to individuals with a diagnosis of Histrionic Personality Disorder, yet less successful

and more extreme. Their main concern is about securing attention, affection and approval, however, the strategies they employ to secure support and encouragement inadvertently have the opposite effect. Their excessively flighty and erratic style of interaction in relationships often result in them generally lacking the secure base and consistent source of attention they crave. In response to this unsatisfied need, they may intensify attempts at securing affection through acting seductively and impulsively, which creates further distance in their interactions with others.

These individuals are also prone to extreme hyperactivity, flightiness and distractibility. They may at times express a frenzy of cheerfulness, exaggerated boastfulness as well as a manic, unquenchable need for social contact and excitement. At other times, they may be prone to frantic displays of warmth and friendliness as well as an irrational sense of euphoria in which they lose sense of rational judgement. In these times, they are also likely to manically engage in an excess of activities. In addition, these individuals may at times also be restless, act on the spur of the moment and fail to plan or consider pragmatic alternatives. They are also less likely to consider the consequences of their actions, which together with their hasty and irresponsible behaviours, result in them experiencing social difficulties. Fearing their behaviour may result in a loss of approval and support, they may succumb to periods of hopelessness, self-deprecation and self-doubt. These feelings tend to intensify over time, ultimately resulting in extreme feelings of emptiness, abandonment and gloom (Millon 2011).

ii. The petulant borderline type.

Petulant BPD individuals are characterised by their extreme levels of unpredictability, restlessness, irritability, impatience and complaining attitude. They are typically defiant, discontent, stubborn, sullen, pessimistic and resentful. Any enthusiasm they show is short-lived and they are easily disillusioned and slighted. They tend to be envious of others and generally feel unappreciated and cheated in life. Although they are generally angry and resentful, they fear separation and are preoccupied with achieving affection and love. Their interpersonal dealings are thus

characterised by ambivalence, inner conflict and a push-and-pull dynamic of interaction.

In seeking the independence they long for, patients with BPD with petulance ultimately tend to withdraw too much from others and, accordingly, end up feeling isolated. They tend to resent their dependence on others, hating those whom they turn to for esteem and affection. In this regard, they are prone to openly venting their anger and disappointments, yet later, retract, feel guilty and remorseful. They are generally erratic and vacillate between being apologetic and submissive in some instances and stubborn, resistant and opposing at other times. Their oscillation between these two extremes eventually result in them becoming severely depressed, feeling worthless, futile, agitated and becoming self-destructive. At times, their negative demeanour may break through their controls and become excessive, resulting in periods of rage, faulty reality testing and a tendency to place excessive demands on others. During these times, they are prone to viciously attack others whose support and affection cause them considerable inner conflict (Millon, 2011).

iii. The discouraged borderline type

These individuals tend to be chronically depressed, overly flexible and submissive, avoiding any competition and lacking in initiative. They lack a variety of secure attachments and tend to attach only to a limited number of people, on whom they become overly dependent. These limited attachments also tend to be insecure, leaving these individuals preoccupied with fears of abandonment and rejection. In response to these feelings, they tend to cling incessantly to others, submerging their individuality and autonomy for the sake of approval and support. This lack of security results in considerable distress, which leads to these individuals easily becoming hopeless, helpless and depressed. In this regard, they may tend to feel empty and overburdened to such an extent that everyday responsibilities are considered too demanding.

Lacking much needed personal agency, they may start to feel unworthy, useless and despise themselves. Underneath their submissive exterior lies an

explosive fury, which may manifest itself as brief outbursts of angry resentment at those who do not acknowledge their need for encouragement and nurturance and have exploited their submissiveness. In most instances, they are likely to fear their anger and resentment will result in desertion and rejection. As such, they tend to turn their anger inward and may become severely self-punitive and self-critical. At the extreme, self-mutilation and suicide acts as a means of punishment and to express the resentment and anger they have for themselves (Millon, 2011).

iv. The self-destructive borderline type.

Most notable about the self-destructive borderline type is that they tend to vacillate extremely in their approach to others and in their emotional expression. For the most part, they attempt to be submissive, overly responsible and conscientious, in order to gain approval, nurturance and support. These individuals also have a high degree of dependence on others yet crave independence. They, however, fear self-assertion and strivings toward independence, as this may result in rejection and a loss of support. As a result, they resent those whom they have grown dependent on. Instead of engaging in anger outbursts and expressing any form of oppositionality, which characterises their inner feelings, they are prone to turning their anger inward. This results in many depressive and masochistic traits and chronic levels of anxiety. They generally tend to be highly self-punitive, self-deprecating and self-destructive, focusing all their negativity on themselves. Although they may become high-strung and moody at times, they generally tend to suppress any negative feelings or awareness of their inner deficiencies. As a result, they are prone to experiencing somatic complaints and may feel they are treated unfairly, and that their high levels of conscientiousness and responsibility are not adequately appreciated. These feelings only act to deepen their depression and, as a result, the risk of suicide becomes omnipresent. Caught between the extremes of submissiveness, buried resentment and deep-seated depression they struggle to stabilise themselves and remain trapped in a self-destructive cycle (Millon, 2011).

In summary, the literature reviewed in this chapter increasingly supports the need and importance of acknowledging the personality-psychopathology relationship. The impact of environmental forces upon the development of both personality and psychopathology was also reviewed and evidenced the importance of considering the interplay between childhood traumatic experiences, personality development and resultant psychopathology.

Previous research has indicated individuals who have experienced childhood trauma, and who later present with psychopathology, typically evidence a tendency of adopting ineffective coping mechanisms in response to such a trauma. Environmental pressures that exceed normal environmental circumstances forces the individual to find alternative strategies of relating to the world. In turn, the collection of coping mechanisms of these patients later becomes inherent to their personality structure and begins to direct their everyday interactions with their environment. According to Herman (1992a), traumatic events essentially disorganises the personality in such a manner that balance, and flexibility is mostly not achieved. This is due to the coping strategies of traumatised individuals being rigidly applied to ensure survival and ultimately results in symptom outbreak.

Millon's theory, and the other theories, reviewed with regard to personality-psychopathology development, emphasise the importance of balance between the domains of self and other, activity and passivity, thinking and feeling, as well as pleasure seeking and pain avoidance, in the formation of an adaptive personality structure. According to these views, psychopathology, thus, ensues as a result of inflexibility and imbalance in the personality structure when some facets are over developed at the expense of other facet expressions.

If such a view is adopted, then studying the components of *complex childhood trauma*, personality structure and psychopathology jointly, should offer a more holistic understanding into the manner in which psychiatric difficulties manifest in affected patients' lives. Such a focus will also prove valuable since, to the researcher's knowledge, few studies to date have focused on exploring the

interrelationship between childhood trauma, personality structure and psychopathology in a South African population.

Chapter 3. Methodology

The main objective of the methodology section is to offer a detailed description of the research procedures, followed by the researcher, to allow for research replication. According to Ponterotto (2005), the research methodology of a study should summarise the process and procedure followed by the researcher in conducting the research project. In order to achieve this objective, the purpose of this research project and the research design that guided the planning and execution of this research, will be discussed. Thereafter, a detailed description of the method used to conduct this research will be explained, and includes an explanation of the type of enquiry used, the selection of participants, as well as the gathering of the data. Data analysis strategies used are also elaborated on. Finally, the chapter concludes with a discussion on the trustworthiness of the data gathered, and the ethical considerations the studied adhered to.

3.1. The Research Design

3.1.1. The purpose of the research.

This research study's overarching purpose was aimed at describing and explaining how *complex childhood trauma* interacts with the development of the participant's personality to form a pathological means of coping in the form of a personality disorder and co-morbid diagnoses. An additional focus, was on better understanding the continuum of functioning between normal personality and pathological personality, and how these two constructs are related. Of further interest was cultivating a deeper understanding of BPD which goes beyond the DSM classification criteria but produces a rich description of the lived experiences of psychiatric patients with BPD. This will be offered in the form of clinical profiles which aid case conceptualisation and treatment planning of these patients in the field of clinical psychology.

3.1.1.1. Research questions.

In order to accomplish the purpose of the study, the following research questions were posed:

a. How are normal personality characteristics related to maladaptive personality found in the personality structure of female inpatients with a diagnosis of BPD, and who share a similar contextual background of exposure to *complex childhood trauma*?

b. Will an analysis of personality characteristics of patients with a diagnosis of BPD and a shared history of exposure to *complex childhood trauma*, reveal a characteristic personality structure or clinical profile?

c. What are the similarities and differences in personality structure of patients with a diagnosis of BPD and a shared history of exposure to *complex childhood trauma*?

3.1.1.2. Research aims and objectives.

With the stated research questions in mind, the study had the following aims and objectives:

Aims:

The overarching aim of this study was:

a. A holistic investigation of the personality structure of individuals with a diagnosis of BPD and a shared contextual background of *complex childhood trauma*.

Secondary aims included:

b. The exploration of the normal-maladaptive personality continuum; and

c. To assist in elucidating the personality-psychopathology spectrum relationship in a qualitative and descriptive manner.

In order to achieve the above-mentioned aims, the study had the following objectives:

Objectives:

a. Explore the personality structure of inpatients with a shared contextual background of exposure to *complex childhood trauma* and a diagnosis of BPD, from the perspective of general personality functioning, by using a variety of assessment measures focussed on adaptive, and maladaptive personality functioning.

b. Provide an in-depth and rich description of the observed personality structure of participants through the inclusion and qualitative analysis of both structured and projective personality assessment measures.

c. Explore the similarities and differences between the personality structures of participants through thematic analysis of obtained personality test results.

3.1.2. A qualitative research design.

The study was based on the assumption that a more in-depth understanding is needed in order to appreciate the complex relationship between trauma, personality and mental health. Due to a need to go beyond the research enquiry of mere statistical correlations, and to produce a greater understanding of the meaning of the data obtained, a qualitative research design was used in this study.

The study aimed to transcend the traditional variable-oriented approach in favour of a more person-centred approach that places the person, as a whole, at the centre of interest (Magnusson, 1990). Although the research process made use of quantitative personality assessment results, it should be noted these results only represent one aspect of the inquiry into the participant's personality organisation. The main focus of the study was to analyse the quantitative results obtained from the various personality assessments thematically, in order to identify common themes and differences among the personality organisations of psychiatric patients with a similar history of exposure to *complex childhood trauma* and a diagnosis of

BPD. In addition, it should be mentioned that according to Yin (2012), the incorporation of quantitative data into qualitative research, aids in producing a chain of evidence or an audit trail, which will increase the dependability of the qualitative research. The main intention of this study was to provide a qualitative analysis and description of the quantitative data obtained in the research process.

In general, qualitative research is characterised by its sensitivity to context, thus the emphasis is on uniqueness and individuality, rather than seeking universal generalisations (Schutt, 2015). It is due to a greater appreciation of the complexity of personality, and the need for an emphasis on specificity and uniqueness, that a qualitative investigation of psychiatric patients' personality structure, in terms of similarities and differences, was used in this research study.

In addition, it should be mentioned that deterministic models may be appropriate for explaining single variables, such as the relationship between neuroticism and depression; however, it is unlikely they will be appropriate to make sense of multifaceted phenomena, such as thoughts, emotions, motivations and behavioural strategies, which result from various factors that interact in a non-linear, probabilistic and an unpredictable manner (Caprara, 1992). It is thus fitting that, within a qualitative framework, the focus is on the whole of the phenomenon being studied, as the whole is assumed to be greater than the sum of its parts. The focus will be on how the whole interacts to produce a certain outcome and behaviour (Schutt, 2015), and ultimately aid the profession of clinical psychology in better understanding and treating psychiatric patients with BPD within the South African context.

According to Capara (1992), personality patterns are more relevant than single variables. It is thus assumed the personality patterns and the combination and interaction of the clinical features that underlie the diagnosis of BPD, is then more relevant than the overarching diagnostic label and corresponding diagnostic criteria provided to the participants. It was regarded to be necessary, to go beyond specific behaviours, to grasp the different meanings they may assume as part of the

participant's personality constellation. An emphasis was, accordingly, placed on the relationship among personality aspects, with a specific focus on the personality patterns that emerged within and between participant assessment results. The qualitative research design employed sought to find important themes, patterns and relationships in the data gathered, with an in-depth orientation focused on the meaning of phenomena. The focus was on gathering much data from key informants, in order to generate a greater understanding of what is studied (Schutt, 2015).

3.2. Research method

3.2.1. Qualitative case study methodology.

Qualitative case study methodology is a method that facilitates the exploration of phenomenon within the context in which it occurs, using a variety of data sources. Bromley (1990, p. 302), defines a case study as a “*systematic enquiry into an event or a set of related events which aims to describe and explain the phenomena of interest*”. In addition, case study methodology has been described as the preferred research strategy when answers to why and how questions are sought (Yin, 1994). The value of this approach is that it allows for phenomena to be explored from a variety of lenses and, accordingly, allows for multiple facets of the subject matter to be revealed and understood (Baxter & Jack, 2008). The advantage of using a case study method lies within its ability to offer a close collaboration between the researcher and participant, to allow participants to describe their view of reality, which enables the researcher to better understand the participant's actions (Lather, 1992). This ultimately suits the aim of this research endeavour, to better understand how *complex childhood trauma* impacts the behaviour of individuals with a diagnosis of BPD.

Yin (1994). distinguishes between single case study designs and multiple case study designs. Likewise, Stake (1995), identifies three types of case studies that can be chosen to serve different purposes. Instrumental case studies are used to gain insight into a particular topic, whereas intrinsic case studies are utilised to gain a

deeper understanding of a case. Collective case studies, which are multiple case studies, are studies focused on a number of cases in order to explore a particular phenomenon. In a multiple case study design, a researcher can examine several cases in order to understand the similarities and differences between these cases (Baxter & Jack, 2008).

Because the focus of this study was to understand the similarities and differences in the personality structure found in participants with similar contexts, a multiple case study design was adopted to best represent the objectives of the study. With a multiple case study design, the opportunity to analyse within each case and across cases is thus afforded (Yin, 2003). According to Yin (2003), multiple case studies can be used to either predict similar findings or predict contrasting findings but for predictable reasons, such as described by a particular theory. As such, one of the main benefits of using multiple case studies is that the data obtained is considered robust and dependable.

In summary, this research attempts to contribute to efforts in the study of personality psychology to construct a descriptive and explanatory model of the joint structure of personality, experiences and psychopathology. Specifically, the interrelationship between *complex childhood trauma* and the development and expression of BPD in later life was of interest. In order to achieve this goal, the study aimed to capture the unique pattern of the personality psychopathology relationship that characterise specific psychiatric patients at specific points in their lives through the use of multiple case studies.

3.2.2. Selection of Participants.

As mentioned, the purpose of this study was to gain an in-depth insight into the personality structure of female patients of a tertiary psychiatric hospital, with a diagnosis of BPD, who have personally experienced a history of *complex childhood trauma*. This will be accomplished by identifying and exploring commonalities and differences in personality themes experienced by these patients.

Due to the focus on a specific sample, a random and representative sampling of the entire population would not have been suited to this study. With qualitative research's focus on individuality rather than universal generalisation, the study focused on obtaining a variety of data from a limited number of cases. A criterion sampling procedure was used, in which cases were selected based on a number of predetermined criteria of importance (Patton, 2002), where all participants were required to meet the following criteria:

First, participants had to have reported a history of childhood abuse and had to be patients at a government psychiatric hospital. The rationale for inclusion of this criterion is due to the research's focus on the impact of similar traumatic life experiences on personality structure and mental health. Second, participants had to be between the ages of 21- and 50-years and female. A specific gender and age group was chosen in order to access inpatients who are in similar developmental stages and share similar intrapersonal and interpersonal dynamics. Specifically, participants were chosen who found themselves in the Eriksonian developmental stage of intimacy versus isolation and generativity versus stagnation (Erikson, 1950). Third, participants had to be South African citizens who have lived in South Africa their entire lives, as this provides a similar environmental context which can be expected to have impacted the nature of their trauma and their reaction to it. In addition, all participants had to be well-versed in English, as all personality assessments utilised were structured in that language. Finally, due to the sensitive nature of the research, which explored the private and internal worlds of participants, voluntary participation was required.

A study conducted by Guest, Bunce, and Johnson (2006), investigated the ideal sample size for qualitative research using purposeful samples. In their study they were able to show the more similar participants in a sample were, in terms of their experiences with respect to the research domain, the sooner a researcher can expect to reach data saturation. The present research study aimed to accomplish this goal by including participants highly similar in their demographic characteristics,

who had similar trauma experiences and were all psychiatric patients at the same hospital, and had received the diagnosis of BPD. In addition, Guest, Bunce, and Johnson (2006), also demonstrated that a sample size of six participants was able to achieve very high levels of data and thematic saturation. The identification of a sample size of six participants as adequate for producing dependable and saturated qualitative data, was also supported in other studies conducted by Morse (1994), and Nielsen and Landauer (1993). As a result, a total of six cases were included in this study. A sample of six female participants, who were attending a psychiatric patient programme at a tertiary level government psychiatric hospital, were selected based on the above criteria.

3.2.3. Data collection.

A combination of structured and objective personality assessments, and projective assessment techniques, were used in order to gain a holistic picture of the participants' personality structure. In addition, a brief biographical questionnaire was administered to the participants to obtain identification data about the participants, along with important contextual information that ensured they met all the selection criteria of the current study. The information gained from this questionnaire aided in contextualising the assessment data and offered a richer interpretation of assessment results. The questionnaire focused on eliciting information regarding the participant's age and gender, home language and level of schooling, along with other information regarding the participants' history of *complex childhood trauma*. This information was corroborated with the clinical information contained in their patient files.

The structured personality assessments focused on assessing the participants' basic tendencies, attributes and personality traits. According to proponents of these assessments, personality traits are internal factors that influence an individual's behaviour across a variety of contexts. These traits are considered stable across time and, accordingly, it is assumed these consistencies can be reliably assessed to

describe an individual's behaviour. These assessments also succeed in describing stable differences between people, and the accompanying behavioural implications of these differences, that can be applied to the prediction of psychopathology and other life areas (Foxcroft & Roodt, 2005). Due to the mentioned characteristics, a variety of structured assessments were included in the data collection strategy of this study. These included the Childhood Trauma Questionnaire (CTQ), the 16 Personality Factor Questionnaire Fifth Edition (16PF-5), and the Millon Clinical Multi-axial Inventory IV (MCMI-IV).

According to McAdams (1994), knowledge of stable personality traits is not enough to constitute a complete knowledge of a person. He argues that personality traits only portray a decontextualised version of an individual's general behaviour, across an array of situations and, accordingly, does not acknowledge the importance of the context in which this behaviour takes place. Trait assessment also overlooks the importance of motives, desires and aspirations that underlie behaviour. These imperative aspects of personality can only be assessed through the use of indirect methods such as projective assessments that provide access to these motives. The projective measure included in this study was the Rorschach Inkblot Test (Rorschach, 1921), specifically the Rorschach Performance Assessment System (R-PAS; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011).

In summary, four assessment measures were used in the study in order to holistically assess the participants' personality organisation:

i. The Childhood Trauma Questionnaire (CTQ; 1998).

The CTQ is a 28-item, self-report inventory, that provides a brief, yet reliable and valid screening of histories characterised by abuse and neglect. The CTQ is appropriate for use with adolescents from ages 12-years to adults. This assessment enquires about five types of maltreatment which includes emotional, physical and

sexual abuse and emotional and physical neglect. Each category includes five question items representing that scale. The CTQ also includes a Minimisation/Denial scale for detecting false or negative trauma reports. The assessment measure only takes five minutes to complete and includes a series of statements about childhood events the respondent should respond to by indicating the existence of these events on a 5-point Likert-type scale. Items are scored and summed to produce scale scores that quantify the severity of maltreatment in each of the five areas (Bernstein & Fink, 1998). After participants were assessed on the CTQ their responses were scored manually and category scores interpreted according to assessment manual guidelines. Scale scores were then interpreted according to their severity rating and included in the description of assessment results.

ii. The Rorschach Inkblot Test (R-PAS; 2011).

The Rorschach Inkblot Test (Rorschach, 1921), is a projective measure consisting of a set of 10 bilaterally symmetrical inkblots. The assessment makes use of complex stimuli structured in such a manner as to provide multiple suggestive, yet partial and imperfect perceptual reproductions, that form competing visual images, (Meyer et al., 2011).

Respondents were requested to articulate what the inkblots remind them of, by responding to the examiner's question, "What might this be?" (Groth, 2003; Meyer et al., 2011). The general aim of the technique was to assess the structure of an individual's personality by eliciting information that is implicit and may not be recognised by the respondents themselves. Accordingly, the Rorschach Inkblot Test was used as a valuable supplement to other self-report measures of personality (Meyer & Eblin, 2012). Particular emphasis was placed on how individuals construct their experience, also referred to as cognitive structuring, and the meanings they assigned to their perceptual experiences, that is their thematic imagery (Weiner, 1994). The Rorschach Inkblot Test has been shown to provide information on concepts such as an individual's motivations, response tendencies, cognitive operations, affectivity, and personal and interpersonal perceptions (Groth, 2003). It

is a behavioural task in which the testee's responses, and accompanying enacted behaviours, are believed to provide an expression of an individual's personality features (Meyer et al., 2011). In addition, the Rorschach Inkblot Test also assisted in gaining insight into the respondent's level of organisation and sophistication of information processing, problem-solving and coping style, interpersonal behaviour, representations of self and others as well as the accompanying schemas for their interactions (Meyer & Eblin, 2012).

In essence, the Rorschach Inkblot Test results yielded rich and multifaceted information with regard to the participants' functioning, or as Meyer and Eblin (2012, p. 108) describes, "*the personality in action*". It is based on the Rorschach Inkblot Test's ability to produce implicit and hidden information, outside the respondent's conscious awareness, in a rich and multifaceted fashion, that this assessment measure was included in the study. In order to overcome many of the criticisms with regard to the Rorschach Inkblot Test's validity and reliability, the Rorschach Performance Assessment System (R-PAS) was used in order to score and interpret the participants' responses.

The R-PAS (2011) is an evidenced-based internationally-oriented approach to using the inkblot task, which seeks to build on the advantages of the Rorschach Inkblot Test in assessing personality (Meyer & Eblin, 2012). It aims to enhance the psychometric foundation of the Rorschach Inkblot Test method by providing the assessment with a stronger psychometric basis (Meyer et al., 2011). It also assists in providing examiners with a more user-friendly approach to scoring, interpreting and understanding the Rorschach Inkblot Test, by using more practical terminology, symbols, calculations and data presentation methods. The R-PAS also offers a practical online scoring system, which allows novel and experienced test users to score and interpret Rorschach Inkblot Test responses with ease, while adding a more standardised approach to Rorschach assessment practices in the process. R-PAS standard scores are displayed in five domains: administration behaviours and

observations, engagement and cognitive processing, perception and thinking, stress and distress, and self and other representation (Meyer & Eblin, 2012).

After the administration of the Rorschach on the participants, the responses and clarifications gained from the participants were first coded manually using the guidelines set forth in the assessment manual. The coding done by the researcher was also verified by her one supervisor, who is a senior clinical psychologist and has extensive experience with the Rorschach Inkblot Test. Thereafter, coding was analysed electronically through the R-PAS online system to generate standardised electronic reports. The content of each participant's assessment report was then summarised according to four different categories, which literature indicated as prominent areas affected by *complex childhood trauma*. Only results which were clinically significant, deviating from the population norm, were included in the summary of these results. The personality profiles of each participant, produced as a result of the Rorschach Inkblot Test administration, can be found in the results chapter.

iii. The 16 Personality Factor Questionnaire Fifth Edition (16PF-5; 2002).

The 16PF (Cattell, 1946), has established itself as one of the most widely used assessments of normal personality worldwide (Foxcroft & Roodt, 2005). The 16PF is a useful assessment measure in applied psychology that can assist enquiry into personality structure (Cattell & Cattell, 1995). It provides a comprehensive measurement of normal range personality and has been found to be effective in a variety of settings in which an in-depth assessment of the whole person is required. However, the 16PF can also be used in a clinical setting to provide clinical insight into which personality variables underlie pathological behaviour (Cattell & Mead, 2008).

In general, the 16PF provides a multi-levelled hierarchical assessment of an individual's personality structure. Five secondary factors are provided that are a variant of the big five personality factors identified by Costa and McCrae (1992)

(Neuroticism, Extraversion, Agreeableness, Conscientiousness & Openness), which describe personality at the broader level. Sixteen primary factors are included to reveal the finer details and nuances that contribute to each person's unique character, and have been proven to be more effective in predicting behaviour (Cattell & Mead, 2008). An overview of both primary and secondary factors measured by the 16PF can be found in **Table 1**. By using both broader domains of personality description and more detailed facets to create a richer description of a person, the 16PF succeeds in offering an integrated understanding of an individual's whole personality.

The rationale for including the 16PF in the study was directly related to its ability to provide a detailed insight into the personality organisation of the respondents, which is in line with the overarching goal of this study. It also allowed the researcher to gain a better understanding into how normal personality traits are related to pathological personality characteristics. The assessment questionnaire contains 185 multiple choice items with a three-point answer format. The administration and scoring of this assessment closely followed the procedures used for the indicated test populations, as presented in the 16PF-5 manual, to ensure the guidelines of standardised testing were adhered to. Item content is non-threatening and includes questions regarding daily behaviour, interests and opinions. Respondents need to be at least 16-years of age and have attained an equivalent of a fifth-grade reading level. In addition to the 16 primary factors and five secondary factors measured, three response bias scales are also provided to assess for the validity of responses. The questionnaire does not have a time limit, but takes about 35 to 50 minutes to complete, and can be presented in either pencil and paper or computerised format (Cattell & Mead, 2008). After all the participants completed the computerised version of the 16PF questionnaire, responses were scored via electronic software to generate standardised electronic reports describing their personality profiles. Thereafter, the content of each participant's assessment report was summarised according to four different categories which literature indicated as prominent areas affected by *complex childhood trauma*. Only results which were clinically significant, deviating from the population norm, were included in the

summary of these results. The 16PF personality profiles of each participant can be found in the results chapter.

Table 1

16PF-5 Factors

16 Primary factors	Description
A: Warmth	Level of readiness to become involved with others
B: Reasoning	Measure of cognitive ability and influences expression of other traits
C: Emotional Stability	Perception of current level of coping with daily demands of life
E: Dominance	Strength of tendency to attempt to exert influence over others
F: Liveliness	Excitement seeking and spontaneity of expression
G: Rule Consciousness	Degree to which social standards of behaviour and externally imposed rules are valued and followed
H: Social Boldness	Level of ease in social situations
I: Sensitivity	The extent to which subjective feelings about issues influence judgement
L: Vigilance	Likelihood of questioning the motives behind what others say and do
M: Abstractedness	Degree of balance between attending to concrete aspects of the external environment and attending to thought processes triggered as a result
N: Privatness	Likelihood of keeping personal information private
O: Apprehension	Level of self-criticism and apprehension
Q1: Openness	Openness to new ideas and experiences
Q2: Self-reliance	Strength of tendency to want to be around people and involved in group activities

Q3: Perfectionism	Importance attached to behaving in line with clearly defined personal standards and being organised
Q4: Tension	Level of physical tension as expressed by irritability and impatience with others
Global Factors	Description
EX: Extraversion	Level of social participation
I: Independence	Degree of agreeableness or independence displayed
TM: Tough-Mindedness	Refers to level of receptivity to new ideas
SC: Self-Control	Level of restraint displayed
AX: Anxiety	Level of perturbation experienced

Notes. Adapted from Lord (2000).

iv. The Millon Clinical Multiaxial Inventory IV (MCMI-IV; 2015).

The MCMI is an objective personality assessment widely used by clinical professionals to diagnose and evaluate personality disorders and pathological syndromes within a psychiatric population. Its value lies in its theoretical underpinnings, which closely reflects the content of Millon's evolutionary theory, the brevity of its administration, structural characteristics, as well as its alignment with the DSM classification system of personality disorders (Jankowski, 2002). The MCMI-IV (2015), is the latest revision of the MCMI instrument and is based on Millon's latest research with regard to personality and pathology. The rationale for including the MCMI-IV in the test battery was not only based on its ability to offer insight into the personality-psychopathology relationship, but also its strong foundation in Millon's evolutionary theory.

The MCMI-IV expands Millon's work, done on the previous versions of the MCMI instruments, by more adequately capturing the broader range of personality, ranging from adaptive to maladaptive (Pearson, 2015). This introduces a spectrum

view of personality and results in behaviour being described on three levels, which are normal personality style, also known as generally adaptive personality patterns, abnormal personality traits, or moderately maladaptive personality attributes, and clinical disorders, in other words a likelihood of greater personality dysfunction. The MCMI-IV allows a clinician to gain a cohesive understanding of the person behind the statistics of assessment results, as the instrument offers a well-rounded balance between theory and statistics.

Administration of the assessment was done as set forth in the instructions of the MCMI-IV manual, in order to ensure the guidelines of standardised testing were adhered to. The instrument consists of true or false items that thoroughly assess clinical patterns and syndromes. The inventory yields 25 clinical scales arranged into four groups, namely: clinical personality patterns, severe personality pathology, clinical syndromes, and severe clinical syndromes. Additional scales, such as the validity index and modifying indices, which comprises a disclosure index, desirability index and debasement index, is also incorporated in order to measure a respondent's response bias (Jankowski, 2002). A list of the scales measured by the MCMI-IV is presented in **Table 2**. After participants completed the paper and pencil versions of the MCMI-IV questionnaire, responses were scored via electronic software to generate detailed yet standardised electronic reports. The content of each participant's assessment report was summarised according to four different categories, which literature indicated as prominent areas affected by *complex childhood trauma*. Only results which were clinically significant, deviating from the population norm, were included in the summary of these results. MCMI-IV results for each participant can be found in the results chapter.

Table 2*MCMI-IV Scales*

Clinical personality patterns:	Severe personality pathology:	Clinical syndromes:	Severe clinical syndromes:
Schizoid (Scale 1)	Schizotypal (Scale S)	Anxiety disorder (Scale A)	Schizophrenic Spectrum (Scale SS)
Avoidant (Scale 2A)	Borderline (Scale C)	Somatic Symptom (Scale H)	Major depression (Scale CC)
Melancholic (Scale 2B)	Paranoid (Scale P)	Bipolar Scale (Scale N)	Delusional (Scale PP)
Dependent (Scale 3)		Persistent Depression (Scale D)	
Histrionic (Scale 4)		Alcohol Use (Scale B)	
Turbulent (Scale 4B)		Drug Use (Scale T)	
Narcissistic (Scale 5)		Posttraumatic stress disorder (Scale R)	
Antisocial (Scale 6A)			
Sadistic (aggressive) (Scale 6B)			
Compulsive (Scale 7)			

Negativistic

(passive–aggressive)

(Scale 8A)

Masochistic

(self-defeating)

(Scale 8B)

Note. Adapted from Pearson (2015)

The relevance and utility of using the above assessments, in studying the relation between personality and mental illness, is seen in other studies that have employed these assessment measures in various combinations to better understand clinical phenomena. A study conducted by Brand and Lanius (2014), focused on exploring the clinical profiles of individuals diagnosed with BPD as well as dissociative disorders. They argue that studies that compare these two disorders using psychometric instruments are rare and a need exists to explore these two disorders in terms of comorbidity and shared diagnostic features. Furthermore, Brand and Lanius (2014) state research that focuses on exploring either BPD or dissociative disorders in isolation, is equally sparse; again, indicating a need for more in-depth research into the psychological profiles of these two disorders. According to these researchers, the Rorschach Inkblot Test in particular has been useful in identifying important information with regard to these disorders. In their study, Brand and Lanius (2014) explore the use of a range of personality assessments in exploring the relationship between BPD and dissociative disorders. In their study, they used the MCMI, MMPI-2, Personality Assessment Inventory (PAI) and Rorschach Inkblot Test, is explored. Their findings suggest the personality assessment profiles of BPD and dissociative disorder participants indicate that although similarities do exist, important differences with regard to personality organisation were found between BPD and Dissociative Disorder. In this regard Brand and Lanius (2014) found that individuals with Dissociative Disorders' thinking appears to be more logical, reflective, and

reality-based than that of many BPD patients. In addition, patients with BPD's interpersonal schemas were more damaged than those with Dissociative Disorders. These findings assisted in better explaining the difference between these two diagnostic categories and aids in better treatment conceptualisation. More specifically, the findings suggested that treatment of complex trauma individuals, with moderate and severe dissociation, should be conducted in such a manner that emotion regulation skills and management of dissociative symptoms be taught before any trauma processing begins. Treatment programs such as Dialectical Behaviour Therapy (DBT) was recommended in this regard to precede trauma processing. It was also shown that patients with more intense dissociative symptoms showed a poorer treatment prognosis.

