Lived Experiences of Women with Dissociative Disorder: An Interpretative Phenomenological Analysis

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ABSTRACT

Background: In the Indian setting, several studies have documented that dissociative disorders (DDs) are more common in females, and the most commonly elicited stressors are interpersonal. However, much of the research up to now has been quantitative. There is a notable paucity of qualitative studies exploring the subjective experiences of women with DD. Therefore, the present study sought to explore and gain an in-depth understanding of the lived experiences of women diagnosed with DD.

Methods: Five women were recruited who were seeking psychological treatment for dissociative symptoms at a tertiary care neuropsychiatric institute in North India. In-depth interviews were conducted with each, and the transcripts were analyzed using the analytic method of interpretative phenomenological analysis.

Results: Three superordinate themes that emerged were: patients' illness perspectives, the salience of relationships, and dealing with relationship conflicts.

Conclusions: Our findings highlight the role of culture in influencing the participants' illness perspectives. Women with DD tend to define their self in relational terms and, thus, inhibit the expression of one's needs and opinions, to avoid conflict and to maintain harmony in relationships.

Keywords: Dissociative disorder, interpretative phenomenological analysis, lived experiences, women mental health

Key Messages: This qualitative study explored the lived experiences of women diagnosed with DD. Silencing the self to make adjustments against the demands of the family and relationships emerged as a key factor that influenced the emergence of dissociative symptoms. The cultural impact on the manifestation and an understanding of their illness was striking.

Dissociative disorders (DDs) are understood as a disintegration in the functions of consciousness, memory, identity, or perception of the environment.[1] Overall, its prevalence stands at 10% in both inpatient and outpatient psychiatric settings.[2] While its prevalence tends to vary across countries, DDs form a significant proportion of the caseload at the emergency and outpatient department (OPD) of tertiary mental health institutes in India.[3]

Among the many contending theories of DDs, the trauma model has been focused on significantly.[4] The trauma model emphasizes etiological factors such as childhood sexual abuse.[5] However, in the Indian setting, the linking of trauma abuse to DDs as an etiological factor has been rare.[6] Instead, they have been more commonly described in terms of etiological factors such as somatization, low psychological sophistication, and neuroticism personality traits.[3,7] Moreover, they are commonly interpreted according to supernatural beliefs.[8] Patients, who attribute the cause of their illness to such beliefs, prefer to seek treatment through rituals and practices carried out by faith healers.[9]

Indian literature abounds with quantitative studies pertaining to DDs. For instance, studies found DDs to be higher among young adult and married females belonging to the lower socioeconomic strata and having intermediate education.[10–12] Moreover,

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across these studies, the most commonly elicited stressors were familial or interpersonal.[10,12] Thapa and Shyangwa[13] found a history of immediate stressful events precipitating the event in the majority of the cases. The most common type of stress described by the patients was a family conflict, followed by a broken affair and the death of a family member.

Collectively, these quantitative studies highlight the higher female preponderance and outline a critical role for psychosocial processes in contributing to the onset and maintenance of dissociative symptoms in women. Therefore, it becomes important to gain a deeper insight into such psychosocial processes from their perspective. Such an understanding is essential to consider when engaging with them in treatment. While no previous study has utilized qualitative methods to examine such patients' lived experiences, it is necessary to acknowledge that they offer an effective way of comprehensively examining the processes and experiences of the participants. Therefore, for the present study, the analytic method of interpretative phenomenological analysis[14] (IPA) was chosen because IPA, with its phenomenological focus, emphasizes how people make sense of their experience. IPA as a method of qualitative analysis has been found to be relevant in the arena of mental health since it allows the researcher to situate and understand the participants in their sociocultural context.[15] Therefore, this study is aimed to explore and gain an in-depth understanding of the lived experiences of women diagnosed with DD, using IPA. Drawing upon the strands of quantitative research into DD, this study attempted to answer the following research questions: how do women diagnosed with DD understand their illness, and what is the significance and impact of interpersonal relationships on their illness.

