

Psychological Interventions for Dissociative disorders

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INTRODUCTION

Dissociative disorders as described by ICD 10 include a range of disorders and combine what are conversion disorders (assumed under somatoform disorders in Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) and the cluster of dissociative disorders. The mutual idea shared by these disorders is a partial or complete loss of usual integration between memories, cognizance of identity, and immediate sensations and voluntary control of body movements. Conversion occurs when there are clinical symptoms representing alteration of functioning of motor or sensory systems and which do not follow a pattern of a known neurological or medical disease. Dissociation is a mechanism that allows the mind to compartmentalize certain memories or thoughts from normal consciousness. These split-off mental contents are available and may return to consciousness either by an event or spontaneously.

Broadly, dissociative disorders may be viewed as shown in Table 1.

Common dissociative disorders in the Indian setting have been dissociative motor disorders and dissociative convulsions. Dissociative stupor and possession states were next most frequent with multiple personality disorders

being rather infrequent. Depression and borderline personality disorder often coexist.

Role of culture in presentation

The expression of disease is affected by culture, and there are distinct differences which need to be understood while planning management, particularly in the Indian context [Table 2].

ETIOLOGY

To plan management, understanding some elements of etiology is important. Broadly, it may be viewed as a reaction to an external trauma or secondary to a personality attribute which incline the patient to dissociate [Table 3].

Psychotherapy is the cornerstone of treatment for dissociative disorders and hence choosing the right therapist is of paramount importance. The following section enumerates the characteristics of a therapist ideally suited to engage in therapy for dissociative disorders.

1. The therapist must be cognizant with the clinical features and the psychodynamic aspects of dissociative disorders and be able to accurately diagnose it. An early and appropriate treatment plan can only be framed after a proper diagnosis which is often hampered by the lack of awareness among clinicians about the dissociative process, the effects of psychological trauma, and by misconceptions about the varied clinical symptoms. Furthermore, the usual diagnostic interviews and mental

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Table 1: Types of dissociative disorders

Type of disorder	Symptomatology
Dissociative amnesia	Either partial or complete loss of memory for recent events that are usually of a traumatic or stressful nature
Dissociative fugue	Along with amnesia there is an apparently purposeful wandering away from home or place of work during which self-care is maintained
Dissociative stupor	Stupor following a trauma and absence of a physical or other psychiatric disorder that might explain it
Trance and possession disorders	Temporary loss of the sense of personal identity and complete awareness of the environment; occasionally the individual acts as if possessed
Dissociative disorders of movement and sensation	Loss of or interference with movements or loss of sensations
Dissociative motor disorders	Loss of ability to move the whole or a part of a limb or limbs
Dissociative convulsions	These mimic epileptic seizures
Dissociative anesthesia and sensory loss	Loss of sensation over the skin or loss of functioning of other special senses
Mixed dissociative (conversion) disorders	
Others	

Table 2: Cultural presentation of dissociative disorders

Dissociative experience	Presentation in Eastern culture	Presentation in Western culture
Splitting of consciousness	Dissociative trance	Depersonalization
Splitting of identity	Possession trance with external control	Dissociative identity disorder
Splitting of memory	More likely in possession trance than dissociative trance	Dissociative amnesia
Loss of somatic control	Dissociative trance, e.g., lata	Conversion disorder
Treatment	Role of faith healer who enters trance to combat the spirit	Therapist resolves dissociation with hypnosis/therapy