In another study, Hyer, Woods, Boudenwyns, and Tamkin (1990) attempted to construct a personologic description of Post-Traumatic Stress Disorder (PTSD) through the study of a group of American military veterans who share a diagnosis of PTSD. Their study attempted to compare personality profiles, obtained from the MCMI and 16PF, in order to identify personality patterns characteristic of the participating veterans' experience of PTSD. These researchers also note that little effort has been made in prior research studies to compare the MCMI and 16PF. Their study succeeded in showing correlations exist between the 16PF and MCMI scales in conceptualising PTSD.

The combined use of the Rorschach Inkblot Test and the 16PF was explored by a study conducted by Greenwald (1991), in which the psychological adjustment of 62 university students was explored. Research findings suggested the combined use of the Rorschach and the 16PF is able to offer detailed information with regard to the prediction of university students coping ability.

An assessment of individuals who report substance abuse was conducted using the MCMI-III and the Rorschach Inkblot Test in a study conducted by Vanem, Krog and Hartmann (2008). The focus of the study was to describe the psychopathological characteristics found within the research sample of substance

abusers through the use and comparison of the MCMI-III and the Rorschach Inkblot Test. Results indicated both assessment measures identified various pathological patterns that deviated significantly from the normative population. In addition, results indicated the Rorschach Inkblot Test and MCMI-II are useful as complimentary measures in exploring patterns of psychological behaviour, as the Rorschach Inkblot Test was able to identify details of participant behaviour the MCMI-II overlooked and, in turn, the MCMI-II was able to identify certain behavioural patterns and categories of psychopathology that was not captured by the Rorschach.

The reviewed studies show the importance of using personality assessment measures in cultivating a better understanding of clinical phenomena related to various diagnoses and other psychological difficulties. In particular, the usefulness of the MCMI, 16PF and Rorschach as complementary measures of personality and psychopathology is demonstrated. These research studies also point to the utility of the MCMI, 16PF and Rorschach in exploring important clinical phenomena, and has highlighted the role examinations of personality and psychopathology plays in the cultivation of a greater understanding of various mental health phenomena as well as greatly assisting in informing treatment conceptualisation.

3.2.4. Data analysis.

The data obtained was analysed in two steps. Firstly, the raw data obtained from the individual personality assessments was scored and interpreted according to each assessment's scoring procedures, as set forth in the test manuals. In particular, the Rorschach Performance Assessment System (R-PAS) method for the scoring of the Rorschach Inkblot Test responses. Thereafter, the data was thematically analysed to identify commonalities across the various data sets.

3.2.4.1. Thematic Analysis of Test Results.

As previously stated, although quantitative assessment data formed part of the data collection, the quantitative data obtained was further analysed using thematic analysis, in order to describe the data obtained in a qualitative manner. Thematic analysis is a flexible method of qualitative data analysis developed by Virginia Braun and Victoria Clarke (2012). It is a data analysis method that allows the researcher to systematically identify and organise the data gathered into patterns of meaning that offer insight into the themes emerging across a set of data. The researcher is, thereby, allowed to make sense of the collective or shared meanings and experiences found within the data (Braun & Clarke, 2012). Thematic analysis is interpretive in nature, with the researcher at the core of identifying the patterns and themes that were focused upon, playing an active role in the selection of which patterns are regarded as interesting and which themes are reported on. In this regard, Ely, Vinz, Downing, and Anzul, (1997, p.205-6) caution researchers against the common misconception:

...that themes reside in the data, and that if we just look hard enough, they will emerge... If themes reside anywhere, they reside in our heads from our thinking about our data and creating links as we understand them.

More specifically, Braun and Clark (2012) describe thematic analysis as a method of identifying the commonalities in the way the topic is talked about and the process of making sense of those commonalties. Importantly, the patterns of meaning identified needs to be related to the particular research question and topic being explored. Thematic analysis thus allows the various research questions posed to be answered, although the exact question being answered may only become apparent as the analysis is being completed (Braun & Clarke, 2012). This is in line with qualitative research's flexible nature, in which research questions may be formulated and reformulated as the research process progresses (Pistrang & Barker,

2012). Thematic analysis can thus be described as a flexible method that allows the researcher to focus the data in various different ways. It also offers a method of analysing data systematically, which could subsequently be linked to broader theoretical or conceptual matters (Braun & Clarke, 2012).

According to Braun and Clark (2012), thematic analysis can be conducted in a number of ways. However, as a general guideline, they have outlined a six-phase approach to thematic analysis this study adhered to (see figure 1):

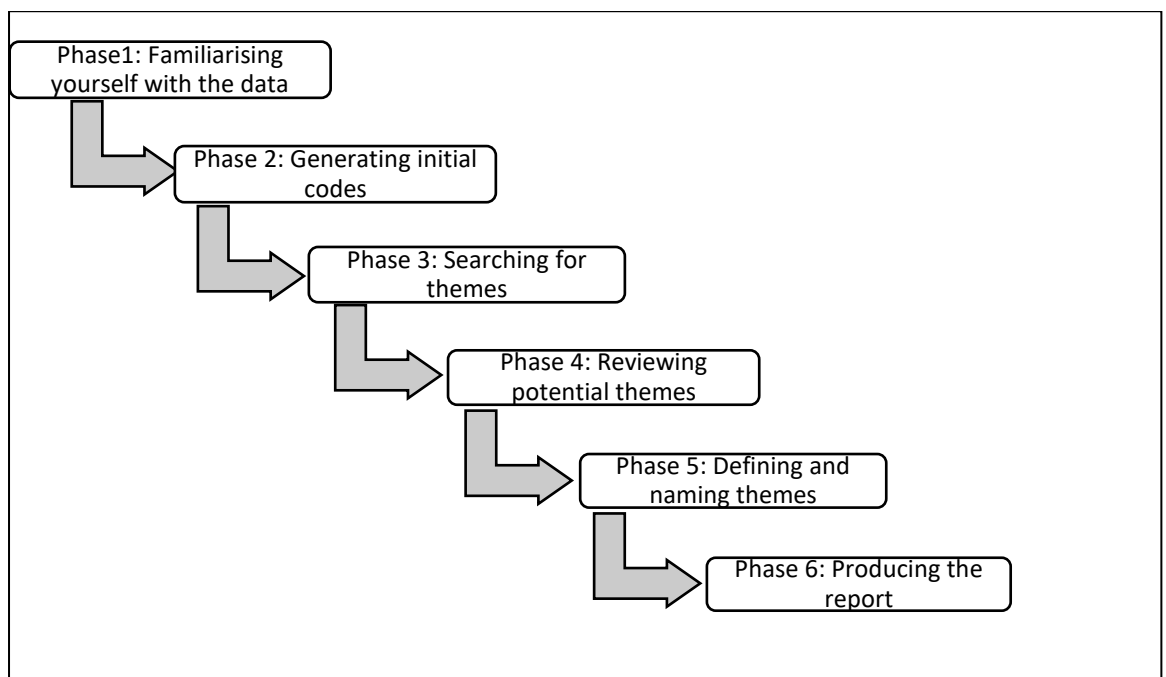


Figure 1. Braun and Clarke's (2012) thematic analysis process.

Based on the procedures outlined by Braun and Clark (2012), the study accordingly aimed to identify and organise the emerging patterns and themes found in the data obtained from the personality assessments conducted. The cases included were individually analysed for themes that emerged in the various personality assessment data collected from each participant, and collectively analysed across the various cases to identify wider patterns of meaning that emerged throughout the various cases. Numerous patterns were identified across the data obtained and coded as potential themes. As such, thematic analysis allowed the researcher to analyse meaning across the entire data set, as well as allowed for an in-depth examination of

a particular aspect (Braun & Clarke, 2012). The purpose of this analysis was to identify the relevant patterns that enabled the researcher to answer the posed research questions, and better describe and understand the phenomena studied. The emerging patterns found in the data were also compared to relevant theory and literature in order to add meaningful explanation to the themes observed. In this regard, analysis was guided by various theoretical concepts and ideas used to code and interpret the data. Although the study relied significantly on theory-driven data coding and analysis, that is a deductive strategy, both inductive analysis and deductive analysis techniques were used in coding the identified themes. According to Braun and Clark (2012, p. 59):

it is impossible to be primarily inductive, as we always bring something to the data when we analyse it, and we rarely completely ignore the semantic content of the data when we code for a particular theoretical construct – at the very least, we have to know whether it is worth coding the data for that construct.

Analysis, ultimately, involved a constant moving back and forth between the entire data set, the coded extracts of the data analysed as well as the analysis of the data that was produced. It was not a linear process, but more recursive in nature, as the researcher moved through the phases of analysis that unfolded over time (Braun & Clarke, 2012). More specifically, the following steps were taken in producing the final themes:

1. The summarised results for each participant were analysed qualitatively line by line and coded thematically.
2. The researcher relied on two techniques, as identified by Ryan and Bernard (2003) for identification of themes. *Recurring regularities*, such as the repetition of word and concepts, was the primary technique used to delineate themes (Guba 1978). In this regard, words and concepts that reoccurred within the various

assessment results for each participant, as well as between the results of all six participants were deemed as significant. The more frequently a concept reoccurred in the results, the more significant the theme was regarded to be. A secondary technique used to indicate themes was the identification of similarities and differences in the data obtained, also called the *constant comparison* method (Ryan & Bernard, 2003)

3. Repetitions, similarities and differences were colour coded based on the categories used to organise the participant results, which was identified by literature as areas of functioning significantly impacted by complex childhood trauma. These categories included: Self-image, Interpersonal Relationships, Emotional Stability, Cognitive Patterns and Behavioural Patterns. Different colours were assigned to each category.

The coded data was, thereafter, processed further using two processing techniques, *cutting and sorting* and *use of theory related data*, identified by Ryan and Bernard (2003). The *cutting and sorting technique*, was used to identify groups of coded data which are related to each other on a semantic and concept level (Lincoln & Guba, 1985). These grouping were then arranged together based on their similarity, named and regarded as themes. Further analysis within each grouping, subsequently, gave way to meta-themes and sub-themes. An additional processing technique used to delineate themes was the use of *theory related data*. In this regard, concepts found in the data were also related to theory identified in the literature review, in order to guide theme identification and grouping. The importance of including these theory-related themes specifically lay in an ability to assist the researcher in making connections between the data and the posed research questions. To avoid significant contamination of the researcher's thought and coding processes, the relevant theory was only consulted at the end of the thematic analysis process to finalise the identification of themes.

3.2.5. Data Description

Ayres, Kavanaugh and Knafl (2003) refer to within-case and across-case descriptions as a way to describe data after it has been analysed. This example was followed with detailed descriptions of each case referred to as *within-case description*, which is presented in the results chapter. In addition, to the within-case descriptions, *across-case descriptions* were also included. This was done by highlighting the similarities across the various cases in the form of qualitative themes, which are presented in the Findings and Discussion chapter. This method of description respects the uniqueness of the participants' experiences while also emphasising the cross-cutting aspects of clinical significance in this study.

3.3. Trustworthiness of Data

The trustworthiness of qualitative studies are often questioned by researchers from other schools of thought, such as positivists and proponents of the quantitative or scientific methods (Shenton, 2004). Due to qualitative research's identification with a mostly non-realist epistemology, the favoured concepts of reliability and validity found in quantitative research become difficult to apply in a simplistic manner. It should, however, be mentioned that many qualitative researchers have attempted to address this critique of the qualitative strategy by developing other strategies that parallel those found in quantitative research and opt to ensure the trustworthiness and credibility of qualitative studies (Shenton, 2004).

One such strategy is found in the work of Guba (1981), who proposed four criteria believed to enhance the pursuit of trustworthiness in qualitative data: credibility, likened to the concept of internal validity; transferability, likened to the concept of generalisability/external validity; dependability, likened to the concept of reliability; and confirmability, likened to the concept of objectivity. The study aimed to incorporate the criteria proposed by Guba throughout the process of the research in the following ways:

i. Credibility

The credibility of the study was partly ensured through the process of *data triangulation*. This involves the use of various methods of data collection. The use of these various psychometric measures acts to compensate for the individual limitations of the separate measures by taking advantage of their respective benefits (Shenton, 2004). This was primarily accomplished through the use of four different assessment measures developed to gain access to an individual's personality make-up. In addition, the comprehensive assessment battery also included both structured as well as projective assessment measures, which aided in producing objective yet detailed data of the participants' personality structures. As stated previously, the incorporation of quantitative data into case study research aids in producing a chain of evidence or an audit trail, which increased the dependability of the qualitative research (Yin, 2012). The quality and psychometric properties of the assessment measures, in themselves, also added to the overall trustworthiness of the data collected.

An additional manner in which the triangulation was achieved was through the involvement of a wide range of informants (Shenton, 2004). The reliance on a multiple case study method, as opposed to a single case study, acted as a method of including a variety of data sources and further promoted greater confidence in the study's theoretical findings (Yin, 2012). The ability of a multiple case study approach, to verify the various viewpoints of the included participants against each other, resulted in a rich picture of attitudes, needs or behaviour and, accordingly, the data obtained represented the contributions of a range of individuals as opposed to a single source (Shenton, 2004).

Credibility was further enhanced by ensuring the honesty of informants who contributed to the data collection phase through inclusion of voluntary participation, encouraging honesty of participants and establishing good rapport with all participants at the onset of the data collection phase (Shenton, 2004).

According to Shenton (2004), frequent debriefing sessions with research supervisors also assists in enhancing the credibility of the study. In this regard, the consultation of others acted to widen the vision of the investigator and incorporated the perceptions and experiences of others. The study adhered to this criterion through the inclusion of two research supervisors, who are both clinical psychologists, and oversaw and guided the investigator's research endeavours.

According to Patton (1990), the credibility of the researcher is an important factor in qualitative research due to the researcher's instrumental role in data collection and analysis. This aspect, accordingly, relates to the researcher's background, qualifications and experience. In this regard, the researcher's qualification and registration with the Health Professions Council of South Africa (HPCSA), as a Psychometrist in Independent Practice and an Intern Clinical Psychologist, aided the study in a number of ways, due to the knowledge and experience of psychological assessment and, specifically, personality assessment, gained as a result of these qualifications and accompanying assessment experience.

ii. Transferability

The transferability of the study is concerned with the degree to which the study's findings can be applied to other situations. According to Stake (1994), although each case included in case study research is unique, it may also act as an example of a broader phenomenon and, as a result, the knowledge gained might be transferable. This is supported by Yin (2012), who argues although statistical generalisation may not be possible, analytic generalisation can still be achieved with case study research.

Analytic generalisation depends on using a study's theoretical framework to establish a logic that might be applicable to other situations. Claims made in these studies are, furthermore, not represented as absolute truths but rather as a working hypothesis subject to further investigation. In this regard, the theoretical framework of the study, namely Millon's evolutionary theory of personality, was used as a base from which findings could be interpreted, and a set of relationships could be

suggested, about why the findings and data patterns occurred in the manner they did (Yin, 2012).

iii. Dependability

In order to ensure the dependability of the proposed study, the following strategies, as described by Shenton (2004), were adhered to. A detailed description of the research design and its implementation, reflecting a systematic approach to the research process, has been provided. In addition, an account of the operational detail of the data-gathering process as well as an evaluation of the effectiveness of the project and the process of enquiry that was undertaken, has been provided in the Methodology chapter, as described above.

iv. Confirmability

The concept of confirmability relates to the qualitative researcher's concern for an equivalent to quantitative research objectivity. Once more, the role of triangulation in data sources, and participants, as well as triangulation of the various assessment measures used, supervision sought and voluntary participation of participants, aimed to enhance the confirmability of the study. Although the study made use of objective assessments and test results, the interpretation of these findings could arguably be seen as one of many possible interpretations. The role of the researcher can, thus, not be overlooked in the production of these research findings. Accordingly, investigator bias has been reduced as far as possible by an acknowledgement of the researcher's own role in the produced knowledge, as well as any other predispositions the researcher potentially held (Shenton, 2004).

3.4. Ethical Considerations

The nature of psychological research renders participants vulnerable due to the private and personal information participants are asked to reveal about themselves (Babbie, 2005). Ethical clearance was accordingly sought from two ethical

committees to ensure the proposed research was carried out responsibly and the rights of participants were adequately respected.

Ethical clearance was first requested from the Unisa Ethics Review Committee (see Appendix C), thereafter, sought from the Health Sciences Research Ethics Committee (University of Pretoria; see Appendix D), which ensured ethical access to the research participants at the chosen government tertiary psychiatric hospital. Only when ethical clearance was granted by both ethical committees, was the research undertaken.

Although ethical clearance allowed the researcher to gain ethical access to the research participants, it was first necessary to liaise with a gatekeeper who could identify and gain the co-operation of the potential research participants. According to Shenton and Hayton (2004), one of the most pressing concerns for researchers conducting qualitative research, lies in gaining access to their intended sample population. In this regard, negotiating access to the research participants was dependent on building relationships with identified gatekeepers (Burgess, 1991). With the intention of gaining access to, and the co-operation of hospital staff and potential participants, use was made of a gatekeeper at the psychiatric hospital (head of department of clinical psychology), where data collection took place. To address the concern of gaining access to participants, the researcher identified important gatekeepers (mental health professionals) at the psychiatric hospital for data collection. Contact was then made with these gatekeepers to inform them of the purpose of the study and to determine the possibility of accessing participants at their hospital. In particular, the Head of the Psychology Department at the psychiatric hospital was contacted, and feasibility of the study at the institution was deemed possible and provided written permission for the study to take place (See Appendix E).

Due to the sensitive nature of the information required by the study, it was deemed best if each potential participant's personal clinical psychologist act as a liaison between patients who volunteer for the research study and the researcher. In

this regard, the researcher provided the various clinical psychologists, treating female patients with the diagnosis of BPD, with a list of the participant selection criteria. The patient's individual clinical psychologists, ultimately, took responsibility for recruiting potential participants and informing the researcher of willing participants. This was carried out in the following way: upon identifying potential participants, who met the selection criteria, the clinical psychologist presented the patient with a *proforma* information letter, which informed all potential participants of the purpose and process of the research study. Only once the participants agreed to participate in the research process, and were willing to disclose their identity to the researcher, did the clinical psychologists involved communicate the possible participants to the researcher. The researcher only approached potential participants after they had agreed to be approached by the researcher. In addition, to safeguard participants' rights, with regard to research participation, the following ethical guidelines were adhered to:

3.4.1. Non-maleficence.

The researcher took the necessary steps to ensure no harm came to any of the participants in the study (Gravetter & Forzano, 2009). This was accomplished by treating participants in a respectful and sensitive manner, building rapport, as well as interacting with participants in an open, honest and transparent manner, with regard to the research process. Due to the possibility that assessment material contained sensitive content, the researcher took the necessary steps to ensure participants had access to debriefing while taking part in the study.

3.4.2. Informed Consent.

Informed consent was obtained from all participants prior to commencement of the study, in a language that was understandable to those involved. A consent form was given to all participants which contained the following information (Gravetter & Forzano, 2009):

- The purpose of the research study, expected duration and procedures to be followed during the research process.
- The participant's right to decline participation in the research and right to withdraw from the study without suffering any negative consequences.
- Any prospective research benefits or risk factors involved in their participation. The benefits of participating in the study included that the participants would gain a deeper understanding of their personality dynamics, in the form of assessment reports, shared with their treating clinical psychologist. This could be incorporated into their therapy process, at their request. Potential risk factors of participating in the study included, the emotional impact sharing sensitive trauma-related information with the researcher would have on participants' emotional state at the time.
- Any limits to the study's confidentiality, which included the sharing of participant information with the researcher's supervisors as part of the research process.
- Details of a contact person for further information or questions regarding the research.

These details were also communicated to the participants verbally and an opportunity was provided for participants to ask any questions regarding the study. A copy of the consent form can be found in Appendix F. All participants were requested to read and sign the consent form before they participated in the study.

3.4.3. Privacy and Confidentiality.

The researcher ensured participants' confidential information was adequately protected. Confidential information was only shared with other professional individuals directly concerned with the study for academic and professional purposes, and done so with the consent of the participants. Any limits to this confidentiality in this regard were also discussed with the participants. To ensure anonymity of participants, a coding system was used to identify participants in the research study. A

code number was assigned to each participant, which aided in reconnecting participants with results when needed; specifically, should they wish to have their results shared with their treating clinical psychologist.

3.4.4. Record-keeping.

All records of participant information, assessment results and analysis of data, will be stored securely for a time period of six years as stipulated by the South African Health Professions Act (Act no 56 of 1974), in order to enhance confidentiality. In addition, this will ensure transparency in the data collection process and allow for possible replication of the research study if needed (Gravetter & Forzano, 2009).

Chapter 4. Results

Investigating the manner in which *complex childhood trauma* influences and shapes the personality of the trauma survivor is a complex endeavour in itself. Since personality organisation is made up of a vast array of facets, it becomes difficult to decide which facets to measure and to discuss when exploring the interaction between these two aspects. The females who participated in this study opened up about their traumatic childhood experiences, and revealed the inner workings of their personality, by completing several carefully selected personality assessments. The significant quantitative findings of the various assessments are presented for each participant in this chapter. These results are followed by the qualitative themes that emerged from further interpretation of the assessment data. The chapter concludes with a summary of the most salient themes and sub-themes found in the data gathered from all the participants.

4.1. Participant A

Participant A is a 26-year-old African, English-speaking, female who was admitted to the tertiary psychiatric hospital due to her feeling suicidal and struggling with Major Depressive Disorder (MDD). She also reported experiencing symptoms of social phobia and having severe difficulty with interpersonal relationships due to a lack of trust. She explained she doesn't let anyone come close enough to her to form a relationship. This resulted in her feeling lonely and isolated from others, which worsened her MDD. Frequent anger outbursts and seething hostility and irritability further characterised her behaviour.

She indicated she was still haunted by her childhood and she believed this was the reason for experiencing these current difficulties. During her admission at the tertiary psychiatric hospital she was diagnosed with MDD as well as BPD. Although not formally diagnosed with an anxiety disorder, she frequently complained of debilitating anxiety and a low self-esteem, which has resulted in her withdrawing

from most daily activities, ultimately, leading to her being financially dependent on her mother and sister. The lack of independence was also reported as a cause of severe distress, describing herself as being stuck in her current circumstances.

Regarding her childhood, Participant A described a longstanding history of verbal, physical and emotional abuse by various individuals in her life throughout most of her childhood. She described the verbal and physical abuse she received from her father, as well as her witnessing his bouts of physical violence directed toward her mother and sister, as particularly traumatising. She specifically recalled an incident where she witnessed her father chasing her sister around the house at gunpoint. Fearing for her, and her sister's life, she described the image as permanently etched into her mind. She also recalled the constant criticism and described overly harsh punishment she received from him. Not only did she feel abused by her father, but also felt abandoned by him when he left her, her mother, and her siblings to care for themselves, when he moved to another country.

As an adolescent, she also experienced an incident of attempted rape. She recalled this as especially traumatic, as no one took her seriously when she tried to talk to her significant others regarding the incident. As a result, she recalled feeling isolated and alone. She also recalled a time during her childhood when she was abused by the family domestic worker, and recollected an event in which the domestic worker attempted to drown her in the bath while washing her hair. Her accounts of these childhood traumas were characterised by multiple instances of betrayal of her trust, and a lack of support and connection with significant others, to assist her in dealing with these traumas. These themes still currently pervade her view of the world.

4.1.1. Participant A assessment results.

4.1.1.1 The Child Trauma Questionnaire (CTQ).

Results of the CTQ indicated that Participant A's childhood trauma falls mostly within four categories, these include severe levels of emotional and physical

abuse, emotional and physical neglect. Results also indicated that she experienced a level of sexual abuse, as some elements of sexual abuse were present.

4.1.1.2. The 16 Personality Factor Questionnaire-Fifth Edition (16PF5).

a. Self-image.

Results indicated that Participant A had an overly negative view of herself. She regards herself as inept and, as a result, is highly critical of herself. Due to her tendency to view herself as incompetent, she also possesses high levels of self-doubt, which leads to uncertainty and inner conflict in most situations.

b. Interpersonal relationships.

Overall, Participant A displayed a preference for distant interpersonal relationships. She is likely to remain detached and withdrawn from others and may come across as serious and restrained in interpersonal dealings. She values privacy in her interactions with others and, as a result, will be hesitant to share personal details of her life, which could hamper any attempts at interpersonal connection. Likewise, she is unlikely to express her needs or any form of disagreement, which could increase her dissatisfaction in interacting with others. She is prone to avoid conflict at all costs and, accordingly, prefers to remain interpersonally submissive. She is also sensitive to criticism, which she might misinterpret as possible conflict, and which acts to reinforce her negative view of self. Overall, she is shy and timid in interpersonal exchanges, which is also a likely reflection of poor self-image. She generally does not trust others and questions others' motives. This lack of trust likely underlies her withdrawn and distant nature. Her lack of trust also results in her being overly self-reliant and attempting to solve problems on her own, not asking for, or accepting assistance when needed.

c. Emotional stability.

With regard to Participant A's emotional stability, it was found she generally lacks self-control and is likely to follow her impulses at the expense of responsibility

and other's needs. She was described as generally unrestrained and impulsive. Results further indicated she is expedient and likely to break rules and reject convention. She is reportedly tense and restless most of the time and easily becomes impatient and frustrated. This leads to an increased amount of 'acting out' behaviour and a lack of emotional control. Results indicated she experiences a pervasive level of anxiety and has a characteristic style of worry in most situations.

d. Cognitive and behavioural patterns.

Participant A's results indicated a high level of cognitive rigidity. In this regard, it was found that she is generally not open to change or new ideas and prefers familiar situations that create a sense of safety and comfort for her. As such, she may experience difficulty in adapting to new situations and is likely to experience any form of change as stressful. In addition, results indicated she is easily overwhelmed by life-stress and, generally, feels unable to meet life's demands and everyday challenges. These tendencies are likely to greatly impact her ability to adequately function in everyday life.

4.1.1.3. The Millon Multiaxial Clinical Inventory-IV (MCMI-IV).

a. Self-image.

Results of the MCMI-IV indicated that Participant A has an uncertain self-image. She generally regards herself as inept and has deficit self-confidence. She likely views herself as weak, inadequate and fragile, and as a result harbours feeling of self-pity. Not only does she possess a negative self-image, but she also further belittles her own abilities. In this regard, it was found she is self-condemning on most occasions, falters toward self-defeating acts and courts blame and criticism. Results further suggested she is likely to look for situations where she can suffer, which further reinforces her negative view of self. Lastly, it was found she lacks much needed internal consistency and cohesion, which can lead to a wavering sense of self and result in inconsistent behaviour and emotions.

b. Interpersonal relationships.

Participant A's results indicated a significant amount of instability in interpersonal relationships. Her approach in relationships is likely to involve her vacillating between being agreeable and being passive aggressive. On the one hand, she can be experienced as submissive and co-operative, with high needs for interpersonal dependence and a manoeuvring for closeness to secure the needed nurturance. On the other hand, she may display periods of petulance and irritability, and attempt to keep others at a distance. The unpredictability of her push-and-pull pattern of interaction with others, may cause a great amount of confusion in relationships and ultimately results in alienation from others. The reaction she receives from others, due to her wavering interactional style, further results in her feeling misunderstood and isolated. Underlying her interpersonal style is likely an anticipation for disillusionment and disappointment, which she inadvertently creates by questioning other's motives and testing their genuineness.

c. Emotional Stability.

Participant A's results indicated she struggles to regulate her emotional controls, which results in erratic moodiness and a labile temperament. Various signs of depression were indicated, which include a diminished capacity for pleasure, feelings of worthlessness, an absence of confidence, a pessimistic attitude and suicidal ideation. Indications of low self-esteem were present along with feelings of emptiness and loneliness. A pervasive sense of guilt and unworthiness seems to further characterise her depression. Results further indicated she tends to suppress the anger she feels and turn it inward. This acts to deepen her dysphoric features and depression. As a defence against the depressive feelings she possesses, results indicated she utilises periods of hypomanic excitement and physical hyperactivity to nullify the upsurge of painful thoughts and feelings she cannot otherwise deny. She also displayed a significant level of anxiety, characterised by physical symptoms, such as panic attacks and agoraphobia, as well as generalised anxiety in which she expects the worst to happen in most situations. Results further indicated she is

plagued by anxiety ridden and painful memories, which are reactivated by minor social stressors.

d. Cognitive and behavioural patterns.

Various indications of unpredictability and wavering behaviour were found throughout the MCMI–IV results of Participant A. Additionally, it was found she is overly passive with regard to life responsibilities and, additionally, lacks personal agency and healthy self-assertion. Results indicated she generally avoids adult responsibilities and displays few functional competencies. This avoidance of engagement in everyday life responsibility and activities, further necessitates dependency on significant others and places a large amount of strain on personal relationships.

e. Possible DSM–5 diagnoses.

The following DSM diagnoses were offered based on the MCMI–IV results:

- Dependent Personality Disorder;
- Avoidant Personality Disorder;
- Borderline Personality Disorder;
- Unspecified Personality Disorder – Masochistic type;
- Major Depressive Disorder;
- Generalised Anxiety Disorder; and
- Bipolar I Disorder.

4.1.1.4. The Rorschach Inkblot Test (R-PAS).

a. Self-image.

Participant A's responses indicated she possesses a negative view of herself. In this regard, she identifies with being damaged, flawed and harmed by life and external events. Results further indicated she has an ineffective understanding of

herself and lacks the self-knowledge and awareness needed for psychological growth.

b. Interpersonal relationships.

Participant A's interpersonal relationships seem to be characterised by an overly simplistic view of others. More specifically, she experiences difficulty in understanding other people as complex, complete and multifaceted individuals. This view leads to a faulty perception of others and complicates interpersonal relationships. In addition, it was also found she does not view relationships as supportive and expects malevolence from others. As a result, she is generally vigilant and wary toward others, and overly aware of signs of potential threat. Accordingly, she prefers to maintain a high degree of interpersonal distance in order to protect herself from expected harm.

c. Emotional stability.

Participant A's results indicated she tends to react spontaneously to emotions and is prone to affectively driven and impulsive behaviour. Various indications of emotional distress were also found in her responses. In this regard, it was found she tends to foster a dysphoric and negative view of the world and displays an elevated risk for suicide and self-harm. Elevated levels of aggression were also found in her responses, which indicated she identifies with power.

d. Cognitive and behavioural patterns.

Widespread cognitive difficulties were indicated in Participant A's responses. Overall, a wavering cognitive processing style was found. In this regard, she may at times show mature executive functioning and cognitive processing, yet at other times, tend to engage in overly simplistic processing and refrain from reasoning before she acts. Results indicated this inconsistency in her cognitive style is largely due to her high levels of emotional reactivity, in that her cognition is highly influenced by her emotional state at the time. This results in high levels of unpredictability and irregularity. It was also shown she tends to engage in less

effective problem solving and typically utilises trial-and-error reasoning when approaching problems. She is also prone to an overly vigilant and inflexible information processing style, which also complicates her functioning. As a result, she may have difficulty navigating everyday challenges and may experience coping difficulties. Results further indicated that she shows problematic over productivity at times and may lack inhibitory control. Likewise, she is prone to obsessive thinking and impulsive behaviour. Of greater concern is her displayed difficulty in thinking clearly and perceiving her environment accurately. This is indicative of difficulty with reality testing. She also tends to display disorganised and illogical thinking, which combined with her reality testing difficulties, may dispose her to be vulnerable to psychotic episodes.

