Editor's note: Some readers will find it valuable to start by first reading the case studies of Susie and Anna, and then reading from the beginning to see the cases in the context of the theory of Schema Therapy.

***Commentary on <u>Kelly's Circle of Safety and Healing: An Extended
Schema Therapy Narrative and Interpretative Investigation</u>***

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients With Dissociative Identity Disorder (DID): The Cases of Susie and Anna

JUDITH MARGOLIN [a,b]

[a] Private Practice, Princeton, NJ

[b] Correspondence concerning this article should be addressed to Judith Margolin, 601 Ewing St. C20A, Princeton, NJ 08540
Email: drjmargolin@gmail.com

_____

ABSTRACT

David Edwards' case of Kelly is a vivid demonstration of the power of Schema Therapy to address the present day emotional difficulties of Kelly, an individual with a background of traumatic childhood experiences. The therapy drew on Kelly's imagination and emotional memories to elicit distinct child-parts (called child "modes" in Schema Theory) of herself emerging from that traumatic background. Specifically, Edwards' interventions involved entering Kelly's inner world and therapeutically interacting with her modes. While Kelly's problems were primarily limited to her inner experience rather than to her behavioral functioning, I have found that Edwards' approach with Kelly applies to the cases I see who are much more seriously disturbed than Kelly. Specifically, I see cases with Dissociative Identity Disorder (DID), who share the experience of childhood trauma with Kelly, but whose behavioral lives can be chaotic and highly disturbed, sometimes requiring hospitalization. In this commentary I will briefly describe Edwards' Schema therapy model exemplified in the case of Kelly and illustrate the value of the model as applied to two cases of DID, Susie and Anna, that I have seen.

Key Words: corrective emotional experience; Early Maladaptive Schema; Imagery Rescripting; Schema Therapy; Schema Mode; Dissociative Identity Disorder (DID); case study; clinical case study

_____

DAVID EDWARDS' SCHEMA THERAPY APPROACH IN THE CASE OF KELLY

David Edwards' (2022) rich and detailed study of the Case of Kelly draws the reader into Kelly's journey to make meaning of an internal experience that has resulted from a childhood of instability, abuse, neglect, and unmet needs. The reader joins her on this journey as implicit

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
273

memories are made explicit, and as she comes to understand how she made sense of her world through the emotionally charged meaning of early memories. We witness the development of a coherent narrative as the meaning of those memories is first unpacked and then rescripted within a safe and nurturing context that allows for true emotional healing to occur.

Edward's use of Schema Therapy as the vehicle for change vividly illustrates the movement from Kelly's basic understanding and insight to a deeper level of true emotional healing and schema change. Schema Therapy provides a basis for conceptualizing "the understandable patterning of cognition and affect that developed from Kelly's past, and structured her current experiences" (Edwards, as cited from Stein and Young, 1997, p.162). At the core of Schema Therapy is the belief that maladaptive schema (the lenses through which we see the world) unfold when significant developmental needs are not met by attachment figures. It is these maladaptive schemata that lead to problems in later life.

Edwards describes two kinds of remembering, characterized as (a) implicit, episodic, emotionally charged reexperiencing, and (b) reliving, explicit-language-based, narrative memory. The episodic memories often represent composite constructions of multiple experiences rather than literal records and are closely associated with the themes and patterns of emotional schema that are maladaptive. These themes and patterns became the focus of Kelly's therapy as they are what perpetuated the difficulties Kelly experienced as an adult. Because episodic memory is mostly implicit (sensory, perceptual, affective, and nonconceptual in nature), problematic meaning is not easily shifted through traditional talk therapy. The experiential techniques of imagery and chair work that Edwards uses with Kelly allow her to experience the feelings attached to these memories as the new meaning assigned to them allows schema healing.

Edwards guides us through this process in his description of the development of the Circle of Healing to address the needs of Kelly's different child-parts (called child "modes" in Schema Theory). A mode consists of a distinct self-state or voice within the client that is currently active for the individual. The mode can be adaptive or maladaptive. Several of these "schema modes" were explicitly involved in Edwards' therapy with Kelly

Through the experiential interventions, Kelly comes to identify the different modes holding the implicit memories that correspond to her unmet needs. The meaning of these memories is reflected in the different child modes she imaginally develops (incubator Kelly, the 3-year-old, the ugly duckling, and the anxious one); and the different coping and adult modes she also develops. These modes are clarified and processed through the imagery, resulting in the development of new meaning, understanding, and strengthening Kelly's healthy adult self. A key part of this process is superimposing the trauma content (Kelly's experiences of instability, abuse and neglect) with a new relational image of her needs being met. The new memories and meaning are incompatible with the negative messages previously encoded (Lee & Boterhoven de Haan, 2020, p. 132).

