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A significant number of individuals receiving mental health care exhibit a history of traumatic experiences. Accompanying dissociative symptoms often amplify the complexity of their required treatment. This article introduces a novel understanding and treatment approach for post-traumatic stress symptoms, inclusive of dissociation, derived from attachment and mentalization theories. Initially, we outline the different expressions of dissociation and the prevailing knowledge concerning their associations with diverse clinical manifestations and their role in trauma. We subsequently reinterpret these clinical symptoms through an attachment and mentalization lens, then proceed to elaborate on the new trauma-focused mentalization-based treatment and its therapeutic objectives. The article culminates with a case study that exemplifies the application of this approach in a clinical setting.

Keywords: dissociation; post-traumatic stress symptoms; mentalization; attachment; trauma

Dissociative experiences, as natural reactions to stress, are not only found in the general population but are also prevalent across various mental health disorders (American Psychiatric Association, 2013; Carlson, 1998; Dalenberg & Paulson, 2009; Spiegel et al., 2011). There’s considerable research evidence linking these experiences to a history of adverse childhood experiences. In a clinical setting, dissociation can add another layer of complexity to patient treatment, potentially impacting outcomes. Thus, it is imperative for clinicians to learn to navigate dissociative experiences, integrating them into treatment goals for trauma patients to enhance their care.

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This article presents an exploration of dissociation, its manifestations, its connection with several mental health disorders, its origin, and its role. We will also delve into recent advances in the understanding of trauma through the lens of attachment and mentalizing theory. Subsequently, we introduce a novel therapeutic method, trauma-focused mentalization-based treatment (MBT-TF), and delineate its therapeutic goals which encompass addressing epistemic mistrust, dissociation, shame, and alien-self experiences, and promoting embodied mentalizing. The article concludes with a real-world case study that demonstrates this approach.

Dissociation

**Definition and clinical manifestations**

Dissociation, as defined by the American Psychiatric Association, is a discontinuity or lack of integration in subjective experiences like emotions, memory, somatic sensations, consciousness, and identity (American Psychiatric Association, 2013). Dissociative experiences span a wide spectrum, from normative behaviors like daydreaming to intense symptoms like depersonalization, derealization, and in its most acute form, dissociative identity disorder (DID). Depersonalization involves a sense of unreality about oneself or one’s body, experiencing an ‘autopilot’ mode, out-of-body experiences, disconnectedness from thoughts or emotions, or lack of usual bodily sensations. On the other hand, derealization involves feeling as though the external world is unreal or as if looking through a fog (Allen, 2013b). These symptoms, which typically co-occur, are identified as psychological forms of dissociation, contrasted with somatic forms like alterations in pain perception or loss of voluntary motor control (Krause-Utz et al., 2021; Spiegel et al., 2011).

Dissociative experiences occurring during traumatic events are called peritraumatic dissociation. Another way to categorize these experiences is into detachment and compartmentalization. Detachment refers to disconnection from oneself or the external world and includes absorption, depersonalization, or derealization. Compartmentalization involves instances where parts of a person’s experience or personality become inaccessible to others, as seen in dissociative amnesia or dissociative identity disorder (Allen, 2013a). Further, dissociation can be classified into negative dissociative symptoms, denoting a loss of memory or self-information or a loss of bodily control, and positive dissociative symptoms characterized by intrusive symptoms like flashbacks (Spiegel et al., 2011). Both negative and positive dissociative symptoms disrupt an individual’s functioning, personal narrative, and self-perception (Spiegel et al., 2011).

There exists considerable debate over the precise classification of dissociative experiences and the demarcation point at which such experiences become pathologized (Carlson, 1998; Dalenberg & Paulson, 2009; Spiegel et al., 2011). It’s critical to recognize that several dissociative manifestations are observable
within the general population and can function as adaptive coping mechanisms in certain contexts, notably in response to stress. This dynamic further complicates the task of discerning ‘normal’ from pathological dissociation.

**Etiology and function**

While the origins of dissociation and its models remain subject to debate, particularly since such symptoms can emerge in the absence of adverse life events, substantial evidence underscores the link between traumatic experiences and dissociation (Dalenberg et al., 2012; Krause-Utz et al., 2021; Loewenstein, 2018; Lyssenko et al., 2018). A meta-analysis encompassing 65 studies revealed that early onset, prolonged abuse duration, and parental maltreatment significantly contribute to heightened dissociation levels (Vonderlin et al., 2018). The trauma etiological model proposes that dissociative symptoms function as protective shields against overwhelming and emotionally distressing experiences (Loewenstein, 2018). From an evolutionary and biological viewpoint, they may represent survival strategies when fight or flight responses are impracticable or ineffective.

Dissociation is typically part of the involuntary stress response spectrum, beginning with a freeze state (characterized by immobility but heightened danger awareness) or a fight/flight reaction, ultimately transitioning into tonic immobility, a state of surrender and shutdown (Fanselow & Lester, 1988; Schauer & Elbert, 2010). These conceptual frameworks are often used to understand dissociation symptoms in individuals exposed to developmental trauma (Allen, 2013b). From an attachment and mentalizing perspective, dissociation could serve an unconscious defensive role by inhibiting children from mentalizing the mental states of abusive caregivers, especially when escape is impossible, and survival is contingent on caregiver attachment (Allen, 2013b; Fonagy & Target, 1997). Although dissociation aids survival by disconnecting from bodily experiences and mental states, it also obstructs self-development, identity formation, and affect regulation. The result is a fragmented self-experience that leads to self-alienation and estrangement from others, leaving individuals more susceptible to stress and predisposed to automatic dissociative coping mechanisms in response to life’s later challenges (Classen et al., 1993).

