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Addressing Dissociative Trance Disorder Patients in India: An Interpretative Phenomenological Analysis of Adolescent Girls' Help-Seeking and Encounters with Inaccurate Medical Information

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Addressing Dissociative Trance Disorder Patients in India: An Interpretative Phenomenological Analysis of Adolescent Girls' Help-Seeking and Encounters with Inaccurate Medical Information

Dissociative trance disorder (DTD) refers to a temporary change in consciousness during which individuals may lose their usual sense of personal identity, have limited awareness of their surroundings, and exhibit repetitive movements that are involuntary (1) and is most frequently experienced by young adult women (2). Trance and possession disorder is categorized as a form of dissociative illness in ICD 10 and entails a brief loss of the sense of one's own identity as well as full awareness of one's surroundings (3). In India, DTD poses a significant challenge, particularly among adolescent girls, due to the prevalence of cultural beliefs and misinformation surrounding the condition (4). Witchcraft and demonic possession are widely accepted as common causes of mental illness across Indian communities. Dissociative experiences are a common and accepted part of social and religious practices in many communities (5).

Moral principles and belief systems are fundamental to human existence, and for many people, cultural and religious factors have a significant, beneficial impact on their lives. Cultural and religious norms can have a detrimental effect on people's mental and physical health. In India and Asian communities more generally, culture-bound syndromes are widespread in basic care, with cases occurring that manifest psychiatric and related somatic symptoms (6).

Even after adjusting for fantasy propensity, there is substantial empirical evidence that dissociation is associated with a history of trauma and that dissociation is triggered by traumatic stress (7). Research on dissociation as a regulation reaction to fear or other intense emotions with quantifiable biological correlations supports the trauma theory of dissociation (8). It is also recognized that traditional healers' services are sought to alleviate suffering, particularly in nations with a dearth of western psychological treatments (9).

Although there is a growing movement in this century to link the possession phenomenon to mental illness, opposing viewpoints continue to exist. Treatment providers should be able to gain a comprehensive understanding of paranormal experiences so that we are qualified to offer expert advice to patients who appear to be experiencing symptoms of DTD. It is envisaged that more psychiatric studies are conducted in this

area and that DTD is no longer considered taboo in the field of medicine (4).

This research aims to shed light on the help-seeking behaviors and encounters with inaccurate medical information experienced by adolescent girls with DTD in India, using an Interpretative Phenomenological Analysis (IPA) approach. At present, limited research exists regarding the experiences of adolescent girls with DTD in India, and the impact of inaccurate medical information on their journey toward seeking appropriate care.

According to the researchers' personal experience of working as a psychologist at Sikkim, the misinformation surrounding DTD in India operates at three different levels within the society. First, parents may hold the belief that their daughter is possessed by a goddess, considering it a divine blessing that requires worship rather than medical intervention (10–12). Consequently, they assemble a temple-like environment where their daughter is revered as a living incarnation of the goddess. Second, some parents seek shamanic healing from exorcists, viewing it as the appropriate treatment for DTD-like symptoms, rather than consulting medical professionals (13–15). Lastly, at the primary healthcare centers (PHCs) in rural areas, the medical officers often lack the necessary training to identify and diagnose DTD accurately, resulting in misdiagnosis and inappropriate treatment. The public healthcare system in India, especially in rural areas, offers incredibly poor-quality medical care. Lack of quality control, which is characterised by widespread doctor and healthcare staff absenteeism, is one of the key flaws of India's health system (16–21).

The main reasons the researchers decided to conduct this study included misconceptions and misinformation that exist at the three levels explained above and a lack of awareness in society about DTD among girls and women, the absence of an evidence-based, dependable framework for the management of DTD, the scarcity of trained professionals in the healthcare system, and stigma associated with seeking mental health support.

This study looks into the personal experiences and recovery process of 6 young females from a Sikkim's community with different ethnic backgrounds, beliefs, religions, and superstitions. This study's research question is: How do adolescent girls with DTD in India navigate

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help-seeking behaviors and interpret their encounters with inaccurate medical information?

By conducting an in-depth analysis of their experiences using the IPA methodology, this research aims to capture the nuanced perspectives and insights of the affected individuals, shedding light on the challenges they face and their strategies for seeking appropriate care.

The objective of this research is to generate a comprehensive understanding of the help-seeking behaviors and encounters with medical misinformation among adolescent girls with DTD in India. By identifying the barriers they encounter and the cultural beliefs that influence their decision-making process, this study aims to inform interventions and initiatives targeting improved care and support for this population.

Ultimately, the findings of this research contribute to the existing literature on DTD, advance the field's understanding of the complexities surrounding help-seeking behaviors, and advocate for evidence-based practices that address the unique challenges faced by adolescent girls with DTD in India.

MATERIALS AND METHODS

Context of the study

Participants in this study came from Sikkim's East, West, North, and South districts. The majority of Sikkim's 7 lakh residents live in rural areas, where agriculture and tourism are the key economic drivers. The Sikkimese, including the Lepcha, Bhutia, and Nepali ethnic groups, practice traditional medicine and have strong beliefs in supernatural entities and deities (22–24).

Sample

IPA was chosen as the qualitative method for this research due to its flexibility, inductive approach, and focus on exploring participants' experiences from their own perspectives. It aims to uncover the meaning of individual experiences, which aligns with the research focus. Additionally, IPA emphasizes researcher reflexivity and acknowledges the potential power imbalances, making it suitable for the sensitive nature of the topic. Previous publications on dissociative disorders have also utilized IPA to study individuals' experiences. For example, Pietkiewicz et al used IPA in qualitative research psychology (25–28).

According to the IPA methodology's tenets, a homogeneous sample was purposefully chosen in compliance with the selection criteria (29). Six females, aged 16 to 27, living in urban and rural areas, seeking outpatient treatment, and fluently speaking Hindi or English, were diagnosed with DTD by the psychiatrist based on DSM-V criteria. They voluntarily agreed to take part in the study, meeting the inclusion criteria set by the principal researcher, who was well-versed in these languages.. Exclusion criteria were pregnancy, serious co-occurring medical or mental illness, a history of any head injury or neurologic condition, and use of psychiatric medications. As per the guidelines proposed by Smith et al (29), a sample of 3-6 participants is a suitable size to conduct an IPA study and provide a meaningful description of the lived experiences of the participants.

Participants

Six Sikkimese girls and women who had been labelled as being possessed by members of the local religious communities because of their out-of-control behavior, health ailments, or troubles in life, participated in this study (see Table 1 for their demographic characteristics). Following are details of the participants, whom the psychiatrist diagnosed with DTD per DSM-V criteria.

