



Effect of socio-cultural factors in therapeutic intervention

Abstract

Comorbidity and presence of family dysfunction in personality disorders, namely borderline personality disorder have been found commonly with bipolar affective disorder clients. Dialectic behaviour therapy (DBT) though has shown efficacy in treatment of such conditions, at times due to the socio-cultural differences of the models adopted from the western concept, there is a felt difficulty in the formulation of the therapeutic model making it necessary to collaborate with other models for smoother formulation and improvement in the overall functioning in the clients. A 21-year-old female of bipolar affective disorder with emotionally unstable personality disorder traits was referred to a psychiatric social worker for assessment and plan of intervention inclusive of DBT and family-focused therapy (FFT). Twenty sessions, each lasting for one hour were conducted with the client and family, each on an inpatient basis to (1) Assess and grade the problems in hierarchy, (2) Understand the socio-cultural constructs in sessions, (3) Teach DBT concepts and relaxation techniques to ameliorate stress and help her to improve the relationship and dynamics with her family through FFT. At the time of discharge, the client had improved nearly 30%, and the client and family were more confident in facing social situations, emotional dysregulation, interpersonal issues, distress tolerance goals which has been explained in the context of the socio-cultural factors focusing on alliance, institutions, expectations, and cultural adaptation involved in therapy and the involvement it had in the therapeutic process.

Keywords: Borderline Personality Disorder. Bipolar Disorder. Dialectical Behaviour Therapy. Family Therapy.

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INTRODUCTION

Bipolar affective disorders (BPAD) are brain disorders that cause changes in a person's mood, energy, and ability to function.[1] It is a mental health condition in which common emotions become intensely and often unpredictably magnified. Swinging from an extreme of happiness, energy, and clarity to another extreme of sadness, fatigue, and confusion, seem to be a cardinal feature of individuals with BPAD. These shifts can be so devastating that individuals may choose suicide.[2] Borderline personality disorder (BPD) is a common comorbidity in depressed clients that is also underdiagnosed.[3] Smith *et al.*[4] suggested that a strong case could be made that a significant percentage of clients with BPD fall into the bipolar spectrum, and Belli *et al.*[5] concluded that the two disorders are closely linked in phenomenology and treatment response.

The established first line of treatments for BPAD is cognitive behavioural therapy (CBT), family-focused therapy (FFT), and interpersonal and social rhythm therapy (IPSRT).[6] Interventions for BPD were based on five major treatments, namely dialectic behaviour therapy (DBT), mentalisation-based treatment (MBT),[7] schema-focused therapy (SFT),[8] transference-focused psychotherapy

(TFP),[9] and systems training for emotional predictability and problem-solving (STEPPS).[10] It is to be understood that these have been found to create an impact as evidence-based treatments (EBTs) for BPD.[11]

Culture and therapy

Culture is a term we use to describe the values, beliefs, practices, and ways in which a community or society lives. It also includes the way people express themselves, communicate, and interact with one another. In a therapeutic alliance, it is found that the core beliefs of a particular model which is scientifically proven beneficial for a BPAD with BPD could be affected by the cultural background of a particular person.[12] In this context, we present a case study, living in the patriarchal background of the family, restricted the gender-based movement of the client, making it difficult to use a specific therapy model in its rich form, making it important for the therapist to include the elements of FFT along with the core aspects of DBT, making it contextual.[13]

In a country like India, where culture has been considered as an important element, cultural competency is one of the most important aspects as a mental health professional that we require. Cultural competency helps us to decide how

appropriate our communication is, the approach we have towards sensitive issues in terms of parenting and family communication, and how do we facilitate problem-solving in therapy making the therapy tailor-made for the client.

Reviews have been done to understand the social influence of research in counselling stating the need to use the particular model, the type of methodology to be used in the process of therapy, the variables under the purview and the social influence on the literature as a whole.[14] Thereby establishing the rationale.

The individuals with an emotional personality disorder with high suicidality, who did not improve with standard CBT intervention, improved over Linehan's DBT model which incorporates the concept of dialectics and the strategy of validation into a treatment focused on skills acquisition and behavioural shaping. DBT formulates the problems of BPD as a result of the transaction between individuals born with high emotional sensitivity and "invalidating environments" that is, people or systems (i.e. families, schools, treatment settings, workplaces) that cannot perceive, understand, and respond effectively to their vulnerabilities.[4]

CASE STUDY

Nafeesa (pseudonym), a 22-year-old female, presented with eight years of illness with complaints of hearing voices in isolation, inappropriate behaviour of wandering, constant lying, disobedience, engaging in multiple relationships with rapid fluctuation of feelings of opposite polarities with overall duration of episodes with average high mood greater than low mood in the background of multiple deliberate self-harm attempts, and was admitted with consent from the client and family for diagnostic clarification and treatment. Nafeesa was diagnosed with BPD through the ICD-10 criteria.[15] On the use of the Thomas and Chess Temperament Scale,[16] the temperament and mood regulation of the client was confirmed. Nafeesa was shown at multiple centres but never received pharmacological and/or psychotherapeutic treatment. Nafeesa was seen for 50 minutes inpatient DBT sessions every day and FFT sessions for the family for over eight weeks. The family was extremely autocratic with a poor understanding of the condition in the background of maladaptive coping, increasing the dysfunctionality in the family dynamics. The case was referred to a psychiatric social work scholar by the unit consultant and was supervised by the unit consultants.

