Clinical Practice Guidelines for the Management of Dissociative Disorders in Children and Adolescents

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INTRODUCTION

Dissociative or conversion disorders (hereafter referred to as dissociative disorders) are characterized by disruption in the usually integrated functions of consciousness, memory, identity, immediate sensations and control of body movements. The symptoms of this disorder are not due to substance use, are not limited to pain or sexual symptoms and the gain is primarily psychological and not social, monetary, or legal. In these disorders, it is presumed that the ability to exercise a conscious and selective control is impaired, to a degree that can vary from day to day or even from hour to hour. However, it must be added that it is usually very difficult to assess the extent to which some of the loss of function might be under voluntary control. The diagnosis is made by the presence of specific clinical features, no evidence of a physical disorder that might explain the symptoms and evidence for psychological causation, in the form of clear association in time with stressful events and problems or disturbed relationship (WHO 1992).

According to the ICD-10 (WHO 1992), the specific disorders in this category are dissociative amnesia, dissociative fugue, dissociative stupor, trance and possession disorders, dissociative motor disorders, dissociative convulsions, dissociation anesthesia and sensory loss, mixed dissociative (conversion) disorders, other dissociative disorders and dissociative disorder, unspecified.

INDIAN STUDIES

A search for literature was done on PUBMED medline using key words dissociative disorders, conversion disorders, hysteria, children and adolescents. Common disorders seen are dissociative convulsions and stupor

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(Srinath et al., 1993, Chandrasekaran et al., 1994, Prabhuswamy et al., 2006, Malhi & Singhi, 2002). Symptoms of motor weakness, amnesia, aphonia are less commonly seen. The common stressors reported were academic difficulties, family problems, peer problems, sibling rivalry and at times difficult situations like marriage etc (Sitholey & Singh, 1986, Srinath et al., 1993, Sharma et al., 2005). Common comorbidities reported were depressive disorder, anxiety disorders, adjustment disorders, oppositional defiant disorder and specific developmental disorder of scholastic skills (Prabhuswamy et al., 2006). Differential diagnoses could be epilepsy, involuntary movement disorders like chorea, dystonias, syncopal attacks, panic attacks and other neurological disorders. Good outcome of dissociative disorders have been reported (Srinath et al., 1993, Prabhuswamy et al., 2006, Malhi & singhi, 2002). Early diagnosis, presence of a psychosocial stressor and appropriate intervention have been associated with good out come in these patients.

ASSESSMENT AND DIAGNOSIS

The assessment of dissociative disorder involves a comprehensive medical, neurological, psychiatric and psychosocial evaluation of the patient. The key points in the assessment of patients with dissociative disorders are delineating dissociative phenomenon from non-dissociative ones, ruling out physical illness, looking for comorbid psychiatric and physical conditions and evaluating the subject's psychosocial environment.

RULE-OUT PHYSICAL AND OTHER PSYCHIATRIC ILLNESS

As mentioned above, a thorough initial medical and neurological assessment is crucial in the assessment of any patient where a possibility of dissociative disorder is being kept. The treating psychiatrist should always consider seeking appropriate consultations for the same. Relevant investigations like urinary drug screen to rule out drug use, EEG to rule out complex partial seizures, IQ testing to rule out borderline or low intellectual functioning and CT scan of brain to rule out structural brain lesions should be done wherever indicated. The possibility of dissociative symptoms superimposed on neurological or medical disorders, or other psychiatric disorders should always be considered.

If dissociative symptoms appear for the first time in preschool children, a strong suspicion of underlying physical or psychiatric illness should be kept in mind.

DIAGNOSIS SHOULD NOT BE MERELY BASED ON THE ABSENCE OF OBJECTIVE SIGNS OF PHYSICAL ILLNESS

Although it is very important to exclude an underlying or associated physical illness, as well as other primary psychiatric disorders, the diagnosis of dissociative disorder is not merely based on the absence of objective

signs of physical illness. It is imperative to remember that absence of physical findings applies universally to an earliest stage in the development of all diseases. Moreover, physical findings that appear non-relevant at first may assume significance later.

The diagnosis of dissociative disorder is not just of exclusion. The clinician should always keep in mind the overall biopsychosocial context of patient and symptoms. When the diagnosis is made with too much certainty without proper assessment, other medical illnesses are often missed. When the diagnosis is too tentative, multiple and irrational medical evaluations are conducted, and iatrogenic reinforcement and harm are produced.

PSYCHOSOCIAL PROBLEMS OR STRESSORS

Attempts should be made to systematically identify the patient's psychosocial environment. Stressors and coping abilities of the child to handle stressful life situations, as well as secondary gains due to dissociative disorder, if any, should be careful elicited.