4.2. Participant B

Participant B is a 31-year-old Indian, English-speaking female, who sought treatment at the psychiatric hospital due to her inability to regulate her emotions, which she described as “rapidly fluctuating”. She indicated she felt irritable most of the time and had frequent anger outbursts. She went on to mention her difficulty in remaining emotionally stable has negatively impacted her relationships with others and causes her distress. She indicated gaining control of her emotions was her primary goal in therapy. Since she could remember, she recalled experiencing childhood abuse and indicated she still feels abused, in some ways, by her family members. She recounted experiencing various instances of sexual, physical and emotional abuse as well as physical and emotional neglect, all of which was by family members, particularly her parents. Participant B indicated that she never felt wanted, that she was left alone at home daily since the age of seven years old and had to move around a lot after her mother passed away.

Participant B also recalled multiple instances of sexual abuse, particularly where she was forced to engage in sexual activities with her brother and her uncle. She also stated her parents exposed her to sexual content from a young age in the

form of sexual videos, and that her parents also had sexual intercourse in front of her on various occasions. The physical abuse she received from her father resulted in her fearing for her life. In this regard, she recalled an instance during her childhood where her father tied her to a cupboard and threatened her with a knife. She indicated that not only had most family members abused her in some way during her childhood, but she still regards them as extremely critical of her. This has led to her feeling detached from her family and others around her, with her fiancé as the only person she feels she can truly trust.

During an admission at the psychiatric hospital, she was diagnosed with BPD. Currently, she described low self-esteem, her labile emotions and generally high levels of anxiety, as her primary concern.

4.2.1. Participant B assessment results.

4.2.1.1. The Child Trauma Questionnaire (CTQ).

Results of the CTQ indicated that Participant B's childhood trauma is spread across the five categories of abuse and neglect. Results indicated she experienced extreme levels of emotional abuse and physical abuse. Severe levels of emotional neglect were also present. Results also indicated she experienced moderate levels of sexual abuse and physical abuse.

4.2.1.2. The 16 Personality Factor Questionnaire-Fifth Edition (16PF5).

a. Self-image.

Results of the 16PF5 indicated Participant B's self-image is plagued by self-doubt. She is unsure of her own abilities and feelings and, as a result, prefers to keep to herself and not expose herself to any situation where there is potential for criticism. Additionally, she will also hesitate to express her feelings and needs, due to her insecurity and lack of confidence. Her insecure view of herself in turn negatively impacts various other areas of her functioning.

b. Interpersonal Relationships.

Due to low levels of self-esteem Participant B is likely to be timid and shy in interpersonal dealings. In general, she prefers to avoid interaction with others and may struggle to form close attachments in relationships. She is likely to be experienced as restrained and serious when interacting with others, which serves as another way to create interpersonal distance. When interacting with others, she can be expected to be submissive and accommodating, conforming to the needs and standards of others. Although this could aid relationship formation, it may lead to her own needs and standards being neglected and overlooked. Although she generally will tend to defer her own needs, and be shy in interpersonal interactions, results also indicated she has an equal tendency to be forthright when disclosing personal matters and to be genuine in interactions. The combination of these two aspects could likely indicate a lack of appropriate interpersonal boundaries and result in her being vulnerable to exploitation by others.

Results further indicated she has trouble trusting others and is vigilant in interpersonal relationships, questioning the motives of others. As a result, she also prefers to be self-reliant and not ask for help when needed.

c. Emotional stability.

Emotionally it was found Participant B possesses a tendency to be reactive and overly rely on emotions when making decisions. Results further indicated her levels of self-control and self-discipline tend to waver, resulting in periods of impulsive behaviour. She possesses a typical style of worry and unease, which characterises her existence. In general, she can be expected to feel tense and restless with high levels of permeant anxiety. Frustration and irritation are also experienced and displayed on a regular basis.

d. Cognitive and behavioural patterns.

Results indicated Participant B displays characteristics of cognitive rigidity. In this regard, she is not open to change and new experiences and prefers familiarity, due to a general difficulty to adapt to new circumstances. She can be expected to be rule-conscious and cautious in most situations. Results also indicated she often feels overwhelmed by life's challenges and demands and, as a result, may struggle to deal with everyday life-stress. This will likely negatively impact her ability to adequately function in everyday life.

4.2.1.3. The Millon Multiaxial Clinical Inventory-IV (MCMI-IV).

a. Self-image.

Overall, the MCMI-IV results indicated that Participant B possesses a negative self-image, which is characterised by insecurity and feelings of inadequacy and self-consciousness. Due to a poor self-image, it was found that she is also likely to experience marked periods of self-pity. Her profile, further, indicated a lack of internal cohesion as well as marked incongruency and a lack of consistency. This will likely result in wavering behaviour and interactions with others. Furthermore, she experiences identity confusion at times, which also impacts multiple areas of her functioning. Results further indicated she thinks poorly of her abilities and has a general tendency to devalue her achievements. In addition, she is also likely to perpetuate this negative view of herself by engaging in self-defeating and self-sabotaging behaviour.

b. Interpersonal relationships.

Participant B's MCMI-IV profile indicated a general sense of social anxiety. Results further indicated she is likely to be unpredictable in interpersonal relationships and vacillates between the extremes of seeking closeness with others, and withdrawing interpersonally and manoeuvring for distance. On the one hand, it was found she displays a marked degree of dependence in interpersonal relationships; seeking nurturance, constant reassurance and security from others by

being submissive and self-sacrificing. This need for dependence results in her allowing others to exploit her and perpetuates harmful relationships that foster and aggravate her misery. On the other hand, she may at times withdraw from relationships and become passive aggressive toward others, likely brought on by her perception of being abandoned by others when they fail to meet her needs for nurturance and constant reassurance. Her wavering approach to interactions with others may result in confusion in others and, ultimately, avoidance by others. This lack of healthy relationships finally leads to feelings of loneliness and isolation.

c. Emotional stability.

Results indicated that Participant B experiences grave emotional instability. Multiple indications of chronic depression were found characterised by pessimism, inappropriate guilt and suicidal thoughts. In addition, a tendency to experience pervasive and severe generalised anxiety was also found. In this regard, she is likely to be experienced as restless and tense and may report generally feeling fearful. Periods of irritability and feeling on edge is also likely, as well as being easily distracted.

Her emotional symptoms may also be expressed in the form of somatic complaints, which likely develop in response to her attempts to suppress these emotions. In this regard, her profile indicated she may attempt to avoid painful thoughts and feelings through engaging in periods of increased activity as a defence.

It should, however, be mentioned that she vacillates between avoiding all emotions and experiencing and expressing all the intense emotions that overwhelm her simultaneously. This wavering approach to emotional expression results in a general inability to stabilise her emotions and marked emotional lability.

d. Cognitive and behavioural patterns.

Overall, Participant B's emotional difficulties result in her being unable to function adequately in everyday life. Results indicated she struggles to cope with life's demands and, due to her lack of confidence in her own abilities, cannot bear ordinary life stressors. This results in her becoming passive and lacking personal

agency. Furthermore, results have shown she may attempt to avoid adult responsibility by regressing in functioning, when placed under severe stress, and may lose touch with reality and display signs of psychosis.

e. Possible DSM-5 diagnoses.

The following DSM diagnoses were offered based on the MCMI-IV results:

- Avoidant Personality Disorder;
- Borderline Personality Disorder;
- Unspecified personality Disorder Melancholic type;
- Unspecified personality Disorder Masochistic type;
- Generalised Anxiety Disorder; and
- Bipolar I Disorder

4.2.1.4. The Rorschach Inkblot Test (R-PAS).

a. Self-image.

Results indicated Participant B generally feels helpless and insecure. Her responses further indicated she views herself as damaged, flawed and harmed by life and external circumstances. Multiple indications of a past trauma were found, which negatively impacts her view of herself and her world.

b. Interpersonal relationships.

With regard to Participant B's interpersonal dealings, ambivalent findings were indicated. Results showed she has the potential to experience healthy interpersonal relationships and possesses the interpersonal skills needed to enjoy rewarding interpersonal interactions. In this regard, she can be expected to strive toward pleasing others and having positive interpersonal exchanges. It should, however, be mentioned that results also, paradoxically, indicated she displays strong

tendencies to be overly cautious, vigilant and guarded toward others, which could create interpersonal distance and deter the formation of relationships.

Results also indicated she is likely to misunderstand others and have misconceptions of people, possibly due to her low levels of trust. She is also likely to react defensively in her interactions with others and may tend to expect challenges from others and respond with a self-justifying reaction.

c. Emotional stability.

Results indicated Participant B wavers between experiencing both positive and negative emotions. Although prone to displays of mixed affective experiences, it was found her negative feelings tend to compromise her positive feelings and enjoyment. Due to her experiences of emotional ambivalence, she may tend to inhibit spontaneous emotional reactions, in an attempt to avoid uncomfortable, vulnerable and distressing consequences. Furthermore, results went on to show she also possesses poor psychological boundaries and may lack external censorship. She may also struggle to manage internal experiences, which may overwhelm her at times. Indications of overall poor emotional control were present. In this regard, it was found she tends to be affectively driven, internally preoccupied and distracted, and prone to be flooded by affect, which results in hasty, changeable and reactive behaviour. In addition, signs of disinhibition and poor inhibitory controls were also present. It was found that she is highly influenced by situational stressors, which intensifies her emotional upset, and leads to impulsive, unpredictable and unstable behaviour. She may also tend to be overly aware and sensitive, which can lead to her experiencing considerable distress, anxiousness, irritation, dysphoria, loneliness and helplessness.

In general, she is prone to experiencing a depressed mood and possesses a dysphoric and negative view of the world. She is also prone to an increased risk of suicide and self-harm. Results indicated she may easily feel overwhelmed, depleted and depressed and may tend to shut down emotionally when her coping mechanisms are exceeded. It should also be mentioned that results indicated she has a paucity of

psychological resources to aid coping and, as a result, may be less resilient than others. She also experiences increased anxiety and agitation. This may lead to self-defeating rumination, obsessive and vigilant behaviour. Her anxious insecurity may further be accompanied by signs of dissociation in times of perceived stress. Her high levels of anxiety may also lead to hypomanic overactivity, which is likely employed as a defence during times she feels highly self-conscious and anxious. Although she may generally tend to be agreeable, results also indicated she is prone to aggressive ideation and fosters an acceptance of aggression.

d. Cognitive and behavioural patterns.

Participant B's results indicated that she demonstrates intelligent and sophisticated cognitive functions. Although this can be seen as a strength, it was also found she displays high levels of complexity in her thinking, which could interfere with her cognitive processing. In this regard, she showed an inability to allow things to be uncomplicated, which leads to her ideas and behaviour becoming overly complex and difficult to understand. As a result, she may display poorly controlled ideas and may show poor perceptual accuracy, and struggle to think clearly and logically. This manner of processing information may compromise her everyday functioning.

She is equally prone to be overly sensitive and highly aware of her external and internal environment. This, too, may interfere with her coping and adaptation. Due to her high levels of sensitivity, she may also struggle to make benign interpretations of emotional events, which could lead to frequent misunderstandings and a display of irrational reactions.

Results further indicated she experiences difficulty with accurate thinking, logic and reasoning; and, accordingly, is likely to exhibit immature and ineffective reasoning. She is also prone to embellish experiences in fantasy and projection, and may be overly imaginative at times, to the point where she could lose touch with reality. Accordingly, she might be disposed to psychotic-like episodes and delusional thinking.

Finally, it should be mentioned that her manner of thinking leads to a high degree of indecisiveness and, at times, results in her displaying a problematic sense of personal agency and a lack of purposeful action.

4.3. Participant C

Participant C, a 22-year-old Caucasian, English-speaking female, was admitted to the psychiatric hospital due to a longstanding history of depression, self-mutilation and various suicide attempts.

During admission, she was experienced as severely depressed and described herself as feeling depressed since she was very young. She conveyed feelings of hopelessness and that she no longer wishes to live her life with all the painful emotions she experiences daily. She had a lack of motivation and energy and stated she has lost faith in mental health care professionals, as she has been feeling depressed for most of her life. Nevertheless, she indicated she desperately wants to get better and would like to make use of the psychotherapy, admission provides. She also had a history of marked impulsivity, instability in relationships, and significant substance abuse, as well as high levels of anxiety. During admission, she was diagnosed with BPD as well as Persistent Depressive Disorder, due to the symptoms she was presenting with.

She described a childhood characterised by extreme neglect; indicated she does not have much contact with her family; and she had nowhere to stay, as no family member was willing to care for her any longer. She further described experiencing verbal, emotional, physical and sexual abuse from the age of five-years-old, which she reported as still experiencing at the time of admission. She indicated the various types of abuse were perpetrated by family members and close friends.

She described her father as physically, verbally and emotionally abusive. She recalled he would hit her frequently and she always felt fearful of him. In addition,

she mentioned he would tell her that he does not want her as his child and made her admit to things she did not do, or face physical punishment. When 19-years-old her father died, leaving her with no one to take care of her. Although she was fearful of her father, she mentioned that she felt abandoned by him after his death. She described her mother as abandoning her when she was 12-years-old and described their relationship as inconsistent for the most part, characterised by long periods without any contact.

The sexual abuse experienced during childhood was described as repetitive, committed by various family members. She also recounted an instance where one of her friends sexually abused her. At the time of admission, she reported still experiencing physical and emotional abuse by her boyfriend with whom she had a volatile and instable relationship.

Participant C was admitted at the psychiatric hospital for a lengthy period and continued to struggle with severe depression, impulsivity and substance abuse as well as anxiety, which continued to plague her after discharge. Several months after discharge it was reported she had committed suicide.

4.3.1. Participant C assessment results.

4.3.1.1. The Child Trauma Questionnaire (CTQ).

Participant C reported experiencing trauma in all five of the CTQ trauma categories. Extreme levels of emotional abuse, physical abuse and emotional neglect were reported. Severe levels of sexual abuse were also found along with moderate levels of physical neglect.

4.3.1.2. The 16 Personality Factor Questionnaire–Fifth Edition (16PF5).

a. Self-image.

Results indicated Participant C had an inept self-image. She, generally, viewed herself as inadequate and incapable. As a result, she frequently doubted

herself, which complicated decision making and problem solving. Her feelings of inadequacy resulted in low self-esteem, which negatively impacted various other facets of her life.

b. Interpersonal relationships.

With regard to Participant C's dealings with others, it was found she tended to be interpersonally serious and restrained. In general, she showed a strong preference for introversion, which resulted in her being more oriented toward her inner thoughts and feelings, than focus on the external world and people. As a result, she tended to avoid interaction with others and preferred to remain interpersonally detached and withdrawn.

Results further indicated she had a deep mistrust of others and would vigilantly question others' motives. Accordingly, she attempted to be exceedingly self-reliant and abstained from asking others for assistance when facing life difficulties. This, however, resulted in her becoming isolated and lacking needed support. Although she was mistrustful of others, results did, however, indicate she would try to avoid conflict by being overly accommodating.,

Paradoxically, results also indicated she would tend to be open and readily talk about personal matters, which is in contrast with her tendency to be vigilant around others. This could, however, indicate difficulty with setting appropriate boundaries, with her vacillating between rigid boundaries that do not allow others close, on the one hand, and open boundaries where she shares too much of herself and opens herself up to possible exploitation by others. This pattern ultimately results in a wavering approach to interpersonal relationships.

c. Emotional stability.

Results indicated Participant C tended to be emotionally reactive, which resulted in her being easily influenced by her emotions when making decisions. It was also found she experienced high levels of frustration and impatience and was restless most of the time. High levels of anxiety were also found, characterised by apprehension, worry, unease and permeant feelings of tension. Her lack of emotional

stability likely led to her being unpredictable and negatively influenced her functioning in everyday life.

d. Cognitive and behavioural patterns.

Analysis of Participant C's 16PF5 profile indicated she could be inflexible at times and reviled change. In this regard, she was generally hesitant to try new ideas and preferred the familiar. Change was experienced as highly stressful and exacerbated by her tendency to feel incapable of meeting life's demands and challenges. Results further indicated an abstract thinking style, which complicated problem solving at times. In this regard, she tended to be overly imaginative and frequently overlooked pragmatic issues when making life decisions. This style of thinking acted to increase the possibility of disappointment and failure and reinforced her inept view of herself.

4.3.1.3. The Millon Multiaxial Clinical Inventory-IV (MCMI-IV).

a. Self-image.

The MCMI-IV results indicated Participant C regarded herself as negative and depraved, with a severely low self-esteem. As a result, she tended to view herself as deserving of suffering and possessed a chronic self-defeating attitude. These negative feelings toward herself led to her engaging in self-defeating and self-debasing acts, in which she would sabotage any possibility at experiencing pleasure. Viewing her life as mostly negative and hopeless, she tended toward self-pity. Her lack of internal cohesion further led to a wavering sense of self, and unpredictability in behaviour and relationships.

b. Interpersonal relationships.

Participant C's interpersonal relationships were characterised by a tendency to waver unpredictability. She would tend to vacillate between the extremes of being socially agreeable and being sullen, aggrieved and despondent. On the one hand, she demonstrated marked dependency needs, which would lead to anxiously seeking reassurance. She also had an intense fear of separation from those who offered

support and would be overly compliant and self-sacrificing to obtain approval and sustenance from others. In this regard, she would frequently place herself in demeaning positions and go to the extreme of searching for situations where she could occupy the role of a martyr. These tendencies would later be contrasted by complaints of being treated unfairly, despite her efforts to search for opportunities in which she could undermine herself. She would also tend to undo the efforts of others to help her and provoke rejection. This resulted in her alienating those she depended on.

Because she anticipated disillusionment in relationships, she would inadvertently behave in such a manner as to create the expected disappointment. As a result, she would end up feeling misunderstood and treated unjustly by others. She also possessed the tendency to criticise others, yet envy them, all of which acted to create immense distance from others and feelings of loneliness. Realising she might have violated too many boundaries, she would express guilt and self-condemnation in a hope of regaining the much-needed support. This push-and-pull dynamic, which characterised her interpersonal dealings, acted to create much uncertainty, instability and turmoil in her relationships.

c. Emotional stability.

Results indicated Participant C frequently experienced periods of marked emotional dysfunction, characterised by moodiness, frustration and irritability. She was also prone to episodes of obstructive anger. Various indications of prolonged depressed moods were found, which indicated the presence of a Persistent Depressive Disorder. Her depressed mood was characterised by feelings of emptiness and loneliness, as well as assertions of guilt and unworthiness. In general, she displayed a diminished capacity for pleasure and a pessimistic outlook on life, in which she believed nothing will ever work out well for her. She also, controversially reported experiencing pain as pleasure, which further reinforced her depressed mood. The inability to control her sorrowful state amounted to recurrent suicidal thoughts and behaviours.

She frequently experienced periods of marked anxiety, indicative of severe Generalised Anxiety Disorder. Results indicated her anxiety was likely characterised by restlessness, edginess and distractibility, which coexisted with somatic symptoms of insomnia and exhaustion. Signs of a somatic disorder were also present, which likely provided an outlet to the anger and emotional turmoil she attempted to keep internalised. As a means of managing these overwhelming emotions, she reported turning to substance abuse as a coping mechanism. It should also be mentioned that results indicated that she would utilise periods of hypomanic excitement as a means to distract from, and nullify, her painful thoughts and feelings she could not otherwise escape. Multiple signs of a past trauma and accompanying Post Traumatic Stress Disorder (PTSD) symptoms were present, which likely underlie all her symptomatology.

d. Cognitive and behavioural patterns.

Participant C's assessment profile indicated she was prone to experiencing episodes of cognitive and behavioural dysfunction. Her behaviour could be expected to waver unpredictably, with periods of displayed oppositional behaviour and an overall tendency to complain about her circumstances. Results also indicated she displayed few functional competencies, which negatively impacted her everyday life. In general, she would tend to be docile and passive, avoiding self-assertion and lacking in personal agency. In this regard, results indicated she tended to withdraw from adult responsibilities and frequently acted in a child-like manner. It was found that she would regularly manifest procrastination, purposeful inefficiency and obstinate behaviour, which inadvertently assisted her in remaining dependent on others. Although unhappy with her circumstances, her assessment profile showed she did not seek to improve herself in any way and her behaviour sabotaged any opportunity for change.

e. Possible DSM-5 diagnoses.

The following DSM diagnoses were offered based on the MCMI-IV results:

- Dependent Personality Disorder;
- Unspecified Personality Disorder, Masochistic-type;
- Persistent Depressive Disorder;
- Generalised Anxiety Disorder; and
- Substance Use Disorder.

4.3.1.4. *The Rorschach Inkblot Test (R-PAS).*

a. *Self-image.*

R-PAS results indicated Participant C viewed herself as damaged, flawed and harmed by life and other external events. Her responses indicated she felt helpless and insecure and had a negative self-image.

b. *Interpersonal relationships.*

Participant C's interpersonal dealings were characterised by some ambivalence. On the one hand, she demonstrated potential for healthy interpersonal relationships and, at times, could be compliant and dutiful. On the other hand, results also indicated severe difficulty in relationships with others. In this regard, she demonstrated difficulty in understanding others as complex and complete individuals and was rather prone to view others based on their social roles.

Likewise, she was prone to mentally represent herself and others in an incomplete, unrealistic and fanciful way, which complicated relationship formation. Accordingly, results indicated she lacked a mature understanding of people and their qualities. She was also likely to be hasty and changeable in interactions and demonstrated an adverse feeling to being controlled and pressured by others. This led to displays of oppositional behaviour at times. In addition, results also indicated she expected challenges from others and, as a result, would react in an aggrandising, self-justifying and defensive manner. This likely resulted in others perceiving her as

self-defensive, self-centred and irritating, which ultimately led to others avoiding interaction with her.

Her responses further indicated she had restrictive interpersonal qualities and was generally removed and detached in interactions, increasing the distance between her and others and leading to a lack of much needed relational attachments. Accordingly, she was prone to be less interested and attentive to other people and, likely, lacked empathy. Her interpersonal style possibly led to her feeling lonely, isolated and lacking support, which further negatively impacted her emotional well-being.

c. Emotional stability.

Overall, results indicated Participant C was a highly sensitive individual and, accordingly, was prone to experiencing distress, anxiousness, irritation, dysphoria, loneliness and helplessness. As a result, she was frequently flooded by affect and easily felt overwhelmed, depleted and depressed. To guard against her overwhelming feelings, she would attempt to maintain a distance from all affect and uncomfortable emotions. Results further indicated she would attempt to deaden and dampen her emotional reactivity and tended to shut down emotionally when she felt helpless and overwhelmed.

Her emotional style was mostly characterised by severe depression, low energy levels and poor motivation. In line with these findings, her responses further indicated a dysphoric and negative view of the world, as well as a general melancholic outlook in life. Her responses also indicated she was drawn to dreary and gloomy stimuli, which served to deepen her depression.

Results further indicated her negative emotionality led to her experiencing disruptive, irritating and disquieting internal stimuli, which resulted in her being internally distracted. As a result, she indicated a tendency to be emotionally reactive, which also led to impulsive and emotionally driven behaviour.

d. Cognitive and behavioural patterns.

Participant C's thinking is characterised by an intelligent and intellectually curious cognitive style. Although this generally indicated an area of strength, it should, however, be mentioned this also led to her being overly aware of her environment. In this regard, she was prone to be overly sensitive to her internal and external environment, which could also become distracting and may have interfered with her coping and adaptation. Due to her increased awareness, and higher levels of distractibility, she may accordingly have overlooked important aspects in the decision-making process, and struggled to ignore irrelevant aspects, leading to compromised problem solving.

Results further indicated she was also prone to use a trial-and-error approach to problem solving, that she lacked reflectiveness, and was less likely to reason before she acted. As a result, she was prone to impulsive behaviour, which again complicated problem solving. Not only was she distracted by the abundance of stimuli in her external environment, but she was also internally distracted. This led to experiencing unwanted and distracting ideation, which results indicated was exacerbated by environmental stress.

Generally, results indicated that she struggled to cope with stress, lacked resiliency, and experienced stress-related cognitive disorganisation. Her responses also indicated her behavioural style was unpredictable and wavering. In this regard, she tended to vacillate between a lack of personal agency and purposeful action, on the one hand, which was counteracted by periods of oppositional and impulsive behaviour, on the other hand.

4.4. Participant D

Participant D is a 29-year-old Caucasian, Afrikaans speaking, female, who was admitted to the psychiatric hospital due to her inability to function at work. She described herself having constant altercations with co-workers and that she felt

angry and irritable, most of the time. She described herself as being on edge most of the time and hyper alert to sounds in her environment, which would increase her irritability and anxiety. She indicated she felt overly emotional in the time leading up to her admission and felt like she had no control over her emotions. She described herself as “*four seasons in one day*”, indicating her mood would change frequently and without any apparent cause. She described herself as behaving very impulsively and overly energetic at times, during which she would spend significant amounts of money, which she later regretted. Yet at other times, she was more teary than usual and reported her mood would become so low she would have severe suicidal ideation.

Participant D also indicated her labile emotions were affecting her ability to parent her two children and feared losing custody of both her children to their fathers, with whom she had conflictual relationships. She indicated she would become so angry at the thought of this, she would also have homicidal ideation and that her violent thoughts scared her.

In general, she described having conflictual relationships with most people she would come across and stated she does not let anyone come too close. She also indicated she feels like she wears a mask most of the time and does not show her true self; instead she relies on an outer display of aggression and dominance to keep others at an arm’s length. She further reported lapses in memory, during which she would do and say things she had no recollection of. In this regard, she joked, saying her colleagues would frequently comment on her having different personalities. Various symptoms of dissociation were noted in this regard. Ultimately, she felt like she could no longer cope and her life stress and emotions at the time of the admission were just too overwhelming. During admission, she was diagnosed with BPD as well as Bipolar I Disorder.

With regard to her childhood, she described verbal, emotional, physical and sexual abuse as well as physical and emotional neglect. She indicated the abuse suffered was ongoing and of a longstanding nature, occurring through most of her

childhood until she left home at the age of 16-years, to fend for herself, to escape her home environment.

Participant D indicated that her father abused alcohol and drugs and he would become violent when he was intoxicated. She went on to report he would also sell their household belongings to fund his substance abuse and, at times, the family did not have enough food to eat. Her father would also frequently threaten her mother and maternal grandmother stating that he would kill them; leaving her fearing for their lives.

Although she did not, specifically, report any sexual abuse from her father, she did recall an incident where he forced her to pretend she was his girlfriend and stuck his tongue in her mouth in front of his friends. She stated she still has nightmares about this.

Her paternal grandmother was also described as a primary source of abuse. She recalled how her grandmother would verbally and physically chastise her and make demeaning remarks which severely damaged her self-esteem. She also recalled an incident in which her grandmother once walked past her and chopped off her ponytail with no warning, as a joke.

Participant D stated her home environment was unpredictable and that she never felt safe. She also reported her paternal uncles frequently molested her, and her sister, when they were younger.

4.4.1. Participant D assessment results.

4.4.1.1. *The Child Trauma Questionnaire (CTQ).*

Analysis of Participant D's CTQ responses indicated she experienced trauma in four of the five categories of abuse and neglect. Most prominent was the extreme levels of sexual abuse reported. Severe levels of emotional abuse and physical neglect were also reported, along with moderate levels of emotional neglect. Low levels of physical abuse were also found in her results.

4.4.1.2. *The 16 Personality Factor Questionnaire–Fifth Edition (16PF5).*

a. Self-image.

Results on the 16PF5 indicated Participant D has an overly negative view of herself. This is further reinforced by her being very self-critical. She is also likely to doubt herself and her abilities, and view herself as inadequate. Overall, she is prone to an introverted personality style, in which she is more oriented to her inner world of thoughts and ideas.

b. Interpersonal relationships.

With regards to interpersonal exchanges, it was found she generally tends to avoid interacting with others. In this regard, she can be expected to be overly private, not allowing others to come too close to her emotionally. This, however, complicates the formation of relationships and acts to keep others at a distance. Likewise, she avoids asking others for assistance when needed. This can result in her feeling alone and isolated, as well as overwhelmed, when faced with life difficulties she cannot cope with on her own.

Results further indicated she is likely to conform to expectations and might find it difficult to exert control around others that are dominant and forceful. This results in an accommodating, agreeable and submissive interpersonal style, in which she might suppress her own needs and opinions to avoid disagreement and criticism.

It should, however, be mentioned results also indicated that a deep sense of mistrust underlies her interactions with others, in which she is likely to be overly vigilant and constantly questioning others' motives.

c. Emotional stability.

In general, results indicated that Participant D exhibits an unrestrained and reactive emotional style. She is likely to be impulsive and possesses low levels of self-control. High levels of frustration and impatience characterise her emotional experience. Results further indicated she is overly influenced by her emotions when making decisions and, as a result, generally may tend to indulge her own wishes and

neglect responsibilities. She can be expected to show a lack of concern for rules and convention and may frequently display expedient behaviour. High levels of anxiety were found in her profile, characterised by a typical style of worrying. In this regard, she is likely to be apprehensive, vigilant and tense, which results in feelings of unease and restlessness.

d. Cognitive and behavioural patterns.

Participant D's profile was indicative of cognitive rigidity. In this regard, it was found she is not open to change, and experiences change as stressful. As a result, she is likely to prefer the familiar and may be hesitant to try new approaches or consider new ideas. Results further indicated she feels unable to meet life's challenges, which might negatively impact her functioning.

Overall, she displayed an imaginative thinking style, which is characterised by a tendency to overlook pragmatic matters and, at times, may result in unrealistic thinking.

4.4.1.3. The Millon Multiaxial Clinical Inventory-IV (MCMI-IV).

a. Self-image.

Participant D's MCMI-IV results indicated a profile suggestive of intense inner conflict and a lack of internal cohesion. In addition, she possesses an insecure sense of self in which she feels valueless, insignificant and inconsequential. As a result, she feels unworthy and possesses a deep sense of personal inadequacy. She reinforces this negative view of herself by engaging in self-defeating acts and self-deprecation. She has a tendency to turn the anger she experiences inward, resulting in deep seated feelings of self-loathing.

b. Interpersonal relationships.

Results indicated Participant D experiences severe inner conflict between her need for nurturance from others and an urge to behave in an angry self-assertive

manner. These conflicting needs result in a wavering and unpredictable approach to interpersonal relationships, leading to tenuous and turbulent relationships.

Her inconsistent approach toward others is, in turn, reciprocated by others acting in an inconsistent and avoidant manner toward her. This ultimately results in her feeling misunderstood and abandoned in interpersonal exchanges.

Results were also indicative of a lack of trust in others and a tendency to anticipate disappointment in relationships. This underlying mistrust in others may also act to explain her wavering approach to relationships. In addition, it was found she may also be overly sensitive and defensive, excessively alert to any sign of disillusionment. Her misinterpretation of events as malignant further reinforces her low levels of trust in others. As a result, she generally attempts to keep others at a distance, and may use offensive bouts of irritability and anger outbursts to push people away. Results further indicated aggressive and sadistic tendencies toward others, in which she will purposely obstruct the pleasure of others or frustrate them in various ways.

When fearful she has overstepped a boundary, she may resort to manipulation in order to secure the much-needed nurturance of others. In this regard, she is likely to use her physical ailments and self-deprecation to secure care and support from others.

c. Emotional stability.

Results of the MCMI-IV indicated that Participant D's behaviour and emotions waver unpredictably. In this regard, she may display a rapid succession of moods and appear unstable. Driven by her erratic and reactive emotions, she is prone to impulsive behaviour, which is characterised by self-destructive tendencies and periods of substance abuse.

