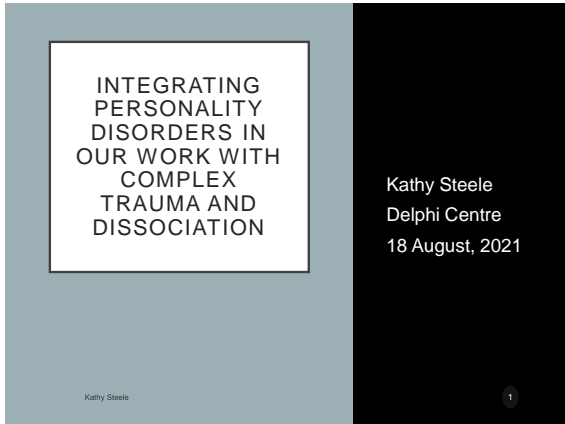


**Integrating Personality Disorders in our Work with
Complex Trauma and Dissociation**

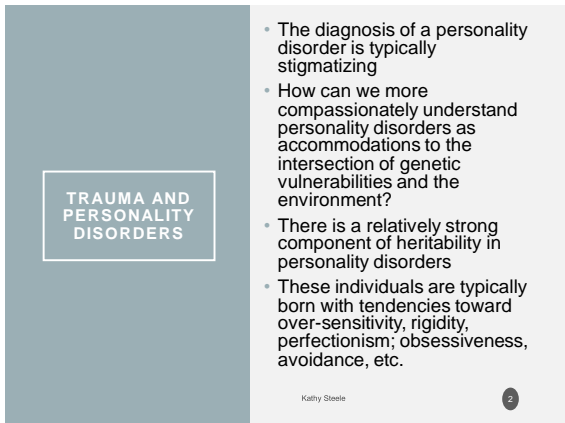
Presented by Kathy Steele, PhD



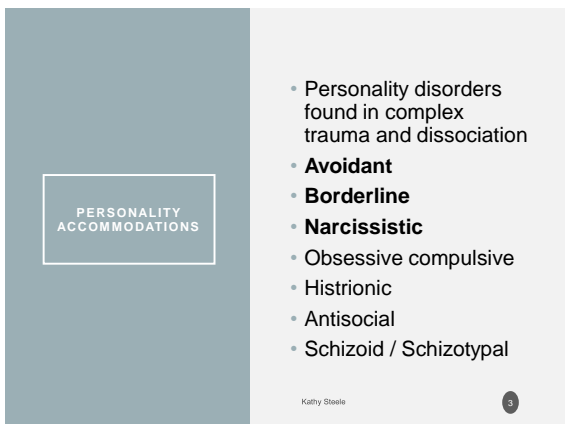
3 CPD Hours



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PERSONALITY ACCOMMODATIONS

- Personality disorders are rarely "pure," but rather most clients exhibit a number of different personality traits from different "disorders."

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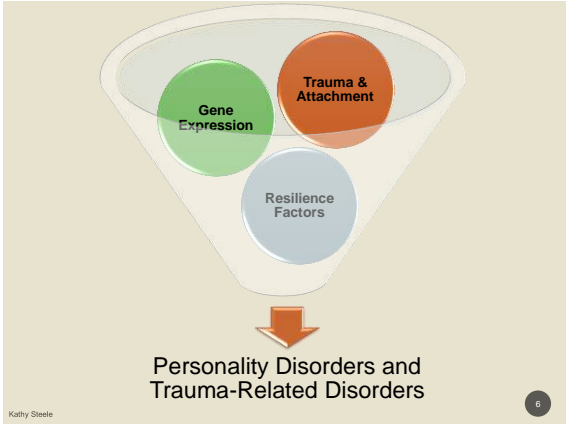
NATURE VS. NURTURE?

