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UNDERSTANDING OF THE MECHANISM OF DISSOCIATIVE DISORDERS: NARRATIVE REVIEW

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ABSTRACT:

Anthropological approaches to trance and possession have predominantly relied on antiquated psychodynamic models or have interpreted these dissociative experiences merely as discursive processes, assigning actions and sensations to external entities rather than the self. In psychology and psychiatry, the comprehension of dissociative disorders has been impeded by contentious "either/or" debates: either dissociative disorders represent genuine, spontaneous changes in brain states indicative of fundamental neurobiological processes, or they are contrived, socially constructed performances shaped by interpersonal expectations, power dynamics, and cultural narratives. This study provides a framework for comprehending dissociative phenomena, such as trance, possession, and spiritual and healing practices, by synthesizing neurological mechanisms with sociocultural processes of narrative formation and social self-presentation. This integrative model, based on cultural neuroscience, may enhance ethnographic research on dissociation and improve clinical procedures by meticulously examining the influence of social context.

KEYWORDS:

DISSOCIATIVE DISORDER, DISSOCIATION, POSSESSION, CULTURAL PSYCHIATRY, TRANCE.

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INTRODUCTION

Dissociative disorders include many experiences and behaviors marked by memory, perception, and identity alterations, which are often induced by psychological and physiological mechanisms. (1) These experiences vary from commonplace phenomena such as "highway hypnosis" to severe conditions like Dissociative Identity Disorder. (2) Dissociation frequently occurs in three contexts: as a response to trauma, as an element of culturally sanctioned rituals (such as trance or possession), and as subtle alterations in ordinary conscio-usness that remain unacknowledged (3). Psychiatrists typically associate dissociation with trauma, but anthropologists emphasize its social and cultural implications. The psychiatric-adaptive approach perceives dissociation as a physiological response to stress or trauma, whereas the anthropological-discursive model interprets it as a socially produced means of articulating specific self-states within particular cultural contexts. These methods typically function independently; for instance, psychiatrists often disregard cultural interpreta-tions, while anthropologists tend to underemphasize biological mechanisms. This division parallels the discourse in hypnosis research regarding state theories, which assert that hypnosis encompasses distinct cognitive or physiological states (4), and role theories, which contend that hypnosis constitutes a behavior performed in a social context devoid of a singular mental state (5). A study contests the notion of mind-body dualism, asserting that dissociation is a typical cognitive process influenced by both neurological and social factors. (6) Dissociative experiences may occur independently or in accordance with cultural scripts. The authors advocate for a comprehensive model that considers both neurological and cultural dimensions. This paradigm seeks to integrate psychiatric and anthropological perspectives.

NORMATIVE DISSOCIATION

Psychiatric and anthropological perspectives on dissociation have focused on its more severe symptoms, such as identity disorders, fugue states, and trance or possession. Most common, non-pathological signs have not been studied (7). Dissociation occurs spontaneously when attention and consciousness shift, commonly during intense focus or absorption, causing time, self-awareness, and external environment awareness to fade (14). Films, music, literature, daydreams, imaginations, and contempl-ations can captivate one. Nearly 90% of people daydream. (6) This activity can take up 50% of younger people's cognitive time. Normative dissociation is linked to pleasant life experiences like hobbies, prayer, sexuality, and nature.

This resembles "flow," which can be defined as a seamless integration of action and awareness with less self-consciousness.

Depersonalization and derealization can also occur in healthy people (8). Amnesia and identity disruption are rare in healthy people, although regular absent-mindedness may imply moderate dissociation (12). The DES to show normative dissociation is common. At least one absorption claim was supported by 83% of 1,055 Canadians. (13) DES involves forgetting, absorption/ imaginative engagement, and depersonalization-derealiza tion. Young adults, especially college students, reported more dissociative episodes than older adults (12), although they did not meet DSM-IV clinical distress criteria. This suggests that many people, especially youth, may have heightened dissociation that is not harmful. Researchers say dissociation helps with daily duties and creativity. (7) Some of these states can be helpful, pleasurable, or even beneficial. This expands our understanding of dissociation beyond clinical aspects.

