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A brief cognitive-behavioural treatment approach for PTSD and Dissociative Identity Disorder, a case report

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ABSTRACT

Background and objectives: We described a new treatment model for Posttraumatic Stress Disorder (PTSD) and Dissociative Identity Disorder (DID), based on cognitive-behavioural principles. In this model, dissociation is seen as a maladaptive avoidant coping strategy. In addition, we stress that patients have dysfunctional beliefs about dissociation. Both elements, avoidance behaviour and dysfunctional beliefs, are challenged during the brief, intensive trauma-focused treatment. When the PTSD-symptoms decrease, the patient is offered a fare-well ritual to say goodbye to their identities in one or more additional sessions.
Methods: We illustrate this treatment approach with a case report of a woman with PTSD as a result of sexual abuse in her childhood, and DID with four identities. Treatment outcome was measured at intake, at pre-treatment, at post-treatment and at 3 and 6 months follow-up.
Results: After the short treatment of only 2 weeks, she no longer fulfilled the DSM-5 diagnostic criteria for PTSD nor DID. These results were maintained at the follow-ups.
Limitations: Although we included a baseline-controlled time phase, it was not a controlled study, and only one patient was treated.
Conclusions: This new treatment model for DID-patients is promising but results should be interpreted cautiously since we described only one patient.

1. Introduction

Dissociative Identity Disorder (DID) is defined as a severe disruption of identity characterized by two or more distinct personality states and recurrent gaps in the recall of everyday events (APA, 2013). Thus far, few controlled studies are available demonstrating the effects of treatment for DID, and hence, there are no evidence-based treatment guidelines available (see also a recent Cochrane review; Ganslev et al., 2020). Following practice-based guidelines (e.g. International Society for the Study of Trauma and Dissociation, 2011), typically, DID treatment consists of psychodynamic psychotherapy, and is delivered in three phases; first phase: safety and symptom stabilisation; second phase: trauma-focused treatment, and third phase: identity integration. The first phase can take several years to complete. It is often assumed that trauma-focused treatments are not indicated for patients with severe forms of dissociation, at least not without the first phase of stabilisation preceding it. However, a recent meta-analysis showed that patients with elevated dissociative symptoms may profit safely from cognitive behavioural trauma-focused treatments (Hoeboer et al., 2020), which questions the necessity of the first phase. Also, it is unknown how effective interventions aimed at the identity integration (the third phase) are and related to this, not many patients reach this phase. More importantly, the idea for the need of identity integration is based on the idea that identities are separate compartments with their own memory, while there is inter-identity amnesia. However, several studies showed that, though DID-patients *subjectively* indicated inter-identity amnesia, objectively no memory deficits, including amnesia were found (see e.g. Huntjens et al., 2012). These findings question the need of an (extended) third treatment phase aimed at integration, because there is no objective disintegration to begin with.

Based on the above-mentioned empirical findings, questioning the necessity of a phase-based model, a new treatment model was developed, based on cognitive behavioural principles. Although there has been much debate about the aetiology of DID, the different etiological

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models, e.g. the posttraumatic and sociocognitive model, are more convergent nowadays, and share some points of view: (1) DID may develop following severe stressors, including trauma (Lynn et al., 2019). Patients use dissociation as an avoidant emotion regulation strategy when confronted with painful traumatic memories (see also Huntjens et al., 2014; Cloitre 2012) and (2) DID-symptoms may be influenced by suggestions of others, including therapists, and patients have dysfunctional meta-cognitive beliefs about dissociation and memory (Huntjens et al., 2020). This avoidance behaviour and maladaptive beliefs are assumed to maintain the dissociative symptoms, and therefore, in our treatment model we try to address these maintaining factors. Two elements are key: (1) address avoidant behaviour by directly applying trauma-focused treatment and (2) counter meta-cognitive beliefs: no reinforcement of dissociative behaviour or beliefs. The last step in the treatment model is (3) saying farewell to the identities that once may have had a positive function but are now no longer needed.

We present a case report to illustrate this new treatment model, and in this case report, the trauma-focused treatment consisted of a brief, intensive trauma-focused treatment programme, developed for patients with complex or severe PTSD. This treatment programme consisted of a total of 8 days, on each day 2 sessions of individual trauma-focused treatment sessions, Prolonged Exposure (PE; Foa et al., 2017) and EMDR-therapy (Shapiro, 2017), both considered to be guideline first choice treatments for PTSD. In addition, patients received psycho-education and participated in physical activity, both in a group format. This brief treatment program has been proven to be effective (Van Woudenberg et al., 2018).