Table 3: Three principles for treatment of dissociation in a contextual approach

Psychoanalytical symptoms have a relation with the unconscious conflict	Psychological (learning) Symptoms are learnt in childhood as a means of coping with unpleasant events. Role of trauma and altered information processing	Biological: Various findings on imaging such as impaired cerebral hemispheric connections, excessive cortisol secretions and subtle changes in neuropsychological tests.
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- status examinations taught during training often do not explore about dissociative processes and psychological trauma, and the onus is on the therapist to inquire specifically about features suggestive of dissociation
2. A formal training in psychotherapy is desirable before the therapist attempts to undertake therapy for dissociative disorders. Patients with dissociative disorders may need to be approached from a psychodynamic perspective to gain a better understanding of the role of past trauma in the manifestation of their current symptoms and unless the therapist is well versed in the nuances of psychodynamic approach and trained formally in psychotherapy, only crisis intervention and supportive therapy will be done, which will partially ameliorate the patient's symptoms. Ideally, an experienced therapist should be able to incorporate eclectic therapeutic techniques, psychoeducation and skills development flexibly within an overall psychodynamic framework and undertake therapy.
 3. The therapist should be able to detect any psychotic breakdown while the patient is undergoing therapy and intervene accordingly. Persons with dissociative disorders frequently suffer from other comorbidities such as affective disorders, anxiety disorders, and substance abuse. The therapist should ideally also be trained to detect any such condition which may hinder the progress of therapy
 4. As therapy progresses, the therapist explores the patient's unconscious conflicts which may be a cause of maladaptive functioning. Also, resistance emerges and the therapist may experience counter transference. The therapist should be experienced enough to recognize counter transference which can provide valuable information about the original trauma by its re-enactment within the therapeutic context and to manage it sensitively so that trust in the therapeutic alliance is maintained
 5. Culturally patterned dissociative symptoms have been well documented globally. In a country like India where there is immense socio cultural variability it is of particular importance as the dissociative symptoms can vary in presentation across regions and cultures. The occurrence of dissociative motor disorders, dissociative convulsions, and dissociative stupor and possession states are common in the Indian scenario while dissociative identity disorders were less frequently reported than western studies. In some situations, dissociation may be a culturally sanctioned way of disclaiming certain experiences or it may arise in religious context and may be perceived to be beneficial and the therapist should be sensitized about their occurrence to prevent unwarranted pathologization (Eli Somer, 2006). The therapist should be experienced enough to be aware of and pick up the same.

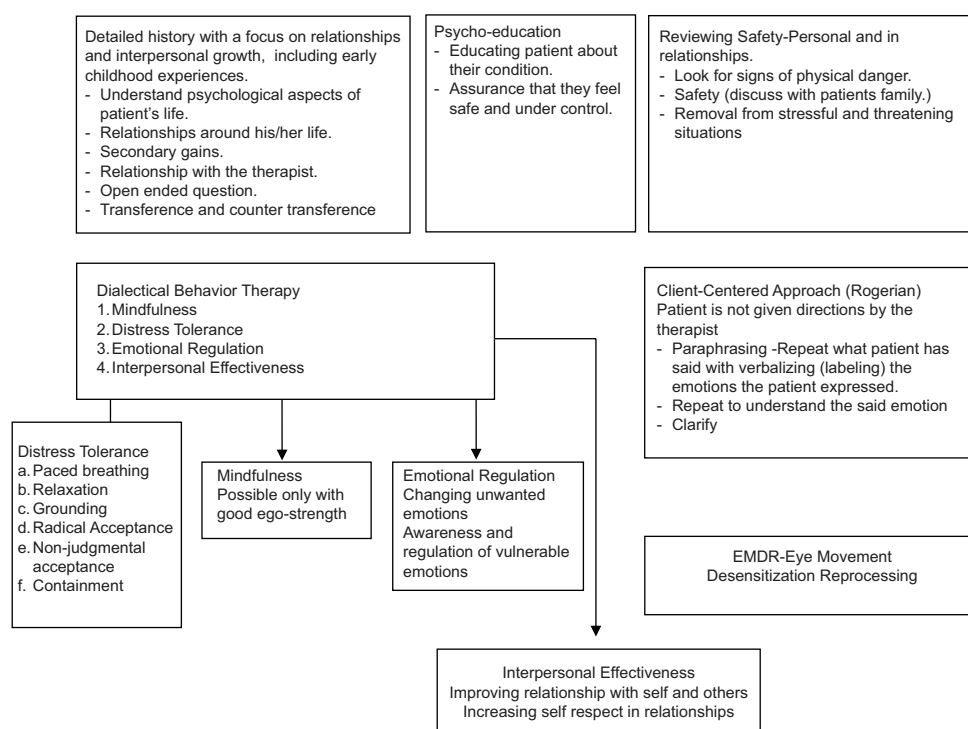


Figure 1: Overview of approach to treatment of dissociative disorders

To summarize, there has to be an amalgamation of theoretical expertise, specific therapeutic knowledge and human skills encompassing a broader context on the part of the therapist for the development of an ideal therapeutic alliance.