Participant 1 is a female student studying in the 11th grade in a private school. She is the eldest of 3 siblings and comes from a family with an upper-middle-class socioeconomic status. Over the past 2 years, she has experienced a number of severe mental health symptoms, including depression, panic attacks, feelings of detachment from reality and herself, suicidal thoughts, and even a suicide attempt. Despite taking her to several physicians, her parents did not believe that she had a mental health issue and instead took her to a faith-healer who claimed that she was possessed by a female goddess (*Mata*). Eventually, when her condition deteriorated, her parents did take her to a psychiatrist, but they did not follow through with the recommended treatment of medication and therapy. It wasn't until she sought help from a health-psychologist through a local support group that she was able to receive *Pranayama* and meditation therapy. During her history-taking session, it was revealed that she had suffered childhood sexual abuse, and in 2021, she somehow came into contact with the offender, which triggered her mental health issues. She had no significant history of neurologic or psychiatric

disorders, and her developmental history was normal, with cordial family relations. Her affect was detached, but her attitude was cooperative and there was no history of substance abuse. However, with the therapy, she showed significant improvement across all her symptoms.

Participant 2 is a 17-year-old female student preparing for her class 12th exams privately as she had dropped out of school 4 years ago. She was referred to a psychiatrist by the medical officer at the local district hospital due to her complaints of breathlessness, restlessness, chest pain, palpitations, insomnia, fainting spells, memory lapses, violent behavior, and headaches for the last 4 years. No physical or biochemical evidence was found. Her affect was anxious, and her attitude was cooperative. Her father's death due to kidney failure 4 years ago caused her to leave school due to fainting spells and health deterioration. Her mother noticed her staring off into the distance and frequently severing her hands with shards of her glass bangles, and the daughter claimed to have memory lapses and to occasionally hear the voice of a black spirit (*kaala saya*). The family took her to a local faith healer, who said that she was possessed by a malevolent spirit (*Jinn*) and gave her several sessions of faith healing. Later, during a therapy session with the psychologist, it was revealed that she was in a relationship with a person from a different community for the past 4 years, and he forced her to get an abortion as he was not interested in marrying her. She was unable to share her trauma with anyone including her mother. There were no notable prior neurologic or mental disorders. A *Pranayama* and meditation therapy was provided to her, which resulted in significant improvement in her symptoms.

Participant 3 is a 17-year-old girl in her 12th grade, preparing for a national pre-medical test. She was hospitalized for attempting to commit suicide by overdosing on sleeping pills. She had symptoms of severe depression, memory lapses, excessive thinking, altered state of consciousness, fatigue, vomiting, diarrhea, indigestion, stomach pain, loss of appetite, breathlessness, loss of attention, loss of concentration in her studies, aggression, and violent behavior. She was once an excellent student, but her performance at school had deteriorated significantly over the past 2 years. Her parents had sought help from a local faith healer, who suggested that she was a reincarnation of a Hindu goddess (*Mata*) and that her family should construct a temple and perform rituals and prayers to appease the goddess. Despite all the rituals, her health continued to deteriorate. Later, her elder sister took her to a health

psychologist who uncovered that she had been sexually abused when she was 4 years old by a tenant living in her parents' house. Two years ago, she saw the abuser again, and all her traumatic memories were revived. She had excessive anger towards him and revealed her childhood abuse to her mother, who asked her to ignore it and focus on her studies. She became overwhelmed and developed suicidal thoughts. During the mental status examination, her affect was sad and attitude was cooperative. A *Pranayama* and meditation therapy was planned for her by the psychologist, which helped her recover well.

Participant 4 is a 17-year-old student in class 12 who belongs to a tribal community in Sikkim. She is the only child and her parents are separated. Her family is considered upper-middle class. She lives with her mother, but they do not have a good relationship. Despite this, she is a good student and the school captain. She sought help for mental health issues at the local hospital, reporting symptoms of severe dissociation, restlessness, emotional breakdown, crying, and suicidal thoughts. Earlier, her family took her to a *Fedang Ma* , a local faith healer, who performed ritualistic prayers and suggested that she was cursed by an evil spirit. He advised her not to eat goat meat and requested a goat donation for the ritual. When her condition did not improve, they consulted another faith healer, *Bomthing*, who also performed shamanic rituals and advised her not to eat pig meat. She loved eating meat and would often get violent when meat was not served to her at home. During her history taking, she revealed her childhood trauma of sexual abuse and how it caused her condition to deteriorate. Her family believed she was possessed, and her caregivers believed that they could hear the evil spirit's voice through her. After a Pranayama and meditation therapy, by the psychologist, she showed remarkable improvement.

Participant 5 is a 23-year-old woman currently undergoing on-the-job training at a livelihood school in Sikkim. She is the eldest of 3 siblings and her father passed away when she was 6 years old. She has a disability certificate, which indicates that she has a 60% disability in her eyes and a 40% disability in her left leg. Her affect was anxious, but she was cooperative. There was no history of substance abuse. Since childhood, she has experienced breathlessness and suffocation during times of stress, which has led to low self-esteem, due to her disability. Additionally, she was sexually abuse by a cousin and possibly raped by a shopkeeper in her village, which has left her with somatic memories but no

clear recollection of the events. Her relationship with her mother has been troubled since childhood due to physical abuse, and she has experienced fainting spells and panic attacks with pseudoseizure symptoms. During childhood, her mother had beaten her often. She took the sheep out to pasture, and her mother would beat her until she was black and blue later in the day if one of the sheep went missing. She spent a lot of nights in the forest, sleeping by herself in a pitch-black cave, trying to evade her mother's beating. She said that over the years she visited more than a dozen faith healers who said that she had a curse of the *Kul-Devta*, a clan deity, and many shamanic rituals were performed but nothing helped her. An intervention included *Pranayama* and meditation therapy, and she improved significantly thereafter.

Participant 6 is a 27-year-old unmarried nurse working at the local district hospital. She was referred to the psychiatric OPD by a medical officer. Her attitude was cooperative, and her affect was anxious. She comes from a middle-class family and is the third of 5 siblings. She suffered from severe dissociation, often feeling numb and disconnected. Symptoms such as insomnia, restlessness, anxiety, loss of appetite, and panic attacks occurred almost daily. She would sometimes cry and cut her hands, with no memory of doing so later. She has attempted to harm herself by cutting her hands and even slitting her throat due to unbearable trauma from a recent breakup. She experienced memory loss and often found herself in unfamiliar places. She would often hear foreign voices though she understood what those voices said. She had suicidal ideation and experienced palpitations, headache, sweating, and vertigo. Her limbs locked during pseudoseizures. Over the last couple of years, her family had taken her to various faith healers, believing she was possessed by the female Hindu goddess *Mata*. No history of substance abuse was noted. A *Pranayama* and meditation therapy was planned for her, and she improved significantly afterwards.

