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Opinion Paper

Complex trauma, dissociation and Borderline Personality Disorder: Working with integration failures

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ABSTRACT

A history of childhood trauma and ongoing dissociation are common in clients with Borderline Personality Disorder (BPD). Symptoms that occur in clients who have Complex PTSD or dissociative disorders (OSDD or DID) have a significant overlap with those of BPD, such as self-harm, suicidality, hearing voices, alterations in sense of self and states of consciousness, amnesia, depersonalization, chronic dysregulation, relational destabilization, and phobic avoidance of traumatic experiences. While many approaches focus on symptom management in BPD, we will describe a practical trauma-informed approach that emphasizes the need to identify and work with the individual's unintegrated inner structural organization as a means to address the root causes of symptoms.

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Traumatic experiences are ubiquitous in clients with borderline personality disorder (BPD). There is a significant overlap in symptoms of Complex PTSD and BPD. Debate about whether Complex PTSD and BPD are the same diagnosis has settled into some agreement that ultimately, while the two disorders may be commonly comorbid, they are distinct to some degree (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Driessen et al., 2002; Ford & Courtois, 2014; Heffernan & Cloitre, 2000; Herman, 1992; Pagura et al., 2010; Van Dijke et al., 2011). Nevertheless, traumatic experiences and/or severe attachment problems underlie both disorders, as well as dissociative disorders, with unresolved issues related to these experiences paramount in maintaining symptoms.

To a large degree, a particular collision of genes and temperament with a suboptimal or hostile environment may explain the development of borderline personality disorder. Studies on temperament in BPD demonstrate these clients have higher levels of emotionality, activity, novelty seeking, and harm avoidance, along with lower levels of cooperativeness, sociability, shyness, and self-directedness (Atefia, Dolatshahia, PourShahbaza, & Khodaieb, 2011; Barnow, Rüge, Spitzer, & Freyberger, 2005; Stepp, Keenan, Hipwell, & Krueger, 2014; Zanarini & Frenkenburg, 1997). They may struggle with abandonment, intolerance of aloneness, and self-harm more than clients who are traumatized but who do not have BPD.

Temperament and other genetic factors may explain why some clients with BPD do not report overt trauma, but still appear to be traumatized. After all, “trauma” is not an event, not external to the individual, but rather is the subjective experience of the person. When integrative capacity is overwhelmed, this constitutes trauma, whether it involves actual abuse, the absence of experience (neglect), or an event that many others might experience as merely a stressful situation (such as being yelled at). Young children are especially prone to being overwhelmed by “hidden traumas” that involve the caretaker's inability to modulate affective dysregulation (Lyons-Ruth & Spielman, 2004). Ample research has demonstrated that clients with BPD typically have a wide variety of experience that are traumatizing to them including severe neglect, attachment ruptures and overprotection (Mosquera et al., 2013).

The harmful effects of overprotection generally have received less attention in the literature than neglect, but are no less pernicious (Parker, 1983; Ungar, 2007; Mosquera et al., 2013). Extreme overprotection may result in traumatic experiences in some clients. Those who have “helicopter parents” who constantly hover and rush to fix problems for the child, yet remain emotionally unavailable, may never learn how to manage on their own and cope with the inevitable stresses and challenges of life. While children need much support and nurturance on the one hand, they also need to be encouraged to try new activities, allowed to fail and learn from mistakes, and to learn to be self-sufficient when necessary. Once adults, these clients may begin to struggle and are required to engage in more functioning than their

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parents might have permitted. They experience themselves as helpless and easily overwhelmed, unable to self-soothe.

1. Dissociation and BPD

Dissociation as a symptom and also as a division of personality and BPD also have a significant relationship. A body of research has indicated that dissociation and dissociative disorders are, in fact, common in BPD (Conklin & Westen, 2005; Korzekwa, Dell, Links, Thabane, & Fougere, 2009; Ross, 2007; Sar et al., 2004; Sar et al., 2006). For example, Korzekwa and colleagues noted that 24% of a sample of BPD clients do not report dissociation, 29% experienced mild dissociation (amnesia and depersonalization), 24% met the criteria for Other Specified Dissociative Disorder (DDNOS/OSDD), and 24% met the criteria for DID (Korzekwa et al., 2009). Conversely, BPD is also common in dissociative identity disorder (DID) (Ross, 2007; Ellason, Ross, & Fuchs, 1996).

Dissociative experiences in BPD. While the majority of clients with BPD experience at least some dissociation, it is essential to understand what we mean by dissociation. Indeed, not all dissociation is the same and in the literature there is considerable vagueness about whether dissociation is a symptom or a division of personality. Three different categories of experiences that are referred to as “dissociation” can be distinguished in the literature:

- symptoms of absorption (focus on one thing to the exclusion of others, including preoccupation and rumination) and detachment (spaciness, thinking of nothing/dorsal vagal shutdown) (Allen, Console, & Lewis, 1999; Schore, 2009);
- symptoms of depersonalization/derealisation (Lanius et al., 2010);
- and division of the personality (Van der Hart, Nijenhuis, & Steele, 2006; Steele, Dorahy, Van der Hart, & Nijenhuis, 2009).

