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Opinion Paper

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

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INFO ARTICLE

Keywords:

Borderline Personality Disorder
 BPD
 Trauma
 Complex PTSD
 Dissociation
 Dissociative disorders

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 & Abugel, 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

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