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients   274
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin

Edwards also illustrates other central concepts in Schema Therapy, including schema healing, limited reparenting, and empathic confrontation. "*Schema healing* is the ultimate goal of Schema Therapy" (Young, Klosko, & Weishaar, 2003, p. 31), which occurs when the impact of the memories relating to the emotionally charged schema (with associated somatic sensations and maladaptive cognitions) is diminished and more adaptive behaviors can emerge. This requires the "willingness to face the schema and do battle with it" (Young et.al., 2003, p. 32).

In Schema Therapy, it is the therapy relationship that provides the crucible for the battle to be fought and for change to occur. Coined *limited reparenting*, this relationship provides the safe and supportive space to identify, explore, and *empathically confront* the (maladaptive) schemas and modes which developed as the client tries to make sense of her world and cope with the experience of unmet needs.

These two interventions, limited reparenting and empathic confrontation, are at the core of Schema Therapy providing both the "corrective emotional experience" (written about by Alexander & French [1946] and Winnicott [1954], as cited by Edwards [2022]), and the vehicle for change as the client's maladaptive beliefs and schema, and their self-defeating patterns of behavior are empathically challenged. Edwards states "reparenting, a central intervention in Schema Therapy, means providing the child, trapped in memories of neglect, misattunement, and abuse, a corrective experience in which her needs are met" (Edwards, 2022, p. 245). He cogently describes this as an extension of Winnicott's "holding environment," the secure base of attachment theory which allows "the space in which the child is no longer alone and needs can be experienced and met" (Edwards, 2022, p. 245). In Kelly's own words, one of Edwards' most important contributions was his ability to "speak for the child" through his attunement, understanding, and articulation of the child's experiences (p. 246).

APPLYING EDWARDS' SCHEMA THERAPY APPROACH TO TWO CASES OF DISSOCIATIVE IDENTITY DISORDER: GENERAL CONSIDERATIONS

Kelly, the client in David Edwards' case study, was born to "a very unstable and abusive mother, and a largely ineffective and emotionally absent father" (p.213). However, although these experiences strongly impacted the quality of Kelly's inner life at the time Edwards began seeing her in therapy, Kelly's problems did not reach the level of a formal DSM-5 diagnosis (American Psychiatric Association, 2013). Moreover, at the time of therapy, she had been generally functioning well, as "a professional woman … in a stable marriage and had two small children under 6."

In spite of Kelly's apparent solid level of functioning, Edwards' Schema Therapy uncovered a series of distinct, problematic child parts within her inner life. Specifically, starting in session 52, the process of therapy involved

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 18, Module 3, Article 3, pp. 272-286, 10-27-22 [copyright by author]

275

> Kelly [seeing] … an image of a circle of caring people within which a series of child parts of herself [technically called "modes"] were able to find a sense of safety and holding. Over the course of the sessions, eight different child parts approached and eventually entered the circle, each representing a different dissociated set of early schema patterns, each with its own related emotional distress (Edwards, 2022, p. 210).

In reviewing in detail Edwards' case of Kelly, I have seen a strong connection to the patients I work with who suffer from dissociative identity disorder (DID; see below). It's true that these patients are more disturbed than Kelly, manifesting conflicting and problematic child and adult parts/modes (sometimes called "alters") that manifest in the client's behavioral functioning in addition to just their imagination as in Kelly's case. However, I have found that these individuals with DID respond in a parallel way to Schema Therapy as did Kelly, with the therapy addressing—for both Kelly and my clients—the emotionally overwhelming experiences in early childhood that continued to contribute to current life difficulties. Below I will describe in some more detail both the nature of DID and two examples of my schema therapy with them.

Dissociative Identity Disorder (DID)

Dissociative Identity Disorder (DID) is labelled as disorder 300.14 in the DSM-5 diagnostic manual (American Psychiatric Association, 2013, pp. 292-298). DID was formally known to the public as "Multiple Personality Disorder". It was first depicted in the case of Chris Costner Sizemore (https://en.wikipedia.org/wiki/Chris_Costner_Sizemore), whose story was dramatized in the movie, *The Three Faces of Eve.* More current and sensitive portrayals include the TV show *United States of Tara* (Showtime, 2009-2011, https://en.wikipedia.org/wiki/United_States_of_Tara); the television show, *Mr. Robot* (USA Network, 2015-2019, https://en.wikipedia.org/wiki/Mr._Robot); and the documentary, *The Many Sides of Jane* (A&E TV, 2019; https://www.aetv.com/shows/many-sides-of-jane).