During the trauma-focused treatment sessions, symptoms of dissociation, such as depersonalisation (e.g. I do not feel my body), somatoform (e.g. paralyzed legs), amnestic (e.g. I can't access the trauma memory) and identity fragmentation (e.g. another identity is appearing) are consistently labelled as avoidance behaviour ('you are dissociating now to avoid the traumatic memories, try to let go of this avoidant behaviour and expose yourself fully to the traumatic memory'). In addition, dysfunctional beliefs about memory and dissociation are countered ('I can't remember' becomes 'you think you can't remember, but you probably mean: 'I am too afraid to remember because I think that I will be overwhelmed and lose control'). The hypothesis is that due to the decrease in PTSD-symptoms, the dissociation-related symptoms no longer serve a positive function, and will also decrease along with the PTSD-symptoms. This was indeed found for symptoms associated with the PTSD dissociative subtype (Zoet et al., 2018) and somatoform dissociative symptoms (Zoet et al., 2020). These findings are also in line with neurobiological findings showing that DID is closely related to PTSD (Reinders et al., 2014). However, because many DID-patients spent years 'living with' their identities, who sometimes can feel as 'imaginary friends', additional sessions may be needed to officially say farewell to their identities, using a farewell ritual. In this article, the treatment will be described of a patient with DID who underwent intensive trauma-focused treatment and received one additional session for saying farewell to her four identities.

2. Material and methods

2.1. Design

A single AB design was used. After 4 weeks of baseline, the intervention phase was introduced, consisting 2 × 4 days of trauma-focused treatment within 2 weeks, and at day 6 one session of saying goodbye to the identities.

2.2. Research participant

2.2.1. Case introduction and presenting complaints

The patient is a 36-year old woman, Mary. She is married, has three children, and used to work as a teacher, but because of her symptoms she is no longer able to work. We altered and omitted non-crucial information to ensure anonymity. The client provided informed written consent for this case report. Mary was referred to the Psychotrauma Expertise Centre (PSYTREC) for her severe PTSD symptoms: she had intrusive memories of the sexual abuse by her father. She had nightmares every night, and had flashbacks when she was confronted with trauma-related stimuli, such as the smell of the aftershave of her father, and the smell of whisky. In addition, she avoided to talk or think about the traumatic events, she avoided men, public places, and television shows and newspaper articles about sexual abuse. Also, she was hyperalert, had concentration problems and difficulty sleeping. She was referred to PSYTREC with the following diagnoses: PTSD, DID, alcohol use disorder in remission, anorexia nervosa in remission and depression in remission. The DID was diagnosed by her former therapist, and we confirmed this diagnosis using the DID section of the Dissociative Disorders Interview Schedule (DSM-5 version; DDIS; Ross, 2015) and asking examples of the symptoms of the Dissociative Experiences Scale items (Bernstein & Putnam, 1986, see 2.3.) she scored high on.

2.2.2. Case history

Mary developed PTSD, after experiencing sexual abuse by her father and her uncle in her childhood (age 4–11). During the sexual abuse she dissociated, and experienced depersonalisation and derealisation, such as out of body-experiences and feelings of being in a fog, and felt paralyzed and frozen. She also reported amnesia during daily life and regarding her traumas. In adolescence, to gain control, she stopped eating and developed anorexia nervosa. After her father died, fifteen years ago, her PTSD-symptoms exacerbated and she sought help. She reports that she has never felt alone since childhood, and always has felt the presence of others. Only until she was in therapy, and questioned by the therapist, she realized that that was not a common phenomenon. She reports having four 'alters': two little girls, one boy and one adolescent. At the age of 4 (after her first sexual abuse experience), Mary's first alter developed. Meg was a sweet little girl, 4 years old, was happy and loved Hello Kittie, a well-known girl toy brand. At the age of 6, another alter appeared, also a playful little girl, Sophie. Both girls loved French fries and their function was to feel light-hearted and joyful, and to be able to feel like a child again, and to forget about the traumas. However, when these girls identities 'took over', Mary experienced no control, bought a lot of toys and candies, and her living room was very messy. At the age of 10, she developed another alter, a boy, named Jim. He found the two younger girls annoying and loved tractors. His function was to be cool and to protect her, he stood up for her. However, he also criticised Mary, and was often angry at her. The fourth alter was Juliette, a 15-year old girl, who was depressed, very angry and eccentric. Juliette set Mary up to engage in self-injury and suicidal behaviour, to escape from the emotional pain. Mary often felt depersonalised and experienced derealisation. Also, she reported to regularly find girls toys and clothes in her house, without knowing that she had bought them. In addition, she reported time gaps in her daily life with amnesia and hearing voices. She described that due to these identities, inside her head it was always chaotic and she constantly was busy negotiating with all the identities.