However, some clinicians have made the case for division of the personality as the only true form of dissociation as it was originally defined, while absorption and other experiences can be viewed as more general and common alterations in consciousness (Holmes et al., 2005; Steele et al., 2009). It was only much later in history that dissociation began to be defined in a more broad and encompassing way (Van der Hart & Dorahy, 2009). In the general literature on dissociation, absorption and detachment have been referred to as “normal” dissociation, while depersonalization and personality fragmentation are generally referred to as “pathological” dissociation (Steele et al., 2009). However, it is not likely that these three conditions actually belong on a continuum of similar experiences. For example, absorption can be so severe that it may be pathological, indicating it is not always on the “normal” end of a continuum. Furthermore, the extreme of absorption does not seem to be a division of the personality, but rather profound detachment and narrowing of consciousness, that is, a lack of being present. What is accurate to say is that everyone experiences absorption and detachment from time to time, and many experience mild occasional depersonalization when stressed, tired or ill; but only clients with serious trauma-related disorders experience dissociative divisions of personality.

Each type of experience (absorption/detachment, depersonalization/derealisation, and division of the personality) has its own treatment implications, further making the case for careful distinctions among them. Absorption and detachment are best treated with mindfulness approaches and a focus on the present moment (Allen, 2001; Steele, Boon, & Van der Hart, 2017). Depersonalization is viewed primarily an avoidance of emotion, so treatment focuses on emotion recognition, tolerance, and regulation techniques (Phillips et al., 2001; Simeon & Abugiel, 2006).

Dissociative division of the personality is treated by work toward integrating dissociative parts (Chefet, 2015; Gonzalez & Mosquera, 2012; Mosquera & Gonzalez, 2014; Mosquera, 2016; Steele et al., 2017). Even though there are major differences, all three types of experiences seem related at some level, and thus commonly occur in the same individual.

According to the broad view, dissociative symptoms are common in BPD, including memory loss (amnesia) for significant events or time periods events, and people; a sense of being detached from the self and other experiences of depersonalization or derealization; misperception of people and things as distorted and unreal; blurred sense of identity; and hearing voices (which stem from various dissociative parts of the personality).

Studies on the relationship between BPD and dissociation indicate that dissociative division of the personality can correlate with a wide range of indicators of severity and impairment in BPD and complicates response to psychotherapy (Chlebowski & Gregory, 2012; Kliendienst et al., 2011; Yen et al., 2009). The authors believe that it is essential to distinguish what kind of experience a given individual has in order for treatment to be successful.

2. Treatment approaches: how to work with integration failures

Given that dissociation and trauma are common in BPD, the question can then be asked: What treatment approaches are helpful in clients borderline personality disorder who also have comorbid Complex PTSD or dissociation/dissociative disorders? While many clinicians focus on treatment of specific symptoms (e.g., self-harm, suicidality, dysregulation, and conflicts about dependency), in this article we will lay out a practical theoretical approach of working with dissociative and otherwise unintegrated parts of self as a pathway to more integrated adaptation and self and relational regulation in borderline clients. This approach naturally leads to diminished need for coping in less functional ways.

Given that clients with BPD suffer from varying degrees of integrative deficits in their inner organization of self and personality, treatment should focus on integrating their fragmented and conflicted inner world, regardless of the degree of dissociation present. Personality can be understood as a superordinate system of dynamic subsystems, which organizes our experience across time and contexts into a relatively integrated whole, and which contains our sense of self. Subsystems of the personality do not adequately integrate in young children who are consistently traumatized or who have enduring major attachment disruptions (Putnam, 1997, 2016). On a continuum of disintegration, subsystems can be understood as unintegrated mental representations or internal working models (e.g., Bowlby, 1988; Kohut, 1971), schema modes (Young, Klesko, & Weishaar, 2003), ego states (Watkins & Watkins, 1997), self states (Chefet, 2015), or dissociative parts (Mosquera, Gonzalez, & Van der Hart, 2011; Van der Hart et al., 2006). The distinction of dissociative parts from other integrative failures in self and personality organization can be made by the presence of amnesia (especially for current experience, American Psychiatric Association, 2013), Schneiderian symptoms of intrusion (Kluft, 1987; Steele et al., 2017), and separate first-person perspectives in parts (Van der Hart et al., 2006).

We can think of clients with BPD and traumatization as being on a continuum of integrative deficits, wherein a lack of integration is present in different degrees and in different ways for various clients. However, not all lack of integration is dissociation. Integration is an ongoing process: It is a journey, not an event. When we speak more broadly of integration, we actually mean “good enough” integration for best functioning in the present, and

that incorporates our past, present and potential future into who we are and what actions we take. Thus, we all have at least minor integrative failures in our mental representations of self and others, and in our normal ego states.

Integrative failure is a matter of degree. Those with personality disorders, including borderline, have more severe deficits in the integrative functioning of their personality than normal populations. Dissociation of the personality is a special type of integrative failure involving a division into subsystems that are not only insufficiently linked and realized, but which operate somewhat independently and simultaneously, and have a separate sense of self and perspective. More general integrative failures do not include these dissociative parts, but only a lack of adequate linking and realization.