Methods

Participants

In accordance with the principles of IPA methodology, a homogeneous sample was purposively recruited as per the selection criteria.[14] The inclusion criteria were: females with a clinical diagnosis of DD as per ICD 10 criteria (since the study was conducted between April 2018 and August 2018), in the age range 18–45 years, belonging to urban domicile, seeking treatment in the outpatient setting, and with fluency in English or Hindi (i.e., the language of the researchers). The exclusion criteria were: comorbid severe medical or psychiatric illness and history of any head injury or neurological disease. Following the idiographic principle of IPA, which requires a small sample size to carry out an in-depth case-by-case analysis,[14] five participants who provided the consent to be interviewed were selected for the study. In their guidelines, Smith et al.[14] proposed that between three and six participants are a reasonable sample size to carry out a case study level of analysis and provide an insightful account of participants' experiences.

The details of the study participants are as follows.

All participants were diagnosed with mixed dissociative (conversion) disorder as per ICD 10 criteria.

Participant 1 (P1) is an 18-year-old unmarried female with a total duration of illness of around six months. The illness began when she was preparing for her grade 12th final exams. Her family had shown her to numerous physicians before visiting a psychiatrist. She belongs to a Hindu joint family of urban background and is the youngest of five siblings. She had recently finished taking her finals and was awaiting the results. She had plans for further higher education. No psychological intervention had been initiated at the time of the interview.

Participant 2 (P2) is a 21-year-old unmarried female belonging to a Hindu nuclear family of urban background. She had presented with complaints of unresponsive episodes characterized by the posturing of limbs lasting for more than 10 min, for a total duration of around six months. However, with regular treatment from the psychiatry OPD, there was an improvement in her symptoms. She was pursuing her graduation through correspondence and, at the same time, was employed as a primary school teacher for the past few months. She had received counseling sessions from the clinical psychology department.

Participant 3 (P3) is a 26-year-old female, married for the past ten years, with two female children aged 6 and 1 years. She originally hails from a rural background and is not formally educated. Post-marriage, she relocated to her husband's house in Delhi. He works as a driver. Her illness began over a year ago, and initially, she was made to seek intervention from the faith healers. However, because of the lack of significant improvement in her symptoms, she was finally brought to the institute by her family for further treatment. Psychological intervention had not been initiated at the time of the interview.

Participant 4 (P4) is a 36-year-old female, is married for the past five years, and has a daughter aged 4 years. After marriage, she shifted from Delhi, where she lived with her parents, to her husband's house in Rajasthan. Her illness had begun around four months before she visited the institute. Initially, at the onset of the illness, she had been taken to various faith healers for intervention. However, when her symptoms, characterized by the clenching of teeth and inability to speak for intermittent periods, persisted, she was brought to the institute, and pharmacological treatment was initiated. At the time of the interview, psychological treatment had not been initiated.

Participant 5 (P5) is a 38-year-old female, educated till class 8, living in a joint family in Delhi, and married for the past 23 years. She has five children (four daughters and a son). Her illness dates back to ten years when the symptoms characterized by possessive spells began. She was taken to various faith healers for the same. For the past two years, she had been experiencing posturing of limbs, low mood, and various somatic complaints. Now, as the symptoms have started doing much interference in her daily routine, she had come to the institute. She had, earlier, intermittently sought counseling sessions.

The demographic characteristics of the participants are presented in **Table 1**.

Data Collection Process and Analysis

Following the ethical clearance by the ethics research committee of Institute of Human Behavior and Allied Sciences (IHBAS), participants visiting the OPD of the clinical psychology unit at a tertiary care neuropsychiatric institute in North

TABLE 1.