**Dissociation in clinical populations**

Dissociative symptoms are often experienced by individuals with mental health conditions, and several manifestations of dissociation are listed among the diagnostic criteria in the DSM-5 (American Psychiatric Association, 2013) for various disorders including post-traumatic stress disorder (PTSD) and borderline personality disorder (BPD) (Krause-Utz et al., 2021; Lyssenko et al., 2018). Alongside this, childhood abuse is also known to be a risk factor for many mental health disorders later in life, including schizophrenia, bipolar disorder,
complex post-traumatic stress disorder (complex PTSD), and BPD (Maercker et al., 2022; Struck et al., 2020; Zanarini & Frankenburg, 1997), as well as numerous physical health conditions (Felitti et al., 1998). Complex PTSD includes the three symptom clusters found in PTSD (avoidance of traumatic reminders, re-experiencing of the traumatic events and hypervigilance), but additionally encompasses three symptom clusters linked to pervasive disturbances in self-organization: emotion regulation difficulties, negative self-concept and relational difficulties. The disorder appears in the aftermath of chronic and repetitive traumatic experiences of horrific or threatening nature, from which escape is either difficult or impossible (Cloitre, 2020; Maercker et al., 2022; World Health Organization, 2019/2021).

BPD, complex PTSD, and PTSD are associated with a high psychosocial burden (Maercker et al., 2022), are highly comorbid to the extent that they greatly overlap, and are negatively associated with treatment response (Barnicot & Crawford, 2018; Ford & Courtois, 2021; Pagura et al., 2010; Scheiderer et al., 2015). Currently, the prevalence of dissociative symptoms in individuals with BPD is estimated at around 80% (Krause-Utz et al., 2021) and these symptoms seem to be particularly present in patients with complex PTSD compared with PTSD (Hyland et al., 2020; Longo et al., 2019; Møller et al., 2021). In adults with BPD, severity of sexual abuse and co-occurring PTSD were significantly linked to dissociative symptom (Zanarini et al., 2023). Studies also suggest considerable heterogeneity in the level of dissociation symptoms experienced by BPD patients, ranging from absorption to amnesia and depersonalization (Zanarini et al., 2000). While the severity of dissociation appears to decrease over time in BPD patients, these symptoms may persist and remain problematic, particularly in patients with complex trauma (Zanarini et al., 2008). Additionally, dissociative symptoms may account for impeded psychological functioning and symptom severity, and they are associated with increased levels of suicidality in clinical populations compared with patients without dissociative symptoms (Haaland & Landro, 2009; Lyssenko et al., 2018; Webermann et al., 2016). Interestingly, a recently published prospective follow-up study (Shah et al., 2020) showed that a reduction of dissociative symptoms over time was associated with recovery in BPD, suggesting its potential role in the course of BPD.

Given the considerable influence of dissociation on treatment outcomes and the effectiveness of clinical interventions, assessing dissociative symptoms and developing specific interventions to address dissociative states is essential in order to improve care for patients who have experienced childhood maltreatment and who present with complex PTSD and/or BPD.

The mentalizing approach to trauma and dissociation

Theoretical background

Significant strides have recently been made towards adapting existing interventions for BPD to treat complex trauma, a necessary advancement considering the dearth of treatment guidelines for complex PTSD (Maercker
et al., 2022). This section delves into recent developments in the mentalizing approach to psychopathology for trauma treatment, with a specific focus on dissociative phenomena. The discussed approach has been expressly developed for patients with histories of traumatic childhood attachment experiences, which can present as complex PTSD with or without BPD traits or diagnosis. While this paper delves into dissociative symptoms within CPTSD, it does not extend to more severe clinical presentations like DID. Detailed exploration of DID would demand a broader theoretical framework, though certain clinical phenomena in both CPTSD and DID share similarities.

Mentalizing, or reflective functioning, signifies the ability to interpret oneself and others in the context of mental states. Extensive evidence validates the deleterious effects of adverse and traumatic experiences on mentalizing capacities (Luyten et al., 2020). From a developmental perspective, childhood maltreatment is known to create the potential for attachment insecurity, which can profoundly compromise the development of mentalizing. The processes of attachment and mentalizing are intricately interconnected and mutually reliant throughout their developmental journey. The capacity to mentalize initially emerges within early attachment relationships, cultivated by caregivers who perceptively mirror the child’s experiences, thus encouraging the development of a stable self-sense (crucial for self-organization) and affect regulation (Fonagy & Luyten, 2016; Fonagy et al., 2002).

Widespread neglect by caregivers can impair mentalizing by not adequately mirroring mental states, while abuse can cause repeated instances of highly distorted and/or intrusive mirroring. Under these conditions, insecure attachment patterns can form, manifesting as either avoidant (deactivated attachment needs) or anxious (hyperactivated attachment needs) tendencies in self and relational contexts (Allen, 2013a; Fonagy & Luyten, 2016). When a child is raised in a hostile environment by an abusive or neglectful caregiver, and without appropriate mirroring, an approach – avoidance conflict can surface early, with the simultaneous activation of attachment and threat systems, creating self and other confusion. These characteristics are typical of disorganized attachment patterns, commonly observed in individuals with BPD and complex PTSD (Luyten et al., 2020).

As a consequence, patients may exhibit a continuous hyperactivation or deactivation of their attachment system, contributing to their relational vulnerability, along with the internalization of various ‘alien-self’ experiences from abusive caregivers. This condition impedes the development of authentic self-experiences, typically facilitated through consistent and coherent mirroring by caregivers. The mind may become trapped in a pervasive state of avoidance of mental states over time, leading to diminished ability to mentalize self and others, fragmentation of identity, and lack of narrative coherence. Attempts to manage post-traumatic stress symptoms (including hyperarousal, avoidance, and re-experiencing) and the negative effects on self-organization (affect
dysregulation, negative self-concept, relationship disturbances) may further limit the individual’s internal world and lead to social withdrawal.

Traumatic experiences may also breed a deep sense of mistrust in others, including hypervigilance toward externally imparted knowledge, or epistemic mistrust, and shame. Both these factors contribute to increased isolation and mental closure to social learning throughout life (Luyten et al., 2020; Sharp et al., 2012). Epistemic mistrust hinders the ability to benefit from and integrate knowledge from social contexts, leading to prevalent epistemic hypervigilance, which perpetuates a mental ‘freeze’ state, hindering recovery from past traumas and isolating the individual from potential support and help available through relationships (Luyten et al., 2020; Sharp et al., 2012). Consequently, individuals exposed to extensive relational trauma may face heightened vulnerability in life’s adversities and greater challenges in navigating relational complexities (Sharp et al., 2012).

