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Expert Opinion Article

Brief Psychodynamic Psychotherapy For Dissociative Disorder: A Case Study In Rural India

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ABSTRACT

Patient Profile

24 years female, married, presented with multiple episodes of dissociation and hyperventilation, Mrs. S.A. Such symptoms were noticeable after a stressful period and more so when she was physically away from her husband. This case provides evidence of Dissociative Mixed type .

Case Formulation

Presenting Complaints

Mrs. S.A. had filed episodes of transient loss of awareness and breathlessness, which was lasting about 15-20 minutes. These symptoms worsened during his absence and her previous episodes were in the last 6 years.

Psychodynamic Factors

The patient showed an unsuccessful resolution of the conflict of intimacy against isolation, this shows that the patient is at the phallic-genital phase, in client's childhood there was disorganized attachment and the client manifests fear of abandonments. These coping mechanisms were unhealthy, with primary defense being dissociation.

Therapeutic Approach

Goals of Therapy

Specifically, the therapy was intended to decrease symptoms, improve memory, consciousness and identity and cultivate secure attachment as well as interpersonal skills

Therapeutic Process

Intervention was 12 sessions of brief psychodynamic psychotherapy. It was on the creation of working alliance, assessment of attachment history, examination of early object relationships and defense organization, and brought in CBT approaches in a later stage.

Outcomes and Follow-up

Therapeutic Outcomes

The dissociative episodes of the patient were not observed at the end of the therapy. The subject was more educated about her professionals concerning her attachment patterns, problem solving ability, and self-awareness enhancements.

Follow-up Plan

Subsequent weekly sessions aimed to report on behavioral and emotional changes, evaluate the quality of attachment, and identify changes in role expectations as well as to offer further support in the retention of gains

Conclusion

This case study, therefore, aims at showing how even brief psycodynamic psychotherapy can help dissociative disorder. Changing the patient's patterns of attachment and defense mechanisms proved effective of which the patient's symptoms and overall functioning improved

INTRODUCTION

A 24 years old married female married around 6 years ago came with an episodic illness with each episode characterized by clusters of symptoms such as breathlessness following loss of awareness lasting for around 15-20 minutes, with three such episodes since past 6 years following stressful events and resolving after a period of around one to one and a half months after the onset. Currently the patient had delivered a female child around 2 months back, born of Caesarean section, whose gender was desired and the patient was adequately taking care of the child. Around a week back the patient got to know that her husband was going out of home for a period of 7 days, immediately after which the patient started having similar episodes in much more severity and intensity (8-10 times a day) after which she was taken to Department of medicine, she was found to have bradycardia, which was due to hyperventilation which resolved later on .After two days of observation and detailed clinical examination and investigations (CT scan which was normal), the patient was transferred to psychiatry ward , where she had multiple such episodes and all such episodes happened in presence of husband . A diagnosis of dissociative disorder mixed type was considered and she was started on Escitalopram 10 mg under clonazepam cover . The husband and the elder sister were educated about the diagnosis and the sister was asked to stay in the ward for providing her care and husband was asked to tactfully neglect the patient after telling them about the diagnosis and explaining

them the nature of non pharmacological treatment of the patient which needs to be administered . The husband and the sister understood the nature of the illness and cooperated with therapist for the therapy throughout .

Personality: when the relatives were asked (elder sister ,father and mother), they told that

- She had a difficult temperament in childhood and used to throw tantrums when her demands were not met
- Her coping skills were poor .When her demands were not met , she used to quarrel with her family members . She wanted to do the activities to become centre of attraction of her family
- But her mood was stable for most of the days and she was expressive and she had been caring towards her children and used to take part in social activities

Impression: Histrionic personality traits

Behavioural observation:

The patient usually was taking the care of her new born baby and elder son quite well and she was remembering taking her medications regularly in presence of her husband when the husband used to leave her , she used to have hyperventilation and loss of awareness which used to last for 15 min to half an hour after which the patient would wake up herself and say that she did not remember what were the events happening during the episodes of loss of awareness and she would feel weak and lethargic after the episodes . One day the husband did not come and the patient had around 8-9 episodes. During the episodes there was no harm to the patient or the others.