Methods

- a) DBT (third wave of CBT) for the client
- b) FFT by Micklowitz[17] for the family
- c) In the process of therapy, the following scales were being used on the pre-post analysis and thereby the effectivity was established: Beck's Depression Inventory (BDI),[18] Support Systems Scale,[19] Family Interaction Patterns Scale,[20] Opinions about Mental Illness Scale,[21] and Caregiver Burden Scale.[22]

Psychotherapy sessions

The first session involved establishing rapport which is considered to be most important aspect for therapy. In the next

session, the focus was on ventilation and improving the rapport along with an introduction to therapy, psychoeducation, and hierarchy construction of the objectives of therapy. BPAD and BPD were described as being a set of symptoms that have influenced her behaviour related to her symptoms. The session focused on understanding the difficulties in terms of feelings, method of expression, and assessment of the available support system. Through the sessions, it was understood that there was presence of negative expressed emotions from mother especially, which has resulted in worsening of the situation for the client. With the progression of the sessions, information accumulated on the childhood trauma faced by the client, blame inflicted on the client which has resulted in trust issues with the family and friends along with a constant fear towards middle-aged men. It is at the same time, the client stated that she did not want to lose the voices as she felt that it was the voice that had been her companion throughout the bad timings in her life wherein at times she was seen quoting, "In my deep sleep, I would hear a voice telling me that everything is alright, you are a strong woman and no matter what happens, this companion of yours shall stay with you forever." And hence, the client's only request was not to take away the voice from her as she could not imagine a life without him. Hence, the focus was to understand about the childhood, method of an outlet of emotions, the ability of understanding of self, and relations within and outside the family.

On the other hand, as a therapist, it was to understand the method in which socio-cultural differences could interfere in the entire process of therapy. The family being referred for FFT, the family found it difficult to understand the reason for referral as they believed, "Issue is with our daughter, why do you want us to attend the sessions?" The family being autocratic, found it difficult to understand the point of a long stay, the aspect of referral, the therapy for the client, and the reason to resolve the heightened unresolved issues for the client with respect to the family.

It is to be understood that mother was observed to be critical towards the client and these were majorly in the background of the religious concerns wherein mother wanted daughter to follow the aspects of the religion in an orthodox manner while the client finding it difficult to comprehend religious textbook and also not in a position to accept the orthodox aspects of the rules bestowed by mother on her, ended up in constant verbal altercation. The father played passive role in the family, with constant issues with the take of the client on religion, books, and clothing styles. The socio-cultural factors which stated the timings of a meeting of the female gender, the hairstyle chosen by the client along with the previously mentioned aspects resulted in a reduced exchange of ideas, thoughts, and matters between the family members, thereby causing dysfunctionality in the family setting.

On the aspect of using the bargaining method, the client and the family came to a consensus wherein the client shall be using the veil "thattam" and the family shall be allowing her to read the books of her own choice. It is important to understand as to how bargaining as a method works in the Muslim dominated area, where the girl wearing the veil gave the sense of the person conforming to the rules to the external

society. Hence, making the negotiation, internally (within the house) was more available as an option wherein the client was allowed to have one of the choices of her own will and at the same time, the family was convinced that outside the house she would wear the veil, thereby protecting themselves from the perceived stigma.

It was also understood that the client had concerns regarding anger management, a constant need for acknowledgement and validation from the family wherein she was seen quoting, "If I do not conform with the rules of the religion and family, the family shall not accept me back and shall leave me alone". As a therapist, it helped one understand the response received from the family and the method of internalising technique (passive aggression) used by the client which had resulted in the maladaptive thinking. This involved the use of understanding the thought, action, and behaviour which had helped in modifying the behaviour and understanding of the guilt and the triangulation of these, thereby helping in differentiating the reaction and response for which thought-mood diary was used helping the client to understand and manage the anger and the mood.

It is to be understood that anger is an emotion and its outward expression in the socio-cultural context was an accepted behaviour for the men while for the women, it remains as an unacceptable behaviour or rather to say a behaviour against the Holy Scripture's definition of women. Understanding these elements in the process of both the individual and family, and accordingly giving the feedback with the right use of language to each member individually became one of the elements where the therapy progressed, as each felt validated making it easier for the members to understand the scientific and the faith-related connotations to the behaviour exhibited.

Simultaneously, there were tasks given to her focusing both on thoughts and behaviour over the sessions at both individual and family level. The family trying hard to understand the need and method of limit setting rules, the method of communication wherein the family was asked to ponder on the thought, "It is an individual's choice to follow a religion and the customs, and do they think it is right for them to restrict the actions for a person?" Also, the fact, that a client choosing unconventional career option, or choosing a hairstyle, choosing the clothing style, choosing the kind of friends, books, or authors is a person's choice and the fact that it does not fulfil the requirement for an institution of marriage.