Table 1. Participants' Demographic Characteristics

Participant ID	Age	Gender	Family History of Psychiatric Disorders	History of Sexual Abuse	Education	Marital Status	Occupation	Family Type	SES	Domicile

P1	16	Female	No	Yes	11th	Single	Student	Nuclear	Upper middle class	Urban
P2	17	Female	Yes	Yes	12th	Single	Student	Nuclear	Upper middle class	Urban
P3	17	Female	Yes	Yes	12th	Single	Student	Joint	Middle class	Rural
P4	17	Female	Yes	Yes	12th	Single	Student	Joint	Middle class	Rural
P5	23	Female	Yes	Yes	Livelihood diploma after 12th	Single	On-the-job-training	Nuclear	Lower middle class	Rural
P6	27	Female	Yes	Yes	B.Sc.(Nursing)	Single	Staff nurse	Joint	Middle class	Urban

Process of Data Collecting and Analysis

Between 2021 and 2022, this research project took place in Sikkim as a component of a randomized clinical trial. Led by the principal researcher (D.K.S.V.), participants with DTD were identified through extensive field work and outreach programs. Diagnosis of DTD was conducted by a psychiatrist using DSM-V criteria at the district hospital. Consent was obtained from eligible participants and their caregivers. Six participants and their caregivers, who provided written consent, were selected for interviews conducted by the principal researcher in English or Hindi. The interviews, lasting 45 to 60 minutes, focused on various aspects such as the participants' understanding of their illness, beliefs in evil spirits and exorcism, their healing journey, and their outlook on the future. The interviews were recorded and securely stored on the researcher's laptop. The research aimed to explore the help-seeking behaviors and interpretation of medical information among adolescent girls with DTD in India. The study employed a semistructured interview schedule prepared by multiple authors, tailored to the participants' specific needs, and addressing the research question. The questionnaire included queries such as:

Q1. Can you tell me about the first episode and what you actually experienced?

Q2. Can you tell me about your daily life and the challenges you face on a daily basis?

Q3. Can you tell me about your childhood and something about your family while growing up?

Q4. Do evil spirits exist? Do you believe that you were possessed by an evil spirit or the spirit of an ancestor? How can these spirits be cast out of the body?

Q5. How good are you in expressing your feelings with others? Can you give some examples?

Q6. In what way do you feel the adverse life events have affected you?

The interviews conducted were manually transcribed and analyzed according to IPA procedures, as described by Smith et (29). During the transcription, care was taken to include all spoken words, including those by the participant and the interviewer, as well as significant pauses, hesitations, and nonverbal utterances. During the data analysis phase, the first author translated the important interview quotes, which were then reviewed by the second and third authors to ensure accuracy. Research has shown that translating at a later stage of the process yields better outcomes (30), so this approach was taken to maintain the original meaning after translation.

To begin the analysis, each transcript was read multiple times, and exploratory notes were made to understand the participant's account as a whole. A free-textual analysis approach was employed, focusing on significant content, language use, distinctive phrases, emotional responses, and the context of their concerns. From these notes, the emerging themes were identified, and higher-level conceptualization was framed. The emerging themes were then grouped together based on conceptual similarities and defined in detail to establish their interrelationships. The initial notes and themes were developed by the first author and reviewed by the second and third authors to ensure qualitative rigor and coherence. The same process was carried out for each participant to capture their lived experience fully. Finally, the emergent themes developed for each of the 6 cases were clustered together based on similarities and interrelationships. The first author made further improvements to the groupings to create a main table of higher-level themes and grouped them together as the superordinate and subordinate themes that most accurately represented the participants' experiences.

Narrative quotations from the participants' lived experiences were used to provide evidence for the conclusions and analysis.

Checking for accuracy

In every interview, participants were prompted to provide detailed examples that would demonstrate their reported symptoms or experiences. Questions were asked to clarify any ambiguous or unclear points that arose during the conversation. Toward the end of the interview, participants were asked follow-up questions to ensure that their responses were complete. The researchers then analyzed each case thoroughly, discussing and comparing their notes to ensure that they had a thorough understanding of the content and its meaning. This process is referred to as the second hermeneutics.

RESULTS

The participation of all 6 participants in exorcisms by faith healers was associated with their personal experiences and relationships, as per their accounts during interviews. These interviews yielded 3 superordinate themes (Table 2). Each of these themes is explained and supported with direct quotes from the interviews, in line with the principles of IPA analysis.

Table 2. Superordinate and Subordinate Themes Identified Through Analysis

Superordinate themes	Subordinate themes
Challenges in seeking diagnosis and treatment	Difficulty in getting a diagnosis
	Belief in evil spirits and exorcism as confabulatory explanatory models
	Overthinking, nightmares, and hearing voices
Emotional and psychological struggles	Guilt, shame, and difficulty in expressing emotions
	Negative self-image
	Self-harm
Support and healing journey	Seeking the best therapist and the final healing place
	Healing journey
	From being possessed to empowered

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Challenges in seeking diagnosis and treatment

Difficulty in getting a diagnosis

Transcripts from all 6 participants highlighted great difficulty in getting a diagnosis.

P1: "For the past 3 to 4 years, I have been experiencing symptoms of depression, but in 2021, my condition worsened. I sought help from various doctors and physicians at the PHC, as well as private clinics. Eventually, I was referred to a psychiatrist, but my family refuses to accept that I may have mental health issues. They constantly blame me for everything and are always suspicious of me. I even visited a local faith healer who claimed that I was possessed by *Mata*. Throughout this time, I have been silently suffering, with no one seeming to understand me or provide me with any help."

P2: "I experienced chest pain, palpitations, extreme fear, and fainting spells, which left me feeling deeply scared. I sought help from multiple doctors, including a physician, ENT specialist, and a gynecologist, but all my reports came back normal. My mother then took me to a religious center where a faith healer tied a rope around my neck. This caused a panic attack, and I lost consciousness. When I woke up, I was back at home with bruises covering my body. I didn't understand what was happening to me, and nobody seemed to be able to help. My mother claimed that the local faith healer had suggested I was possessed by an evil spirit called *Jinn.*"

P3: "My family holds traditional and superstitious beliefs, and they often belittle and torment me for being possessed by *Mata*. They took me to several local temples where different pujaris suggested different causes for my illness. Some claimed it was due to an evil serpent because I was born in a *Naga Kshetra* (area of a Hindu serpent deity), while others said I was possessed by *Mata*. Despite undergoing many rituals, my condition did not improve. As a science student preparing for a medical entrance exam, I sought help from various doctors and physicians at our village PHC and hospitals in Gangtok, but they all claimed that nothing was wrong with me. I felt lost and confused with no clear solution."

P4: "Amidst the COVID pandemic, my condition worsened, and I began experiencing instability, crying spells, flashbacks, and intense fear. A

doctor at the local PHC got some tests done and said nothing was wrong with me. Due to my family's superstitious beliefs, they sought the help of *Fedang Ma*, a religious healer, rather than taking me to the hospital. One of my cousins, who was a medical student, identified my symptoms as a possible mental health disorder, but my family refused to take me to the district hospital. The rituals performed for my recovery only made my condition worse. I frequently had emotional breakdowns and cried easily over minor things. Despite attending school opposite a district hospital, I lacked the courage to speak to my teacher or seek help."