Overall, her moods are characterised by spells of depression, anxiety and intense anger. Her depressive moods are filled with pessimism and brooding over past negative events. Results further indicated she is likely to fluctuate between self-

deprecation and despair. Her feelings of hopelessness and futility only push her deeper into depression and ultimately result in feelings of suicidality. Her profile suggests that her proneness toward a dejected mood is likely indicative of Persistent Depression.

With regard to the anxiety symptoms she experiences, it was found she tends to be restless, worrisome and agitated most of the time. A fearful apprehension characterises her existence. Results further indicated that her depression and anxiety manifest itself as a series of somatic symptoms, which she interprets as a cause for significant medical concern and increases her anxiety further. Her high levels of anxiety also result in severe distractibility, which significantly interferes with her functioning. At times her mood may turn to extreme anger and irritability.

In general, she can be expected to be passive aggressive as well as bitter and critical of those around her. These feelings intensify over time resulting in ‘acting out’ behaviour, which is characterised by outbursts of discontentment and irrational demands.

Results also indicated that her erratic moods may be indicative of brief periods of hypomanic excitement. During these times, she can be expected to become euphoric as well as extremely hostile. Lacking control over her moods and consequential behaviour, she may be cheerful and buoyant one moment and become explosively enraged and irrationally belligerent the next. These wavering and unpredictable moods have an extremely negative impact on her relationship with others. As a result, her intense anger outbursts are soon followed by feelings of guilt and shame, which acts to reinforce her deep-seated depression, and reactivate the cycle of self-depreciation again. Her profile was also indicative of various PTSD symptoms, which likely underlie her erratic moods.

d. Cognitive and behavioural patterns.

Participant D’s assessment profile indicated her daily functioning is characterised by a low frustration tolerance and difficulty managing stress. Results further specified periods of disorganised and bizarre thinking, which is suggestive

of psychosis. Her profile indicated her periods of psychosis are likely employed as a defence to guard against the persistent painful thoughts, feelings and memories she experiences due to her traumatic past.

e. Possible DSM-5 Diagnoses:

The following DSM diagnoses were offered based on the MCMI-IV results:

- Borderline Personality Disorder;
- Unspecified Personality Disorder, Sadistic type;
- Persistent Depressive Disorder;
- Generalised Anxiety Disorder;
- Schizoaffective Disorder; and
- Substance Use Disorder.

4.4.1.4. The Rorschach Inkblot Test (R-PAS).

a. Self-image.

Results indicated that Participant D generally lacks self-awareness and self-insight. She also identifies with being damaged, flawed and harmed by life and external events. As a result, she fosters a negative view of herself, which negatively impacts other areas of her functioning.

b. Interpersonal relationships.

Various indications of impaired interpersonal relationships were found in Participant D's results. Her responses indicated she possesses problematic and less adaptive understanding of others. In turn, it was also found that others may find it difficult to understand her actions. As a result, she is prone to difficult and ineffective interpersonal interactions.

Results also indicate that she tends toward interpersonal distancing, weariness and shows an anxious attentiveness to signs of threat. This leads to her adopting a

vigilant guardedness toward others. Results further indicated she expects challenges from others and is likely to act in a defensive manner.

c. Emotional Stability.

Participant D's responses indicated she displays poor psychological boundaries. In this regard, she might struggle to censor her behaviour and lack insulation against environmental inputs. In this regard, she easily experiences emotional upset, disruptions in concentration, anxiety, agitation and self-defeating rumination. She is also prone to be emotionally reactive, affectively driven and disinhibited, displaying periods of impulsive behaviour.

Results also indicated she struggles to manage pressing needs, feelings and worries and is severely internally distracted. More specifically, she is prone to experiencing disquieting, disrupting and irritating internal stimuli. This distraction is exacerbated by her high levels of vigilance and her anxious awareness of possible danger.

Participant D's results further indicated she is overly sensitive and prone to experiencing distress, anxiousness, irritation, dysphoria, as well as feelings of loneliness and helplessness. Her responses further indicated she likely possesses a dysphoric and negative view of the world, however, is also likely to display periods of hyperactivity and mania.

Various trauma indicators were present along with indications of accompanying dissociative experiences. The experience of a past trauma likely underlies most of her emotional experiences and negatively impacts her cognition and behaviour.

d. Cognitive and behavioural patterns.

Results indicated although Participant D is likely to be an intelligent female, she nevertheless experiences various cognitive difficulties that interfere with her daily functioning.

A specific aspect that negatively impacts her cognitive processing is her increased awareness of her environment. This may result in her struggling to focus on important features and ignore irrelevant aspects in her environment, which complicates decision making and problem solving. This increased awareness of complexity, ultimately overcomplicates problem-solving, burdens and interferes with her cognitive processing, and leads to a cognitive overload. As a result, she is likely to experience difficulties with thinking clearly and logically and may display poor perceptual accuracy, which complicates everyday functioning. In addition, her responses were also indicative of significant problems with accurate, logical and effective thinking and reasoning. She may thus easily lose ideational control and focus, as well as become indecisive. In addition, these cognitive difficulties may also lead to instances of confused, disturbed and disorganised thought processes.

Participant D also showed a proneness to embellish her experiences in fantasy and projection, which, combined with her disorganised thought pattern, results in her reality testing being questioned and possibly indicates signs of psychotic thinking.

Results went on to indicate her behaviour is largely emotionally driven and easily influenced by situational stressors. Her responses further indicated she easily loses behavioural control as her emotions escalate, and, as a result, she is likely to display unstable and unpredictable behaviour. Multiple indications of a lack in inhibitory control were present, along with signs of impulsive and hyperactive behaviour.

Finally, it should be mentioned that she displayed various indications of struggling to cope with everyday stress. In this regard, it was found that she likely experiences unwanted and distracting ideation associated with environmental stressors. This internal distraction further interferes with purposeful, goal-directed thinking and ultimately leads to her suffering from stress-related cognitive disorganisation. In summary, her confused thinking, difficulty dealing with

environmental stress and unstable behaviour, are indicative of severe pathology and significant difficulty with everyday functioning.

4.5. Participant E

Participant E is a 30-year-old African, Xhosa-speaking, female. She indicated she was admitted to the psychiatric hospital after a suicide attempt. She described her hostile relationship with her mother as her the primary reason for her suicide attempt. She went on by explaining how her mother sent a text message prior to the suicide attempt, in which her mother commented on her negatively, calling her names and accusing her of being a bad person. She stated the relationship with her mother has been problematic for years, and that it still impacts her functioning.

Participant E described being verbally, emotionally and sexually abused from the age of seven, until the age of 28-years. She also described incidents of physical and emotional neglect. She elaborated by explaining her parents never wanted her to stay with them and passed her to their friends and family members to take care of. She indicated she would not stay with a particular family member for a long period before being passed on to someone else to care for her. She described her childhood as unstable and unpredictable and that she never felt like she belonged anywhere.

She also indicated she would experience frequent abuse at the various families she stayed with. Participant E described her uncle physically abusing and raping her. She also stated she felt like she could not tell anyone, as she had nowhere else to live and no one else to take care of her. She also reported her mother knew of the abuse, however, failed to protect her, as they needed a place for her to stay.

She described her maternal grandmother as her primary parental figure and the one place she felt safe. The loss of her grandmother when she was 16-years old was described as particularly difficult for her, as she lost the one person who truly felt like family. Although she had a distant relationship with her father, she described

his death as another difficult loss to come to terms with, as she never had a chance to repair their relationship before his death.

During admission, she was observed to be severely depressed as well as distant, irritable and hostile toward others. She withdrew herself on most occasions and during interactions spoke very little.

During admission, she was diagnosed with BPD and MDD.

4.5.1. Participant E assessment results.

4.5.1.1. *The Child Trauma Questionnaire (CTQ).*

Participant E reported experiencing trauma in all five of the CTQ abuse and neglect categories. Extreme levels of emotional abuse, sexual abuse, emotional neglect and physical neglect were found in her results. Results indicated sexual abuse and emotional neglect was among the most prominent types of trauma suffered. Moderate levels of physical abuse were also present.

4.5.1.2. *The 16 Personality Factor Questionnaire–Fifth Edition (16PF5).*

a. Self-image.

The 16PF5 results indicated Participant E has low levels of self-esteem and lacks self-confidence. Her view of herself is characterised by feelings of inadequacy and insecurity. As a result, she frequently doubts herself and feels uncertain when faced with life difficulties she needs to address. This apprehensive view of herself increases her levels of anxiety and complicates her everyday functioning.

b. Interpersonal relationships.

Participant E's profile is suggestive of a tendency to avoid interactions with others. She is likely to be serious and restrained, as well as shy and timid in interpersonal dealings. A high degree of Introversion characterises her interpersonal style and, as a result, she is likely to be more focused on her own internal world than

on relating with others. Her high levels of privacy further complicate the formation of relationships.

Results further indicated she is can be overly accommodating and lacks independence. In this regard, she will conform to the expectations of others, suppressing her opinions and needs in an attempt to avoid feared conflict.

Her responses also indicated she experienced much difficulty trusting others and is likely to remain vigilant around others, frequently questioning their motives. As a result, she is also likely to abstain from asking others for help when faced with life difficulties. Consequently, this avoidance of others likely results in feelings of loneliness and a general lack of support.

c. Emotional stability.

Results indicated that Participant E lacks emotional stability and is emotionally changeable. She is prone to be emotionally reactive and may struggle to calmly cope with the challenges of everyday life. In addition, she is likely to base her decisions largely on her emotional state at the time, leading to the possibility of irrational life choices.

Participant E's results further indicated high levels of anxiety marked by a characteristic style of worry and unease. These high levels of anxiety and emotional turmoil likely negatively impact her daily functioning.

d. Cognitive and behavioural patterns.

Participant E's cognitive functioning is characterised by an abstract and imaginative thinking style. Although this can lead to high levels of creativity, results indicated she may be likely to overlook pragmatic matters and practical considerations in everyday life. Results also indicated she feels uncomfortable with her ability to meet life's demands. As a result, she is equally uncomfortable with change and experiences any form of change or adaptation as stressful and a source of emotional upset.

4.5.1.3. *The Millon Multiaxial Clinical Inventory-IV (MCMI-IV).*

a. Self-image.

Participant E's self-image is generally characterised as overly negative. She is prone to feelings of inadequacy, inferiority and vulnerability. Her deflated sense of self further results in her being extremely self-conscious and self-critical, expecting failure and humiliation. She is likely to be hypersensitive to her shortcomings and may easily feel worthless and undesirable. Her negative view of herself leads to her judging herself as insignificant and inconsequential to others. Not only does she view herself as inferior, but she also reinforces this negative self-concept by devaluing her achievements, being extremely self-punitive, and engaging in self-defeating acts.

Results further indicated she lacks internal cohesion and is unsure of her identity. This leads to a significant degree of inconsistency in her thoughts and actions, as well as her wavering unpredictably in various areas of her life.

b. Interpersonal relationships.

Participant E can be expected to be extremely wavering in her approach to others. Results indicated an intense inner conflict between her desire to withdraw from others and a fear of acting autonomously, due to high levels of self-doubt. On the one hand, she displays an anxious wariness about social encounters, which is underlain by an entrenched lack of trust. Results indicated she has learned to anticipate pain and disillusionment and, as a result, retreats defensively from interactions with others. Likewise, she had become indifferent to the feelings of others and tends to disengage from most interactions. Her attempts at isolation, although designed to keep her safe, isolates her from potential sources of support and gratification. Results further indicated she possesses significant feelings of resentment and deep-seated anger toward others for their lack of support. Likewise, she also fosters feelings of loneliness, betrayal and feels forsaken. On the other hand, her high levels of self-doubt and feelings of inadequacy and inferiority act to keep her dependent on others.

In essence her results indicated that she is caught between the extremes of dependency and interpersonal withdrawal, which serves to create significant anxiety for her and negatively impacts her approach to others.

c. Emotional stability.

Overall it was found that Participant E is prone to periods of emotional dysfunction and lacks emotional stability. She vacillates between experiencing periods of acute emotional turmoil followed by moody and erratic outburst, and between suppressing her emotions, becoming emotionally impassive, affectively blunted, and displaying severe apathy. At the one extreme, she can be expected to display increased levels of irritability, hostility, irrational anger and extreme paranoia and suspicion. At the other extreme, she is prone to turn her anger and other emotions inward in fear of retribution. This results in her becoming anxiously depressed and displaying a cornucopia of other mental health symptoms, such as depression, anxiety and somatic symptoms.

The depressive symptoms she experiences is characteristic of MDD, in which she likely displays a pessimistic, mournful, joyless and morose disposition. She also reported experiencing excessive guilt and worry, sleep difficulties and generally feels hopeless about her life. Suicidal ideation and threats also characterises her depressed mood.

Results further indicated she is prone to periods of high anxiety, indicative of a Generalised Anxiety Disorder. Various indications of a past trauma were present with accompanying PTSD symptoms. Most significant was the reported experience of anxiety-ridden and painful memories that are frequently reactivated by minor social stressors. Accordingly, her reaction to her past trauma likely underlies and triggers most of the emotional turmoil she experiences. Results also indicated her emotional difficulties are further exacerbated by her possessing few avenues for tension relief and gratification, which reinforces her depressed and anxious disposition.

d. Cognitive and behavioural patterns.

Results on the MCMI-IV indicated Participant E tends to waver unpredictably in her behaviour. Periods of significant cognitive and behavioural dysfunction were also found to be present.

Her cognitive style is characterised by irrational thinking, paranoia, ideas of reference and persecutory beliefs. In this regard, she is prone to experiencing psychotic episodes, which results indicated is employed as a subconscious defensive effort at deflecting unexpected social pressure and anxiety.

Results further indicated she struggles to cope with ordinary life tasks and lacks mature behaviour. In this regard, it was further found that she tends to display regressive behaviour, characterised by physical impassivity and a blunted affect. Her bouts of psychosis were also found to inadvertently serve the purpose of assisting her in avoiding everyday responsibilities, which she does not feel adept to cope with.

Participant E's results indicated that she is prone to unpredictable and impulsive outbursts and is likely to engage in risky and self-destructive behaviour during those times. Overall, her lack of behavioural stability negatively impacts her ability to function adequately in everyday life.

e. Possible DSM-5 diagnoses.

The following DSM diagnoses were offered based on the MCMI-IV results:

- Avoidant Personality Disorder;
- Dependent Personality Disorder;
- Schizophrenia;
- Major Depressive Disorder;
- Somatic Symptom Disorder; and
- Post-traumatic Stress Disorder.

4.5.1.4. *The Rorschach Inkblot Test (R-PAS).*

a. Self-image.

Results indicated Participant E fosters feelings of insecurity and helplessness. She demonstrated an insecure self-image in her responses, which negatively impact other areas of her functioning. In addition, her responses also indicated she denies the complexity of her own internal experience and lacks an effective understanding of herself. As such, she lacks much needed self-knowledge and awareness, which hampers her psychological functioning.

b. Interpersonal relationships.

With regard to Participant E's interpersonal dealings, it was found she is generally disengaged, distant and uninvolved. Her responses indicated she lacks interest in, and attentiveness toward others and prefers to remain interpersonally removed and detached. Results further indicated she tends to be reserved and restricted in her interactions with others and tends to hide her true self. Her limited self-disclosure in this regard, creates difficulty for others to know her, reinforces interpersonal distance. Results also indicated she distrusts others, which likely underlies her efforts at creating interpersonal distance.

Furthermore, it was also found she tends to view others in an overly simplistic manner. As a result, she is prone to lack an effective understanding of others, which might lead to significant misunderstandings and misperceptions. She also showed a general lack of empathy toward others.

c. Emotional stability.

Participant E's emotional stability was found to be questionable when considering her responses. Her responses indicated she tends to be overly sensitive, which results in her being easily overwhelmed and depleted. In addition, she also demonstrated limited psychological and affective resources, which increases her vulnerability to stress and emotional upset.

Various indications of depression, and depressive withdrawal, were found in her responses. She also indicated some ambivalence in her emotional reactions and tends to vacillate between traumatic numbing and passivity and being emotionally reactive and impulsive. Concerns about being psychologically vulnerable and experiencing somatic symptoms were also found in her responses.

d. Cognitive and behavioural patterns.

Indications of wide-spread cognitive difficulties were found in Participant E's results. Her cognitive style was found to be characterised by cognitive rigidity and processing difficulties. Most significantly it was found she engages in overly simplistic cognitive processing. In this regard, she may tend to struggle to process complex environmental stimuli and may be less likely to think and reason before acting. She is likely to use trial-and-error reasoning when engaging in problem solving, which negatively impacts her problem-solving efforts. She also seems to lack imagination and reflectiveness. Difficulties with perceiving her environment accurately were also found, which interferes with her perceptual accuracy and was found to be indicative of pathological reality testing and possible psychosis.

Her behavioural style was also found to be problematic. She is prone to displays of oppositionality and evasiveness as well as passive aggressiveness. Results also indicated she experiences difficulty engaging with the world and struggles to cope with everyday challenges. Various indications of low levels of motivation, a lack of productivity and a general difficulty with purposeful action and personal agency, was found. This exacerbates her coping difficulties and decreases her ability to function adequately in everyday life.

4.6. Participant F

Participant F is a 47-year-old Caucasian, Afrikaans-speaking, female, who sought treatment at the psychiatric hospital due to her longstanding history with MDD. She reported she had an extensive history of mental health admissions at other

hospitals before she was referred to the psychiatric hospital. She described the time leading up to her admission as reaching a breaking point, that she could not keep quiet about the childhood trauma experienced, it all just caught up with her and she could no longer function.

She reported a history of verbal, emotional, physical and sexual abuse by various offenders. She also indicated she experienced emotional neglect in her parental home, which worsened the other forms of trauma she experienced. She reported being raped by one of her father's farm workers from the age of five years old until the age of 12-years-old. She stated the rape would cease for periods of time and later start again. She further stated that the perpetrator would threaten her, to assure her silence, by threatening to kill her father. He also manipulated her by claiming her father would kill him if he found out and would, in turn, go to jail. Due to her fear, she kept quiet about her experiences. She indicated she vividly remembers every detail of the experiences and that certain stimuli in her environment would trigger memories of that time.

With regard to her father, she recalled always feeling fearful of him. She stated he was an extremely angry and violent man, who would act violently in her presence. She recalled a time when her father brutally killed her sister's dog while she watched. She mentioned feeling helpless and powerless in this regard as everyone was too scared to stand up to him. She also reported her father was hostile toward her and frequently abused her verbally, which severely injured her self-esteem. She explained she still struggles to look others in the eye, as she does not feel worthy and feels ashamed of herself. She went on to mention her father would also reject her and would continuously say she is not his child. The rejection and abuse by her father are still experienced as difficult for her, and she stated she still cannot face him or stand up to him.

In addition to the depressive symptoms she experiences, she also reported struggling with severe anxiety. She indicated she worries about most things and struggles to remain calm in stressful situations. She indicated the anxiety negatively

impacts her ability to function independently and her interpersonal relationships are also negatively impacted. She described herself as only interacting with her immediate family as she feels self-conscious and anxious around other people.

Participant F further described numerous dissociative symptoms, such as not having memory of her actions and feeling absent at times. During admission, she was diagnosed with BPD, with symptoms indicative of MDD, and Generalised Anxiety Disorder.

4.6.1. Participant F assessment results.

4.6.1.1. The Child Trauma Questionnaire (CTQ).

CTQ results indicated Participant F experienced trauma in all five categories of abuse and neglect. Moderate levels of emotional abuse and physical neglect was reported, and extreme levels of physical abuse, sexual abuse and emotional neglect was indicated. Overall, sexual abuse was found to be the most prominent trauma experienced, according to her assessment profile.

4.6.1.2. The 16 Personality Factor Questionnaire–Fifth Edition (16PF5).

a. Self-image.

Results indicated Participant F's view of herself is negatively compromised. She regards herself as inferior and often feels inadequate. She frequently doubts her abilities, which complicates various aspects of everyday life. In general, her negative view of herself, and high levels of self-doubt, are indicative of low levels of self-esteem, which gravely impacts her functioning.

b. Interpersonal relationships.

Overall, Participant F can be expected to be extremely introverted, tending to avoid interaction with others. In this regard, she is unlikely to form close attachments with others and may tend to be overly reserved and distant in

interpersonal dealings. She may be regarded as lacking interpersonal warmth and, as such, may not show personal affection easily. She also tends to be overly private, which may lead to difficulty in forming connections with others.

Results further indicated she may tend to be overly accommodating and agreeable. She is accordingly likely to conform to the expectations of others and, in turn, defer her own needs and opinions. Further analysis indicated her high levels of compliance is mostly employed as an effort to avoid conflict. It should, however, be mentioned that her tendency to defer her own needs, lead to her being unsatisfied in interpersonal relationships and could negatively impact her mood.

Furthermore, it was found that Participant F possesses a deep-seated lack of trust in others, which likely underlies her tendency to be distant in relationships. In this regard, she can be expected to be highly vigilant around others, frequently questioning their motives. As a result, she is also likely to tend to be overly independent and may not accept the assistance of others when needed. This leads to her living an isolated existence and results in intense feelings of loneliness and a general lack of support.

c. Emotional stability.

Results on the 16PF5 indicated Participant F is prone to high levels of anxiety, characterised by feelings of being tense and restless with a characteristic style of worry and unease. Results further indicated she is likely to be emotionally reactive and lack emotional stability. She may tend to base her decisions on emotions, which could lead to her acting impulsively and unrestrained at times. In addition, she also reported occasionally experiencing feelings of frustration and impatience, which exacerbates her impulsive behaviour.

d. Cognitive and behavioural patterns.

In general, Participant F displays an abstract and imaginative thinking style. Although this could lead to high levels of creativity, it may also result in her

overlooking pragmatic concerns and practical considerations when making decisions.

Results further indicated she does not feel comfortable in meeting life's expectations and reported struggling to cope with life's difficulties. In addition, it was found she questions her abilities and may act in an overly cautious manner. She generally prefers the familiar and likely experiences change as stressful, causing her emotional upset. As a result, she may not be open to change and may display low levels of adaptive functioning.

4.6.1.3. The Millon Multiaxial Clinical Inventory-IV (MCMI-IV).

a. Self-image.

Results indicated Participant F generally has a negative view of herself. She reported feeling insecure, excessively self-conscious, inadequate, and views herself as isolated and undesirable. In addition, it was also found she feels vulnerable most of the time and exhibits a high degree of self-pity. Results further indicated she possesses a self-defeating attitude and is prone to devalue her achievements, engaging in self-defeating behaviour. She is likely to amplify her worst features and sees herself as worthy of being shamed, reproached and demeaned. Viewing herself as unworthy, she reported feeling deserving of anguish and abuse. It should, however, be mentioned that results also indicated she likely acts in this weak, self-depriving and self-doubting manner, in order to gain support, assurance and guidance.

Various indications of difficulty with identity integration was also found. In this regard, results indicated she is unsure of her identity and self-worth, and tends to submerge her individuality to possible abandonment. As a result, she generally lacks internal cohesion and is prone to displaying wavering behaviour in various areas of her functioning.

b. Interpersonal relationships.

Results indicated Participant F tends to waver unpredictably in her relationships with others. Above all, it was found she has strong dependency needs and largely depends on others for security and nurturance. In this regard, she is likely to be overly submissive and self-sacrificing, to evoke nurturance from others and avoid rejection. She generally tends to be placating and conciliatory and will submit her personal desires and needs to avoid abandonment. Likewise, she is willing to place herself in an inferior and demeaning position, which opens her up to being vulnerable to exploitation and abuse.

Results further indicated she is likely to feel deep-seated resentment toward those who fail to supply her with the needed nurturance and affection; however, hesitates to express this resentment due to fear of abandonment. As a result, she tends toward passive-aggressive behaviour, which inadvertently acts to keep others at a distance.

Results further indicated she vacillates between withdrawing from painful relationships, which results in her feeling alienated from others, and deciding to endure the suffering and remain dependent. Since she is also likely to restrict her emotional involvements to problematic relationships, she generally ends up feeling unsatisfied in her interactions with others, which has widespread negative emotional consequences.

c. Emotional stability.

Analysis of results indicated Participant F displays a tendency to be emotionally reactive and is emotionally unstable. Her behaviour and decisions are largely influenced by her emotions, which results in unpredictability and impulsivity. Frequent periods of emotional dysfunction characterise her emotional style.

She displayed various symptoms indicative of MDD, which includes: displays of inappropriate guilt; a mournful attitude; feelings of pessimism, loneliness and

emptiness; and suicidal thoughts. Results also indicated she tends to experience pleasure, when pain would be a more appropriate reaction. As a result, she is prone to self-sabotaging behaviour, which tends to exacerbate her depressive and other negative emotions.

Participant F also displayed symptoms indicative of Social Anxiety and Generalised Anxiety. In this regard, she is prone to feelings of restlessness, edginess and fear, as well as experiencing distractibility, insomnia and exhaustion. She also reported fearing humiliation and feeling anxious and self-conscious around other people.

Results further indicated she experiences deep-seated feelings of underlying anger and resentment. In this regard, the resentment, and other unfavourable emotions she attempts to suppress, periodically slip through her controls and result in anger outburst. During these times, she tends to feel irritable, frustrated, and experiences irrational anger and suspicion. At other times, her suppressed emotions are expressed as bodily symptoms and somatic complaints. Periods of hypomanic excitement were also found to be present in her results, which was found to act as a defence against her overwhelming depression. Reports of a past trauma were made along with various PTSD symptoms, which likely underlie the presentation of her emotional state.

d. Cognitive and behavioural patterns.

Results indicated Participant F's cognitive and behavioural functioning is characterised by periods of marked dysfunction. Her behaviour is also likely to waver unpredictably. Results further indicated she generally struggles to function in everyday life and reported severe difficulty in coping with simple responsibilities. In this regard, she is likely to succumb easily to exhaustion and illness and lacks resilience. She shows marked deficiencies in social and personal attainments; however, does not seek to improve herself in any way. Results accordingly indicated she fosters and aggravates her own misery through self-sabotaging behaviour and ultimately remains trapped in her dysfunction. Her cognitive and behavioural

rigidity is further reinforced by her constant efforts to avoid humiliation, her preference for the familiar, which provides a false sense of safety, and her aversion toward change and new experiences.

Results went on to indicate that her sense of reality is also severely compromised at times. During these times, she is prone to experience transient, stress-related, mini-psychotic episodes. She exhibited signs of delusional thinking, characterised by ideas of reference, persecutory beliefs and paranoia. Her feelings of paranoia are reinforced and intensified by her feeling betrayed and forsaken by others. Her psychotic episodes are further marked by regressive behaviour, physical impassivity, suppressed emotional expression and a lack of behavioural initiative. Analysis of the results indicated her periods of psychosis is most likely an attempt to deflect any unexpected social pressures and anxieties, and ultimately serves as an intense coping response for life's discomforts. As such, she is prone to use her bizarre thinking, behavioural withdrawal and regression, to avoid personal responsibility and adult functionality.

e. Possible DSM-5 diagnoses.

The following DSM diagnoses were offered based on the MCMI-IV results:

- Borderline Personality Disorder;
- Avoidant Personality Disorder;
- Major Depressive Disorder;
- Schizophrenia;
- Somatic Symptom Disorder; and
- Post-traumatic Stress Disorder.

4.6.1.4. The Rorschach Inkblot Test (R-PAS).

a. Self-image.

Participant F's responses indicated her self-image is generally characterised by feelings of insecurity and helplessness. Her results indicated she views herself as damaged, flawed and harmed by life and external events. She also tends to be overly self-critical and self-focused, which leads to widespread emotional difficulties.

Results further indicated she possesses a problematic understanding of herself and, as such, has low levels of self-knowledge and self-awareness to grow psychologically.

b. Interpersonal relationships.

Participant F's responses indicated she has the potential to experience healthy interpersonal relationships, but various factors complicate the formation and maintenance of such relationships. In this regard, results indicated she may be overly sensitive in relationships and, as such, likely experiences ineffective and difficult interactions with others.

In addition, her characteristic manner of processing and understanding her environment, causes further interpersonal difficulties. Incidentally, it was shown she possesses a problematic and less adaptive understanding of others, which frequently leads to misconceptions and misunderstandings. Not only may she struggle to understand those around her, but others may also struggle to understand her, due to a lack of clarity in her self-representation. These interpersonal dynamics further result in a lack of connection to others, which lead to feelings of loneliness and a lack of support. She also further increases the amount of distance between her and others through her own actions, as results indicated she is averse to feeling controlled and pressured by others and accordingly may become oppositional. Results also indicated she has low levels of interpersonal trust and tends to be vigilant, guarded and watchful around others. As mentioned, she is prone to distance herself from

others, which is likely underlaid by chronic levels of wariness and anxious attentiveness to signs of threat.

c. Emotional stability.

Participant F's emotional stability is negatively impacted by her display of poor psychological boundaries. This leads to her being easily overwhelmed by upsetting emotions and intrusive environmental stimuli. Accordingly, she might be prone to displays of heightened sensitivity and, as a result, likely experiences increased levels of distress, anxiousness, irritation, dysphoria, loneliness, helplessness and difficulties with concentration. Results indicated she is significantly internally distracted and is prone to experiencing disquieting and disrupting internal stimuli.

This pattern of emotional experiences also increases her vulnerability to psychopathology. In this regard, her results were indicative of pathological anxiety, agitation, depression and possible mania. Results further indicated her high levels of rumination acts to sustain her distress, and leads to a generally melancholic outlook on life. She was also found to be drawn to dreary and gloomy stimuli, which exacerbates her depression. Her dysphoric and negative view of the world and herself was also found to significantly increase her risk for suicidality and self-harm, which is a great cause for concern.

d. Cognitive and behavioural patterns.

Results indicated significant cognitive difficulties, which impact Participant F's functioning negatively. Most significantly, she shows an increased tendency toward problematic over-productivity. This is not only seen in her increased energy levels, hyperactivity, impulsivity, disinhibition and lack of behavioural control, but also in her overly complex cognitive processing. In this regard, she tends toward excessive complexity in her thinking, which interferes with effective information processing. In essence, she tends to overcomplicate her problem solving, which results in less successful efforts and immature thinking. Likewise, she is also prone to losing ideational control and focus, and may struggle with indecisiveness. Her

complex processing style also results in her ideas and behaviour being difficult for others to understand, and may be indicative of a disturbance in thinking.

Significant problems with thinking clearly and logically and accurately perceiving her world was found. Various indications of pathological reality testing were found in her responses. Her disturbed and disorganised thought processes were further indicative of a vulnerability to psychotic states.

Results also indicated various behavioural and coping difficulties. In this regard, her responses were indicative of instability and unpredictability. She was also found to be obsessive and demonstrated a fearful loss of control. Results also indicated she is easily overwhelmed by environmental stressors due to poor psychological boundaries.

In general, it was indicated she struggles to cope with external stressors and demonstrated compromised functioning in everyday activities. Low levels of purposeful action and personal agency were also found, which further exacerbates her coping difficulties.

Chapter 5. Findings and Discussion

When considering each participant's results, it became apparent that many similarities were present within the various assessment results of each participant, as well as between the results of all six participants. It should also be mentioned that there were a number of differences between participant results, which is considered to be clinically significant. These similarities and differences gave way to themes that aid in clarifying and better describing the phenomena being studied.

Five overarching meta-themes were identified in the data gathered, each with corresponding subthemes, which provide a descriptive richness to these participants' characteristic style of thinking, behaving, and feeling. An account of the themes generated, and the clinical significance of these themes, will accordingly be discussed in this chapter. The information gained from the participants' personality assessment results will also be integrated with relevant theory and literature to provide a comprehensive discussion of these findings and the impact, thereof, on clinical practice. The various research questions posed will accordingly also be answered.

