FAMILY CASEWORK WITH A PERSON HAVING RECURRENT DEPRESSIVE DISORDER WITH DISSOCIATIVE FUGUE AND MARITAL CONFLICT

Athira KV[1] & Sinu Ezhumalai[2]

[1] Lecturer in Psychiatric Social Work, Department of Psychiatry, Yenepoya Medical College Hospital, Deralakatte, Manglore, [2]Additional Professor, Department of Psychiatric Social Work, NIMHANS, Bangalore

Correspondence: Sinu Ezhumalai, E-mail: esinu27@gmail.com

ABSTRACT

Introduction: Dissociative fugue is a rare mental health condition reported with a significantly lower prevalence rate and presenting symptoms of amnesia along with the sudden onset of travelling without knowing about self and whereabouts. There will be psychological trauma and stressors in this health condition. The multidisciplinary team is effective in managing ongoing psychosocial stressors impacting the episode. The current case study focuses on the psychosocial aspect of the client who presented with such an illness. **Assessment and diagnosis:** This case focusing on a 37 year old female diagnosed with recurrent depressive disorder and dissociative fugue who had several psychosocial stressors in her family of origin and procreation. The client was treated with pharmacological and non-pharmacological interventions. The Therapist has done a psychosocial and family assessment and found poor functionality, assertiveness, and interpersonal skills at the individual level. At the family level, interpersonal relationship issues between client and spouse, poor communication, and poor understanding of the client's condition among spouse and caregiver burden were identified. **Interventions:** The psychosocial intervention focuses on individual and family-level issues based on the assessment. Psychoeducation, activity Scheduling, supportive psychotherapy, and couple therapy are the primary interventions done during inpatient care. **Conclusion**: Psychosocial interventions are more significant in dealing with even complicated illnesses. Intervention in communication and interpersonal relationships will always give a better outcome. The multidisciplinary team approach is essential in dealing with mental health issues.

Keywords*:* Recurrent Depressive Disorder, Dissociative Disorder, Psychosocial Assessment,

INTRODUCTION

Depression is considered as a common mental health condition and 350 million people in the globe suffer from depression, according to the World Health Organization, and it accounts for a higher burden according to years lost to disability(YLD) (Smith, 2014). Depression is a mood disorder with the symptoms of low mood, loss of interest in all activity, decrease

or increase in appetite almost all day, fatigue or loss of energy, and feeling of worthlessness that lasts for more than two weeks (American Psychiatric Association, 2013). Recurrent depressive disorder is a condition where at least two depressive episodes should occur with several-month gaps without any mood disturbances (WHO, 2019). *Major depressive disorder* is a mental illness that may have high comorbidities (Hardeveld et al., 2009). Dissociative fugue, formerly called psychogenic fugue, is a group of psychiatric conditions called dissociative disorders. Dissociative fugue is the disruption of the integration of consciousness, memory, perception, identity, or emotion of the person (Igwe, 2013). Dissociative disorders include dissociative amnesia, fugue, depersonalization disorder, dissociative identity disorder, and dissociative disorder not otherwise specified. (American Psychiatric Association, 2000) Dissociative amnesia with dissociative fugue is the "purposeful travel or bewildered wandering associated with amnesia for identity or other crucial autobiographical information. (American Psychiatric Association, 2013)

This case report is of a married woman with recurrent depressive episodes and dissociative fugue who had undergone traumatic life events and psychosocial difficulties at the individual, family, and social levels. The treating team referred the patient to the psychiatric social worker for psychosocial intervention at the individual and family levels. The case report highlighted the importance of psychosocial intervention in recurrent depressive disorder with a dissociative fugue. This case report can elicit the scope of Psychiatric Social Workers, their significance in a clinical setting, and possible outcomes in a case study conducted in NIMHANS, Bengaluru, Karnataka.

ASSESSMENT

Case Introduction

A 37-year-old female educated up to M.Phil in Microbiology was working as a hostel warden hailing from middle socioeconomic status, from Tamil Nadu

Source of Information

Information was collected from the client, the client's husband, and the client's son, as well as from the case file in the medical record department. The information was reliable and adequate.

