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A relational psychoanalytic perspective on trauma, dissociation, and their relationship to psychopathology and borderline organisation[1]

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Abstract. – The paper considers two of the most discussed concepts within the relational perspective in psychoanalysis: dissociation and trauma. Placed within the Italian relational tradition and reflection for over 25 years, the authors propose a model of trauma, dissociation and borderline organisation to highlight their clinical perspective on these phenomena and on the fundamental function of the dissociating mind in a specific psychopathological perspective. Starting with clinical observation of descriptive and phenomenological levels and a model of the psychic processes involved, this contribution aims to reflect on the traumatic experience and how dissociation articulates a possibility of psychic life and residual vitality. Considering the functioning of the individual and his relationships, the paper also focuses on the outcome that dissociation has on the existential aspects of the subjectively and/or objectively traumatic experience. The aim was to provide the clinician with an observational, conceptual and operational perspective that allows for a diagnostic grasp of the different levels of functioning of the patient's mind. The paper in particular focuses on the level of borderline organisation and the specific related psychopathology. Reflection on borderline organisation invites us to connect mind, body, relationships and affections in a systemic manner, from the perspective of attachment and the multiplicity of subjective experience, trying to give maximum emphasis to the specificity of the person in front of us, to his or her subjective resources and multiple levels of functioning.

Key words: Relational psychoanalysis; trauma; dissociation; borderline; attachment; psychopathology.

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[1] Previous versions of some sections of this report have been published in: Albasi, 2006, 2008a, 2008b, 2009a.

Introduction

With the aim of exploring the developments of relational perspectives in psychoanalysis, the reflection proposed in this monographic issue - dedicated to Italian relational contributions - provides an important opportunity to compare concepts considered relevant for the construction of an updated map of the basic values of the therapeutic relationship, not only for relationally oriented clinicians but for clinicians tout court.

Today's landscape sometimes appears disorienting when one thinks of Stephen A. Mitchell's inclusive project: some contributions classify relationals by dividing us into relationals with a capital 'r' or a lower case one. These distinctions are part of a context in which one observes the instrumental use of what began as a strongly ethical movement oriented towards the construction of a psychoanalytic dialogue that would bring to light the problems that theories and theorists defended to the detriment of the patients, in order to feel that they belonged to Psychoanalysis; Theorists who sometimes revealed a lack of aptitude for an epistemologically precise theory, and a fragility of self-esteem that was often the motivation for an uncritical search for institutional affiliations to which patients and 'candidates' have been and are sacrificed. These are serious, worrying problems that have been widely acknowledged and denounced over a long period of time and have marked the history of our discipline, which, being first and foremost and necessarily part of the clinical practice, must have as its ultimate aim the interest of patients as persons and subjects.

Even the International Association for Relational Psychoanalysis and Psychotherapy (IARPP) itself runs the risk of institutionalising traditionalism; a socio-historical process described in the literature. At the most recent IARPP conference held in Los Angeles in June 2022, in her closing remarks Margaret Black Mitchell felt the need to remind everyone present of the fundamental values which led Stephen Mitchell to think of an association for psychoanalysis that would be open, inclusive, dialogic, creative, and capable of keeping alive the spirit of research and clinical rigour. These qualities should strongly characterise clinical theory and relational therapeutic practice.

Even as regards groups that fit in the relational paradigm, there is a risk that in local movements these values tend to wither, to the point of becoming emptied of meaning, drowned in a logic which aims at the consolidation of a self-referential corporate position, of influences and of the market, rather than opening and opening up to scientific dialogues on how to clinically encounter human suffering, in the theoretical spirit proposed and supported by Mitchell.

The conceptual primacy goes to the clinical relationship rather than belief in a theory (relational or otherwise) or institutions of reference.