5.1. Themes and Discussion

5.1.1. Meta-theme 1: Compromised self-image.

5.1.1.1. Sub-theme 1: Negative view of self.

In reviewing the results of the various assessments for all the participants, the matter of a negative view of themselves continually resurfaced. In this regard, they all tended to view themselves as inept, inadequate, inferior and incompetent. This is in line with Herman's (1992a) view of the impact of trauma on the development of the self. More specifically, she states the victims of chronic trauma may feel they are changed irrevocably, or they may lose the sense that they have any self at all. She elaborates by indicating a trauma, especially interpersonal trauma, impacts the individual's autonomy, initiative, competence and identity. These traumatised

participants seemed to lose their basic sense of self and, what could have been a healthy self-concept, was replaced with a negative view of the self (Herman, 1992a).

In line with these findings, participants were also found to feel valueless, insignificant, inconsequential, unworthy and undesirable. According to Feiring, Taska, and Lewis (2002) maltreated children often lack positive core beliefs about themselves and their world due to the negative events they have experienced.

This is clearly evidenced in the assessment results of the participants of the current study. As they foster such a negative view of themselves, they are also more prone to being hypersensitive to their shortcomings and overly sensitive to criticism. In general, they seemed to have a weak and fragile view of themselves and tended to engage in acts of self-pity. Low levels of self-confidence, and poor self-esteem, was shown to pervade these participants' existence. This is supported by a study done by Slaninova and Slaninova (2015) which indicated that trauma has a significant impact on the self-concept of the individual and causes lower self-acceptance, self-esteem and self-image.

Further analysis of participant assessment results also indicated this negative view is most likely due to viewing themselves as being damaged, flawed and harmed by life – and, in some sense, beyond help and repair. These findings are again in line with literature, which indicates the impact of trauma on personality development could include a disturbed sense of self, a disturbed body image as well as viewing the self as helpless, ineffective and damaged (Cole & Putnam, 1992; Hermann, 1992a; van der Kolk, 1987; van der Kolk & Fisler, 1994). This aspect of their functioning seems to have a ripple effect on other aspects of functioning and negatively distorts their self-functioning and other functioning.

5.1.1.2. Sub-theme 2: Plagued by self-doubt.

Traumatized people often fail to maintain an interpersonal sense of significance, competence and inner worth (Herman, 1992a). This results in them doubting themselves significantly, which was a second prevalent theme that arose among participants' results. More specifically, it was found that the participants'

struggle with feelings of self-doubt, leads to them feeling uncertain and insecure in interactions with others as well as in carrying out daily activities. In addition, they are prone to frequently doubt their abilities and feelings, which negatively impact their ability to function effectively and independently. Mash and Wolfe (2005), indicated that the feelings of betrayal and powerlessness, that often characterise maltreated children's life experiences, may later become salient components of their self-identity. In this regard, it is highly likely these participants feel too powerless and incompetent in their own abilities to carry out daily activities, which negatively impact their functioning and independence. They are, thus, typically self-conscious and have an apprehensive view of themselves.

Literature has also shown that these feelings of self-doubt may have its origin in the fact that trauma survivors tend to question their own actions and conduct, when the original trauma took place. In this sense, they may view their own actions during the original trauma as being insufficient to ward off the tragedy they experienced (Herman, 1992b). These individuals may, accordingly, review and judge their own conduct during the occurrence of the trauma negatively, which often results in feelings of guilt, inferiority and the high levels of self-doubt which was observed in the data obtained.

5.1.1.3. Sub-theme 3: Feels deserving of suffering.

Another noteworthy finding was that most participants felt they are deserving of suffering. As a result, they may tend to court criticism and blame as well as possess a self-defeating and self-condemning attitude. A strong sense of self-loathing is also likely to accompany this outlook. They may be prone to be highly critical of themselves, belittle their own abilities and devalue their achievements. In this regard, they are highly likely to be self-punitive and amplify their worst features. Again, this feature of traumatised individuals' behaviour can be attributed to their tendency to view their own behaviour, during the original trauma, as insufficient (Herman, 1992b). They may, thus, blame themselves in part for the occurrence of the trauma and feel that they failed to act appropriately.

As such, they continue to punish and criticise themselves for their failed attempts at stopping the trauma when they were children. As a result, their tendency to feel deserving of suffering may result in them seeking opportunities in which they will experience suffering and, as such, they act to indirectly cause their continued suffering. This will be elaborated upon in the section regarding self-sabotaging behaviour.

5.1.1.4. Sub-theme 4: *Wavering sense of self.*

According to Berman (2016) trauma can disrupt one's sense of identity. This is most likely due to the effects of *event centrality*, which refers to the degree the traumatic event is central to one's identity and sense of self (Bernsten & Rubin, 2006). Results indicated the trauma these participants experienced prominently negatively impacted their sense of self and identity.

More specifically, all the participants were found to be affected by a wavering sense of self. They generally tended to show a lack of internal consistency and cohesion and demonstrated a significant level of incongruency. High levels of identity confusion were present among these participants and an ineffective understanding of the self was found. It seemed that they lacked self-knowledge, self-awareness and self-insight, and typically denied the complexity of their own experience.

These findings are also supported by Slaninova and Slaninova (2015), who indicated that trauma deforms the structure of the personality and, as such, the self-concept is, therefore, developed as traumatised. It should also be mentioned that the impact of trauma on identity development is much more severe when considering the nature of childhood trauma, which occurs at an age where the individual's personality and identity is still in formation (Coutois, 2004). In essence, a trauma ridden identity is developed and continues to impact various other facets of these individuals' functioning.

At this point, it should also be mentioned that the theme of wavering behaviour was very prominent throughout participant results. This sense of

inconsistency and wavering not only affects their view of themselves, but also impacts their interactions with others, as well as other actions and behaviours. These wavering displays can be regarded as extremely important, as it seems to mirror the wavering circumstances these participants experienced in their childhoods as a result of the trauma (Herman, 1992b).

Experiences of complex trauma in itself, is filled with uncertainty and unpredictability, since as children these females never knew when the next trauma insult would rear its head. It appears as if their childhood experiences of instability became permanently infused within their identity and behaviour. With no secure base offering predictability and consistency, these females seemed to develop in accordance with what was modelled to them, and became equally unpredictable and inconsistent in their adult behaviour and view of themselves (Booth & Jernberg, 2010; Herman, 1992a).

5.1.2. Meta-theme 2: ineffective interpersonal relationships.

5.1.2.1. *Sub-theme 1: Ambivalent and wavering interactions.*

With regard to interactions with others, all the participants showed a tendency toward wavering and ambivalent interactions. They were generally prone to instable, tenuous and turbulent relationships. They also exhibit a push-and-pull pattern of interacting with others, wherein they will in some instances manoeuvre for closeness and later push others away to create substantial interpersonal distance. This is in line with a study done by Herman et al. (1989) in which it was found that traumatised patients tended to be dependent on others, on the one hand, and also socially isolated and withdrawn, lacking rewarding social relationships, on the other.

When analysing their characteristic patterns of interacting, it was found these participants tend to display unstable interpersonal boundaries and are inclined to vacillate between possessing rigid boundaries, that act to keep others at a distance, and overly porous boundaries, in which they are overly forthcoming, self-sacrificing and ultimately opening themselves up to exploitation. It is, accordingly, likely these

wavering interpersonal boundaries underlie their vacillating interpersonal style and many other features of their interpersonal behaviours.

The concept of unhealthy interpersonal boundaries is very important when considering how trauma survivors have adapted to the trauma they experienced. The childhood trauma these females experienced signifies an immense boundary violation in itself and, as such, these women never learned what healthy interpersonal boundaries should look like. Zannarini and colleagues (1990), noted that individuals who experienced prolonged interpersonal trauma tend to form unique and dependent relationships with a selective few, post-trauma, whom they regard as idealised caretakers. The extremity of this dependence, however, does not include healthy or ordinary boundaries and, as a result, these individuals frequently experience boundary violations, conflict, and are vulnerable to possible exploitation (Kluft, 1990).

Another important aspect to contemplate, when considering the ambivalent and wavering interactions displayed by these participants, is the concept of attachment in relationships. Studies have shown complex trauma, which involves a significant interpersonal component, has a negative impact on the formation of stable attachments (Cicchetti & Toth, 2005; Rademaker et al., 2008).

More specifically, when examining the nature of the victim-perpetrator relationship that characterised these female's childhood trauma, it becomes clear that the attachments formed with the perpetrators were pathological in nature, a concept frequently referred to as *trauma bonding* (Herman, 1992b). According to Herman (1992b), when examining prolonged and repetitive trauma, the notion of *coercive control* becomes of extreme importance. In this regard, this type of trauma can only occur when the victim is in a state of captivity, unable to flee and under the control of the perpetrator. This type of control is achieved since the victim is dependent on the perpetrator in some way. This can include dependence for physical needs and care, a need for support and affection, or dependence due to a fear of death or harm befalling another loved one. In situations of such captivity, psychological or

physical, the perpetrator becomes the most powerful person in the life of the victim, and the psychology of the victim is moulded over the course of time by the actions and beliefs of the perpetrator. Once the perpetrator has established such a sense of control, he/she becomes a potential source of solace as well as a source of humiliation (Herman, 1992b). This in essence creates ambivalent feelings in the victim and an ambivalent attachment toward the perpetrator.

It also seems as if the attachment style formed during the interpersonal trauma becomes the relational blueprint, which influences how the victim approaches other relationships. Ultimately, all relationships have come to be viewed through the lens of extremity. These trauma survivors, accordingly, transfer the feelings of ambivalence they had toward the perpetrator to others and, as seen in the results obtained in this study, they begin to oscillate between intense attachment and terrified withdrawal in all relationships (Herman, 1992b). Herman (1992b), specifically refers to BPD patients when describing the impact of prolonged childhood trauma on these patient's wavering attachment and interpersonal style. Herman (1992b) elaborates by stating these patients typically find it difficult and intolerable to be alone, yet at the same time may be exceedingly wary of others.

According to Melges and Swartz (1989), BPD patients are terrified of abandonment, on the one hand, and domination, on the other, in a similar manner as when they were held captive by their perpetrator. This serves to explain their oscillation between being overly submissive on some occasions and furiously rebellious in other circumstances.

It should be mentioned that although this wavering interpersonal style represents these female's attempts at resolving the inner conflict, they experience in attaching to others post trauma, this ambivalent style of interacting creates immense confusion in others and, ultimately, results in rejection and avoidance from others. This leaves these females feeling lonely, isolated, depressed and angry, as evidenced in the results obtained.

5.1.2.2. Sub-theme 2: Resorts to interpersonal distance.

In line with their wavering interpersonal style, participants would at times seek interpersonal distance. They would typically achieve this by keeping to themselves, remaining distant and detached in relationships, and avoiding interpersonal interaction where possible. They will also tend to be overly private, hiding their true self and limiting self-disclosure. Their interpersonal demeanour is mostly serious, restrained and reserved. This style of interaction creates immense difficulties for them in relating to others.

According to Luyten and Blatt (2011), *relatedness* is one of the key aspects necessary in order to achieve optimal mental health. Relatedness in this regard is defined as the development of increasingly mature, intimate, mutually satisfying and reciprocal interpersonal relationships. Since the females within the current study possessed an interactional style that hampers their engagement in intimate and reciprocal relationships, their mental health and recovery is bound to be negatively impacted.

Accordingly, the participants were shown to struggle immensely with forming interpersonal connections and close attachments. As mentioned previously, literature has shown that complex trauma survivors generally struggle with forming attachments to others due to the negative impact their past trauma has had on their attachment style. In addition to the attachment difficulties they experience, which can account for their tendency to remain distant in relationships, research has also found that these individuals are prone to utilise avoidance strategies as part of their coping mechanisms, post trauma.

According to van der Kolk (2000), traumatised individuals engage in avoidance manoeuvres in which they are prone to avoid people, actions or circumstances that remind them of the initial trauma. Since their trauma was characterised by abuse and neglect from others, it is fitting that the participants may attempt to avoid interpersonal interactions in an attempt to keep themselves safe from future hurt and disappointment. Likewise, these participants have learned

others cannot be trusted and have come to expect disappointment, as evidenced in their assessment results.

Due to their history of powerlessness in the trauma situations they experienced, the participants of the current study were found to struggle tremendously with issues of powerlessness, trust, helplessness and safety (Herman, 1992a). These feelings reinforce their belief that others should be kept at a distance. Another aspect to consider, as mentioned previously, is that their trauma histories were characterised by significant interpersonal domination (Herman, 1992b). As a result, their avoidance of others can also be seen as a defensive attempt at avoiding interpersonal domination at all costs.

However, in an attempt to safeguard themselves from others, through increased interpersonal distance, these participants are also likely to feel lonely, isolated and alienated from others, as reported in their assessments. It was also found that they lack much needed support, and attempt to be overly self-reliant, not accepting or asking help from others. This pattern of interaction results in them being highly dissatisfied in relationships.

According to van der Kolk et al., (2007), traumatised individuals' tendency to avoid others ultimately results in them lacking the much needed interpersonal support necessary for these individuals to heal from their past traumas. This becomes more noteworthy when considering these participant's traumas were interpersonal in nature. As such, part of the healing process will need to include the restoration of their faith and trust in interpersonal relationships as well as the healing of the interpersonal wounds created. However, this can only be done in an interpersonal context, which will not be achievable if the participants continue to avoid interaction with others and avoid accepting support and help from others. This results in them remaining stuck in their trauma and unable to heal.

5.1.2.3. Sub-theme 3: Seeks interpersonal dependence.

On the contrary, as mentioned, their wavering style of interacting also results in most participants being overly dependent on others. They are inclined to need

excessive support, guidance and reassurance from others and demonstrated a strong need for nurturance and security. The participants were found to seek excessive interpersonal closeness at times, and all participants generally seemed to lack autonomy. Fearing abandonment and rejection, they may tend to avoid disagreement and conflict at all cost. In this regard, findings indicated they are prone to being overly agreeable, submissive and co-operative, to the point where they become self-sacrificing. Likewise, they tend to conform to the expectations of others in order to ensure nurturance.

At the extreme, it was shown that some of the participants may even perpetuate harmful relationships and may place themselves in demeaning positions. This is partly done to ensure nurturance and security, however, is also motivated by their negative view of themselves as deserving of suffering and pain. Accordingly, they may be inclined to occupy the role of a martyr and open themselves up to being vulnerable to exploitation.

As mentioned, the trauma that the participants experienced was characterised by various forms of coercive control. As a result, the methods used by the perpetrator was designed to instil terror and helplessness, and to destroy the victim's sense of self and personal agency. Because of this type of constriction, chronically traumatised individuals are often observed as being passive or helpless, as evidenced in the assessment results of these participants (Herman, 1992b). This is further supported by a study done by Rademaker et al. (2008), in which a negative relationship between traumatic events and the personality trait of self-directedness was found.

This sense of *learned helplessness* and 'paralysis' becomes even more apparent when the trauma is the result of an attack by a family member on whom the victim also depended for financial, emotional and other forms of security (Walker, 1979; van der Kolk, 1987). In these cases, victims are prone to respond to these assaults of abuse and neglect with increased dependence and with a paralysis in their decision-making process (van der Kolk, 2000).

The current study's participant's struggles to function independently, plays a prominent role in their tendency to become and remain overly dependent on others. In this regard, since these women struggle to direct their own lives and take responsibility for their own decisions or life choices, they are thus in need of others to take the necessary responsibility for them. In turn, as they cannot adequately take care of themselves, they become excessively fearful and alert to signs of rejection and abandonment. These fears, ultimately, result in them behaving in overly submissive ways, neglecting their own needs and opinions in order to gain approval and nurturance from others. In essence the participants in the current study remain dependent as a result of the domination and control they experienced at the hands of others in their childhoods (Herman, 1992b). They have thus never learned how to stand up for themselves, make their own decisions and exert control in their own lives, as this would have been seen as rebellion and would likely be punished (Herman, 1992b). However, their dependency also holds them captive in the present, as they are never truly free to grow and learn new ways of behaving, and behaviours that allow them to become independent and self-sufficient.

5.1.2.4. Sub-theme 4: Lack of interpersonal trust.

All the participants were found to experience severe difficulty with trusting others. They generally tend to be overly cautious, vigilant and guarded in their interactions with others. They are also likely to question the motives of others and attempt to test their genuineness. Since they anticipate disillusionment, malevolence and challenge from others, they may generally attempt to protect themselves by creating interpersonal distance. However, these protective manoeuvres employed by the participants only keep them isolated from others and from potential sources of support. Accordingly, they limit their chances of experiencing positive interactions with others, which reinforces their negative beliefs about interpersonal relationships.

Findings also indicated that they are prone to being overly paranoid and suspicious of others, which creates a high level of anxiety in social interactions. This again leads to them withdrawing from social interactions. Literature and previous

research have demonstrated similar findings and have shown interpersonal trauma has a profound effect on the survivor's capacity to trust others (Herman, et. al 1989; Herman, 1992a; van der Kolk 2000). A traumatised individual in this regard tends to perceive all other relationships based on the negative experience they had during the interpersonal trauma.

More specifically, the childhood trauma these participants suffered represents significant boundary violations. These violations severely dishonoured their trust. As such, they may attempt to safeguard themselves from further violation by becoming overly sensitive to signs of threat, fearful and hypervigilant around others, which was observed in the current study's participants' assessment results. These findings are in line with research done by Herman et al. (1989) in which she also found excessive interpersonal sensitivity among survivors of past complex trauma. Due to their history of powerlessness in a trauma situation, these individuals struggle tremendously with issues of powerlessness, trust, helplessness and safety, feelings that pervade their existence and their outlook on their world (Herman et al., 1989).

5.1.2.5. Sub-theme 5: Aggressive interactions.

Analysis indicated most participants were prone toward aggressive interactions with others. Some participants seemed to be more comfortable with overt acts of aggression, which manifests itself in sadistic and oppositional behaviour. These participants are also prone to anger outbursts, which provokes rejection and avoidance from others. Other participants were more inclined to covert displays of anger and acting in a passive-aggressive manner. In this regard, they are likely to become defensive, self-justifying and manipulative toward others, which yet again provokes rejection from others.

All participants were found to foster deep-seated anger toward others, which negatively impacts their interpersonal relationships. Research has found that complex trauma survivors' tendency to harbour intense anger is due to their unexpressed anger toward the perpetrator of their childhood trauma. According to Herman (1992b), the survivor of *complex childhood trauma* carries a burden of

unexpressed anger, not only against the perpetrator, but against all those who remained indifferent and failed to help. The anger mainly remains unexpressed as these individuals have learned any expression of anger, opposition or disagreement may result in retribution. As such, even though the original events during the trauma are no longer occurring, these individuals may still fear expressing their anger as they have learned it will result in further abuse or punishment. Herman (1992b), goes on to state that these individuals' efforts at controlling this deep-seated rage may be responsible for further exacerbating their social withdrawal as well as their paralysis of initiative (underlying their need for interpersonal dependence). Occasional outbursts of misplaced rage against others may also be common and act to further isolate the trauma survivor from others and, ultimately, prevents the restoration of relationships (Herman, 1992b).

The oppositional tendencies seen in the results of the participants may also be attributed to their intense desire to avoid domination, as mentioned previously. In a misguided attempt to assert their independence, these individuals may become oppositional, hostile and aggressive in order to keep themselves safe from perceived coercive control and domination (Herman, 1992b). However, as seen in the findings of the participants, these individuals are overly sensitive and alert for signs of threat and harm and, accordingly, may risk misinterpreting others' intentions and respond in an erroneous manner, which severely complicates interpersonal exchanges.

5.1.2.6. Sub-theme 6: Possesses an immature understanding of others.

Findings indicated almost all participants had an immature and overly simplistic understanding of others. They typically have grave difficulty in viewing others as complex, complete and multifaceted individuals. This leads to them possessing faulty perceptions of others and results in frequent misunderstandings.

Their unsophisticated view of others also increases the amount of confusion they experience in interactions with others and, generally, increases their dissatisfaction in relationships. These misunderstandings and confusion in their interactions with others is also fuelled by their difficulty in clearly expressing

themselves. A study by Rauch, van der Kolk, and colleagues (1996), provides support for this notion, as they found trauma survivors display a significant decrease in activation in Broca's area of the brain, which is responsible for translating personal experiences into communicable language.

Other studies have also shown that during prolonged childhood trauma, survivors may employ *mind-fragmenting operations*, specifically to preserve the illusion their abusers are good (Shengold, 1989). This is even more relevant when the perpetrators of the trauma are the child's parents, as the illusion of a good parent is key to the child's mental wellbeing. These survivors thus protect themselves by creating fragmented, over simplified, and split-off representations of others in order to guard against complete psychological breakdown during the trauma. Shengold (1989) further indicated that the establishment of isolated divisions of the mind, in which contradictory images of the self and the perpetrators are never permitted to coalesce, is of utmost importance in psychologically protecting the self of the trauma survivor. However, these strategies employed as protective manoeuvres hamper the resolution of the trauma in later life.

It should also be mentioned that the participants' understanding of others is mainly influenced by the exchanges they had with the perpetrators of their trauma. Their understanding of others has accordingly been damaged and deformed by the pathological interactions they had in their childhood. As such, they are prone to view others through the same lens as they did the trauma interactions with perpetrators (Herman, 1992b). These individuals are, accordingly, more likely to view others as unprincipled and self-serving, only interested in their own needs and willing to become aggressive and abusive in order to achieve their goals (Coutois, 2004; Herman, 1992b). This faulty view of others, misguides and taints their interpersonal interactions causing significant difficulty in such relationships.

5.1.3. Meta-theme 3: Emotional dysfunction.

5.1.3.1. Sub-theme 1: Emotional instability.

All participants displayed a marked disturbance with regards to emotional stability. They all displayed poor emotional control and struggle to regulate their emotions. This results in an inability to stabilise their emotions. Their behaviour is typically characterised by a high degree of emotional reactivity, labile and erratic moods, and affectively driven behaviour.

This is in line with Millon's view of BPD patients, in which he posits that individuals with BPD are prone to be emotionally unstable, with mood levels that frequently fail to reflect their external reality. They display a cornucopia of affective states and are highly unpredictable due to the fluctuation of these states. As a result, it makes them extremely erratic and difficult to interact with (Millon et al., 2015).

According to Coutois (2004), the inability to regulate affective experiences is one of the most prevalent symptoms of prolonged childhood trauma. This observed difficulty with emotional regulation can be attributed to the physical and emotional changes these individuals go through in order to recalibrate themselves after such an experience. One such area negatively impacted, as a result of exposure to *complex childhood trauma*, is the affected individual's attachment. The concept of attachment is not only crucial to understanding how interpersonal relationships are influenced post trauma, but also how emotional reactions are managed. According to Lyons-Ruth, Yellin, Melnick and Atwood, (2003), episodes of child abuse and neglect can disrupt the important process of attachment, and interfere with a child's ability to seek comfort and to regulate their own physiological and emotional processes.

The negative impact of complex trauma on attachment and emotional regulation is even more profound when the perpetrators of the trauma are the child's parents or caregivers. In this regard parents, who serve as young children's primary social context, teach them the needed skills in order to modulate their emotional regulation. A secure attachment bond with parents is thus a primary defence against

the trauma-induced stress some children may experience, and also acts as a secure base from which they learn to manage intense emotions (Booth & Jernberg, 2010).

More specifically, parent-child attachment, and the general climate in the childhood home, plays a critical role in the development of emotional regulation, which is the ability to modulate and control the intensity and the expression of feelings and impulses in an adaptive manner. Maltreated children generally live in a world of emotional turmoil and extremes, making it difficult for them to understand, label and regulate their internal states (Herman, 1992a). Should they experience a secure attachment with their caregivers, it could serve as a protective factor against such emotional turmoil and teach young children how to deal with these affective states.

However, should the perpetrators of the trauma be the caregivers or parents, as is the case of the participants in this study, emotional regulation and secure attachment becomes impossible. Not only are they not taught emotional regulation strategies, but any expression of emotion may be prohibited in these abusive environments. This is of significance since expressions of affect, such as crying, or signals of distress, may trigger disapproval, avoidance or abuse (Herman, 1992b). As such, maltreated children tend to inhibit their emotional expression and regulation and remain more fearful and on alert, a pattern they continue to repeat into adulthood. These difficulties in regulating and expressing their own emotions are later inadvertently expressed in numerous ways in the form of depressive reactions, anger outbursts, and fearfulness, as well as other forms of psychopathology (Cicchetti & Rogosch, 2001).

It should also be mentioned it is not only the learned behaviour of these individuals that complicates their emotional regulation, but also the biological changes their body makes in order to cope with the prolonged trauma. In this regard, research studies have found that the emotional regulation difficulties experienced by maltreated children are linked to alterations in the development of these children's brain structure. In general, traumatic experiences cause the child's neurophysiology

to become hyper-aroused and the child to feel fearful and easily dysregulated (Booth & Jernberg, 2010). Since their neurobiology is on constant alert, they are more prone to be triggered and upset by environmental stimuli. This ongoing flooding of emotional reactions, accordingly, makes it difficult for them to maintain an emotional equilibrium, thus hampering their efforts at emotional regulation.

5.1.3.2. Sub-theme 2: Wavering and ambivalent approach to emotions.

A noteworthy tendency to experience wavering and ambivalent emotions was found in all participants. In this regard, they will tend to vacillate between either suppressing their emotions, in some instances, and being flooded by extreme emotions, on other occasions. Their inconsistent approach to emotional stimuli/phenomena further increases their difficulty in stabilising their emotions, as mentioned above. They are prone to having mixed affective experiences, with some participants displaying a tendency to experience pain as pleasure. Analysis further indicated all participants show displays of both traumatic numbing and traumatic flooding, which likely underlies their wavering emotional style and indicates difficulty in effectively processing the trauma they experienced. This emotional style likely prolongs their suffering and leads to various difficulties in other areas of functionality.

An explanation for this wavering approach to emotions is offered by Carlson and Dalenberg (2000), in which they propose the aspects of re-experiencing and avoidance of the trauma is central to understanding trauma reactions. *Re-experiencing* symptoms occur when an individual is cued by a conditioned stimulus associated with the trauma. This brings about a range of symptoms, which may include intrusive thoughts, intrusive images, anxiety, fear, increased activity and aggression, physiological reactivity, flashbacks and nightmares (Carlson & Dalenberg, 2000). The symptoms that occur as a result of a re-experiencing episode may be akin to the traumatic flooding the participants of this study were indicated to experience. In these instances, the participants of this study might be flooded with overwhelming emotions they struggle to control. These episodes may also be

characterised by them experiencing of a mixture of emotions simultaneously, as indicated in the participants' assessment results.

According to Carlson and Dalenberg (2000), *avoidance symptoms*, on the other hand, occur because they provide trauma survivors with a relief from the anxiety associated with trauma-related stimuli. In essence this tendency to attempt to avoid stimuli, that might remind these individuals of the trauma, provides them with a temporary escape of their traumatic past. These symptoms may include: amnesia of the trauma, derealisation, depersonalisation, emotional numbing, isolation of affect, avoidance of trauma related situations and sensory numbing (Carlson & Dalenberg, 2000). All of these symptoms are designed in some manner to avoid an aspect of their experienced trauma.

Carlson and Dalenberg (2000) argue even the experience of any emotion may remind the trauma survivor of the intense emotions they experienced during the trauma. These symptoms can thus be likened to the traumatic numbing the research participants were found to experience in their assessment results. In this regard, findings indicated these women will at times attempt to avoid and suppress all emotions in an attempt to block themselves off to the emotional pain they still experience as a result of their past trauma.

Because the participants tend to vacillate between emotional flooding, due to re-experiencing symptoms, and emotional numbing due to avoidance symptoms, they never achieve a state of emotional stability. Their tendency to operate according to the emotional extremes of flooding and numbing also postpones their processing of these emotions and the healing of the trauma, as their extreme emotional states hampers therapeutic endeavours. It will, accordingly, be necessary to first teach these individuals emotional regulation skills before the trauma can be successfully processed.

5.1.3.3. Sub-theme 3: Possesses a paucity of psychological resources.

Most participants demonstrated a scarcity of psychological resources, which leads to them being easily overwhelmed by life stress and their psychological resources easily depleted. They are, accordingly, prone to experiencing frequent emotional distress and turmoil. Analysis also indicated some participants possessed a tendency to shut down emotionally when their emotional resources are overwhelmed, negatively impacting their functioning.

Three aspects can be considered in order to offer an account for these findings. The first facet to consider is the impact a complex trauma has on a developing child's ability to develop *adaptive coping mechanisms*. In this regard, the cycle of normal child development, which includes the development of coping mechanisms and psychological resources, is significantly disrupted by such trauma.

According to Mash and Wolfe (2005), the impact of childhood trauma negatively affects a number of critical developmental areas. More specifically, these developmental failures are likely to lead to adaptation and coping difficulties for the affected individual (Mash & Wolfe, 2005). When considering *complex childhood trauma*, it becomes apparent that the trauma might not only be significant, due to its early onset, but may also occur at a crucial developmental period when many psychological structures are still in the process of formation (Booth & Jernberg, 2010). Accordingly, it can be reasoned that the psychological resources that would have developed, if these individuals had a supportive and adaptive childhood environment, were never given the chance to develop and, instead, unhealthy coping mechanisms were adopted in the place of adaptive strategies. This view is supported by Herman (1992a), who indicated repeated trauma in childhood forms, and deforms, the personality of which psychological resources and coping mechanisms are a part.

Millon also supports these findings in his theory on the development of pathological personalities. In this regard, he refers to the concept of *tenuous stability*, which he uses to describe the lack of resilience and degree of fragility experienced

by certain psychiatric patients when placed under conditions of subjective stress. He elaborates by explaining that these individuals are likely to revert to former pathological methods of coping, since effective coping strategies have not been developed (Jankowski, 2002). This is likely even more applicable when considering the disruption in childhood development experienced as a result of childhood trauma and seems to adequately describe the coping behaviour of the female participants in this study. Millon further states that this lack of effective coping methods, and psychological resources, leave these individuals susceptible to further difficulties and disruptions, which only act to reinforce the use of preferred pathological styles of coping (Jankowski, 2002).

Millon's view not only accounts for the lack of adaptive coping mechanisms in traumatised individuals, but also focuses on the maladaptive coping mechanisms these individuals have developed in order to cope with the trauma. This accordingly marks the second aspect to consider, which is the various *maladaptive coping mechanisms* these individuals possess.

Another prominent theorist and psychologist, Pierre Janet, who was influential in shaping our understanding of trauma and psychopathology, also offered support for this view of trauma and pathological coping. According to Janet (as cited in van der Kolk, 2000), traumatised patients appear to react to reminders of the original trauma with behaviours relevant to their past threat, however, these behaviours currently have no adaptive value. Accordingly, it can be understood that these individuals act as if the original trauma is still occurring and applies coping mechanisms in response to this belief. However, the coping mechanisms employed are ill-suited to their current circumstances. As such, they tend to display rigid strategies for coping with current stressors which are not suited to their current context, and results in them not being able to adequately cope with these life stressors.

This is in line with literature on the impact of childhood trauma on childhood development. Research has indicated that trauma survivors possess the tendency to

engage in multiple coping strategies designed to minimise or avoid the aversive emotions brought forth by the trauma (Write et al., 2007; Zwickl & Merriman, 2011). These maladaptive coping strategies typically include an array of pathological behaviours such as substance use, dissociative behaviours, suicidal or self-injurious behaviour, aggression, over and under sexualised behaviours, and poor self-esteem (Herman, 1992a; van der Kolk, 2000).

In addition, these maladaptive responses may persist into adulthood and cause lifelong impairments, which may include anxiety, depression, academic and occupational difficulties, unhealthy partner relationships, and sexual dysfunction, (Arreola et al., 2009; Black and DeBlassie, 1993; Cohen et al., 2000; Gilbert et al., 1997; Loeb et al., 2000; Mimiaga et al., 2009; Najman et al., 2005; Watkins and Bentovim, 1992). Accordingly, of relevance is the fact that not only do the participants in this current study display a scarcity of adaptive coping mechanisms, but they also seem to possess an abundance of maladaptive coping mechanisms, which intensifies their difficulties and the stress they experience.