- Are personality disorders inherited or created in the environment?
- Evidence points to a dual role of genes and invalidating / abusive environments
- Children with traits of introversion, tendency toward negative emotion, rigidity, etc., would naturally be more vulnerable to coping with a difficult or hostile environment.
- It makes sense that personality disorders are an integral part of developmental trauma

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5

5



6

HERITABILITY OF PERSONALITY DISORDERS

- All personality disorders have a modest to moderate heritability, primarily based on these traits:
 - **Broad vulnerability to personality disorder pathology or negative emotionality**
 - **High impulsivity / low agreeableness**
 - **Introversion**
- Genes linked to functioning of neurotransmitter pathways are involved
- Reichborn-Kjennerud T. (2010). The genetic epidemiology of personality disorders. *Dialogues in Clinical Neuroscience*, 12(1), 103–114.

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7

7

CORE PROBLEMS IN PERSONALITY DISORDERS

Problems with regulation <ul style="list-style-type: none">• Emotions - negativity• Impulsivity	Problems with behavioral acting out	Problems with relationships
Problems with rigid core beliefs / cognitions	Problems with adaptability (rigidity)	Problems with mentalizing
Problems with sense of self	Externalizes	

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CORE PROBLEMS IN PERSONALITY DISORDERS

Relational	Self	Social	Cognitive
Emotional	Somatic – dysregulated arousal	Existential suffering	Motivation
Insight	Mentalizing		

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LIFE THEMES

- People are intrusive and dangerous
- People are stupid / incompetent
- No one understands me and couldn't possibly understand
- I am special (good or bad)
- Life isn't fair
- I can never get ahead; something always pulls me down
- Trauma has broken me
- People / life owes me
- I need to be taken care of / rescued

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THE BIG 5

Five major personality traits

- Openness to experience
- Conscientiousness
- Extraversion
- Agreeableness
- Neuroticism

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OPENNESS TO EXPERIENCE

Degree of curiosity, creativity and a preference for novelty and variety.

Variety of activities vs. rigid routine

High openness = lack of focus and unpredictability; thrill seeking

Low openness = pragmatic, dogmatic, close-minded

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CONSCIENTIOUSNESS

Organized, dependable,
preference for planned
vs. spontaneous behavior

High conscientiousness =
stubborn, obsessive

Low conscientiousness =
sloppy and unreliable

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EXTRAVERSION

Energy, positive
emotions, assertiveness,
sociability, talkativeness.

High extraversion =
attention-seeking, and
domineering.

Low extraversion = aloof
or self-absorbed

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AGREEABLENESS

Compassionate and
cooperative vs. suspicious
and antagonistic

Trusting and helpful nature

High agreeableness =
naïve or submissive

Low agreeableness =
competitive, argumentative,
untrustworthy

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NEUROTICISM

Tendency to experience unpleasant emotions easily, such as anger, anxiety, depression, and vulnerability; degree of emotional stability and impulse control.

High Neuroticism = Reactive and excitable; dynamic but unstable and insecure; low impulse control

Low Neuroticism = Emotional stability; uninspiring, unconcerned

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WHAT THE BIG 5 LEAVES OUT

- Mentalizing
- Religiosity
- Manipulativeness
- Honesty/ Deceit
- Sexiness/sexiness
- Thriftiness
- Conservatism
- Masculinity/femininity
- Snobbishness/egotism
- Sense of humor

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CLUSTER A

- Odd, bizarre, eccentric
- Paranoid
- Schizoid
- Schizotypal

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- Dramatic, erratic
- Borderline
- Histrionic
- Narcissistic
- Antisocial

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- Anxious, fearful
- Avoidant
- Dependent
- Obsessive-compulsive

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21

21

COUNTERTRANSFERENCE

- Therapist's experience with client is a big clue as to whether a personality disorder is present
- Often feel incompetent, stuck, deskilled, frustrated that client does not change
- May feel intensely negative: anger, frustration, disgust, fear, shame
- May feel intensely positive: love (sexualized or not), may experience client as ideal and powerful or as needing rescue and protection

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22

TREATMENT

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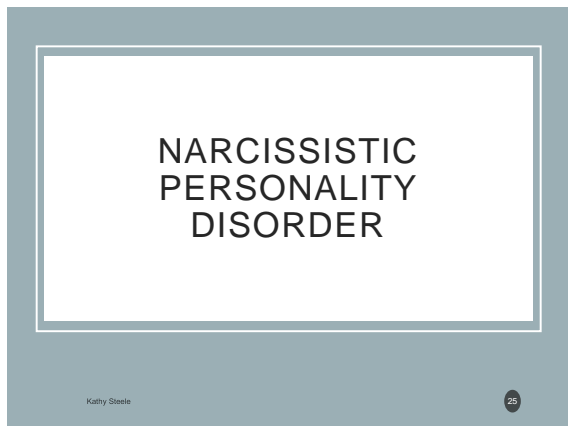
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TREATMENT