ROLE OF THERAPY IN DISSOCIATIVE DISORDERS

Management of dissociative disorders begins with an accurate diagnosis, ruling out other causes for the presentation, assessing for comorbidities and predisposing trauma and personality factors. Acute conversion disorders aim at alleviating the symptom and use reassurance, narcoanalysis, and behavior therapy techniques. The aim of therapy should be immediate alleviation of symptoms as the patients ego state is not available for any other exploration. And the primary goal of this stage is also to make the patient feel safe, where he/she feels safe enough to let go of the symptoms. For chronic cases, exploratory insight oriented therapy is suggested. Whilst medication has a role in treating the co-morbidities and anxieties, psychotherapy plays a large role in the eventual integration and conflict resolution. Caution is to be applied when there is associated psychosis. If there is psychosis one should NOT attempt any form of insight oriented therapy as it will cause further breakdown. When conducting therapy the therapist should continuously be alert and monitor for any psychotic symptoms, if there is a doubt then we should err on the side of caution and temporarily stop therapy and alert the psychiatrist.

The goal of therapy is to reduce dissociation and integrate the functioning of the mind. Whilst many therapies are advocated empirical evidence is lacking.

INITIAL ASSESSMENT AND DETERMINATION OF TREATMENT SETTING

After the initial assessment of a patient with dissociative disorder, the clinician has to determine the treatment setting-whether the patient can be treated on outpatient basis or if hospitalization is warranted. In the initial phases of treatment, establishing the patients' safety is of paramount importance and a thorough assessment regarding safety issues (particularly the risk of harm to self or others) should be made before determining the treatment setting [Table 4].

Therapy in the outpatient setting is vulnerable to disruption due to external factors like influence of family or significant others and stressors in the social context, in the acute stage or imminent threat of harm to self or others. Hence, it is important to factor in such potential disruptions during the initial assessment period to minimize the impact of pathogenic interpersonal patterns on the progress of therapy. However, in the long run, outpatient treatment is preferred.

Inpatient treatment has to be considered in the scenarios as shown in Table 5.

In certain cases of dissociative disorder with complex psychopathology, an entire treatment team maybe

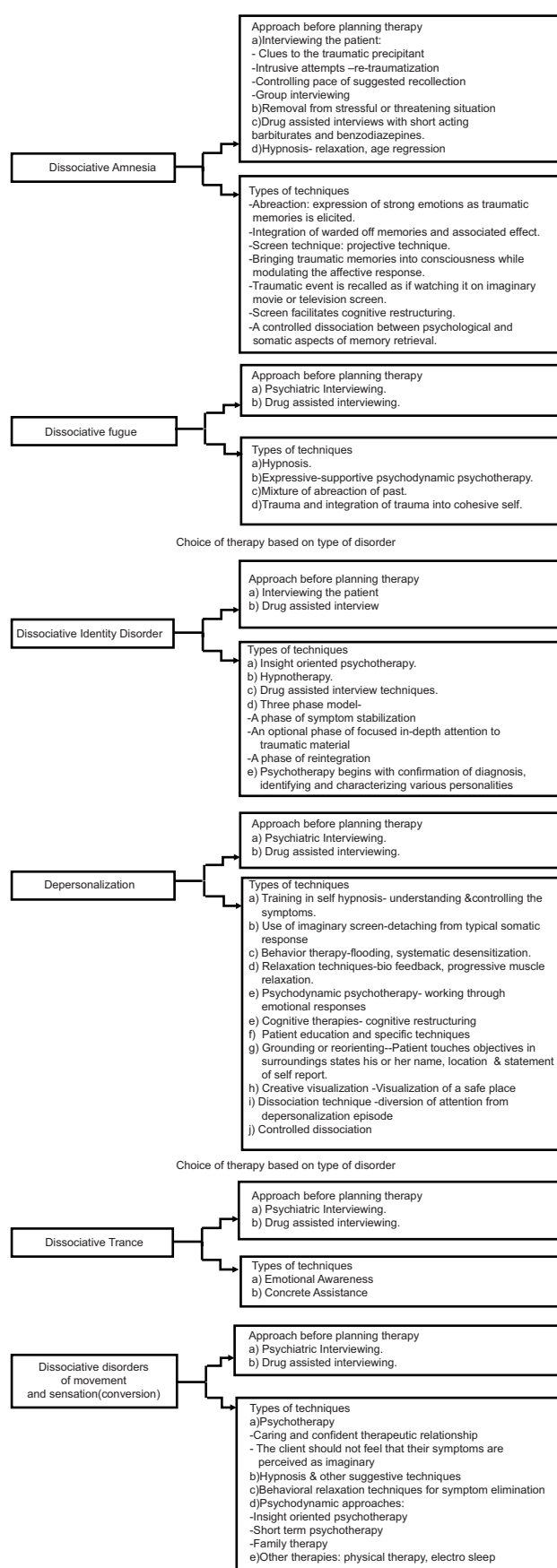


Figure 2: Choice of therapy based on type of disorder

required, comprising of clinicians, therapists, family therapists, specialists in eye movement desensitization and reprocessing etc. In such cases, it is important that the entire team should function in a well co-ordinated and concerted manner but with clear delineation of responsibilities to restore integrated functioning of the patient.