The primary symptoms that occur in all people with DID include sudden alterations or discontinuities in *sense of self* and *sense of agency* and recurrent *dissociative amnesias* (recurrent lapses in memory which go beyond ordinary forgetting). The discontinuity in the *sense of self* is reflected in the presence of at least two distinct dissociated identities that appear to be nonintegrated or incompletely integrated subsystems of the personality (called by names such as "alternate personalities," "alternate identities," "alters", and "modes"). Each of these exhibits a distinct pattern of experiencing, interpreting, and relating to itself, others, and the world, with at least some of these personality parts (alters, modes) able to function in daily life by assuming the tasks of "going on with life as normal" (Van der Hart, Nijenhuis, & Steele, 2005, 2006).

Discontinuity in a person's *sense of agency* occurs when different aspects of self recurrently take executive control of the individual's consciousness and functioning. This is often described as "not feeling in control of, or as if you don't 'own' your feelings, thoughts, or actions", for example, experiencing thoughts, feelings or actions that seem as if they are "not

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 18, Module 3, Article 3, pp. 272-286, 10-27-22 [copyright by author]

276

mine" or belong to someone else. The discontinuity is accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning.

These symptoms are severe enough to cause significant distress and/or impairment in important areas of functioning (family, personal, social, educational, occupational); are not a normal part of a broadly accepted cultural or religious practice; and are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., neurological disorders, complex partial seizures).

Dissociative Identity Disorder and Schema Therapy

Spring (2010) points out that:

> The essence of dissociative identity disorder is "dissociating" or "splitting off" from an experience—and then in time, splitting off from the "parts" of the self (modes) that hold those experiences—to survive otherwise unendurable trauma. It is a creative coping mechanism, not a "dysfunction." However, it becomes dysfunctional when the environment is no longer traumatic and yet the person, and all the "dissociated identities" of that person, still act and live as if it is [traumatic]. This results in the development of multiple levels of maladaptive schema and a wide system of modes (dissociated identities) which can be a challenge to repair and change.

DID modes differ from traditional modes as defined by Schema Therapy. They are three dimensional and multifaceted. The theory of the Structural Dissociation of the Personality (Van der Hart et al., 2005, 2006) proposes that in trauma the patient's personality divides among two or more dissociative subsystems, each with its own first-person perspective, rigid in their functions, and often unavailable to each other. One subsystem, the Emotional Part of the Personality (EP/Trauma part) is strongly associated with traumatic memories and is trapped in sensorimotor and highly emotionally charged reenactments of these traumatic experiences. Their actions may be guided by the innate action system of defense against threat (fight, flight, freeze, collapse, submit, attach). A second subsystem, the Apparently Normal Part of the Personality (AP) is the going on with life as normal part involved in everyday functioning (Van der Hart et al., 2006).

Modes often have different levels of knowledge about their experience. Some are aware of ("co-conscious" with) other "parts" of the personality, while others are not. This leads to gaps in memory and knowledge of experience. Modes may also hold unique memories that are not known to the other modes. Some may assume executive control of the system and function as apparently normal while avoiding their inner experience and traumatic memories. The trauma modes may remain locked in past "trauma memories," keeping those memories hidden and separate.

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
277

These modes have their own personal history, and may present as different ages, genders, identities, having different needs, memories, sensations, beliefs, and ways of coping. There is frequently an interrelationship between modes, with one mode's experiences and feelings influencing the emergence or "flip" into a separate mode. An example of this is when a child mode holding feelings of self-disgust triggers the emergence of a punitive inner critic mode spewing negative messages; this increases the child mode's feelings of self-disgust and self-criticism which then may trigger an avoidant/self-soothing coping mode that wants to detach from painful emotions through bingeing, self-harm, or suicide.

Treatment requires acceptance and treatment of all modes (parts/alters), with individualized reparenting, empathic confrontation and experiential interventions designed to access their memories and meet their specific needs. It entails engaging with those that front (have contact with the external world), connecting those modes that remain disconnected and hidden, and attuning to the different role and function of the behaviors exhibited by each. Specifically addressing the unmet needs of each child mode as Edwards demonstrated in his work can be compared to addressing the needs/function of dissociated modes in DID.

Dissociative Identity Disorder and Limited Reparenting

As mentioned above, limited reparenting within the therapeutic relationship is specifically designed to offset the negative impact of the client's maladaptive schema through providing a safe, healing, corrective emotional experience. As is typical in Schema Therapy, this requires a willingness to extend the limits of traditional therapy, albeit in a bounded way. This involves flexibility in meeting the client where she is, engaging with qualities of sturdiness and stability, caring, genuineness, and authenticity, and a tolerance of strong affect (Rafaeli, Bernstein & Young, 2011).