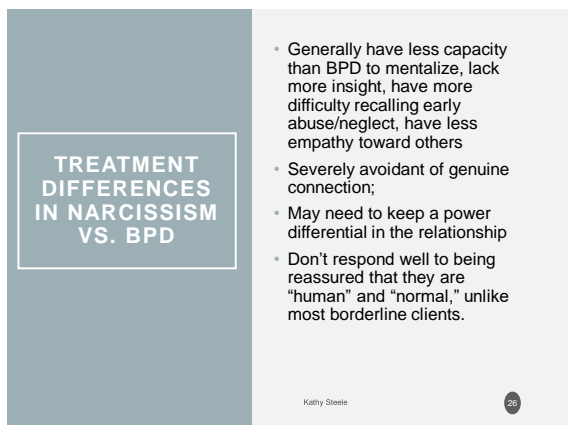
- Limit setting – strong boundaries in treatment with behavioral containmentment
- Set role and treatment expectations early in therapy
- Set concrete and clear treatment goals with the client
- Relational – establish collaborative efforts; work with transference and countertransference implicitly at first
- Regulatory – teach emotional and behavioral regulation skills (e.g., DBT)
- Inner organization – exploration of how client is organized and how this helps achieve goals or not
- Trauma – addressing early history that impacted personality development
- Resistance – compassionate exploration and attunement with reasons patient does not change

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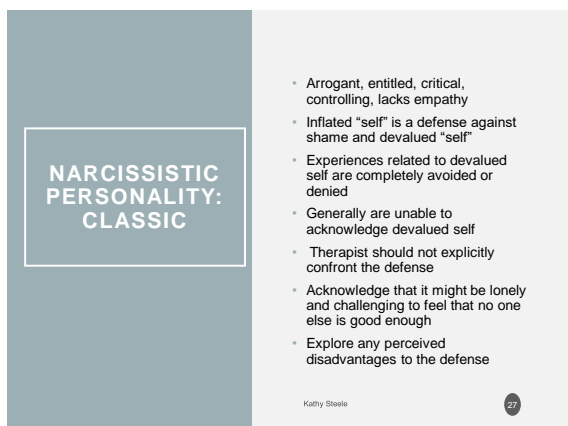
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27

NARCISSISTIC PERSONALITY: FRAGILE

- Alternate between grandiosity and inadequacy
- Unhappy, critical of others, anxious, envious, competitive, and have extreme reactions to perceived slights or criticism
- Tend to obsessively compare themselves with others
- Strong perfectionism
- Have narcissistic defenses that work well until they are criticized or rejected
- Can access their devalued self: therapist can focus on root causes of devalued self

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NARCISSISTIC PERSONALITY: REVERSED

- Strong belief and need to be the worst, the sickest, the most traumatized patient
- Underlying need to be special, but due to dysfunction, not adequacy
- Strong need for validation and compassion
- Therapist focuses on emotional validation and less on content of distress
- Encourage client to communicate through more positive experiences and affect (compassionately shift focus from negative to positive experiences)

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NARCISSISTIC PERSONALITY: GENERAL TREATMENT APPROACHES

- Trauma-based in many clients
- Certainly affected by quality of early relationships (neglect)
- Work with conflicting idealized and devalued selves
- Work with inner critic and perfectionism
- Mentalization based treatment
- Transference based psychotherapy
- Dialectical behavior therapy
- EMDR and other approaches to resolve early traumatic memories (often not explicitly accessible in the narcissistic patient)

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FRAGILE NARCISSISM: TREATMENT APPROACHES

- Identify the conflicting idealized and devalued selves
- Help client notice swings between the two
- Help client recognize the distortions in both
- "I suffer more than anyone; my abuse was the worst; I am completely damaged"
- Versus
- "I could have been and should be the best"
- Help client deal with relentless inner critic