2.2.3. Previous treatment

Previously, she received EMDR-treatment for her PTSD, without any effect, possibly because of her dissociative and addictive behaviour. In addition, she received a phase-based treatment program for her dissociative symptoms, aimed at stabilisation, but her dissociative and PTSD-symptoms did not decrease because of this treatment. Her therapist advised her to not process her traumatic past, because the alcohol use and dissociative disorder would obstruct progress. Hence, she first underwent clinical treatment for the alcohol use disorder, and at the intake at PSYTREC, she has been 15 months abstinent, but still suffers from severe dissociative symptoms. In the addiction treatment centre, they referred her for trauma-focused treatment in our clinic.

Table 1
Treatment programme overview.

Programme	Number of sessions
1. Trauma-focused treatment: intensive trauma-focused treatment	8 sessions prolonged exposure
a. Counter avoidance behaviour	8 sessions EMDR
b. Challenge maladaptive beliefs about dissociation	Physical exercise
	Psychoeducation
2. Farewell ritual for alters	1 session
a. Choosing an identity	
b. Identifying the function of the identity	
c. Relaxation	
d. Imaginal exposure to the identity	
e. Thanking the identity for its support	
f. Giving permission to go	
g. Saying and waving goodbye	

2.3. Measures

PTSD diagnosis was assessed using the Dutch version of the Clinician Administered PTSD Scale for DSM-5 (CAPS-5), a reliable and well-validated structured diagnostic interview (Boeschoten et al., 2018). PTSD symptom severity was measured using the Dutch version of the PTSD Checklist for DSM-5 (PCL-5; Boeschoten et al., 2014), which has an excellent reliability and validity. The cut-off score for the diagnosis PTSD is 31–33 (Bovin et al., 2016), and a decrease of >10 points on the PCL-5 is usually considered a clinically significant change. DID diagnosis was established by the DID section of the Dissociative Disorders Interview Schedule (DDIS; Ross, 2015). Dissociation symptom severity was measured with the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), a well-established valid 28-item self-rating scale that measures the tendency to experience dissociative experiences in daily life (total range: 0–100). A cut-off score of ≥30 is generally used to suggest a possible dissociative disorder. All measures were administered at intake, posttreatment and 3 and 6 months FU. To control for time-effects, the PCL-5 was additionally administered at the start of the treatment (in that way a baseline control time of 4 weeks was created), and after four treatment days (mid-treatment).

3. Intervention

In Table 1 an overview of the treatment program is provided. Mary underwent our intensive trauma treatment program (see for an overview and description Van Woudenberg et al., 2018), consisting of 2 weeks with 8 treatment days. On each treatment day, Mary received one session of PE and one session of EMDR. In between sessions, she participated in group physical exercise and received psycho-education aimed primarily at PTSD and avoidance behaviour. The trauma-focused treatment was aimed at processing all her traumatic experiences and the situations that caused the most intrusive symptoms were treated first. Mary reported during the first morning in the clinic, that she had woken early in the morning, to start with a group session with her and her four alters. She had explained to them what she was going to do, and she had asked the alters not to interfere, and to behave themselves. In addition, she had brought two stuffed animals to the clinic, and the alters were allowed to play with them, while Mary was processing her traumas. Following the advice of one of her former therapists, she wore four bracelets, each representing one alter. In her view, in that way, she could always have contact with the alters and control them.

During the first exposure session, Mary showed avoidant behaviour by shutting down, because she was afraid to feel her trauma-related emotions and dissociated (avoidance behaviour). She was afraid that her memories would be too overwhelming for her and that she would go crazy (maladaptive beliefs). Also, she believed that it would be better to not remember everything. The strategy used by the therapist was to explain the dissociative symptoms as avoidance, and address the accompanying maladaptive beliefs.

"Mary, you are dissociating now. You experience the fear levels elicited by talking about your traumas as too high, and you are afraid that you will lose control and will go crazy. As an avoidant reaction, you are dissociating. This is understandable, and at the time of your traumas this was helpful, but it is no longer helpful for you. Instead of avoiding, I invite you to approach your traumatic memories and activate the fear. So, do what is necessary to overcome your fear of losing control. I will wait for you until you are ready to continue the exposure. Let me know when you are ready" [of note; at this point the therapist will focus his or her attention to something else than the patient and is silent].