Thinking that stressors are "unconscious" creates a barrier in the physician's mind about looking for stressors. Studies in children have shown that stressors are generally present in day to day life of the patients and are known to the patient and the family members. It is important for the clinician to evaluate for stressors from a developmental perspective. It may not be possible to find out stressor in the initial interviews however, by repeated, careful and sensitive interviewing stressors can be elicited. Stressors in children and adolescents may include day to day problems like difficulty in school or family relationships, fights, scolding and punishment, some frightening experiences, educational difficulties in children with lower cognitive abilities, some kind of unwanted or disliked situation like marriage, job or studies and sometimes sex and abuse.

One should also assess the style of parenting, intra-family relationships and functioning.

At times, stressors may not be severe enough to be noticed by the family members of the patient. Moreover, the family members may not be able to correlate the stressor with onset of dissociative symptoms. In such cases, stressors should be assessed systematically and the severity and temporal correlation of stressors with the onset of symptoms should be clearly delineated. One may use ICD-10 Axis V for systematic assessment of stressors in children.

The ICD-10 specifies that there should be convincing associations in time between the onset of symptoms of the disorder and 'stressful (life) events, problems, or needs'. However, Indian studies point out that stressors are found in only 62-82% of cases of dissociative disorder (Trivedi et al., 1982; Sitholey & Singh, 1986, Srinath et al., 1993, Prabhuswamy et al.,2006). Unless all the diagnostic criteria for the diagnosis of dissociative disorder

including temporally related psychosocial stressors are met a confident diagnosis should not be made.

SPECIAL ISSUES IN ASSESSMENT: FALSE-POSITIVE DIAGNOSI

False positive diagnoses of dissociative disorder have been reported in the literature and rates as high as 25% at a 10-year follow-up have been found (Couprie et al., 1995). False positive diagnosis is likely if importance is given only to the symptoms and not to the underlying physical or psychiatric morbidity and psychosocial circumstances. The high false positivity in this disorder is further confounded by the presence of significant comorbidity of medical illnesses in these patients.

Some of the diagnostic difficulties include idiopathic dystonia (Couprie et al., 1995), dopa-responsive dystonia (a type of childhood dystonia, presenting with bizarre gait, unexpected falls, and gait dystonia; Marjama et al., 1995), blepharospasm, multiple sclerosis (Mace and Trimble, 1996), apraxias, paroxysmal choreo-athetosis, frontal and temporal lobe epilepsy, porphyrias, subdural hematoma, early manifestations of AIDS, among many others.

It is also likely that these false positive diagnoses are made more often in females, psychiatrically disordered patients, patients presenting plausible psychogenic explanations for their illnesses, and patients with unusual movement disorders.

SPECIAL ISSUES IN ASSESSMENT: POSITIVE SIGNS

Various "positive signs" of dissociative disorders have been described in the literature like tunnel vision, discrete anesthetic patches, astasia abasia, positive Hoover's test, preserved cough in hysterical aphonia, and hemi-anesthesia sharply separated at the midline. These signs indicate normally preserved physiological functions underlying the superficial appearance of incapacity. In addition to the above "positive signs", hysterofrenic areas (areas on body, which when pressed, abort the hysterical episode, usually convulsive in nature) and hysterogenic areas (areas on body, e.g. a hyperanesthetic spot, which when pressed can induce a hysterical episode) have also been mentioned. It must be kept in mind that dissociative disorders can be easily misdiagnosed or over diagnosed if these 'positive signs' are taken to be pathognomonic of the disorder.

Studies indicate that these positive signs can also be seen in neurological patients. Gould et al (1986) applied the positive signs of hysteria to 30 consecutive neurological admissions (25 of which had acute strokes). These 'signs', including secondary gain, were la belle indifference, non-anatomic sensory loss, midline split of pain or vibratory stimulation, changing boundaries for hypoalgesia, giveaway weakness, and history of hypochondrias. All 30 patients showed at least one out of 7 'signs', most exhibited more than one 'signs' and one patient had all 7 'sings'.

SPECIAL ISSUES IN ASSESSMENT: LA BELLE INDIFFERENCE

La belle indifference is an apparent lack of concern towards the symptoms, despite the apparent severity of disability produced by them. It was argued that as anxiety is converted into somatic symptoms or repressed, the conscious anxiety is 'warded off', presenting clinically as 'la belle indifference'. Although earlier thought to be a hallmark of dissociative disorders, it is now known to be present even in physical illnesses and hence has no discriminatory value and lacks both specificity and sensitivity. Moreover, it is not always present in dissociative states. In fact, Lader and Sartorius (1968) found that a majority of patients with conversion disorder were highly aroused and anxious, as compared to normal controls or even patients with phobic or anxiety states.Katoch et al (1994) also found considerable anxiety levels in patients with dissociative disorders.