At the least, clients with BPD have unintegrated mental representations of self and others, and these representations are perceived as split between all good or all bad. In other words, nuance and conflicts are not included in a single representation of self or other, but instead, are divided among different representations. Clients with BPD and a dissociative disorder will have both unintegrated mental representations and dissociative parts as illustrated in Fig. 1 and Box 1.

In both types of clients, treatment should consistently address integrative failures of the self and personality. First and foremost, this is accomplished by improving self and relational regulation, mentalizing, increasing critical thinking abilities, and acknowledging and reducing inner conflicts, leading to a more integrative vision of self and others. The more dissociative the client, the more “parts” work can be helpful. Working with parts directly addresses the dissociation of personality that impedes the usual interventions that support mentalizing and reflective functioning. If treatment as usual for BPD is not being particularly effective, the therapist can consider whether more work involving dissociative parts can be helpful. However, therapists should not treat any internal structures as though they are completely separate from the client as a whole. Thus, when using the term “parts,” care should always be taken to infer that these are aspects of the client.

Below we discuss specifics of treating various types of parts (subsystems) in clients with BPD, ranging from working models, to schema modes, to ego states, to dissociative parts.

3. Working with integrative failures: key factors in treatment

There are several major elements that contribute to a more effective understanding of the presenting problems in clients with complex trauma and BPD. Each of these factors contributes to ongoing dysregulation and integrative failures. Their resolution is

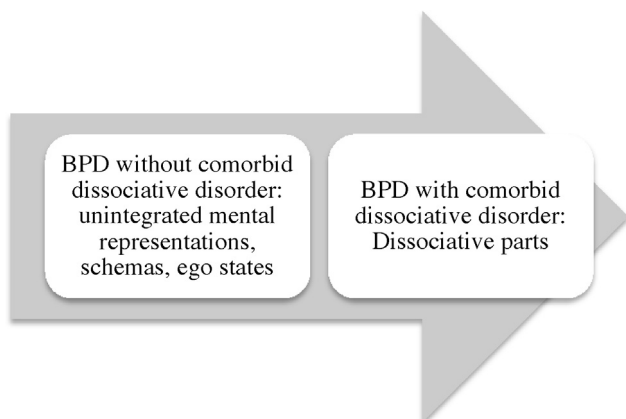


Fig. 1. Lack of Integration in BPD With and Without Dissociation.

Box 1. Differences in Presentation of “Parts” in BPD.

BPD without dissociative features:

- unintegrated mental representations, ego states, and schemas without amnesia;
- splitting between primitive positive and negative / good and bad representations as a psychological defense rather than a biological defense;
- conflicts avoided by switching between good and bad mental representations of self and other; avoidance and denial;
- capacity to reflect and hold conflict depends on overall integrative capacity and whether they are emotionally triggered or not. Some clients have good capacities when stable, but lose them quickly when triggered.

BPD with dissociation* or dissociative disorder:

- unintegrated mental representations, ego states, schemas, AND dissociative parts with amnesia;
- dissociative parts have biological underpinnings of animal defenses and attachment seeking action systems;
- dissociative parts developed primarily from traumatization;
- conflicts avoided by amnesia between parts and by switching from one part to another;
- capacity to reflect and hold conflict depends on overall integrative capacity. It fluctuates depending in which part is present; it can be higher in some parts, while other parts have little to no capacity.

necessary in order to promote adaptive integrative functioning. These factors include:

- internalization of toxic messages with subsequent development of unintegrated maladaptive schemas;
- triggers and their link to traumatizing events;
- mentalizing functions and the capacity for logical thinking;
- and inner conflicts and trauma-related phobias.

Internalization of Toxic Messages: Core maladaptive cognitions are frequently unintegrated negative messages from abusive figures. This explains why clients are so entrenched in their patterns of coping and find it so difficult to change. Clients often continue to look at themselves through the eyes of the abuser many years after the abuse has ended. Indeed, these messages are often encapsulated in unintegrated parts that mimic the perpetrator. Thus, clients may actually hear an inner voice expressing negative ideas: “You are so stupid; nobody could love such a loser like you.” This message is congruent with and reinforces the client’s chronic sense of badness and worthlessness.

These messages and core beliefs are often impervious to cognitive interventions alone. They require careful attention to the inner dissociative organization of the client. The therapist should address the part of the client that imitates the perpetrator. This should be done with curiosity about the protective functions of this part and an attitude of compassionate understanding of this aspect of the client so he or she can learn to accept and understand this part of him or herself.

4. Case example: you are bad

Diana is 27 years old. She has BPD and hears voices. She does not experience herself as having parts, because she does not experience the voices as even belonging to her. This indicates a much stronger degree of nonrealization than would be seen in ego states or schema modes. This, along with other dissociative symptoms resulted in the diagnosis of OSDD, in addition to

borderline personality disorder. One of her voices often tells her that she is “bad” and deserves to be punished. The client does not know how to deal with this statement and frequently ends up in the hospital with severe injuries from self-harm, which is how she copes. In the following vignette the therapist will try to help the client understand what the voice is trying to communicate to her. The hypothesis is that the voice probably expresses unintegrated negative messaging from the client’s childhood. She repeatedly hears it, but does not know how to respond differently.