THE PSYCHIATRIC-ADAPTIVE DISSOCIATION MODEL

The psychiatric-adaptive approach suggests that dissociat-eon helps people cope with trauma, but it confuses its definition. This hypothesis proposes that trauma- induced dissociation is a neurobiological defensive mechanism. Historically, Freud, Janet, Breuer, and Morton Prince believed trauma might cause dissociation symptoms (15). Dissociation and repressed trauma were stronger in the 1970s as child maltreatment knowledge expanded (9), yet dissociative amnesia arguments continue. A recent study links dissociation to abuse, disasters, and wars. The key indicator of PTSD is a trauma-induced dissociation (10). Dissociation lowers memory recall; however, depersonali-zation improves environmental awareness and reduces emotional excess, benefiting evolution (11) This adaptive technique was promoted in the 1980s. Emergency dissociation reduces fear, increases compliance, and generates protective amnesia (12). Mild, temporary dissociation may be advantageous, while persistent dissociation, such as amnesia or dissociative identity disorder, is harmful (16). Dissociating without trauma or stress is considered unusual by most people. Dissociation may initially protect you from trauma, but it may impair processing and recovery, increasing the risk of PTSD (15). Critics say these assumptions often use correlation instead of causality (17).

Due to cultural differences in dissociation interpretation and manifestation, context is key to understanding its effects. Dissociation may have social or spiritual meaning in non-Western paradigms, but Euro-American psychiatric theories ignore them (6) It is also known that people communicate emotions through rituals and avoid verbal communication (18). Such situations may benefit from separation. Spiritual traditions like Brazilian Candomblé view dissociation as a major change (19). Different social roles can cause dissociation, not trauma (20). Cultural narratives, self-identity demands, and indigenous healing methods affect dissociation (6). Based on context, perspective, and cultural compatibility, it may be useful or damaging. Understanding it requires psychology and anthropology.

THE ANTHROPOLOGICAL-DISCURSIVE FRAMEWORK

This framework emphasizes the sociocultural dimensions of dissociative disorders, whereas the psychiatric-adaptive model concentrates on the psychological or neurological mechanisms that underlie them. Anthropology examines the construction and cultural representation of different self-states through dissociation (21), but psychiatry generally neglects the impact of social significance on dissociative phenomena. In numerous non-Western civilizations, alterations in the self are more readily accepted by society than in Western societies. Anthropologists frequently examine dissociation in religious rituals, therapeutic practices, and spirit possession, wherein spiritual beliefs are employed to interpret events rather than perceiving them as indicators of disease (6). Dissociation serves as a means of communication, identity negotiation, and "the articulation of thoughts and wishes that may otherwise remain hidden" (20). One study examined women in Northern Sudan who experienced Zar possession, concluding that spirit possession functions as a socially endorsed method for women to contest traditional gender roles. (22) Zar treatment differs from Western psychotherapy by initially instructing individuals to perceive these aspects as distinct from themselves. Another study examined spirit possession among Malaysian factory women, perceiving it as a form of protest against adverse working conditions. (23) She asserted that management's medicalization of possession as an illness eradicated the social and political dimensions of the phenomenon. Anthropologists assert that dissociation is not merely an instinctual reaction to pain but a deliberate, socially significant, and at times beneficial behavior. However, they frequently overlook the emotional and psychological repercussions of marginaliz-ation, as well as the physical and mental triggers of dissociative episodes. Anthropological methods effectively elucidate the influence of culture on dissociative experiences; yet, they do not consistently clarify the mechanisms by which dissociation occurs through the interplay of the body, mind, emotions, and language.

