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

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INTRODUCTION

Dissociative or conversion disorders (ICD-10; hereafter referred to as dissociative disorders) are characterized by disruption in the usually integrated functions of consciousness, memory, identity, 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 monetary, or legal. In these disorders, it is presumed that the ability to exercise a conscious and selective control over the symptoms 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 life events and problems or disturbed interpersonal relationships. Dissociative disorder can be of different types as given below in Table 1.

Table 1: ICD-10 category of Dissociative (Conversion) Disorders

1	Dissociative amnesia
2	Dissociative fugue
3	Dissociative stupor
4	Trance and possession disorders
5	Dissociative motor disorders
6	Dissociative convulsions
7	Dissociation anaesthesia and sensory loss
8	Mixed dissociative (conversion) disorders
9	Other dissociative disorders
10	Dissociative disorder, unspecified

These guidelinesare an update to previous IPS guidelines on dissociative disorders (2008) in child or adolescent (hereafter child unless specified). Theseare broad guidelines which will help in systematic assessment and management of a child with dissociative disorder.

ASSESSMENT AND DIAGNOSIS

The assessment of dissociative disorders involves a detailed psychiatric and developmental history. An assessment should be made of the child's temperament,schooling and peer relationships. The family functioning should be explored. A comprehensive medical, neurological andmental status examination should be done. An assessment of psychosocialcircumstances and problems

should be done specially to find out which ones are temporally associated with the onset of dissociative symptoms.One should obtain psychiatric history from all the possible sources including the teachers, if possible. Also, assessment should be made of the perception of the child and parents about the dissociative symptoms.An attempt should be made regarding presence of physical and psychological symptoms in the other family members or the neighbours which may act as a model.
The key points in assessment of paediatric dissociative disorders are given below in Table 2.

Table 2: Key points in assessment

1. Reliably rule out physical disorder that may explain the symptoms
2. Find out and establish comorbid psychiatric or physical disorder, if present
3. Find out the family functioning and parenting style
4. Find out psychiatric/physical disorders in the family member, if present
5. Assess the temperament of the child

RULING-OUT PHYSICAL AND OTHER PSYCHIATRIC DISORDERS

As mentioned above, an initial comprehensive medical and neurological assessment is crucial in any child where a possibility of a dissociative disorder is being kept. In this regard the treating psychiatrist should always consider seeking appropriate consultations. Relevant physical and psychological investigationsmust be done (Table 3).An assessment of educational achievement of the child with regard to the child's potential and the level of education provided should be done,which is often indicated. The possibility of dissociative symptoms superimposed on neurological or medical disorders, or other psychiatric disorders should always be carefully considered.
If dissociative symptoms appear for the first time in a preschool child, a strong suspicion of an underlying physical or psychiatric disorder should be kept in mind because dissociative disorders are very rare in this age group.

Table 3: Investigations for ruling out physical or psychiatric disorders.

Investigations	**Disorders**
EEG (Video EEG)	seizure disorder
IQ test	Intellectual disability or borderline intellectual functioning
Urine drug screen	Substance abuse
Neuroimaging	Structural lesions eg. Brain tumours
Blood tests	Eg. Postictal Prolactinelevation, physical disorders

DIAGNOSIS OF DISSOCIATIVE DISORDER SHOULD NOT BE MERELY BASED ON THE ABSENCE OF OBJECTIVE SIGNS OFPHYSICAL DISORDER

Although it is very important to exclude an underlying or associated physical

disorder, as well as other primary psychiatric disorders that may explain the dissociative symptoms, the diagnosis of dissociative disorder should not be based merely on the absence of objective signs of a physical or psychiatric disorder**.** 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 the child and the symptoms. When the diagnosis of a dissociative disorder is made with too much certainty without proper assessment, other physical or psychiatric disorders are often missed. When the diagnosis is too tentative, multiple and irrational medical evaluations may be conducted, and iatrogenic reinforcement of the symptoms and harm are possible.
Pseudoseizures or nonepileptic seizures are a common presentation of dissociative disorders in children which must be differentiated from true epileptic seizures (Table 4).