While not specific to working with clients with dissociative identity disorder, the importance of providing a safe environment for these individuals cannot be overstated. Especially when working with DID, however, it is essential to anticipate their hypervigilance to danger, distrust (of self and others), their lack of feelings of safety, and to remember that when working with multiple modes, it is possible to establish safety for one dissociated (child) part while other parts remain unsafe (Young et. al., 2003, p. 46). The client may wish to have greater control over their environment, over the sounds, sights in the room, the proximity of the therapist, the pacing of the treatment, for example.

Attachment injuries from family, from prior failed treatment relationships, as well as ruptures in the current relationship may need to be worked through before the client can have a "grounded experience of safety" as described by Edwards (2022). Imagery is a valuable tool to create this felt sense of safety for the client, through the development of a personal safe space, using limited reparenting within the imagery rescripting, or providing a feeling of protection through challenging antagonists. It is often difficult for these clients to imagine any place as safe,

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
        With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
278

however, and this may take time to establish and may benefit from the use of more unconventional methods. Fry (2021) provides an example of her work with *direct nurturing,* a controversial intervention that extends traditional limited reparenting and imagery. Direct nurturing is defined as the process of using physical touch to provide direct nurturance (soothing, calming, comfort, care) when a client is in a vulnerable child mode.

Stretching the limits even beyond those of limited reparenting, direct nurturing may more directly meet the needs of the child modes in the moment, providing an opportunity for coregulation and calming of the dysregulated body. It should be emphasized, however, that this intervention is not appropriate for every client. It requires a mindful and considered approach, a strong, stable, and trusting therapeutic relationship, a discussion of the limits and boundaries of this approach, informed consent, and ongoing monitoring of the client's responses.

SUSIE AND ANNA: CASES WITH DID

Susie: Employing Limited Reparenting and Direct Nurturing

An example of the powerful impact of limited reparenting and direct nurturing is illustrated in the case of Susie, a 39-year-old single Caucasian female first diagnosed with Dissociative Identity Disorder after a serious suicide attempt. She has struggled to accept the diagnosis, reflecting what is known as "phobia of her inner parts." She does not trust her different parts, nor do they trust her, so internal communication is poor, and she often loses time when in other modes. Susie presents as guarded and hypervigilant in most social interactions.

Susie grew up in a dysfunctional, multifamily environment where she was the object of severe sexual abuse for profit. The only two family members she trusted and loved died in an accident and suicide. In addition, Susie experienced an additional loss of a newborn during a tragic birth when she was a teenager. This trauma is frequently the source of unremitting flashbacks and nightmares. She expresses guilt about all these deaths, blaming herself for making poor choices that resulted in the infant's death.

While her family was the source of her early abuse, she maintains an ongoing relationship with them today, is frequently scapegoated and humiliated publicly, and continues to be the victim of unpredictable, vicious sexual assault. She submits to this for many reasons, including distrust of the legal system, the belief that she does not deserve more, and the need to protect others from her perpetrator. This too is the trigger for unremitting flashbacks, nightmares, and intrusive memories.

Therapy has focused on meeting unmet needs through the therapeutic relationship, increasing trust in herself and her internal system, increasing her safety within the therapy room, and when possible, in the external world. This has been made more difficult due to the ongoing, unpredictable abuse she falls victim to, and to her extreme caution engaging with others and her reluctance to experience/show any vulnerability.

One of Susie's major complaints has been her struggle containing flashbacks and intrusive memories of her abuse and particularly, the death of her infant. We hypothesized that the flashbacks were communications from parts of internal system that wanted her to "know" this experience. As she began to process memories of the birth through imagery, Susie was better able to see the fear and helplessness of the 15-year-old self who birthed a child alone during a four-day complicated labor, without support from any adults. Although the seeds of compassion were sown for the first time, self-blame and self-loathing (of the 15-year-old self) generated by a critical and punitive mode interfered with her ability to truly "know" this traumatic memory to grieve the loss effectively.

Recently, Susie witnessed the birth and death of another newborn infant. This experience triggered a major dissociative episode with unrelenting flashbacks to her own infant's birth/death. She remained stuck in the 15-year-old mode as she relived the birth and death of her own child. She was incoherent and unable to communicate when meeting with me. The usual grounding, containment, and stabilization efforts were ineffective. It was clear that Susie was lost in a never-ending loop of fear, despair, and helplessness.