Participant Group Demographics

Participant ID	Gender	Age	Education	Marital Status	Employment Status	Family Type	Domicile
1	Female	18	Class 12th	Single	Student	Nuclear	Urban
2	Female	21	Graduate	Single	Employed	Nuclear	Urban
3	Female	26	Elementary	Married	Homemaker	Nuclear	Urban
4	Female	36	Elementary	Married	Homemaker	Joint	Urban
5	Female	38	Middle	Married	Homemaker	Joint	Urban

India were identified by Ashti Emran. Participants who fulfilled the selection criteria were briefed about the study using a participant information sheet. The voluntary nature of the participation was emphasized. They were ensured that their data would be kept confidential and that anonymity will be maintained in all documents arising from the study. For instance, each participant was given an ID (such as P1, P2, and so forth) to maintain anonymity. Moreover, assurance about the continuation of treatment was provided. The first five participants who provided written consent were selected for research interviews. The consent included permission to record the interviews digitally and to use the data for academic purposes. Interviews were scheduled in consultation with the participants at the time of their next OPD visit. The interviews were conducted individually with the participants by Ashti Emran, and all participants were Hindi speaking. The interviews lasted between 40 and 60 min. The data was stored in a password-protected file on the researcher's laptop, to ensure security. The research interviews were conducted using a semi-structured interview schedule prepared by the first, second, and third authors. The schedule was flexibly used across the participants. Based on the research questions, the interview schedule covered topic areas of participants' understanding of their illness, the significance of relationships, and their responses to emotionally upsetting situations. Some of the questions asked were as follows.

1. Can you tell me about the time when you had the first dissociative episode?
2. How do you view your illness?
3. In what ways do you link the role of the specific events in your life with your illness?
4. How do you respond to a conflict in a relationship?

The interviews were transcribed and analyzed manually using the procedures of IPA as explicated in Smith et al.[14] To ensure that the key contents are not lost during transcription, everything spoken by both the participant and the interviewer was included. Moreover, important nonverbal utterances, significant pauses, and hesitations were noted.[14] The first author undertook the translation process at the end of data analysis, i.e., the key interview quotes were translated. The second and third authors checked these for accuracy. Translation at a later stage of the research process has been shown to produce better results.[16] Therefore, this decision was taken to preserve the original meaning after translation.

For the analysis, a transcript was read multiple times, and exploratory notes were made to become familiar with the participant's account as a whole. It was a free textual analysis that involved focusing on anything significant said by the participant, language use, distinctive phrases, emotional responses, and the context of their concerns. From these notes, the emerging themes were framed at a higher level of conceptualization. The next stage involved grouping together the emerging themes with conceptual similarities. They were further defined in detail to establish the interrelationships. The initial notes and themes were developed by the first author and checked by the second and third authors to ensure qualitative rigor and coherence. These same steps were carried out case by case to ensure that each participant's lived experience was fully captured. Lastly, the emergent themes developed for each of the five cases were clustered together based on the similarities and interrelationships. The fourth and fifth authors further refined these groupings to produce a master table of superordinate themes that best reflected the participants' experiences. The experiential narrative quotes are used to substantiate the findings and analysis.

Results (Table 2)

Illness Perspectives

A Supernatural Explanation

Three participants' descriptions of their symptoms were characterized by possessive spells. Drawing from the Indian lexical tradition, *upri ka chakkar* ("demonic possession") was the expression that featured multiple times in the participants' narratives.

P5 described:

> "It started with *upri ka chakkar*. It started after two months of my marriage. It was said that it was because of *upri ka chakkar*."

P4 described:

> "We were on the way back when I started throwing up and started running barefoot. My hair was untied.

TABLE 2.

Summary of Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Illness perspectives	A supernatural explanation A psychosocial explanation
Salience of relationships	A relational self
Dealing with relationship conflicts	Relationship crisis Experience of negative affect Inhibition of action leading to emotional dissonance

When I stepped on something, a soul entered me, and I started to shout loudly. Because of that I fell more ill."

P3:

"We went to the village. When they saw me, they said a ghost has probably entered my body…"

Their families had made these three participants seek intervention from faith healers, thus emphasizing and reinforcing their supernatural beliefs shaped by the culture. For all three participants, the exorcism did immediately lead to a resolution of the symptoms. However, the violent nature of the exorcist means was spelled out by P3 and P5. For example, P3 described the brutal rituals as:

"They would take the lamp and burn it here (pointing at her throat)…and I was tied with chains to the buffalo… Sometimes they would take my hands and break it, other times they would tie my legs."