**Trauma, mentalizing and trauma reminders**

Central to the mentalizing approach to trauma is the understanding that the trauma doesn’t lie in the event itself, but in the associated experience wherein the individual feels isolated in insurmountable emotional pain (Allen, 2013a). Adverse experiences typically entail a failure in mentalizing. However, when a secure environment offers a safe space for reflection, the traumatic experience can be processed with another mind through marked mirroring, enabling the recontextualization of the experience (Luyten et al., 2020). Understanding the experience with the help of a validating and empathetic other aids in restoring agency and selfhood, as well as trust and a sense of belonging. This process also offers an opportunity to integrate and construct new knowledge about oneself, others, and the world.

The challenge with developmental trauma is the absence of a supportive other, combined with profound mistrust and shame, leaving the individual isolated and bearing the traumatic experiences in an unmentalized form. These can be recurrently triggered later in life by reminders of the original event. Without a reflective process following the event to integrate the experience into the individual’s narrative and distinguish the past from the present, such reminders continue to elicit intense distress due to the emotional experience associated with the memory and its sense of immediacy, as if continually reliving the event. The mental experiences tied to the memory, triggered by reminders of the event, can become unbearable for the individual, leading to the need to avoid them through cognitive or emotional psychological processes, or even physical action.

Moreover, reminders of trauma may often initiate the emergence of prementalizing modes of self and other experiences. There are three forms of prementalizing modes in mentalization-based treatment: psychic equivalence (mental states are viewed as defining physical reality), pretend mode (captures a disconnect between mental states and the external reality,
and importantly, without any undertones of intentionality), and teleological functioning (characterized by actions taking precedence over reflective thought) (Bateman & Fonagy, 2016). For instance, individuals with post-traumatic stress symptoms experience a high degree of psychic equivalence: thoughts of the traumatic event, or reminders of it, trigger mental states linked to the event that feel as real as if the event is happening again. In other words, these individuals feel as if they are reliving the event and are trapped in the past (Luyten et al., 2020). This phenomenon is exemplified in dissociative symptoms such as flashbacks of the traumatic event. A varying degree of disconnection between objective reality and subjective experience can occur, leading to disorientation and confusion. In these circumstances, patients may become ensnared in intense feelings of defeat and powerlessness, feeling as though there is no escape from their emotional pain and no hope of recovery.

The chronic condition of hypervigilance, a manifestation of hyperarousal, and the activation of the fight/flight system can also be seen through the lens of psychic equivalence. Patients endure a continuous sense of threat, both physically and mentally. A persistent, distorted perception of danger and lack of safety is maintained and experienced as if it were an actual reality.

Psychic equivalence can also surface in the form of maladaptive and ego-destructive feelings of shame, frequently elicited when an individual encounters trauma reminders or social situations viewed through the trauma lens as a repetition of past experiences. Alien-self experiences, defined as internalized derogatory attributions from past abusers (e.g., ‘You are worthless’, ‘You deserve it’), or beliefs ascribed to the abusive figure (e.g., ‘I must be awful for them to treat me this way’), become activated, leading to deep-seated feelings of shame, self-defectiveness, vulnerability, and helplessness. These feelings can provoke a sense of overwhelming humiliation and a need for social withdrawal. Moreover, this repetitive pattern can help sustain shame over time, leaving patients feeling ill-equipped to handle everyday adversities, as many situations can swiftly and unpredictably trigger this state (due to the lower activation threshold of the attachment system and simultaneous fight/flight response), resulting in overwhelm. Moreover, in the absence of a social buffer and with diminished mentalizing abilities, feelings of shame are experienced with even greater intensity. Consequently, hypervigilance toward potential threats to the self is sustained, and both physical and mental avoidance become pervasive survival mechanisms, as well as dissociation, ranging from emotional numbing to full-blown symptoms of depersonalization and derealization. Therefore, chronic and alienating shame can contribute to and perpetuate the tendency to dissociate due to its potent self-dissolving effect (Bateman et al., 2023; Luyten et al., 2020). The emotional threat prompted by alien-self experiences might result in a disconnection from one’s internal emotions and a detachment from external surroundings. This disengagement can manifest in various degrees, from emotional numbing to more severe states of depersonalization and
derealization. However, readers should remember that this description doesn’t encapsulate the intricate nature of identity shifts inherent to DID.

Depersonalization and derealization, or emotional numbing, can also be triggered when arousal levels rise, as traumatic reminders can provoke intense physical responses or activate overwhelming mental states and emotional distress through the fight/flight response. The disconnection between external reality, bodily experience, and mental state can be viewed as an extreme form of ‘pretend mode’ that serves a protective function. The term ‘pretend’ does not imply intentionality, and can be understood in this case as a form of psychological escape from painful and intense mental states.

Escaping painful experiences and regaining a semblance of control can also be achieved through action in the teleological mode. As distressing mental states remain unmentalized, self-destructive behaviors are utilized for relief, sometimes as a result of alien-self experiences or in the context of traumatic events being reenacted in an attempt to change the outcome. However, in some situations, individuals might view self-harming actions as a necessary means to regain a sense of control and reconnect with their body. Indeed, dissociative symptoms can lead to extreme anxiety and feelings of losing control over bodily functions, thereby adding a layer of self-distrust. Patients can struggle to identify their triggers and, due to a lack of understanding of these experiences, may feel vulnerable, with no solution other than to act in order to regain control over their bodies.

These manifestations define the three prementalizing modes (psychic equivalence, pretend mode, and teleological functioning) that signal a breakdown in mentalizing and potentially a shift into dissociative states after exposure to trauma triggers. Thus, identifying these different modes, potential shifts into dissociative states, and their triggers is of paramount importance in Mentalization-Based Treatment for Trauma (MBT-TF).