P5: "Since I was a child, I have met many doctors who were unable to identify what was wrong with me, despite conducting normal medical tests. Local doctors were also unable to provide any solutions. I tried many treatments, but nothing seemed to help me. In desperation, my family sought out *Jhakris* or faith healers, and many of them performed shamanic healing, but I don't recall what happened during those sessions. Eventually, my condition worsened, and I began experiencing long-lasting attacks where my hands and feet would lock up. I was taken to the emergency in a hospital, but later my mother refused to let me seek help from a psychiatrist, and instead blamed me for the family's problems."

P6: "I have been suffering silently since many years despite working in a hospital as a nurse. I was frequently having attacks in which my limbs used to get locked and once I even tried to choke my own throat and slit my wrists. The local doctors were not able to diagnose what was wrong with me. Last time I was given treatment for dyspepsia, but it did not help me a bit. I have visited many *Jakhri's* (faith healers) since the last 9 years. I even have a *booti* tied to me in the arm by one of them."

All 6 participants were seen by doctors at their local PHC but could not get a diagnosis for their symptoms. They shared their experiences of struggling to get a diagnosis for their physical and mental health issues. Despite seeking medical help from various doctors, physicians, and specialists, their symptoms remained undiagnosed. Instead, they were either blamed for their condition, by their caregivers, or referred to faith healers who performed rituals, which did not provide any relief. Their families' traditional and superstitious beliefs hindered them from seeking professional medical help, and they were subjected to different forms of rituals and beliefs. Participants expressed feelings of confusion, frustration, and helplessness, leading to a sense of isolation and

loneliness. The inability to receive a proper diagnosis led to the worsening of their symptoms and mental health. This theme highlights the need for improved mental health awareness and education at the PHC level and the importance of seeking professional medical help to address and manage mental health issues. The misinformation surrounding the participants' symptoms and the role of parents' religious and spiritual beliefs hindered their ability to receive appropriate care. Despite experiencing physical and mental health issues, the participants struggled to obtain a proper diagnosis. Instead of seeking professional medical help, their families turned to faith healers and performed rituals based on traditional and superstitious beliefs. This misinformation perpetuated by their parents prevented the participants from accessing effective treatment and support.

Belief in evil spirits and exorcism as confabulatory explanatory models

P1: “I don’t believe in evil spirits. But like there is positive energy on earth, there exists negative energy also. We don’t know much about it. I don’t believe in all those things which my family did as suggested by the faith healer to ward off the evil spirit, like donating a cock to him and releasing another one in the jungle to appease the evil spirits.”

P2: “I do not believe in evil spirits nor has any religious healing helped me. But I do hear voices of a *kaala saaya* (dark spirit). I get very sacred and feel that someone evil is watching me.”

Though P3 did not have any confabulatory EM she said: “I’m a science student and absolutely don’t believe in evil spirits or being possessed by *Mata.*”

P4: “I don’t think that I have been possessed by any evil spirit or ghost; however, like positive forces, negative energies also exist in the universe. I was so lost in this dark world.”

P5: “I don’t believe in ghost or spirit possession. But the faith healer said that my *kul-devta* (ancestral deity) has a problem with me and all my problems are because of it. I have been to so many *jhakris* (faith healers) but nothing has helped me. Though the last female *jhakri* I met at Rhenock was quite helpful.”

P6: “Over the last few years, I have been to so many *jhakris* and I have tied so many *bootis* (medicinal plant) to myself given by them. What can I do, being a Hindu, I have to believe in the religious practices?”

The data shows that participants had varied beliefs regarding evil spirits and exorcism. P1 believed in the existence of negative energy but did not believe in the traditional practices followed by the faith healer. P2 heard voices of a dark spirit and felt that someone evil was watching her, but she did not believe in religious healing. P3 did not believe in evil spirits or possession by *Mata*, as she was a science student. P4 believed in negative energies but did not think she had been possessed by any evil spirit. P5 did not believe in ghost or spirit possession, but the faith healer suggested that their ancestral deity was causing the problems. P6 had been to multiple faith healers and followed religious practices due to her Hindu beliefs. The participants' responses indicated a range of beliefs--from complete disbelief to a mix of traditional practices and belief in negative energies.

Misinformation plays a role in the lack of appropriate care for the young women due to the disparity between their beliefs and their families' beliefs regarding evil spirits and possession. While the participants expressed skepticism or disbelief in evil spirits, their families strongly held these beliefs. The misinformation surrounding evil spirits and possession led their families to seek religious healing and perform rituals, which did not address the participants' actual needs. As a result, the participants were unable to receive the necessary medical and psychological care, as their families' beliefs hindered them from accessing appropriate resources and interventions.

Overthinking, nightmares, and hearing voices

P1: “I can't stop overthinking and having nightmares. I hear voices while lying down in the bed. The voices in my head won't go away. Sometimes I feel that someone is calling my name, but actually no one is there. The local faith healer thinks I'm possessed, but I know something deeper is going on. It's hard to talk to anyone.”

P2: “I am so stressed out because of overthinking, fear, and restlessness. I am unable to fall asleep and I often see nightmares and hear the voice of

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a *kaala saaya* (black spirit), who is constantly talking to me. Sometimes it says that he loves me; most of the time it torments me. I am so scared."

P3: "I don't feel like talking to anyone and wish to stay alone. I am not able to control my negative thoughts... I find it very difficult to fall asleep. My sleep is disturbed and I often see bad dreams and wake up having a panic attack… I also hear scary voices of two females and a baby crying in my ear during sleep."

P4: "I'm constantly daydreaming and have excessive negative thoughts throughout the day… I have strange and weird dreams because of which I feel scared most of the times… I often hear a voice, as if some-one is asking for help. Maybe a child, screaming for help."

P5: "Whenever I am angry or stressed out, I feel suffocated and I am not able to breathe. I have vivid thoughts like a video playing in my head, which drive me crazy…I am not able to sleep and often see bad dreams… I often feel that someone is calling my name, but actually no one is there."

P6: "I am unable to control my thoughts. Because of which I have headache, palpitation, sweating, vertigo, and my limbs get locked… I go to bed early but not able to fall asleep for many hours… I often see bad dreams and I am not able to go back to sleep if I wake up in the night… I often hear a voice while awake or lying in bed. I don't know whether it's a male or female or what language it is speaking, but I am able to understand what it is saying. I reply to it also, when I turn around, I find that no one is there."