Reason for referral

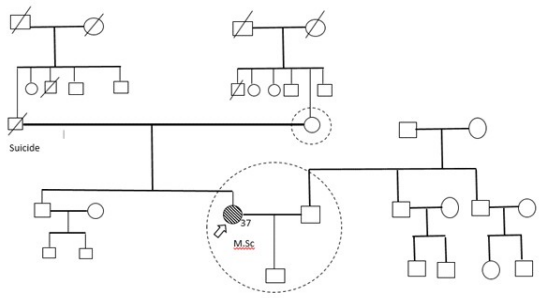
- To provide family casework
- To facilitate supportive psychotherapy

Clinical diagnosis

Recurrent Depressive Disorder with Dissociation Fugue (ICD-10 F.33 & F.44.1).

The client maintained well till 2014. However when her husband compared her to his colleague, who was also a family friend client began to suspect him of having an extramarital affair with that colleague. It became severe when her husband went for exam preparation for ten days and stayed in a hotel. The client firmly believes that he spent those days with the same colleague and enquired about them in the hotel where he stayed. The hotel staff refused to reveal her husband's details, making her more suspicious. She further reported that the villagers spoke ill of her and mocked her, which caused significant emotional distress. During the same period, she had a friendship with Mr P, who resides in the same place. She collected his number and contacted him by phone for three months. In 2017, she had an episode of low mood, low energy, decreased sleep, and reduced interaction. She had several minor episodes of fugue along with loss of memory.

Family Genogram



Family History: Alleged history of suicide in a first-degree relative. The client's father died by suicide when the client was 13 years old and the reason was unknown.

FAMILY COMPOSITION

Husband: is a 39-year-old male working as a Lawyer. He was educated up to graduation in law and did not report any health issues. He was very bothered about his status and had a social stigma regarding illness. Criticality was present towards the client. He was stressed and had burnout as he had to manage many roles and responsibilities in the house and workplace. He was ready for the treatment and quite supportive. However, he had poor knowledge about illness, which made him more stressed. They have a good relationship with each other after marriage. Later, some issues arose in their relationship. He was concerned about the treatment period, the effectiveness of the medication, and family life.

Wife: The index client. The client lives with her husband and son. She was more attached to her son. A cordial relationship was maintained initially, and a communication decline also existed in the latter part of their lives.

Son: They had only one child, a 13-year-old studying in the eighth standard. He was a easy child who was very much attached to his parents. He used to take care of his mother during her illness and was very much concerned about his mother's health. He is emotionally supportive of his mother.

FAMILY DYNAMICS IN FAMILY OF PROCREATION

Boundary: The boundary of the family of procreation was clearly defined and open. *Inference***:** The boundary was clear and open.

Subsystem: In this Family, two types of subsystems exist. One was the couple subsystem, and the other was the parent-child subsystem. Both subsystems functioned well earlier. A decrease in the functioning of a couple subsystems existed during the past four years. The illness affected the parent-child subsystem and significantly affected the mother's involvement.

Family developmental stage: The family is in the IV stage of development, a family with school-going children (Duvall, 2002). The son is 13 years old and studying in the eighth standard.

Leadership: The client's husband is the nominal leader in the family. The client less involved in decision-making other than the household chores. She reported less confident in making decisions and expressing her opinions. He ignored her as she responded less and did not give suggestions. Hence, the husband himself decides. The patient's only concern is that any decision regarding their son should be discussed with her. *Inference:* Leadership was accepted, and Democratic decision-making was present

Role structure and functioning: Roles and responsibilities are clearly defined in the family. The client does household chores. Both husband and client are earning. The client takes care of the child and used to go to work. Mutual support was present in the family. No role confusion or conflict was reported. Due to illness, there was decline in client functioning and the husband took many of the client's roles before hospitalization. *Inference***:**

Complimentary, instrumental, and expressive roles were present. The multiplicity of roles is present in the husband.

Communication: Both verbal and nonverbal communication was present in the family. Communication among spouses was primarily affected due to interpersonal relationship issues among couples. Verbal communication was also reduced between the client and the son. The family had less expression of feelings and emotions due to the illness. *Inference***:** Communication in the family of procreation was affected due to the illness.