Table 4: Differences between dissociative convulsion and epileptic seizure

Dissociative convulsion	**Epileptic seizure**
Pre-ictal phase	
Anxiety	Wide range of auras
Seizures may be induced	Rarely induced
Ictal phase	
Inconsistent and variable sequence of events	Consistent and invariable sequence of events
Occur only when others are present	Can occur when alone or during sleep
Gradual onset	Abrupt onset
Prolonged duration (>2min.)	Short duration (<2min.)
Asymmetricallimb movements, pelvic thrusting, sideways shaking of head	symmetrical movements
Rare incontinence, injury due to fall, frothing, tongue biting	Incontinence, injury due to fall, frothing, tongue biting often present if generalized
Normal autonomic reactivity, pupillary responses	Disturbed autonomic reactivity, pupillary responses
Vocalizations may occur throughout seizure	Single vocalization, if present, at onset
Avoids noxious stimuli	Cannot avoid noxious stimuli
Resists eye opening, or there is avoidant gaze	Cannot resist eye opening
Normal ictal EEG	Abnormal ictal EEG
Post ictal phase	
No postictal delirium	Typical postictal delirium
Subsequent recall of events during ictus	no or fragmentary recall of events during ictus
No rise in serum prolactin	Rise in serum prolactin10-20min. postictally

PSYCHOSOCIAL PROBLEMS OR STRESSORS

Psychological distress overt or covert is an essential causative factor for dissociative disorders. A list of common stressors in paediatric dissociation is given below (Table 5). Stressors are not mutually exclusive.

Table 5- Psychosocial factors

1. Individual factors-
   a. Temperament (anxious, behavioural inhibition, harm avoidance)

b. Poor coping skills
c. Borderline intellectual functioning
d. Psychiatric/physical illness (anxiety, depression, seizure disorder)

2. Family
   a. Parenting (critical, overinvolved)
   b. Parental physical/ psychiatric problem
   c. Parental substance abuse
   d. Marital or family disharmony
   e. Poor communication with child
3. Environmental
   a. Peer group problems
   b. Bullying
   c. Academic stress
   d. Harsh, critical teacher
   e. Abuse

Attempts should be made to systematically identify the child's psychosocial environment,stressors and copingabilities to handle stressful life situations. An attempt should also be made to find out the secondary gains due to dissociative disorder.

A view that stressors are "unconscious" creates a barrier in the physician's mind about looking for stressors. Studies in children with dissociative disorders have shown that stressors are generally present in day to day life of the patients and are known both to the patient and the family members.However, they may not reveal them for certain reasons. It is important for the clinician to evaluate the child for the stressors from a developmental perspective. It may not be possible to find out stressor in the initial interviews.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 in family relationships, fights with other children, scolding and punishment by the teachers or family members, some frightening experiences and educational difficulties.The child may find oneself in some kind of unwanted or disliked situation like marriage, job or studies, bullying and sometimes abuse and neglect. The stressor could also be an unaddressed physical illness or deformity.

Assessing in detail about the onset of symptoms may give clue to the possible stressor for eg. becoming unconscious at school in English period.

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 multiaxial 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. 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.

Differential diagnosis and comorbidities

Dissociative symptoms could be the presenting symptoms of underlying undetected psychiatric disorder like separation anxiety disorders, generalised anxiety disorder, panic disorder, school phobia, depression and at times impending psychosis**.** Then dissociative disorder may also have comorbid oppositional defiant disorder, attention deficit hyperactivity disorder, intellectual disability specially in boys. Therefore, it is important to screen for all age appropriate psychiatric disorders in the child to avoid missing an underlying primary or a comorbid diagnosis.

Dissociative disorders should be differentiated from factitious disorder and malingering. In latter two situations the symptoms are intentionally produced to a assume sick role. The gain is psychological in factitious disorder. In factitious disorder by proxy the parent(s) induce illness in the child for their own psychological gains. In malingering, the symptoms are feigned to obtain an incentive like money or some other material gain or to avoid a disliked responsibility or punishment. Apparent fabrication of symptoms or gross inconsistencies in history should raise possibility of malingering or factitious disorder.

FALSE-POSITIVE DIAGNOSIS

Rates of misdiagnosis are around 4%.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. One must assess the case with open mind. One should review the past medical records carefully and, if required, further assessments should be done.

Some of the diagnostic difficulties are mentioned in table 6.