In this theme, all 6 participants describe a range of experiences--from hearing voices while lying down in bed, to having vivid thoughts, to feeling suffocated and experiencing panic attacks. Participants describe having difficulty sleeping and often having bad dreams. They also hear different kinds of voices, ranging from a voice asking for help to scary female voices and a baby crying. These experiences lead to feelings of fear, stress, and anxiety. Participants are also reluctant to talk about these experiences with others, as they are afraid of being judged or labelled as possessed. The theme suggests that participants are struggling with their mental health and experiencing a range of symptoms that are interfering with their daily lives. These experiences are complex and require further exploration to understand their nature and impact.

Emotional and Psychological Struggles

Guilt, shame, and difficulty in expressing emotions

P1: "I feel guilty and ashamed of myself for not being able to control my episodes. I can't express my emotions to anyone as I'm afraid they'll judge me. The faith healer labelled me as possessed, making me feel even more misunderstood and alone."

P2: "I am burdened with guilt and shame due to my inability to manage my disorder. It is difficult for me to confide in anyone including my own family. A lot is going on inside me, and I feel as if I'm going to explode. Everything around me seems to be adding to my sense of isolation and lack of understanding."

P3: "I'm overwhelmed with guilt and feel very ashamed of myself and my situation. I don't feel like talking to anyone or going to the school. This loneliness and depression is driving me mad."

P4: "I feel guilty and ashamed of what happened to me. I have not spoken to my mother about my sexual abuse because of this, and I also feel that she would hold me responsible for whatever happened to me. I have become more devoted in my studies because of the guilt and shame I carry."

P5: "I carry this guilt from childhood and feel ashamed and hold myself responsible for it. I have vague memories of the abuse I suffered as I child. I have not told about these incidents to anyone including my mother and feel very ashamed of myself. These memories keep haunting me, and my seizures have increased."

P6: "I've endured significant trauma in the past 8 years and feel a sense of shame and reluctance to discuss it with anyone. I often feel guilty and blame myself for whatever happened to me."

This theme is prominent in the data provided for all participants. Each participant seems to feel guilty and ashamed of their disorder or traumatic experiences, and find it challenging to express their emotions to others due to the fear of being judged or misunderstood. They also seem to carry a sense of isolation, loneliness, and lack of understanding from those around them, which only intensifies their guilt and shame. P4 and P5 share a history of sexual abuse, and both express reluctance to

confide in their mothers due to the guilt and shame they carry. P6 appears to have experienced significant trauma, which has resulted in feelings of shame and self-blame. Overall, these narratives suggest that guilt, shame, and difficulty in expressing emotions are significant barriers for individuals with mental health conditions or traumatic experiences, preventing them from seeking the support they need to cope and recover.

Negative self-image

P1: “I hate myself and feel very bad about what happened to me. I often feel alone and confused because of the trauma I faced, which has led me to depression. Even though I know I should talk to someone, I'm scared to tell anyone including my mom because I think she might blame me for what happened, which would make me feel even worse about myself. I was not at fault; still I blame myself for it and often think that I should have done something.”

P2: “My boyfriend is from a different community, and he convinced me to have an abortion since neither of our families would accept us getting married and living together. I feel so hopeless and depressed and feel bad about myself and what happened to me. It makes me feel lonely and sad.”

P3: “As a young girl, I was sexually abused by our tenant, and it has been haunting me ever since I saw him again after so many years during the Covid period. I feel so alone and burdened by the weight of my trauma; these thoughts keep tormenting me. I feel guilty and hate myself for whatever happened to me, and I can't bring myself to tell anyone about what happened to me. It's like a dark cloud following me everywhere I go.“

P4: “I felt very unsettled and cried most of the time. I also experienced flashbacks and had a headache throughout the day. My weight was increasing and my immune system was getting weaker. I felt a lot of self-hatred and blamed myself for whatever had happened to me.”

P5: “I dislike myself and have a very low opinion of myself due to the disability in my left leg. Adding to my distress, my mother frequently taunts me about my physical condition, which makes me feel even worse. This makes me scared and worried all the time.”

P6: “I don't feel like the same person I once was. I'm very unsure of myself and lack confidence. I have a lot of negative thoughts about myself and

often feel sorry for myself. Almost every day, I even have thoughts about killing myself."

The theme of negative self-image emerged across all 6 participants. P1 felt alone and depressed due to the trauma she faced, blaming herself for not doing enough. P2 felt hopeless and depressed after having an abortion at the insistence of her boyfriend, leading to feelings of loneliness and sadness. P3 was burdened by the weight of her trauma from being sexually abused as a young girl, feeling guilty and hating herself. P4 felt unsettled, blaming herself for what had happened to her and experiencing flashbacks and physical symptoms. P5 disliked herself due to her physical disability, worsened by her mother's taunts, leading to fear and worry. P6 lacked confidence, had negative thoughts about herself, and even regularly thought about killing herself. These participants' experiences demonstrate the pervasive and detrimental impact of negative self-image on individuals' mental health, highlighting the need for support and interventions to address these issues.

In addition to the negative self-image, the participants also described their struggles with their self-concept. P1 mentioned feeling confused and alone, suggesting a lack of identity and sense of belonging. P2 expressed feelings of hopelessness and depression, which could indicate a lack of purpose or direction in life. P3 described feeling burdened by the weight of her trauma, suggesting a sense of being defined by her past experiences. P4's physical symptoms and self-hatred suggest a disconnection between her physical and mental self, leading to a fractured self-concept. P5's dislike for herself due to her physical disability suggests a negative perception of her body and a lack of acceptance of herself as she is. Finally, P6's lack of confidence and negative self-talk suggest a weak and fragile self-concept.

Self-harm

All 6 participants related suicide ideation; however, 4 of them mentioned episodes of self-harm.

P2: "Sometime I feel very scared and I don't know what to do. My ears turn red and palpitation starts. I often cut my hands after breaking my bangles, and I don't remember when and where I did that."

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P3: “I was so frustrated and overwhelmed that I took an overdose of medicine at home thinking that it would end my life.”

P5: “I was so dejected that I decided to end my life by tying a rope to my neck.”

P6: “I don’t know what was wrong with me. I used to slit my wrists and choke my neck while having an attack. I would often cry without having any thoughts and cut my hands without remembering anything.”The theme of self-harm and suicidal behavior was shared by the 6 participants. P2, P3, P5, and P6 shared their experiences of engaging in self-harm and/or attempting suicide in response to overwhelming emotions such as fear, frustration, dejection, or experiencing an attack. P2 specifically mentioned cutting her hands while P3 attempted to end her life by taking an overdose of medicine. P5 tried to commit suicide by tying a rope around her neck, and P6 engaged in self-harm by slitting her wrists and choking herself. The narratives also highlight the participants' lack of control and memory of their self-harm behavior, indicating the severity and potential danger of these acts.

