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Commentary: Schema therapy for Dissociative Identity Disorder: a case report

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A Commentary on

Schema therapy for Dissociative Identity Disorder: a case report

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Introduction

We sincerely appreciate new research on the treatment of dissociative identity disorder (DID), which adds important information on a relatively understudied diagnosis. More specifically, we value the new avenues Bachrach et al. (1) explore and describe the course of Schema Therapy (ST) in DID in more detail. We have some concerns and comments to raise, many of which relate to issues that have been discussed before (2, 3). These are combined with clinical consensus on how to treat individuals with DID.

Subsections

First, we would like to highlight that even though ST is presented as a new treatment for individuals with DID, there are many overlapping interventions with the guidelines for phase-oriented trauma treatment (POTT) (4). As described in this case report, ST interventions cover many stabilization techniques frequently described and used within POTT treatment, which are therefore not unique to ST. This also contradicts Bachrach et al.'s (1) notion that ST pays little attention to stabilization in the first phase of treatment. Furthermore, ST's biweekly sessions may involve a more intensive approach than POTT's standard weekly sessions (3). The total length of both treatments is, therefore, probably comparable. Bachrach et al. (1) also mistakenly present POTT as a solely practice-based psychodynamic psychotherapy approach. POTT is an eclectic treatment that incorporates various approaches such as psychodynamic psychotherapy, cognitive behavioural therapy,

systemic therapy, mindfulness, imagery rescripting, sensorimotor psychotherapy, and EMDR (5, 6). Both models focus on trauma and its effects when treating Dissociative Identity Disorder (DID), including reducing avoidance during the stabilisation phase. As for Bachrach et al.'s (1) statement that research results indicate that POTT effects are small or absent regarding the core symptoms, we disagree. The review by Brand et al. (7) suggests that dissociative disorder (DD) treatment is associated with improvement in symptoms of dissociation. In addition, in their TOP DD study (Treatment of Patients with Dissociative Disorders; 8), patients showed reduced manifestations of dissociated self-states, including subjective self-division and hearing voices of self-states. The last imprecise assumption is that the randomized controlled trial by Bækkelund et al. (9) would be exemplary for regular POTT; the Bækkelund study only covers a 20-session skill-based group treatment.

Secondly, we would like to stress our concerns regarding the intervention described by Bachrach et al. (1) in summoning a punitive part to leave. In DID treatment, close attention is given to the function of aggressive and critical dissociative parts while pacing and validating their needs (10, 11). This basic assumption holds for ST and POTT; therefore, rejecting the punitive part seems inappropriate.

In our regard, this is a gravely invalidating intervention, dismissing the patient's natural ability to cope with highly threatening circumstances. When appropriately acknowledged, these punitive parts become the patient's strongest allies in their healing process and in finding the strength to cope with daily life issues (e.g. being assertive). Removing punitive parts, if that is possible at all, would undermine the patients' development to establish a healthy balance between dependent and autonomous functioning. Furthermore, the expert clinical consensus is that critical or aggressive parts will not respond to being sent away by disappearing altogether in authentic DID. It is more likely that the working alliance between the therapist and the patient and between the patient and the punitive part becomes harmed and for the punitive part to reappear as time passes.

Moreover, the particular structure of the inner world of the patient described in this paper seems highly atypical for genuine DID. This makes us question the validity of the DID diagnosis given to this patient. In general, a dissociative system consists of more parts carrying trauma material, mostly child parts that are stuck in the past, portraying bodily behaviours matching the stress reactions (fight, flight, freeze and collapse), than parts that are highly avoidant of trauma content and emotions, which enables them to keep performing tasks in daily life. In the case described by Bachrach et al., (1) significantly more adult avoidant parts are reported than child parts. Diagnosing DID is a rather complex endeavour which needs sufficient clinical experience to differentiate between genuine DID and factitious cases of DID and cases where identity confusion is due to borderline personality disorder (BPD) (2, 12). The differential diagnosis of these conditions can be challenging and is crucial to ensure the reliability of DID diagnoses (4, 13).

Discussion

We aim to highlight the intricacies of treating Dissociative Identity Disorder (DID) and essential considerations. Some final questions about the ST study can therefore be added. The study is introduced as a case report to illustrate the application of an adapted form of ST for DID. In this respect, we would appreciate more detailed information on how "ST for DID is personalized to each patient" and what adaptations they made to ST for DID patients, a suggestion previously done by Brand et al. (2), in response to the original rationale and study protocol (14). Furthermore, we would appreciate a more comprehensive outline of how trauma-focused treatments are administered for sexual abuse cases and the level of expertise of the diagnosing clinician to ensure accuracy in this report. The presentation of baseline data in the absence of post-treatment measures, together with mentioning a "strong" reduction in dissociative symptoms, leaves us with the suggestion that these symptoms reflect an improvement in DID. It remains unclear, however, whether these reduced dissociative symptoms reflect core DID symptoms, as improvements may result from reduced comorbid BPD- and posttraumatic stress disorder symptoms, or the termination of cannabis usage since the use of this substance is associated with derealization and depersonalization (15). We are interested in whether the described patient's modi were integrated after the treatment or whether she merely learned to cope with them, at least for now. A longer follow-up is crucial as DID can have a relapsing and remitting course across the lifespan (2, 4). Overall, it is essential to continue research on DID treatment, and while we raised concerns as the above, our goal is to consolidate DID treatment and expand knowledge on how these severely traumatized individuals have the best chances to heal.

Author contributions

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Conflict of interest

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