ROLE OF GROUP THERAPY

The role of traditional group therapy in the treatment of dissociative disorders is limited. In particular, patients with dissociative identity disorder have difficulty in participating in generic therapy groups where participants are encouraged to discuss their traumatic experiences and may even have worsening of symptoms if they are unable to tolerate the distress engendered in the process. However, select groups focused on psycho-education, problem solving and specific skills development can be a valuable adjunct to individual psychotherapy.

Conversion disorder

This term is another name for dissociative disorders. As per ICD 10, they are a host of dissociative disorders with partial or complete loss of the normal integration between memories of the past, awareness of identity, immediate sensations and control of bodily movement. As per Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, conversion disorders also called the Functional Neurological Symptom Disorder is a type of Somatic Symptom and related disorder is characterized by alteration in voluntary motor or sensory symptom characterized by similar features as described above. The assessment and management of this disorder is similar to as mentioned in the dissociative disorders.

THE DIFFERENT THERAPEUTIC INTERVENTIONS AVAILABLE IN THE MANAGEMENT OF DISSOCIATIVE DISORDERS

A broad overview of the treatment of dissociative disorders is outlined in Figure 1. Based on the type of dissociative disorder, the choice is shown in Figure 2.

In order to decide the form of therapy needed in dissociative states, it is important to understand the possible genesis of dissociation [Figure 3].

A few techniques which may be practised while managing the patient are as follows.

Psychoeducation

Psychoeducation is an inevitable aspect in the management of dissociative disorder. Psychoeducation should focus on normalizing and acknowledging patient's symptoms and relating them with dysfunction in daily life. It also enables

Table 4: Comparative overview of outpatient and inpatient therapy

Outpatient-based individual psychotherapy	Inpatient-based individual psychotherapy
Is usually the preferred treatment modality	More expensive and difficult as it is usually long term
It is easier to arrange an outpatient based mode of treatment	Difficult to arrange inpatient stay exclusively for therapy
Difficult to sustain sessions and patients may drop out of therapy	Adherence to therapy is better by virtue of patient being admitted in the hospital
The frequency of sessions and duration of treatment is dependent on multiple factors like the clinical presentation, availability of skilled therapist, patient's preferences and financial considerations	

Table 5: Indications for inpatient therapy

When there is persistent and severe suicidal ideation
 There is a high risk of self-injurious behavior
 When there is risk of harm to others
 For diagnostic clarification in patients with complex presentation of psychopathology
 In situations where dissociative symptoms are overwhelming and inpatient treatment can expedite recovery
 For management of acute crisis situations in patient's life
 Presence of co-morbidities requiring intensive monitoring and treatment
 The patient is non-adherent/unresponsive to outpatient treatment and there is worsening of clinical picture
 For the development of skills and coping strategies

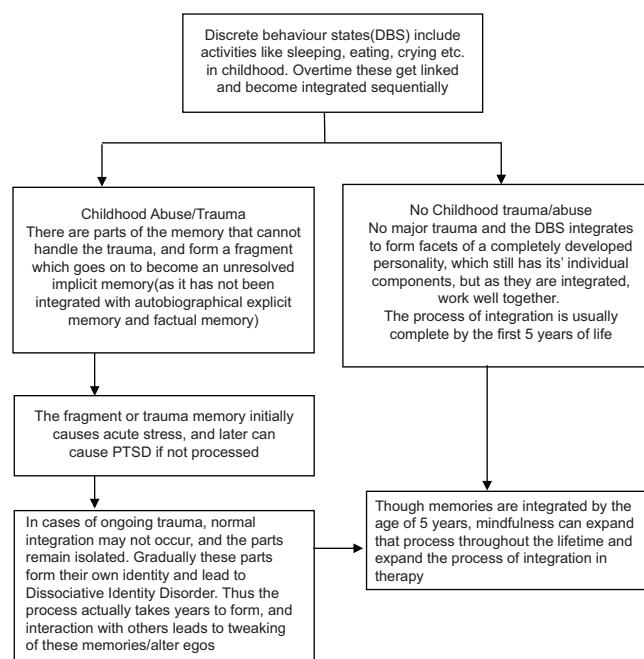
an understanding in the patient and family members about the intellectual strengths and the key role of coping skills in therapy. Psycho-education must focus on the biological and neural basis of the involved feature and as a result shift focus away from victimization. Another aspect, knowing what is wrong with them enables them to give some meaning to symptoms and help them feel safe and under control. The therapist must explain in simple terms and must be easy to understand exercising caution to avoid making them sound manipulative.