Client (C): I can’t stand her, she (the voice) is making my life miserable

Therapist (T): I know this is difficult for you; could we try to understand what the voice is concerned about?

C: She is not concerned about anything, she just repeats the same thing over and over, until I can’t stand it any longer and bang my head against the wall

T: Could we try to be curious about the voice and try to understand why she says these things?

C: Sure, we can try but I don’t think we will get anywhere

T: Ok, let’s just try it out

C: Nods

T: Is this voice activated when you feel good?

C: No.

T: How about when you are calm?

C: No

T: Does it happen when you feel bad?

C: Yes.

T: Is it when you feel overwhelmed, anxious...? (give a possible menu)

C: She appears when I am sad.

T: When you are sad... so maybe there is a part of you that is afraid of being sad or finds something intolerable about being sad? Or maybe she doesn’t know what to do when you are sad?

C: (thoughtful) I guess. I hadn’t thought about that.

T: How did people react when you felt sad as a child? (Linking current experience to the past, and to toxic messages the client might have received).

C: They (parents) couldn’t take it. They didn’t know what to do, I guess. They would ignore me. If I didn’t stop crying they would get angry and tell me I was bad.

5. Psychoeducation: helping the client to understand to purpose of the voice

T: So, when you felt bad, there was someone who did not tolerate it, or who did not know how to help you. I wonder, is it possible that a part of you, when you are sad, reacts in a similar way, because you did not learn to do it in a different way?

C: Yes. That makes sense.

T: This voice may need to understand that she can help you in a more effective way. I think she can learn different ways to respond. Do you think that she knows how bad you feel when she says these things to you?

C: No, she probably doesn’t (reflection, compassion and understanding are increasing)

6. Exploring how the voice can change

T: Does this make sense to this voice too?

C: Yes.

T: I think this voice can learn to help you differently. Maybe we can help her learn how.

C: OK, but I don’t have a clue how.

T: Well, let’s see. As a start, how could this voice help you?

C: Well, it would help if she stopped telling me that I am “bad,” and stop blaming me. When I was a child I was called “bad” without doing anything bad. For example, if I cried they would tell me “you are bad” just because I was crying, or when I was afraid of going to places, things like that.

7. Introducing an adult perspective

T: It’s important that you, as the adult you are now, can realize that a little girl is not bad because she is crying. A little girl may cry because she is sad, afraid, hungry, frustrated; she can cry for many reasons. A little girl does not cry for no reason or because she is bad. The fact that you can understand this will probably help this voice to understand it as well, and helps her change her perspective.

C: Nods, paying attention. (The client is learning to understand and relate to self in a more compassionate way. Voices or parts that carry internalized negative messages can learn new adaptive ways of communicating their concerns or needs once they are understood by the client and therapist.)

An overall fragile identity usually goes hand in hand with internalized negative cognitions. When clients have not had the experience of being looked at with love and acceptance, their identity is deeply affected and shame becomes a major dynamic. It is difficult for clients to change the way they see themselves without first working to repair the attachment system.

8. Understanding out-of-proportion reactions and their link to trauma: identifying triggers

Triggers occur when unresolved experiences are reactivated, evoking reactions to apparently neutral stimuli in the here and now. Triggers can be related to internal experiences as well as to external cues. For example, a feeling of sexual arousal can trigger panic, compulsive sexual acting out, or self-harm, when the arousal reactivates memories of early sexual abuse. A kind of circularity occurs, in which unresolved experiences trigger unresolved trauma and old coping mechanisms. Old coping strategies are not sufficiently adaptive and the person has an increasingly difficult time in managing internal experience and external events.

Many impulsive reactions observed in BPD clients are conditioned responses to previous, unresolved trauma. These reactions can be viewed less as impulsive and more as reactivity to triggers. By understanding triggers, we can work with the issues that are generating apparently impulsive reactions in the present (Mosquera, 2015, 2016).

Triggers are a particular problem in the realm of relationships, in which perceived rejection, abandonment, or even small changes in perceived proximity may evoke massive negative reactions. After all, it is typically relationships that have been the cause and context of traumatization; it is only natural that clients would be inordinately triggered by relational experiences. In fact, clients are caught in an insoluble dilemma: they desperately need to connect, but fear that connection is hurtful or even dangerous. Thus, we see the disorganized attachment paradigm of “I hate you/don’t leave me,” so common in clients with BPD (Fonagy, Target, & Gergely, 2000; Mosquera & Gonzalez, 2014; Mosquera, Gonzalez, & Leeds, 2014).

Triggers are related to deeply embodied visceral experiences, particularly in relation to painful experiences and memories. These may be implicit and nonverbal, and sometimes are pre-verbal. For example, a client becomes very suspicious due to a gesture from the therapist that reminds the client of a person who hurt her; or she feels overwhelmed when unresolved abandonment experiences get triggered by the lack of presence of relevant others (or someone arriving late to meet with her). She is not aware of what has triggered her in the moment.