P3's account suggested her disillusionment with the harsh exorcist practices as she openly rejected her family's reattempts to make her accept such an intervention. On the other hand, the rest, whose possessive spells had resolved, were now grappling with the more unfamiliar clinical presentations of their illness. The symptoms were now characterized by convulsions-like tonic-clonic movements, clenching of teeth, posturing of limbs, and unresponsiveness.

P4 said:

"It was said it's because of *upri ka chakkar*. But I did not understand the reason behind my clenching of teeth. I think I was tensed about my brother, but it wasn't that much. I think the soul that had entered me was the most problematic."

P5:

"There would be a tingling feeling in my hands and legs, inability to breathe, and posturing of limbs…."

Since the course of their illness was marked with progression from one clinical manifestation to another and the conjunctive limitation in explaining the symptoms using the same explanatory lens, a shift toward a psychosocial explanation in accounting for the symptoms was found.

A Psychosocial Explanation

This theme deals with another of the participants' illness perspective. It revolves around their understanding of how "psychological" the problem is, or, in other words, the impact of the ongoing stressors in contributing to their illness. While P2 and P3 explicitly cited the role of stressors as a precipitating factor, the remaining only partially accounted for their role. For example, P2's description was indicative of the temporal association that she has built up between the stressors that she was facing and their role in the onset of her illness.

P2:

"Yes. If I get stressed or think too much, I start shivering and faint."

P2's narrative was marked with instances wherein the onset of her symptoms was always preceded by a conflict at home. One of them was an ongoing altercation between her and the extended family, for not agreeing with their plans to get her married.

P2:

"I am still a little tensed because of my relatives. There is a thing going on related to me, and they have made it so big that they are blaming it on me. Meaning, that it is not my fault and they repeatedly say that I have made a huge mistake, and everyone is angry with me. I just have a normal friend, and my family has taken it in the wrong way…"

P3:

"I started thinking something wrong…. getting angry at something….I began to feel tense…Sometime because of the happenings at home…there was tension in the brain."

P5's life course illustrated various hurdles, such as her mother's death in childhood, leading to increased responsibility to look after the household and then getting married at a young age. It was followed by six miscarriages and giving birth to five children, all within ten years and only to fulfill the marital "duty" of bearing a male child. To add to it were the glaring consequences that she had to face, ranging from verbal abuse to physical violence. P5's narrative was striking and indicative of no less than a trauma.

P4 was forthcoming about the "tension" she was experiencing as a result of familial conflicts.

However, she reasoned that those stressors in no way contributed to her illness. She reiterated her belief in *upri ka chakkar*, though she failed to understand the symptoms of clenched teeth and being unable to speak.

P4:
"This illness developed on a journey and is not related to my brother."

P1 expressed failing to understand the "psychological" nature of the symptoms as put forth by her doctors, since she experienced no distress. She acknowledged the pressure associated with academics and the anticipation of not doing well. However, at the same time, she repudiated any of those reasons to be the cause of her illness, since her family was supportive.

P1:
"It happens all of a sudden. I don't take any pressure or tension, but it happens all of a sudden."

Salience of Relationships

A Relational Self

The participants' accounts were rife with representations of their self in interdependent terms, i.e., in terms of their relationship with others.

P1's narrative was reiterative of the close bonding she shared with her family members, and it tended to be the focal point around which she defined herself and her needs. Being the youngest in her family, the parents granted the special familial role of "favorite child." She said that, to maintain this harmony and honor the special parent–child relationship, she maintained a desire to obligate. She expressed a wish to become a police official; however, given her elder brother's dictums, she stated that considering his and the family's opinion is important since it stands in one's interest.

P1:
"Yes, I do as they say. We should not go against what our brothers and sisters say."