The MBT approach to trauma and dissociation: treatment strategy and interventions

Treatment structure and setting

Trauma-focused mentalization-based treatment (MBT-TF) is a specialized, group-based intervention designed to treat trauma and dissociation in patients with a history of complex trauma. This research emphasizes PTSD treatment, especially targeting dissociative symptoms within the realm of complex trauma. While adaptations are underway to address DID more comprehensively, such discussions remain outside the scope of this paper. This approach can be used as a standalone treatment or in conjunction with other therapeutic interventions. MBT-TF is an adaptation of the standard mentalization-based treatment (MBT), specifically developed to address posttraumatic stress symptoms and to improve mentalizing in relation to traumatic events that the patient identifies as consistently distressing. The underlying hypothesis is that fostering a reflective process
around these events may lead to generalized improvements in the patient’s overall mentalizing capacity. MBT-TF may offer an additional framework for clinicians using MBT and therapists interested in the model to treat patients with complex trauma.

The treatment consists of a group intervention structured into three phases that reflect established practices in the field of trauma therapy (Herman, 1998): (i) stabilization and psychoeducation on trauma and mentalizing; (ii) processing traumatic memories; and (iii) mourning, acceptance of loss, and moving on. The program can be implemented over a period of 6 months as an adjunct to standard MBT, or over 9 to 12 months as a standalone intervention. It places particular emphasis on working through traumatic memories in the group sessions (Bateman et al., 2022, 2023).

In MBT-TF, similar to standard MBT, patients are encouraged to collaboratively work with the therapist to develop a formulation that assesses their mentalizing difficulties in four domains: (i) mentalizing of the traumatic event(s), (ii) mental avoidance/isolation, (iii) vigilance, and (iv) mentalizing of the self and experienced shame. In addition, prototypical trauma memories are elicited, and the patient is asked to identify which aspects of these memories they feel comfortable discussing in the group setting. These specific aspects are then targeted in the group therapy sessions, supplemented by individual sessions as necessary. A particular emphasis is put on supporting the development of reflective function through each stage of the treatment, individually and in the group.

The initial phase of MBT-TF emphasizes psychoeducation, mental function stabilization, and risk management. This includes learning to manage dissociative symptoms and cultivating a safe mental space during times of high anxiety, building a therapeutic alliance, and agreeing on a therapeutic focus. The second phase prioritizes working with traumatic memories and facilitating mentalizing of these traumatic experiences. This helps in developing a more coherent self-narrative around these events and integrating them into the individual’s life narrative. The final phase focuses on reflecting on the insights gained from the second phase, mourning and accepting loss, and looking towards the future, including life post-therapy, and moving forward.

In both group and individual sessions of trauma-focused mentalization-based treatment (MBT-TF), the aim is to foster epistemic trust by cultivating a shared group experience, progressively encouraging curiosity about self and others, and effectively addressing conflicts that arise within the group. The group component of this intervention is designed to counteract the sense of isolation that patients often experience due to feelings of shame and a state of hypervigilance.

The group setting provides a unique opportunity for patients to engage in new social interactions, which can be particularly beneficial for those grappling with the effects of complex trauma. Observing other group members who are dealing with similar challenges can make it easier for patients to open up about their own traumatic experiences. Furthermore, it allows them
to gain a deeper understanding of how these traumatic events have affected them not only on a personal level, but also in their relationships with others. The group also offers a space where trauma symptoms may be reflected on with others that share comparable difficulties, allowing for direct exchanges of experiences between patients that may also be received with greater epistemic trust.

In essence, the group therapy component of MBT-TF helps create a safe space where individuals can share their experiences and learn from others in similar situations. This collaborative environment can help reduce feelings of isolation, validate individual experiences, and promote the development of new coping strategies and insights.

**Specific focus on dissociation**

Addressing dissociation is a crucial component of the MBT-TF process, and several strategies are put in place to facilitate this.

Identifying Dissociative Symptoms and Integrating Them into the Treatment Goals: During the initial stages of MBT-TF, a comprehensive assessment of the patient’s symptoms, including any dissociative symptoms, is conducted. Recognizing the specific manifestations of dissociation in each patient’s life allows for the tailoring of the treatment plan to the individual’s needs. Once these symptoms are identified, they are integrated into the treatment goals. Additionally, psychoeducation is provided to help patients understand dissociation’s function and manifestation, with the goal of increasing their ability to recognize and manage their symptoms.

Building Epistemic Trust: Developing trust between the therapist and the patient is fundamental to the success of the therapy. This trust enables the patient to believe in the relevance and helpfulness of the therapist’s insights and suggestions, allowing them to be open to changing their thinking and behavior patterns. Epistemic trust can be cultivated through consistent, reliable, and empathetic interactions over time.

Embodied Mentalizing: As a part of MBT-TF, patients are encouraged to become more aware of their physical sensations and experiences, particularly those associated with dissociative states. This process of embodied mentalizing helps patients to understand how their bodily experiences relate to their emotions and thoughts, providing another layer of insight into their mental states.

Addressing Shame and Alien-Self Experiences: Feelings of shame and alien-self experiences, which involve feeling detached or estranged from oneself, are common among individuals who have experienced trauma. These feelings can be detrimental to mentalizing, leading to avoidance and withdrawal. In MBT-TF, therapists work with patients to explore these feelings, understand their origins, and develop strategies for managing them.
By systematically addressing these elements, MBT-TF supports patients in managing dissociation, improving their mentalizing capabilities, and ultimately enhancing their emotional and social well-being.

Identifying dissociative symptoms and integrating them into the treatment goals

The therapeutic journey in Trauma-focused Mentalization-based Treatment (MBT-TF) commences with a comprehensive evaluation undertaken by the individual therapist. This primary appraisal seeks to understand the impact of dissociative occurrences on the patient’s psychosocial functioning and daily life, their presentation in various settings, and their manifestations within therapeutic encounters. The therapist may discern, in collaboration with the patient, potential deficits in the recognition of triggers and the transitions into dissociative episodes, thus establishing the need for guided facilitation to enhance the patient’s comprehension and introspection into their unique experiential world.

In order to construct a more profound understanding within the patient of their own dissociative processes, an educational approach, psychoeducation, is employed from the treatment’s inception. Psychoeducation serves as a critical tool to elucidate the functional aspects of dissociation and its manifold representations. The aim is to foster a heightened embodied awareness within the patients, augmenting their ability to perceive and attend to their own experiences. This knowledge facilitates the normalization of symptoms, offers explanations for their existence, and aids in shifting the focus from potential shame associated with such symptoms towards empowerment through enhanced understanding.