A third aspect to consider is the impact of the trauma on the *psychological resources* that are available to the survivors. According to Janet (as cited in van der Kolk, 2000) trauma survivors' internal struggle with trauma memories and their attempts at avoiding any reminder of the trauma negatively impacts their ability to cope with everyday life. He specifically indicated that the efforts to keep the fragmented traumatic memories out of conscious awareness, basically eroded the psychological energy of these individuals.

As such, these participants within the current study may possess a paucity of psychological resources as indicated in their assessment results, since the little resources they do possess are being depleted by their internal struggles with their unprocessed traumas.

5.1.3.4. Sub-theme 4: Demonstrates poor psychological boundaries.

Analysis indicated a widespread difficulty with psychological boundaries among all participants. This results in difficulty managing their internal and external

experiences. Internally, they are prone to be distracted and may experience an abundance of disruptive internal stimuli. Similarly, they also lack insulation against environmental inputs and tend to be overly sensitive and aware. This significantly impacts them emotionally and increases their emotional turmoil.

When considering the relationship between poor psychological boundaries and the experience of past childhood trauma, of greatest significance is the fact that the acts these women were exposed to during their trauma, presented significant boundary violations (Herman, 1992a). More specifically, the lack of boundaries displayed by these individuals can be regarded as a natural maladaptive consequence when considering the degree of domination and control these women had to endure as a part of their childhood trauma (Herman, 1992b). In this regard, the development of psychological boundaries was prohibited, and, in fact, any act of self-assertion and independence would have been regarded as oppositional and deserving of punishment (Herman, 1992b).

In this sense, a psychological boundary can be thought of as a limit an individual sets in order to protect him/herself from emotional or physical harm. According to Whitfield (2010), psychological boundaries thus, assists in protecting and delineating where one individual's reality ends and another's begin. Accordingly, a psychological boundary is extremely important in defining where an individual's sense of self begins, and what they deem as appropriate and acceptable interactions with others. However, not only do psychological boundaries define a limit between the self and others, but it also defines a limit between the self and the external world. In this regard, these psychological boundaries also determine what an individual pays attention to and which external stimuli they allow to have an impact on them. Should they be overly aware and open to external stimuli, they may risk becoming overstimulated and overwhelmed, as observed in the assessment results of these participants. On the other hand, should they be too cut off from their external world they risk losing out on much needed stimulation and may risk becoming isolated and depressed. This is confirmed and expanded on by van der

Kolk (2000), who states that the trauma survivor's heightened awareness to external stimuli, which resembles the past trauma, results in a degree of oversensitivity, where innocuous stimuli may be misinterpreted as potential threats. In order to compensate for the overwhelming feelings they may experience as a result of this heightened awareness, trauma survivors may also tend to shut down when they have reached the limit of their stimulation tolerance. However, the consequences of shutting down is decreased involvement in ordinary and everyday life (van der Kolk, 2000). As such, it becomes apparent that these individuals struggle to stabilise the manner in which they apply their psychological boundaries.

The findings of this study, similarly, showed the participants tended to vacillate between displaying too open and too rigid psychological boundaries. In some circumstances they may allow too much external stimuli to interfere with their emotional well-being, which is characterised by over-sensitivity and feeling overwhelmed. On the other hand, they may tend to shut all external stimuli out and limit their engagement with the external world, which can be seen as a display of avoidance mentioned earlier. In this regard, they ultimately lack healthy psychological boundaries, balance and stability.

As indicated by the assessment results, the participants also tended to become internally distracted by their own emotional stimuli and thoughts. Not only did they display poor external boundaries, but they also demonstrated poor internal ego boundaries. As such, they are likely to become emotionally triggered and overwhelmed by both external stimuli and internal stimuli, such as their own thoughts, emotions and memories. In essence assessment results indicated that the participants of the current study did not know how to set psychological limits within themselves, between themselves and others, and between themselves and their external worlds. A behavioural pattern which was learned as a result of their inability to set appropriate limits during their experience of childhood trauma. This lack of protective boundaries against external stimuli, internal stimuli and in relationships,

however, severely impacts their emotional stability, and leads to an increase in emotional turmoil.

5.1.3.5. *Sub-theme 5: Displays an avoidance of emotions.*

Many of the participants showed a tendency to suppress their emotions in an attempt to avoid painful thoughts and accompanying emotions. In this regard, these participants are prone to deaden and dampen their emotional reactivity, become affectively blunted and display severe apathy. This makes it difficult for them to resolve their psychological trauma, as mentioned previously.

According to Mineka (1979), a traumatised individual will attempt to systematically avoid reminders of the trauma, however, this results in no opportunities for the trauma reaction to become extinct. This view is supported by Janet (as cited in van der Kolk, 2000), who posited that the very avoidance of emotional reactions to past traumas keeps these traumas from being processed by the brain. More specifically, he stated that should an emotional reaction to the trauma be suppressed, the affect it elicits stays attached to the memory of that trauma. Accordingly, the trauma survivor's reaction to the trauma can only exercise a complete cathartic effect, or release, if the emotional reaction of that person is an adequate reaction. This Janet termed an *Abreaction*.

However, a multitude of literature exists which shows traumatised individuals tend to do the exact opposite, that is they attempt to avoid all reminders of the trauma and all emotionality which could trigger trauma memories. A study conducted by Carlson and Dalenberg (2000), particularly focused on the avoidance behaviours of trauma survivors. As mentioned previously, they indicated avoidance symptoms, which includes the avoidance of emotions in general, occurred because it offered significant relief from the anxiety trauma survivors experienced as a result of the trauma. It also offers these individuals the chance to avoid any reminders of their past trauma. In this regard, they specifically mentioned the avoidance of affective states typically presents itself as emotional numbing. This behaviour is typical since a traumatised individual may feel reminded of the past trauma as a result of

experiencing any strong emotions. As such, strong emotions are all reminiscent of the extreme anxiety and emotional arousal trauma survivors experienced during the time of the trauma (Carlson & Dalenberg, 2000).

However, these individuals' emotional avoidance and numbness become completely disconnected from the protective purpose it serves, and, accordingly, can be confusing to outside observers and even to the trauma victims themselves. Viewing this avoidance of emotions as a maladaptive, yet protective factor, accordingly, becomes crucial in assisting these individuals' healing from the trauma and starting to view and experience emotions in a non-threatening manner.

5.1.3.6. Sub-theme 6: Experiences severe depression.

All participants showed high levels of depressive symptoms. Their depressive reactions are typically characterised by a diminished level of pleasure, feelings of worthlessness, pessimism and hopelessness. They also displayed a characteristically low level of self-confidence and was indicated to frequently feel guilty, unworthy and exhibit self-depreciation. All participants possessed a dysphoric and negative view of their world. Their negative feelings typically tended to compromise their positive experiences and enjoyment. This view is intensified by some participants' proclivity toward increased displays of brooding over negative past experiences. Most participants had low levels of motivation and energy. Some participants further showed an inclination toward being drawn to dreary and gloomy stimuli, which intensifies their depression.

At the extreme, all participants reported some form of suicidal ideation, attempts or self-harm behaviour. Underlying feelings of emptiness, loneliness and helplessness were also found for all participants.

Coutois (2004) states that clinicians run the risk of classifying the depression trauma survivors present with merely as a comorbid diagnosis, when in fact it is actually better conceptualised as a part of the trauma reaction and part of post-traumatic adaptation seen in complex trauma.

Carlson and Dalenberg (2000) similarly conceptualises depression in trauma survivors as a secondary symptom, when the core symptoms of trauma, which they regard as re-experiencing and avoiding symptoms, as elaborated upon earlier, lead to feelings of loss of control and subsequent feelings of despair. The concept of loss of control is extremely relevant in this regard when considering a trauma survivor's depressive state.

According to the *learned helplessness* model of depression, the belief that one has no control over what happens to you can lead to despair (Seligman, 1975). More specifically, when individuals are exposed to a negative and painful event, which they cannot control, such is the case with *complex childhood trauma*, they will learn that any attempt at protecting themselves from harm is pointless. Accordingly, they stop trying to help themselves, or to protect themselves, rendering them defenceless, hopeless and powerless in their own eyes. Not only do these individuals adopt this belief to cope with the initial trauma, but research has shown they continue to perceive themselves as powerless long after the trauma has passed, and they have regained a level of control (Maier, 1984; Seligman, 1975). This can account for many of the depressive symptoms observed in trauma survivors, such as feelings of helplessness and worthlessness, passivity, negative thinking and apathy.

It should also be mentioned that protracted depression is reported as the most common finding in many clinical studies on complex trauma survivors (Goldstein et al. 1987; Herman 1992b; Hilberman 1980; Kinzie et al., 1984; Krystal 1968; Walker, 1979). According to Herman (1992b), all aspects of complex trauma combine to aggravate and cause the depressive symptoms observed in trauma survivors. In this regard, she specifically mentions how the paralysis, and lack of initiative of trauma, combines with the apathy and helplessness in depression. She also mentions that the disruptions in attachment caused by trauma, reinforces the isolation and withdrawal from others in depression. The dissociative syndromes of trauma in this regard, also closely resembles and exacerbates the concentration difficulties of depression. Furthermore, the negative self-image and feelings of guilt and worthlessness created

by the trauma is also found in the symptoms of depression. Instead of sitting with various independent diagnoses and symptoms, it would appear that complex trauma results in a combination of complex symptoms, which are all interconnected in some manner, with depression closely connected to the past trauma experiences of trauma survivors.

Sub-theme 7: Experiences excessive anxiety.

Another prominent symptom found in the assessment results of all participants was excessively high levels of anxiety. In this regard, they all have a characteristic style of worry and unease that characterised their existence. In general, all participants tended to be overly vigilant, apprehensive, restless and tense. Their high levels of anxiety also led to increased distractibility and them feeling agitated and on edge. Some participants were found to experience panic attacks, while others were more prone to social anxiety.

Abram Kardiner (1941), in his work with the trauma experienced by war veterans, noticed sufferers of traumatic neuroses tended to develop an enduring vigilance and sensitivity toward environmental threat. He went on to describe this hypervigilance, and heightened physiological arousal from trauma, as a physioneurosis. He stated that trauma patients display a lowering in their threshold for stimulation and seemed to be in a constant state of readiness for fright reactions.

This finding has also been confirmed in numerous other studies, which describe the alterations that trauma survivors' central nervous systems undergo (Booth & Jernberg, 2010; Heim et al., 2000; Herman 1992a; van der Kolk, 2000). In this regard, studies have shown that trauma impacts the developing child's neuroendocrine system, which becomes highly sensitive to stress. Specifically, the emotional-anger centre of the brain, the amygdala, is activated, triggering chemical responses associated with fear and anger (Gerhardt, 2004). The impact of trauma on the neuroendocrine system also results in high levels of the stress hormone, cortisol, to be released in the trauma survivor's body. Although this is an adaptive biological response to short periods of stress, victims of complex and prolonged childhood

trauma suffer prolonged stress. When an individual's stress reaction becomes chronic, higher levels of cortisol are released in their systems and a decline in their ability to manage stressors is accordingly manifested (Meyer & Quenzer, 2005). More specifically, chronic high levels of cortisol can cause receptors to malfunction and constantly remain activated, keeping the trauma survivor in a constant state of vigilance, which results in them being overly suspicious of any sensations that might signal possible danger (Booth & Jernberg, 2010).

Another study also noted that the cingulate gyrus, and areas of the limbic system, are significantly impacted by complex trauma. This typically results in a higher level of sensitivity to emotional signals and these individuals being more sensitive to situations that evoke sadness, anxiety and fear responses (Dubin, 2001).

According to Fisher and Kelly (2007), trauma survivors' brains ultimately become "fear-driven" and are conditioned to react reflexively to the slightest hint of past trauma. Although these individuals' bodies typically employ these adaptations as a means to protect themselves from future danger, the emotional turmoil and chronic anxiety these individuals experience causes more long-term dysfunction than it offers protection.

5.1.3.7. Sub-theme 8: Experiences intense anger.

All participants showed an inclination to experiencing some form of underlying anger. While some participants would be openly aggressive, others prefer displays of passive aggressive behaviour. Those who overtly express their anger were found to be prone to displays of obstructive, extreme and irrational anger. They were, accordingly, likely to have erratic anger outburst, be hostile, frustrated and irritable. These displays were found to significantly damage their interpersonal relationships and the guilt that followed these anger displays acted to increase their depressive and anxiety symptoms. Passive aggressive acts were engaged by those more fearful of an outright display of the anger they felt. Although still an indication of underlying anger, these acts were rather characterised by more subtle displays of hostility and irritability, yet also tended to negatively impact relationships.

As mentioned, previous research has indicated the origin of these individuals' anger lies in their unexpressed anger toward the perpetrators of their complex trauma. As children exposed to coercive control and domination by the perpetrators of their trauma, the participants of the current study could not express the anger they felt during the trauma due to fear for retribution (Herman, 1992b).

Carlson and Dalenberg (2000), also noted the displayed anger and aggression found with trauma survivors could be a secondary symptom of the trauma they experienced; in that this likely, reflects the frustration these individuals experience with regard to the core trauma symptoms they are plagued with. In this regard, a trauma survivors' constant struggle with re-experiencing the trauma, being constantly hyperaroused and attempts at avoiding trauma triggers, likely cause significant frustration which is expressed as anger and aggression.

The aggression displayed by trauma survivors can also be conceptualised as an associated response to trauma, which may result from social learning and conditioning (Carlson & Dalenberg, 2000). This becomes of relevance if the nature of the trauma experienced by the individual in their childhood was aggressive, and the individual identified with the perpetrator's actions (Herman, 1992b). In this regard, these individuals could have learned aggression solves problems and gains co-operation from others, and may likewise attempt to utilise similar strategies to those they were exposed to in their childhood.

Another aspect of relevance when considering aggression post trauma, is that of self-directed aggression. According to Carlson and Dalenberg (2000), this could also be a secondary response to trauma, which can take the form of self-harming behaviours, disordered eating, compulsive sexual behaviour, risk-taking, suicidality and substance abuse, most of which was observed in the assessment results of study participants and is accounted for in the BPD DSM-5 diagnostic criteria. In this regard, Carlson and Dalenberg (2000) also postulate these displays of self-directed aggression are again reflections of the frustration these individuals experience in response to their trauma symptoms. However, since outward displays of anger are

frowned upon, some individuals rather turn their aggression inwards and inflict it upon themselves.

Herman (1992b), also mentions that these individuals' tendency to attempt to internalise their rage, in effect, results in increased self-hatred and chronic suicidality. This finding is also confirmed by Hilberman (1980), who stated that the humiliated rage that prolonged trauma survivors harbour, also increases their depressive burden. The negative impact suppressed anger has on trauma survivors' functioning was further described in studies done by Segal et al. (1976), and Gayford (1975). These studies indicated increased symptoms of tenacious suicidality, homicide, suspicious accidents and depression, which they attribute to the suppression of anger in their participants.

5.1.3.8. *Sub-theme 9: Displays PTSD symptoms.*

Multiple accounts of PTSD symptomatology were found throughout all participants' assessment results. Those aspects that mostly seemed to negatively impact their functioning included anxiety-ridden, painful memories, as well as frequent nightmares and flashbacks regarding the trauma. Many of the participants were found to be experiencing dissociative states, which is also accounted for in the BPD DSM-5 diagnostic criteria. A general tendency of avoiding any stimuli that may trigger trauma-related memories was also found among participants.

Various studies have indicated that *complex childhood trauma* survivors display multiple PTSD symptoms, however, these individuals also display numerous symptoms that go beyond the diagnostic criteria for PTSD, yet still seem to be directly related to their past trauma (Carlson & Dalenberg, 2000; Coutois, 2004; Herman, 1992b; van der Kolk 2000). This has complicated the task of clinicians when it comes to the diagnosis and treatment of complex trauma survivors (Coutois, 2004). Common PTSD symptoms experienced by complex trauma survivors include nightmares, flashbacks and intrusive memories of the trauma, avoidance of stimuli associated with the trauma, such as emotional numbness detachment and withdrawal from everyday life, increased arousal, such as hypervigilance, irritability and an

increased startle response, sleep disturbances, cognitive distortions or mood disruptions and concentration difficulties (van der Kolk, 2000). The exact DSM-5 criteria for PTSD can be found in Appendix G.

However, complex trauma survivors also display numerous symptoms that go beyond the diagnostic criteria for PTSD and are, at most, classified as associated features of PTSD in the DSM-5. These symptoms include: alterations in the regulation of affective impulses, such as difficulty modulating anger and being self-destructive, alterations in attention and consciousness leading to amnesia, dissociation and depersonalisation, alternations in self-perception, such as chronic sense of guilt and responsibility and chronically feeling ashamed, alterations in relationships to others especially with regard to the inability to trust or be intimate with others, somatisation difficulties for which no medical explanation can be found, and alterations in system of meanings (van der Kolk, 2000).

As a result of this phenomena, a PTSD task team (van der Kolk, 2000) was established as part of the DSM-IV field trial in order to delineate a psychological syndrome frequently associated with histories of prolonged, severe and interpersonal abuse. This syndrome was termed Complex PTSD or Disorders of Extreme stress Not Otherwise Specified (DENOS). However, although substantial evidence was produced to indicate sufferers of *complex childhood trauma* presented with a psychological syndrome, which seems to combine symptoms of PTSD, Depression, Anxiety, BPD and other personality disorders, Dissociation, Somatisation and Psychosis, no such inclusion has been made in the DSM-5, and clinicians are still faced with a conundrum when diagnosing and treating complex trauma patients.

According to Kolb (1989), the heterogeneity of PTSD is not sufficient to account for the trauma symptoms that victims of *complex childhood trauma* display. He mentions PTSD symptoms may, at different times, mimic every personality disorder, and those individuals who have experienced trauma over long periods of time are especially prone to suffering long-standing and severe personality disorganisation. Accordingly, many authors and researchers have called for an

expanded concept of PTSD, which accounts for the effects of severe and prolonged trauma (Courtois, 2004; Herman, 1992b; Horowitz, 1986; Kolb, 1989; Kroll, 1989, van der Kolk, 2000). According to Herman (1992b), three broad areas of disturbance can be identified in complex trauma survivors that transcends simple PTSD. The first area entails the complexity of trauma symptoms complex trauma survivors display, which appears to be more complex, diffuse and tenacious than simple PTSD symptoms. A second point Herman (1992b) makes is survivors of prolonged trauma tend to develop characteristic personality changes, which includes distortions in their ability to relate to others as well as in their own identity. A third area of significance, when considering trauma symptoms of complex trauma survivors, is their vulnerability to suffer repeated harm, self-inflicted as well as from others. These typical behaviours encompass both PTSD-like symptoms as well as other characteristic behaviours.

In summary, although the female participants of this study displayed multiple PTSD symptoms, their psychiatric symptoms go far beyond a diagnosis of simple PTSD and need to be understood holistically in order to diagnose and treat them effectively.

5.1.4. Meta-theme 4: Behavioural futility.

5.1.4.1. *Sub-theme 1: Self-sabotaging behaviour.*

Most participants were found to engage in self-defeating and self-destructive behaviour. These participants typically showed a tendency to undermine themselves and their abilities. Likewise, they are prone to be overly self-sacrificing and to suppress their needs and opinions in order to favour others. Most participants were found to look for situations in which they can suffer. In this regard, it was also found the participants tended to provoke the disappointment they expect from others through their behaviour, which serves to confirm their low levels of trust in others, and likely underlies their self-sabotaging behaviour to some extent. It was also shown the participants did not typically seek to improve themselves and will go so

far as to inadvertently sabotage opportunities which can lead to change and growth. This acts to keep them stuck in their cycle of destructive behaviour and reinforces their emotional turmoil.

As mentioned earlier, chronically traumatised individuals possess a tendency to view themselves as deserving of suffering. As such, they are prone to inflict self-harm or self-sabotaging behaviours, which is in line with their beliefs of themselves (Herman, 1992b). Briere and Gil (1998) also found complex trauma survivors tend to use self-mutilation as a means of punishing themselves. This is further confirmed by Carlson and Dalenberg, (2000), who indicated the self-injurious behaviour of traumatised individuals is related to the feelings of self-hatred and disgust they foster as a result of being a victim of an interpersonal trauma.

Another aspect to deliberate, when considering the tendency of traumatised individuals to unconsciously sabotage themselves and cause their continued suffering, is the concept of *repetition compulsion* (Freud, 1920). This refers to an individual's unconscious tendency to reconstruct situations in the present that parallel failures or disappointments of the past, and to persist in the attempt to undo these disappointments even though these attempts repeatedly have proven unrewarding (Millon, 2011). More simply put, this tendency of traumatised individuals to 'repeat' their past traumas in certain ways, presents itself as an intense yet subliminal need in which they inadvertently rearrange their lives in such a manner in order for them to repeat the underlying pattern of their past trauma and intense suffering (van der Kolk, 2000). In this regard, the female participants of this study were found to repeat the past patterns of suffering and hurt through active efforts to re-create and overcome what was not achieved fully during the original trauma. Their tendency to be overly self-sacrificing and to suppress their needs and opinions, in order to favour others, can thus be viewed as a repetition of their past trauma, in which they place themselves in the position of a victim being dominated by someone in the same manner as the perpetrators of their trauma dominated them in their past.

Janet (as cited in van der Kolk, 2000), also described how chronically traumatised individuals tended to re-enact their traumas in the form of intense emotional reactions, aggressive behaviours, physical pain, self-injurious behaviours and certain bodily states that may all be understood as the return of certain elements of their traumatic experience. As such, self-harming behaviour is yet another way in which traumatised individuals sabotage themselves and continue to re-enact the pain and suffering they endured during their childhoods.

It should also be mentioned that some self-harm behaviour also serves the purpose of alleviating the intense emotions these individuals experience as a result of the trauma. This is confirmed by Carlson and Dalenberg (2000), who conceptualise self-harm as a form of self-directed aggression in an attempt to alleviate the high levels of frustration trauma survivors experience post trauma. Another reason for the self-harming behaviour, given by these authors, is it may serve as an attempt by traumatised individuals to interrupt the emotional numbness they are prone to. Herman (1992a), also suggested trauma survivors engage in self-injurious behaviours in order to improve their affective states. Other researchers indicated trauma survivors reported their self-inflicted pain as preferable to the emotional numbness they usually experience, that it makes them feel alive, and allows them to feel that their body is real (Briere & Gil, 1998).

5.1.4.2. Sub-theme 2: Behavioural instability.

Various indications of behavioural instability were found throughout the results of all participants. This was characterised by displays of wavering behaviour and unpredictability. Furthermore, participants were found to be prone to engage in emotionally-driven behaviour as well as to make emotional and irrational choices in this regard, which tended to have negative repercussions and increase their levels of stress and anxiety experienced. They were also found to vacillate between displaying a lack of agency in some circumstances and becoming behaviourally oppositional on other occasions. This amplified their unpredictability and creates confusion in their relationships with others.

Based on the findings mentioned, it is highly likely that there is an interrelationship between these participants' wavering emotions and their wavering behaviour, since results indicated they are prone to emotionally-driven behaviour. In this regard, the emotional state they are in at the time will have a significant impact on the behaviour they display. According to van der Kolk (2000), patients exposed to *complex childhood trauma* are prone to display emotion-focused coping and behaviour. In this regard, they seem to attempt to alter their emotional states instead of altering the circumstances that triggered their emotional state. As such, they are prone to be more vulnerable in engaging in risky behaviours, such as self-mutilation, substance abuse and risky sexual behaviour, in an attempt to modulate their emotions (van der Kolk, 2000).

Trauma survivors' impulsive behaviour may, likewise, be seen as a display of emotionally-driven behaviour. In this regard, the impulsive behaviour may seem out of the ordinary to outside observers, however, internally it is extremely likely these trauma survivors have been emotionally triggered by stimuli in their external world reminding them, consciously or subliminally, of their trauma and, accordingly, producing intense emotions which others are not aware of. In response to these intense emotions, these individuals might act impulsively as a means to counteract these negative emotions. These impulsive behaviours may include spending large amounts of money, anger outburst with no apparent trigger, substance abuse behaviours, self-mutilating behaviours, emotional eating, gambling or risky sexual behaviours. All these behaviours are inadvertently designed to assist trauma survivors in regulating their emotions, since they have not learned appropriate emotional regulation skills during childhood, due to the experience of complex trauma during those earlier years (Briere, 1992; Briere & Gil, 1998; McCann & Pearlman, 1990).

Another aspect, which should be mentioned when considering these participants' wavering behaviour, is the impact complex trauma has on their neurobiology and how this shapes their unpredictable behaviour. According to van

der Kolk (2000), *complex childhood trauma* survivors' neurobiology become hyperaroused to the point where they are on constant alert, feeling irritable, anxious, hypervigilant and on edge. Living with these constant levels of hyperarousal make traumatised individuals extremely susceptible to unpredictable behaviour, as minor stimuli in their external worlds might overwhelm their already overloaded central nervous systems, and result in them either over-reacting by acting out, or becoming passive and shutting down in order to down regulate their overstimulated levels of arousal (Myers, et al., 2002).

This phenomenon is also adequately explained by The Window of Tolerance theory (Siegel, 1999). According to this theory the *window of tolerance* can be thought of as the optimal zone of arousal in which individuals are able to manage and thrive in response to everyday life and situational demands. Every individual has an optimal level of arousal and a limit to the degree of arousal they can tolerate at any given time. When people are within their optimal zones of stimulation tolerance, they are typically able to readily receive, process, and integrate information and otherwise respond to the demands of everyday life without much difficulty. However, should an individual's limit for arousal and stimulation be overwhelmed or exceeded, they are likely to engage in flight, fight or freeze behaviours in order to ensure their psychological survival (Siegel, 1999).

Of significance is that traumatised individuals have been found to have narrower windows of tolerance, in essence they are more easily and more frequently overwhelmed by situational demands. In this regard, Siegel (1999), mentions individuals who have been exposed to childhoods characterised by recurrent and prolonged fear, may later associate feelings of fear with a sense of dread or terror that is disorganising to their systems, and significantly impacts their functioning and behaviour. Likewise, exposure to repeated traumatic experiences characterised by a sense of being out of control, that is experiencing emotions without a sense of others or themselves helping to calm them down, can result in these individuals being unable to soothe themselves as they develop. This description adequately seems to

capture the experiences of *complex childhood trauma* survivors and the participants of this study. Of greater significance is this lack of self-soothing can directly lead to the development of a narrow window of tolerance (Siegel, 1999).

The aftermath of such a narrow window of tolerance is that these traumatised individuals may respond to even minor stressors with extreme hyper- or hypo-arousal. In this regard, they are thus prone to either over-reacting or becoming passive and withdrawn, shutting down when faced with more than they can tolerate. This assists in explaining some of the unpredictable behaviour observed with traumatised individuals. Since their capacities for coping with everyday life may become exceeded at unpredictable times, and without much external warning, their behaviour may in turn also be regarded as unpredictable. However, their unpredictable behaviour, in actuality, merely serves as an attempt to regulate themselves back to a state of tolerance. As such, a traumatised individual's unpredictable and impulsive behaviour can thus be regarded as a direct reflection of their internal upset and emotional disorganisation.

5.1.4.3. Sub-theme 3: Displays impaired functioning.

All the participants were found to severely struggle in coping with everyday life challenges and demands. They are easily overwhelmed by life stress and their daily functioning was indicated to be impaired. In addition, it was also found these individuals show a tendency to be overly passive and generally lack personal agency. In this regard, they may avoid self-assertion and, at times, display physical impassivity. They are prone to avoid adult responsibilities, which in part may be due to them possessing few functional competencies. On the other hand, they may be prone to procrastinate and display purposeful inefficiency and obstinate behaviour due to their aforementioned high levels of interpersonal dependency. Accordingly, displays of regressive behaviour may be frequent to avoid adult responsibility and maintain this dependency. In line with this, they may also lack maturity and are prone to act in a child-like manner.

As mentioned previously, survivors of *complex childhood trauma* possess various maladaptive coping mechanisms and display a poverty of adaptive coping mechanisms. As such, they are prone to a multitude of adaptation and coping difficulties (Mash & Wolfe, 2005). Since these individuals have not learned how to effectively cope with stress, and do not possess the needed psychological resources in order to do so, they may be more easily overwhelmed when expected to deal with certain life difficulties.

Of equal importance is their tendency to become more easily overwhelmed than non-traumatised individuals. This can, again, be attributed to their narrow windows of tolerance, as discussed earlier. In an attempt to compensate for their lack of adaptive coping and limited ability to tolerate stimulation and stress, these individuals may start to withdraw from life and responsibilities because they preempt that they will not be able to deal with these challenges effectively (Siegel, 1999). These individuals may also begin to arrange their environments in such a manner as to avoid most stressors. This, however, only limits their opportunities to learn adaptive coping mechanisms and to widen their window of tolerance, ultimately keeping them dependent on others, and unable to adequately and independently deal with life stress. Millon also referred to this phenomenon as a lack in adaptive flexibility (Jankowski, 2002).

Another aspect that needs to be considered, when contemplating these individuals' tendency to avoid responsibility and independence, is the nature of the trauma they were exposed to and how it shaped their dependence on others. In this regard the passivity that they display can be regarded as a learnt behaviour on which their survival during childhood depended. As mentioned previously, these individuals were exposed to significant amounts of coercion and domination by the perpetrators of their childhood trauma. As such, they had to be subordinate, passive and accommodating or they might risk retribution from the perpetrators (Herman, 1992b). Due to the prolonged interpersonal control and domination they were exposed to, the participants in this study never learned to be independent, and seem

to replicate this pattern of subordination and passivity long after the threat of the trauma has passed.

5.1.4.4. Sub-theme 4: Insufficient behavioural control.

All participants were shown to be prone to displays of insufficient behavioural control. They may, accordingly, struggle to censor their behaviour, be impulsive and prone to impulsive outbursts. Likewise, indications of problematic over-productivity and a lack of inhibitory control was also found, which is in line with their poor psychological boundaries, noted earlier. As mentioned, some participants also have a proclivity toward passive-aggressive and oppositional behaviour which demonstrates their underlying anger breaking through their inhibitory controls and presents another display of insufficient behavioural control.

These participants' lack of behavioural control can again be attributed to their lack of emotional stability and inability to regulate their emotions. In this regard, their behavioural outbursts mirror the internal emotional disarray they experience. Many authors and researchers have shown their lack of emotional control results in impulsive behaviour (Briere, 1992; Herman, 1992b; Siegel, 1999; van der Kolk, 2000), as discussed in the sections above. These individuals, accordingly, may feel compelled to act in order to alleviate the intense emotions they experience, resulting in the lack of inhibitory control displayed in the findings of this study.

Of additional relevance is the heightened levels of problematic over productivity displayed in the assessment results of most of these female participants. It seemed these women lacked much needed censorship over that which they produced in their assessment sessions, indicating poor psychological boundaries, as previously mentioned.

Although the impact of poor psychological boundaries on the participants' behaviour has already been discussed in previous sections, of additional interest is the lack of stimulus discrimination, which accompanied their poor psychological boundaries and censorship. In this regard, van der Kolk (2000), indicated traumatised individuals struggle with concentration and are easily distracted by

irrelevant stimuli. They, accordingly, struggle to entertain a range of alternatives without acting upon them and becoming disorganised.

This was clearly seen in the assessment results of these participants, as they often produced more than what was expected of them and struggled to inhibit their responses without interference from the researcher. In this regard, the participants of this study have never learned to discriminate between relevant and irrelevant stimuli. This complicates their ability to inhibit their behaviour and results in them impulsively acting on their environment (van der Kolk, 2000). This increased awareness of environmental stimuli can further be attributed to their heightened levels of sensitivity, as discussed previously, with their increased awareness and difficulty in inhibiting their actions feeding into one another.

5.1.4.5. Sub-theme 5: Displays behavioural rigidity.

Behavioural rigidity was found in all participants. This results in them typically displaying inflexible behaviour, which may further lead to adaptation difficulties. All participants were also found to prefer the familiar as this provides a false sense of security. In line with this preference, is an intense aversion to change and new experiences, where all participants were found to view change as a source of severe stress. This aversion to change also keeps them trapped in a dysfunctional cycle of emotions, thinking and behaviour, and delays their healing from past trauma.