Table6: Physical differential diagnosis

Epilepsy
Movement disorders
Multiple sclerosis
Myasthenia Gravis
Polymyositis
Periodic Paralysis

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

POSITIVE SIGNS

Various “positive signs” of dissociative disorders have been described in the literature like tunnel vision, discrete anaesthetic patches, astasia abasia, positive Hoover’s test, preserved cough in hysterical aphonia, and hemi-anaesthesia 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 hyperaesthetic 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 looked for the positive signs of hysteria in 30 consecutive neurological admissions (25 of which had acute strokes in adults). These ‘signs’ were la belle indifference, non-anatomic sensory loss, midline split of pain or vibratory sensations, changing boundaries for hypoalgesia, giveaway weakness, and history of hypochondriasis. All 30 patients showed at least one out of 7 ‘signs’, most exhibited more than one ‘signs’ and one patient had all 7 ‘signs’.

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. The treatment usually consists of two parts: (a) early treatment directed towards symptom removal, and (b) long term treatment directed towards resolution of stressors, 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. Table 7 gives the key points of treatment.

Table 7- Treatment

ACUTE TREATMENT
Assurance
Relaxation
Doctor- Child and family relationship
Restoration of communication in the family
Realistic solution of the problems
Reduction of sick role and secondary gains
Promotion of positive behaviour
Teaching heathy coping
Treatment of comorbid psychiatric or physical disorders
TREATMENT OF CHRONIC CONDITION
Family focused Cognitive behaviour therapy

PRINCIPLES OFACUTE MANAGEMENT

RAPPORTAND THERAPEUTIC ALLIANCE

The cornerstone of successful therapy is establishment of therapeutic rapport and alliance with the child. It is also very 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. One should listen to the concerns of the family carefully and try to understand their perception of the child's symptoms.

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 diagnostic 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 nothingphysically seriously wrong with the child and the symptoms are psychogenic 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 with their 'severely ill'child, their parenting or with their family functioning, is totally unacceptable to the parents. 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 non-confrontational, calm approach towards the disorder the child and family.When the treatment team's point of view is understood and accepted by the family, only then it would be possible for them to cooperate in psychosocial assessments.

Table 8: Key points in psychoeducation

It should be acknowledged that the child has real symptoms and sufferings but the reasons could be psychological and not physical.
Harmlessness of the symptoms should be emphasised. It should be emphasized that symptoms are not dangerous or fatal.
Symptoms in absence of serious physical disease are common. These symptoms could be better explained by the mind body relationship, for eg.,anxiety can lead to palpitations, tremors, rapid breathing, sweating etc.
Emotions can cause physical symptoms and this can happen even in children.
Stressors may not be severe or unimportant from an adult point of view but may be very important matter of concern for the child.

ADDRESSING THE PSYCHOSOCIAL PROBLEMS

Once the causesare 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. Throughout the treatment, attention should be focused on the child and his functioning rather than on the symptoms. This helps in 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.

Table 9: Behavioural management of children

Reassuring the child that he/she is not seriously ill
Encouraging the child to gradually resume normal daily activities and functioning
Encouraging physical exercise and play
Relaxation exercises eg. deep and slow abdominal breathing
Paying attention to the child when normal without symptoms.
Engaging the child in age appropriate activity of interest like drawing, colouring, story book reading etc.
Encouraging joint activities with parents
Praise and appreciate for positive behaviour.

SYMPTOM SUBSTITUTION

As the dissociative symptoms begin to subside, the child may sometimes manifest other new dissociative symptoms in their place. Occasionally, distress may be expressed by deliberate self-harm, demanding and histrionic behavior or the child may develop depressive symptoms. In such a situation, consistent limit setting may be essential for continuation of psychological treatment. Regularity of follow-up visits is important so that the patient does not need to 'produce'a symptom to visit the therapist.

Lastly, the physician should not feel pressurized to cure the child very quickly. He should retain his calm and be prepared to face the hostility and aggression of the family and coercion for not using medication and quickly improving the child.

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 physician and 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 coupled with an alternative, healthy, socially acceptable and age appropriate roleor activities for the child in which he or she can be trained and rewarded for doing something positive.

ABREACTION AND AVERSION THERAPY

Aversion therapy for unwanted behaviour 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 behaviour 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.