The psychoeducational component may particularly benefit from articulating the detrimental effects of trauma on the capacity for mentalization and attachment, along with the impact on self-regulatory mechanisms. It can be valuable to convey to patients the restricted emotional responses resulting from trauma, often limited to states of anxiety, rage, fear, or numbness, coupled with a decreased threshold for activation of the fight/flight response and the onset of dissociation. An essential aspect of the process then becomes the identification of personal triggers and early indicators (prodromal symptoms) of dissociative episodes, both mental and bodily, as well as the cultivation of skills to discern the patient’s arousal level to prevent full-blown dissociative states.

Additionally, it is vital for the patient to consent to jointly tackle dissociative symptoms within the context of individual and group sessions, acknowledging the necessity of mitigating these symptoms. This collaborative process necessitates the patient’s receptivity to feedback from clinicians and group members when dissociative states appear imminent during therapy sessions, and the effort to anchor themselves and reengage with their bodily sensations. Such demands may provoke ambivalence in the patient for various reasons, including the patient’s entrenched patterns of mental state avoidance, fear of relinquishing the perceived protective function of this avoidance against distressing
experiences, and heightened exposure to discomfiting emotions. These conditions may be perceived as threatening, potentially inducing feelings of vulnerability. Furthermore, the patient may struggle with the perception of a lack of control over these symptoms, doubting their ability to address them effectively, leading to heightened anxiety about experiencing these symptoms in a social setting.

Acknowledging these difficulties is crucial while also taking into consideration the limitations imposed by the patient’s current functional state, and juxtaposing these with their aspirations and desire for future change. The discomfort encountered while traversing novel experiences can be validated, while concurrently contemplating the critical importance of acquiring the skill to manage dissociative states for the overall treatment process, as these states may hinder effective mentalization and obstruct the integration of new social learning. This process might offer an opportunity for the patient to reclaim a sense of agency and work toward desired future changes.

Building epistemic trust

Another crucial phase of the therapeutic process is the gradual cultivation of a sense of security within the therapeutic framework, as well as towards the therapists and group members. To facilitate this, it is important for the therapists (group facilitators and individual therapist) to adopt a stance of mentalization, working in collaboration with the patient from a humble, not-knowing position that focuses on exploring mental states and working explicitly through situations that foster the development of epistemic trust (Bateman & Fonagy, 2013). This approach involves transparency, clarification of misunderstandings and intentions, admission of errors, and a readiness to mend the therapeutic relationship following any ruptures. It is crucial to maintain a process of reflection on what transpires during the sessions, and to draw connections to relational challenges arising from the patient’s traumatic past.

In addition, the therapist supports the patient’s sense of agency and control, a vital recovery step following traumatic events that may have left the patient feeling helpless and powerless. The therapist aids the patient in gradually constructing a shared understanding of their difficulties while modeling curiosity about the patient’s experiences. The patient’s expertise about their own experiences is recognized, and the therapist shows a thoughtful and genuine interest in understanding the patient’s functioning and challenges. The therapy also involves helping the patient express boundaries regarding what they can manage and tolerate during sessions, which aids in preventing feelings of being overwhelmed and supports the development of agency. The clinical challenge lies in balancing the treatment focus and working through the patient’s avoidance tactics.

Patients may at times display explicit (e.g., refusing to explore further or answer questions) or implicit (e.g., avoiding specific questions, changing the
subject) resistance to sharing their experiences with the therapist and group members. Acknowledging and working through the discomfort and hypervigilance that may arise from exploring mental states in self and others is critical. Building epistemic trust is a gradual process; learning to accept and trust information from therapists or other group members can be challenging for patients who have previously experienced harm from others. This, therefore, may become an important treatment goal. Learning to navigate relationships in new ways to benefit from them and reduce isolation can be identified as a crucial recovery step, as well as engaging in a process of reflection on the balance between adaptive trust and mistrust.

In cases where traumatic experiences are reactivated, leading to a strong psychic equivalence mode in the patient, it’s crucial to aid the patient in engaging in reflective processes to begin differentiating past traumatic experiences from the present, thereby reducing confusion and emotional arousal. For instance, the patient might perceive receiving attention as particularly painful or even threatening, indicative of an approach-avoidance conflict resulting from the simultaneous activation of attachment and the fight/flight response. This can be particularly pronounced in patients who have suffered emotional manipulation and abuse. A titrated approach can be beneficial, focusing on slowing down, sharing different perspectives, and reflecting on the patient’s activations, conflicting affects, and associated discomfort and confusion. A connection can gradually be made between the impact of past events and the patient’s current coping mechanisms for distress and relational difficulties, which may often involve an immediate attempt to manage problems independently. The discomfort associated with negotiating new experiences and the accompanying uncertainty may need acknowledgment.

**Embodied mentalizing**

Integrating bodily experiences is a fundamental aspect of trauma work, as described in this field (Cloitre et al., 2011; van der Kolk, 2006). Frequently, trauma victims start viewing their bodies as dangerous territories due to their symptoms and a perceived lack of control (Herman, 1998). Hence, fostering embodied mentalizing, which is the ability to introspectively consider one’s bodily experiences and sensations and their connection to intentional mental states in oneself and others (Luyten et al., 2012), is a pivotal aspect of trauma recovery and managing dissociative symptoms.

Identifying dissociation necessitates heightened self-awareness and attention to both mental and physical states, which the patient may have consistently avoided due to their threatening nature. The clinician will need to collaboratively monitor the patient’s response to increased attention to their mental and physical states, noting changes in arousal and the activation of protective mechanisms designed to avoid distress or maintain relational or emotional distance. These challenges can be progressively worked through
with the patient to build a shared understanding of the ongoing experiences. The therapist, in turn, mirrors back to the patient their understanding of the patient’s experiences and explores potential methods to manage the distress and possible dissociative symptoms. A personalized toolkit and approach may be necessary for each patient due to the diversity of clinical presentations.