Reinforcement: The family has a positive reinforcement mechanism. The husband and son are attached to the client. The emotional expression on the part of the client was less. Positive and negative reinforcement was used to rear the child. *Inference:* Both reinforcements were present.

Family rituals: Initially, the family used to have a standard time for sharing and relaxation. Sometimes they go for an outing and shopping or a picnic. During the past four years, the quality of time spent by the members was reduced. The family attended religious functions and social gatherings. *Inference***:** Family rituals present.

Adaptive Pattern: The family uses good adaptation and coping strategies to deal with the problem. Over the past four years, the communication gap affected the family's coping strategies. *Inference*: Positive coping mechanisms and adaptive patterns were present.

Social Support System: Primary Support: Primary social support was present from husband and son. Secondary Support: Extended family members emotionally supported the client and family. Tertiary Support: NIMHANS, Bangalore is the tertiary support for the family.

PERSONAL HISTORY

Birth and early development: No reliable informants were available.

Behavior during childhood: The client was shy and inclusive during childhood. She had fewer friends and less attachment to others.

Physical illness: No physical disease was reported in childhood.

School: The client started schooling at the age of six. She was an above-average student and studied MPhil in Microbiology.

Occupation: The client worked as a hostel warden for the past four years and travels one and a half hour from her home. She had three shifts in this job, significantly affecting her sleep and changing her routine. Previously she used to work as a liaison officer in the information center of the Distance Education department at Vadalur, which was 15 minutes away from their home. It is a permanent job.

Menstrual history: The client attained menarche at the age of 14 years. She had regular periods and menstruation became irregular in the past 12 months due to PCOD.

Sexual history: The onset of puberty was at 13, and she learned about sex from friends and books. She has had no extramarital relationships. In 2016, spouses had no sexual relationship for six months.

Marital history: The client married at the age of 21 years, and the husband was 25 years old. It was a marriage by choice without the consent of the family of origin.

SOCIAL ANALYSIS

A 37-year-old married female studied up to post-graduation belongs to the middle socioeconomic status from a Hindu religion, born out of a non-consanguineous marriage and history of suicide in father. She was diagnosed with Recurrent Depressive Disorder, Dissociative Fugue.

The psychosocial assessment revealed that the client's illness affected her social functioning and her family. The client had poor self-esteem and is an introvert by nature. She had poor self-care, stress, problems in

interpersonal relations and activities of daily living, and deliberate self-harm behavior. At the family level, there was interpersonal relationship issues with her spouse, caregiver burden, and poor communication in the family of procreation. The assessment revealed that she had single-parenting, and extended family members were involved in the child's rearing. The client reported marital conflict among parents, and the father's death was a traumatic stressful life-event in childhood. The client's family of origin had a close and rigid boundary, and the mother carries out instrumental roles. Decision-making was democratic and later became authoritative. Mother had complementary and multiple roles. Communication was direct, and both types of reinforcement were present. Family dynamics in the family of procreation revealed that communication and interaction between the husband and the client were significantly affected. The client used to do the routine work very slowly and showed less interest in talking with family members and spending time with her son. The family interaction had a moderate level of disruptions.

Social Diagnosis

Single-Parent Child, Childhood Adversities

Family Casework

Goals of intervention

Individual Level

- To improve activities of daily living
- To increase the client's knowledge about the illness
- To enhance the client's assertive, coping, and interpersonal skills.

Family Level

- To improve the family's knowledge about illness and management of the client
- To enhance communication among the couple
- To strengthen the interpersonal relationship among the family members
- To involve the client in the decision-making of the family

Intervention Strategies

- Psychoeducation, Activity Scheduling
- Supportive Psychotherapy
- Couple Therapy

Intervention with the Individual

Intervention with the individual was started by building rapport with the client.

Psychoeducation

Psychoeducation is 'systematic, structured, didactic information on the illness and its treatment, and includes integrating emotional aspects to enable clients and family members – to cope with the illness' (Bauml, 2006). The focus of psychoeducation may be compliance/ adherence-focused, illness-focused, treatment-focused, and rehabilitation-focused. As per the Assessment, it was found that the client lacked adequate knowledge about her illness. The client was given a medical model of explanation about her condition of recurrent depressive disorder with dissociation fugue. The Therapist addressed the issue of self-harm during the episodes. A detailed description of the nature of the illness, symptoms, and causes, as well as its effects on socio-occupational function, treatment, and management, was given during the session.

