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Research Paper

Managing Dissociative Disorder with Cognitive Behaviour Therapy: A Case Study

Gavneet Kaur Pruthi[1]*

ABSTRACT

The presentation of dissociative symptoms is not uncommon in clinical settings, particularly when the client has suffered trauma. The phenomenon of dissociation ranges from benign incidents, such as daydreaming, to potentially life-threatening experiences when it precipitates self-harm. Its presentation may be subtle, belying the distress which it can provoke. Cognitive therapists are well equipped to help clients formulate a working conceptualization of the dissociative episode and to develop a range of coping skills to manage and overcome the experience. This paper discusses practical ways in which the cognitive therapists use standard cognitive behaviour therapy to help clients to better deal with the distressing aspects of dissociation.

Keywords: *Dissociative disorder, cognitive behaviour therapy*

Dissociative disorders are characterized by an involuntary escape from reality characterized by a disconnection between thoughts, identity, consciousness, and memory. According to the text revision of the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000), 'the essential feature of the dissociative disorders is the disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic. In India, possession syndrome or hysterical possession is the most common form of dissociative disorder. Prevalence of possession trance in India has been estimated to range from 1 to 4 percent of the general population (Sadock & Sadock, 2005).

People from all age groups and racial, ethnic and socioeconomic backgrounds can experience a dissociative disorder. Different psychotherapies are used to treat dissociative episodes to decrease symptom frequency and improve coping strategies for the experience of dissociation. Some of the more common therapies include cognitive behaviour therapy. (CBT) helps change the negative thinking and behavior associated with depression. The goal

[1] (Clinical Psychologist, New Delhi, India)
*Responding Author

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of this therapy is to recognize negative thoughts and to teach coping strategies. Cognitive behaviour therapy approaches to dissociative patients (DD) are well known, (Andreason & Seidel, 1991; Caddy, 1985: Ross, 1989; Fine 1991a). The goals of treatment for dissociative disorders are to help the patient safely recall and process painful memories, develop coping skills, and, in the case of dissociative identity disorder, to integrate the different identities into one functional person. It is important to note that there is no drug that deals directly with treating dissociation itself.