The paper presented here focuses on the concepts of trauma, dissociation

and borderline pathology developed in the theoretical, epistemological and ethical framework outlined above, as they have been developed in the authors' work over the last 25 years during which, as a relationally oriented group in Turin, the authors (Capello & Albasi, 1995; Albasi, & Boschiroli, 2003; Boschiroli 2001, 2003, 2018, 2020; Boschiroli, Albasi, & Granieri 2003; Paradiso 2012, 2015, 2017, 2018, 2022; Paradiso, Celentani, & Albasi, 2017) have been committed to the development and dissemination of a relational culture in clinical practice, research and training both within the University, by founding the Relational Studies Association, and with the activities at the School of Psychotherapy of the Mitchell Institute.

Trauma and dissociation in relational psychoanalysis

The concepts of trauma and dissociation have been among the object of clinical and scientific reflection for several decades now. A fervent debate has taken place about them in many areas of psychological, psychiatric, neuropsychiatric and neuroscientific disciplines. In relational psychoanalysis, these concepts provide a reference point for all clinicians and theorists. As Sue Grand argues in her contribution to the landmark anthology, *Decentering relational theory: a comparative critique,* edited by Aron, Grand, Slochower: 'Today, trauma is the focal point of relational psychoanalysis. Dissociation, fragmentation enactment, affective dysregulation, multiple self-states, somatic communications, attachment disorders, gaps in mentalization: these terms are now familiar to us. (...) The term trauma has today become a broad container that includes anything from genocide to Gerson's concept of dead third, to the chronic non-tuning relationship in infancy and early childhood. And all of these relate to the collapse of mentalization' (2018, p. 7).

The large amount of research available to us has highlighted some common dimensions: i) first of all, the evidence that trauma is a consistent object of scientific study (or research hypothesis, or construct). This implies an invitation, in clinical work, to keep in mind the clinical hypothesis that severe disorders of mental functioning (including psychosis) and personality (to which we refer with the concept of borderline organisation) have developed in a context of traumatic experiences; ii) furthermore, that trauma is *a specific experience of a serious failure in the actual relationship between the individual and his or her caregivers, or in more general terms: between organism and environment*[2]; iii) finally, that the particularity and

[2] From a theoretical point of view, from a psychological-clinical and evolutionary perspective, we can analogically understand 'environment' to mean attachment figures and 'organism' to mean mental processes.

specificity of this failure relates to the *subjectivity of the individual*; it is therefore not easily classifiable through discrete categories and must therefore be understood in terms of *intersubjective processes*[3].

In clinical research on trauma, therefore, the theoretical moment is of considerable importance: it requires a careful conceptualisation of both the internal and relational properties and processes that constitute its essence, as well as the critical conditions and processes specifically aimed at coping with it defensively, and among these in particular the dissociative processes.

Conceptually, many perspectives on the study of trauma have been proposed[4]. In this contribution we adopt a *relational psychoanalytic perspective that focuses on the subjective and intersubjective processes of attachment, trauma and dissociation*; not, therefore, an external observational, descriptive and taxonomic point of view. We will attempt to formulate some hypotheses about the mental and relational processes (of the individual and of attachment figures) that might mark a specific configuration of experience as traumatic. In fact, in order for the concepts of trauma and dissociation to generate thinking in support of clinical practice in an essential way (for example, therapeutic work with a relational psychoanalytic orientation, but not only), their formulation must imply the dimensions of subjectivity, relationship, processes (*i.e*. the sense of the processuality of phenomena)

[3] These considerations are by no means taken for granted: the history of psychoanalysis has been built around the hypothesis of a traumatic relational etiopathogenesis for psychic disorders, passing through divisions and obscuration of various kinds. Suffice it to remember how many people in the world have resorted to psychoanalytically oriented treatments (in private or public practice, in services): the fact that its underlying models revolve around drives and repression, rather than trauma and dissociation, has meant a great deal for the health of so many people.