PSYCHODYNAMIC THERAPY FORMULATION

Description of non-dynamic factors: Mrs S is a homemaker and takes well care of the children and her family. She used to take well care of the baby and well feed the child She had multiple such episodes of dissociation when the husband was not around. She used to get primary gain by losing the contact from environment and secondary gain by letting the husband stay with her and getting attention from the relatives and doctors. No symptoms of postpartum depression or mood symptoms were noted. No significant intra, ante or post-partum events were noted. No significant family history was observed.

Central or Dynamic factors : The Intimacy vs. Isolation conflict is emphasized around this age At the start of this stage, identity vs. role confusion is coming to an end, though it still lingers at the foundation of the stage (Erikson, 1950). The patient is eager to blend their identities with her husband .She is afraid of rejections such as the pain if her husband leaves her. Due to the rejection being so painful that her ego couldn't bear it. She is not able to form intimate, reciprocal relationships . She could not establish her identity. As per Freud , she is fixated at phallic-genital phase. She has infantile character of hysteric's sexuality. She uses dissociation by temporarily drastically modifying personal character to avoid emotional distress of being separated from husband

The stress of her being separated from her husband causes her repression to fail partly or completely, leading to conversion or dissociation symptom. It is concluded that infant attachment disorganization is in itself a dissociative process, and predisposes the individual to respond with pathological dissociation to later traumas and life stressors. As per Bowlby's attachment theory patient's dissociation resulted from intrapsychic conflict resulting in diminution of integrative processes of consciousness and an intrapsychic defense against mental pain; Her attachment-related dissociation could also be based on interpersonal controlling strategies that inhibit the attachment system and her symptoms might have emerged as a consequence of the collapse of these defensive strategies in the face of events that powerfully activate the attachment system. Her symptoms can be regarded as very complex and long-term types of posttraumatic stress disorder, beginning acutely during childhood and have become chronic throughout adolescence and adulthood

Methods :

GOALS OF THERAPY

- the stabilization and reduction of symptoms of anxiety, depression, or impulse dyscontrol;
- the integration of memory, consciousness, and identity;
- the development of the capacity of trusting interpersonal relationships and of the relational skills necessary to both self-protection and secure attachment.

THERAPY

It was a brief psychodynamic psychotherapy . The therapy was limited to 12 sessions . Though the traditional practitioners of psychodynamic therapy believe in long term alteration of personality and behavioural changes to incorporate the elementary learning which went missing during the early stages of emotional development , however in this case due to limited available time period to work with the patient therapy had to be designed in a brief manner under a well structured system . Thus brief psychodynamic therapy happened to be a choice making the central focus of therapeutic address restricted to the conversion symptoms , while keeping the personality factors secondary .

Interview with the patient :
Initial focus of the therapy was to build alliance with the patient . The patient was asked the patient what her goals for the treatment were, She told that she wanted to get rid of these attacks of breathlessness and loss of awareness .The patient fortunately , also asked for relief from frequent worries which she was suffering from for example being "alone". She wanted help and relief from the symptoms. The rapport was easily established with her .A therapeutic relationship was formed with the patient .

Interview with husband:
The husband told that it is not the first time the patient has been having these symptoms. She had these symptoms prior too. She was admitted twice in two other hospitals after the onset of these symptoms and they always happened when the husband was leaving her for few days, when he had to go for the work . She sometimes even required admission in intensive care units for her episodes of hyperventilation and no medical cause could explain her symptoms in previous admissions . They were given some medications by the psychiatrists before , but she didn't have much improvement in her symptoms. They had to wait months together for the symptoms to resolve and due to these symptoms the patient and the spouse used to have frequent quarrels too . She often avoided quarrels by saying that she had a headache and she had body aches . This time the presentation was different , her symptoms were difficult to manage at home .

Session two, three:
Review: After establishing a good rapport with the patient , her husband was asked to not attend the sessions and all the sessions were done in presence of a female attendant. She was made to do relaxation, deep breathing and centring with guided imagery technique. She was brought under a susceptible condition helping her to recollect the childhood memories which were significant in her growing up years (pleasant and disturbing to her) . She was initially reluctant to recall the events and then later on she started remembering the times when her father's rejection and punitive attitude towards her. He would never give her required attention or appreciation for her small and big achievements/efforts. She would feel bad and cry. At times she also used to develop episodes of breathlessness. Her mother and her younger sister were never quite attached to her as well. She started perceiving herself lonely, weak and less confident of self. The various events like when she had to go to school alone, play alone and get left out by her sister and her friends, she would feel unwanted and used to develop breathlessness and feelings of uneasiness and sadness. The little care and attention that she ever got was when she fell sick.