Intuitively, I decided to use direct nurturing/limited reparenting to meet the needs of the grieving child in the moment. Asking her permission, I moved to sit alongside her (the 15-year-old child), simply communicating that she was not alone and that I was there to hold her sorrow and pain with her. I offered her one end of a felt strip to enhance the physical connection between us (she held one end while I held the other end) (Farrell and Shaw, 2014). We sat this way for a while, and then she gave permission to hold her hand as well. I softly repeated the message that she was not alone. Relying less on words, I slowly attuned my movements to hers, repeating minimally only what she verbalized (e.g., "It wasn't fair," "I was so frightened," "I was so alone"). As we sat there, tears began to roll down her face for the first time since I have known her, and 15 year old Susie began to speak of her experience, of the hopes and dreams she had placed in this child, of the beauty of the newborn infant, the depths of despair she felt when she awoke and found the child had died, her futile attempts to revive the infant, and her final action of leaving the body to be found outside a hospital door. The physical connection of direct nurturing allowed a faster route to accessing implicit memory and provided the corrective emotional experience that allowed Susie to know, and most importantly, feel that she was not alone.

Two days later, the dissociative loop had stopped, and Susie was able to remain present and engaged during our session. She reported that she had been crying since our last session, but no longer had flashbacks. However, understandably, progress has been slow. During a later session, though she still had not fully processed what had happened, she struggled to find words to describe the impact of the experience. She acknowledged that it had been "profound," and yet she, Susie, expressed great shame about having allowed such vulnerability. As she put it "I don't do touch and I don't cry".

Anna: Affect Regulation, Working With the
Internal System, and Use of a "Circle of Support"

Imagery and mode dialogues (chair work) are also effective interventions both for affect regulation and for increasing communication, cohesiveness, collaboration, and co-consciousness in the internal system (the 4 C's of working with DID; Lemke, 2007). They are used both to identify and address the individual needs of specific modes, and to increase the client's ability to regulate a dysregulated system. The case of Anna illustrates the use of these strategies.

Anna is a 57-year-old, married, Caucasian female, mother of three young adult males. She is a college graduate but is currently unemployed and homebound due to multiple debilitating illnesses and surgeries, including cancer, major gynecological problems, and severe back pain that have limited her mobility and independence.

Abuse and neglect, alcoholism, aggression, and violence defined her early life. School provided the only respite for her. Trauma history includes long-term verbal, emotional, and sexual abuse and neglect by family members beginning at age three, lasting until she left home for college. Core memories include these themes of abuse and neglect, for example when left repeatedly with an abusive relative or with violent siblings, or when left alone from an early age. Her current family environment is also invalidating, and emotionally abusive.

Anna was first diagnosed with dissociative identity disorder in 2003, after multiple hospitalizations. She has also been diagnosed with Major Depression, PTSD, and Eating Disorder NOS. She has a history of past suicide attempts and non-suicidal self-injury but has not been hospitalized for over 10 years.

Anna has a chaotic and fragmented sense of self, with frequent episodes of dissociation. She has identified distinct "parts" (modes/alters) with their own personalities, needs, and functions--some female, some male. These parts can be characterized by the different mode categories as described by Edwards (2022).

When Anna was six, she witnessed a violent beating of her brother by her father. Two adolescent modes evolved from this experience. One is classified as an angry child mode, **The Fighter**. This adolescent part evolved to protect younger parts witnessing aggression in the home and can also be considered a "coping part who shuts down the vulnerability of the child to protect her from the disappointment and betrayal she would experience if she did reach out" (Edwards, p. 247). A second adolescent mode, **Sensitive One**, displays vulnerability in holding the feelings of sadness, hopelessness, hurt, and pain experienced by younger child modes. He is frequently suicidal, expressing the desire to escape the burden he carries.

Multiple child modes hold the memories of the early trauma and neglect. These modes tend to be frightened, needy, lonely, and distrustful. One child mode, the 10-year-old **Abused**

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 18, Module 3, Article 3, pp. 272-286, 10-27-22 [copyright by author]

281

Child, holds the memories of the worst abuse, as well as the strongest attachment to her father. This mode embodies her own coping mode, **Overcontroller**, as she imposes rigid rules around hygiene and eating. She restricted eating in an attempt prevent developing into a woman's body, after her father declared that all women are whores. An 8-year-old child mode, **Schoolgirl,** evolved as a going-on-with-life-as-normal child mode who was playful and successful in school, coping by pleasing others and being the "good girl."

Finally, two adult modes evolved as introjects of her parents, the **Father** mode, JJ, as critical and judgmental, and the **Mother** mode, L, as angry and rejecting.