Special attention is given to learning how to identify and trust interoceptive and proprioceptive signals, which might signify changes in arousal and mental states. The goal is to aid the patient in initiating a reflective process and forge connections between their bodily and mental states to foster an understanding of their subjective experience. Sensorimotor processes can also be employed for this purpose (Ogden & Fisher, 2015; Ogden & Minton, 2000). Patients are progressively guided towards finding a balance between top-down (using the mind to recognize and soothe the body) and bottom-up (using the body to identify and soothe the mind) processes to regulate their arousal level. Excessive top-down regulation can lead to over-management and disconnection into a pretend mode, while too much bottom-up processing can cause bodily experiences to become reality without reflective processing, leading to psychic equivalence (Bateman & Fonagy, 2021).

In individual sessions, the therapist is urged to periodically check in with the patient, guided by the patient’s external bodily cues, and to take a moment to assist the patient in recognizing their internal experiences. The therapist may share their observations with the patient, noting nonverbal physical signs such as agitation, avoidance of eye contact, fixed gaze, change of tone, silence, or signs of withdrawal and disengagement from the external environment. All these may be indicative of a pretend mode and potential disconnection from the body and emotional experience, thereby averting further disconnection.

This method enables both the patient and therapist to closely track and observe changes in internal states and the emergence or presence of dissociation, which may disrupt mentalizing. Subsequently, the patient is guided to evaluate their level of arousal and engage with their body to calm or ground themselves. Maintaining an external focus on this soothing activity can help lower arousal by redirecting attention from the internal state to a joint distraction effort. The therapist can join the activity with the patient (e.g., using a stress ball, grounding and breathing exercises), mirroring the patient’s experiences. The therapist and patient monitor the effect of this intervention, and the patient is encouraged to observe any impact it has on their internal state or any other mental states brought about by the process. Once arousal has decreased to a level where some reflective functioning is restored, the clinician and patient can jointly explore triggers, reflect on the function of the body, and share the experience of working through this together. This helps to build a shared understanding and mentalize the experience. Repetition of this exercise over time can bolster the patient’s self-confidence and their ability to manage these symptoms, both independently and with the help of others.
In group therapy, activities might include group-wide breathing or grounding exercises. Check-ins could incorporate an embodied mentalizing approach that encourages patients to identify bodily sensations and make connections to their current mental states. Individual interventions may be necessary during group sessions if a patient dissociates. These interventions would begin by clearly identifying the dissociative state, then assessing the patient’s individual needs to soothe or ground them, clarifying what the group can contribute, allowing the patient to self-regulate, and agreeing to check back with them later. The group can support this process, offering a space to reflect on the dissociative experience and mentalize it later. In both group and individual sessions, attention is given to the body, recognizing it as a resource to aid the mentalizing process.

Addressing shame and alien-self experiences

In treatment, significant focus is directed towards feelings of shame and the emergence of alien-self experiences. Developmental trauma often impacts patients, leaving them with a deep-rooted mistrust of their own experiences in relation to past events. This bolsters their belief that they are incapable of making decisions to ensure their own safety and that they are inherently flawed as individuals. Moreover, their chronic disconnection from and avoidance of mental states and bodily sensations can lead them to be perplexed about their own experiences and lack self-knowledge. Revealing these difficulties has the potential to intensify feelings of shame and trigger alien-self experiences.

The aim during MBT-TF (Mentalization-Based Treatment for Trauma) is to provide a space that is attuned to allow and support the development of curiosity and the generation of compassion towards oneself and others. Sessions strive to cultivate new authentic self-experiences, which are highlighted and reflected back by the therapist and the rest of the group members. This process involves providing empathetic validation in response to the intense psychic equivalence of the patient’s alien-self experiences, while also demonstrating curiosity and maintaining differences between minds. The goal is to integrate new perceptions. This process may provide patients with opportunities to gain new insights that challenge their internalized beliefs about themselves and help distinguish past internalized beliefs from their current self-experience.

Case illustration

Case history: Rose

This case illustration amalgamates the experiences of several patients with dissociative symptoms who received Mentalization-Based Treatment with a trauma focus. We’ll call the composite patient Rose. In her thirties, Rose lived alone and had minimal contact with her two younger siblings since leaving home at 18. Rose’s avoidance of her family was later linked to her effort to avoid reminders of her past. She completed school but dropped out of university due to
struggles with her studies and mental health. Rose had been working in retail sales for several years. She was referred for treatment by her general practitioner due to persistent symptoms connected to her traumatic childhood.

Throughout her assessment and treatment sessions, Rose described a history of childhood trauma that included physical abuse and witnessing domestic violence. Rose’s father had left the family before her birth, and her mother and stepfather were unpredictable. Rose felt continuously on edge, never knowing whether her actions might incite hostility or anger. This state of hypervigilance persisted into adulthood, causing difficulties with sleep as she felt perpetually unsafe. Rose also endured emotional abuse and neglect. Her parents showed little interest in her emotional well-being and were intrusive and controlling. Growing up, Rose lacked supportive adult figures and was constantly trying to manage her issues alone. This reinforced her belief that no one could be trusted.

School was also challenging for Rose. She was often bullied by her peers and felt different, noticing that her clothes were unkempt compared to her classmates. Witnessing the family lives of her peers only amplified her feelings of shame about her own circumstances. This early shame influenced Rose to shy away from forming close relationships, fearing further rejection. Rose carried the belief that if others knew about her past, they would reject her, confirming the feelings of unworthiness and ‘badness’ she held about herself. To escape her life and distress, Rose often disconnected from both the outside world and her internal experiences.

**Identifying dissociative symptoms and integrating them in the treatment**

During the assessment phase, Rose expressed feeling isolated despite having friends and colleagues. She struggled to understand her own emotions, which were either extremely intense without clear triggers, or completely absent, causing her to feel detached. Others would often notice when she seemed off or distant, making her self-conscious. Because of previous emotional outburst in the past, she learned to avoid her internal experience, as it felt easier to avoid her feelings and too dangerous to experience and share them. Rose spoke of the effort she put into appearing tough and self-reliant, and how important it was for her to hide any vulnerability from others. She easily dissociated in work situations or during conflicts, as she would later describe, going numb, feeling as if she was not really there and experiencing loss of time. Rose’s protective disconnection from her feelings and maintenance of appearances, along with her depersonalization symptoms, all suggested multiple levels of pretend mode.