MECHANISMS OF DISSOCIATION

Methods of Dissociation Longitudinal research employing neuroimaging and psychophysiological methodologies has demonstrated correlations between cerebral function and dissociation, particularly in contexts associated with trauma (24, 25). According to the psychiatric-adaptive paradigm, these data indicate that dissociation frequently serves as a mechanism for self-protection against acute stress. While these biological techniques may prove beneficial, they risk oversimplifying the intricate interplay among social, cultural, cognitive, and physiological aspects

that contribute to dissociative events. Psychophysiological Principles Previous theories associated trauma with hyperarousal; however, contemporary research indicates that trauma-related dissociation is frequently connected to diminished physiological arousal. It was also discovered that rape survivors who dissociated during the assault exhibited reduced heart rates and skin conductance when recalling the incident. (15) Adolescents who experienced maltreatment and individuals involved in automobile accidents exhibit elevated dissociation and demonstrated reduced catecholamine levels. (26) Another study employed script-guided imagery to demonstrate that a patient with Dissociative Identity Disorder (DID) exhibited reduced autonomic arousal, indicating diminished mental discomfort while recalling traumatic memories. (6) Although these individual case findings are intriguing, they should be approached with caution. The Neurobiological Foundation of Dissociation Dissociation can manifest in several forms, complicating the identification of its neurological foundation. Models such as the cortico-limbic framework (27) propose that experiences such as depersonalization result from the prefrontal cortex inhibiting emotional regions like the amygdala. Research corroborates this by demonstrating reduced activity in emotional regions and diminished autonomic responses, despite sustained alertness (28). It was also discovered that elevated norepinephrine levels were associated with diminished dissociation levels. (25) Another study demonstrated that PTSD patients with strong dissociation have increased prefrontal brain activation and decreased limbic system activity during traumatic memory. (29) This indicates that they were repressing their feelings hierarchically. Cortical inhibition is also involved in functional neurological symptoms, such as conversion disorders. Research employing fMRI and hypnosis showed that despite the individual's apparent paralysis, the motor regions of the brain remained active. (30) This indicates that the parietal and prefrontal systems were inhibiting consciousness (31). Research on hypnosis corroborates this dissociation mechanism: Individuals who are more susceptible to hypnosis exhibit less activity in the anterior cingulate during suggestion (32), reinforcing the notion that distinct regions of the brain operate independently. Dissociative Identity Disorder (DID) is more challenging to comprehend due to the temporal variability of its symptoms. Research utilizing brain imaging indicates that individuals with Dissociative Identity Disorder exhibit reduced volumes in the hippocampus and amygdala, akin to findings shown in PTSD (33). These alterations may relate to difficulties in encoding and recovering memories contingent upon the state (40, 41). Individuals with Dissociative Identity Disorder frequently have functional dissociations in their cognition, demonstrating diminished awareness in their actions. This may be attributed to the influence of cortical inhibition on memory and consciousness (34). Certain individuals assert that Dissociative Identity Disorder (DID) arises from societal or cultural influences (35), but others contend it is a result of genuine psychological distress (36). In summary, dissociation is neurobiologically connected to networks that regulate emotions, memory, and awareness. To comprehensively comprehend it, we must examine all three dimensions: biological, psychological, and social. Information on PTSD and depersonalization is more comprehensive; however, DID and complicated dissociative states require further investigation.