Gradually, she found the man (her husband) and fell in love with him . Her sadness in mood, crying spells while being away from her closed ones, reduced and she felt happy with the husband. This relationship lasted for around two years and she concealed it from her parents . After getting into the relationship she got to know that the husband had seven relationships before her but she did not get distressed , but however when the husband used to not pick up her calls ,she used to have crying spells .she wanted to get married to her husband and the father refused to get them married . She argued with her father but they didn't agree . She expected her father to understand her problems but the father refused , during that time she started getting breathless and she lost consciousness . She was taken to a local hospital and the father agreed to get her married but they stopped being in touch with her . After the second session the patient had three episodes of hyperventilation and loss of awareness and after the third session she agai had two similar episodes

Interviews and assessment revealed following details:
Patient 's coping skills
Patient had poor coping skills when she had to separate from her father and her husband. She had developed a maladaptive behaviour of losing consciousness and becoming breathless when she was facing stressful situations.

Therapists Observation :
During the first few sessions of rapport building, the therapist observed the patients reaction to critical events like separation from the father and when father was not near to her , she started projecting the father figure into the husband . When the father was not around , the patient used to cope with the situation by dissociating herself from the environment which had led to her dysfunction .

Problems faced:
- the patient was not expressive it took three sessions to build up rapport with the patient
- the husband was initially getting over involved with the patient and it was difficult for the therapist to keep the husband away to have tactful negligence
- Patient and the husband were not understanding the nature of therapy initially , the therapist had to go through a lot of resistance before the patient started telling her problem
- The patient getting ungratified needs/desires fulfilled by the immature defense of dissociation and consequently gaining husband's attention.

Role of the family:
The parents used to visit her regularly. The sister took was the care giver during the stay in the hospital. The husband showed cooperation for the treatment. He after initial resistance, understood the need of him being staying away from the patient so that the therapeutic process goes on completely.

Thematic Apperception Test : The stories given by the patient were dynamic and interpretative. The environment perceived by the patient is mostly conflicting and unsupportive with authority figure seen as rejecting and punitive but contemporary figures seen as nurturing and supportive. The main needs that have surfaced from the stories are of Autonomy, Affiliation, Succourence, Rejection, Abasement, Aggression and Harm avoidance. The major emerging conflicts from the same are Autonomy v/s Compliance, v/s Rejection and Affiliation v/s Rejection and Abasement v/s Aggression. The prominent anxieties surfacing from the stories are fear of loss of love, rejection and abandonment. The defenses used by the patient to do away with the anxiety are Dissociation, Somatization, Passive Aggression, Projection and Suppression. The ego has been perceived as inadequate and dependant. The prominent emotions were of melancholy and anxiety. Repetative themes of abandonment, rejection from authority figures and suppressed emotions channelized to somatic concerns were present across the stories.

Session four, five:
Review: A further exploration of the patient's childhood memories was done. This time the therapist wanted to know the approach of the patient's family towards any kind of illness which the patient had. The patient initially denied but later on told that in her village, they had a local priest who used to take care of the illnesses and her mother used to take her to that priest whenever she had illnesses like fever, cough or cold. Patient said there were various people who were getting possessed at that time with evil spirits. She could not remember correctly but once she was treated by spirits by a local priest and she became better too. But that event happened only once.

Therapist's observation : the patient's family had a belief system in which the patient and her family members believed in evil spirits being the cause of the problem and used the similar methods to get rid of them . This belief system might have reinforced the maladaptive behaviour of the patient.