Grounding skills

Grounding helps the patient detach from emotional pain, regain focus from the intense emotional sensation. Often patients experience symptoms in relation to the trauma that are associated with past events in their life. They get consumed by emotion and don't have the immediate tools to manage them. This subsequently overwhelms them, which may cause the need to dissociate. Grounding helps to shift their attention from the negative emotions to the external world and also enables them to anchor to the present moment. They are taught coping responses like washing hands, describe their immediate external environment, describe the texture of the sofa, identify 10 colours in the room etc., These techniques allow them to detach from strong emotions and establish contact with the present moment in the immediate external world through sensory and cognitive awareness. This will help manage overwhelming anxiety and limit the panic.

Cognitive awareness

Patient is asked to answer cognitively oriented questions like: Where am I? What is today? What is the date? What is the month and year? How old am I? What season is this?

**Figure 3: Possible genesis of dissociation**

Sensory awareness

This technique involves using the senses to anchor to the present moment. For example; feel the back of the chair and describe its texture, count all the red items in this rooms, identify 5 sounds around you, name two things you can smell right now, place a cool cloth on your face and describe how it feels, have a cup of tea and focus on its warmth, etc., [Table 6].

DISTRESS TOLERANCE

Distress Tolerance skills teaches the patients to tolerate painful emotions and uncomfortable feelings without resorting to impulsive and unhealthy behavior like substance abuse, self-harm, dissociation etc., It does not aim to solve the core issue and to bring about long term conflict resolution. The aim of distress tolerance is to increase the patient's capacity to bare the painful emotion when the situation cannot be changed immediately. First the patient is taught the role of emotions in life and the consequences of resisting them. They are then taught how to identify and label an emotion; after which they are a taught various tools to handle the emotion. It is observed that once the patient learns this emotional first-aid, they start to feel relatively confident and safe

in the face of an emotion because now they have tools to manage them.

Various distraction and other related DBT skills are taught under DT:

1. Self-soothing: where the patient can identify and engage in activities that employ their senses, that sooth them
2. TIPP: This acronym stands for temperature, intense exercise, paced breathing and paired muscle relaxation. This helps to reduce extreme emotional arousal quickly
3. ACCEPTS: Acronym stands for activities, contribution, comparison, emotions, push aways, thoughts, and sensations
4. IMPROVE: This acronym stands for imagery, meaning, prayer, relaxation, one thing in the moment, vacation, encouragement
5. Cost-benefit analysis: They are asked to reflect on the pros and cons of their behavior
6. Containment imagery: These are skills that help in regaining control over intense emotions
7. Mindfulness
8. Radical acceptance: Patient is taught to accept undesirable circumstances that cannot be changed. Decreasing resistance to what-is, will reduce the distress associated with it. This concept teaches them that how to manage an unchanging painful situation is a matter of choice. They have a choice to accept something that is not going to change and move on or choose to resist it and deal with the consequent pain and dysfunction [Figure 4].

For example, when a patient ABC diagnosed with a chronic illness, understands from the doctors about the chronicity and restriction it will pose in his life. He goes through various thoughts, “Why me,” This is not fair,” “how can this be my life ahead” and many such thoughts which reflect the inability or difficulty in accepting a situation.

Another example, when a person XYZ is concerned about an argument they had with a family member and called her by a nasty name, XYZ may find herself constantly worried about the consequences and is anxious or goes through guilt.