Similarly, for P2, her future aspirations were aligned with fulfilling the family's

needs, and being able to do so would enhance her self-worth. At the time of the interview, she was dealing with the guilt of having difficulty in doing so. The same was being compounded by her family's desire to get her married, which she stated she will eventually have to abide by.

P2:
"I could not do much. But before my marriage, I would like to secure my family and then go. Like I want to do a job for my family, buy a nice house for them, and pay for my sister's study. So I am a little stressed because of this."

Similarly, P4 describes her daily routine as revolving much around her family's needs. Having been afforded the role of the daughter-in-law, wife, and mother, she is expected to fulfill her duties as per these roles. In doing so, P4 expresses a sense of satisfaction and affirmation being derived.

P4:
"I like doing all this household work, serving others, staying with the family, looking after the kids, and stitching the clothes. There is no time for sitting idle because we stay in a joint family."

Despite P5's emotionally turbulent marriage, she sought to maintain the relationship through her efforts. She affords this responsibility to a woman in any relationship, to maintain peace in the relationship. P5 said:

"It is said that only a woman can make or break the house. So that is the thing."

Furthermore, she normalized her ongoing struggle by attempting to put her problems in a larger perspective and expressing that perhaps it is in a woman's destiny. She derived the strength to face it from her mother. The latter had undergone a similar trajectory of emotional turmoil within her own marriage.

P5:
"This has been happening from the beginning. This is probably the girl's life. The same thing happened to my mother."

Relationship Crisis

With three out of the five participants being married, at least two participants' accounts were rife with adverse instances perforating their relationship. P2 got married at the ripe age of 16 years. She expressed how her husband's needs are primary and how she has been reduced to an auxiliary in the process. Her mobility has been restricted, and all she is expected to fulfill are her duties to her "new" family. Also, she had no say in the other household matters.

P2:
"He would not let me go to my parents' home."

P5's narrative resonated with similar themes of lack of agency, she being pushed to a subjugated position wherein she had no say in the household matters, including the finances. She became a target of her in-laws for not bearing a male child. Eventually, despite fulfilling her "duty" and providing the family with a male child, she still found herself in shambles. P5 described:

"I did not get the love I thought I would get. He would hand over only 100 rupees for daily consumption. He still does that; he gives me money in measured terms to run the house. I look at my sister and see no matter how much she spends, her purse is always full. On the other hand, I have to provide the entire details of how the money is being spent. He wants me to be concerned with only the basics like food, and that's it. So I do the same."

P2, in her early twenties, is at a juncture wherein her marriage is being planned. However, with the sense of responsibility she harbors, she voices her reasons to delay the marriage process. When it does not go down well with the extended family, conflicts begin to brew, she finds herself in the spotlight, and questions are raised.

P2:
"My mother voices her concern that if you have not done anything wrong, then why is anything bad being made out of it. So she is a little stressed about it… She fears that the relatives may say some rubbish about it if there is an arranged proposal for my marriage in the near future. It's not that my relatives don't like me. It is just their habit to meddle into my life and tease me."

Dealing with Relationship Conflicts

Experience of Negative Affect

Since the relationship crisis was immanent in the participants' narratives, it inevitably led to anger, sadness, and hopelessness. Though P1 did not explicitly reveal any significant troubles within her relationships, she did acknowledge experiencing bouts of anger or irritation when her wishes are not fulfilled. Many a time, she would channelize her anger via breaking stuff or shouting.

P1:

"I always answer back, and I don't keep quiet. When I am angry, I shout at everyone."

Similarly, in P2's context, the ongoing strife within the family did not stop her from voicing her concerns, which came across as "dissent" in her extended family's perspective. However, being verbal about her preferences about marriage did not go down well with the family.

P2:
"When I had dengue, my entire family, including my cousin brother, was there to take care of me. And they cared for me so much that I cannot forget it ever. But I cannot handle the present situation because everyone is so angry with me and I am unable to understand this… I just normally spoke with a boy whom I like only, and we are not even in a relationship. But people are interpreting it wrong and thinking what not in their minds. So I am very tensed because of this."

