The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 12, Issue 2, April- June, 2024
DIP: 18.01.287.20241202, DOI: 10.25215/1202.287
https://www.ijip.in

Research Paper

Third Wave Therapies for An Adolescent with Depression and Dissociative Coping Styles

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ABSTRACT

Depression is a common mood disorder which negatively affects activities of daily living in patients due to low mood. Many association studies have found depressive disorder to be highly prevalent in women than men. Brooding tendencies over past failure are significant among adolescent girls increasing the risk of depression. Similarly, familial discord and violence are antecedents for onset of adolescent depression. This case study illustrates a psychotherapeutic intervention using, cognitive behavior therapy and dialectical behavior therapy for an adolescent female to address clinical picture of depression. Although she has history of adverse childhood experiences such as corporal punishments and domestic violence, the client wanted to focus on present problems. This case discusses the clinical judgement and decision making to explore the clinical features of adolescent depression in a systematic approach using a single case discussion. The case study highlights complex presentations of clinical cases, assessment findings and importance of clinician decision making with third wave therapies for addressing complex clinical cases.

Keywords: *Depression, Cognitive Behavior Therapy, Panic, Dissociation, Self-Harm*

Depression is a significant contributor to global disease burden and reported as a leading cause of disability by World Health Organization (Grover, Raju, Sharma & Shah, 2019). Depression is prevalent across different age groups. Findings of The National Mental Health Survey for 2015-16 concluded a prevalence of 0.8% for childhood depression (11-17 years) in India (Raja, Singh, Chail & Dangi, 2020).

Depression is a well-studied mental illness in adult population, however less attention is given to adolescent depression. There is a lack of awareness about significant bio-psycho-social causes that contribute to childhood and adolescent depression. Research findings report 1 in 20 adolescents experience at least one major depressive disorder episode in their lifetime (Devgun, Kaur & Singh, 2017). Depression in adolescents is associated with poor scholastic performance, drug use, delinquency, panic and phobic behavior, eating disorder and increased risk taking behaviors (Raja, Singh, Chail & Dangi, 2020). Early psychological concerns are probably increase the risks and may impact quality of life in adulthood. Onset of early childhood depression is associated with conflicts between parents and troubled

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Received: March 17, 2024; Revision Received: June 06, 2024; Accepted: June 10, 2024

parent-child interpersonal relationship. These also contribute to chronic depressive episode in adolescents (Malhotra & Sahoo, 2018).

School based sample found clinical depression prevalent in the age group of 14 – 16 years without gender difference in urban adolescents belonging from Pune (Raja, Singh, Chail & Dangi, 2020). According to Jha et al. (2017) female school goers were found to be depressed compared with male students in Bihar. Clinical features included pessimism, past failure and guilt related feelings.

In the management of depression, cognitive behavior therapy (CBT) is widely used. CBT is a time-limited and outcome oriented approach. Cognitive behavior therapy helps to identify cognitive distortions, increase self-awareness of patient towards automatic thought patterns and provides alternate ways of coping. Researchers Sondhi, Gulgulia and Shriharsh (2013) assessed the efficacy of CBT along with family therapy and interpersonal therapy for an Indian adolescent with moderate depression. They found CBT to be effective in treatment. Recent research from the Indian context explores that dissociative coping mechanisms are often adopted by the clients wherein socio-occupational functioning is impacted (Hussain, 2023). For this reason, psychotherapeutic modalities such as trauma focused cognitive behavior therapies may be utilized to enhance the coping skills of the clients (Hussain, 2023).

Clinical decision making is a crucial skill, often spoken less about. When a client is referred from one clinician to another or any information is presented regarding a client, we begin to formulate hypotheses in our mind. As psychotherapists, we make efforts to place and position the clients before we interact with them and in that case, we fall into the anchoring bias. However, questioning and being curious about the client will often lead to appreciating uniqueness each client brings in the therapy space. Thus, what Kahneman (2011) referred to as representative heuristic mentioned by Magnavita, (2016).

CASE INTRODUCTION

Patient Characteristics

At the time of the treatment, Ms. A was a 17-year-old Hindu female. She comes from a middle socio-income group who lives with her parents and an elder sister. Ms. A just completed twelfth standard and was appearing for her college entrance examinations. Ms. A was self-referred. She visited the clinic accompanied with her elder sister.

Socio-cultural context

The client belongs to an Indian family system wherein, there is increased socio-cultural variability. The family system functions on hierarchical pedagogy in most parts of India and collectivistic, inter-dependent approach in the family unit is noticed. The governance of Indian families is heavily relied upon compromise versus autonomy (Yadava, Awasthi & Pandey, 2017). In the recent years, there has been a transition from a traditional joint family to a nuclear family setting wherein, studies have concluded has given rise to presentations of mental disorders (Yadava, Awasthi & Pandey, 2017). The dysfunctionality patterns in a family are likely to increase the risk of problem behaviors in future generations. As recorded by Wells and Joseph (1991), marital discord in parents increases likelihood of problem behavior in children.

Family psychotherapy in India is going through many challenges due to the factors such as stigma against mental illnesses and manifestations of symptoms as a cultural representation.

Therefore, psychotherapists require to be well-trained and informed about cultural practices to prevent misdiagnosing or viewing pathology in a culturally sanctioned presentation. In India, dissociative identity disorders are less common compared with other countries (Subramanyam, Somaiya, Shankar, Nasirabadi, Shah, Paul & Ghildiyal, 2020) and dissociative symptoms can present themselves as long term trauma related concerns.

Presenting complaints

With respect to depression, client's chief complaints were persistent sadness, feelings of loneliness, social withdrawal from activities, fatigue, insomnia, worrying thoughts, difficulty concentrating, deliberate self-harm and low self-concept. She often expressed, "*my brain is bullying me with thoughts and I just space out".* The onset of present illness is insidious that is, symptom presentation was noted from November 2020. This was a period of COVID19 pandemic which impacted her social activities. The feelings of sadness and difficulty to concentrate significantly impacted her academic work. The course was continuous and progress was deteriorating.

Client History

Ms. A has two years' history of experiencing racing heartbeat, shortness of breath, numbness (paraesthesia) in face and arms, disconnected from her physical setting and intense crying spells. Ms. A recalled, experiencing excessive thoughts with regard to her upcoming grade tenth examinations which marks the first episode of panic. She also complained of headaches at that time. She describes being disengaged from her family and friends during that period. She reflected, *"I feel spaced out and disconnected from my surroundings".* She reported that during this period she is able to hold conversations but does not have recollection of it later. Ms. A had reported an incident of not able to connect with her body. She had described using a lit match stick to feel the heat on her body to feel better.

At that time, client had received psychological support upon her father's insistence. She was also taken to a general physician by her father. She participated in group therapy sessions as reported. However, the objectives of these group therapy sessions have remained unknown. The client discontinued after two sessions, as she did not find comfort in a group setting.

The client reported experiences of adverse childhood instances while growing up such as witnessing verbal and physical fights between her parents. As an infant, Ms. A reported frequent shifting from one city to another within India and abroad to Dubai. The stays were of small number from months to years. This was for her father's job and more than often her father would not be available to stay with the family. Her parents used corporal punishments at home for Ms. A and her elder sister. Her mother would often use inappropriate words towards her and struggles to regulate her emotions when things are not followed as per her needs. Ms. A seeks support from her father, however, describes him as cold and detached. She reported, she often supresses her emotions as it creates fights at home. Ms. A narrated, is unsure of her sexual orientation/preference. She is worried to be vulnerable to her parents about her sexual preferences. Ms. A's mother and sister has a history of clinical depression.

Traumatic experiences of bullying have been reported by Ms. A. She was bullied during 9th standard as she had recently moved to India from Dubai and did not know much Hindi (Local language). She was boycotted by her friends and was ridiculed after that. Before the onset of the symptoms, the client described herself to be anxious and paranoid. She was not able to trust others easily and was not very active speaker or communicator. In terms of

stress management, the patient says she likes to clean her room to feel more control over herself and her surroundings.

Ms. A achieved developmental milestones age appropriately. There is no history suggestive of head injury and seizures, brain fever, use of substance(s), suspiciousness, hearing or seeing objects/people, unusual thoughts, elevated mood, repetitive thinking and ritualistic acts.

Assessment

At the initial visit, Ms. A was conscious and oriented. She maintained eye contact, speech was coherent, goal directed and of normal rate. Her affect was depressed, which was congruent to her mood of feeling distressed and reactivity was in appropriate range. No significant formal thought concerns were observed. Thought content included depressive cognitions and poor self-esteem. There were no noticeable gait or psychomotor concerns. Patient's cognitive abilities were intact and she exhibited intact judgement. Insight was present.

As the client had reported she had intentions to hurt herself, psychological assessment findings from brief suicide risk assessment revealed, the intensity and lethality for deliberate self-harm was of low significance (that is, without suicidal intent).

The client lives in a nuclear family with her mother, father and elder sister. Ms. A reported, not sharing a cordial relationship with her parents. She believes her father is emotionally guarded and lacks acceptance of her condition. Client has a stronger percept about her mother criticizing her about her skills and uses silent method when client has made a mistake. Ms. A shares a room with her elder sister and finds herself relatively less anxious around her sister. Her sister was the only informant for psychotherapy sessions.

During the initial visit, it was understood that client had already reviewed about her experiencing symptoms on google and repeatedly said, *"I feel spaced out".* She described this feeling as a phase in which she is not aware of what she is saying or doing but being there in the body. She was determined and believed she should be diagnosed with depersonalization. Upon clinician's probing, she reported triggers to the current problems are regular verbal arguments and disagreements with the patient's mother and stress for her upcoming CLAT exam entrance. The maintaining factors include relationship with mother and excessive worry about one's future. The client says she wants to clear the exam and move out of the house and the thought of not being able to clear the exam becomes too much for her. The client felt her mother was very controlling of her day-to-day schedule due to her CLAT exam. The restrictions increased and so did the arguments. The patient reported to have lost the ability to recognize herself in the mirror and used to lose track of time during her depersonalizing sessions. However, the patient has not been facing loss of attention or problems in decision making. The patient has not experienced confusion.

Ms. A presents with history of panic like symptoms in the past. Her present symptoms of depression and her personal conduct of the condition may also have been related to dissociative concerns, systemic concerns of family giving probable rise to temperamental issues as well.

The client was asked to complete Beck's Depression Inventory, Minnesota Multiphasic Personality Inventory (MMPI), Sack's Sentence Completion Test (SSCT) and Cambridge

Depersonalization Scale. Additionally, clinician conducted Depersonalization Severity Scale and Hamilton Anxiety Rating Scale (HAM – A) was also conducted.

Findings of psychological assessments such as, Ms. A scored a raw score of 20 indicative of moderate depression on Beck Depression Inventory (BDI). The characterizing symptoms include low mood, lack of energy, somatic concerns and reduced appetite. On Hamilton Anxiety rating scale, her anxiety was rated as 14 indicatives of mild anxiety. Findings from Minnesota Multiphasic Personality Inventory (MMPI) indicate the client's t-score was found to be 62 on the Depression Scale which can be interpreted as dysphoric. The client lacks energy in life, is dissatisfied with her life, expresses anxiety, is introverted and withdrawn and has a restricted range of interests. She also lacks self-confidence. T- scores on the Paranoia Scale was 62. According to this, she displays moderate Paranoia. She is overly sensitive, guarded. She does not trust people easily and is often found to be angry and resentful. On Social Introversion Scale, her t-score was 42. She showed low social introversion. She was found to be extroverted, sociable and friendly in social situations.

Sack's sentence completion test was used to assess areas of family, self and interpersonal relationships. Findings suggest disturbance in the areas of family and future related concerns. The client was found to be presenting anger and frustration when it comes to mother whom she considers controlling. She considers father as someone who is not very emotionally receptive or expressive which is also impacting her mental wellbeing. According to this, she does not consider her parents to be a positive resource when looks upon working upon her mental health. The client expresses positive emotions towards women. The client shows anxiety provoked by excessive worry about the future or losing friends.

Findings of the Cambridge depersonalization scale reveal the patient's total score for Depersonalization is 110, for frequency it is 2 and for duration it is 2.137. The cut-out score for depersonalization is 113. This is suggesting that the patient's score is not enough to give a probable diagnosis of depersonalization disorder. She has obtained a full score on frequency but below than average score on the duration of episodes which suggests that the severity of Depersonalization is not severe.

According to the clinician rating on Depersonalization Severity Scale, the client had obtained a total score of 13. According to this score the client had crossed moderate score (12) of Depersonalization. This score suggests that the patient could be developing severe depersonalization in the future. This rating scale was able to tell us about the severity of her symptoms and support the probable diagnosis.

According to ICD 10, Depersonalization and Derealization is a disorder in which the sufferer complains that his or her mental activity, body and/or surroundings are changed in their quality, so as to be unreal, remote or automatized. Individuals may that they are no longer doing their own thinking, imaging or remembering; that their movements and behaviour are somehow not their own; that their body seems lifeless, detached or otherwise anomalous. This phenomenon mostly occurs in the context of depressive illnesses, phobic disorder and obsessive-compulsive disorder. If the depersonalization – derealization syndrome occurs as part of a diagnosable depressive, phobic, obsessive-compulsive or schizophrenic disorder, the latter should be given precedence as the main diagnosis. In Moderate depressive episode Depressed mood, loss of Interest and enjoyment, increased fatiguability, reduced self-esteem, disturbed sleep, and bleak views of the future.

Post psychotherapy evaluation, Beck's depression inventory (BDI) was conducted to evaluate change in intensity of the symptoms experienced by her during the onset of therapeutic management, her raw scores were of 14 indicatives of mild depression. The characterizing symptoms include low mood and anhedonia. On Hamilton anxiety rating scale, her anxiety was rated as 11 which is minimal anxiety. The characterizing symptoms include anxious mood, depressive mood and tension.
According to ICD – 10, Ms. A's provisional diagnosis of Moderate Depression (F32.1) was insidious, continuous and deteriorating in nature.

Case Conceptualization

As an infant, Ms. A stayed with her mother and sister as her father travelled due to professional engagements. Over the years, Ms. A and her family members have moved to various locations such as Dubai, Gurgaon, Ahmedabad and returned to Gurgaon. Ms. A was witness to violent fights between her parents. She received corporal punishments for her mistakes and frequent anger was displaced on her by parents (especially, mother). She perceives her father to be emotionally withdrawn and mother to be controlling in nature. In fact, confusing behavior by both her parents is clearly noticed. Her father may physically be present yet be emotionally withdrawn and mother may listen to her when the client experiences low mood but hold that against her which creates chaos in the patient. Ms. A is also exploring her sexuality and identifies herself as bisexual. A year ago, her romantic attraction and partnership with another female left her feeling rejected and unworthy.

Various factors contribute to the problems reported by Ms. A such as, there is a likely biological vulnerability to mood disorders (mother and sister are diagnosed with clinical depressive episode) and Ms. A experiences physical symptoms such as headache and fatigue when thinking excessively about her problems. Cognitive factors include thinking that others ignore or reject her, finds herself questioning her sense of worth ("*I am not good enough as a partner or friend*") and feels hopeless towards the future ("*when will all this get over or things work out for me the way I want*"). These automatic negative thoughts arise from conditions such as (*"If I am not good in studies, I won't be loved").* Such thoughts are behaviorally expressed by crying out loud, thinking to hurt herself and unable to contain herself. Safety behaviors adopted by Ms. A during stressful situations include isolation and disconnecting with her own thoughts and feelings. She often detaches herself from her thoughts and associated feelings.

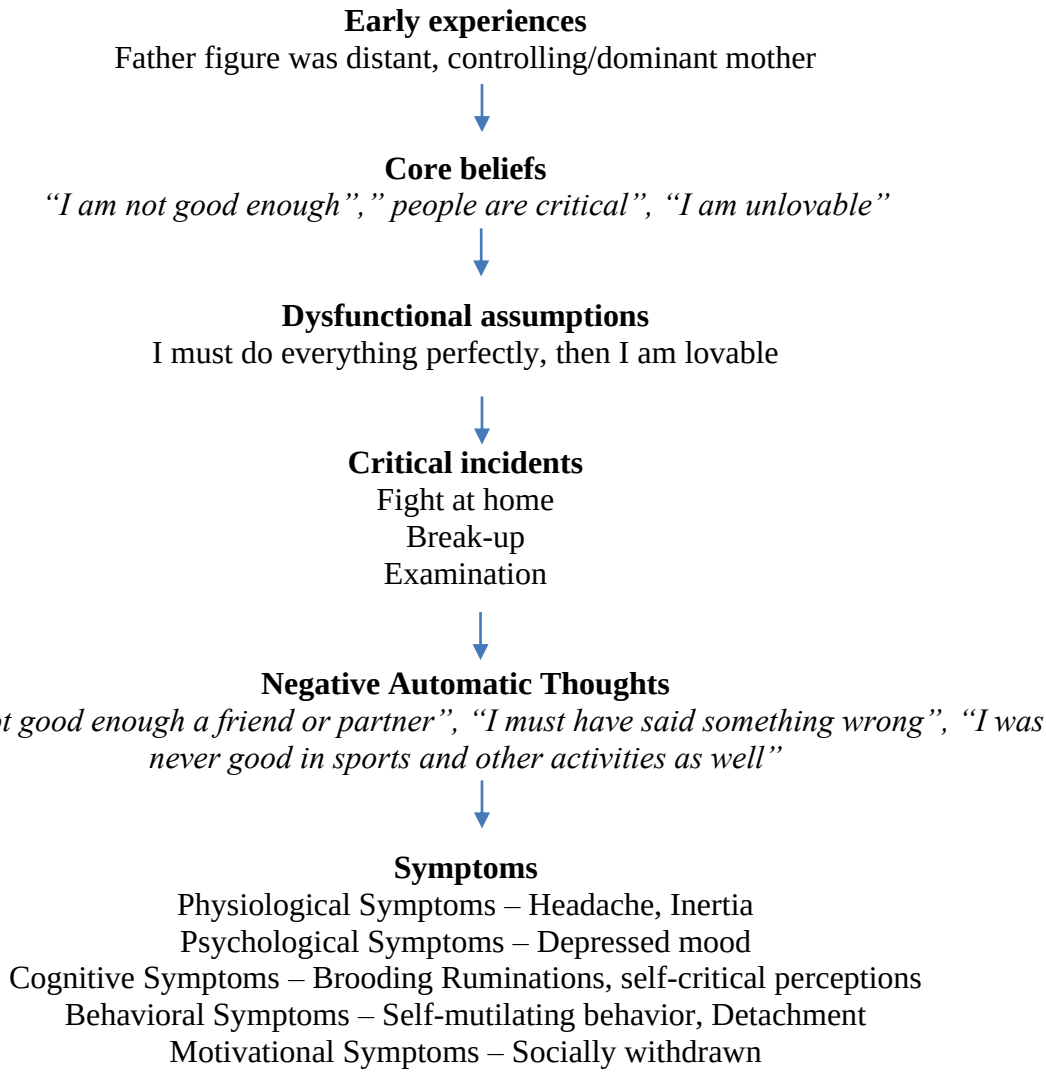
It has been evident in the case history, examination acts as a trigger for the client. In the past and present situations, her anticipation to secure highly is correlated with her opinion about herself as worthy. Her mother's expectations significantly contribute to the client's functioning in her day to day activities. Upon not achieving as desired (e.g.: clearing college entrance examination), Ms. A questions her self-worth and experiences extreme discomfort. She becomes significantly self-critical of herself.

Clinical interview clearly indicates a pattern of interaction adopted by parents called triangulation. The focus is upon the client's presenting problems and interpersonal difficulties amongst them seems non-existent. Another systemic concern in the family system comes from unsaid boundaries and diffusion of boundaries within the family system. When the client faces with present triggers such as a break up with a romantic partner, she strongly experiences all the chain of events that trigger feelings of rejection and not a good enough self. There is a sense of hopelessness experienced by the client and dissociative defenses are clearly practiced by her.

Recently, the COVID19 lockdown and the stress of entrance examinations might have triggered such feelings and thoughts.

Ms. A's view of herself so critically and others as rejecting suggests moderate depressive episode and suicidal impulses.

Figure 1: Case formulation for present case.
(Adapted from Hatwon, Salkovskis, Kirk, & Clark, 1989).



Course of Treatment

Phase I: Cognitive Behavior Therapy - Therapeutic Relationship

This phase entailed three intervention sessions focusing on establishing therapeutic alliance, psycho-education, goal setting and behavioral activation.

The first two sessions played a crucial part to validate the client's feelings. Her insistence upon depersonalization disorder after reading about it on the internet was not looked down, however, she was acknowledged for putting effort to begin the process. An empathy focused client-centered approach was adopted to reassure the client that her trust can be established.

The Goal Form was used to explore client's expectations in therapy setting and from the therapist. Patient identified following goals "*coping with emotions, accepting my emotions, being vulnerable/comfortable about how I actually feel, be less self-critical, to be more grateful*".

Psychoeducation helped to educate the patient about the causes and treatment of symptoms along with prognostic factors. As part of the psycho-education process, the second and third session was used to inform the client about the interdependent relationship shared by thoughts, feelings and behavior. This was helpful as the client began recognizing her detachment might have come from excessive thought spiraling her into distressing feelings. Post activity monitoring, behavioural activation worksheet was adopted to break patterns of vicious cycle and use as reinforcements for herself. For example, patient actively introduced exercise to her routine to work on inertia and loss of motivation. This significantly helped her to monitor her daily routine independently with clearer goals.

Phase II: Cognitive Behavior Therapy – Socratic Questioning and Perceptive Attributions

Phase two aimed to conduct a cognitive behaviour therapy brief panic assessment adapted from Hawton, Salkovskis, Kirk and Clark (1989) for exploring the client's thought attributions About five sessions were used in therapy.

Brief panic assessment involved exploring problem behavior, situations, avoidance, modulators, beliefs of others, causes, onset, course and personal strengths of the client. Attributions of the panic state were explored which affect the self, future and world related thoughts of the client. The panic assessment explored that it was the thought concerning the triggering event ("*What will I do after the exams, how will my career be made, I am tired of all this*") and simultaneous event such as a fight at home contributed to other excessive thoughts ("*my mother will help me now if I go to her but she will mock at me later on*") which led to distracting herself by bringing her attention onto her physical symptoms (eg. fatigue) and the client would use escape by detaching herself from her parents, noises at home of fights and uneasiness within herself. The panic chart revealed that the client only experienced feelings of unreal and racing heart beat when fights would take place at home. The perception chart indicated that the client perceived racing heart as if she is angry and her heart would beat so fast so something would happen to her.