During such instances, the patient can be asked to list out various responses:

Table 6: Sensory awareness strategies

Senses	Sensory awareness strategies
Sense	Sensory awareness strategy
Tactile	Stress ball, palm object, stone
Olfactory	Lotion or perfumes
Taste	Gums, chocolates, candies, mints
Visual	Watch a clock, object, flower vase
Auditory	Sound of a clock, song, soft music

Options

- Alter the source of the problem – change the situation if possible. However, not in all cases, this may be possible. In cases of interpersonal conflicts being the situation, one can work towards it and work on improving relations and conflict
- Change the painful emotion – that is to change how you feel about the problem. This includes thinking of alternate responses. This includes skills to improve moment skills– distraction and self– skills. Using the defense of suppression
- Stay miserable – scream, regret, guilty ideas, complain, curse
- Make it worse – becoming aggressive, impulsive actions, consume substance, further worsening conflicts in case of interpersonal conflicts.

(Readers may refer to other books and resources on each of these DBT skills for comprehensive understanding of the concepts).

TALKING THROUGH

It is also referred to talking to the personality system as a whole. It is an effective and useful technique in working with a patient with Dissociative identity disorder. The therapist can approach this situation by means of being directive and asking the different identities to acknowledge the presence of a conflict and unmet needs. Emphasizing that working together is essential to enable the functioning. “Listening in” and cooperating is the requirement in this procedure. Every session can have the therapist sharing and emphasizing this. This enables coconsciousness and awareness of one’s own internal process.

Co consciousness involves internal awareness of existence and experiences of other self-states. The process allows self-aspects to align to one’s directives. This allows symptom reduction, fewer episodes of time loss, fewer behaviors outside of awareness and improves general functioning.

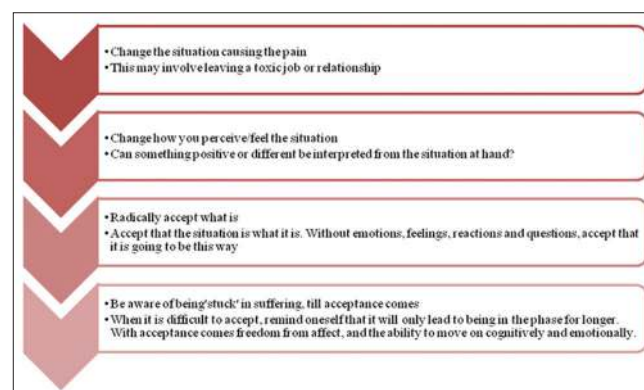


Figure 4: Radical acceptance

INTERNAL MEETINGS

It is inevitable for the therapist to take into account the different self-states. Initial stages of treatment is challenging as the different self-states may not cooperate. Internal meetings are taught, also a part of the Dissociative table technique where the patient recognizes internal ego and control switching and internal communication. This strategy is effective in reducing internal conflict and resolving safety issues. They are important in safety planning and identifying a self which is suicidal and hopeless self-aspect. Furthermore, the more organized the meetings are, the more successful the outcome; this enables problem-solving.

The internal meetings start with “introduction” describing the age, interests, needs, wants, roles, etc. Second, it can focus asking the needs towards which one needs to work on. Also, record the verbatim in a diary. This enables the patient to also look within and identify the conflict, bringing about a deeper level of awareness.

TRAUMATIC RE-ENACTMENT

This phenomena occurs which occurs at an external or internal level. There are several biologic and psychological theories which explain the re-enactment of memories, learned behaviour, disorganized attachment. Vulnerability to re victimization which results in traumatic re-enactment can be explained by Karpman Drama triangle. The trauma triangle also includes the “bystander.” The self which internalizes the persecutor, victimized self and the rescuer. Acceptance and calmness from the part of the therapist is essential as is working with the needs of self and address the aggression.

Accept it

The process of dealing with the reality, what actually is happening and figure out what the situation calls for.

In the first instance, it could involve accepting the situation of illness, understanding that illness is a reality, however despite it one need not suffer, that is an attempt to radically accept deeply and willingly following the help required.

In the second example, apologizing, working on improving communication, asking the family member on how one can contribute toward repairing conflicts.

Acceptance is a choice and turning the mind involves practising the skill of acceptance in a particular situation. Furthermore, acceptance does not involve approval. It involves understanding the reality for what it is, painful emotions that one can cope with by means expression of emotions in an adaptive way and getting adequate support.