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BORDERLINE PERSONALITY DISORDER

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BORDERLINE PERSONALITY

- Frantic efforts to avoid abandonment
- Unstable relationships, swinging between idealization and devaluation
- Unstable sense of self
- Impulsivity
- Suicidality or self harm
- Emotional reactivity / instability
- Chronic feelings of emptiness
- Anger issues
- Transient psychotic or dissociative symptoms

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BORDERLINE PERSONALITY

- Skills building to improve:
 - Emotion regulation
 - Distress tolerance
 - Interpersonal relationships
 - Black and white thinking
- More consistent mentalizing
- Reduce / eliminate self harm and suicidality
- Relational strategies to modulate idealization and devaluation
- Work with inner critic
- Sometimes there is an absence of sense of self rather than a dissociative disorder: "Who am I?"

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AVOIDANT PERSONALITY DISORDER

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AVOIDANT PERSONALITY

- **Fearful avoidant** – highly dysregulated and explicitly fearful of rejection or criticism. Avoids relationships in order to avoid being hurt. Typically has insight into this conflict.
- **Dismissive avoidant** – Over-regulated. Unaware of need to connect; finds relationships useless or peripheral to work or other activities. View relationships as a "bother." Has same fear of being abandoned or rejected, but lacks insight and reflection. More challenging to treat.

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AVOIDANT PERSONALITY

- Not only avoidant of relationship but of inner experience in general
- Strong emotions are highly avoided
- May be highly functional / intellectual
- May be less functional, unable to work because of avoidance
- May have co-occurring shyness / introversion

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37

TREATMENT OF AVOIDANT PERSONALITY

- Therapist should use a collaborative approach, making efforts not to over-activate the client's attachment system.
- Dismissive clients work well when they have specific collaborative goals to work on.
- Therapist should not try to get the client to discuss the therapeutic relationship early in treatment. Let the relationship work in more implicit ways ("in the back seat of the car")
- Allow the client to regulate distance and closeness. Therapist should stay steady and not pursue or distance from the client.
- Limit session to once a week; keep firm boundaries; don't encourage dependency or regression

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38

ASSESSING TREATMENT TRAJECTORY

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HOW WILL THERAPY PROGRESS?

- How can we predict whether treatment is going to go smoothly, have some difficulties, or be extremely challenging?
- Prognostic factors
 - General
 - Relational
 - Emotional
 - Cognitive
 - Dissociative

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Slow, limited, highly challenging, Chronic or long term mpasses, Defenses are ego syntonic

Moderate, workable mpasses, Defenses can be worked through

Highly collaborative, Defenses are ego dystonic, Highly motivated and capable

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41

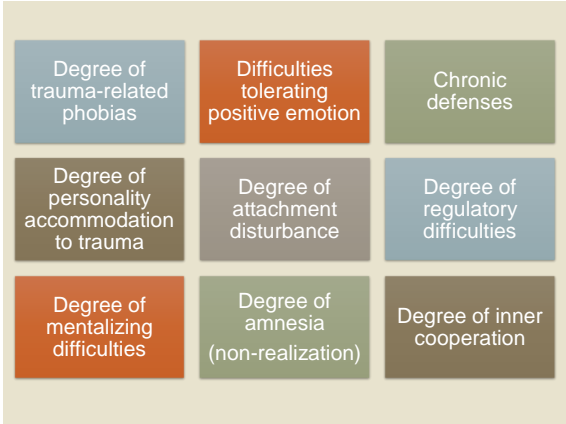
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PROGNOSTIC FACTORS

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42



43

GENERAL
PROGNOSTIC
FACTORS

- General degree of chaos in daily life
- Stability of basic shelter, food, finances
- Current and ongoing abuse
- Degree and severity of comorbidity
 - Major psychiatric diagnoses
 - Personality accommodations (disorders)
- Some level of insight into the nature of problems
- Some motivation to improve and willingness to try new things
- Some periods of better functioning over lifetime

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RELATIONAL
PROGNOSTIC
FACTORS