Anna has only recently challenged the "conditions of worth" imposed by these modes (Rogers, 1959, p. 209, as cited in Edwards, 2022) as she acknowledged and expressed the feelings of hurt, anger, and betrayal she has harbored toward her parents. Therapy has focused on meeting Anna's unmet needs of acceptance and unconditionality of all modes to counteract the conditions of worth. Therapy has involved increasing co-consciousness, cooperation, and collaboration and cohesiveness within Anna's internal world. This has necessitated working independently with many of her different modes while increasing Anna's ability to tolerate the distress and regulate the emotions generated by the different modes. Empathic confrontation has challenged the rule bound, rigid, and ineffective behaviors imposed by these conditions.

Anna describes her different modes in this way:

> I think about all parts of me and how they can all come together more but not losing their qualities, like L's assertiveness, not her aggression, or F's anger, not the rage, or S's sensitivity, not the suicidality, JJ's help, not the criticism and obstacles he presents, SU's sensuality, P's faith, RO's reason, AO's concerns about her health, and the innocence and playfulness of the young parts.

> Some are afraid they will have to go away. WE keep telling them they don't have to but can come out at times when it is safe, when they can be happy, and playful, and not have to hold memories. WE tell them they are only memories, and the bad people aren't here anymore. WE tell them we will protect them. But, they still want a mommy and daddy, and we don't feel we can give them what they need.

> Most people have trouble remembering what it is like to be a kid and get so caught up in daily life of being a parent, a spouse, a worker. WE have other problems; we see the world from children's eyes.

Limited reparenting, empathic confrontation, imagery, and chair dialogues were core elements of therapy with Anna. These strategies and techniques were used (a) to provide the corrective emotional experience that allowed transformation of the trauma narrative; (b) to facilitate affect regulation, grounding, and containment of flashbacks and intrusive memories; (c)

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
        With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 18, Module 3, Article 3, pp. 272-286, 10-27-22 [copyright by author]

282

to increase internal communication and cooperation among the modes; (d) to address the needs of specific modes; and (e) to rescript trauma memories.

Anna has difficulty regulating her emotions and tolerating distress, with intense feelings of depression (what she calls "the pit"); anxiety; shame; and guilt—all leading to a high level of self-invalidation and self-blame. Loneliness was often a trigger, stirring memories of early neglect, isolation, and helplessness. Self and environmental invalidation frequently led to downward spirals into emotionally dysregulated modes, with sharp escalation of anxiety, panic, self-loathing, agitation (hyperarousal); and then swings into a state of blunted emotions and dissociation, and collapse (hypoarousal). In these behaviors we see the pattern of interaction between modes, with the child modes experiencing the anxiety, shame, and guilt leading to negative messaging from the inner critic mode, which then leads to a downward spiral of dissociation and maladaptive coping responses.

Anna described how loneliness often triggered a downward spiral of hopelessness and despair as different child and critical modes were activated:

> When we are in the dark pit of gloom, there does not seem to be any light or any way out. There is only us. We go deeper, frantic to find something to help, waiting, praying. Why did they not love us? What did we do wrong? Why didn't they just give me away? Our whole life we tried so desperately to be love. We are just hopeless—for whatever reason—afraid, unmotivated, do not want responsibility, want to be taken care of, feeling alone. The emotions are too strong, memories too dangerous, self-hatred even worse.

The pain experienced in these modes then activated Anna's avoidant and/or surrender modes leading to thoughts of self-harm or suicide to escape the pain:

> My body is so shaky and nervous. I cannot shut down my brain, nor the noise in my head. I just want to run away; I want to die. I cannot take the feelings I am having, not just emotional, physical. The body memories took over last night, we could not shake them. Today we are filled with fear. What is happening? What do we need? Crawling out of my skin, needing to cut to feel real. Maybe some release. Cannot concentrate or feel any peace. Anxiety is too much, cannot calm down enough. The urge to just end it is so strong right now. Thinking about what happened to me when I was younger causes much turmoil. I just want it to stop.

> The little ones are trapped and breath softly. The body feels horrible. The panic, the fear, the body sensations. Memories come flashing back.   We keep saying it is not happening now, but we want to scream get us out. Instead, must use our tools—breathing, self-hypnosis, imagery—to help contain these intrusive images and thoughts.