EMOTION REGULATION SKILLS

Emotional regulation is a term that is often used to understand how people manage and respond to their internal emotional experiences. And emotional dysregulation can be understood as a person's inability to use healthy strategies to moderate or diffuse negative emotions. Learning ER skills enables individuals to identify why emotions are important, the identification of emotions and process of change in emotions. It also involves how to evaluate emotional responses which are effective. Patients with dissociative experiences and symptoms often present with emotional dysregulation. The process of dealing with intense emotions involves the following steps:

- Reduce emotional vulnerability-By decreasing the frequency of unwanted emotions, practising ways to reduce emotions such as shame, guilt, anger, sadness– starts with nonjudgementally observing the emotions, accepting them and letting them go by means of various techniques such as mindfulness
- Identify whether these emotions are primary– which are emotions that occur after the initial event and secondary which result from emotional reactions to our primary emotions
- Identify the function emotions serve for example. Survive, cope with situations, communicate with others, avoid pain, seek pleasure or remember people or situations
- Goal of emotion regulation skills are to help cope with your reactions to your primary and secondary emotions in a newer and more effective way.

Steps are:

- Recognize emotions
- Overcome barriers to healthy emotions
- Reduce physical and cognitive vulnerability
- Increase positive emotions
- Being mindful of your emotions without judgment
- Emotion exposure
- Problem-solving.

INTERPERSONAL SKILLS

Interpersonal effectiveness skills consists of social skills training, assertiveness training and listening skills.

These are particularly inevitable as interpersonal behaviors and patterns influence relationships. It involves the individual identifying the pattern of interpersonal style and behavior – passive or aggressive. Both patterns can result in unhealthy and destructive relationships. The key interpersonal skills which facilitate change are: Knowing what you want, asking for what you want, negotiating conflicting wants, getting information, saying “no” in a way that protects the relationship and acting according to values.

These are particularly required in cases where interpersonal conflicts exacerbate dissociative experiences and also the goal is to improve the overall health of the relationship.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

It is a form of psychotherapy that helps people address and process traumatic life experiences and systematically facilitate adaptive responses to the conflicts created. It is a psychotherapeutic technique that engages clients in traditional elements of therapeutic methods which are organized in a unique way. This technique is used especially in patients with posttraumatic stress disorder. The technique involves:

- History and treatment planning, where evaluation and assessment of targets of reprocessing that are selected based on past and present experience and concerns about future
- Therapeutic alliance is built and the patient is explained the process of the treatment. This phase also is used to ensure that the patient has the emotional tools to manage the painful emotions that may emerge
- Assessment of worst moment of the target event and the accompanying negative and positive cognitions
- Evaluating the validity of the desired cognition and emotions present. The level of emotional distress experienced as the image is re-imagined and emotions are experienced along with physical symptoms.

The process of desensitization involves:

- Therapist guided lateral eye movements and substitute activities in the patient, in order to process the target picture, emotion, physical symptoms, and cognitions
- Once the process of desensitization is achieved a positive/healthier cognition is paired with eye movement
- Once entire processing is achieved, the patient is asked focus on the body and closure is brought about when the therapist debriefs the client.

At a glance one can see the various types of coping skills in Table 7.

When dealing with dissociative disorder, the approach to dissociative identity disorder must be mentioned in a little more detail.

DISSOCIATIVE IDENTITY DISORDER

While approaching dissociative identity disorder, it is preferable to work through 3 stages, for the purpose of chalking out a plan or understanding. It is also important to keep in mind that integration of all identities as one may not occur, and treatment goals have to be small and tailored accordingly [Figure 5].

Phase oriented treatment approach is widely used and is a sequenced staged process given by for dissociative disorders.

1. Establishing safety, stabilization, and symptom reduction
2. Confronting, working through and integrating traumatic memories
3. Identity integration and rehabilitation.

Establishing safety, stabilization, and symptom reduction

Goals:

- Ensure personal safety
- Stabilization
- Internal communication
- Containment
- Symptom management
- Affect modulation
- Stress tolerance.

Self-soothing and self-regulatory strategies are used to reduce the physiological and dissociative symptom.

Skills training is an inevitable part of safety and stabilization phase.

Goals of skills training are:

- Enhancing emotional awareness and emotional regulation
- Decrease affect phobia
- Distress tolerance
- Relationship effectiveness.

Also, the process of working with different identities is by means of talking through and internal meetings.