Therefore, in BPD it is important to explore the experiences that influenced how the person develops particular behaviors or symptoms. Understanding apparently out-of-proportion reactions is crucial, since most of these reactions make complete sense if we are familiar with the client's trauma history and difficulties with self and relational regulation in the face of traumatic triggers. Therapists should be attentive to the many triggers in the relationship and respond with a curious, non-defensive attitude. This will serve as modelling for the client, who is usually confused by his or her apparently "out of the blue" reactions. After all, relationship has been the context for traumatization, so even small changes in approach or withdrawal may signal danger to the client, who can become easily dysregulated and temporarily lose any mentalizing and thinking abilities that have been present. For clients who are not dissociative, it may be sufficient to offer some psychoeducation about relational triggers and how their symptoms are related to severe attachment disruptions. For clients who are more dissociative, direct access to these memories may be limited or absent. Parts work can help decrease reactivity to triggers and begin to help the client regulate even before traumatic memories are directly accessed (Mosquera & Gonzalez, 2014).

Treatment of triggers. Treatment consists of first recognizing that the client is being triggered. When the client is not yet sufficiently stable, psychoeducation about traumatic triggers can be helpful, with a focus on distinguishing what is different about the trigger in the present, rather than focusing on what is similar to the past. Some triggers can be eliminated or avoided (such as putting a photo of the abuser away, or refraining from watching certain movies or reading certain books); using imaginal rehearsal to better anticipate and cope with triggers; and planning ahead for times that might be triggering (e.g., being with family for the holidays) (Van der Hart et al., 2006; Steele et al., 2017).

However, while focusing on here and now issues and managing triggers can be useful to stabilize and as a preparation to work with traumatic issues (Mueser et al., 2008; Harned, Jackson, & Comtois, 2010; Mosquera, Leeds, & Gonzalez, 2014), it is not sufficient to help clients resolve their symptoms. Many approaches for BPD are focused on here and now interventions. Although these approaches have shown efficacy in symptom reduction, they do not seem to achieve a complete integration of the personality. The individual has to make an ongoing strenuous effort to stay stable and not resort to familiar but maladaptive coping strategies. Triggers remain a problem. We believe that working with the here and now and avoiding unresolved issues is exactly what the client has learned to do in order to avoid dealing with the past. Far too often, they are experts at diverting attention from memories or intrusions that are too painful by using alcohol, drugs, self-harm, sex, bingeing, and so on. All of these "strategies" tend to numb their emotional pain from the original traumatization (Mosquera, 2013, 2016). Trauma resolution is in many cases essential to achieve comprehensive symptom resolution. Thus, once the client is stable, a focus understanding and processing traumatic memories is essential, so they can be resolved. At that point, triggers lessen and even disappear completely, so that client can focus on the present without having to ignore or suppress the past.

9. Reflective capacity and the ability to think logically

Research indicates that clients with BPD have a generally lower capacity for self-reflection, less accurate perceptions of reality, and less ability to think logically than those with DID (Brand, Armstrong, Loewenstein, & McNary, 2009). However, we propose a more nuanced formulation. Clients with BPD and complex dissociative disorders (OSDD or DID) can be found on a continuum of reflective functioning and reality testing. When not under stress,

higher functioning clients in both categories can have relatively good abilities in these arenas. Others have much less. Nevertheless, with BPD, even in higher functioning cases, these abilities can be lost under stress. DD clients may retain these capacities in some dissociative part(s), such as observers or some adult parts, but other parts may not have these capacities under any conditions. So, it depends upon which parts are in the forefront as to whether clients with dissociative disorders demonstrate these abilities.

Extra emphasis may need to be placed on the ability to mentalize under stress in these clients, and to improve their logical thinking capacity. Approaches like DBT are generally effective in this regard, but therapists should be aware that additional difficulties can be encountered with BPD clients who are also dissociative.

For example, clients who have child modes and parts often engage in developmentally young thinking while these parts are active. Mentalizing then needs to include self-awareness of parts and support from the adult self to engage with child parts who might be stuck in time. Parts stuck in trauma-time are not only fixated on the trauma, but typically have lapses in logic due to a regression to developmentally young thinking patterns and lack of mentalization. Linking child parts to adult parts and orienting them in time with compassion are essential components of improving reflective and thinking capacities.

10. Internal conflict and trauma-related phobias

Lack of integration of the personality is present in BPD to varying degrees, ranging from unintegrated mental representations to ego states to dissociative parts, as mentioned above. This lack of integration manifests in internal conflicts among parts are a prime focus of treatment. Traumatic experiences generate dissociative responses. Thus, dissociation of the personality (and therefore these responses) is maintained due to internal conflict, phobia of inner experience, lack of realization, and lack of social support (Van der Hart et al., 2006; Steele et al., 2017). Understanding these issues is crucial for case conceptualization and treatment planning (Mosquera, 2016).

The concept of dissociative phobias, that is, phobias that maintain dissociation (Van der Hart et al., 2006), is central to the work with clients who have BPD and dissociation. The first phobia to address in treatment is that of inner experience: intense fearful or shameful avoidance of thoughts, emotions, sensations, wishes, and fantasies, etc. This generates intense avoidance which interferes with mentalization. Confrontation with inner experience can lead to rapid dysregulation and decompensation, leading to a cycle of further phobic avoidance and overwhelm. Additional phobias may be present and include a phobia of dissociative parts, of traumatic memories, of attachment and attachment loss, and of adaptive change (Van der Hart et al., 2006; Steele et al., 2017). The client's world becomes smaller and smaller in order to avoid more experiences and triggers.