[4] For example, it is possible to adopt a descriptive point of view that is more linked to the definition of event types, defence or avoidance behaviour and symptom collections, a point of view that we could schematically define as outwardly oriented (cf. the research traditions on stress, coping, post-traumatic stress disorder, *etc*.). Also possible is a nosological perspective which, looking at external, symptomatic manifestations, has mistakenly been defined atheoretical in an attempt to suspend etiopathogenetic hypotheses, such as the one proposed by the various A.P.A. DSMs. (even though, in fact, the diagnosis of post-traumatic stress disorder refers to the aetiology); but the syndromic classificatory nosological approach to psychopathology, only one of many possible (Albasi, 2008b), as has increasingly been acknowledged, is not the most useful for case formulation and psychotherapeutic care (for a bibliography on the subject, see PDM Task Force, 2006; Lingiardi, McWilliams, 2017). From a classificatory and nosographic point of view, it continues to be considered interesting to make descriptive distinctions between nosographic frameworks, thus between borderline pathology and trauma/dissociation (Lewis, Caputi, Grenyer, 2012; Lewis, Grenyer, 2009), and between different traumatic symptom frameworks such as PTSD (post-traumatic stress disorder) and complex post-traumatic stress disorder (Herman 1992a, 1992b), and extreme stress disorder not otherwise specified (DESNOS: disorder of extreme stress not otherwise specified) (van der Kolk, 2005).

and the multiplicity of levels of functioning; dimensions that represent the cornerstones of psychotherapeutic praxis.

With reference to this aim (and to confront the contemporary use of the term dissociation which, as noted by many, may be 'elusive, vague, confusing and contradictory', Dell, O'Neil 2009, p. 225), combining the traditions of the *Infant Research*, attachment theory and the relational perspective in psychoanalysis, the concept of dissociation was developed, emphasising its processual dimensions and responding to the clinical need to make specific the psychopathological phenomenology encompassed by this concept.

The first point is that dissociative processes are sometimes confused with dissociated contents (hence clinicians reason of *dissociated parts, dissociated aspects*, *etc*.). Dissociative processes are a mental activity, a mental function, they are structured in terms of functions, operations. Hence, to understand patients with borderline organisation one must reason of a concept of *dissociating mind* rather than *dissociated mind*; have a process-oriented epistemological and clinical sensibility; and learn to express oneself with adverbs and verbs rather than with nouns and adjectives.

The observational perspective for understanding this pathological problem is therefore to look at the patient's mind as *active*, and his or her experience as dissociatively *structuring*.

The second point is that dissociation or, rather, dissociative processes should be understood as *preventing the search for the meaning of experience* (as far in advance as possible), that is, paradoxically, the functioning of the mind itself (and we are faced with the first need to reason by paradoxes: the mind functioning by actively suspending its functioning). Here too we wish to emphasise that, rather than speaking of *dissociated meanings* which implies that the mind possesses those meanings and excludes them from consciousness (as it does in the case of neurotic conflict), it is better to think in terms of the patient's experience of *confusion*, of feeling unable to formulate an experience with meanings, that is, of feeling the experience as his own (*i.e*. *fully subjective*), thus *not feeling the inner reality* of what he is nevertheless experiencing in his relations.

As we know, the concept of psychological defence which is most useful in describing the functioning proper to *neurotic organisation,* implies a defensive exclusion from consciousness of experiences formulated and articulated in the mind, for example with links between representations and affections. The formulation of these experiences within the mind is sufficient to involve, subjectively, a meaning that would be experienced as disturbing, activating important conflicts. Hence, the mind's defensive activity intervenes by deteriorating these experiences (*e.g*. also by intervening on the representation-affection nexus, as in the case of repression, which disengages representations, or rationalisations, which disengage affections). Defences keep the consciousness clear by preventing the subjective experi-

ence of certain connections, thus preventing the subjective experience of the meanings that would result from these connections.