Confronting, working through, and integrating traumatic memories

Focus:

- Remembering, tolerating and processing and integrating these memories
- Process includes abreaction and the release of strong emotions in connection with an experience or perception of a past experience

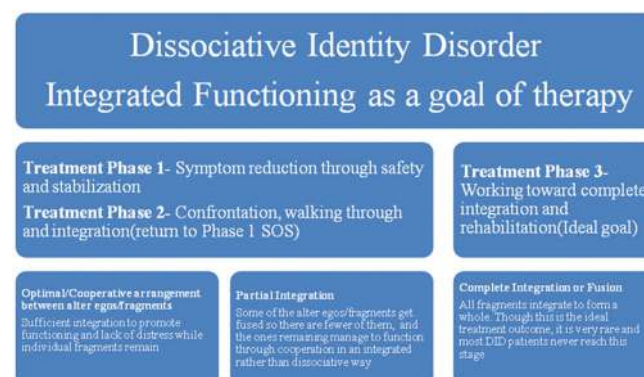


Figure 5: Approach to dissociative identity disorder

Table 7: Type of coping skills

Self - soothing Comforting yourself through 5 senses: Eg. Stress ball (tactile), Meditative music (hear), Happy pictures (see), flavored tea (taste), Scented candles (smell)	Distraction Taking one's mind off the problem for a while Eg. Reading, cooking, gardening, crosswords, sports, etc	Opposite action Doing something which is the opposite of the detrimental impulse and yields a positive emotion. Eg. Affirmation and inspirations (quotes, sayings, etc) Funny/quirky videos/movies, etc	Emotional awareness Identification and awareness of one's own feelings and emotions which can be maintained through a diary, e diary, pages, etc	Mindfulness Tools to aid grounding oneself in the present moment. Eg. meditation, breathing, use of grounding rock, etc	Crisis plan A plan ready in case one fails/one is an acute emergency Contact numbers of close contacts on speed dial family, friends, teachers, employer, therapist, psychiatrist, - creates a psychological safety net. Plan the steps of the crisis - follow the techniques of coping, talk to someone, and if still no remission, visit the psychiatrist.
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Table 8: Checklist to help prediction of stabilization treatment

Cluster	Components
Lacking motivation Severe axis I disorder	High secondary gain, no motivation to lead a normal life, coping skills poorly developed Schizophrenia, psychotic disorder, bipolar disorder, combination of personality and more than axis one disorder, organic mental disorders and severe cognitive distortion
Severe axis II disorder	Antisocial, paranoid, narcissistic, schizoid, schizotypal personality disorders
Absence of healthy relationship Absence of healthy therapeutic relationship	Ongoing abusive relationship, ongoing abuse of family member, prior treatment with abusive therapist Inability to build relationship, poor closeness of fit, inability to deal with transference, severe inability to follow rules, dissociated personality does not cooperate with therapist
Poor attachment Self-destruction	Inability to trust, empathy issues Persistent self-blame

- Develop a sense of control over the emergence of traumatic material.

Specific interventions:

1. Exposure requires adequate time in sessions and can work without significant disruptions in functioning. Material in the traumatic memory is transferred to a narrative memory.
2. Abreaction involves bringing about changes in thoughts, addressing the intense emotional dysregulation by enabling change in the thinking pattern and self-mastery.

Integrating traumatic memories is meant by bringing together the different aspects of traumatic experiences, memories and sequence of events, associated affects and physiological and somatic representations. It also involves establishing a sense of self and the impact of trauma from the past into their life. As traumatic memories integrate, the different identities tend to be less distinct [Table 8].

PHASE 3: INTEGRATION AND REHABILITATION

Goals

Achieve a solid and stable sense of how they relate to others and to the outside world. Also, patient may begin to focus more on the channelizing their energy towards living in present and a purpose instead of the traumatic memories.

COGNITIVE BEHAVIOR THERAPY

Once the patient has stabilized and the therapist based on her/his judgment of the patient's ego strength may want to attempt CBT or other cognitively oriented therapies.

This allows the patient a different and more structured view of his/her emotional life. These therapies through their psycho educational methods teach the patient how to identify and challenge irrational core beliefs. In the long run this knowledge helps develop meta-cognitive skills and helps in relapse prevention too. Understanding this helps many patients realize that they have the power to influence their emotional world. Moreover, the tools to change them that are taught in cognitive therapies create a sense of empowerment.

Points to note:

1. Continue medication along with therapy
2. Be aware of handling breakdowns
3. Psychosis is a contraindication to psychotherapy.

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Conflicts of interest

There are no conflicts of interest.

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