Rose also shared that she often felt hypervigilant at home, regularly checking her apartment for security purposes if she heard any suspicious noises. She constantly felt in danger, leading to sleep difficulties. These states of hyperarousal can be viewed as psychic equivalence (a feeling of danger interpreted as actual danger) and teleological mode (only physical actions like checking locks
could provide a sense of safety). She cycled between states of hyperarousal, intense anxiety, anger, or helplessness, and states of numbness, with little room for more nuanced or positive emotions. When distressed, Rose reported excessive drinking and use of sleep medication to numb herself – another example of teleological mode. She described intense feelings of self-hatred, which she was certain were shared by others. This belief reinforced her social withdrawal and avoidance of intimate relationships, and could be triggered by situations where she felt out of place or self-conscious. These states represented alien-self experiences, often linked to shame experienced in psychic equivalence.

In her individual treatment sessions, Rose initially came and presented well and very articulate in the description of her difficulties, with some disconnection from her emotional experiences. In her narratives, there was little regard of her internal experience and how these affected her. Her therapist noticed signs of hyperarousal, as Rose tended to look repeatedly at the time, talked fast and seemed physically agitated, shaking her legs, looking around the room, with crossed arms. After a few sessions, she appeared at times more silent and withdrawn. Her therapist explored these moments asking Rose what she noticed was going on on the inside, while explaining what she was seeing from the outside. She marked her curiosity towards Rose’s experience and stated her uncertainty of what was taking place for her. Rose often answered that she did not know, that she felt numb. As they slowly began to focus on her feelings of numbness over several sessions, more information came out on its frequency and how it led Rose to feel lost and uncertain of what was going on for her. Her therapist gave her information about dissociation and its functions, which helped Rose build an initial understanding of her reactions when she seemed to close down. This opened up more conversations on the topic. Later in treatment, it was also possible to link how she feared coming to the therapy and her high levels of arousal during the sessions. She talked about how anxiety provoking it was to talk to someone, especially to have to think about her feelings and then to ‘go numb’. She experienced a sense of threat and would feel angry after the sessions, feeling as if she lost control, would be judged for not knowing and for her silences. This would lead her to regret her efforts she put into trying to trust and a feeling of helplessness would then ensue, as she felt stuck in her current situation and acknowledged that she needed support. Rose talked about her fear of coming in with these mixed feelings and at risk if she were to express her anger towards her therapist. Through the exploration of these hyperarousal, angry and dissociative states, Rose was able to talk about her difficulties to slow down and bring awareness to her bodily sensations that were indicating that her anxiety was rising, leaving her struggling with what she was feeling and then going numb during the session. Collaboratively they aimed to work on increasing her awareness of these symptoms, noticing the rise in her heartbeat, her breathing and the pace of her speech. They focused on attending to her bodily sensations, identifying her anxiety level, linking it to a sense of threat and to her emerging understanding of the ambivalence she felt of opening up on her
feelings and connecting to her inner experiences. This process took repetitions of loops of explicit observation, rewinding to the events before she would go numb during the sessions, and reflecting to build an understanding of them when she felt grounded again. This could take whole sessions, at times she would leave with some level of persisting dissociation symptoms, that she felt was manageable for her. This supported Roses’ capacity to trust her ability to manage through her emotional experience and come back from the numbing. As this process was worked through during the session, trauma triggers outside of the sessions became apparent as well. Rose worked on noticing when she felt disconnected or numb, and recognizing triggers for these states. She noticed that reading news about childhood abuse or experiencing anger – such as aggressive tones – could trigger a fight/flight state (her body going tense, her heart rate increasing and feeling in danger, wanting to escape), depersonalization (feeling as if she was unreal), and derealization (others becoming increasingly distant and as if they were actors). Before these episodes, she experienced symptoms like feeling light-headed, tingling, a racing heart, faster breathing, and an increasing urge to escape, all coupled with a rising sense of danger. These symptoms could present with different durations and intensity, depending on the trigger she encountered and her state of being.

Rose and her therapist noted that her difficulty identifying her feelings and connecting them with her bodily sensations led to confusion about her needs and a fragmented self-experience. The vulnerability she felt in relation to these states resulted in her preferring to keep up her mask, appearing pleasant to others as a means of maintaining a semblance of safety and distancing herself from intense emotions related to past memories. This strategy felt safer but isolated her in the pain she felt and maintained her perpetual feelings of difference and displacement.

Formulating a shared understanding of Rose’s experiences in relation to her past was crucial for Rose and her therapist to make sense of her struggles and consider treatment options. This also initiated Rose’s reflection on her relational patterns and their impact on her present interactions with others and herself. Among her treatment goals, Rose hoped to develop compassion for herself, establish connections in the group, be more open about her feelings, and gain more control over her dissociative symptoms.

**Building epistemic trust**

Throughout the course of her treatment, Rose gradually began to experience a newfound sense of safety with her therapist and fellow group members. This progress unfolded gradually over the first 4 months (phase 1 of treatment) and further deepened during phase 2. A full year of individual therapy before the group sessions began also significantly facilitated this process. A crucial initial step was recognizing and articulating the feelings of unsafety she sometimes experienced during therapy sessions, as mentioned above. Being given the
opportunity to express her feelings with her therapist, associated with a sense of safety and not resulting in catastrophic consequences opened up new perspectives for Rose. Experiencing closeness and more transparency concerning what she was feeling supported the emergence of a sense of agency in relation to herself and to others. She was learning to trust her emotional experience and the process of sharing it, in that it brought conversations that increased her awareness of herself and allowed her to connect with others. This changed from her belief that others mainly judged or misunderstood her. This acknowledgement allowed her to begin challenging her presumptions about what others might be thinking or intending towards her.

This development was further supported and generalized to the group experience. When misunderstandings in the group sparked anger in Rose, these instances provided opportunities for her to move beyond the façade she preferred to maintain and expose her genuine inner emotions, despite her fear. This step brought with it the new realization that expressing her true feelings did not inevitably lead to immediate danger or negative repercussions.