Imaginal techniques provided resourcing that allowed Anna to regulate her internal system. Connecting memories with emotions was facilitated when Anna was within her window of tolerance (the zone of optimal arousal, neither hyperaroused nor hypoaroused; Ogden, Minton,

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 18, Module 3, Article 3, pp. 272-286, 10-27-22 [copyright by author]

283

& Pain et al., 2006; Siegel, 2012). Through imagery, Anna was able to develop a resource to contain intrusive memories, thoughts, images, and feelings put forth by different modes until she was safely able to unpack them:

> Put it in a box and watch it flow through the galaxy and into Jesus's hands. Breathe 10, 9, 8, 7 slowly counting backwards Relax. Turn it over to Jesus. He will keep you safe. Slowly breath in and out 6,5,4, Watch all the tension flow to Jesus. His hands are open reaching out to take it off your shoulders, breath. 3,2 Now there will be calmness because you watch it float away in Jesus's hands. Remember to breathe and when it feels so overwhelming, close your eyes and turn it over to Jesus. Breath. 1,0.

Safe place imagery is another resource designed to help clients work with frightening memories and high emotional arousal. Edwards (2022 p. 247) reminds us of two important features of this type of imagery, the interpersonal nature of that safety and the need to establish safety for all dissociated child parts.

In Anna's preferred safe place image, she imagines herself walking down a long path into a wide-open grassy field with a big shade tree. All child modes were able to find some respite and peace in this image. For example, the mode burdened with sadness and hopelessness "laid down his load" and went to sleep under the shade tree; the youngest parts played duck, duck goose in the field; the angry adolescent mode was able to be a child as he expended his built-up energy and rage in a game of football. When first learning to use this image, Anna included me in the game of duck, duck goose; she later replaced my figure with those of her own "adult" modes. Anna repeatedly used this imagery to help calm and regulate her system when she was outside her window of tolerance.

We used a Circle of Support image similar to Kelly's Circle of Healing to counteract memories of early neglect, loneliness, and isolation. This intervention helped create a corrective experience for Anna as she surrounded herself with many of the caring, supportive, stable figures in her life (real or imagined).

> We feel like a lost child who is just looking for love and direction. For nurturance, reassurance, and love. That is too much to ask because no one can give it to us. WE just want to be loved and told it will be okay. WE just want a hug when we are in a bad place or sad. We yearn for a mother that can give us unconditional love. WE imagine someone hugging us and holding on for dear life. When we are in the dark pit of gloom, there does not seem to be any light or any way out. There is only us. We go deeper, frantic to find something to help, waiting, praying. Then a glimmer goes through, and we realize we are not alone. All we must do is call out. Someone will hear. Just let someone know the pit is too much to bear. The pit will stay dark only if we don't reach out.

Imagining a Circle of Support can provide a sense of inner safety, stability, and calm when there may not be a lot of trusting and non-judgmental people available at the moment. An

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
   With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin

effective Circle of Support can include people you trust and feel supported by, imaginary people, spiritual figures, beloved pets, a wiser self.

> Visualizing ourselves as encircled by real or imaginary friends who "have our back" can greatly enhance our ease and resilience as we face an unknown or frightening situation (Graham, 2013).

The powerful effect of imagination and visualization creates new pathways for healing.

Anna was asked to imagine herself in the center of a circle and to think of a specific situation for which she would like support. She was then asked to identify several people or things she would like to have by her side in this situation, and to imagine them fully present, fully supportive, providing the message that she is not alone. After each addition, she was asked who/what else might be helpful to extend the sense of inner calm. Once the circle was created, she was asked to remember the feelings and to repeatedly practice imagining the circle that elicited this sense of inner calm until it becomes a resource that she could call on any time she needed it (Daitch, 2007; Graham, 2013).

Fraser's Dissociative Table Technique (Fraser, 2003) is another example of working with DID clients by accepting the existence of the different modes and working with them—e.g., by diagramming them—through combining the use of mode dialogues within imagery with DID clients.

> The Dissociative Table helps stabilize the client by organizing and making sense of their internal experience. It allows them to access and identify the internal parts of the personality, to help them understand the roles, functions, interrelationships, and serves as a forum to communicate and work with the parts throughout treatment. This helps…them gain more understanding and compassion for these mode states (Martin, 2012).

The client's ability to use their imagination is central to the success of the intervention. The client is asked to invite all the various aspects or parts of themselves to come into the room/meeting place they have imagined. Clinical information can be gathered on names, functions, ages, alliances, and phobias among and between the modes, degree of time orientation and coconsciousness among the parts. Different parts may appear or stay in the background, but all are welcomed. Issues arising within the internal system can be addressed between modes through this meeting like format.   It can also be used to identify additional modes to be included in an experiential scene such as the Circle of Support. When this technique was first used with the previously mentioned client, Susie, only two other parts, identified as gatekeeper parts, were willing to participate. While not uncommon, this resistance perhaps reflects her phobia of her parts, their distrust of her and of the therapist.