On the contrary, dissociative processes concern situations in which one is unable to formulate experience in any way. The experience of feeling alive, with a living, functioning mind that seeks the meaning of experience, is compromised. Schematically, we must imagine dissociative processes as processes that anticipate the formation of connections, in that they are deployed *to exclude from consciousness, not the experience of a possible conflicting meaning, but the confusion brought about by the experience of not being able to search for meaning*; We also call this confusion the sense of fragmentation and, ultimately, it is the anguish of going mad, in other words the fear of having a radical panic attack (as Pao, 1979, defined the psychotic experience), the fear of having an attack of anxiety so strong that one imagines one cannot recover. Dissociation is activated because a person is afraid of dying. And, in fact, the death of the mind coincides with the impossibility to seek meaning. The threat one experiences in the experience of trauma is the fear of going mad, of losing contact with reality, of no longer knowing what is real, and not feeling real; a psychotic crisis, in its experiential components, is to experience the disappearance of one's mind, its death; which, not being the death of the body and the complete cessation of existence, entails the paradox of having to witness one's inability to live as an integral person, with one's capacity to seek the meaning of experience. Dissociation is an attempt to survive by 'standing outside'.

A relational perspective on psychopathology: trauma, dissociation, levels of personality organisation

Various levels of personality organisation have been hypothesised in the psychoanalytic tradition, often also acknowledged in the broader non-psychoanalytically oriented clinical literature. Although it would be necessary to broaden the debate on psychotic organisation beyond what is the actual focus of this paper, as the term 'psychotic' can be used either exclusively for a disorder (as is the case in the first edition of the PDM - Psychodynamic Diagnostic Manual, PDM Task Force, 2006), or also for a personality organisation, the concepts healthy, neurotic and borderline levels enjoy broad consensus.

These concepts can be used more from an 'aut-aut' categorical perspective (the patient either has one organisation or the other, in the tradition of Kernberg[5], and, with due distinctions, Bergeret), or from a dimensional per-

[5] Kernberg (1967, 2004).

spective, according to which each one of us can be described as functioning on all these levels even when the prevalence of one level characterises our current functioning.

With regard to the *borderline* concept, we have to consider separately: on the one hand, the psychopathological contents that all authors (or manuals) acknowledge and describe in more or less the same way; and on the other hand, the use of these contents within a diagnostic system or theory. The psychopathological contents, *i.e*. the borderline phenomenology, are well summarised, for instance, in the nine statements that the DSMs have proposed from 1980 onwards. All clinicians may converge around those. But the psychiatrists who compiled the DSMs have then: i) considered the psychopathology described by means of this concept as a nosographic personality disorder among others listed as personality disorders (far more defined and specified by pathological features limited to single main dimensions, while from this point of view the borderline concept has been much discussed and articulated on several dimensions); ii) followed the nosographic tradition that has subjected the use of this concept to the cut-off requirements entailed by a system based on statistical and solely categorical logic. These choices, theoretical (despite the DSMs being self-styled as atheoretical), if not ideological, or power-based, or commercial (Kutchins, Kirk, 1997; Gøtzsche, 2015), are at least purely conventional and, as we know from decades of literature on the subject, not motivated by unambiguous clinical reasons.

The core, or conceptual dimensions of the construct, of borderline pathology have been described with some differences by the various authors who have dealt with it (*e.g*. Kernberg, 1967, 1975; Adler, 1985; Linehan, 1993; Liotti, 1999; Fonagy & Target, 2001; Fonagy *et al*., 2002; Dell & O'Neil, 2009; Meares, 2012), but revolve around the following clinical issues: regulation issues (involving both internal dimensions such as affections and mental states, and dimensions of impulsivity and conduct); problematic self-experiences and identity diffusion (instability, mutability, oscillations, painful incoherence), related to division processes; relationship issues including chaos and disorganisation, related to projective identification mechanisms, and decompensated reactions to fantasies or experiences of abandonment, separation, loneliness, and other anaclitic issues.

The aforementioned clinical issues can be integrated into a theoretical model which interprets the level of borderline functioning through the concepts of trauma and dissociation as formulated predominantly in relational psychoanalysis.