MEDICATION

Medication may be usedonly for concomitant anxiety, depression or behavioural problems and not for the dissociative symptoms**.** The family should be tactfully made to understand that medications are not required nor approved 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 thinking that medication will cure the dissociative symptoms. 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 overcome resentment or hostility of the family.

NEED FOR HOSPITALIZATION

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

Dual Diagnosis

If the dissociative symptoms are present with the physical disorder then the physical disorder should be treated first. When the physical disorder is stabilised then the dissociative symptoms if still present should be managed as per the guidelines.

TREATMENT OF CHRONIC DISSOCIATIVE DISORDER

Chronic cases are more difficult to treat and the management should always begin with a rational comprehensive evaluation, and clear explanation to the child 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 child taking into account his ability to understand and accept the information. The family should be explained that, although the symptoms are real and impairing, but a serious physical disorder is not causing them and there is hope of full recovery. Psychotherapy may be useful but contraindicated in a patient who is resistant to it or gets worse when it is initiated.

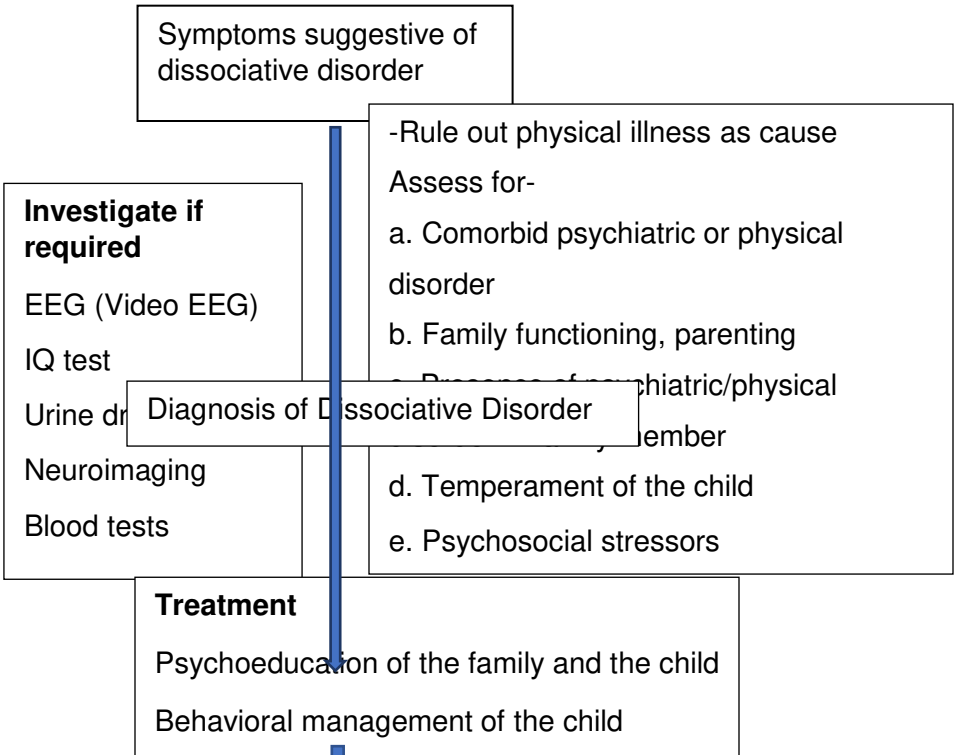
COGNITIVE BEHAVIOUR THERAPY

Family focused cognitive behavioural therapy (CBT) helps the affected child to become aware of, examine, and if appropriate revise the way they think, respond and behave rationally to their symptoms. The aim of CBT is to maximize functioning and reduce the dissociative symptoms. Gradually onus of treatment should be shifted from the physician to the child and the family. The following are the principles of CBT in chronic dissociative states:

1. Give positive explanations for symptoms.
2. Persuade the child that change is possible, he or sheis not “damaged”, and they do have the potential to recover.
3. Discuss the treatment rationale with the patient and the key family members.
4. Encourage engagement in daily routine activities.
5. Teach relaxation, and distraction away from unpleasant thoughts and the symptoms.
6. Encourage the patient to rationally reconsider unhelpful and negative thoughts.
7. Negotiate a phased return to work and studies.
8. Joint activities with family in symptom free periods

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

Management Scheme for paediatric Dissociative Disorders



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