As previously mentioned, individuals who have experienced prolonged and *complex childhood trauma* tend to exhibit hyperarousal of their central nervous system. In this regard, their bodies are in a constant fight, flight or freeze reaction as their neurobiology has adapted in such a way as to suggest threat and danger is imminent (van der Kolk, 2000). Although these adaptations might, in some manner, serve a protective function to shelter these individuals from future harm, it also leads to them viewing the world as unsafe and dangerous. These individuals might, accordingly, engage in avoidance behaviours in order to protect themselves and to remain safe, and to escape the chronic levels of anxiety they experience as a result

of their hyperarousal (Coutois, 2004). This may, in turn, lead to them avoiding all new experiences, since the unfamiliarity of these circumstances could be regarded as more dangerous and more threatening than the circumstances they have grown accustomed to and have learned how to function in.

Millon (1990) also accounts for the behavioural inflexibility that the participants in this current study displayed in his evolutionary theory of pathology. This he termed *adaptive inflexibility*, which refers to an inappropriately rigid strategy an individual relies on to relate to the environment. In this regard, Millon describes these individuals as being unable to effectively adapt to life circumstances and, accordingly, they might attempt to arrange their environment in such a manner as to avoid events perceived as stressful. In this regard, the preference of these participants for the familiar and the avoidance of new experiences and change, is a display of this phenomenon.

Millon (1990) further indicates that individuals with personality pathology, such as the participants in this study, may become caught up in what he describes as *vicious circles*. More specifically, the preferred rigidity and inflexibility these participants display, results in a tendency toward a circular causality, whereby, protective manoeuvres, such as avoidance behaviour, employed accordingly limit opportunities for new learning. At its extreme, this can result in benign events being misconstrued as malevolent and an accompanying provocation of reactions from others reinforce and reactivate earlier difficulties experienced (Jankowski, 2002).

In essence the participants of this study have become stuck in a never-ending cycle in which they believe the world is unsafe and others are untrustworthy, a belief cultivated as a result of the complex trauma they suffered in childhood. Consequently, they may avoid change and new experiences to protect themselves and end up feeling lonely isolated and depressed. These negative feelings they experience, as a result of their own lack of action, further reinforces their belief there is nothing good in the world and nothing will ever change. Their ‘captivity’ in this vicious circle, and the accompanying feelings of hopelessness it creates, may

accordingly also underlie their aversion to change, as they may view any attempts at change as pointless.

5.1.5. Meta-theme 5: Cognitive dysfunction.

5.1.5.1. Sub-theme 1: Ineffective cognitive processing.

All participants displayed inflexibility and rigidity in their style of thinking, which hampers their cognitive processing abilities. Most participants showed an overly complex style of cognitive processing, characterised by excessively complex ideas leading to a cognitive overload, unclear expression of ideas and, accordingly, a proneness to misunderstandings. Other participants, on the other hand, displayed an overly simplistic style of cognitive processing, which leads to many oversights and cognitive errors. Despite the differences among the participants, in their style of information processing, they all, nevertheless, showed marked dysfunction in their cognition.

According to Siegel (1999), emotion and cognitive processing are interweaved. As such, should an individual struggle to modulate their emotional impulses, as has been seen in the findings of these participants, it will also have a negative impact on their ability to cognitively process internal and external stimuli. According to van der Kolk, (2000), traumatised individuals have difficulty evaluating sensory stimuli and mobilising appropriate reactions to these stimuli. This occurs due to the excessive stimulation of the central nervous system that ensues at the time of trauma and continues to have a negative impact on learning, habituation and stimulus discrimination, long after the actual trauma has passed (van der Kolk, 2000). Due to a central nervous system that is constantly hyperaroused, these individuals tend to react with hyper-arousal or hypo-arousal in response to external stimuli. When reacting in a state of hyperarousal, these individuals may experience a racing of thoughts, emotional reactivity, obsessive thinking, and impulsivity (Siegel, 1999). These experiences significantly interfere with their cognitive processing and might make them more inclined to overcomplex processing. In this

regard, there is likely to be a lack of stimulus discrimination and, as such, these individuals may become overwhelmed by the various external stimuli they need to take into account. Accordingly, information overload is more likely to occur, which overcomplicates their cognitive processing.

They may also tend to respond to external stimuli in an impulsive manner and have difficulty censoring their responses and behaviour. In essence, because of the overstimulation that occurs as a result of complex trauma, these participants tend to have difficulty in only acknowledging and responding to the essential details in their environment needed for effective cognitive processing (Siegel, 1999; van der Kolk, 2000).

Overly simplistic processing can be explained in a similar manner. At other times when individuals experience overstimulation, and their tolerance for such stimulation is exceeded, they may also go into a state of hypo-arousal. When this occurs, these individuals will tend to display limited energy, experience disabled cognitive processing, feel disconnected, shut down and become passive (Siegel, 1999). During these times, these individuals' cognition becomes over-simplistic, as their cognitive resources are limited and in a sense is shut down. As a result of their disconnection from their environment, they may overlook important stimuli that needs to be processed in order for them to function effectively.

When considering the cognitive inflexibility and rigidity these individuals display, their emotional capacity at the time, as well as their learned behaviour during the trauma, becomes of relevance. According to Siegel (1999), when an individual's emotional capacity and stimulus tolerance is overwhelmed, their cognition becomes disrupted. More specifically, these individuals' capacity for response flexibility is temporarily shut down. When considering traumatised individuals typically have a more limited capacity for stimulus tolerance and, accordingly, become overwhelmed more easily, it stands to be reasoned they will have more frequent displays of cognitive inflexibility (Siegel, 1999). According to Siegel (1999), these states of overstimulation is characterised by inflexibility and

chaos and, as such, is not adaptive to these individual's internal or external environments. Siegel (1999), also indicates traumatised individual's ability to adapt to future stress is also severely impacted; this can be due to their displayed cognitive inflexibility, behavioural inflexibility and emotional instability, as indicated in the assessment result of the participants within the current study.

The nature of the trauma the participants of the current study were exposed to, along with its impact on their development, is of extreme importance when considering their lack of cognitive flexibility. Since their childhood traumas were characterised by coercive control and excessive domination by the perpetrator, they were robbed of the opportunity to develop healthy emotional and cognitive skills (Herman, 1992b). Their childhoods were accordingly characterised by a high degree of constriction, in which they were forced to constrict their emotional expression, their opinions, their independence, autonomy and their thinking, in order to ensure their survival (Herman, 1992b). This constriction, which served as a means to protect themselves from the retribution of the abuser, however, continues to impact their current functioning. According to Kelly (1955), *constriction* refers to the process of reducing one's perceptual field, thereby limiting what is construed. Kelly (1955), further indicated that individuals may use constriction to limit the anxiety they experience, reducing the world, which they find overwhelming, to something they regard as manageable.

This is of clinical significance when considering traumatised individuals' neurobiology is severely impacted as a result of complex trauma and, accordingly, becomes hyperaroused, characterised by increased levels of anxiety and fear (van der Kolk, 2000). It can be reasoned that in an attempt to cope with the constant anxiety and fear these individuals experience, they engage in *psychological constriction*, emotionally, cognitively and behaviourally, in order to manage their limited resources more effectively. One such instance of constriction is the displayed levels of cognitive inflexibility observed in the participants' assessment results. In essence these individuals have become rigid in their thinking and processing, since

they are reducing the external world to something they can better manage. However, in doing this, they overlook many alternatives and opportunities in their environment, which negatively impacts their thinking, problem-solving, psychological growth and functioning.

5.1.5.2. Sub-theme 2: Irrational thinking.

All participants showed a proclivity toward irrational thinking, in which they struggle to think clearly and logically about matters. However, the manner in which these irrational thoughts are expressed and presented, differed among participants. Some participants displayed a tendency toward overly abstract and imaginative thinking. These individuals are, accordingly, prone to overlook pragmatic issues, which negatively impacts problem solving. Other participants were more inclined toward displays of obsessive thinking, which also interferes with efficient information processing. Yet at the extreme, other participants were prone to delusional thinking characterised by paranoia, ideas of reference and persecutory beliefs.

According to Siegel (1999), an individual's thinking can become disrupted if their tolerance for external or internal stimulation is overwhelmed. In this regard, when a person is overwhelmed, which happens more frequently with complex trauma survivors, their higher cognitive functions of abstract thinking and self-reflection become shut down. As a result, rational and flexible thought becomes impossible. Siegel (1999) also notes that during these times, more sophisticated integrated processing becomes replaced with reflexive responding, which could account for these participants' displayed tendency toward irrational thinking. When these individuals' emotional states become dysregulated, it will be reflected in their thinking. Although the underlying process of these participant's irrational thoughts might be similar, the manner in which they express these thoughts remain unique and distinct for each individual. The methods of coping they utilise, to cope with their emotional dysregulation cognitively, will accordingly vary among the participants. This can be attributed to the maladaptive coping mechanisms they

prefer to use in response to overstimulation. Although similarities can be found in the participants' behaviour, these individuals are still different in a number of ways and, accordingly, will express these differences in the manner in which they respond to life stress.

5.1.5.3. Sub-theme 3: Impaired perceptual accuracy.

Most participants, within the current study, struggled immensely with perceptual accuracy. In this regard, they are prone to possess an inaccurate perception of their environment, which in turn negatively impacts their interaction with their environment. Most participants were also found to be prone to pathological reality testing, fantasy and projection, which makes them extremely vulnerable to psychotic episodes.

According to William James (1890), the power of one's intellect is determined by one's perceptual processing style. This entails the ability to comprehend accurately and depends on stimulus sampling and the formation of schematic representations of reality. However, there seems to be a significant difference between the manner in which individuals, who have experienced considerable trauma, sample and categorise experience in comparison to the ways non-traumatised individuals do (van der Kolk & Ducey, 1989). This is attributed to the difficulty these individuals had in comprehending the traumatic experiences they were exposed to as children and seems to impact their ability to accurately comprehend experiences beyond the trauma and in other contexts (van der Kolk, 2000).

The difficulties these individuals have with perceptual accuracy can also be attributed to brain changes that occur as a result of the complex trauma. According to van der Kolk (2000), neuroimaging of traumatised patients' brains has indicated that these individuals show decreased hippocampal functioning, which in turn interferes with the localisation of incoming information in time and space. As a result, these individuals struggle significantly with fragmentation of experience,

which negatively impacts their perceptual accuracy and reality testing (van der Kolk, 2000).

Other researchers have also indicated the negative ideas traumatised individuals have about themselves, their constant anxiety, and reoccurring depression, which was produced by past childhood trauma, are significant risk factors for paranoia and other psychotic symptoms (Fowler et al., 2006; Freeman, 2007). A study conducted by Freeman and Fowler (2009), also showed that it is the chronic levels of anxiety that complex trauma survivors experience which underlies their disposition to developing psychotic symptoms, such as persecutory thinking and paranoia. As such, accompanying brain changes, and changes in the neuroendocrinology of these participants, seem to significantly impact their ability to perceive accurately and disposes them to the development of psychotic symptoms.

Millon has similarly noted that BPD individuals are, in particular, prone to experiencing psychotic episodes as a result of their *split architecture*. In this regard, Millon describes these individuals as possessing an inconsistent and incongruent inner psychic structure. As a result, these individuals' level of consciousness may shift suddenly, and they may be prone to experiencing contrasting perceptions, memories and affects. This results in them experiencing difficulties with reality testing and leaves them prone to experiencing stress-related mini-psychotic episodes (Millon et al., 2015).

5.1.5.4. Sub-theme 4: Affectively driven cognition.

Analysis indicated that all participants' cognition was highly influenced by their emotional state. In this regard, they are prone to rely on their emotions when making decisions. Accordingly, they tend to refrain from rational reasoning before acting, which results in negative consequences for them. In addition, it was also found, that due to their poor internal and external psychological boundaries, these participants are prone to experience unwanted and distracting ideation, due to environmental stress, as well as display poorly controlled ideas. At the extreme, this

may result in them being prone to experiencing stress-related cognitive disorganisation.

As mentioned earlier, emotion and cognition are interweaved and, as such, influence one another (Siegel, 1999). Literature has indicated traumatised individuals have significant problems separating their emotions and cognitions (van der Kolk, 2000). Since their emotions are significantly overwhelmed by the trauma they have experienced, their cognition becomes overwhelmed in a similar manner and impacted by the emotional states they are in.

Certain brain structures have also been implicated in this tendency of traumatised individuals to be influenced by their emotions when making decisions. The amygdala, which assigns emotional significance to incoming stimuli and helps regulate responses to that information, has specifically been implicated in these individuals' decision-making process. Research has also shown that traumatised individuals' right brain hemisphere seems to be dominant and, typically, overrides the more logical left-brain hemisphere when cognitive processes need to take place. This is of relevance, since the right brain hemisphere is excessively sensitive to emotional nuances, however, has an undeveloped capacity to think and communicate analytically and to reason logically. As a result, these individuals are more inclined to emotional reasoning and emotionally-driven cognition (van der Kolk, 2000).

Millon also notes that in order for an individual to maintain mental health they need to be balanced in their thinking and emotion, however individuals who are unbalanced in this regard tend to sway toward pathological behaviour (Millon et al., 2015). This is clearly demonstrated in these participants' assessment results, which indicate an imbalance in these individuals' tendency to favour emotion over rational thought, when cognition and decisions are concerned. In essence these individuals' emotions, ultimately, hijack their cognitive functions (Siegel, 1999).

As mentioned, these participants' poor psychological boundaries, and difficulty in censoring what they pay attention to in the external environment, also

significantly impacts their cognition negatively and leads to them becoming easily overwhelmed and unable to think rationally. In this regard, research has shown that chronically traumatised individuals experience increased cerebral activity and blood flow to the temporal lobes. This leads to a heightened perception of surroundings due to the temporal lobe's involvement in the processing of environmental stimuli, which interferes with their ability to process environmental stimuli (Shin et al., 1999). The changes in brain functioning traumatised individuals experience could, accordingly, further account for these participant's tendency to become easily overwhelmed and unable to make rational decisions.

5.1.5.5. Sub-theme 5: Ineffective problem solving.

All participants showed a proclivity toward struggling with effective problem solving. Some participants were prone to use trial-and-error reasoning, which negatively impacts the successful resolution of their problems. Others were found to be inclined to overcomplicate problem-solving, leading to confusion and ineffective information processing. Yet, others tended to overlook pragmatic issues when solving problems and typically seemed to not reason before taking a course of action. All the above-mentioned styles, although different in approach, result in the participants experiencing grave difficulty with problem-solving and hampers their everyday functioning.

Although the various participants' problem-solving strategies differ, nevertheless, they remain ineffective due to them being distracted and influenced by their emotions when rational reasoning and thinking is required (Herman, 1992b; Siegel, 1999; van der Kolk, 2000). The dominance of these individuals' emotions, when cognitive processing and problem-solving is required, can again be accounted for by the various brain structures impacted as a result of their childhood trauma.

According to van der Kolk (2000), the impact trauma has on the hemispheric dominance of these individual's brains, further accounts for their difficulties in problem solving. In this regard, the left-brain hemisphere has been found to be less active in complex trauma survivors. This greatly impacts these individual's ability

for verbal communication, problem-solving, organisation and processing of information, all of which is determined by the left-brain hemisphere (van der Kolk, 2000). As mentioned previously, a decrease in functioning in the frontal lobes of traumatised individuals has also been found, which negatively impacts their ability to carry out executive functions, such as anticipatory planning and decision making, which form a crucial part of problem solving (Booth & Jernberg, 2010; Davies, 1999; Wilson, 2003).

It can also be reasoned that due to the domination and coercive control these individuals experienced, as part of their complex trauma, they have never learned effective problem-solving skills, and instead are plagued with feelings of helplessness, powerlessness and passivity, when faced with life problems and difficulties (Herman, 1992b). These learned responses, that occurred during the trauma, still impact the participants of the current study currently, as indicated in the participants' assessment results, and complicate their ability to show personal agency and solve everyday life problems.

A summary of the meta-themes and sub-themes found in the assessment results of the participants, can be found in **Table 3**. The analysis of these themes not only allowed for a rich and holistic description of the psychiatric patients who participated in the current study's personality, but also allowed important research questions to be answered. The clinical significance of these findings, and their relevance to the various research questions posed, will accordingly be discussed and elaborated on.

Table 3

Meta-themes and sub-themes identified in participants' assessment results

Meta-themes	Sub-themes
Compromised self-image	<ul style="list-style-type: none"> • Negative view of self • Plagued by self-doubt

	<ul style="list-style-type: none"> • Feels deserving of suffering • Wavering sense of self
Ineffective interpersonal relationships	<ul style="list-style-type: none"> • Ambivalent and wavering interactions • Seeks interpersonal distance • Seeks interpersonal dependence • Lack of interpersonal trust • Aggressive interactions • Possesses an immature understanding of others
Emotional dysfunction	<ul style="list-style-type: none"> • Emotional instability • Wavering and ambivalent approach to emotions • Possesses a paucity of psychological resources • Demonstrates poor psychological boundaries • Displays an avoidance of emotions • Experiences severe depression • Experiences excessive anxiety • Experiences intense anger • Displays PTSD Symptoms
Behavioural futility	<ul style="list-style-type: none"> • Self -sabotaging behaviour • Behavioural instability • Displays impaired functioning • Insufficient behavioural control • Displays behavioural rigidity
Cognitive dysfunction	<ul style="list-style-type: none"> • Ineffective cognitive processing • Irrational thinking • Impaired perceptual accuracy • Affectively-driven cognition • Ineffective problem-solving

5.2. The Cyclical Interrelationship between BPD Personality Characteristics: A Demonstration of Circular Causality

When discussing and interpreting the themes that emerged from the participant data, it was found these themes, or typical character traits, seem to interact with each other and influence each other to produce a holistic and intertwined pattern of behaviour. A visual representation of the interrelationship of participant symptoms and behavioural patterns can be found in figure 2.

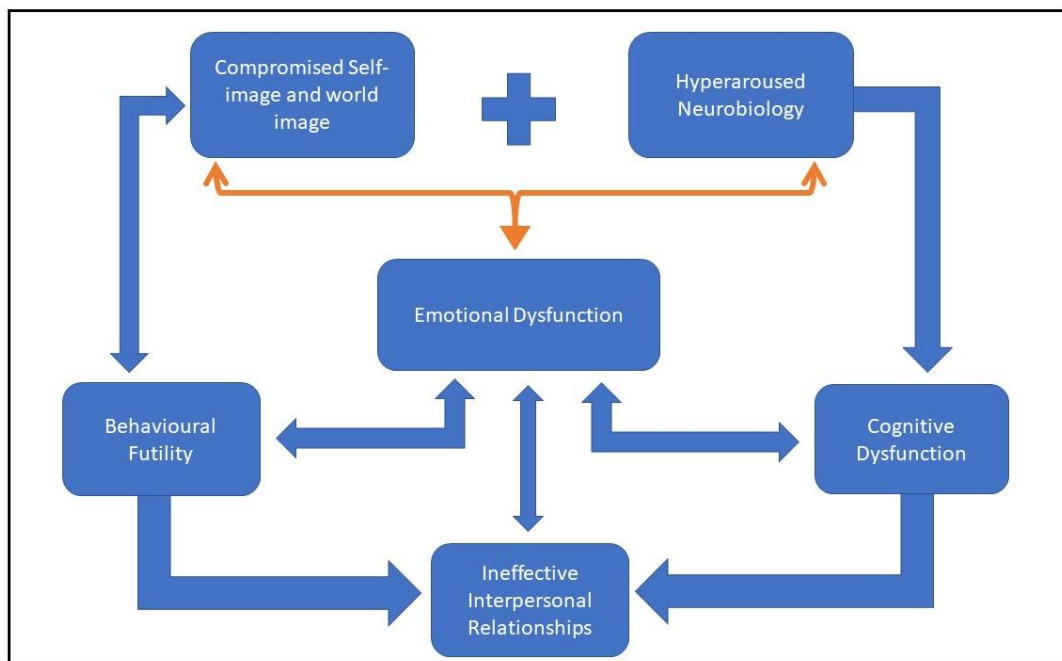


Figure 2. Depicted interrelationship of BPD phenomena.

Based on the findings of this study, and other research reviewed, it appears as if these participants' compromised view of themselves, and their external world, combined with their hyperaroused neurobiology, seems to underlie all their other behavioural patterns, that is their Emotional Dysfunction, Behavioural Futility, Cognitive Dysfunction and Ineffective Interpersonal Relationships. The influence their negative view of themselves, and their external world, as well as their hyperarousal has on their emotions, is noteworthy.

In this regard, findings indicated their view of themselves as damaged, not good enough, powerless, and deserving of suffering, significantly impacts their emotions negatively, and leads to their feelings of hopelessness and depression,

anxiety, and anger observed in the assessment results of this study. In addition, their negative view of the world as unsafe, dangerous and untrustworthy, further fuels their anger, anxiety and depression. The impact of their hyperarousal on their emotions was also shown to be noteworthy, in that the constant feelings of anxiety and irritability this hyperarousal creates, directly leads to their other emotional difficulties, such as depression, anger, irritability, impulsivity and low frustration tolerance.

More specifically, it also seems their emotional dysfunction, which is secondary to their compromised self-image, world-image and hyperarousal, significantly influences these participants' behavioural futility, cognitive dysfunction and ineffective interpersonal relationships. In this regard, it was found their intense emotions overrule their capacity for rational decisions and cognitive processing, and results in affectively-driven cognition. These intense emotions also result in behavioural impulsivity and affectively-driven behaviour, and accounts for their tendency to display wavering and unstable behaviour.

Their unstable emotions also negatively impact their relationships and results in anger outbursts, anxiety and a lack of trust in relationships, dependent behaviour and interpersonal withdrawal. At its most severe, these intense emotions can become so disorganising they may result in paranoia, delusional thinking and other psychotic symptoms as observed in the participants' assessment results. In this regard, the impact their unstable emotions have on the rest of their functioning becomes crucial in understanding these participants' wider personality patterns.

It was also found that their behavioural futility, in terms of extreme passivity, impulsivity, rigidity, and self-sabotaging behaviour, also negatively impact on their interpersonal relationships. Likewise, their displayed cognitive dysfunction, in terms of impaired perceptual accuracy, irrational thinking and affectively-driven cognition, also leads to difficulties in perceiving others accurately, presenting themselves clearly and avoiding misunderstandings with others, as well as making impulsive and irrational decisions when it comes to relationships.

At this point it should be mentioned the importance of their negative view of self should not be overlooked. In this regard, it can be argued a healthy self-image could serve as a protective factor against their intense emotions, negative cognitive beliefs and maladaptive behaviours. However, it appears as if the compromised self-image these participants display only fuels their emotional upset and complicates the stabilisation of their intense emotions.

Their compromised self-image also directly leads to their behavioural futility, specifically their passive approach to life and avoidance of responsibility. In this regard, their view of themselves as powerless and inept to solve their own problems, negatively impacts on their motivation to demonstrate personal agency. However, it should also be mentioned that the less personal agency these individuals display, the less competent they feel in life and, accordingly, their self-image becomes more compromised. A reciprocal relationship thus exists between their self-image and their behavioural futility. As mentioned, this negatively reinforced self-image only further leads to emotional turmoil, which in turn has been shown to have a ripple effect on all other areas of functioning.

The intertwined nature of these participants behaviour and personality patterns thus becomes undeniable, and severely complicates treatment endeavours. This intertwined pattern of thinking, feeling and behaving, clearly demonstrates the *vicious circles* and circular causality Millon described as being prevalent in personality pathology (Jankowski, 2002; Millon, 1990). Millon also indicated that this display of circular causality is noticeably present in the behaviour of BPD patients. More specifically he noted the interaction of BPD patients' personality traits is circular in nature and their difficulties experienced thus self-sustained (Millon, 2011). This was clearly evidenced in the assessment results of these participants, as described above.

5.3. Conceptualising BPD as a Trauma-saturated Personality

When considering the themes derived from the data, as discussed above, the impact of the complex trauma on the formation of these participants' personality

structure, and their accompanying psychopathology, becomes undeniable. According to Herman (1992a), repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality. *Complex childhood trauma* accordingly has a significant impact on the development of a child's personality. Janet (as cited in van der Kolk, 2000), in his work with complex trauma survivors, observed and described these patients' personality as having "*stopped at a certain point*", and, as such, they cannot enlarge anymore by the addition or integration of new elements. In this regard, it is as if complex trauma survivors', such as the participants in this study, personality development, or more specifically, healthy development, has ceased and has struggled to develop beyond the trauma. Instead, it seems these individuals have merely adopted a personality pattern developed around the trauma in order to assist them in adapting to and surviving the aftereffects of their past horrors. This view of arrested personality development, that is lack of healthy personality development, post trauma, could also account for the degree of 'stuckness' and rigidity observed in the behaviour, thinking style and views of these participants. In this regard, it seems as if they are being held captive by their past trauma and cannot change and adapt to new circumstances, since they struggle to develop much needed adaptive coping mechanisms and life skills, and grow beyond the maladaptive behavioural patterns learned as a result of the trauma. They, accordingly, continue to apply these maladaptive behavioural strategies despite it causing them additional difficulties and pain.

The literature reviewed, and findings discussed above, further indicated the extent of the emotional and behavioural consequences of *complex childhood trauma*, and how it invades the trauma survivors' personality, in such a manner it impacts nearly all areas of functioning. Terr (1991) also supported this view of the impact of complex trauma on the trauma survivors' personality. In this regard, she indicated individuals subjected to prolonged, repeated trauma tend to develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality structure (Terr, 1991). As such, it can be argued that these individual's

trauma symptoms, and subsequent adaptation post trauma, becomes a part of their personality structure. Moreover, it can be argued BPD, that ensues after exposure to *complex childhood trauma*, is in fact a display of the manner in which past trauma has invaded these patients' personality structure and is, in actuality, a *trauma saturated personality*.

Courtois (2004), similarly, indicated that conceptualising and understanding BPD as a post-traumatic adaptation, and not just another typical display of a disordered personality, can assist clinicians in being more empathic and more even-handed in the treatment of BPD patients. Myers, et al. (2002), also postulated BPD behaviour and symptoms can, instead, be seen as triggered implicit memories, schemas and feelings associated with early and prolonged relational traumas and the accompanying avoidance behaviours these patients employ to try and psychologically escape the trauma.

The applicability of conceptualising BPD as a trauma saturated personality can further be seen in the similarity between BPD, PTSD and Complex PTSD symptoms. According to van der Kolk (2000), PTSD is characterised by three major elements, which includes the repeated reliving of memories of the traumatic experience, avoidance of reminders of the trauma, and a pattern of increased arousal. The complete DSM-5 criteria for PTSD can be found in Appendix G.

However, van der Kolk (2000), also mentions that complex trauma survivors experience a range of symptoms that go beyond PTSD criteria, which includes affect dysregulation, aggression against self and others, amnesia and dissociation, somatisation, depression, distrust, shame and self-hatred. He also goes on to mention most psychiatric patients with histories of complex trauma, do not typically seek treatment for the PTSD symptoms but rather for the other accompanying symptoms they experience. The symptoms most trauma survivors seek treatment for include depression, anger outbursts, self-destructive behaviour, feelings of shame and self-blame, distrust, behavioural impulsivity, affective lability, depersonalisation and

dissociation, feelings of being permanently damaged, and difficulty in relationships with others (van der Kolk, 2000).

This description of symptoms closely resembles the findings of the difficulties the current study's participants struggle with. It also closely resembles the diagnostic criteria of BPD which can be found in Appendix B. Furthermore, the symptoms described by van der Kolk (2000), which were also found to be experienced by the participants of this research study, also bare notable similarity to the proposed symptoms of Complex PTSD, as conceptualised as part of a DSM-IV field trial. These proposed symptom criteria included: (i) alterations in the regulation of affective impulses, including difficulty with modulation of anger and being self-destructive; (ii) alterations in consciousness leading to amnesias and dissociative episodes and depersonalisation; (iii) alterations in self-perception such as chronic sense of guilt and responsibility as well as chronically feeling ashamed; (iv) alterations in relationships with others including trust difficulties and difficulty with intimacy; (v) somatisation complaints; (vi) alterations in systems of meaning (van der Kolk, 2000; Courtois, 2004).

Accordingly, it can be seen there is considerable overlap between the symptoms of trauma reactions such as diagnosed in PTSD or conceptualised in Complex PTSD, and BPD symptoms. This overlap is clinically significant as it indicates that BPD could be conceptualised as a trauma condition and not necessarily solely a personality disorder. Moreover, the comorbid diagnoses BPD patients are often diagnosed with, such as depression, bipolar, anxiety, substance use disorders, dissociative disorders, somatisation and psychosis, may also be regarded as trauma symptoms and not merely as independent and separate diagnoses.

As mentioned previously, the participants in this study displayed many PTSD symptoms, but also displayed symptoms of BPD, depression, mania, anxiety, psychosis, dissociation, somatisation, and other symptoms, possibly indicative of other personality disorders, such as Avoidant Personality Disorder and Dependent Personality Disorder. It can thus be reasoned that all of these symptoms are in fact

interrelated and secondary to the trauma these participants experienced and, ultimately, should be treated as such.

5.4. A Characteristic Personality Profile of Normal Personality Functioning in Complex Trauma Survivors' Psychopathology

Analysis also found a considerable overlap between the normal personality traits of the study participants as measured by the 16PF. Accordingly, it can be argued there is much clinical utility in conceptualising BPD and complex trauma survivors' pathological behaviour from a stance of normal personality functioning.

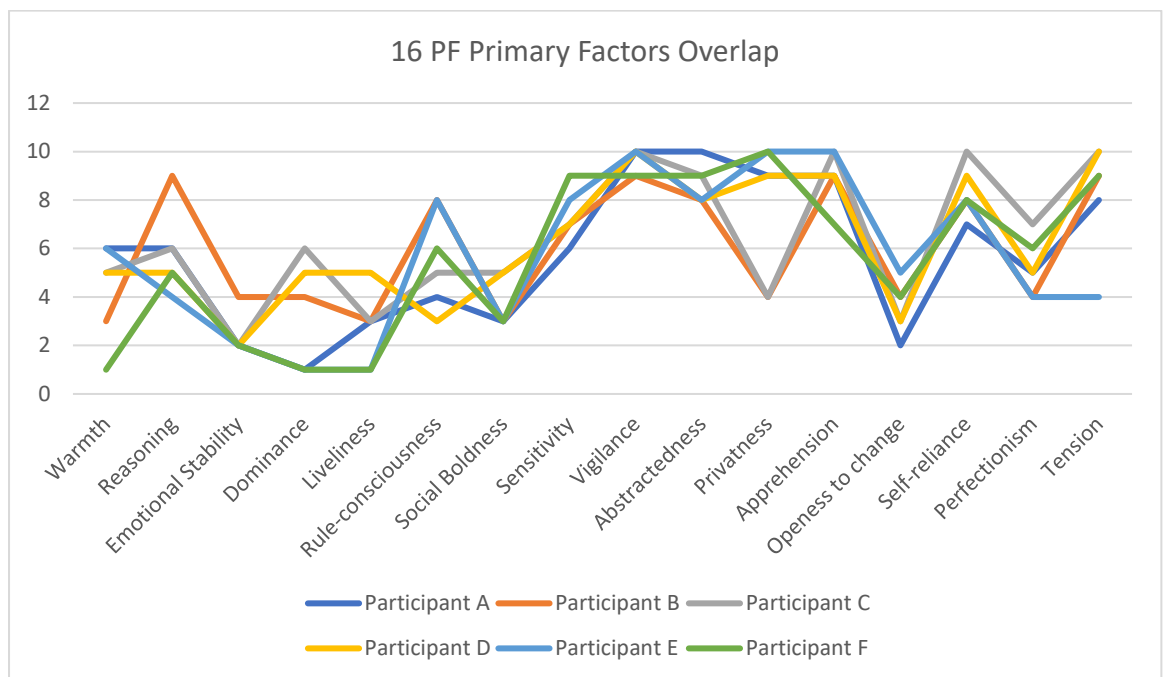


Figure 3. Personality facet overlap in BPD and complex trauma.