A COMPREHENSIVE EXAMINATION OF DISSOCIATIVE PHENOMENA

Besides stress, dissociation has psychophysiological and social-discursive effects. When people attribute certain actions or feelings to unconscious impulses in Western civilizations or deities and spirits in other cultures, they experience this phenomenon. Dissociation occurs when attention, memory, emotion, and perception are disorganized. The brain can prioritize survival information when a person is strongly focused on a threat or trauma (42). The bio-cultural loop between attention, cognition, and cultural interpretation causes dissociation, according to this paradigm. Cultural scripts affect dissociated perceptions and feelings. Dissociation and hypnosis are more common in children, but they usually outgrow them as they learn self-awareness and conform to social standards. Trance or absorption enthusiasts can develop and maintain dissociation until adulthood. Trauma increases separation. Childhood trauma is linked to dissociative experiences (43, 44). Such situations make children more hypnotic (45). This confirms the stress-diathesis concept, which states that patients with dissociation grow sick under stress. Dissociation is not always a problem. Certain civilizations embrace dissociation as a spiritual practice and ceremonial component. Afro-Brazilian Candomblé values possession for its dissociative qualities. Many mediums have suffered traumatic experiences, but they view them as divine ownership by Orixás (20), allowing them to understand their suffering without feeling broken or unwell. Mrs. T, a South Asian refugee in Canada, shows trauma-induced dissociation. She experienced memory lapses, confusion, pseudo seizures, and a decreased sense of identity after her torture and exile from home, especially in emotionally intense settings. She felt worse after seeing her children and at religious holidays like Diwali, which brought back sad memories. Although neurological tests ruled out epilepsy, her episodes were upsetting and culturally meaningful. She showed dissociation and a faith crisis at the Gurdwara by pointing her feet at the sacred text, according to a cultural specialist. This example shows how trauma, attention, and spiritual background can cause dissociation as a coping technique and a sign of discomfort. In Euro-American cultures, dissociation is seen as a medical condition, while in non-Western cultures, it may be social, spiritual, or therapeutic (35, 36). In conclusion, a model that encompasses neurobiological processes, cultural narratives, cognitive mechanisms, and social circumstances best explains dissociation. This comprehensive theory explains why dissociation can be useful or harmful in different settings and how it manifests

differently among individuals and civilizations.

CONCLUSION

Dissociative experiences such as trance, possession, and therapeutic states are sometimes misconstrued as either socially manufactured performances or neurological impairments. Researchers now propose a more complete hypothesis, asserting that dissociation results from the interaction of psychological traits, cultural narratives, and neurobiological mechanisms (7). Dissociation often serves as a self-regulatory coping strategy activated by severe stress or trauma, which impairs attention and higher-order integration (37). Variations in individual characteristics such as hypnotizability and trauma history impact susceptibility, whereas societal narratives shape the perception, validation, or pathologization of these experiences (38). Cultural neuroscience (39) employs techniques such as functional brain imaging to examine the impact of culture on neurological networks associated with dissociation. Mild dissociation should be regarded not merely as a pathological indicator but also as a normal and occasionally adaptive response in clinical contexts. Dissociative behavior can be interpreted more accurately and empathetically when examined via both neuro-psychological and sociocultural perspectives, especially in circumstances with varied cultural backgrounds.

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REFERENCES

1. National Alliance on Mental Illness. (2025, August 26). Dissociative disorders | National Alliance on Mental Illness (NAMI). National Alliance on Mental Illness (NAMI). https://www.nami.org/about-mental-illness/mental-health-conditions/dissociative-disorders/

2. Mitra P, Jain A. Dissociative Identity Disorder. [Updated 2023 May 16]. In: StatPearls.Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK568768/

3. Kirmayer LJ, Santhanam R. The anthropology of hysteria. In: Contemporary Approaches to the Study of Hysteria [Internet]. Oxford University PressNew York, NY; 2001 [cited 2025 Oct 14]. p. 251–70. Available from: https://academic.oup.com/book/50735/chapter/420795962

4. APA PsycNet. (n.d.). https://psycnet.apa.org/record/2007-19668-002

5. Wieder L, Brown RJ, Thompson T, Terhune DB. Hypnotic suggestibility in dissociative and related disorders: A meta-analysis. Neuroscience & Biobehavioral Reviews. 2022 Aug; 139:104751.

6. Seligman R, Kirmayer LJ. Dissociative Experience and Cultural Neuroscience: Narrative, Metaphor and Mechanism. Cult Med Psychiatry. 2008 Mar;32(1):31–64.

7. Lynn CD. Adaptive and Maladaptive Dissociation: An Epidemiological and Anthropological Comparison and Proposition for an Expanded Dissociation Model. anthro of consc. 2005 Dec;16(2):16–49.