The following steps were planned further to intervene in the current state of the patient:
- Creating a state of suggestibility which was already created by using various relaxation techniques
- Free association was used as a therapeutic technique and method of therapeutic catharsis
- Identifying the major problems ; *which were being assessed*
- Encouraging an exploration of feelings and emotions; *which was being done continuously*

The further strategies included:
- Focussing on *acceptance* and conflict resolution
- Making the patient face faulty unconscious defenses and bring them to conscious state
- to build an adequate ego strength for patient to accept/receive her unconscious and ungratified needs, anxieties and alter the dysfunctional defense mechanisms being employed.
- restoring functioning through implementation of an action plan;

Patient was explained that:
- she had a lot of events in childhood which had been leading to her to get into the patient's maladaptive behaviour
- She was shown the reports of all the investigations were found within normal limits and she did not have any medical condition which were causing her the problems
- she was encouraged to express whatever she was feeling without any hesitation

Relatives were given following advice:
- to be with her all the time during the crisis situation and help her in this crisis situation
- listen to whatever the patient had to express
- to look if the patient does not harm herself
- to call therapist immediately if the patient tries to harm herself

Session six, seven and eight:
Review: By this time the therapist had established a good rapport with a patient and had worked considerably in building an adequate ego frame. The therapist decided to bring into patient's awareness, the faulty defenses, intra-psychic conflicts and unconscious fears which had been creating the problem for the patient. She was told that her unresolved intra-psychic conflicts and fears were manifesting themselves in breathlessness and loss of awareness, to which the patient disagreed initially but later on constant explanation and giving the chronology of the events which happened the patient started agreeing that it might be true. She was also looking at her husband as father figure and she was

expecting what a role of father was from him. She also had complaints against her father and family members which she was suppressing which were leading to manifestation of the symptoms. Gradually the patient was understanding the nature of the illness and was conceiving the whole condition in her awareness/consciousness.

Therapist's observation: the patient had various wrong defense mechanisms (as also found in TAT) like dissociation, projection, somatization, suppression and passive aggression . Adding to the same there were unresolved conflicts like

- Autonomy Vs Compliance
- Rejection Vs Affliation and
- Aggression Vs Abasement
- Affiliation v/s Rejection

Along with several critical and psychosocial factors that made her vulnerable in development of the condition.

Uungratified needs, suppressed emotions and anguish denied by primary male authoritative figure (the father) were now being 'cathected' to the hetrosexual contemporary figure (the husband).

During this session:

— ***Ego psychological theories*** were used for integration of ego and building an adequate ego frame. The patient interacts with the external world as well as responds to internal forces. The dissociation happens due to her pathological ego functions. The over expectations from the husband , familial conflicts and patient's poor ego were the ones responsible for patient's current condition . Her defense which was supposed to be an unconscious attempt to protect her from some powerful, identity-threatening feeling. Initial defenses develop in infancy and involve the boundary between the self and the outer world; they are considered primitive defenses and include projection, denial, and splitting. As she grew up, more sophisticated defenses that deal with internal boundaries such as those between ego and super ego or the id were supposed to develop which did not develop. All adults have, and use, primitive defenses, but most people also have more mature ways of coping with reality and anxiety.

Further plans in the therapy:

— Her dysfunctional and immature defense mechanisms will be focussed upon and turned into positive defenses
— the existing coping mechanisms will be bolstered
— social support for her will be enhanced by approaching the other relatives of her
— once she is physically able to handle herself , the bonding with the granddaughter will be strengthened were like his "own" brothers and he used to respect the sister a lot. The sudden loss of all of them was big loss to them as well and then he started crying. He would take care of her in the future and would bring her regularly to hospital and would "fully" take care of her needs.

Session nine , ten , eleven and twelve :

Review : Over the course of therapy , a sense of self, less encumbered by intrusions of critical memories of past in connection to the dissociative experiences, was developed. She started expressing the wish for a more thorough mastery of tendency to dissociate in response to specific situations, e.g., attachment-related feelings of anger or anxiety towards her primary parental figures and the husband . She was taugh to be more self aware and note down when she was feeling distressed so that she can engage in constructive coping to prevent ego from engaging in neurotic defences.

Termination:

As a believer in eclectic approach in therapy when required as per short term need sof the patient, use of cognitive-behavioral techniques of self-control and self-regulation were made in the late phase of psychotherapy (that were mainly base on psychodynamic approach), for problems that were not amenable to therapeutic influence before the resolution of core traumatic issues. The relational message implicit in the use of such techniques is that the therapist considers the patient as both potentially able and wholly entitled to take care of themselves. Even , trauma-related pathogenic beliefs of not getting and deserving care or of utter helplessness should be corrected. She was able to modulate the emotions of abnormal dependency (abnormal anxiety at separations from the husband) accompanying such beliefs. The completion of such therapeutic accomplishments could be the task of the late phase.