The findings in this part of the study highlight the detrimental impact of misinformation on young women, leading to increased trauma and a lack of appropriate care. First, the participants' experiences of self-harm and suicidal behaviour can be linked to misinformation that perpetuates negative beliefs and misconceptions about mental health. Misinformation may contribute to stigmatization, making it difficult for individuals to seek help or access proper care. Second, the lack of control and memory reported by some participants regarding their self-harm episodes can be linked to misinformation that distorts their understanding of coping mechanisms and healthy behaviours. Lastly, the participants' narratives reflect a lack of awareness and knowledge among parents, caregivers, and healthcare providers, suggesting that misinformation at the societal and healthcare levels can hinder the recognition and provision of appropriate care. The solution to addressing the extreme effects of misinformation on these young women involves implementing comprehensive education and awareness programs to dispel myths and promote accurate information about mental health. Additionally, it is crucial to provide accessible and culturally sensitive mental health services by training healthcare providers to recognize and respond to the needs of individuals experiencing trauma and self-harm. By combining accurate

information, destigmatization efforts, and improved care infrastructure, we can work toward ensuring that young women receive the support and care they need to overcome the negative impacts of misinformation and achieve better mental well-being.

Support and Healing Journey

Seeking the best therapist and the final healing place

P1: "I'm glad that I took help from the psychologist who visited our school to conduct an awareness program. I got sessions at the school as well as the hospital by the same psychologist for 8 weeks, and it's been over a year that I'm regularly doing follow-ups."

P2: "The *Pranayama* (breath-work) therapy, which I learned from the psychologist, makes me feel light, peaceful, and happy. Those haunting voices have disappeared, and I have learned to control my emotions and excessive thinking. I would suggest all my friends to seek help from the psychologist at the district hospital."

P3: "I'm very happy that my sister got to know about a psychologist through an NGO who specializes in therapy and management for disorders related to girls and women and referred me to him. The first session was very helpful, and I learned *Pranayama* and meditation to connect to my body and understand and regulate my emotions. He has been more helpful than my parents, and I have referred my friend from the school to meet him at the hospital for her panic attacks. One should always seek help from the nearest hospital."

P4: "I have been very depressed and my family will never believe that I have a mental health crisis. I'm so happy that I took help from the psychologist from the local district hospital. The therapy has been very effective and I have learned *Pranayama* and meditation, which provides me immediate relief, and would always suggest everyone to seek help from him."

P5: "I improved a lot through the counselling done by a female social psychiatric counsellor at the local district hospital. A year ago, when I relapsed, she referred me to a very good psychologist who provided me very easy and simple to-do techniques using breathing exercises and meditation. It really helped me to regulate and calm down. It's been a year and I am regularly doing follows-ups once in a while. My situation has

improved and I feel he is the best therapist and would suggest others to meet him."

P6: "I'm absolutely okay now. The *Pranayama* and meditation sessions with the psychologist at my hospital really helped me. I have regained my zest for life."

This theme emerged from the narratives of the 6 participants. All participants sought help from a psychologist, who was said to be the best therapist by the 6 participants. The district hospital was the final healing place. Participants' experiences with therapy were generally positive, and they attributed their healing and improvement to the therapy and the expertise of the therapist. Participants also recommended their therapist to others who might need mental health services.

The most common source of mental health services was the local district hospital, with some participants also mentioning non-governmental organizations (NGOs) and school-based programs. Participants stressed the importance of seeking help for mental health issues, even when family members are not supportive or understanding. The narratives suggest that the quality of care provided by the mental health professionals played a significant role in participants' healing process. Overall, the participants' experiences suggest that mental health services are effective and valuable and highlight the importance of having access to trained mental health professionals.

Findings from this theme highlight the positive impact of seeking help from mental health professionals. All the participants had positive experiences with the *Pranayama* and meditation therapy, attributing their healing to the effectiveness of the therapy and the expertise of the therapist. They recommended these services to others, emphasizing the importance of seeking help for mental health issues. Accessible mental health services through district hospitals, NGOs, and school-based programs were mentioned, challenging misconceptions and promoting awareness. Overall, the findings contribute to reducing misinformation by showcasing the benefits of seeking professional support for mental health.

Healing journey

P1: "I was struggling badly with depression and anxiety in my life. I felt disconnected from my body and experiencing episodes of panic attacks

and seizures. No one around me could understand me, and my problem kept on worsening. Seeking help from a psychologist was a turning point in my healing journey. My sleep and appetite have improved, panic attacks have stopped, and I'm able to concentrate in my studies. Through therapy, I was able to explore my past traumas and emotions and learn coping mechanisms to ground myself during dissociative episodes. Though it was a difficult process, I am grateful for the progress I have made towards a healthier and happier life. I want to become a scientist and fulfil my dreams."

P2: "I battled severe depression and anxiety and constantly lived in fear. Panic attacks and seizures made me feel detached and isolated. However, daily *Pranayama* exercises as part of my therapy have brought me peace, happiness, and lightness. My condition has improved, and the fearful thoughts and voices have vanished. Through therapy, I have learned to regulate my emotions and thoughts. I'm very optimistic about the future and wish to become a beautician. I hope to continue these practices in the future."

P3: "After the first therapy session, I felt much better for the first time in so many months. I decided life cannot go like this forever and I have to do something. I continued with the therapy and made meditation a part of my daily routine, as suggested in the therapy. The grounding techniques and the breath work along with the meditation was very effective in managing my symptoms. I'm preparing for the NEET (medical entrance test) and my attention and concentration has improved greatly. In the last 6 weeks I felt so refreshed and have been able to revise all my subjects. This is a big achievement for me, and I wish to continue the meditation program. I have regained my lost confidence and I want to be a very successful doctor one day and heal others."

P4: "My dissociative episodes, which used to happen almost every day for around 1 hour to 90 minutes, have stopped. I had one episode in the last month (when I was looking at an old photo album), which lasted for about 5 minutes. The therapy has really helped me. My sleep has improved, I have less panic-related symptoms, and my appetite has improved. I used to shiver a lot in school during assembly and often used to faint. This has stopped now. I also no longer hear those voices. I'm no longer restless or crying for silly things. I have regained interest in everything around me. I have great hopes for my future and I wish to be a doctor."

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P5: “I am feeling much better now as my problems have reduced though sometimes when I get stressed I feel uneasy. My sleep is much better, and the negative thoughts related to the past have reduced. I used to have seizures in which my limbs used to get locked. It has stopped. Earlier, once in 1 or 2 weeks, this used to happen, but since the last 8 weeks, it has not happened. The therapy was very effective, and I have been able to successfully complete my hotel management course and internship. I’m looking for a good job now.”

P6: “I instantly started improving after the very first therapy session. I am able to concentrate on my job and pay attention to my daily routine. I have regained my confidence. I am eating and sleeping better, and the panic attacks have also stopped. The dissociative episodes have greatly reduced, and I have learned to connect to my body and let go of all negative emotions when triggered. The therapy has really helped me and I feel very happy and excited.”