TREATMENT

It is imperative to treat dissociative disorders promptly to prevent habituation and future disability. The longer the symptoms remain, the more aggressive the treatment should be (Hollifield, 2004). The treatment usually consists of two parts: early treatment directed towards symptom removal, and long term treatment directed towards resolution of conflicts, and prevention of further episodes. Dissociative disorders are seen very less internationally. Therefore there are no practice guidelines for the management of dissociative disorders. The proposed treatment guidelines are based mainly on Indian work in this area.

PRINCIPLES OF ACUTE MANAGEMENT (SITHOLEY, 1987, GIRIMAJI, 2000)

1. RAPPORT AND THERAPEUTIC ALLIANCE

The cornerstones of successful therapy include establishment of rapport and therapeutic alliance with the child. It is also important to have good doctor-parent relationship because the parents have to become an ally in treatment of the child. Parental influences on the child are significant even in the hospital setup. Unless the parents understand the clinician's point of view, it may not be possible to alter their overprotective and overindulgent attitude and behaviour towards the child.

2. PSYCHOSOCIAL EXPLANATION OF DISSOCIATIVE SYMPTOMS

First of all, the diagnostic assessment must be done in an impressive manner and the parents should be involved in the assessment process. It would be useful to explain to them why a particular assessment is being done and what the results are expected to show. When the results of this assessment are obtained, there significance should also be explained to the parents. After reliably ruling out physical or other psychiatric illness as the cause of dissociative symptoms, the child and the family should be strongly assured that there is nothing

seriously wrong with the child and that the child will make a complete recovery. When physical or psychiatric disorders are ruled out and the possibility of the dissociative symptoms being psychogenic is put forward, it is usually very vehemently rejected by the parents. That there could be anything psychologically wrong their 'severely ill' child, their parenting or their family functioning is totally unacceptable to them. Any suggestion of this possibility is met with resentment, anger and sometimes open hostility. Therefore, any confrontation about the nature of the symptoms should be avoided at all costs and all the members of the treating team should adopt the same approach towards the disorder and the child and family.

It would require some patience and tact to explain to the family members that emotions can cause physical symptoms and this can happen even in children. When this is understood and accepted by the family, only then it would be possible for them to cooperate in psychosocial assessments.

3. SOLVING THE PSYCHOSOCIAL PROBLEMS

Once a cause is known then attempts should be made to solve the "problem". The problem should be discussed with the child and the family. In case of adolescents, if the problem has been revealed to doctor or the ward staff in confidence, then consent of the adolescent should be taken to discuss it with the family. The physician should not force his opinion on the child or the family. Problems of family relationships should be discussed and family should be told that the child is being adversely affected by the family problems and their resolution will improve the child. At times family therapy may be required. It is also important to open up the channels of communication between the child and his family. Through out the treatment, attention should be focused on the patient rather than on the symptoms to ensure a speedy recovery. In most of the patients, reassurance and suggestions of recovery coupled with attention to the patient's psychosocial needs lead to a rapid recovery.

SYMPTOM SUBSTITUTION

As the symptoms begin to subside, patient may sometimes manifest other dissociative features (called as symptom substitution). Occasionally, distress may be expressed by deliberate self-harm, demanding histrionic behavior or patient may develop depressive symptoms. In such a condition, consistent limit setting may be essential for continuation of psychological treatment. Regularity of follow-up visits after discharge is important so that the patient does not need to 'produce' a symptom to visit the therapist.

Lastly, the physician should not feel pressurized, should retain his calm and be prepared to face the hostility or aggression of the family for not using medication and quickly improving the child, and for exploring psychosocial situations.

SPECIAL ISSUES IN ACUTE MANAGEMENT: SECONDARY GAINS

Reduction in secondary gains is not advisable very early in the treatment and without adequate explanations to the family because of three reasons. First, the physician himself may not be certain about the origin of the symptoms. Secondly, the family may perceive reduction in secondary gain as neglect of the child. Also, initially the family may not have full confidence in the hospital's ability to take total care of their child.

Later on, the family should be offered adequate explanations regarding secondary gains. Reduction in secondary gains in a child should be provided with an alternative, healthy, socially acceptable and age appropriate role in which he or she can be rewarded for doing something positive.