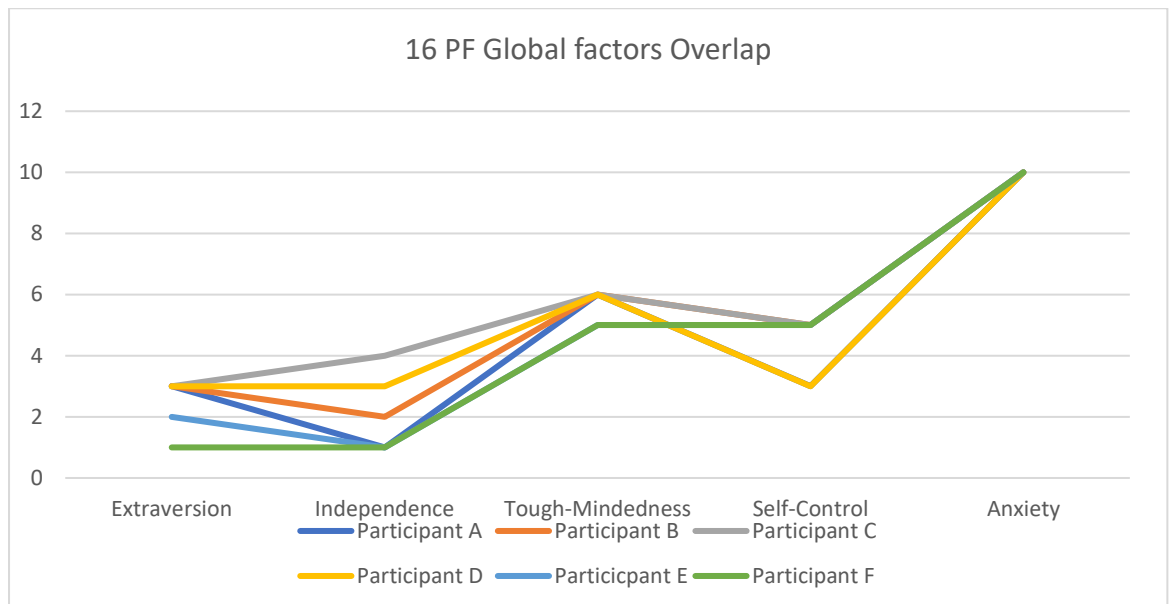


Figure 4. Personality trait overlap in BPD and complex trauma.

The primary 16PF traits, or personality facets, of Vigilance, Abstractedness, Apprehension and Self-reliance, were found to be consistently elevated among all participants, as depicted in figure 3. The personality trait of Tension was found to be significantly elevated among all participants except participant E. The primary traits of Emotional stability, Liveliness, Social boldness and Openness to change, was found to be significantly low among all participants. Participants also showed significant overlap between the global 16PF traits, that is wider personality traits, of Extraversion, Independence and Anxiety. Their scores on Extraversion and Independence were found to be significantly low, whereas their scores on the Anxiety scale were all extremely elevated. The personality trait of sensitivity was found to be elevated among some participants, while low among others.

It should also be mentioned a number of differences were also present in participants' normal personality results. The primary traits of Reasoning, Dominance, Rule-consciousness, Privatness, and Perfectionism, were found to vary among participants. Likewise, the global personality traits of tough-mindedness and self-control also showed unique variations among participants. This serves to indicate, despite the similar histories of *complex childhood trauma* and same BPD diagnosis shared by the participants, various individual differences can still be found

in the personality profiles of trauma survivors and BPD psychiatric patients. As such, these differences should be taken into consideration when conceptualising each patient and planning treatment.

In essence, the findings of this study indicate certain characteristic personality patterns, or more specifically normal personality traits, characterise these BPD psychiatric patients' functioning. As such, there is definitely a characteristic personality pattern of normal personality functioning to be found in the assessment results of these psychiatric patients and, accordingly, it can be deduced that a link exists between the normal personality functioning and pathological personality functioning of these female BPD patients. Knowledge of how these normal personality traits underlie these patients' pathological behaviour could assist in expanding on and describing these individual's behaviour in more relatable terms other than just focusing on pathological functioning.

5.5. The Utility of the 16PF, MCMI, Rorschach, and CTQ in Assessing Personality Patterns of Complex Trauma Survivors

The chosen assessment battery used in this research study has proven extremely useful in identifying and describing a wide range of personality traits and behaviours of complex trauma survivors with a diagnosis of BPD. In analysing the results obtained from the various participants, it became clear certain assessment measures were more adept at identifying and describing certain aspects of these individual's functioning.

The MCMI-IV was specifically useful in highlighting the various clinical syndromes and personality pathologies that characterise these participant's functioning. More specifically, the computerised report generated, based on the MCMI-IV results, provided rich descriptions on each participant's interpersonal style and interaction tendencies, their emotional difficulties likely experienced, typical behavioural patterns and their views of themselves. This assessment is also useful in offering a list of possible diagnoses, based on the participant's described behaviour, and could guide the clinician's decision-making processes. However, it

should be mentioned although this assessment measure provides a list of clinical diagnoses to consider, at times it failed to distinguish between different diagnoses and seemed to offer conflicting diagnostic suggestions. In addition, the diagnosis of BPD, which was diagnosed by a team of professionals at the tertiary psychiatric hospital, was overlooked by the MCMI-IV, on many occasions, despite the behavioural description offered by this assessment indicating the presence of such a diagnosis. Clinicians should thus still use their own professional judgement when considering diagnoses based on this assessment measure.

The 16PF's value lies in its ability to provide a profile of normal personality functioning for the individuals assessed. Although the assessment of normal personality functioning in clinical populations is rarely done, this study has indicated there is considerable clinical utility in assessing the normal personality traits that underlie pathological behaviour, as it provides a more in-depth and relatable description to the behaviour of clinical patients. In this regard, the 16PF was very useful in identifying the array of normal personality traits, and clusters of traits, related to these female BPD patient's functioning. It also proved useful in identifying how *childhood complex trauma* alters the normal personality development and which personality traits are significantly impacted by the experience of such trauma. The 16PF was very useful in identifying the high levels of anxiety these participants struggle with, as well as the various other personality traits related to these high levels of anxiety, or influenced by these high levels of anxiety. It also indicated clinically significant behaviour patterns, such as these individuals' intense aversion to change and cognitive rigidity. The personality traits, which underlie these participant's interpersonal behaviour, was also adeptly identified by the 16PF assessment. The vast array of personality traits and facets identified by this assessment also offers a descriptive richness to the personality description of each participant, as it assesses both wider personality traits as well as more detailed personality facets.

Of further significance, is this assessment has been standardised for use with the South African population, which results in a higher degree of confidence when relying on the inferences made by these assessment results.

The Rorschach Inkblot Test was very useful in showcasing each participant's personality in action. This allowed the researcher to view how each participant approaches tasks requiring reasoning and problem-solving. This active form of personality assessment offers substantial advantages, as opposed to the other self-report measures used. The projective nature of this assessment made it difficult for participants to pre-contemplate their responses and, as such, offers a close resemblance to what their behaviour looks like in everyday life.

The use of the R-PAS system further presented the researcher with the opportunity to statistically compare the responses of each participant to those of a wider clinical sample and generate a standardised report for each participant with a rich description of their behaviour.

The Rorschach Inkblot Test was especially useful in displaying and describing these participants' cognitive processing style and typical cognitive errors these individuals are prone to make. In this regard, a detailed description of these participants' cognitive style was provided, which included their processing style, problem-solving strategies, communication style, and reasoning ability. This is of significant value, since the other assessments used failed to provide such a comprehensive description of participants' cognitive styles, which makes the Rorschach Inkblot Test extremely useful in this regard.

In addition, the Rorschach Inkblot Test was very adept at screening for perceptual difficulties and signs of possible psychosis. As mentioned previously, due to its practical nature, the Rorschach Inkblot Test is also useful in identifying behavioural patterns such as impulsivity, passivity and use of psychological boundaries. Similar to the other assessments used, the Rorschach Inkblot Test also elaborated on the quality of interpersonal relationships and possible emotional difficulties experienced by the participants.

Finally, the use of the CTQ was limited to the identification of the type of complex trauma suffered by these participants in their childhoods. This assessment was useful in categorising the various abusive and neglectful acts these individuals were exposed to and, in addition, was able to show the degree of trauma experienced by these participants, as depicted in figure 5.

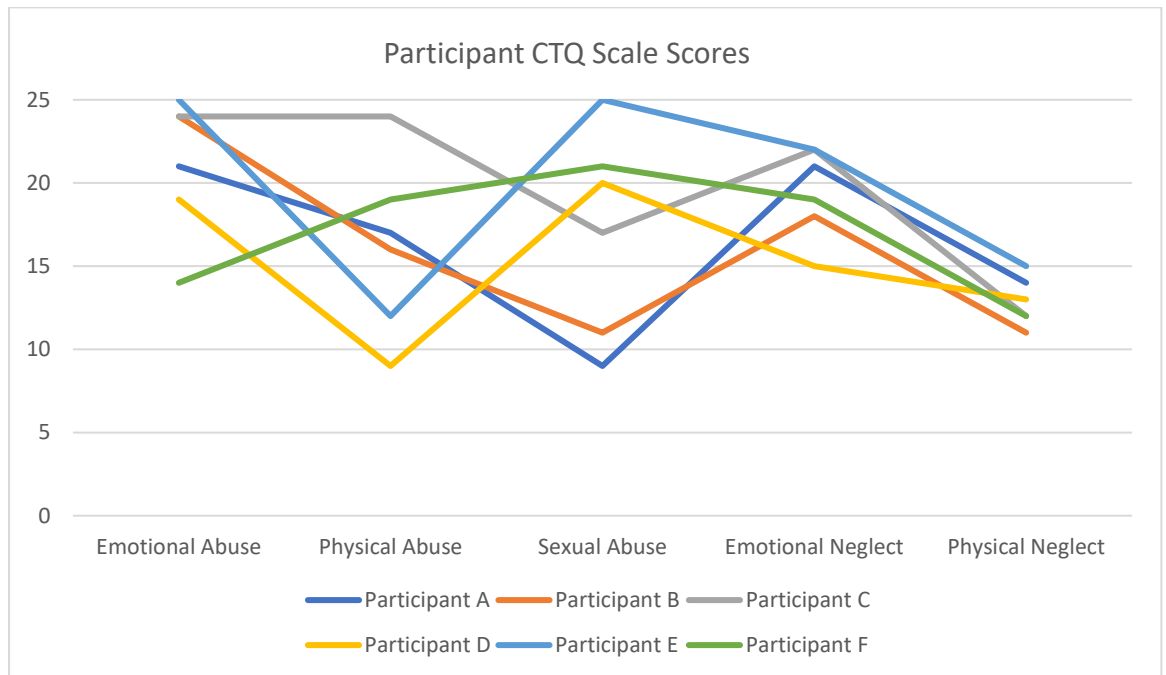


Figure 5. Nature of complex trauma suffered by participants.

This assessment was able to show that all participants suffered severe to extreme levels of trauma in nearly all the categories of abuse and neglect, indicating the nature of their complex trauma as varied and extreme. It should also be mentioned that it is vital to have a means of assessing the extent and nature of BPD patients’ trauma, since the diagnosis of BPD does not necessarily make room for clinicians to assess the degree of these patients’ past trauma.

Although each individual assessment has proven useful in assessing these participants, it was the combination of all of assessments that aided in achieving a holistic and integrated description of these participant’s behaviour. According to Spinhoven, Elzinga, Hemert, de Rooij, and Penninx (2016), a need exists to conduct research that focuses on the use of more extensive questionnaires and assessment measures that tap personality traits and personality organisation of

childhood trauma survivors. They also advocate for a stronger focus in related research on personality trait clusters, which are groupings of personality traits, rather than a sole focus on isolated personality traits.

It can be reasoned that the combination of the assessments used in this study adequately achieved this purpose and offered a detailed description of the participants' interwoven clusters of personality traits and personality organisation. It should also be mentioned that the characteristic adaptations and personality patterns demonstrated by these participants, as a result of their past trauma, was found to be in line with most international trauma research and theory. It can thus be reasoned that these assessments, when used collectively, offer an accurate, in-depth and holistic account of female BPD psychiatric patients' (with a history of *complex childhood trauma*) personality organisation and trauma-related behaviours. These assessments can, accordingly, prove useful in the clinical assessment of this population in the South African context.

Chapter 6. Conclusion

The study provided an examination of the interlinkages between *complex childhood trauma*, personality development and psychopathology, displayed in later life. In order to examine this interrelationship, six female psychiatric patients, with a history of *complex childhood trauma* as well as a diagnosis of BPD, were assessed using a carefully selected battery of assessments. Biographical information, concerning their childhood and the maltreatment suffered during these years, was also gained.

The assessment results gained from each participant were analysed with computerised software, which generated standardised computerised reports, as well as individually interpreted by the researcher, overviewing the various aspects relevant to this study. The results of all the participants were qualitatively analysed for reoccurring themes, similarities and differences. These findings were also compared to relevant literature on *complex childhood trauma*, personality and BPD, which allowed the researcher to answer the research questions posed. This chapter provides a succinct overview of the main findings of the study and their relevance to clinical practice. The limitations of this study will also be discussed. In conclusion, relevant recommendations for clinical practice and future research endeavours will be made.

6.1. Overall Findings

A wealth of information was consulted and obtained as a result of this research study. It is the researcher's premise this information proves extremely useful for clinical psychology practice. Specifically, the research has shown the relevance of *complex childhood trauma* as an aetiological factor in the development of pathological personality and other co-morbid types of psychopathology. More specifically, analysis of results indicated characteristic pathological personality patterns in the female participants of this study, which impacts their view of

themselves, interpersonal relationships, emotional style and difficulties, cognitive style and typical behavioural patterns.

These findings are in line with international research and theory on the impact of complex trauma on personality development and psychopathology (Booth & Jernberg, 2010; Heim et al., 2010; Herman, 1992a; Herman, 1992b; Terr, 1991; van der Kolk, 2000). This characteristic personality organisation was found to be specific to these female participants' contextual background of *complex childhood trauma* as well as their diagnosis of BPD. Although a characteristic personality pattern, and a significant overlap in co-morbid diagnoses, was found in these female participants, results of this study also indicated differences exist among these participants, especially in terms of how they express these various personality patterns. This also indicates that the uniqueness among psychiatric patients should be respected, and taken into consideration, when diagnosis and treatment is concerned.

In addition, the importance of considering a patient's personality, as an organising factor for future psychopathology, was also discussed. More specifically, the current study, along with other studies, have shown that *complex childhood trauma* has a profound impact on personality development, and the development of subsequent psychopathology (Hengartner et al., 2013; Kim et al., 2009; Spinhoven et al., 2016). It was also found that personality can be seen as a modulating factor between *complex childhood trauma* and psychopathology later in life. The relationship between *complex childhood trauma* and BPD was specifically investigated and, support was found for conceptualising BPD as a trauma-saturated personality. The use of the CTQ was found to be particularly helpful in this regard to provide insight into how the severity, and different types of trauma, impacted the personality assessment results and functioning of the participants.

The continuity between normal personality traits and pathological behaviour was similarly addressed, and a correlation in this regard was found in the research results, which confirms and expands on the results of previous studies (Blais, 2010; Luyten & Blatt, 2011; Slobodskaya, 2014). Incidentally, it was found that normal

personality traits underlie pathological behaviour. More particularly, this study found characteristically normal personality pattern aspects among the female participants with a diagnosis of BPD, which confirms that normal personality underlies pathological personality (Clarke & Watson, 1999; Duggan et al., 2003; Krueger & Eaton, 2010; Paris, 1996; Trull et al., 2003). The results of this study also indicated *complex childhood trauma* has an impact on the development of normal personality and, that knowledge of the manner in which normal personality is impacted by childhood trauma, assists in better conceptualising these individuals as psychiatric patients and in describing their pathological behaviours in more relatable terms.

Accordingly, the findings obtained in this study further illustrated a need exists to acknowledge and understand how normal personality traits are related to pathological behaviour, and that pathology should not be regarded as either present or absent, but rather as occurring on a continuum of functioning (Millon, 2011; Strack & Millon, 2012).

In this regard, it should be mentioned that the DSM criteria, and the manner it is taught to training clinicians, runs the risk of those clinicians regarding pathology as either present or absent. This is, however, not the case in practice. With this in mind, it is more useful for clinicians to understand the underlying pathological patterns that psychiatric patients present with, than merely focus on various clinical diagnoses (Terr, 1991).

The findings of this study also indicated that individuals with a history of *complex childhood trauma* present with various possible psychiatric diagnoses, which could, if not conceptualised correctly, complicate the treatment of these individuals as psychiatric patients (Terr, 1991; van der Kolk, 2000). Although the participants of this study had a primary diagnosis of BPD, many co-morbid diagnoses were also given, and other pathological behaviours identified in their assessment results. The findings of this study showed that these various diagnoses, such as BPD, depression, anxiety, bipolar disorders, somatisation, PTSD,

dissociative disorders, substance use and psychosis, are better conceptualised as interlinked, and trauma-related phenomena (Courtois, 2004; Herman, 1992b; van der Kolk, 2000). The findings of this research study have accordingly assisted in better describing the vastness of the psychiatric symptoms and behavioural consequences prolonged childhood trauma has on its survivors. Acknowledging the impact of *complex childhood trauma* on psychiatric patients' pathological behaviour, thus becomes crucial in the treatment and conceptualisation of these patients.

According to Herman (1992a), trauma survivors challenge mental health professionals to reconnect fragments, to reconstruct history, to make meaning of their present symptoms, in the light of past events. The findings of this study, accordingly, offers support for this argument, and illustrates why it is important for clinicians to be knowledgeable of the repercussions of *complex childhood trauma*, and to utilise this knowledge in the treatment of their patients.

In the event that clinicians overlook the impact of *complex childhood trauma* on their patient's later life, they risk treating these patients symptomatically, and neglect to treat the patient holistically, which includes treatment of the underlying cause of the psychiatric symptoms observed in hospital settings and in private practice. This view is echoed by van der Kolk (2000), who stated that focusing solely on the disparate and distinct psychiatric conditions that ensue after a complex trauma such as PTSD, depression, dissociation, and various personality pathologies, prevents the adequate assessment and treatment of traumatised patients.

Of further value was the study's use of psychological assessment in gaining access to these female participants' behavioural patterns. In this regard, this study has shown there is great utility in using a comprehensive battery of psychological assessments in clinical settings, as this greatly aids the clinician in better understanding their patients. More specifically, this study as indicated the utility of utilising the 16PF, MCMI-IV, Rorschach Inkblot Test R-PAS system and CTQ, collectively, in the assessment of complex trauma survivors, as these assessments

have proven adept to identifying a host of pathological behaviours related to past trauma. In addition, the utility of the 16PF in measuring normal personality in a clinical setting for clinical purposes was also demonstrated.

6.2. Recommendations for Clinical Practice and Training

In line with the findings of this study, the following recommendations are made for clinical practice and training of future clinicians.

The current study and other sources of literature consulted has indicated there is much utility in conceptualising BPD as a trauma saturated personality (Courtois, 2004). As such it is recommended this view of BPD be incorporated into clinical guidelines for treating BPD patients, and be taught to training clinicians at university level. Likewise, this study has also demonstrated that a need exists in recognising the importance of investigating past traumas of patient's, through the incorporation of a detailed personal and trauma history, which could form part of clinicians' clinical interviews in both in-and-outpatient settings. The importance of focusing on trauma in treatment, and abstaining from only treating patients symptomatically, but rather holistically, has also been shown, and is thus recommended to be included in the clinical guidelines for treating traumatised patients. Furthermore, it is recommended that the multiple co-morbid diagnoses traumatised and BPD patients present with, be conceptualised as interlinked trauma phenomena and incorporated in clinical practice. It should also be mentioned that due to the high levels of depression and suicidality found in the participants with BPD, it is recommended that all patients with BPD be assessed in terms of their depression and suicidality on an ongoing basis, with such assessment forming part of the clinical guidelines for treating patients with BPD. Findings of this study also indicated grave impairment in the cognitive functioning of the participants with BPD. As such, it is recommended that the cognitive functioning of patients with BPD be assessed and such assessment incorporated into the clinical guidelines for treating patients with BPD. This will allow clinicians to gain insight into these patients' level of

functioning. It should also be mentioned that the current study showed that the Rorschach Inkblot Test is particularly useful in establishing the cognitive functioning of patients with BPD.

It is also recommended that the importance of recognising the linkage between personality and psychopathology be incorporated in the training of clinical psychologists and other mental health professionals. In this regard, the study has shown the importance of clinicians being knowledgeable about the impact *complex childhood trauma* has on patient functioning. However, it should also be mentioned this is rarely taught in South African universities which focus on diagnosing with the DSM. Accordingly, it is recommended that the training of future clinicians be adapted to incorporate knowledge of the impact of *complex childhood trauma* on the development of later psychopathology. It is also recommended that training incorporates an awareness of how normal personality underlies pathological behaviour, and how pathology presents itself on a spectrum of functioning, and not merely categorically, as present or absent.

6.3. Limitations of Current Study

A notable limitation of this study lies in the fact that its scope was limited by the use of a small population, which is not representative of the wider South African population. As a result, the findings of this study can only provide an indication of the similarities and differences between female psychiatric patients with a diagnosis of BPD and a past history of *complex childhood trauma* in light of the adopted multiple case study methodology. Although the findings of this study are in line with international trauma literature, and larger studies conducted internationally, the applicability of this study's findings to other populations in South Africa remains limited.

It should also be mentioned that due to the limited number of psychological assessments that have been standardised for the South African population, this study had to rely on some assessments not standardised for the South African population.

More specifically, this study made use of the MCMI-IV, the Rorschach Inkblot Test R-PAS system, and the CTQ, which do not have South African population norms, as yet. As such this study had to rely on assessment measures standardised for use with other populations, which could have an impact on the assessment results obtained.

Likewise, this study had to rely on theory generated internationally, when interpreting and describing participant results, as there have not been enough studies conducted locally to assist in producing local theory on the impact of complex trauma on the South African population. This study accordingly hopes to act as a catalyst for more research to be done of this kind in South Africa.

6.4. Recommendations for Future Studies

Based on the limitations described above the following recommendations are made with regard to future research studies:

Firstly, it is recommended that similar studies be conducted, utilising a larger, more representative, sample of the South African population. This should aid in establishing whether these findings can be generalised to the wider South African population.

It is also recommended more studies be conducted which investigate the interrelationship between normal personality traits, as measured by the 16PF, and other personality pathologies as well as other DSM diagnoses. Similarly, it is also recommended more in-depth studies be conducted to investigate whether characteristic personality traits underlie other pathologies and DSM diagnoses, such as depression, anxiety, obsessive compulsive disorders, eating disorders and so forth.

It is further recommended that more studies be conducted in South Africa focusing on the interrelationship between complex trauma, personality development and psychopathology, in order to assist in generating psychological theory on the

impact of trauma on the South African population. This should aid in providing South African clinicians with a good conceptual framework for treating relevant South African psychiatric patients effectively. It will also allow these clinicians to rely on South African psychological theory, and not merely have to depend on Western, mostly European and American, psychological theory when treating patients.

Finally, it is recommended research be conducted to investigate the utility of the MCMI-IV, Rorschach Inkblot Test R-PAS system and CTQ, in a South African context. More specifically it is recommended studies be conducted to aid in standardising the Rorschach Inkblot Test R-PAS system, MCMI-IV and CTQ, for the South African population, as these assessments are frequently used in local clinical settings. This will allow South African clinicians to confidently rely on these assessments when assessing and treating patients locally.

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Appendix A: General criteria for personality disorder – DSM-5

Criteria:

A. An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
3. Interpersonal functioning.
4. Impulse control.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

(Adapted from American Psychiatric Association, 2013)

Appendix B: DSM-5 Criteria for Borderline Personality Disorder

Criteria:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Adapted from American Psychiatric Association, 2013)

Appendix C: Copy of ethical clearance from the UNISA ethics committee

Ref. No: PERC-16013



Ethical Clearance for M/D students: Research on human participants

The Ethics Committee of the Department of Psychology at Unisa has evaluated this research proposal for a Higher Degree in Psychology in light of appropriate ethical requirements, with special reference to the requirements of the Code of Conduct for Psychologists of the HPCSA and the Unisa Policy on Research Ethics.

Student Name: Roxanne Luther-van Rooyen **Student no.:** 57334234

Supervisor: Christine Laidlaw **Affiliation:** Department of Psychology, Unisa

Co-supervisor: Elmarie Visser **Affiliation:** Department of Psychology, Unisa

Title of project:

An in-depth exploration of the personality structure of adult female inpatients with a history of childhood abuse by utilising personality assessment

The proposal was evaluated for adherence to appropriate ethical standards as required by the Psychology Department of Unisa. The application was approved by the Ethics Committee of the Department of Psychology on the understanding that –

- Clearance is to be obtained from the hospital from where the participants are to be drawn, and all conditions and procedures regarding access to information for research purposes that may be required by this institution is to be met, including any further clearances that may be required;
- All ethical conditions related to voluntary participation, informed consent, anonymity, confidentiality of the information and the right to withdraw from the research must be explained to participants in a way that will be clearly understood and a signed letter of informed consent will be obtained from each of the participants in the study;
- Patient records will not be consulted without explicit consent of the patients involved.

Signed:

A handwritten signature in black ink, appearing to read "P Kruger".

Prof P Kruger
[For the Ethics Committee]
[Department of Psychology, Unisa]

Date: 23 May 2016

Appendix D: Copy of Health Sciences Research Ethics committee clearance

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00022567, Approved dd 22 May 2002 and Expires 02/02/2022.
- IRB 0000 2226 ICR0001762 Approved dd 22/04/2014 and Expires 03/14/2020.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

30/03/2017

Approval Certificate
New Application

Ethics Reference No.: 73/2017

Title: An in-depth exploration of the personality structure of adult female inpatients with a history of childhood abuse by utilizing personality assessment

Dear Roxanne Luther-van Rooy

The New Application as supported by documents specified in your cover letter dated 21/03/2017 for your research received on the 22/03/2017, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 29/03/2017.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year
- Please remember to use your protocol number (73/2017) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

** Kindly collect your original signed approval certificate from our offices, Faculty of Health Sciences, Research Ethics Committee, Tswelopele Building, Room 4.59 / 4.60.

Dr R Sommers; MBChB; MMed (Int); MPharm, PhD

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2016 (Department of Health).

☎ 012 356 3084 🌐 research.ethics@up.ac.za / ethics@up.ac.za 🌐 <http://www.up.ac.za/healthethics>
📍 Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 60, Gezina, Pretoria

Appendix E: Copy of approval letter to conduct study at tertiary hospital



Weskoppies Hospital facility Research approval

The approval is subject to approval by the Ethics Committee of the University of Pretoria.

APPROVAL BY HOSPITAL CHIEF EXECUTIVE OFFICER

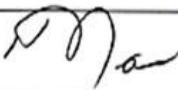
I Mrs. M.A. Mabena Chief Executive Officer / Superintendent of Weskoppies Hospital, hereby agree that this research/evaluation be conducted in Weskoppies hospital.

The officer conducting the trial will be: Roxanne Luther

Research title: Personality Organisation of Female Inpatients with a history of Childhood Trauma

Institution: Weskoppies Hospital

Supervisor: Christine Laidlaw / Elmarie Visser

HOSPITAL CEO / Superintendent			Date		
Signature	Initial(s)	Surname	Day	Month	Year
	<u>MA</u>	<u>Mabena</u>	<u>20</u>	<u>10</u>	<u>2016</u>

Appendix F: Copy of research participant consent form

Informed Consent Form:

Please read this consent form carefully. Ask as many questions as you like before you decide whether you want to participate in this research study. You are free to ask questions at any time before, during, or after your participation in this research.

Title of research project:

An in-depth exploration of the personality structure of adult female psychiatric patients with a history of childhood trauma by utilising personality assessment.

Purpose of research project:

You are being asked to participate in a research study designed to explore the relationship between personality structure and childhood abuse. The purpose of the research study is to assist in generating a better understanding of the personality structure and functioning of women with a history of childhood abuse and how these aspects can be related to enhancing treatment planning of individuals in inpatient settings. The study is being conducted as part of the requirements for the master's degree in clinical psychology at the University of South-Africa.

Research Procedure:

Participants will be asked to complete a biographical questionnaire that focuses on obtaining information regarding each participant's background history which is relevant to the focus of the study. In addition, a number of personality tests will be administered in two assessment sessions. The total duration of these sessions will approximately last 2 hours. Results of these assessments will be analysed for the purpose of this research. The research process will lead to a written report in the form of a master's dissertation, which will be available at the University of South Africa's Main Library.

Potential Risks:

There are no identified potential harmful risks associated with participating in the current study. However, should the research process elicit any distress during the course of the assessment process, you will be referred to your treating clinical psychologist at the current government institution. You will not receive any financial compensation for your participation nor will you incur any costs as a result of your participation in this research.

Potential Benefits:

Should you wish, a copy of a report with regard to your assessment results can be supplied to your treating clinical psychologist to inform your ongoing treatment. This will occur only with your written consent.

***** Please note that the results obtained in the research data gathering are strictly intended for research purposes, and although a copy of the results can be shared with their treating clinical psychologist in the form of a brief interpretive report for therapeutic purposes upon your request, these results are not to be used for forensic/ court purposes as the context in which these results***

were obtained was not forensic and does not form part of a coherent battery of forensic assessments or investigation

Confidentiality:

Your identity in this study will be treated as confidential. Results of the study, including all collected data, may be published in my dissertation and in possible future journal articles and professional presentations, but your name or any identifiable references to you will not be included and will be kept anonymous. However, any records or data obtained as a result of your participation in this study will be inspected by the researcher and the study supervisors who are registered clinical psychologist and bound by the ethics of the Health Professions Council of South Africa. These records will be kept secure and private and only be shared with relevant professionals directly concerned with the study.

Voluntary Participation:

Your participation in this study is of a voluntary nature. Your decision whether or not to participate will in no way affect your present or future care, employment or lifestyle. You will also be allowed to withdraw from the study without experiencing any negative consequences.

Any questions you may have about this study can be answered by Roxanne Luther or her

Research Supervisors/Clinical Psychologists: Christine Laidlaw and Elmarie Visser

Declaration of participation:

I, the participant, have read and understand this consent form, and I volunteer to participate in this research study. I am aware that all identifying details regarding myself will remain confidential and in no way form part of the research data or any subsequent report or publication. I am aware that I may withdraw from this process during the data collection phase and that this decision will not prejudice me in any way. I consent to the procedures, risks, and confidentiality limits of this study. I also agree that the researcher has explained the research process, access to findings as well as the fact that my participation in this study is voluntary to me in English, which I am able to understand. I was granted the opportunity to ask questions and receive answers with regard to any concerns I might have had. No pressure was exerted on me to consent to participation.

I hereby request a copy of an assessment report to be provided to my treating clinical psychologist

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Should you have any queries, please contact:

Principal Researcher: Roxanne Luther

E-mail: roxyluther@gmail.com

Research Supervisors: Christine Laidlaw - laidlc@unisa.ac.za

Elmarie Visser – vissee@unisa.ac.za

Signatures

Participant Name (printed) : _____

Participant Signature : _____

Participant code (to be provided by the researcher):

Date: _____

Principal Researcher's Name (printed): _____

Principal Researcher's Signature: _____

Date : _____

Appendix G: DSM-5 criteria for PTSD

Criteria:

Note: The following criteria apply to adults, adolescents, and children older than 6 years.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific re-enactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2. Reckless or self-destructive behaviour.

3. Hypervigilance.

4. Exaggerated startle response.

5. Problems with concentration.

6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

(Adapted from American Psychiatric Association, 2013)