This theme emerged from the data analyzed using IPA for the 6 participants. They have suffered from severe depression, anxiety, panic attacks, seizures, and dissociative episodes, and their lives have been impacted negatively. Seeking therapy has been a turning point in their lives. They have learned coping mechanisms to ground themselves during dissociative episodes, regulate their emotions and thoughts, and manage their symptoms effectively. The participants have reported improved sleep, appetite, and concentration in their studies and jobs. They have also regained interest in everything around them and feel more optimistic about the future. The therapy has helped them overcome their fears, reduce negative thoughts related to the past, and connect with their bodies. The participants have aspirations to pursue their dream careers and help others heal. Overall, the participants have experienced positive changes in their lives and are grateful for the progress they have made toward a healthier and happier life.

To help other young women seek psychological help sooner and reduce reliance on faith healers by their families, several strategies can be employed. These include raising awareness through targeted campaigns that emphasize the positive effects of therapy, collaborating with faith-based communities to promote understanding of mental health and therapy, integrating mental health education into school curricula, sharing online resources that showcase therapy success stories, establishing

community support programs to provide accessible mental health services, and fostering collaboration between healthcare professionals and mental health providers. These efforts aim to empower young women to prioritize their mental well-being and seek professional help when needed.

From being possessed to empowered

The data provided for the 6 participants, P1 to P6, reveals this unifying theme as they share their individual healing journeys. All participants noted struggling with mental health issues such as depression, anxiety, panic attacks, seizures, and dissociative episodes. However, seeking therapy and adopting a better coping mechanism has empowered them to overcome their challenges and take control of their lives.

Through the *Pranayama* and meditation therapy, the participants have learned to regulate their emotions and thoughts, explore past traumas and emotions, and connect to their bodies to ground themselves during dissociative episodes. Daily *Pranayama* exercises (breath work), grounding techniques, and meditation therapy have been particularly effective in managing symptoms and improving the participants' attention, concentration, and confidence. As a result, they have experienced improvements in their sleep, appetite, dissociative symptoms, and reduced negative thoughts.

The participants shared their aspirations to pursue their dreams and careers with newfound hope and optimism. They wish to become successful doctors, scientist, and beautician to heal others and make a positive impact in their communities. The participants' healing journeys demonstrate the power of seeking help, adopting healthy coping mechanisms, and the potential for anyone to overcome their struggles and become empowered.

DISCUSSION

Misinformation regarding DTD in India operates on 3 levels within society. First, parents may believe their daughter is divinely possessed and create a worshipful environment instead of seeking medical help. Second, some parents turn to exorcists for shamanic healing, considering it the appropriate treatment. Lastly, medical officers at rural PHCs often lack

proper training to accurately identify and diagnose DTD, leading toinadequate treatment.

The main objective of this research is to understand the help-seeking behaviors and encounters with medical misinformation among adolescent girls with DTD in India. By exploring their experiences and cultural influences, the study aims to inform interventions and initiatives that improve care and support for this population. Through the IPA data analysis method, we found 3 superordinate themes: (1) challenges in seeking diagnosis and treatment, (2) emotional and psychological struggles, and (3) support and healing journey. Subordinate themes for each theme were identified, which substantiate the influence of misinformation in the help-seeking behaviors and experiences of adolescent girls with DTD.

The theme of “challenges in seeking diagnosis and treatment” reflects the difficulties these girls face in obtaining a proper diagnosis at the PHC due to lack of training, medical misinformation, and prevalent cultural beliefs.

Difficulty in getting a diagnosis, the subordinate theme of this research, aligns with the results of Worthington and Gogne (31), who state that providing high-quality primary healthcare to large populations in India presents various challenges. Patients' cultural, social, and religious beliefs can cause delays in obtaining medical assistance. State-run outpatient departments are often too busy for physicians to properly investigate the causes of patients' conditions, which can have negative impacts on patient outcomes. Patients with culture-bound symptoms are common in primary care in India and other Asian countries, and proper understanding of these cases is necessary for satisfactory patient outcomes. The causes of these symptoms may be structural or related to cultural values, social practices, and beliefs. Young adult women are particularly affected, and ethical issues may arise. The main reason for such symptoms is a weak coping mechanism toward their internal conflict. Due to insufficient awareness and comprehension of DTD among healthcare professionals, DTD is often misdiagnosed as other disorders (32). Second, the healthcare personnel are part of the local community, and many of them believe in myths and superstitions related to the phenomena of trance and possession.

Our study emphasizes the importance of enhancing knowledge and education of DTD's management and mental health awareness at the

PHC level. A way to be culturally centered, while reducing misinformation by parents and healers and reducing reluctance to seek care for their daughters, is by implementing comprehensive measures at the PHC level. This includes enhancing knowledge and education, recognizing professional medical assistance, developing a treatment manual for PHC centers, and providing training for healthcare personnel..

The subordinate theme “belief in evil spirits and exorcism as confabulatory explanatory models” reveals a diverse range of beliefs and interpretations regarding evil spirits and exorcism. The superstitious belief of the parents, the misinformation about the treatment of mental health issues like DTD, and their help-seeking from the shamans are other causes of not getting timely treatment. The diverse beliefs and interpretations demonstrate the participants' attempts to make sense of their experiences within their cultural and personal frameworks. The presence of confabulating explanatory models suggests the influence of cultural, religious, and supernatural explanations in understanding mental health concerns. Addressing misinformation and providing accurate information becomes crucial in redressing the misconceptions surrounding DTD among adolescent girls. Recognizing the variations in beliefs and interpretations can inform interventions that promote mental health literacy and help-seeking behaviors while respecting cultural diversity. By incorporating culturally sensitive approaches, healthcare professionals can bridge the gap between traditional beliefs and evidence-based practices, empowering adolescent girls to make informed decisions about their mental health.

The subordinate theme “overthinking, nightmares, and hearing voices” in this study is intricately connected to the prevailing misinformation surrounding DTD in India. The participants' narratives vividly illustrate their distressing symptoms, including overthinking, nightmares, and auditory hallucinations, which significantly impact their mental well-being and daily functioning. This link to misinformation becomes evident when participants describe seeking help from local faith healers and exorcists who attribute the participants’ experiences to possession by spirits or supernatural entities, indicating a lack of accurate understanding. To address this issue, comprehensive steps should be taken, including education campaigns, healthcare worker training, accessible mental health services, community engagement, and research

to expand the knowledge base and inform evidence-based practices in tackling DTD-related misinformation.

The theme “emotional and psychological struggles', including subordinate themes 'guilt, shame, difficulty expressing emotions, negative self-image, and self-harm”, are actually symptoms of DTD and strongly linked to misinformation, as delay in diagnosis causes an exacerbation of these symptoms. Participants' narratives illustrate how misinformation worsens their struggles, leading to feelings of guilt and shame, reluctance to seek help, and distorted coping mechanisms. Addressing this issue requires comprehensive education, awareness campaigns, accessible mental health services, and training for healthcare providers. These steps can provide accurate information, reduce stigma, and offer support to mitigate the negative effects of misinformation.