The dimensional approach to the use of levels of organisation has the advantage of being able to describe, and thus diagnose, a patient as predominantly healthy but with psychopathological aspects that are better described in a borderline (dissociative) rather than a neurotic (conflictual)

sense; this same hypothetical patient would be confusingly described as 'neurotic' if personality organisations were used in an exclusively categorical way, as not 'severe' as a borderline[6] patient and not healthy as having pathological aspects. Diagnostic differences are therefore relevant, and clinicians are familiar with working in psychotherapeutic treatment with patients who are predominantly healthy but who show suffering related not to conflicts but to dissociative aspects and problematic areas better described through the concepts of borderline psychopathology (absence of meaning, sense of emptiness and lack of value, inability to feel protagonists of part of their lives or relationships) rather than neurotic pathology (conflict between incompatible meanings).

Dissociation

Dissociation is an hypothesis in order to speak of a mental activity which, in extreme experiences, anticipates the establishment of internal connections; hence it is necessary to reason in paradoxical terms of potential connections that have never been formed, that were prevented in advance; and to hypothesise that dissociation, more specifically, is to be considered rather as a process that anticipates connections, than a destruction of mental connections.

Better still, if we wanted to express this concept of dissociation in the *paradoxical terms* it calls for, we would have to understand the lack of connections, between the implicit and explicit levels in traumatic experiences, as *a loss of the potentiality/possibility of connections* (which is *a natural potentiality of the mind and a requirement of its functioning*). One loses the connections that constitute the psychic registers for recognising, understanding, and formulating meanings that are fundamental to human life and potentially implicated in attachment experiences and relationships (such as anger, conflictuality, sexuality, seduction, enjoyment, *etc*., in particular, the areas where the interpretative nuances of meaning make a difference). The loss of these registers, however, not only results in the failure to recognise (like a blindness) the meanings of reciprocal gestures; paradoxically, it leaves both *a sense of ineluctable unconscious expectation for the occurrence of something* pertaining to them (anger, aggression, abuse and neglect, manipulation, *etc*.)

[6] With regard to disorders as severe as personality disorders diagnosed according to the DSM criteria (from the third edition onwards), despite their specificity of language, authors such as Bromberg (1998), who argues that all personality disorders depend on trauma and dissociation, and Yeomans, Clarkin, Kernberg (2015), who argue that all patients suffering from a DSM personality disorder function at the borderline organisation level, agree. A clinical consistency despite the diversity of language.

and, on the psychopathological level, a sense of the need to be able to recognise the meaning of the gestures of the other. which, on the level of descriptive psychopathology, can variously translate into anxiety, depression, dissociative symptoms, impulsivity and conduct disorders, addictions, *etc*.), and also the inability to recognise relational experiences centred at a procedural level on these registers (and thus to act interpersonally without connections between levels: either at the level of dissociated procedural enactments, or at the level of persecutory defences or rationalisations, *etc*.).

This has important clinical implications: the loss of the potential to construct connections between levels of processing the experience remains as a *deficit* for the individual, *i.e*. not the conflicting inhibition of mental contents and functions, but the lack of the ability to feel and express the different facets of his experience. Patients show that they are not able to grasp the *nuances* of a specific field of meaning, processed by a too imprecise register: for example, aggression may be experienced but not modulated between implicit and explicit (*e.g*. seduction may frighten or may irritate without the opportunity to take pleasure in it and play with it, *etc*.).

This is the paradoxical process typical of trauma and abuse: the abused person dissociates the experience (prevents its integration into his or her subjectivity) and is terrified that something will happen again that he or she would not recognise, even if he or she provoked or induced it. His basic confidence and security has been broken, as well as his courage and motivation to explore the experience.

It is of utmost importance in directing our clinical attention and our theoretical models to the damage that trauma causes to implicit procedural levels: trauma causes loss of confidence in the ways one constructs one's internal experience, the aptitude for integrating self-regulation and interactive regulation of one's states, the ability to trust *intuitive evaluations* as essential information for orienting oneself in intimate and attachment relationships; one disorganises the *ways* of shaping intimate relationships. *In this area, of procedural implicit relational knowledge, of the skills on 'how' to build secure attachment relationships, lies the essence of pathological post-trauma*. Trauma affects the basic implicit skills that are necessary to experience one's existence as a set of potentials for realising oneself in intimate relationships in life.