This was of grave importance as it had a great effect on the functioning of the client. Marriage and religion are the two most important institutions in the Indian subcontinent. Hence, when themes of these manners are brought to the session, it becomes very important for the therapist to use the right words and provide the right facilitation. Thus, rather than ignoring, a consensus was drawn to allow her to pursue her career which would post her academic course completion.

Over a period of time, the client revealed the concerns regarding reduced hope, reduced motivation, and a feeling that life may end, reduced significantly with the help of

the use of the behavioural and thought tasks provided and practiced after culmination of the sessions. This also happened on the individual and family levels, client was able to understand and better manage the situations in terms of using a time-out, bargaining, and better communication. Hence, the consecutive sessions focused on behavioural acts, response patterns, and correlation and validation patterns. As over a period of one and half months, the client was seen improving, the following sessions focused on reviewing and final assessment, thereby stating the improvement felt by the client wherein client was found to have a better understanding in terms of managing her emotions, her fears, her behaviour, and had improved relations with the family.

At that point, the client brought in the next requirement where she wanted to let go of the voice as she did not wish to have any non-existing factor as a dependence factor and wished to replace that by family and friends, thereby to enhance her support system. Though it was easily said, it was a difficult task to do wherein the client found it difficult with constant nightmares, sleepless nights wherein the following two days she was seen stating, "In my sleep, I do see a person who is wearing a black colour cloth and telling me that he shall kill me and chases me, I know it is all because I chose to let go of the person and hence have to go through this." Over a couple of sessions focusing on ventilation and reassurance helped the client to come out of the phase wherein she finally said on the penultimate session, "I am doing much better, I think I can handle myself and the voice is not disturbing me and hence I shall live with it, and he will anyway not cause me any harm, he is my friend and friends do not hurt." Hence, on the last session, the client was departed with a proper pre-discharge counselling and with the expectation that she should use the concepts taught in her everyday life situations.

DISCUSSION

This case is unique for several reasons; first, it highlights that the clinical presentation of BPD may not be always as clear as to how it is defined by ICD-10 or DSM-5.[23] Further, the voice heard by Nafeesa was not hallucination rather her own imagination, a mental construct, a defence mechanism that she had developed over a period of years, and hence she lives peacefully with it and has good functioning with the same. The cognitive components were modified to make it appropriate for Nafeesa. For example, a mood and thought diary was provided, such that she could keep track of the thought, action, and emotions. However, all these were done with the willingness of the client and at no point did the client raise a concern regarding the phrasing of the treatment by the therapist.

The second point is the fact that as a therapist it was important to understand the effect of sociological constructs like society, culture, gender roles, patriarchal culture, and religion affecting the process of therapy and progress. The aspect of initiating FFT for the family wherein the family had to be made to understand the effect of their relations in the improvement in the client as it is a Bronfenbrenner's

model[24] that comes into place with the importance of psycho-social factors and not just medical model was a challenge.

Thirdly, it is to be understood that the core aspects of DBT model do suggest four major aspects of mindfulness, emotional dysregulation, interpersonal issues, and distress tolerance as goals but in the context of Nafeesa, it had to be dealt specifically with the client and her family wherein as per the response, the day would be a good day/bad day thereby affecting her functioning with the risk of self-harm. However, the inclusion of FFT did produce results in the client and the family making it easier for the client and the family to understand the concerns better and to involve themselves.

Fourth, cultural competency which is one of the major core values of social work becomes absolutely valid in situations like these when one has to understand that the method of improvement is to look at an individual in terms of their interaction with self, and with the society making it a “social self”.

Fifth, as a therapist one has to be very mindful of the words used during the process of therapy as certain words and their meanings in the cultural context varies. Socio-cultural factors which may function quite rigid in society may make it difficult for the family to understand the need to differ from the regular and to accept the fact that change is inevitable. Hence, empathy and representative conscientiousness are aspects one needs to understand when observing a case.

Lastly, understanding and evaluating the client on the scales, namely BDI, Support Systems Scale, Family Interaction Patterns Scale, Opinions about Mental Illness Scale, and Caregiver Burden Scale which was done at the time of admission and at the time of discharge did show improvement with the change being of 30% in the client.

Keeping the context of the study, it suggests the utility of these modifications and preparation of the treatment for working with this section of the society. At the same time, the limitation is to understand that this modification was provided in the inpatient care and treatment was based on the clinical judgement and available literature making it appropriate in this context.

Conclusion

Through this case, attempt has been made to understand socio-cultural factors which can have major effects on the functioning of an individual. In institutions like NIMHANS, cases come in as both inpatient and outpatient basis wherein cases are seen from the person-in-environment model focusing on the client and the family. As mental health professionals, whether inpatient or outpatient case, one should always keep in mind the effect of sociological constructs in the psychological wellbeing of a client, thereby affecting the utility of a therapy model. There has been an alarming increase with the Mental Health Act now speaking on family-based rehabilitation shifting the focus from individual into State, from individual into the family, which makes it important for the families to understand the

construct of therapy and the effect of their beliefs into the overall functioning of the client.

Declaration of patient consent

The authors certify that they have obtained appropriate patient consent form. In the form, the patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that her names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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