This therapeutic journey was supported by a consistent curiosity about Rose’s mental states and a quest to understand the situations that triggered her hypervigilance and anger. As these differences were explored and clarified, Rose often experienced feelings of guilt and shame, which sometimes led to avoidance of therapy sessions. However, the therapists (including co-facilitators and individual therapist) remained present, demonstrating humility, genuine interest, and respect for her agency. They also frequently reassured her that she was kept in their minds, which encouraged her to return to therapy.

Being explicit about relational difficulties and expressing willingness to work through them was crucial. Reminding patients of the possible coexistence of contradictory emotional states and offering a safe space to navigate through them allowed a process of building trust in themselves and with others. Concurrently, reminding all group members of their belonging within the group seemed to foster trust and provide opportunities for repairing and transforming their various relationships. These collective efforts helped Rose confront her past traumas and foster healthier relationships with herself and others.

**Working with the body**

Fostering a stronger trust in Rose’s own self-experience was greatly assisted by the process of embodied mentalizing, which encouraged her to attune to her physical sensations with curiosity and kindness. Some bottom-up processes were used when her anxiety rose. When during a conversation she would go silent, appeared to shut down and presented a fixed gaze, her therapist would take out a small stress ball. They had agreed together that her therapist could offer her a distraction from the discussion, as she would focus on throwing the ball gently back and forth. This strategy helped stop her arousal level from increasing. Thus, silences often prompted the question
whether to take out the ball, which would then go back and forth between Rose and her therapist. As she became more active and was able to speak again, after having a few informal exchanges at times out of topic, the therapist would gently assess with her current state of arousal. After confirmation she was ready to explore further, they would go back and try to think about what had happened earlier and reflect together and build a shared understanding on what had taken place. Another strategy was to use putties and she would concentrate on giving them different shapes. Other techniques included breathing exercises, inhaling the scent of perfume on her scarf, or grounding herself by pushing her feet firmly into the ground. Progressively, Rose found ways to use her body to help manage her level of arousal. She would work towards identifying when her arousal went up (heart rate, breathing rate, muscular tension) or decreased (going numb, feeling zoned out) and mobilize her resources. These grounding strategies helped her build confidence in her abilities to manage her body as her understanding of herself grew and navigate through her internal experiences with or without external support.

As she allowed herself to engage more deeply with her feelings, this at times triggered episodes of dissociation, as her arousal heightened and anxiety surged. However, with time, Rose became increasingly adept at identifying the onset of dissociation, which allowed her to use strategies to manage the symptom and bring herself back. Rose explicitly talked about the loop becoming less time-consuming and feeling less anxiety.

Rose also learned to inform her therapist and the group when a dissociative episode was occurring during a session. The other group members supported her by helping her notice and engage with what they observed in her and by sharing their own experiences and methods for managing dissociation. Adapted short mindfulness exercises prompting patients to notice signals from their bodies further supported her capacity to notice her bodily sensations and monitor her level of arousal in a top-down process. This complemented the individual and group work focusing on helping patients to check within themselves and try to make links between their bodies signals and their mental states, and reflect on how this informed them and helped them build an understanding of themselves in relation to their environment and current experience.

As time passed, Rose began to express feeling less vulnerable as she achieved improved awareness and control over her internal experiences. This growth facilitated her ability to identify her bodily sensations and correlate them with her emotional states. The group and individual therapy sessions assisted Rose in reflecting on herself, thinking about and making sense of her bodily experiences, and understanding her mental states in relation to specific events and relational contexts. This process led to a deeper comprehension of her own identity and emotions, and better equipped her to navigate her interpersonal relationships and manage her symptoms of dissociation.
**Addressing shame**

Finally, the group setting provided valuable opportunities for Rose to cultivate new relational experiences that helped alleviate her chronic feelings of shame.

The shame fluctuated through the psychoeducation phase. As acquiring knowledge seemed to help her build more understanding about her difficulties, the acknowledgement of the impact the traumatic experiences brought up painful realizations of her current functioning. Part of the shame reduced over time as she learned to gain more agency in relation to the management of her dissociative symptoms. Navigating through those dissociative states in a safe environment supported her in gaining more control and confidence that she could regain control over herself on her own or with the support of others when needed.

Sharing a traumatic memory within the group allowed her to receive feedback from others and learn about their own experiences. Both individual and group sessions provided a safe space for these explorations, and the feedback she received from others gave her insight into how she was perceived and the impact she had on those around her.

This interactive process enabled Rose to challenge some of the long-held beliefs and assumptions she had about herself and others – beliefs and assumptions that had been impeding the formation of meaningful relationships. This process appeared to offer some valuable insight, as Rose reported an increase in her understanding of how her past experiences had affected her, and how they were impacting her present relationships. Importantly, she noticed that as she developed empathy towards others in the group, it facilitated the cultivation of self-compassion – a critical component in her healing process and ongoing recovery.

**Discussion and conclusions**

This paper provided an overview of the latest developments in Mentalization-Based Therapy (MBT) and introduced MBT with a trauma focus (MBT-TF), an innovative mentalizing approach to addressing trauma and dissociation in patients with a history of complex trauma. This treatment was implemented for the first time as an independent group intervention for less than a year within a clinical service providing specialized psychotherapeutic treatments for adults who have experienced trauma. Patients underwent individual psychotherapy before joining the group, following either a trauma-adapted psychodynamic model or a trauma-adapted MBT approach. Individual sessions continued alongside group sessions to reinforce the therapeutic work carried out in groups. Notably, the program had no dropouts.

Patient feedback indicated that although the group experience was challenging, it was generally deemed acceptable and useful in facilitating a meaningful understanding of trauma symptoms and offering an experience of relationship building with others. Additionally, patients reported some reduction in feelings
of shame and isolation, as well as an increased ability to connect with feelings and emotions, accept changes, and reduce experiences of numbness.

MBT has already proven its efficacy as a treatment for patients with severe Borderline Personality Disorder (BPD), and its adaptation to an expanding range of disorders suggests its potential as a promising new approach for patients suffering from posttraumatic stress symptoms, including dissociative symptoms. A particular emphasis on dissociation and embodied mentalizing seems necessary to manage the clinical complexities that arise from traumatic experiences. Nonetheless, more research is required concerning the treatment process and outcomes.

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