In experiencing trauma, at stake is one's being a person, being treated as less than a person (as an animal, an object, a tool, *etc*.). The mind cannot attempt to give meaning or negotiate this experience at any level, because being a person implies having a mind, and not being recognised within a developmentally essential attachment relationship as a person with a mind of one's own, is incompatible with the minimal needs to formulate one's experience by referring it internally to a representation of oneself and the attachment figures. This is how dissociation works.

Conclusions

Currently, the concepts of trauma and dissociation still appear to us as promising in the study and clinical understanding of the phenomena of the form of severe pathology which we describe in the concept of borderline pathology.

From the perspective of complexity, we can say that as far as immaterial reality is concerned, trauma is the ultimate expression of anti-vital forces that disorganise the principles which are necessary for life.

Observations and descriptions from different theoretical perspectives often articulate a common underlying principle: life is made possible by love. On the level of the immaterial reality of the mind, love is the principle opposed to the threat of trauma. Love is expressed starting with the essential recognition of the other in his or her difference and specificity (within the attachment relationship). The development of the mind is the outcome of processes concerning the development of the complex dynamics of the *encounter of specificity* between something that arises spontaneously from the child's potentialities (as an active and creative proposer of interactive gestures and forms of experience, a concept that is referred to as *agency*) and the process of *recognition* of these specific potentialities built in the relationship with attachment figures. This encounter is the *developmental context for understanding health and trauma.*

The principle of recognition of specificity allows the mind to live, to organise experience as a subjectivity rich in meaning. In the contemporary literature on borderline pathology, it has been observed that on the one hand, there is love which allows organisation, movement, life, and on the other hand, trauma which leads to chaos, confusion, entropy, fragmentation and the death of the mind as the impossibility of searching for meanings.

The concepts of trauma and dissociation are all the more interesting when they focus on a specific psychopathology, rather than becoming synonymous with relational psychopathology in a broad sense. The risk of a generic relational perspective on psychopathology in psychoanalysis is to consider all psychopathology as somehow of traumatic origin, understanding trauma as a synonym of a relational aetiology (to be contrasted with the drive aetiology of Freudian metapsychology). This 'political' use of the term trauma to indicate a non-drive theoretical position is perhaps of little interest to the practical clinician. The term trauma loses clinical specificity and becomes a synonym for 'etiopathogenetic' (any cause of psychopathology is considered trauma, all pathology is of traumatic origin because it is relational in origin, *etc*.). These positions mistake the relational origin of pathology, such as health, for the specificity of trauma with respect to other different conditions of conflictual and/or pathogenic non-traumatic origin (in any case, from the perspective of complexity, we speak of cause in a non-linear sense). The concept of trau-

ma is useful from two theoretical-clinical points of view: in a more categorical perspective, to understand severe pathology, such as the one related to borderline organisation and psychosis; in a more dimensional perspective, the concepts of trauma and dissociation are useful to understand a specific level or mode of pathological functioning which, when understood in this sense (level or mode), is ubiquitous and can cause important difficulties in functioning in healthy, neurotic, borderline, psychotic people, with different intensity or prevalence. Once one has understood what trauma is and how it functions, one can acknowledge it as part of the experience of many patients beyond the categorical aspects which might include them in different diagnostic classes.

REFERENCES

Adler, G. (1985). *Borderline psychopathology and its treatment*. New York, NY: Aronson.

Albasi, C. (2006). *Attaccamenti traumatici. I modelli operativi interni dissociati*. Torino: UTET.

Albasi, C. (2008a). Modelli operativi interni dissociati: una prospettiva relazionale sull'attaccamento, il trauma, la dissociazione. In Caretti, V., Caparo, G. (a cura di). *Trauma e psicopatologia. Un approccio evolutivo relazionale* (pp. 194-227). Roma: Astrolabio.