In some clients, internal conflict can manifest through arguing or critical voices, which clinicians sometimes confuse with psychotic symptoms. Inner voices in individuals who are not psychotic can be understood and treated as fragmented parts of the personality that also hold aspects of traumatic memory. Clients need to learn to understand their voices and to communicate internally in new, more constructive ways. Approaching conflicts with curiosity and compassion leads to understanding and is essential to overcoming dissociative phobias and working towards integration.

11. Case example: my different Me's

Susan is 30 years old. She has BPD and describes several parts of herself that are in conflict. She experiences these as parts of herself,

not as separate, as is illustrated below. Although she has few dissociative symptoms, she has a relatively high integrative capacity. This case illustrates how to move from symptoms to the origin of the problem.

Therapist: I am aware that throughout this time you have done different drawings of how your inner world is doing.

Client: Yes.

T: Would you be able to tell me how you are doing inside now?

C: (Sighs)... In general, it's Me, Myself, and She. Me is the part, let's say the rational part of myself, who the world sees, right? Me is the one that cooks, cleans, shops, smiles at people...

Myself is a teenager who is about 18 years old and she's in charge of the attic.

T: The attic?...

C: Yes, Myself has everything in boxes and everything is organized—my memories, my history. It's all behind closed doors. Myself is in charge of everything being locked up and put away.

T: And what do you think about that?

C: Let's just say that Myself is who deals with my emotions.

T: And she deals with emotions by putting things away in boxes?

C: Yes. But I think that Myself is not doing well, because everything is all over the place, disorganized... The entire attic is a mess.

T: And the attic is something that you see in your head? That you visualize?

C: Yes, it's my interpretation of Myself.

T: It's how you perceive it. You perceive that Myself is in charge of protecting you from emotions by keeping them put away.

C: Yes. "Myself" has been with me for a long time. She's always been a teenager. And the attic, well, she always said, "When I can't deal with something, it goes to the attic."

T: And what do you think about the job that Myself is doing putting everything into boxes?

C: It's hard work, difficult.

T: And do you think it helps you?

C: Well, yes. If it wasn't for Myself I wouldn't be able to manage. I would get too overwhelmed by all of it. (The client already understands the functions of this part, so further exploration can occur. If she had no concept of how this part functions for her, work would focus on promoting understanding and cooperation first.)

T: OK. Why do you think everything so disorganized now? (The client does not really understand what generated the changes. So further exploration might improve reflective abilities.)

C: She has been present a couple times. She is like a three-year-old girl with a temper tantrum, and she just wants to let anger out. When she speaks, what she says is, "Why? Why do I have to be rational? Why can't I throw a rock at that man if he's bothering me? And why do I have to be quiet if I want to scream? And why, why...?"

T: How do you respond?

C: Well... huh... I... I told her that... that she just couldn't do that. I answer "Of course it would be satisfying to throw a rock at that man if he's bothering you..."

T: So you think it would be satisfying for you?

C: Yes, of course... To release the anger.

The client describes several situations where she had the impulse to hurt others. She also describes several episodes since childhood when she lost control and hurt others.

T: So there's a lot of uncontrolled anger, and She has a hard time thinking logically and managing her anger. It's normal for all of us to have those types of thoughts because of unexpressed anger inside, but this does not mean you will actually do it.

C: Yeah, yeah... I know. (Good ability to distinguish between a wish or impulse, and an action)

T: It's great that you can talk about it, so we can understand what is happening and why. Do you remember how you felt after those situations where you lost control?

C: Yes, how couldn't I? Horrible.

T: I wonder, do you think that anger is connected to other parts of you in addition to She? (Attempting to make further links in understanding and working with anger)

C: Let's see... She did not exist until very recently... Or I had no insight about her, so, it didn't seem connected to anything. It's as though I had a mental short circuit and everything disappeared in those moments of rage. (Temporary loss of reflection and thinking capacity)

T: OK, so at that moment it's like you don't care, but do you remember what happened?

C: Yes, Yes. (Confirms there is no amnesia)

T: OK, so then, what was next?

C: The monster showed up. (Mental representation of self as bad)

T: The monster?

C: Yes, the monster is what Myself was keeping away. She had it hidden in the attic behind a door. I think that monster is now She.

I have the impression that Myself couldn't deal with the monster any longer, it got to be too much... too big. And then I think the monster turned into She. (Already the client demonstrates some integration, moving from a primitive image of her anger as a monster, to the anger of a little girl that represents the client as a child).

12. Exploring how the client perceives parts

T: OK. When you talk to me about Me, Myself, and She, who used to be the monster, do you see them as aspects of yourself?

C: They're me, yes, but they're not me at the same time.

T: Explain this to me a little.

C: Let's see, they're me, but they're not me, not like how I would be...but they are part of me, I guess. Parts I don't like very much. I don't want to be that person

T: OK, so then you know that they are you, but it isn't how you want to be, so they feel different that you.

T: So then you're able to see that they are a part of you.