This approach is based on the avoidance model of dissociation. Importantly, we stress that she has control over the dissociative symptoms, as opposed to dissociation being an automatic reaction, and that she uses dissociation actively as an avoidant coping strategy to prevent her from becoming overwhelmed by strong emotions (maladaptive belief). Therefore, it is crucial to not intervene as a therapist in overcoming the dissociation, for instance by providing relaxation or grounding exercises, but to let the patient overcome the avoidance and start approaching the traumatic stimuli by herself. It is also seen as essential not to positively reinforce the dissociative responses, and therefore, the therapist waits in silence with his or her attention focused on something else than the patient (for instance writing the report). Mary reported that it was very difficult to keep the alters calm and quiet, and that she had to give all her energy to this 'group process' and to not switch to another identity. She also indicated being angry at the therapist, because the therapist suggested that she had control over her dissociative behaviour, while she sincerely believed that it was a non-controllable automatic reaction. The therapist patiently kept repeating the message that she was avoiding her emotions, and that she could overcome the dissociation by herself.

On the second day, the therapist suggested that wearing her bracelets, representing the alters, probably was safety behaviour, meaning that it made her feel more comfortable and 'in control'. This safety behaviour, however, is at odds with the goal of exposure, namely to approach the feared stimuli without avoidance of safety behaviour, in order to learn that your dysfunctional beliefs (e.g. 'when I remember the details of my trauma, I will lose control') are challenged. Therefore, the therapist suggested to take off the bracelets, and so she did. Mary immediately sensed a feeling of relieve and rest. The therapist explained again that dissociating was avoidance behaviour, and that avoidance would get in the way of her therapy success. After that, Mary confessed that she was also holding on to two stuffed animals, and that she was playing in her room with these animals and the (young) alters in between therapy sessions. The therapist advised her to hand in the stuffed animals to the therapist, and to keep them until she would go home, and so she did. Subsequently, she could feel some emotions during the exposure and EMDR sessions, but only for a short period of time before she dissociated again. Within the two sessions of the third day, she was able to continue the exposure for about 10 min without dissociating, and on the fourth day, she no longer dissociated during sessions, but she still did so in between the sessions. However, following the treatment program, she engaged in physical activity in between the trauma-focused sessions, and she learned that physical activity helped her to overcome the dissociation even more. On the sixth treatment day, Mary participated in a goodbye session in which she explored which identities she wanted to say goodbye to. Subsequently, as a first step, she analysed the function of each of the alters. To increase the vividness of the imagination exercise, she did a relaxation exercise. In this case, we used hypnosis induction with eye gaze. This took about 5 min. In the next step, she exposed herself to the first identity, Meg. Mary was asked to invite Meg, and to ask her to come closer and closer, so she could see her. Subsequently, Meg was thanked for the function she served during her traumas. The therapist explained this to Mary:

'Meg appeared in a time that you were traumatised, and she made you feel playful and carefree. That was really nice of Meg, she helped you a lot during a time you needed a friend that took your side. Now, you