Albasi, C. (2008b). Modelli operativi interni dissociati, funzionamento mentale e psicopatologia. *Abilitazione e Riabilitazione*, *1*, 9-36.

Albasi, C. (2009a). *Psicopatologia e ragionamento clinico*. Milano: Raffaello Cortina.

Albasi, C., & Boschiroli, A. (2003). Sándor Ferenczi: per un pensiero clinico vivo. In A. Boschiroli, C. Albasi (Eds.), *Incontrando Sándor Ferenczi. Temi ferencziani nella pratica clinica contemporanea*. Bergamo: Moretti e Vitali.

Aron, L., Grand, S., & Slochower, J. A. (Eds.). (2018). *Decentering relational theory: A comparative critique*. London: Routledge.

Bergeret, J. (1974). *La personnalité normale et pathologique: Les structures mentales, le caractere, les symptoms*. Paris: Dunod. Tr.it. *La personalità normale e patologica*. *Le strutture mentali, il carattere, i sintomi.* Milano: Raffaello Cortina, 1984.

Boschiroli, A. (2001). Il trauma e i fondamenti della vita psichica. Una proposta di S. Ferenczi. In *Radure. Quaderni di materiale psichico, vol. I anno V* (p. 19-38). Bergamo: Moretti e Vitali.

Boschiroli, A. (2003). Aspetti evolutivi e costruzione del sé: alcune ipotesi. In Boschiroli, A., Albasi, C. & Granieri, A. (2003) (Eds.). *Incontrando Sándor Ferenczi: Temi ferencziani nella pratica clinica contemporanea* (pp. 121-137). Bergamo: Moretti e Vitali.

Boschiroli, A. (2018). Quando una soggettività disorganizzata impedisce la costruzione di una soggettualità autentica. *Psichiatria e Psicoterapia*, *2018*, 37-3.

Boschiroli, A. (2020). Introduzione. In: Lichtenberg, J. D., Lachmann, F. M., Fosshage, J. L. (Eds.) *Il Sé Prende vita: Sviluppo, lavoro clinico e la mente errante* (pp. XI-XXX). Ed. Italiana a cura di Boschiroli, A. Roma: Giovanni Fioriti Editore, 2020.

Boschiroli, A., Albasi, C. & Granieri, A. (2003) (Eds.). *Incontrando Sándor Ferenczi: Temi Ferencziani nella pratica clinica contemporanea.* Bergamo: Moretti e Vitali.

Bromberg, P. M. (1998). *Standing in the spaces. Essays on clinical process, trauma, and dissociation*. New York, NY: The Analytic Press. Tr. it. *Clinica del trauma e della dissociazione. Standing in the spaces*. Milano: Raffaello Cortina, 2007.

Capello C., Albasi C. (1995), Paradigmi conoscitivi e studio della personalità. Le prospettive relazionali in psicoanalisi. In Lorenzetti, M. L. (Ed.), *Psicologia e personalità* (pp. 61-74). Milano: Franco Angeli.

Dell, P. F., O'Neil J. A. (2009). *Dissociation and the dissociative disorders: DSM-V and beyond*. New York, London: Routledge.

Fonagy, P., & Target, M. (2001). *Attaccamento e funzione riflessiva*. Tr. It. Milano: Raffaello Cortina.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press. Tr. it. *Regolazione affettiva, mentalizzazione e sviluppo del Sé*. Milano: Raffaello Cortina, 2005.

Gøtzsche P. C. (2015). *Deadly psychiatry and organized denial*. Copenhagen: People's Press. Tr. it. *Psichiatria letale e negazione organizzata*. Roma: Giovanni Fioriti, 2017.

Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377-391.

Herman, J. L. (1992b). *Guarire dal trauma: affrontare le conseguenze della violenza, dall'abuso domestico al terrorismo*. Trad. it. Roma: Edizioni Scientifiche MaGi.

Kernberg, O. F. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association*, *15*(3), 641-685.

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism.* New York, NY: Aronson Trad. it.: *Sindromi marginali e narcisismo patologico*. Torino: Boringhieri, 1978.