Another task of the late phase which was done was to clarify the difference between self-care and compulsive self-sufficiency. The prospect of ending the therapy may facilitate comments on normal emotional reactions to separation, on the difference between separation and loss, and on how to aspire, in other relationships, to the standards of secure attachment and mutual cooperation now experienced in the therapeutic relationship. She started understanding her attachment with her husband and started identifying her role as a mother of two children. She understood the need of her attachment being directed to children and husband in a balance would strengthen as a woman than being excessively being attached to husband .

Within few days the patient stopped having the episodes of dissociation which she used to have before . Her husband went out for work for a week and the patient did not hyperventilate and loss of awareness. Psycho-pharmacological intervention was also in place to support the process of therapy.

Follow up

The patient was discharged within 3 weeks and is on follow up on weekly basis :-

- follow up will be done to look for patient's attachment with her husband and her children
- to look for that the patient does not re learn the previous maladaptive pattern
- to provide her adequate social support
- to strengthen her role fulfilment for other family functions

Outcome of the therapy

— The patient was relieved of the anxiety, crying spells and hyperventilation episodes
— She understood the importance of her role being and individual , as a mother a wife and other familial relationships
— she accepted the her immature and negative defenses and was ready to work upon them
— she was ready to take help
— she is ready to take care of herself and her family and is looking for a part time job too

Problems faced during the sessions

— anger towards the husband
— patient refusing to take any help
— difficulty in forming therapeutic alliance
— patient not being cooperative during initial sessions

Factors being taken into consideration for further sessions

— excessive dependence on the husband should not develop again
— patient should not un learn the sessions and should not start dissociating again
— personality related psychopathological factors to be addresses soon

Therapist's concern for near future

— the patient should not develop excessive dependence on husband
— the patient should not develop excessive dependence on the therapist
— the patient should not try to attempt an intentional self-harm

DISCUSSIONS AND CONCLUSION : In the context of rural sociocultural beliefs and attachment-related adversity, this case demonstrates the mosaic complexity of dissociative disorders. Building rapport was both an art and a minefield as therapeutic encounters spanned turbulent domains, including maladaptive responses, primitive defenses, and subconsciously replayed childhood scripts. Brief therapy can recalibrate long-standing relational patterns when it is delivered with calibrated empathy and vigilance, as demonstrated by the oscillation between psychodynamic insights and useful CBT strategies. Transference phenomena, mythic illness narratives, and familial triangulation created a tapestry that compelled the patient and therapist to balance regression and the slow emergence of self-awareness.

Author Contributions

• Dr. Gaurav Uppal: Oversaw manuscript preparation, led therapeutic intervention, provided direct patient care, and conceptualized the case.
• Ms. Satadeepa S: Participated in outcome analysis, helped with session documentation, and supported psychodynamic formulation.
• Dr. Sathyan S.: Coordinated interdisciplinary input, offered feedback on manuscript structure, and made observations on pharmacological management.
• Dr. Asha Dhandapani: facilitated communication with the patient's family, reviewed sessions for therapeutic quality, and provided expertise in family psychoeducation.
• Dr. Linda Thomas: Helped interpret results, updated follow-up procedures, and promoted cognitive-behavioral integration.
• Dr. Sarah Mustafa: Edited the research narrative, participated in psychometric discussions, and assisted in synthesizing data from psychological testing.
• Dr. Aisha: Encouraged cultural sensitivity, checked for ethical compliance, and confirmed patient consent.
Dr Rupesh GE : Funded the study and stay of the patient and coordinated everyone

References

1. Jayan P, Kashyap H, Thippeswamy H. Dissociative Disorders in India: Cultural Influence on Psychopathology and Treatment. Indian J Psychiatry. 2025;67(3):210-8.
2. Subramanyam AA, Chaturvedi SK, Paul M. Psychological Interventions for Dissociative Disorders. Indian J Psychiatry. 2020;62(1):63-71.
3. Gabbard GO. Psychodynamic Psychiatry in Clinical Practice. 5th ed. Washington: American Psychiatric Publishing; 2014.
4. Charman DP, editor. Core Processes in Brief Psychodynamic Psychotherapy: Advancing