P3's narrative, too, was reiterative of her experience of anger throughout:

"He (husband) gets angry at any minor issue. But even I speak up now when I get angry."

Inhibition of Action Leading to Emotional Dissonance

This theme centers on the participants' efforts to avoid conflict to maintain harmony in their relationships. Participants experienced intense negative affect and expressed the same to an extent;

however, they had to face repercussions for it. Therefore, it eventually pushed the participants to avoid the conflict. It is possibly a learning they derive from their experience that articulating their problems and feelings will not prove fruitful; instead, it will add to their existing misery. For instance, P2 said:

> "I have stopped talking to people because if I do, then again they (family) will raise questions, which will further impact my health. I think one can say that I have started to maintain my distance from everyone. And I have distanced myself because my family has been in a lot of tension because of all that has happened in relation to me."

Similarly, while P3 expressed indignation on being restrained by her husband, in the end, she was the one who had to push aside her needs and keep quiet.

P3:

> "So I keep quiet so that we don't fight…"
>
> "I don't say anything…and that has become the reason for my illness."
>
> "Because if I say something, a fight will break out…."

Her acknowledgment of her silencing the self and its impact on her mental health is quite striking.

P5 too described:

> "He would hit me a lot for every minor reason… and he would shut me up with beatings."

Emotional upheaval in her marriage rendered P5 helpless, since her natal family was unwilling to accept her. Yet, at the same time, she had also been trained by the society to fulfill her marital duties irrespective of whether they were pushing her down in the process. Thus, the inconsistency experienced while managing one's internal state and behavioral actions to avoid conflict was perhaps leading to emotional dissonance wherein the participants note a loss of self.

Discussion

This study examined the personal lived experience of women diagnosed with DDs, using the IPA data analysis method. Three superordinate themes were identified: (1) illness perspectives, (2) salience of relationships, and (3) dealing with relationship conflicts.

The findings are illustrative of the participants' reliance on supernatural accounts to understand their illness, since most of the participants' symptoms were characterized by a possessive spell. Bathla et al.[17] found 87% of the DD patients highlighting their perception of supernatural causes. The understanding propounded by the participants for their symptom presentation is reflective of the strong impact of one's sociocultural norms. Rajan et al.[18] also suggested the relative importance of cultural norms and beliefs in shaping the perception of mental illness in India. Possession occurs commonly as a part of the Indian culture. Pathapati et al.[19] asserted that the possession syndrome typically occurs in individuals who cannot directly express their discomfort. Thus, such dissociative episodes may be considered as an "idiom of distress." Concurrently, the participants sought interventions from faith healers. Researchers have highlighted the importance of faith healers as an alternate means of sociocultural intervention for psychiatric illness.[20–22] It is important to acknowledge how local cultural beliefs are likely to influence the type of treatment the patients seek, because patients ambivalent about the role of emotional triggers in their lives will be difficult to engage in treatment. Moreover, imposing an opposite viewpoint on the patient at the first contact itself is expected to make them disillusioned with the process of psychological treatment. Therefore, understanding how a patient makes the meaning of their illness would instead help the clinician negotiate with and restructure their patients' illness perspectives.

The participants also emphasized the role of stressors in accounting for their illness. For a few participants, their life history has been marred with all kinds of hurdles distinguishing a woman's life; for example, domestic conflict, miscarriages, familial burden, financial constraints, and many more. These have been so striking in their narratives that their contribution to the illness and its acknowledgment of the same by the participants is palpable. Moreover, the frequent use of the linguistic articulation "tension" can be understood as a specific expression of distress.[23] Similarly, Biswas et al.[24] had found that the most common psychological symptoms in their sample were anxiety and tension. The findings further highlight how participants experienced a shift in their understanding of illness: their attributions changed from the supernatural to the psychosocial causes. Bäärnhielm[25] too reported a similar restructuring of illness meanings by Turkish women who had somatization disorders.