SPECIAL ISSUES IN ACUTE MANAGEMENT: ABREACTION AND AVERSION THERAPY

Aversion therapy for unwanted behavior has often been employed in resistant cases, e.g. using liquor ammonia, aversive Faradic stimulation, pressure over trochliar notch, tragus of ear or over sternum, and closing the nose and mouth. Aversion therapy for unwanted behavior is not advised as it may harm the patient, has a pejorative connotation equivalent to punishment. It may provide only temporary benefits, if any

Abreaction is bringing to conscious awareness, thoughts, affects and memories for the first time, with or without the use of drugs. This may be achieved by hypnosis, free association, or drugs. Abreaction may further foster dissociative states. Moreover, some patients treated with this technique may perceive the therapist as sanctioning the dissociative states; hence it is not recommended.

SPECIAL ISSUES IN MANAGEMENT: MEDICATION

There is no role for medication in dissociative disorder except for concomitant anxiety, depression or behavioural problems. The family should be tactfully made to understand that medication are not required for dissociative symptoms. Otherwise, the family may perceive that doctor is unable to diagnose the child's problem and treat it. The use of medication will unnecessary expose the child to the side effects**.** In addition, the family may not give enough attention to psychological treatment. However, at times there are families who persistently demand medication despite repeated explanations. In such situations one may consider using a placebo to retain the child in treatment and bypass resentment or hostility of the family.

SPECIAL ISSUES IN MANAGEMENT: NEED FOR HOSPITALIZATION

Hospitalization is required when there is doubt in the diagnosis, severe symptoms, family is very distressed or symptoms are recalcitrant and resistant to outpatient treatment.

TREATMENT OF CHRONIC CONDITIONS

Chronic cases are more difficult to treat and the management should always begin with a rational evaluation, and clear explanation to the patient and the family about the findings**.** Psychoeducation of the family about the nature of the disorder and its course and outcome is necessary. Similar things should also be explained to the patient taking into account his ability to understand and accept the information. The family should be explained that, although the symptoms are real and impairing, there is hope for full recovery and that serious physical disorder is not causing them. Psychotherapy may be useful but contraindicated in a patient who is resistant to it or gets worse when it is initiated (Hollifield, 2004).

COGNITIVE BEHAVIOUR THERAPY (TERTIARY CARE LEVEL)

Cognitive behavioural therapy (CBT) helps the patient to become aware of, examine, and if appropriate revise the way they think, respond rationally and behave in response to their symptoms. The aim of CBT is to maximize functioning and reduce the dissociative symptoms. In formal CBT the patient meets a therapist every one or two weeks and practices new ways of thinking about and responding to their symptoms between these sessions. The following are the principles of CBT in chronic dissociative states:

-Give positive explanations for symptoms.

-Persuade the patient that change is possible, they are not "damaged", and they do have the potential to recover.

-Discuss the treatment rationale with the patient and the key family members.

-Encourage activity.

-Encourage the patient to rationally reconsider unhelpful and negative thoughts.

-Negotiate a phased return to work and studies.

Evidence exists at systematic review level that CBT is effective for a wide range of functional somatic symptoms (Kroenke et al., 2000). Its use has also been described (although not properly tested) in patients with non-epileptic attacks, motor symptoms, and severe and multiple functional symptoms (Goldstein et al., 2004).

TREATMENT OF CHRONIC CONDITIONS: INSIGHT ORIENTED DYNAMIC PSYCHOTHERAPY (TERTIARY CARE LEVEL)

Long-term insight-oriented psychotherapy is chosen not on the basis of dissociative symptoms but on the total personality structure of the patient. The total length of therapy may be five years or more. There are no

controlled studies regarding the efficacy of this technique in dissociative disorder.

Shorter, expressive-supportive psychodynamic psychotherapy and brief, active psychodynamic psychotherapy has been effectively used for treatment of dissociative disorders in some patients.

One should use the psychotherapy with which one is familiar. Usually individual supportive psychotherapy in short-term is used in primary care.

SUMMARY

ASSESSMENT

-Delineate dissociative phenomenon from non-dissociative ones.

-Rule out physical illness in a transparent manner.

-Look for comorbid psychiatric and physical conditions.

-Systematically assess for psychosocial factors.

ACUTE TREATMENT

-Assurance

-Relaxation

-Doctor- Child and family relationship

-Restoration of communication in the family

-Realistic solution of the problem

-Reduction of sick role and secondary gains

-Promotion of positive behaviour

TREATMENT OF CHRONIC CONDITION

-Cognitive behaviour therapy

-Insight oriented dynamic psychotherapy

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