C: Exactly, they are part of me but they are not exactly me. The me that I recognize as me is Me, let's say the part who is the most rational one of all.

T: So, on the one hand, She shows up now because Myself couldn't deal with it anymore. (Once the therapist has a better understanding of the internal system, he or she can use this information to help the client understand why She appeared in the present context.)

C: Yes

T: It seems like She is trying to help?

C: I think that She just wants to get out.

T: Yes, getting out the anger can feel very urgent, and also if she gets out, she has the opportunity to be seen and understood by us. That is also so important. I wonder if perhaps another possibility is that She shows up because Myself is overwhelmed, and she's trying to help.

C: Uh-huh, yes, I understand.

13. Promoting empathy and common goals

T: OK, so if this is it, what is She trying to do?

C: Lighten the burden.

T: OK, so She understands that in order to lighten Myself's burden she has to do things (throw things at others, hurt others...).

C: Yes

T: And what does Myself think about this?

C: If She came out like she wants to come out, I think that Myself would not feel good.

T: OK, so this is very important for She to know. Do you realize this? If She is trying to help Myself be less burdened, but acts out her anger in order to make that happen, you are actually going to have a lot more burden and need to put even more feelings in the attic.

C: Yes, I can see that. (Again, client demonstrates good ability to reflect and understand)

T: So actually, she would not be helping with the burden. But it would be interesting to see how she could help in a way that can help truly lighten this burden.

C: Well, the only way that She can be helpful without Myself feeling bad, is if She was able to come out little by little and in a...let's say... organized and buffered way. I don't know how to explain it, but in a way that is not hurtful.

T: Yes, that makes sense. You know, I think it's a super heavy load. It sounds extremely hard for a three-year-old girl to have to alleviate the burden of a teenager part and an adult. What do you think about this?

C: (sad) Yes. (Able to have compassion)

T: What does She need? What could this three-year-old part of you need?

C: Love, I guess, lots of love. (Good reflective capacity)

T: And when you realize this, what happens?

C: Sadness.

T: Sadness... yes. It's sad, isn't it, to realize how much she—you—lack love. It's so good that you understand what she needs. (Client seems thoughtful)

T: What else is going on in your head?

C: I realize I know why she needs love. (Mentalizing)

T: Yes... would you like to share something about that?

C: Yes, she needs love because Me and Myself are very harsh.

T: Oh, I see. What is it like to realize this?

C: Well, it's hard to realize this.

T: It's hard, you feel very sad... do you think it can be useful to realize this?

C: Nods yes.

14. Promoting empathy towards the part

C: The three-year-old part of you (She) holds all the anger of the entire lifetime... all those times when she, when you, felt pain... when you felt sadness... when you felt hurt... And She remained quiet. She just put up with it.

T: Yes, that is so much to hold.

C: Everything that was put away in the attic... She has it now.

T: OK, so you can see that She needs that love now. And you understand that also Me and Myself are being too harsh on the little girl. Yes?

C: Yes, with the girl, with Myself, and with Me.

T: OK, so what does that help you understand that is necessary to change?

C: That we need to change the judge that lives in this house.

T: What does the judge need?

C: To stop judging once and for all, and start loving a little bit more.

T: OK, what is that like for you? Would that possibility be interesting for you?

C: It's what I should do. I just don't know how to do it. (Here is an integrative lag between what is known and what can be accomplished with actions. The therapist understands that more work should be done to support this integrative step.)

15. Exploring the phobia of dissociative parts

T: From the perspective of Me, what do you feel towards the girl?

C: Fear and sadness. I am afraid of losing control.

T: Yes, that's a pretty big fear, isn't it? and you said the girl needs love, so if she receives a little bit of love, I wonder, is it possible that she will not need to lose control?

C: Yes. (Impulse control, regulation with compassion, ability to mentalize)

T: Does that make sense?

C: Yes, because more than likely, since the girl needs love, the intensity of the anger will decrease through love.

16. Promoting an adult perspective

T: OK, so could you try thinking about what you would say to a three-year-old girl? What would you say to her?

C: I would tell her that she deserved to be loved.

T: OK, and when you tell her that, what happens to her?

C: The problem is that she doesn't believe it. (Here is a dissociative divide and a conflict between what is intellectually know and what is subjectively experienced)

T: Well, that's fine, she probably has good reasons not to believe that. Can Me understand it? (Modelling a new way of responding with acceptance and compassion)

C: Yes

T: So, from the adult that you are now, do you understand that it's hard for your three-year-old self to believe that?

C: Yes

T: OK, so what do you imagine she needs from you in order to believe it?

C: First I have to believe it from Me and Myself, or else She will never believe it.

T: Yes, somehow all of you need to believe it. And what do Me and Myself need in order to start believing that a little more?

C: Pfft... I have no idea. Well, first I have to stop being so mean to myself.

T: Well, that would be quite an interesting step. I already see that you have compassion for that little girl and thus for yourself today. That's a wonderful start, don't you think so? Do you think you could try taking care of yourself a little bit more these days and not be so harsh with yourself? And see how your inner world responds to that?

C: I can do some "thought stopping."

T: OK, do you imagine that will help?

C: It helped me once when I was depressed.