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 18, Module 3, Article 3, pp. 272-286, 10-27-22 [copyright by author]

285

SUMMARY

Edwards' narrative of Kelly's therapy demonstrates how "problematic, embedded meanings are corrected and fundamentally changed" (Edwards, 2022, p. 249). Illustrating strategies central to Schema Therapy, particularly rescripting and limited reparenting, he offers an example of how we can facilitate the healing of past wounds. This commentary has explored how the Schema Therapy principles and processes of Schema Therapy as illustrated and concretized by Edwards in the case of Kelly have been helpful to me in my work with patients with   Dissociative Identity Disorder. This is a population struggling to make sense of their early traumatic and fragmenting experiences so they too can heal their problematic memories.

RFEFERENCES

Alexander, F. G., & French, T. M. (1946). *Psychoanalytic therapy: Principles and applications*. Ronald.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders, fifth edition.* American Psychiatric Association.

Daitch, C. (2007). *Affect Regulation Toolbox: Practical and effective hypnotic interventions for the overreactive client.* W.W. Norton and Company.

Edwards, D.J.A. (2022). Kelly's circle of safety and healing: An extended schema therapy narrative and interpretative investigation. *Pragmatic Case Studies in Psychotherapy*, 18(3), Article 1, 210-261. Available: https://pcsp.nationalregister.org/

Farrell, J.M., & Shaw, I.A. (2014). *The schema therapy clinician's guide: A complete resource for building and delivering individual, group and integrated schema mode treatment programs.* Wiley-Blackwell.

Fraser, G.A. (2003). Fraser's "Dissociative Table Technique" revisited, revised: A strategy for working with ego states in dissociative disorders and ego-state therapy. *Journal of Trauma and Dissociation, 4*(4), 5–28.

Fry, M. (2021, April/May, Brisbane, Australia). Direct nurturing. In J. Margolin, R. Spiro, & M. Fry, *Advanced techniques for working with complex trauma and dissociative identity disorder.* Webinar, recording available from the author: megan@mfry.com.au. Also see the web site: https://mfry.com.au.

Graham, L. (2013). *Bouncing back: Rewiring your brain for maximum resilience and well-being.* New World Library.

Lee, C.W., & Boterhoven de Haan, K. (2020). Working with trauma memories and complex post-traumatic stress disorder. In G. Heath & H. Startup (Eds.). *Creative methods in schema therapy: Advances and innovation in clinical practice.* Routledge.

Lemke, W. (2007). Fostering internal cooperation through the use of imagery in the treatment of dissociative identity disorder. *Journal of Trauma and Dissociation 8*(4), 53-68.

Applying the Schema Therapy Approach of Edwards' Case of Kelly to Patients
    With Dissociative Identity Disorder (DID): The Cases of Susie and Anna
J. Margolin
286

Martin, K.M. (2012). How to use Fraser's Dissociative Table Technique to access and work with emotional parts of the personality. *Journal of EMDR Practice and Research, 6* (4), 179-186.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. W. W. Norton and Company.

Rafaeli, E., Bernstein, D. & Young, J. (2011) *Schema Therapy: Distinctive features*. Routledge.

Rogers, C. R. (Ed.). (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.) *Psychology: A study of a science, Formulations of the person and the social context. Vol. 3* (pp. 184-256). McGraw-Hill.

Siegel, D.J. (2012). *The developing mind: How relationships and the brain interact to shape who we are, 2nd edition.* Guilford Press.

Spring, C. (2010). A brief guide to working with dissociative identity disorder. https://www.carolynspring.com/blog/a-brief-guide-to-working-with-dissociative-identity-disorder/

Stein, D., & Young, J. E. (1997). Rethinking repression. In D. Stein (Ed.), *Cognitive science and the unconscious* (pp. 147-175). American Psychiatric Press.

Van der Hart, O., Nijenhuis, E., & Steele, K. (2005). Dissociation: An insufficiently recognized major feature of complex PTSD. *Journal of Traumatic Stress, 18* (5), 413-424.

Van der Hart, O., Nijenhuis, E., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization.* W.W. Norton and Company.

Winnicott, D. (1954 / 2016). Withdrawal and regression. In L. Caldwell, & H. Robinson (Eds.), *The Collected Works of D. W. Winnicott: Volume 4, 1952-1955* (pp. 283-289). Oxford University Press. https://doi.org/10.1093/med:psych/9780190271367.003.0063

Young, J. E., Klosko, J., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford.