Psychosocial Intervention in a Young Adult with Dissociative (Conversion) Disorder & Borderline intellectual functioning: A Case Study

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ABSTRACT

Introduction Dissociation is a complex psychological phenomenon where thoughts, feelings, and experiences are not fully integrated into conscious awareness (Bernstein & Putnam, 1986). Manifesting as memory lapses, detachment, or a sense of unreality, dissociation significantly impacts emotional well-being and mental health. Freud's concept of "conversion disorder" suggests that these symptoms arise from unconscious conflicts. This condition is prevalent among children, young adults, and individuals from rural, middle-class backgrounds, with a higher incidence in females (2.5:1). Parenting factors also contribute to the development of dissociation.

Methodology: This single-subject case study describes an 18-year-old male diagnosed with dissociative (conversion) disorder and borderline intellectual functioning. Following informed consent, a comprehensive psychosocial assessment was conducted in the inpatient ward at the Central Institute of Psychiatry. Assessment tools included the modified Kuppuswamy scale, McMaster Family Assessment Device, Zarit Burden Interview, Family Attitude Scale, and Parenting Style Questionnaire. Psychosocial formulation tailored interventions in a collaborative approach between the individual, their family was made.

Result: The findings highlighted the complex, multifaceted nature of dissociation. Psychosocial factors, including a discordant family environment, adverse life events like stringent punishment and harassment in tuition classes, inconsistent parenting, and unmet emotional needs, shaped the disorder's trajectory. These issues were addressed through psychosocial interventions with both long-term and short-term goals.

Conclusion: Comprehensive psychosocial evaluation and targeted interventions provided valuable insights into the patient's family dynamics and contributing factors. Early detection and holistic intervention are crucial in addressing dissociative disorders in youth.

Keywords: Dissociative disorder, Borderline intellectual functioning, family dynamics, psychosocial factors

INTRODUCTION

Dissociation is a complex psychological phenomenon characterized by a lack of integration of thoughts, feelings, and experiences into the normal stream of consciousness (Bernstein & Putnam, 1986). It can manifest in various forms, such as dissociative amnesia, depersonalization, and derealization, and often significantly impairs emotional stability and mental health. Sigmund Freud coined the term "conversion disorder" and proposed that its symptoms reflect unconscious conflict (Blitzstein, 2008). While dissociative experiences can

occur in anyone, their nature, severity, and frequency vary across populations (Bernstein & Putnam, 1986). Dissociation is often used as a coping strategy to deal with stressful or overwhelming situations, especially in early life. Understanding the factors leading to dissociation is crucial for early detection, treatment, and prevention, particularly in youth. In the development of dissociation in young individuals, various psychosocial aspects are essential considerations. Childhood abuse is the most significant trauma leading to pathological dissociation in children and young individuals (Putnam, 1997). Conversion disorders are more common in children, young people, housewives, students, and middle-class individuals from rural areas and nuclear families, with females affected more frequently than males (2.5:1). Dissociation typically occurs in the context of stressful life events and psychosocial stressors. Parenting factors, such as parenting style, parental education, parent-child relationship, and parental coping, also impact the development of dissociation in young adults. Understanding the precipitating psychosocial factors and stressors that overwhelm an individual's coping abilities is a vital aspect of treatment.

Moreover, individuals with dissociative disorder often experiences comorbid mental health conditions such as anxiety, depression, and post -traumatic stress disorder (PTSD). The presence of) Borderline intellectual functioning (BIF) can further complicate the diagnosis and treatment of dissociative disorder BIF refers to a level of cognitive functioning that is below average, but not sufficiently impaired to be classified as intellectual disability. It is typically defined as an IQ score between 71 and 84, which is one to two standard deviations below the mean. Individuals with BIF often faces challenges in academics, social skills and daily living making it essential to consider the interplay between dissociation, mental health and cognitive functioning in treatment approaches. By understanding the cognitive interplay of these factors, mental health professionals can develop effective interventions.

METHODOLOGY

This case report involved a comprehensive psychosocial evaluation and intervention. Using a single-subject Case study design, the study conducted thorough assessments, followed by targeted psychiatric social work interventions that engaged both the individual and their family. With informed consent from the patient and caregiver, the case report data was collected from the inpatient ward at the Central Institute of Psychiatry. The primary focus of the psychiatric social work intervention was on supporting both the caregiver and the patient.

Tools For Assessment.

- **The Modified Kuppuswamy scale (Saleem & Jan, 2021)** is a tool devised by Kuppuswamy that used to assess an individual's or family's socioeconomic status. This scale considers three parameters and scores range from 3 to 29, categorizing families into five socioeconomic classes: upper, upper middle, lower middle, upper lower, and lower class.
- **The McMaster Family Assessment Device (FAD; Epstein et al., 1983)** evaluates family functioning based on the McMaster Model of family functioning, which identifies characteristics and interaction patterns that distinguish healthy and unhealthy families. The FAD consists of seven scales that assess various domains, including problem-

solving, communication, roles, affective responsiveness, affective involvement, behaviour control, and general functioning."

- **The Zarit burden interview (Zarit et al.,1980)** first developed in 1980 by Zarit and his team, is a widely utilized instrument for evaluating caregiver burden. Initially comprising 29 items, the tool was later refined to 22 items, assessing caregivers' experiences of burden across three dimensions: emotional, financial, and social.
- **The Family Attitude Scale (FAS; Kavanagh et al., 1997)** is a 30-item device that uses a Likert scale to assess the emotional environment within families. Respondents rate the frequency of certain behaviours or experiences, ranging from 'Every Day' (scored as 4) to 'Never' (scored as 0). The total score, which ranges from 0 to 120, is calculated by adding up the responses, with higher scores indicating a more critical or burdensome family atmosphere
- **Parenting style questionnaire (Robinson et al., 1995)** It is a scale derived for parents of young individuals to measure Baumrind's (1971) authoritative, authoritarian, and permissive type of parenting styles. it has been modified from 62 item parenting styles and dimension questionnaire created by Robinson, Mandleco, Olsen and Hart It has a set of 30 questions which rates how often the parents engage in the different parenting practices. The scores range from Never to Always on a five-point scale.

The patient was 18 years old unmarried male studying in class 11 belonging to lower middle socioeconomic status family, hailing from semi-urban part of Bihar. The client was referred to detailed psychosocial assessment and management from Kraepelin ward of Central Institute of Psychiatry.

Index patient was born out of a non- consanguineous marriage in 2005. When his mother was 22 years and father was 26 years old. He was a planned and wanted child and was second in birth order in a family of total three children. He had developmental delay in gross motor skills He attained neck holding at around 6 months of age, began to stand with support at around 18 months, without support at 2 years, walked alone at 2.5 years, and was able to run at around 3 years of age. He started babbling at around 8 months, said "Dada", "mama", "papa" at 1.5yrs, 2-3 word sentences at the age of 2.5-3 years, he knew his full name and gender at around 4-5 years, was able to tell poems at around 6 years. He also had difficulty in comprehension from childhood. At 4 years of age, he was sent to play-school where he would remain indulged in playing without excessively crying and looking forward to spending time in the play school. He would like going to school as he had friends there with whom he played. He used to live in a locality, where the children weren't allowed to leave the premises of the house for playing or any other purposes. So, he would look forward to meeting new people in school and playing there. But his father noticed that his peers hesitated to take him in their team while playing Kabaddi, cricket, football etc. On asking them he got to know that the child made frequent mistakes while playing, and it seemed that he could not understand the rules of those games properly. Even though he has been maintaining well since 8th class. In 8th class he was admitted to a nearby tuition centre where the adolescent had experienced cruel punishments and regular harassments. As he was promoted to 10^{th} class, his teacher began to give him more homework like asking him to read and recall 16-18 pages of Hindi,

Sanskrit or history books, more difficult math problems than he used to give before. Every day before the class starts, he used to check the homework and punish the students who did not do these properly in front of everyone. He would punish them by either making them kneel down for around 10-15 mins or by beating with the sticks almost each and every day in front of his batchmates and sisters After these incidents, He started to spend more time studying. guardians started noticing the low mood. His interaction with the family members also decreased. He often refused to attend social gatherings and made excuses for not going to any relative's home. If his mother forced him to attend, he would insist on coming back as soon as they finished eating. He stopped going to his friend's house with whom he used to play sometimes previously. As per his father, they started thinking that he was taking excessive pressure of study and behaving like this. After a few days he told his father that he didn't want to go to the same tuition class as the teacher would scold and beat him a lot every day in front of everyone which made him feel humiliated. But father denied. It was around the month of March, 2023, his mother noticed that he began to sleep less throughout the night, at the middle of the night also whenever his mother woke up, she noticed him studying. He got irritated when she asked him to go to sleep and shouted at her saying they did not let him study properly. On 31st March, 2023, suddenly at the middle of night at around 2:00 am, he started screaming in fear and went to his parents crying and saying that Manohar sir is knocking at the door and scolding him the entire day he kept screaming in fear intermittently saying Manohar sir is coming. At around 5:00 am in the morning he started to have abnormal jerky movements of his body. As described by his parents, he tilted and jerked his shoulders towards the right side 6-7 times then was about to fall on ground but was held by his father who made him lie on bed, then he started to roll over the bed saying in a changed voice which was hoarser than his actual voice. Similar episodes continued to happen once his needs were not fulfilled. He has been taken to CIP OPD with chief complaints of Delayed development of gross motor and speech functioning, Difficulty in comprehension, Episodes of low mood, decreased interaction, decreased interaction in previous pleasurable activities for 1.5 months, Episodes of talking in different voices and abnormal behaviour along with abnormal body movement for 8 months. and medications were prescribed. Similar episodes continued to happen and with these symptoms they were admitted in CIP for further management.

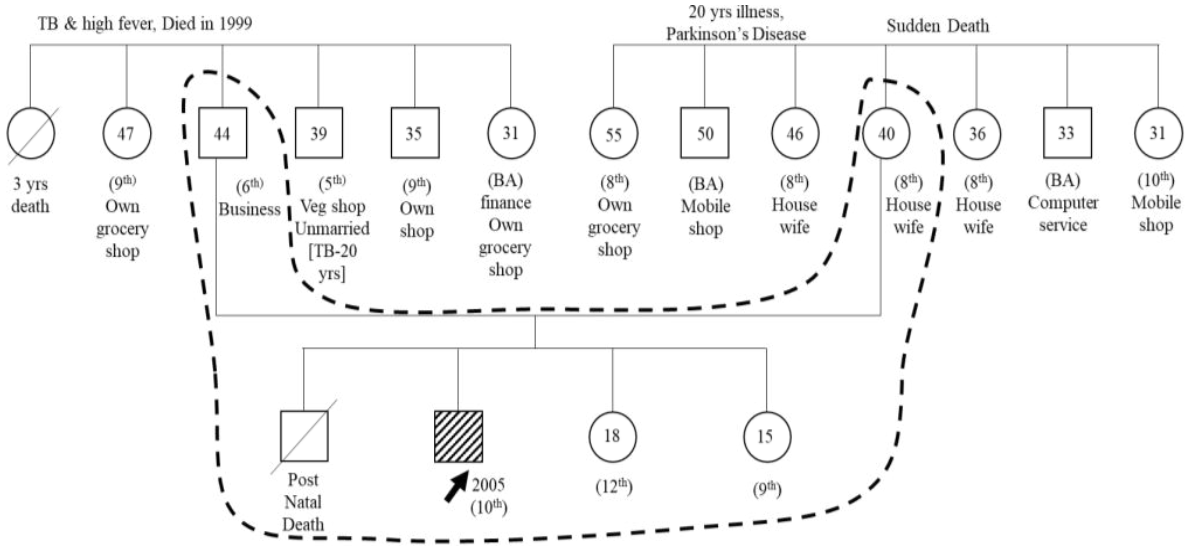

Figure 1: Family Genogram

The psychosocial assessment revealed that the patient was born in a joint family where the emotional environment was non congenial due to verbal altercations between mother and in laws. The father followed an authoritarian parenting style and the mother followed a permissive style of parenting. Both the father and mother were having high expectations towards the patient as he was the only male child of the family. The patient studied in a regular school till 8th class where he was good in studies. Later on, due to the pandemic lockdown he stopped going to a regular school and continued the studies in a private tuition centre. The patient had traumatic events from the tuition class. The teacher of the private tuition centre used to provide an enormous amount of work, like studying fifteen pages every day. The index patient's stress level grew since he was unable to accomplish that When he didn't finish the task, the tuition teacher would punish him severely, beating him in front of others, making him stand on his knees, or making him walk barefoot during the peak summer. These led to a decline in the patient's sense of confidence and self-esteem. He didn't communicate this to anyone including the parents. But showed unwillingness to go to the tuition class. Even after learning about the incident from their sibling, the parents chose not to replace the centre, As the centre have a good result.

The currently the family is in life cycle stage 5'family with teenagers' family dynamics suggest that Internal boundaries are clear, as the members discuss the issues with others. External boundaries are rigid as they are not much connected with the extended family members and neighbours. There are three subsystems present in the family- Couple subsystem, parent-child subsystem and sibling subsystem. Couple subsystem (between parents) is formed and functioning adequately, Parental subsystem is formed but not functioning adequately Materialistic needs are met but the emotional needs are unmet in the family. Sibling subsystem is formed but has a need-based relationship. The father is the nominal and functional head of the family. Decisions are taken democratically mostly by both father and mother.

Instrumental role is carried out by father and expressive role is unmet. Father is adequately performing his role as a father and earns for the family. Mother takes care of the children as well as the household chores, role multiplicity present in mother. Communication pattern is direct among members in the family. The affective status is poor among family members. The involvement of the client in social, personal and emotional activities of the family is minimal. We feeling is present but due to the illness, the participation in family rituals has been reduced. Problem solving abilities and coping strategies are inadequate in the family. The family is mostly dependent upon the decision of the parents. Family celebrates festivals and attends social gatherings together. But the client is not much interested due to illness. The client has good primary social support from all family members. Secondary social support in the form of extended family members is inadequate the client's tertiary support system is also adequate.

RESULTS

The modified Kuppuswamy scale reveals that the family belongs to a lower middle-class family. The family assessment using the Mc Master family assessment device reveals that

problem solving, roles, affective responsiveness, affective involvement, behavioural control are dysfunctional. The Zarit burden interview identifies moderate to severe burden in both mother and father. In The family attitude scale shows a moderate range indicating the average level of criticism present. The parenting style questionnaire tells that mother is following a permissive parenting style and father follows a authoritarian parenting style.

The interpretation has been given in the following tables.

SCALE	SCORE	INTERPRETATION
Modified Kuppuswamy Socio-Economic Status Scale To measure the socio-economic status of the family.	11	Lower Middle Class
The Zarit Burden Interview To assess the caregiver burden on the family members.	Mother: 59 Father: 43	Moderate to severe burden
Family Attitude Scale (Kavanagh et al., 1997) To assess emotional climate of the family	56	Moderate
Parenting style Questionnaire		Mother- Permissive parenting Father – Authoritarian parenting

Mc Master Family Assessment Device

SL.NO	DOMAINS	CUT OFF	SCORE OBTAINED	IMPRESSION
1	Problem Solving	2.2	2.4	Dysfunctional
2	Communication	2.2	1.5	Functional
3	Roles	2.3	2.3	Dysfunctional
4	Affective responsiveness	2.2	2.2	Dysfunctional
5	Affective Involvement	2.1	2.7	Dysfunctional
6	Behavioural Control	1.9	2.3	Dysfunctional
7	Generic Functioning	2.0	1.8	Functional

Social Diagnosis based on ICD 10

- Z55- Problems related to education and literacy.
- Z60.1- Atypical parenting situation.
- Z62.4 - Emotional neglect of child.
- Z62.6- Inappropriate parental pressure and other abnormal qualities of upbringing.
- Z73.4- Inadequate social skills.

PSYCHOSOCIAL INTERVENTIONS

1. Intake Counselling

Intake counselling was done after file review where the patient along with the family members were briefed regarding the admission and stay in the hospital. Initial assessment of the patient's profile including his socio- demographic details, family background, date of

admission, etc. was done. Based on the preliminary assessment of the case, intervention was planned with both the individual as well as guardians.

2. Rapport building

Rapport building being an important interpersonal communication skill helps the therapist to create harmonious understanding with clients that enables greater and easier communication. It is an ongoing process, where the therapist uses skills, such as expressing empathy, reflective listening and summarizing of the patient's statements. In the initial phase, the therapist focussed on building a basic level of trust. The phase involved gathering basic information and addressing the immediate concerns. On the next phase, the therapist continued to reinforce the therapeutic relationship and worked on the complex issues along with the patient.

3. Activity scheduling

Activity scheduling derives from the principles of behavioural activation and focuses on encouraging the patient to approach activities which they are avoiding and to structure their day. After the rapport was established with the adolescent, he was explained about the rationale for activity scheduling, and in the consultation with the adolescent, an appropriate activity schedule was prepared. It started with an unstructured Activity schedule focused on regularizing sleep-wake cycle, exercise and self-care and focusing on recreational activities. Later on it was made structured giving focus to basic academics as well.

4. Psycho-education

Psycho-education sessions was initiated with the family based of information model of psychoeducation where they were helped to develop the understanding and insight into his illness, causes and symptoms. During the middle phase adolescent was explained the causes and nature of his illness with strong focus on proper contributing stress factors and negative consequences of social dysfunction. Primary and secondary gains of the illness were also explained to the family members and the techniques to reduce these were explained. Later sessions focused over prognosis, treatment procedure and post discharge rehabilitation.

5.Social skills training

Social skill training is a psycho therapeutic program, for encouraging the social functioning of the individuals. An initial was made of patient's current social interactions. It was found that he faced difficulty in interacting with others and attending a social gathering. Therefore, conversational training was emphasized. Role play was also used for better understanding the situation. He has been assigned simple exercises such starting a conversation casually with other wardmates and pass smiles when met with them.

6.Supportive Psychotherapy

The trainee had supportive counselling with the parents as they were distressed about the condition of the adolescent. The session was initiated with ventilation technique. During the sessions, father expressed his worries, concerns, and problems faced by them in their day-to-day life due to adolescent's behaviour. They expressed their distress regarding adolescents'

health and future as well. They were reassured and told to express their distress to any confiding person instead of suppressing all the problems within.

7. Family Intervention

Family Intervention was done mainly on Setting of realistic expectations, Contingency management, working on rigid external boundary, Communication of feelings and Involving children in decision making. Five sessions have been conducted with the parents. The initial sessions were regarding the illness and his capabilities and limitations. The guardians were helped in setting up realistic goals. The second session mainly focussed of contingency management. They have been explained regarding the meaning and need for contingency management. Trainee helped the guardians in identifying the situations in which they have to follow the contingency management.

The next three sessions mainly targeted the problems within the family dynamics. The guardians have been explained regarding the need of maintaining proper boundaries as well as clear and open communication. The need of active listening and expression of feelings was also emphasised. They have been also helped to identify the barriers of expressing feelings and emotions. Finally, the need for involving children in decision making process was focussed. The guardians were helped to identify the benefits of including children in decision making and the areas where children can contribute to decision making within the family.

DISCUSSION

The present case study highlights the relationship between psychosocial stressors and dissociation in a young adult male with borderline intellectual functioning. The comprehensive psychosocial assessment provided valuable insight in to different factors contributing to the patient's dissociative symptoms and overall mental health. The patient's exposure to severe punishment and harassment at the tuition centre emerged as a critical precipitant of his dissociative experiences. This aligns with the existing literature indicating that advertise experiences, particularly in formative years, can profoundly disrupt cognitive and emotional development leading to dissociation as a coping mechanism (Putnam,1997).

Assessments revealed a discordant family environment characterized by conflicting parenting styles and unmet emotional needs, the father's authoritarian approach combined with mother's permissive style, high parental expectation likely contributed to the patient's emotional distress. The studies have shown that inconsistent parenting style and high parental expectations can increase stress in children potentially triggering dissociative behaviour (Bernstein and Putnam,1986).

The families' lower-middle socioeconomic status as indicated by Kuppuswamy scale suggests limited resource and support system which can increase stress and hinder effective coping mechanism. The authoritarian parenting style by father characterized by high demandingness and low responsiveness can lead to increase anxiety, low self-esteem, and behavioural issues in children. Conversely, permissive parenting style marked by high responsiveness and low demands can result in a lack of structure and difficulty in developing self-discipline (Robinson et at.,1995)

The Mc Master family assessment device revealed significant dysfunctions in problem solving, roles, affective responsiveness, affective involvement and behavioural control. These dysfunctions coupled with moderate to severe burden in both the parents on Zarit burden interview indicates substantial strain on family resources and dynamics. As per the literature, effective family functioning is crucial for the emotional well being of all members and dysfunctions is this area can have profound implication on mental health of vulnerable individuals (Epstein et al.,1983).

The psychosocial interventions were designed to target these issues by providing support to both patient as well as the family.

CONCLUSION

The case highlights the multifaceted nature of dissociation and its association with psychosocial stressors particularly in an adolescent, male from a lower-middle class background. The comprehensive psychosocial evaluation and targeted intervention gave important insights into the patient's family dynamics and contributing factors. This case underscores the critical importance of early detection and holistic intervention in addressing dissociative disorder in youth. It also highlights the need for a tailored psychosocial intervention that considers individual, familial and environmental factors to effectively support the young individuals dealing with complex psychological phenomena like dissociation. Future interventions should continue to emphasize a family centred approach and explore additional support mechanism to ensure comprehensive care and long-term mental health stability for affected individuals.

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