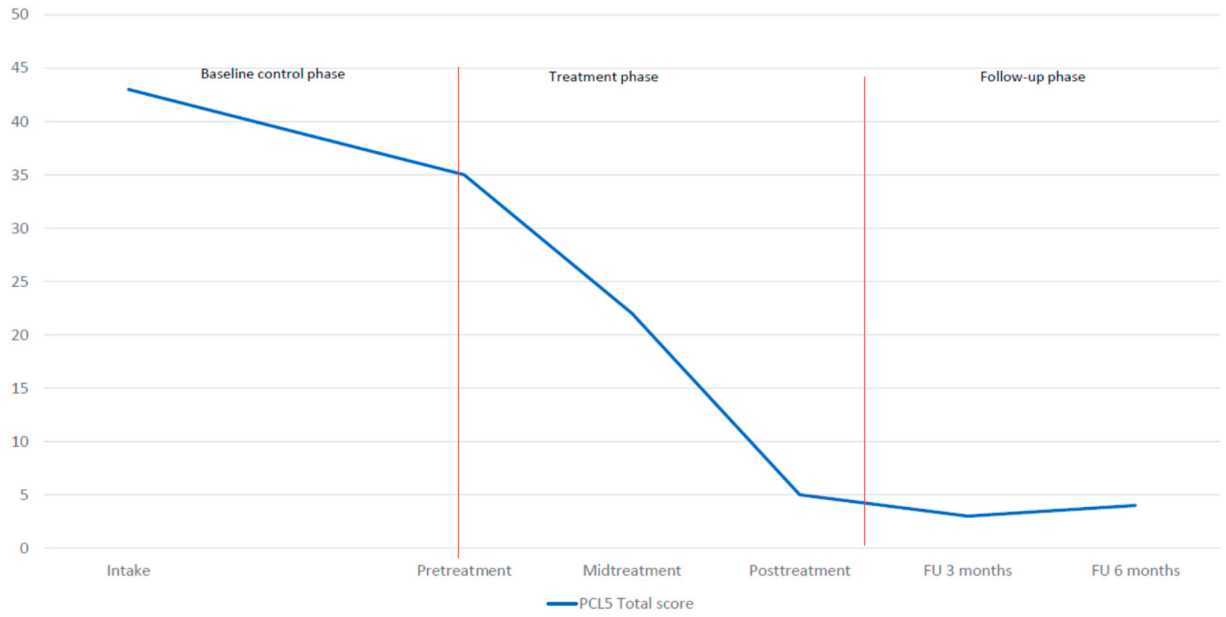

Fig. 1. PCL5 total scores.

are safe, and you have processed your traumas, so Meg is no longer needed. Thank her for what she has meant to you, tell her that you can do it on your own now and that you don't need her anymore, and gratefully wave her goodbye.

Mary thanked her

'Bye Meg, all the best, have a nice life, thank you for taking care of me, but I can do it on my own now, bye bye'.

However, she felt that Meg could not go on her own, because she was too little. Therefore, we decided to wave goodbye to Meg and Sophie together, so that they could support each other. After thanking Sophie for helping her, and for taking care of Meg as if she were her older sister, Mary waved them both goodbye, while they were holding each other hands. Mary was encouraged by the therapist to keep waving until they were really gone, and she could no longer see them. Accordingly, this waving goodbye ritual was repeated for respectively Jim and Juliette. When saying goodbye to Juliette, Mary cried and felt sad. She had the feeling that all her alters were dead. The therapist suggested that instead, they may be helping other traumatised children now, and this thought gave Mary some comfort. After the goodbye session, Mary still felt a bit sad, but also very relieved and very lightheaded. She successfully finished her trauma-treatment and went home after the planned eight treatment days.

4. Results

4.1. PTSD-symptoms

At intake, Mary was diagnosed with PTSD with dissociative subtype, and at posttreatment and 3 and 6 months follow ups she no longer fulfilled the diagnostic criteria for PTSD.

Both at intake and at the start of treatment (a baseline control period), her PCL-5 scores fell above the cut-off score (>31–33). Although the PCL-5 scores decreased somewhat during this 4-week baseline control phase, this decrease (8 points) was not considered a