Activity Scheduling

Activity scheduling (AS) is an effective behavioral treatment that addresses social isolation in clients with depression. It is an approach that actively involves clients by increasing the daily activities they do and participate in (Lewinsohn & Atwood, 1969). As her diagnosis was RDD with Dissociation Fugue, engaging her in different activities is essential, making her more productive and

reducing her anxiety and other negative thoughts. The client's activities were carried out according to the client's wish, and the client started following the activity, which was scheduled gradually. The client started doing the activities and functions in which she was interested. The Therapist monitored the activities and changed them according to the client's convenience. The client engaged in maximum activities and utilized the yoga center, library, and garden space effectively.

Supportive Psychotherapy

Supportive psychotherapy is a form of treatment whose principal concern and focus is to strengthen mental functions that are acutely or chronically inadequate to cope with the demands of the external world and the client's inner psychological world. It enhances the client's strength, coping skills, and capacity to use environmental supports and reduces the client's subjective distress and behavioral dysfunction (Werman, 2014). Due to family issues, clients have poor self-esteem, coping skills, assertive skills, and distress. Individual sessions were conducted to improve her self-confidence and self-esteem, and she also provided sessions on problem-solving skills, decision-making, and other life skills. Illness-related family issues were also addressed, and relaxation techniques for reducing distress were provided. The Clinical Psychology team gave assertive skill training, Grounding, emotion regulation, and role-play.

Process of Psychotherapy

Supportive psychotherapy was conducted after formulating the case. It used strategies such as therapeutic alliance, maximizing adaptive coping mechanisms, and raising self-esteem with various techniques such as guidance, empathy, and verbal soothing, allowing the client to ventilate and express her thoughts and emotions (Misch, 2000).

Family Casework

Family-centered casework is " based on an understanding of the social, physical and emotional needs of the family as a unit for the purpose of helping the family members attain the best personal and social satisfaction of which they are capable". (Scherz, 1953)

Psychoeducation to the family members

Psychoeducation is a process by which mental health professionals impart knowledge of the illness to the family and, with continual assistance, modify their attitude. It also involves formulating and implementing better coping skills and other preferred interactions with the affected member (Varghese et al., 2002). As per the Assessment, the family consists of a husband and only son. The Therapist explained to family members the nature of the illness, its causes, and the role of family support in improving the client's condition. They were educated about the influence of stress and interpersonal relationship issues on this illness. The Therapist explained the symptoms, the importance of treatment and medicine adherence, and medication supervision.

Couple Therapy

The couple therapy sessions were based on emotion-focused couple therapy, techniques from the Gottman Method (Mordechai & Schwartz, 2008), and other effective communication techniques. The assessment found that these couples have deficits in severe areas, such as problems with communication, intimacy, sharing, problem-solving, and decision-making. There is a lack of attachment and bonding, and the therapist used emotionally focused couple therapy to deal with those issues. The Therapist concentrated on their interactive pattern in the home and how negatively it affects them. The importance of being empathetic and understanding each other was emphasized in

the session. Couples have difficulty sharing their emotions. The importance of sharing and acceptance was explained. A considerable communication gap was observed between the couples, and the importance of effective, open, and direct communication was also specified in the session, along with communication techniques. As pointed out in consecutive sessions, appreciation and gratitude are essential for good interpersonal relationships. The Therapist used techniques such as loving each other by understanding the stress, emotion, and expectation, appreciating each other, conversing with interest and respect, building trust and commitment, the balance of power, and problem-solving skills used in the therapy.