8. Mauss IB, Shallcross AJ, Troy AS, John OP, Ferrer E, Wilhelm FH, et al. Don't hide your happiness! Positive emotion dissociation, social connectedness, and psychological functioning. Journal of Personality and Social Psychology. 2011 Apr;100(4):738–48.

9. Trifonova, T. (2010). Multiple personality and the discourse of the multiple in Hollywood cinema. In The European Journal of American Culture (No. 2; Vol. 29).

10. Boyer SM, Caplan JE, Edwards LK. Trauma-Related Dissociation and the Dissociative Disorders: Delaware Journal of Public Health. 2022 May;8(2):78–84.

11. Levin KK, Gornish A, Quigley L. Mindfulness and Depersonalization: a Nuanced Relationship. Mindfulness. 2022 Jun;13(6):1479–89.

12. Goodwin, J., & Sachs, R. (1996). Child abuse in the etiology of dissociative disorders. In L. Michelson & W. Ray (Eds.), Handbook of dissociation. New York: Plenum Press

13. Ross, C.A., Joshi, S., & Currie, R.(1991). Dissociative experiences in the general population:A factor analysis. Hospital and Community Psychiatry, 42,297-301

14. Klinger, E. (1978). Modes of normal conscious flow. In Springer eBooks (pp. 225–258). https://doi.org/10.1007/978-1-4684-2466-9_9

15. Griffin, M. G., Resick, P. A., & Mechanic, M. B. (1997). Objective assessment of peritraumatic dissociation: Psychophysiological indicators. American Journal of Psychiatry, 154(8), 1081–1088.

16. Mitra, P., & Jain, A. (2023, May 16). Dissociative Identity Disorder. StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK568768/

17. Merckelbach, H., Muris, P., & Rassin, E. (1999). Fantasy proneness and cognitive failures as correlates of dissociative experiences. Personality and Individual Differences, 26(5), 961–967.

18. Haferkamp L, Bebermeier A, Möllering A, Neuner F. Dissociation is associated with emotional maltreatment in a sample of traumatized women with a history of child abuse. J Trauma Dissociation. 2015;16(1):86-99. doi: 10.1080/15299732.2014.959149. PMID: 25365464.

19. Seligman, R. (2005a). Distress, dissociation, and embodied experience: Reconsidering the pathways to mediumship and mental health. Ethos, 33(1), 71–99.

20. M. Lambek (Eds.), Tense past: Cultural essays on memory and trauma (pp. 173–198). London: Routledge.

21. Hollan J, Hutchins E, Kirsh D. Distributed cognition: toward a new foundation for human-computer interaction research. ACM Trans Comput-Hum Interact. 2000 Jun;7(2):174–96.

22. Boddy, J. (1993). Subversive kinship: The role of spirit possession in negotiating social place in rural northern Sudan. PoLAR: Political and Legal Anthropology Review, 16(2), 29–38.

23. Ong, A. (1987). Spirits of resistance and capitalist discipline: Factory women in Malaysia. Albany, NY: State University of New York Press.

24. Krystal, J. H., Bremner, J. D., Southwick, S. M., & Charney, D. S. (1998). The emerging neurobiology of dissociation: Implications for treatment of posttraumatic stress disorder.

25. Simeon, D., Knutelska, M., Nelson, D., & Guralnik, O. (2003). Basal norepinephrine in depersonalization disorder. Psychiatry Research, 121(1), 93–97.

26. Koopman C, Carrion V, Butler LD, Sudhakar S, Palmer L, Steiner H. Relationships of dissociation and childhood abuse and neglect with heart rate in delinquent adolescents. J Trauma Stress. 2004 Feb;17(1):47-54. doi: 10.1023/B:JOTS.0000014676.83722.35. PMID: 15027793.

27. Sierra M, Berrios GE. Depersonalization: neurobiological perspectives. Biol Psychiatry. 1998 Nov 1;44(9):898-908. doi: 10.1016/s0006-3223(98)00015-8. PMID: 9807645.