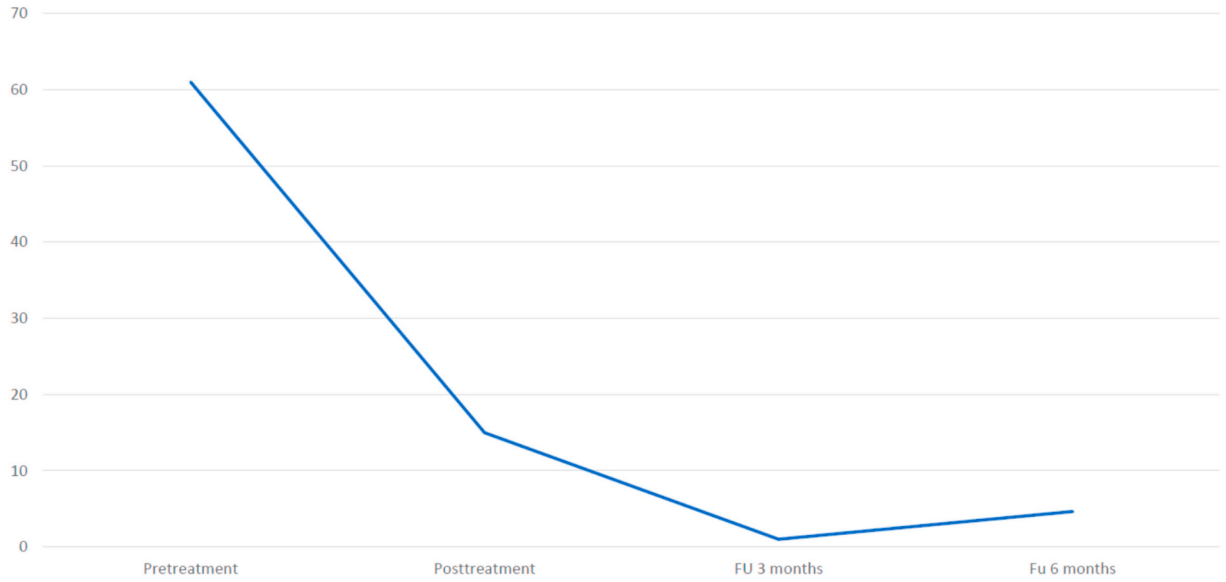

Fig. 2. DESII total scores.

clinically significant change (>10 points). From the start of the treatment, her PTSD-symptoms decreased with 30 points and at posttreatment she scored below the cut-off. These results were maintained at 3 and 6 months follow up. (See Fig. 1).

4.2. Dissociative symptoms

Following the DSM-5 criteria, Mary no longer fulfilled the diagnostic criteria for DID. At intake, Mary scored 61 on the DES, a score that is far above the commonly used cut-off score of ≥30 to suggest a possible dissociative disorder. At posttreatment, she scored 15 and at 3 months follow-up only 1 and at 6 months follow-up 4.64, indicating that the treatment was effective for her dissociative symptoms and that this result was maintained at follow-ups (See Fig. 2).

5. Discussion

In this case report, a treatment is described in which a patient with PTSD and Dissociative Identity Disorder is successfully treated within the short time frame of 2 weeks, and these effects were maintained at 3 and 6 months follow-up. For this treatment, a cognitive behavioural treatment model was used, in which it is hypothesised that the dissociative symptoms serve as a maladaptive avoidant coping strategy to cope with emotions and distress evoked by trauma-related stimuli and patients hold dysfunctional beliefs about trauma and dissociation. Because PTSD is very common in patients with DID (Rodewald et al., 2011), directly treating the PTSD-symptoms is essential. After successful trauma treatment, dissociative symptoms lose their function and will decrease along with the PTSD-symptoms. Many DID-patients build a longstanding 'relationship' with their identities. Their identities, as was the case with Mary, may feel to them like imaginary friends, and it may be hard to say goodbye. Therefore, additional farewell ritual sessions can be added, in which the patient exposes herself to the identities, thank them for their role and wave them gratefully goodbye.

This new treatment, however, is at odds with 'traditional' treatment models for DID and practice-based treatment guidelines, in that is does not comprise a stabilisation phase before the trauma-focused treatment, the patient is not offered any techniques (such as grounding techniques) to overcome their dissociation during sessions, there is no aim to establish communication with or between the identities or integration of the identities, and it has a very brief format. The successful and brief format of the treatment of Dissociative Identity Disorder in this case, is in line with other studies that show that relatively brief CBT-approaches are effective for patients with complex dissociative-and-trauma-related disorders, like depersonalisation disorder (Hunter et al., 2003), conversion disorder (Myers & Lancman, 2017), and DID (Mohajerin et al., 2020), complex PTSD (Voorendonk et al., 2020) and for PTSD-patients with elevated dissociative symptoms (Hoeboer et al., 2020).

Limitations are that, although we included a baseline-controlled time phase, it was not a controlled study, and only one patient was treated, and thus our findings do not generalize to other patients with DID. What is more, this patient was open to this new technique, had some control over her identities, and was willing to talk with and say goodbye to her identities, which may not be the case for all DID-patients. It is of importance though, to offer the goodbye ceremony only after the trauma-focused treatment has proven its first effects, and the patient has experienced that he or she has some control over the dissociation. Another limitation is that the DID-diagnosis was not assessed using the golden standard, the Structured Clinical Interview for Dissociative Disorders (Steinberg, 1994).

In conclusion, this new treatment model for DID-patients is promising, but results of this treatment model should be interpreted cautiously since we described only one patient. More extensive research among larger groups with DID-patients is needed.

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Credit author statement

Agnes van Minnen: Conceptualization, Methodology, Investigation, Recources, Writing- Original draft preparation, Supervision.

Marleen Tibben: Conceptualization, Writing- Reviewing and Editing.

Declaration of competing interest

We have no conflicts of interest to disclose.

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