- Able to establish a collaborative relationship focused on treatment goals
- Able to share significant personal thoughts and feelings with the therapist or a few others
- Willing to respect treatment frame and boundaries
- Has at least a minimal support system beyond the therapist

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**EMOTIONAL
PROGNOSTIC
FACTORS**

- Intensity and chronicity of dysregulation
- Chronic "default" emotion such as shame or anger
- Willing to learn and practice emotion regulation skills
- Capacity for positive emotions and experiences; the ability to enjoy and take pleasure in life
 - Sense of humor

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**COGNITIVE
PROGNOSTIC
FACTORS**

- Rigidity of thinking and core beliefs (black and white thinking)
- Degree of maladaptive beliefs
- Capacity to reflect on own experience and that of others
- Ability to "read" people relatively accurately, especially the therapist (mentalizing)

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**DISSOCIATIVE
PROGNOSTIC
FACTORS**

- Extreme phobia of parts
- Extreme investment in remaining separate
- DID as a lifestyle
- Extreme entrenched conflicts among parts
- Adult self unable or unwilling to engage in therapy
- Frequent uncontrolled switching

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DISSOCIATIVE PROGNOSTIC FACTORS

- Severe current and/or past amnesia
- Sadistic parts
- Parts unable/unwilling to be oriented to the present despite persistent efforts
- Unable to stay grounded in the present at least some of the time
- Unable to stay present in therapy at least some of the time

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LEVEL OF MOTIVATION: READINESS FOR THERAPY

- No motivation: referred by legal system or treatment is demanded by family or work
- Fantasy motivation: My therapist will fix me
- External motivation: "I want to keep my job or my relationship"
- Limited motivation: "I want to get better but am sure I will fail, so what is the point of trying?"
- Moderate motivation: "I want to get better, but I am scared."
- Good motivation: "I am here to work hard, even though I know it won't be easy."

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DEGREE OF DEFENSES

- Ego syntonic or ego dystonic
- Degree of externalization
- How rigid and intense are defenses?
- Do defenses manifest in the therapeutic relationship with intense negative (or idealized) transference?
- Can client recognize and acknowledge defenses?

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DEGREE OF FUNCTIONING

- Difficulty functioning for long periods?
- Highest level of functioning has been poor?
- School, work, & home – ability to perform and complete tasks and be productive
- How do others perceive the client?
- Struggles with emotional and relational difficulties across time and situations
- Relational
 - Has client ever had vulnerable and deep relationships? (friends, romantic)
 - Degree of avoidance

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HISTORY OF THERAPY

- Previous hospitalizations
 - When? Why? How long?
- Previous therapies
 - What was the focus of treatment?
 - How long?
 - Why did therapy end?
 - What was and was not helpful?
 - How does client describe previous therapists? (look for idealization or devaluation)

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53

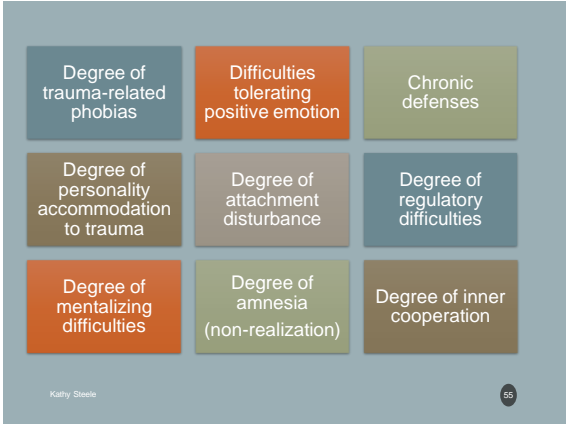
BEHAVIORAL PROBLEMS THAT MAY AFFECT PROGNOSIS

Generally, these accompany personality accommodations

- Chronic self harm
- Chronic suicidality
- Chronic eating problems
- Addictions : substance, sex, gambling, etc.
- Severe isolation
- Extreme risk-taking behaviors
- Violence and aggressiveness
- Inability to work or function in daily life
- Sociopathic behaviors: stealing, manipulation, violence, etc.