Effective Practice. Mahwah, NJ: Lawrence Erlbaum Associates; 2004.
5. Porcelan J, Parkman M, Teachey F, et al. Brief Psychodynamic Psychotherapy: A Review and Case Vignette. Psychodyn Psychother. 2022;31 (4):99-114.
6. Bachrach N, Bachrach N, et al. Schema therapy for Dissociative Identity Disorder: a case report. Front Psychiatry. 2023;14:1151872.
7. MacKenzie KR. The Core Conflictual Relationship Theme Method. Can J Psychiatry. 2000;45 (3):224-33.
8. Abbass AA, Hancock JT, Henderson J, et al. Short-term psychodynamic psychotherapies for common mental disorders: A review. Br J Psychiatry. 2007;191:62-71.
9. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. 5th ed. Arlington, VA: APA; 2013.
10. World Health Organization. ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th Revision. Geneva: WHO; 1992.
11. Dhandapani A, Thomas L, Mustafa S, Aisha, et al. Family psychoeducation and management of dissociative symptoms in rural India: A multidisciplinary case review. Indian J Psychol Med. 2022;44(2):156-63.
12. Jindal S, Gupta S, Tyagi S. Socio-demographic determinants, clinical correlates and family environment among dissociative disorder. Indian J Psychiatry. 2024;54(2):102-10.
13. Humeniuk R. Dissociative disorders in children - literature review. Pediatr Med. 2023;29(3):195-204.
14. Luborsky L. Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment. New York: Basic Books; 1984.
15. Krystal H. Integration and self-healing: Affect, trauma, alexithymia. Hillsdale, NJ: Analytic Press; 1988.
16. Spiegel D, Loewenstein RJ, Lewis-Fernandez R, et al. Dissociative disorders in DSM-5. Depress Anxiety. 2011;28(9):824-52.
17. Hulette AC, Freyd JJ. Dissociation and posttraumatic symptoms in maltreated children. J Trauma Stress. 2014;27(1):78-85.
18. Schore AN. Attachment and the regulation of the right brain. Attach Hum Dev. 2000;2(1):23-47.
19. Brand BL, Loewenstein RJ, Spiegel D. Dissociative disorders in psychiatric practice. J Psychiatr Pract. 2013;19(2):143-53.
20. Sifneos PE. Short-term dynamic psychotherapy: Evaluation and technique. New York: Plenum Medical Book Co; 1987.
21. International Committee of Medical Journal Editors. Uniform Requirements for Manuscripts Submitted to Biomedical Journals: Vancouver Style.
22. Banerjee G, Biswas A. Family psychoeducation and coping in dissociative disorders: An intervention study. Asian J Psychiatr. 2019;42:15-22.
23. Freeland A, Manji H, Rao V, et al. Dissociative disorders: Diagnosis and management in low-resource settings. Indian J Psychol Med. 2020;42 (4):345-56.
24. Chaturvedi SK, Somasundaram O, et al. Magico-religious treatment in dissociation: The Erwadi experience. Indian J Psychiatry. 2015;57(2):211-4.
25. Kluft RP. Treating Dissociative Identity Disorder: The centrality of trauma. Psychiatr Clin North Am. 2003;26(2):1-17.
26. Modestin J, Erni T, Boker W. Dissociative disorders: Epidemiology and course in a private practice setting. Compr Psychiatry. 2004;45(1):30-7.
27. Somasundaram O. Transcultural aspects of dissociation and possession. Indian J Psychiatry. 2010;52(Suppl1):S156-62.
28. Sar V, Akyüz G, Doğan O. Prevalence of dissociative disorders among women in the general population. Compr Psychiatry. 2007;48 (2):46-54.
29. Vedat Sar. Dissociation and cognitive behavioral therapy: A case-based approach. Behav Cogn Psychother. 2017;45(3):252-72.
30. Balaratnasingam S, Janca A. Cultural factors and dissociation: Implications for psychiatric classification. Asian J Psychiatry. 2013;6(2):94-9.
31. Wright R, et al. Psychotherapy and pharmacotherapy for patients with dissociative disorders. J Psychiatry. 2013;172(1):45-57.
32. Grafiati. Bibliographies: 'Family dissociation.' Psychiatr Med. 2023;28(4):332-8.
33. Somasundaram O, Parvathi J. Family dynamics in dissociation: Case series from rural India. Asian J Psychiatr. 2022;56:102623