T: Perfect, so then it would be good that you use whatever helps you to not be so harsh. And if you are harsh, just notice the circumstances that activated that inner judge. Maybe you could remind the judge that you are safe and OK now? Something like that?

17. Preparing the client for possible negative reactions and using her own resources so she can learn to respond more adaptively to herself

T: You're an adult now and you have a son.

C: Yes

T: When your son is restless, how do you usually respond to calm him down?

C: Hugging him and kissing him.

T: Does it work?

C: Yes, most of the time.

T: OK, so then from your adult, when She is restless, what could you do?

C: Calm her down, say loving things.

T: OK. How good that you know just what to do! So, it would be very important that if She responds by not believing she is loved, that you respond by compassionately understanding why she doesn't believe it, from your adult self. To say something like, "I understand that you don't believe it but I'm trying to understand and help you feel accepted."

P (Nods yes)

T: In order for She to truly believe that she deserves to be loved, you have to show her these kinds of things little by little.

C: Right. So let's see if the thought stopping works.

T: Great. Try it out, because you know it has worked before. And if it doesn't work, no problem! We'll explore other ways and find the ways that are right for you. The important thing is to simply practice and notice what happens. You have many options, something the adult part of you can remember. What is important is to understand that when there is a part of you that loses control, it's usually because you don't yet know that there are other options. Now that you understand why She loses control, you can help her see other options. Above all try not to get frustrated with the messages, just try to understand, "I understand that she's feeling sad or angry, that she doesn't feel love." And from there, you can start to understand and learn how manage better.

18. Sequential steps to improving integrative capacity by working with parts

As outlined in the two cases in this article, there are somewhat sequential steps to working with parts and improving integrative capacity, as follows:

- promote curiosity;
- enhance reflective thinking and capacity to mentalize;
- promote compassion and understanding;
- identify when and why parts/voices appear:
 - when do they appear – what is the function/purpose/goal?
 - what are they trying to achieve; what purpose do they have?
 - how do they appear or respond to the moment? Are their coping strategies working or are there other ways that work more effectively (as in the case above)?
- link impulses/urges/reactions with triggers to traumatizing events;
- explore how parts experience therapy (or whatever is happening with the client in the moment);
- promote collaboration and cooperation:
 - engage parts, help them feel they have an important role in achieving a better functioning;
 - model new, more effective ways of communicating and relating between parts,
 - What does this part think about what is going on?, What do you as the adult think about what is happening? Are there any other parts that feel differently than you do?, Can we listen to them too?
 - If parts are less developed and separate: What do you experience when you respond from the perspective of that part of you?
- Introduce an Adult perspective. If the adult part can be present most of the time while being aware of and compassionate toward other parts, there can be better integration and less switching in the more dissociative cases.
- Introduce common goals that are shared, accepted, and make sense to the whole system.
- Prepare clients for future difficulties with parts of themselves, given that work is ongoing. The process may not always go as smoothly as the client wishes for. This normalizes therapeutic

challenges, helps the client hold the dialectical tension between acceptance of where parts are and the need for change and avoids going back to conflictual responses between parts. Helping the client anticipate potential problems supports them in being more open and understanding to challenges from parts of their system (e.g., hearing critical comments or commands to self-harm, or voices that wish to avoid therapy).

These steps can be followed in all cases where integrative failures are present. The main differences in the work will be related to the degree of development and autonomy of parts. In clients without serious dissociation, parts will be less developed, and dissociative phobias will not interfere as much as they do in dissociative BPD cases. Although there is still conflict in these clients, the work tends to flow more smoothly, with less resistance. Some issues can be solved by simply helping clients understand what their symptoms are related to, introducing adaptive information that was not available before, and working with and integrating core traumatizing experiences that are preventing better functioning. In dissociative BPD cases, dissociative phobias and barriers will be stronger and it may take considerably longer to begin resolving conflicts. Psychoeducation and cognitive work are not sufficient in themselves, and integrating traumatizing experiences is not always possible due to the fragility of the client's inner structure. The more amnesia the client has for the traumatic past and the less realization, overall, the more the therapist understands the client has more limited integrative capacity and needs to go slower.

19. Conclusions

Trauma and dissociation are frequent in BPD. Those with personality disorders, including borderline, have more severe deficits in the integrative functioning of their personality than those with only Complex PTSD or dissociative disorders. Dissociation of the personality is a special type of integrative failure that is on the far end of a continuum of personality organization with mental representations, schema modes, and ego states. All of these integrative failures of self and personality organization can occur in traumatized clients with BPD, and all need treatment.

As illustrated in the cases above, integrative failure is a matter of degree. By identifying deficits in integrative functioning, the therapist can adapt interventions to the client's needs by focusing on internal conflicts and understanding their links to traumatizing experiences. Through understanding the client's inner structure—mental representations, schemas, ego states, dissociative parts—more effective and nuanced treatment strategies can be developed that address these specific integrative failures. This allows the therapist to structure the work and safely adapt to the client's pace. It is essential to distinguish what kind of dissociative experiences a given individual has in order for treatment to be successful. "Parts" work can be an effective strategy for working with client who have both borderline personality and complex traumatization.

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