28. Sierra M, Baker D, Medford N, David AS. Unpacking the depersonalization syndrome: an exploratory factor analysis on the Cambridge Depersonalization Scale. Psychol Med. 2005 Oct;35(10):1523-32. doi: 10.1017/S0033291705005325. PMID: 16164776.

29. Sierk A, Manthey A, Brakemeier EL, Walter H, Daniels JK. The dissociative subtype of posttraumatic stress disorder is associated with subcortical white matter network alterations. Brain Imaging Behav. 2021 Apr;15(2):643-655. doi:10.1007/s11682-020-00274-x. PMID: 32342260; PMCID: PMC8032639.

30. Simeon, D., Guralnik, O., Hazlett, E. A., Spiegel-Cohen, J., Hollander, E., & Buchsbaum, M. S. (2000). Feeling unreal: A PET study of depersonalization disorder. American Journal of Psychiatry, 157, 1782–1788.

31. APA PsycNet. (n.d.-b). https://psycnet.apa.org/record/2000-15385-007

32. Egner T, Jamieson G, Gruzelier J. Hypnosis decouples cognitive control from conflict monitoring processes of the frontal lobe. Neuroimage. 2005 Oct 1;27(4):969-78. doi: 10.1016/j.neuroimage.2005.05.002. PMID: 15964211.

33. Vermetten, E., Schmahl, C., Lindner, S., Loewenstein, R. J., & Bremner, J. D. (2006). Hippocampal and amygdalar volumes in dissociative identity disorder. American Journal of Psychiatry, 163, 630–636.

34. Kihlstrom JF. Dissociative disorders. Annu Rev Clin Psychol. 2005;1:227-53. doi: 10.1146/annurev.clinpsy.1.102803.143925. PMID: 17716088.

35. Hacking, I. (1995). Rewriting the soul: Multiple personality and the science of memory. Princeton, NJ: Princeton University Press.

36. Kirmayer, L. J. (1996). Landscapes of memory: Trauma, narrative and dissociation. In P. Antze & M. Lembek (Eds.), Tense past: Cultural essays on memory and trauma (pp. 173-198). London: Routledge

37. Spiegel D, Cardeña E. Disintegrated experience: the dissociative disorders revisited. J Abnorm Psychol. 1991 Aug;100(3):366-78. doi: 10.1037//0021-843x.100.3.366. PMID: 1918616.

38. Hilgard ER. The problem of divided consciousness: a neodissociation interpretation. Ann N Y Acad Sci. 1977 Oct 7;296:48-59. doi: 10.1111/j.1749-6632.1977.tb38160.x. PMID: 279254.

39. Chiao JY, Immordino-Yang MH. Modularity and the Cultural Mind: Contributions of Cultural Neuroscience to Cognitive Theory. Perspect Psychol Sci. 2013 Jan;8(1):56-61. doi: 10.1177/1745691612469032. PMID: 23710245; PMCID: PMC3661285.

40. Becker-Blease, K., Freyd, J. J., & Pears, K. C. (2004). Preschoolers' memory for threatening information depends on trauma history and attentional context: Implications for the development of dissociation. Journal of Trauma and Dissociation, 5(1), 113–131.

41. van der Kolk, B. A., & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. American Imago, 48, 425–454.

42. Damasio, A. (1994). Descartes' error: Emotion, reason, and the human brain. New York: Putnam Books.

43. Mulder, R. T., Beautrais, A. L., Joyce, P. R., & Fergusson, D. M. (1998). Relationship between dissociation, childhood sexual abuse, childhood physical abuse, and mental illness in a general population sample. American Journal of Psychiatry, 155, 806–811.

44. Simeon, D., Guralnik, O., Schmeidler, J., Sirof, B., & Knutelska, M. (2001). The role of childhood interpersonal trauma in depersonalization disorder. American Journal of Psychiatry, 158, 1027– 1033.

45. Bremner, J. D. (1999). Acute and chronic responses to psychological trauma: Where do we go from here? American Journal of Psychiatry, 156, 349–351.