Socratic questioning skills were adopted by therapists to allow patient to reach an alternate thought, solution and build perspective. The client was able to identify triggers antecedent to panic and self-evaluate physiological symptoms present at that time. A panic and mood chart was used as homework for patient to access agency and control. She also identified activities which helped to cope such as sensation grounding, cycling, changing her location, looking at the moon and speaking with a friend.

Phase III: Cognitive Behavior Therapy - Cognitive Restructuring

Cognitive reframing included acknowledging unhelpful thoughts, identifying cognitive errors and increasing self-monitoring behavior. The third phase actively explored five number of therapy sessions using thought record form and behavioral experiments. The following cognitive distortions were identified -

1. Labelling: "*Unrecognisable, Burden, Waste, Unlovable*"
2. Mind Reading: "*Can't stop thinking about how they will react, They won't get me, they will pity me*"

3. Overgeneralization: "*No one sees me"*
4. Discounting the positives: "*I feel so Hopelessness, nothing goes my way*"

Therapeutic techniques like evidence seeking and cost benefit analysis were used in order to work upon the theme of thoughts created by distortions. Client was helped to find evidence that supports her negative automatic thoughts. The behavioral experiment was designed to increase her emotional expression. The experiment was practiced through first through a role play in the session. The experiment was a success and the patient was successfully able to share her emotions. Ms. A was able to find the evidence of still being liked even after emotional expression. She had decided to express her about feelings of disappointment towards a friend who she might have been attracted to. She found herself thinking of rejection as her friend may have distant themselves from the client. After the role play in the session, an alternate thought was developed and action was practiced.
Homework assignment of journaling was mutually decided by the therapist and the client to self-monitor thought patterns.

Phase IV: Dialectical Behavior Therapy - Skills Training
There were four sessions planned in the management of teaching skills of emotional regulation to patient. These skills included problem solving, distress tolerance and mindfulness. The goal was to increase attentional awareness during states of impulsivity and improve tolerance to distressing information.

Distress tolerance was used in order to learn skills that help the client in sailing through difficult everyday events. She had incurred difficulty in tolerating refusal and rejection for which "STOP" technique was taught and practiced during the session. Role plays were performed in the session and client responded to distressing situations by providing adaptive coping solutions and active application of 'STOP' technique. Past situations were analyzed with the addition of skills and new outcomes that could have been present were acknowledged. Ms. A was introduced to mindfulness meditation in a session facilitated by the clinician and encouraged to practice at home before sleep. Mindfulness exercises like 'Stone on the lake' were used to further integrate the skill in her. Client was able to contain herself and take adequate control of herself. The client was validated for her efforts.

Post Distress tolerance, emotional regulation was worked upon. An exercise on building emotional awareness was conducted, worksheet on emotional regulation were used to adapt to undesired emotions.

Phase V: Termination and Follow Up
This phase included three sessions for termination and follow up. It was noted there have been no cancellations by the client or therapist for the appointments.

As part of termination, Ms. A's therapeutic goal form was evaluated and re-assessed. Ms. A reported, a change in her mood, ability to contain herself during distressing events and adequately assessing her resources to stabilize herself.

The client was given an opportunity to ask her doubts for post therapy concerns and need for connecting again. Relapse prevention was conducted where the client was psycho-educated of relapse of depressive episode. Client was educated that symptoms may re-appear and management of it was discussed thoroughly. Client's locus of control was examined by

identifying coping strategies and support networks to reach out. Steps were laid in case of emergency.

Follow-up sessions, Ms. A reported identifying low moods and mindfully using coping strategies such as journaling, STOP techniques to respond at that time. Familial conflict remained as is, but the client started using other coping measures such as changing location, listening to music to prevent herself from hearing the loud noises. She noticed that through active application of thought record form, she was able to work upon thoughts which acted as precursors to dissociating episodes which can initially happening as a form of coping. She also reported that she has not been experiencing those episodes anymore.

Complicating Factors and Access/Barriers to Care

There were various complicating factors during therapeutic work with the client. The clinical picture presented by the client was biased to her prior understanding of depersonalization. Thus, her symptom presentation could easily create confusion in exploring probable diagnosis for the client and selecting the treatment.