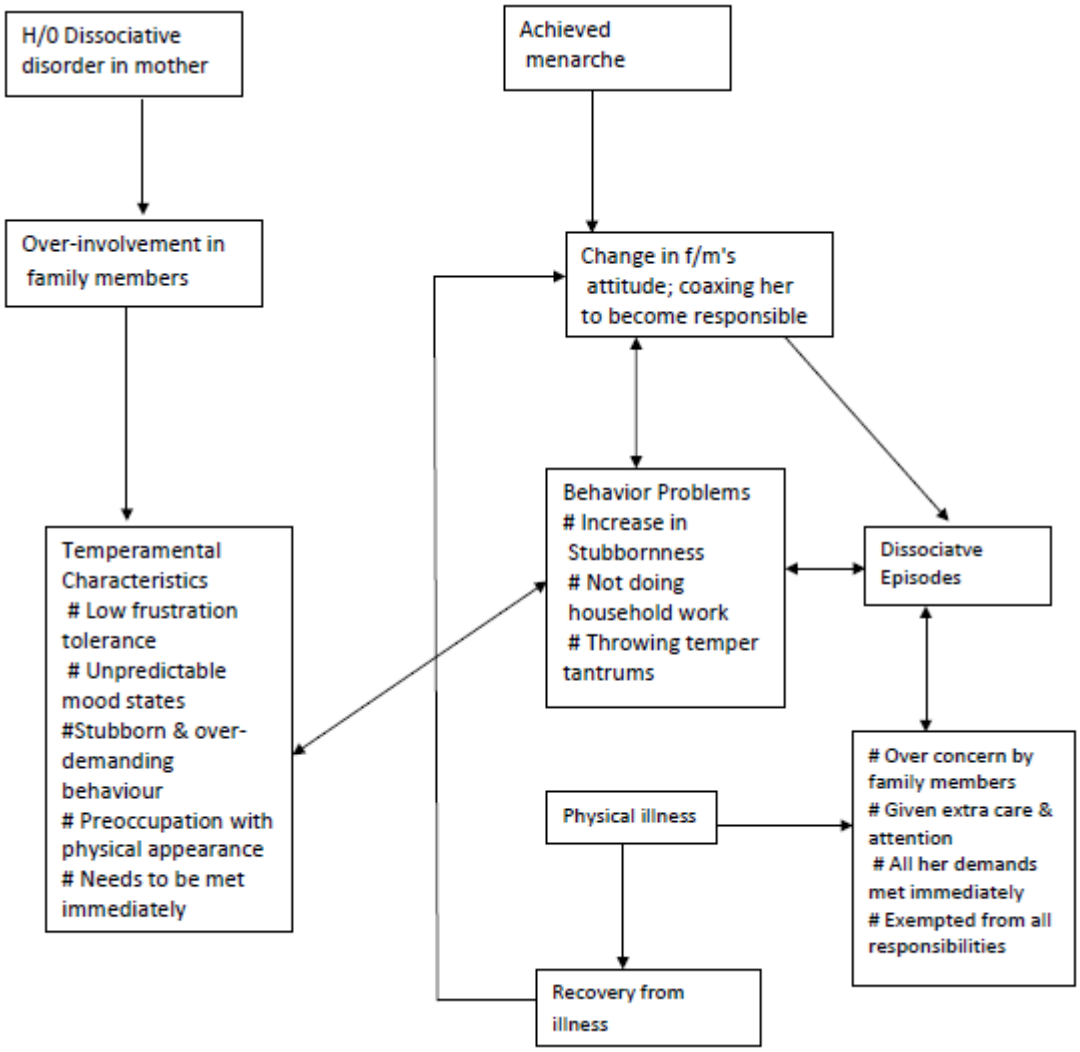
CASE SUMMARY

Patient X, the 14 year old girl from lower socioeconomic status, presented to our clinic with complaints of episodes of unconsciousness, increased stubbornness, not going to school, not doing anything at home and keeps watching television, since last 2years. The child was apparently alright till about two years back when she had high-grade fever for one week and was completely bed ridden. After a week, fever came down and would come only at night. Due to this, she became irregular in going to school. This continued and after a month, she started complaining of stomach-ache and headache. This would also be followed by episodes of muscle contraction, her teeth would clench and she would say, '*ab to main bachoogi nahin*'. And then she would lose consciousness. She was taken to a private psychiatrist where treatment was taken for a year and there was a decrease in the frequency of the episodes. Again she had high-grade fever and had to be hospitalized for 4-5 days. After her fever remitted, she was brought back home. After a few days, her father scolded her badly for not going to school and she started complaining of following symptoms: fearfulness of people, making sounds like, '*ee aa'*. She would cover her face with cloth and abuse people around her and then she would lose awareness of the surroundings. She was, then brought again to our clinic and was started on medicataions. Some improvement was noticed initially but then she again started having episodes characterized by making sounds, abusing family members and saying, '*mere sir mein kuch ho raha hai'*. She would then have loss of consciousness and would regain it after a couple of hours. These episodes led to increased attention from family members. She would not be asked to do any work and all her demands were met and she was also not sent to school. This paper presents a case report of CBT with an adolescent girl diagnosed with the dissociative disorder with behaviour problems.

MEASURES

Assessment of the child was done with the help of MISIC, to assess the intellectual functioning of the child. The test findings revealed an IQ of 90, which puts the child in the category of average intelligence. From the case history and other relevant information collected during the initial phase, a psychopathological formulation was prepared, which have been presented here.

PSYCHOPATHOLOGICAL FORMULATION



Reason for referral

The child was referred from psychiatrist clinic to our private clinic for psychotherapeutic intervention aimed at treating her dissociative episodes and behaviour modification in light of behaviour problems.

Diagnosis- Dissociative disorder with behaviour problems

INTERVENTION

Initially, the sessions were taken once in fifteen days, then the time duration was increased to once in one month as the child came from a far away place and reported difficulty in coming.

Therapy process

The therapy process has been divided into three phases- initial, middle and termination phase and has been prescribed below:-

Initial phase

First and foremost, in the initial phase, the focus was to establish rapport with the child, psycho-educate a child and her accompanying father, clarify goals of therapy, and socialize them to CBT. The collaboration of child and her father was emphasized to ensure the success of therapy. History taking was done and information from the child as well as the father was corroborated and incorporated. An IQ assessment was also planned and completed, and MISIC was used for the same. The test findings revealed an IQ of 90, which puts the child in the category of average intelligence.

Middle Phase

This phase primarily consisted of therapeutic interventions. Our mode of therapy was Cognitive Behaviour therapy. Techniques employed were:

Psychoeducation
Self-monitoring
Setting goals
Distraction and refocusing
Breathing excercises
Addressing unhelpful thoughts
Problem-solving
Differential reinforcement
Addressing avoidance

Psychoeducation

Client and family were given psychoeducation about the cognitive behavioural model of dissociative seizure which suggests that:

a) the seizure onset is attributable to single or multiple events in the client's recent or distal past,
b) that once triggered, seizures are maintained by a combination of behavioural, cognitive, affective, physiological and social factors (including social reinforcement from well-intentioned others),
c) that a primary response to seizures is fear and anxiety, leading to a cycle of increasing avoidance and reduction in daily functioning which perpetuates both the seizures and associated disability.