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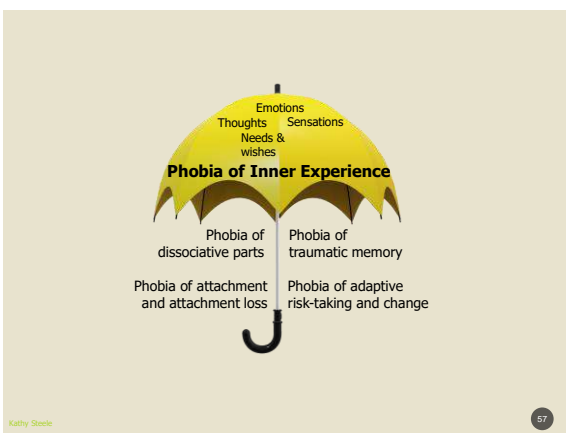
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57

**MAPPING
PHOBIC
AVOIDANCE**

- How intense and pervasive are the phobias?
- Which emotions are avoided? Why?
- Which wishes/needs are avoided or conflicted?
- Which dissociative parts are avoided / despised / feared?
- How is relational closeness is avoided in each part?
- How is relational rejection is avoided?
- Particular traumatic memories that are avoided?
- Ways in which change is avoided. Why?

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**ASSESSMENT OF
CONFLICTS**

- What are the client's core conflicts (e.g., "I want to be close; *Being close is dangerous*;" "I want to feel better; *I don't deserve to feel better*;" "I love my father; *I hate my father*")
- Do not take one side or the other, but hold both for and with the client!
- How does the client avoid the conflict?
- What emotions, cognitions, predictions, etc. are at the heart of the conflict?
- How do these conflict manifest among dissociative parts and in the therapeutic relationship?

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**TYPICAL INNER
CONFLICTS THAT
CONTRIBUTE TO
RESISTANCE**

- I want to know / I don't want to know
- It's true / I made it up; it's not real
- Avoidance of parts
- Loyalty to the perpetrator: I love him / I hate him
- Avoidance of closeness / Fear of abandonment
- I want to get better / Getting better means things will be worse

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60

TYPICAL INNER CONFLICTS THAT CONTRIBUTE TO RESISTANCE

- I want to get better / If I am better my perpetrator will not have to pay the cost
- I am bad or evil / I need to be loved
- I have needs / Needs are bad or stupid
- I want to be known and seen / I want to hide

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DEFENSIVE FANTASIES

These may be held in particular parts or may be held by the person as a whole. They prevent therapeutic engagement, grieving, and realization.

- Someone (the therapist) will fix this / make this go away
- Someone will love me unconditionally and perfectly
- Someone will meet all my needs and I won't ever have to suffer
- I am completely enough for someone else; they won't need anyone but me
- Someone is completely enough for me; I won't need anyone else
- Other

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LOW TREATMENT TRAJECTORY

- Significant personality accommodations
- Rigid thinking
- Difficulty collaborating
- Difficulty regulating emotions and impulses; little to no acceptance of positive emotions
- Entitlement or strong fantasies that the therapist can fix or rescue
- Significant hopelessness and helplessness
- Self-harm and chronic suicidality

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LOW TREATMENT TRAJECTORY

- Significant relational avoidance or demands that others care take / rescue
- Significant anger or shutdown
- Severe chronic shame
- Major defenses and resistances
- Client unwilling to accept parts
- Parts unwilling to work together
- Significant behavioral problems
- Difficulties with therapeutic boundaries

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LOW TREATMENT TRAJECTORY: TREATMENT IMPLICATIONS

- Stick with stabilization strategies
- Continue to work on behavioral containment both in and out of therapy
- Avoid rescue and development of dependency
- If able to work with parts, focus on functioning in daily life, not traumatic memories
- May not be able to work with parts
 - Client may be unwilling or
 - It may be too destabilizing

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ESTABLISHING TREATMENT GOALS

- The highly avoidant / resistant client may struggle with accepting stabilization skills
- Self reflection may be a struggle
- Focus on treatment goals that the client can agree on (e.g., having less trouble at work; feeling less stressed)
- May not be able to work with parts
 - Determine intensity of client's avoidance of working with parts

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