DISCUSSION

The case report explored the impact of psychosocial intervention on an individual and family in a rare condition like a dissociative fugue. The case work with the couples helped to understand each other and fill up the lacuna in several aspects of family dynamics and interpersonal relationships. The session also addressed the caregiver burden through the micro-skills of active listening, paraphrasing, and summarizing, which helped the client's husband improve his mental health—along with psychiatric social work intervention pharmacotherapy, individual therapy by clinical psychologists and inpatient care also played a significant role in improving client's psychiatric condition. The casework approach, along with pharmacological treatment, shows effective outcomes among persons diagnosed with depression, which also substantiates this study. (Keyho et al., 2020) The biopsychosocial approach also shows a better impact among people diagnosed with depression, and the case report from Assam states that a tailored psychiatric social work intervention indicated a reduction in symptoms as well (Bora et al., 2021). Psychological intervention for dissociative disorder found that supportive psychotherapy, interpersonal skill development, psychoeducation, and emotional regulation skills can be a part of treatment along with other psychological interventions. (Subramanyam et al., 2020)

OUTCOME OF FAMILY CASEWORK

- The client regularly goes for work and manages both household and office work.
- Communication between husband and wife improved, and the client started to share her emotions and feelings with the husband.
- Improved interpersonal relationships with family members.
- The family managed social gatherings, which reduced the stigma
- The client and family gained adequate knowledge about the illness and adhered to medication.
- The family is very supportive to the client and regular to follow-up.

CONCLUSION

The case report shows the effectiveness of psychosocial intervention among couples and caregivers. The approach of the client's husband changed drastically at the end of the intervention, and he accepted the patient with the illness.

REFERENCES

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (Text Revision). American Psychiatric Publishing.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders V (Fifth Edition). American Psychiatric Association.

Bauml, J. (2006). Psychoeducation: A Basic Psychotherapeutic Intervention for

Patients With Schizophrenia and Their Families. Schizophrenia Bulletin, 32(Supplement 1), S1–S9.

Bora, D., Deuri, S. P., & Saha, A. (2021). Psychiatric Social Work Intervention with a Woman with Depression: A Case Report from Assam. International Journal of Indian Psychology, 9(2), 1015-1022.

Duvall, E. M. (2002). Evelyn Duvall's Life. Marriage & Family Review, 32(1–2), 7–23.

Hardeveld, F., Spijker, J., De Graaf, R., Nolen, W. A., & Beekman, A. T. F. (2009). Prevalence and predictors of recurrence of major depressive disorder in the adult population: Recurrence of major depressive disorder. Acta Psychiatrica Scandinavica, 122(3), 184–191.

Igwe, M. N. (2013). Dissociative fugue symptoms in a 28-year-old male Nigerian medical student: A case report. Journal of Medical Case Reports, 7(1), 143.

Keyho, K., Gujar, N. M., Ali, A., & Sahu, K. K. (2020). Psychiatric social work intervention with a person with severe depression based on cognitive behavioral casework approach: A case study. Indian Journal of Psychiatric Social Work, 11(1), 36.

Lewinsohn, P. M., & Atwood, G. E. (1969). Depression: A clinical-research approach. Psychotherapy: Theory, Research & Practice, 6(3), 166–171.

Misch, D. A. (2000). Basic strategies of dynamic supportive therapy. The Journal of Psychotherapy Practice and Research, 9(4), 173–189.

Mordechai, G. J., & Schwartz, G. J. (2008). Gottman method couple therapy. Clinical Handbook of Couple Therapy, A. S. Gurman (Ed.) (The Guilford Press), 138–164.

Scherz, F. H. (1953). What is Family-Centered Casework? Social Casework, 34(8), 343–349.

Smith, K. (2014). Mental health: A world of depression. Nature, 515(7526), 180–181.

Subramanyam, A., Somaiya, M., Shankar, S., Nasirabadi, M., Shah, H., Paul, I., & Ghildiyal, R. (2020). Psychological Interventions for Dissociative Disorders. Indian Journal of Psychiatry, 62(8), 280.

Varghese, M., Shah, A., Kumar, G. U., Murali, T., & Paul, I. M. (2002). Family interventions and support in schizophrenia: A manual on family intervention for the mental health professionals. WHO/National Institute of Mental Health and Neuro Science.

Werman, D. S. (1989). Practice of Supportive Psychotherapy (1st ed.). Routledge.

WHO, W. H. O. (2019). International Statistical Classification of Diseases and Related Health Problems (ICD-11) (11th Ed).

Conflict of interest: None

Role of funding source: None