Kernberg, O. F. (2004). *Aggressivity, narcissism, and self-destructiveness in the psychotherapeutic relationship.* New Haven, CT: Yale University Press. Tr. it. *Narcisismo, aggressività e autodistruttività nella relazione psicoterapeutica.* Milano: Raffaello Cortina, 2006.

Kutchins, H., & Kirk S. A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders*. New York, NY: Free Press. Tr. it. *Ci fanno passare per matti - DSM: la bibbia della psichiatria e la creazione dei disturbi mentali*. Roma: Giovanni Fioriti, 2003.

Lewis, K., Caputi, P., & Grenyer, B. F. (2012). Borderline personality disorder subtypes: a factor analysis of the DSM-IV criteria. *Personality and Mental Health*, *6*(3), 196-206.

Lewis, K., Grenyer, B.F. (2009). Borderline personality or complex post-traumatic stress disorder? An update on the controversy. *Harvard Review of Psychiatry*, *17*(5), 322-328.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford. Trad. it.. *Trattamento cognitivo-comportamentale del disturbo borderline*. Milano: Cortina, 2001.

Lingiardi, V., e McWilliams, N. (Eds.) (2017). *Psychodynamic diagnostic manual, second edition (PDM-2).* New York, NY: Guilford Press. Tr. it. *Manuale diagnostico psicodinamico, Seconda Edizione (PDM-2).* Milano: Raffello Cortina, 2018.

Liotti, G. (1999). Il nucleo del disturbo borderline di personalità: un'ipotesi integrativa. *Psicoterapia*, *5*(16/17), 53-65.

Meares, R. (2012). *Dissociation model of borderline personality disorder.* New York, NY: W. W.

Paradiso, D. (2012). L'ipocondria come 'flashback relazionale' psicosomatico. *Abilitazione e Riabilitazione*, *1*, 7-26.

Paradiso, D. (2015). L'ipocondria dalla psicoanalisi classica alla prospettiva relazionale. *Psichiatria e Psicoterapia*, *34*(4), 267-285.

Paradiso, D. (2017). Il paradosso della soggettività del terapeuta nella terapia di coppia. In: Ringstrom, P. (Ed.) *Psicoanalisi relazionale e psicoterapia di coppia* (pp. XVII). Ed. Italiana a cura di Paradiso, D. Roma: Giovanni Fioriti Editore.

Paradiso, D. (2018) I processi di desomatizzazione intersoggettiva nel trattamento psicoanalitico relazionale. *Psichiatria e Psicoterapia*, *37*(3), 231-246.

Paradiso, D., Celentani, B., & Albasi, C. (2017). Analisi con metodo CCRT di una ricaduta di una paziente con Disturbo Borderline di Personalità. *Psichiatria e Psicoterapia*, *36*(4).

Paradiso, D., Albertazzi, A., Izzo, F. (2022). Studio CCRT di una psicoterapia interpersonale di una paziente adolescente con disturbo borderline di personalità. *Psichiatria e psicoterapia, forecoming.* [In press].

PDM Task Force (2006). *Psychodinamic diagnostic manual.* Silver Spring, MD: Alliance of Psychoanalytic Organization. Tr. it. *Manuale diagnostico psicodinamico*. Milano: Raffaello Cortina, 2008.

Pao, P. N. (1979). Primitive internalized object relations: a clinical study of schizophrenic, borderline, and narcissistic patients: by Vamik D. V. *Psychoanalytic Quarterly, 48*, 652-655.

Van der Kolk, B. A. (2005). Developmental trauma disorder: toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*(5), 401-408.

Yeomans, F. E., Clarkin J. F., & Kernberg O. F., (2015). *Transference focused psychotherapy for borderline personality disorder. A clinical guide*. Washington, DC: American Psychiatric Association. Tr. it. *La terapia focalizzata sul transfert per il disturbo borderline di personalità*. Roma: Giovanni Fioriti, 2017.

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