Self-monitoring

The child was told the importance and potential benefits of maintaining self- monitoring diaries for eg:- seizure diary, which tracks the frequency, duration, type and location of seizures, the situations in which they occur and the consequences of the seizure. Also, graded exposure diary, which tracks exposure to previously avoided activities/situations, thought diary, which helps to identify and to challenge unhelpful/negative thoughts, and monitor progress and identify areas of the difficulty of concern.

Setting goals

Short term goals were identified, that the child and family would like to achieve (particularly in relation to situations that they have been avoiding), and these goals were set that were realistic and achievable, including enjoyable activities as well as those which are currently anxiety- provoking. In this case, this goal was restarting school of the child. The child was helped to restart her school, and spend time with her friends.

Distraction and refocusing

Child was taught distraction and refocusing when she experiences seizure warning and practice distraction and refocusing techniques, that she finds most effective e.g., focussing on the environment and concentrating on specific details of objects around them, rather than focussing on internal stimuli, undertake an absorbing physical activity and absorbing mental activity (as counting backwards from 100, doing a crossword or word puzzle).

Relaxation and breathing techniques

The rationale for using relaxation was discussed with the child, i.e., (to help reduce stress and tension and to help prevent a seizure). Further applied relaxation was taught to the child and ways to implement applied relaxation when she experiences a seizure warning and when in high risk for seizure situations. Breathing exercises were also taught, by describing how the vicious cycle created when stress leads to hyperventilation and then to anxiety symptoms, and the way in which this cycle can be broken by learning to control breathing. She was taught how to control her breathing by first relaxing and then employing slow diaphragmatic breathing.

Addressing unhelpful thoughts

Unhelpful negative thinking styles were discussed with the child and her father, and common thinking errors were identified and she was helped to challenge negative thoughts that were relevant to the maintainance of her symptoms.

Problem-solving

Problem-solving techniques were used to identify ways in which stressful situations could be managed more effectively, by the child and family i.e., the family should not talk about her attack in front of her, they should not pay extra attention to her dissociative attacks.

Differential reinforcement

Child's father was explained the technique of differential reinforcement, so that he can use whenever child displays behaviour problems, i.e., to reinforce positive behaviours by rewards and to negatively reinforce her negative behaviours by punishment or taking away rewards.

Addressing avoidance (graded exposure)

The rationale for graded exposure was explained to the child and family i.e., repeated exposure to a hierarchy of feared situations enables clients to tolerate anxiety and she was

helped to identify areas of current avoidance and to specify when they will undertake exposure, for how long and how often.

Termination Phase

This phase consisted of two sessions. In this phase progress was reviewed with the child, identifying areas of change as well as any areas which remain problematic. Then further child was helped to identify the strategies she can use to identify gains (in order to support her capacity to make a further change after the intervention has ended) and ways were discussed which she can use during the intervention in order to cope with any setbacks. Then further child was confident about restarting school. A behavioural contract between father and child was developed, promoting differential reinforcement of problem behaviours and to follow them consistently.

DISCUSSION

Dissociative states are common and accepted the expression of cultural activities and religious experiences in many societies. In India, possession syndrome or hysterical possession is the most common form of dissociative disorder. Prevalence of possession trance in India has been estimated to range from 1 to 4 percent of the general population (Sadock & Sadock, 2005). The present case report was designed to assess the efficacy of CBT in improving dissociative symptoms and daily functioning related to dissociative disorder in an adolescence girl. After 10 sessions of CBT child's dissociative episodes decreased significantly. The child started going to school and there was an increased initiative in doing household work, along with a decrease in child's stubbornness.

Therefore combining CBT with medication is optimal treatment for dissociative disorders as with other symptoms of dissociation. These results are supported by the study done by (Bethany, 2009) of review of dissociative disorders examined empirical reports of treatment for dissociative disorders (DD), including 16 DD treatment outcomes studies and 4 case studies that used standardized measures. Collectively, these reports suggest that treatment for DD is associated with decreased symptoms of dissociation, depression, posttraumatic stress disorder, distress, and suicidality. Effect sizes based on pre/post measures are in the medium to large range across studies. Patients with a dissociative disorder who integrated their dissociative self-states were found to have reduced symptomatology compared with those who did not integrate. This particular case was challenging because the child was an adolescent girl with a background of trance and possession disorder. It was somewhat difficult to treat this child because there is not a well-established therapy for trance and possession disorder. Though psychoeducation and family counseling helped in modifying the perception of child and family members regarding trance and possession disorder and ensured better care from family members. Activity scheduling made her active and busy and she also started going to school. This decreased the frequency of her episodes and helped to improve her confidence in coping with dissociative episodes.

Findings of the present case report suggest that cognitive behaviour therapy has a significant remedial role in improving symptoms of dissociative disorder which further facilitates the improvement in daily functioning.

CONCLUSION

The case illustrated here indicates that psychotherapeutic interventions (Cognitive Behaviour therapy) are effective and highly indicated in dissociative disorders.

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Conflict of Interest

There is no conflict of interest.

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