The subordinate theme ”guilt, shame, and difficulty in expressing emotions” resonates with the findings of Pathapati et al (33), who claimed that individuals who have difficulty expressing their distress often exhibit symptoms of possession syndrome and that the dissociative episodes are actually idioms of distress.

A study by Pietkiewicz et al (34) examined the experiences of Polish Roman Catholic women who believed they were possessed and sought deliverance ministries or exorcisms. Our study focused on adolescent girls with DTD, exploring dissociative disorders and possession experiences from a cultural and clinical perspective. Both studies use IPA and analyze in-depth interviews. Participants in both studies discussed difficulties with expressing emotions and needs. However, our study identified additional themes and highlighted the role of religious beliefs and stigma hindering help-seeking. Our study also addressed misinformation and lack of awareness among healthcare professionals, which the Polish study did not cover. Overall, our study provides a more comprehensive understanding of adolescent girls with DTD and their experiences compared to the Polish study.

Another Polish study (26) examined women labelled as possessed due to sexual abuse, hindering their access to medical help. This study emphasized that educating religious leaders about psychopathological symptoms is crucial. Our research focuses on adolescent girls with DTD, highlighting cultural influences on their experiences. We emphasize the importance of considering culture in DTD diagnosis and treatment. Our study is more comprehensive than the Polish one. Our study reveals

challenges in diagnosing and treating DTD amid misinformation and stigma. Basic training exists for faith healers, but a robust framework is necessary. There is a need to educate Indian religious leaders: raise awareness, provide comprehensive training on psychopathological symptoms, foster collaboration with mental health professionals, emphasize cultural sensitivity, develop customized training programs, engage the community, and promote collaboration with healthcare professionals.

The experiences described regarding negative self-image and self-concept among all the participants in our study highlight the profound influence of trauma and negative encounters on mental well-being. Likewise, numerous studies have reported diminished self-esteem and negative self-image among individuals with dissociative disorders (34,36–39). The presence of misinformation exacerbates these challenges. Healthcare professionals and psychologists play a vital role in addressing these issues by providing support, therapy, and counselling to cultivate a more positive self-image and self-concept. Enhancing self-esteem, self-worth, and a sense of identity facilitates the healing process, leading to improved mental health outcomes. Effective health communication for parents and caregivers involves educating them about the consequences, encouraging open dialogue, fostering positive self-esteem, challenging societal pressures, and promoting professional assistance. Implementing these approaches contributes to the mental well-being of girls and fosters a healthier self-perception.

Our study identified the theme of self-harm in 4 of the 6 participants. Their narratives revealed experiences of fear, frustration, and overwhelming emotions leading to acts of self-harm, including cutting, overdose, and suicide attempts. Participants reported not always remembering these acts or having thoughts associated with them.

A review article by Ford and Gomez (40) examined the relationship between exposure to psychological trauma and nonsuicidal self-injury (NSSI) and suicidality in individuals with dissociative disorders and PTSD. Both suggest a link between traumatic experiences and self-harm behaviors, including suicidal ideation and attempts. The presence of misinformation, including parents' beliefs and inadequate training of PHC staff, along with a lack of understanding of healthy coping strategies, can contribute to the emergence and worsening of self-harm behaviors by causing delays in appropriate treatment. It is important to address

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misinformation, provide accurate information, and offer support to effectively prevent and manage these harmful behaviors.

Emran et al (41) used IPA to explore subjective experiences of women with dissociative disorders. In contrast, our research specifically focuses on DTD in adolescent girls. While both studies emphasize the influence of cultural beliefs on dissociative disorders, our research provides a more in-depth analysis of coping strategies and healing journeys of adolescent girls with DTD. It also addresses the challenges of diagnosis and treatment in a community with misinformation and stigma. On the other hand, Emran et al (41) examine the impact of cultural norms and family relationships on dissociative symptoms among women more broadly. Our study offers a comprehensive understanding of DTD experiences within a specific cultural context, while the other study provides a broader perspective on dissociative symptoms among women in India influenced by culture and relationships.

A study by Bhavsar et al (42) on indigenous healers in western India found that while healers and patients were in agreement with psychiatrists in the diagnosis and identification of “serious” symptoms of mental illness, the majority of patients had consulted more than one kind of healer for their problem and there was no association between a patient's choice of healer and their age, wealth, or formal level of education. Overall, our research offers a more comprehensive and nuanced understanding of the experiences of individuals with dissociative disorders in a specific cultural context, while the study on indigenous healers provides insights into the preferences and practices of patients and healers in a broader cultural context.

Another study by Suprakash et al (4) focuses on DTD's clinical presentation, treatment, and cultural factors in India. Our research complements this by exploring adolescent girls' experiences with DTD, including coping strategies and beliefs about possession. We highlight the challenges of diagnosis and treatment in a stigmatized community with misconceptions and misinformation. Both studies emphasize the influence of cultural factors on DTD's manifestation and treatment.

The theme of "support and healing journey" reflects the resilience and agency of these girls with DTD in seeking healing. Despite the challenges, they actively search for the best therapists and suitable healing environments and undergo transformative healing journeys. This demonstrates their shift from a state of feeling possessed to empowered

individuals, eager to overcome their condition and pursue a healthier life. *Pranayama* and meditation emerged as an effective therapy for DTD.

Our study has two main implications. First, it calls for awareness campaigns to dispel misconceptions about DTD, promoting accurate understanding among parents, communities, and healthcare professionals. Second, targeted training programs are needed to equip healthcare professionals with accurate knowledge and skills for proper diagnosis and treatment of DTD in rural areas. This study had limitations, including a small sample size and a focus on a specific community in Sikkim, which may restrict the applicability of the results to a broader population. It is also acknowledged that some religious beliefs remain nonrefutable by empirical evidence, and yet certain myths contradict established evidence on effective trauma treatment practices. It is essential to recognize that not all religious beliefs can be classified as misinformation based solely on scientific evidence.

CONCLUSION

Misinformation regarding DTD in India operates at multiple levels, influencing help-seeking behaviors and experiences of adolescent girls. Cultural beliefs, reliance on exorcism, and inadequate training of healthcare professionals contribute to delays in diagnosis and inadequate treatment. To address this, awareness campaigns are needed to dispel misconceptions and promote accurate understanding among parents, communities, and healthcare professionals. Targeted training programs should equip healthcare professionals with accurate knowledge and skills. This study highlights the importance of cultural sensitivity, accurate information dissemination, and support to mitigate the negative effects of misinformation. Collaboration between stakeholders is essential for improving care and support for individuals affected by DTD in India.

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