The interview findings threw light on an essential aspect of the participants' self-concept wherein significant relationships occupied an important part of their self-space. In the literature, this has been termed "interdependent self-construal."[26] It is characteristic of a collectivistic society in which the definition of self is based on the pursuit of harmony with others. An important function of the self entails self-modification, and in the present study, it was evident when the participants espoused the view that it is a woman's responsibility to maintain a relationship. As delineated from the participants' experiences, the importance of family relationships and abiding by the family's decisions were prominent findings. Markus and Kitayama[26] asserted that individuals who construe their self in relation to others tend to engage in behaviors that consider the needs of others, and rather than being cumbersome, the same promotes a sense of satisfaction. This was highlighted in the participants' account of deriving a sense of satisfaction in fulfilling their multiple roles. These findings also concur with the Cross et al.[27] study, which concluded that compared to individuals with low relational self-construals, those with high relational-interdependent self-construals were more likely to base important decisions on the needs and wishes of important others. Thus, despite the conflicts, the relationships were salient to the participants, indicating the conceptualization of self as collectivistic.

Moreover, the relationship crises found in the participants' narratives illustrate the sociocultural mechanisms. For instance, the restricted mobility her husband and his family imposed upon the woman reflects the concept of patriarchy. The violence being meted out against women was striking in the participants' narratives, and the same may be inferred as a means of pushing

the woman to a subjugated position. The findings are consistent with previous research that quantitatively studied the various stressors precipitating the onset of illness.[13] For example, Amin et al.[11] asserted that married people are exposed to additional life event stressors such as a change of place and relationship problems. The innumerable difficulties permeating the participants' narratives did not deter them from expressing the negative affect of sadness, anger, hopelessness, and helplessness. However, since voicing their dissatisfaction led to severe repercussions, the participants were eventually required to tone down their expression of emotional reactions, thus setting the stage for inhibition of emotional expression and conflict avoidance. Conflict avoidance entails emotional labor characterized by suppression despite the experience of intense negative affect. These findings are consistent with previous studies related to emotional processes in DDs.[28,29] They suggested that suppression or avoidance of such negative affect could contribute to intermittent episodes of excessive emotional dysregulation. The present study adds to this literature by highlighting the social and psychological processes that explain how emotional perturbations lead to dissociative responses. Our findings reveal that gender-specific cultural directives may guide the tendency to inhibit emotional expression, and to remain "in control" in the face of interpersonal conflicts, which may then be understood as contributing to and maintaining the emotional processing deficits. Therefore, allowing the patient to disclose and process emotionally significant events in the safe space of the therapeutic environment will set a precedent for doing the same in their interpersonal context. Also, while the goal of altering the patient's or their significant others' belief systems about social constructs may be far-fetched, engaging in self-nurturing practices, assertiveness skills, and adaptive coping strategies may be emphasized.

Reflections

The research team carefully reviewed each step in the research process to ensure the trustworthiness of our findings. We have documented the steps in detail in the methods section. Firstly, we ensured that a rich corpus of data was collected from carrying out in-depth interviews. For this, careful consideration was given to establishing a good rapport with each participant. Also, emphasis was laid on developing interviewing skills, and subsequent interviews were refined in the light of the learning from the previous one. The analysis was carried out on rich interview transcripts. Numerous discussions were held between the first, second, and third authors while finalizing the theme categories. Moreover, additional mini-audits were carried out independently by the fourth and fifth authors to ensure that interpretative claims were grounded in participants' accounts. Sufficient verbatim extracts from the participants have been provided to ensure that the findings are warrantable.

Conclusions

This qualitative study builds upon the quantitative studies on the DD in the Indian context and complements their findings. Notwithstanding the relatively limited sample, this work offers valuable insights into the dissociative patients' underlying beliefs and affective state about their illness. These findings especially draw our attention to the importance of considering the role of sociocultural factors in impacting women's mental health; for instance, how it impacts the experience and expression of psychological distress. Another important issue emerging from these findings relates to the prominence of faith healing as a mode of mental health care in India. Therefore, as a clinician, it is essential to become cognizant of the sociocultural factors and formulate and tailor therapy in light of the social context in which the patients' problems are embedded.

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