The financial barriers were also kept in mind when working with the client. The parents were not informed about the initiation of psychotherapy sessions and her elder sister had consented to her visiting the clinic or attending psychotherapy sessions online. This significantly impacted the client's belief process as she was also guilty of her sister being diagnosed of clinical depression. She could use the support for herself.

As an adolescent seeking psychotherapy sessions independently, it was difficult to witness individuation process from her parents. Thus, discordant family relationships were daily triggering situation for the client. The psychotherapist had to work on plausible events where therapy resourcing techniques can be implied in the outer context and free of cost resourcing skills (eg. grounding, going for a walk, exercise, meeting a friend in the park).

Due to the COVID19 pandemic, after the assessment, client had to take her sessions in the online modality, she felt unsafe at home to freely attend psychotherapy sessions. This often-created apprehensions in the client.

At last, there were two different psychotherapists who worked for the assessment and psychotherapy sessions for the client, as a protocol of the clinical set-up. This added to the client's advantage to view to have two lens perspective on her presentations. However, it also created difficulties for the client to switch between two therapists and establish alliance, as rejection sensitivity persists in the client.

Treatment Implications of the Case

Conceptually, this case study falls under the umbrella of complex clinical cases. The use of third wave therapies were adopted to work on the present problems as the client had limited time to invest in psychotherapy sessions and wanted an outcome specific approach.

The case study clearly enhances the strengths and illustrates the limitations of third wave therapies. We acknowledge that the case study with limited number of twenty sessions was divided among using cognitive and dialectical behavior therapy session, as per the need of the client.

Cognitive behavior therapy was particularly useful in the alliance by using psycho-education about the client's current situation. It made her aware and motivated her to explore different ways to cope with her distressing feelings. However, the client presented with adverse childhood experiences and systemic concerns within the family setting. A trauma focused cognitive behavior therapy approach was not opted for as the home setting was not felt secured by the client. Thus, traumatic memories or events were not significantly addressed in the therapy sessions.

Dialectical behavior therapy was integrated to the use of cognitive behavior therapy to work on regulating emotions during triggering events. The client would have benefited from group therapy along with independent sessions, however, in India there are very few DBT groups working on the four core principles (eg. distress tolerance, mindfulness, emotional regulation and interpersonal relationships).

It was evident in the clinical interview and the presence of two psychotherapists meeting with the client on two different roles, such as assessment and psychotherapy, that the therapeutic alliance and rapport in this case study was a beneficial to the witness the progress of the client. An assessment to evaluate the progress was not conducted separately, however, during termination on the re-assessment of goals of the therapy session, the client revealed her ability to trust her therapists was reassuring.

Recommendations for Clinicians and Trainees

It is not uncommon for clients to present with specific concerns to a clinician and be determined to receive approval of their efforts in exploring about their condition. This case study illustrated many instances where clarification was required without making the client feel invalidated. The complex clinical cases may have various layers to work with but require clinical decision making areas during discrepancies. For Ms. A, stress in the environment such as familial conflicts and examination were dominantly affected by parent-child attachment and neurotic tendencies in the client. Third wave therapies targeted to educate the patient by providing corrective feedback on the symptoms, breaking through cycles of fatigue and identifying cognitive errors affecting quality of life. Therapy sessions have been structured and goal oriented to work on attributions of panic and dissociative coping. Active participation by the client is a driving force in third wave therapies. However, detailed clinical history, collaborative history, clarification and clinician's trust in their clinical judgement is imperative to working with clients with adolescent depression.

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Acknowledgment

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Sethi, S. & Gupta, S. (2024). Third Wave Therapies for An Adolescent with Depression and Dissociative Coping Styles. *International Journal of Indian Psychology*, *12*(2), 3249-3260. DIP:18.01.287.20241202, DOI:10.25215/1202.287