

DISSOCIATIVE TRANCE DISORDER

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1. Core Definition

Dissociative Trance Disorder (DTD) is a clinical diagnostic category characterized by an involuntary and temporary alteration of consciousness, identity, awareness, or memory that results in clinically significant distress or functional impairment. This condition fundamentally involves a profound disruption in the usually integrated functions of consciousness and memory, causing the individual to enter a state of altered perception and behavior. While similar phenomena may occur in specific cultural contexts, the diagnosis of DTD is reserved for instances where the trance state is neither desired nor culturally sanctioned, and crucially, where it leads to noticeable occupational, social, or other functional difficulties.

The disorder is often conceptualized along two primary dimensions: simple trance and possession trance. A simple trance state involves a marked decrease in awareness of immediate surroundings, accompanied by stereotyped behaviors or postures that are outside the individual's voluntary control. The individual may appear unresponsive to external stimuli, exhibiting a vacant stare or fixed attention. Conversely, a **possession trance** involves the subjective experience of having been replaced by an alternate identity, spirit, deity, or external force, which assumes control over the individual's actions, thoughts, and speech.

Historically, DTD was sometimes referred to as Possession Trance-Possession Disorder, reflecting the high prevalence of possession phenomenology across various cultures. The hallmark of the disorder is the profound sense of detachment and loss of executive control, distinguishing it from deliberate acts of altered consciousness, such as meditation or hypnotic states. When diagnosing DTD, clinicians must carefully assess whether the alteration in identity and consciousness is truly pathological or simply a manifestation of normative spiritual or religious practices accepted within the patient's immediate social group.

2. Historical Context and Diagnostic Evolution

The recognition of trance and possession states as potentially pathological phenomena has a long history, dating back to early psychiatric observations of hysteria and culturally bound syndromes. However, the formal introduction of Dissociative Trance Disorder into modern diagnostic nomenclature occurred relatively recently. DTD was included in the appendix of the **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)**, under the category of "Criteria Sets and Axes Provided for Further Study." This placement indicated that while the phenomenon was widely observed and clinically relevant, its inclusion as a fully recognized

disorder required further empirical validation.

In the **International Classification of Diseases (ICD-10)**, similar conditions were categorized under 'Trance and Possession Disorders' (F44.3), grouping together states involving temporary loss of the sense of personal identity and full awareness of surroundings, often replaced by actions that appear to be controlled by an external force. The ICD approach acknowledged the high cross-cultural prevalence of these experiences and sought to standardize their diagnosis globally.

The subsequent revision, the **DSM-5** (2013), removed DTD as a standalone criterion set. Instead, the phenomena typically associated with DTD were largely absorbed into the category of **Other Specified Dissociative Disorder (OSDD)**, specifically OSDD Type 1, which includes chronic or recurrent episodes of dissociation, including non-pathological trance states that may be misinterpreted or present clinically. This strategic move aimed to simplify the diagnostic landscape and acknowledge the significant overlap between DTD and other dissociative phenomena while ensuring that culturally relevant trance states, when pathological, could still be accurately classified.

Despite its removal as a distinct category in the core DSM-5, the concept remains vital for understanding culturally influenced psychopathology. The ICD-11, released by the World Health Organization, continues to recognize a similar category, reflecting a more inclusive approach necessary for global mental health practice. This historical development underscores the tension between establishing universally applicable diagnostic criteria and respecting cultural variability in expressions of distress.

3. Key Characteristics

Altered State of Consciousness: The defining feature is a transient state in which the individual experiences a profound shift in their usual level of awareness, identity, or consciousness, often leading to unresponsiveness or non-typical interactions with their environment.

Involuntariness: The trance or possession episode must be involuntary and unwanted by the individual. It is not something induced or controlled, differentiating it from meditative practices or deliberate spiritual rituals.

Functional Impairment and Distress: The episode must cause significant distress to the individual or result in impairment in social, occupational, or other important areas of functioning. This criterion is crucial for pathologizing the state, as many cultures promote non-pathological forms of trance.

Stereotyped Movements or Postures: During the trance state, individuals often display repetitive, purposeless, or stereotyped behaviors, movements, or utterances that are characteristic of the disorder but are outside their conscious control.

Amnesia or Loss of Recall: Following the episode, the individual often experiences full or partial

amnesia regarding the events that occurred while they were in the trance or possession state, linking DTD closely to other dissociative phenomena.

Absence of Culturally Sanctioned Context: The episode must not be an expected part of a collective cultural, religious, or spiritual practice within the patient's context. If the individual is actively participating in a known, accepted ritual, the trance is usually considered normative unless severe distress or impairment persists outside the ritual context.

4. Phenomenology of Possession Trance

The possession form of DTD is clinically striking and frequently involves dramatic behavioral changes. During a possession trance, the individual reports feeling taken over by an external entity, such as a spirit, ghost, deceased person, or supernatural power. This entity then speaks or acts through the individual, often displaying personality traits, voices, and behaviors entirely alien to the host.

The content of the possession state is highly variable and deeply influenced by local cultural narratives. In some contexts, the possessing entity may be benevolent (e.g., an ancestor offering guidance), while in clinical presentations, it is usually perceived as malevolent, punitive, or causing suffering. The possessed individual may speak in a different language, exhibit superhuman strength, or convey messages that are relevant to the surrounding community or family unit, often addressing unresolved conflicts or expressing deep-seated distress that the host cannot articulate in their usual state.

A critical factor in the clinical assessment is determining whether the behaviors displayed are genuinely indicative of a mental disorder or represent cultural idioms of distress. When the possession state is used to communicate suffering or navigate social conflicts in a manner accepted by the society, it may not meet the threshold for DTD. However, when these states occur unpredictably, persist beyond acceptable boundaries, or lead to social ostracization, the diagnostic criteria for DTD (or OSDD) become relevant.

5. Etiology and Underlying Mechanisms

The etiology of Dissociative Trance Disorder is complex, aligning closely with the biopsychosocial model applied to other dissociative disorders. From a psychological perspective, DTD is often conceptualized as a defense mechanism, serving as an extreme form of psychological avoidance or detachment triggered by overwhelming stress or trauma.

Significant research suggests a strong link between DTD and a history of **severe childhood trauma**, including physical, sexual, and emotional abuse, or exposure to chronic neglect. Dissociation, in this context, allows the individual to mentally escape the traumatic experience by altering consciousness or identity, a mechanism that can become maladaptive and involuntarily

triggered in adulthood by environmental stressors.

Neurobiological explanations hypothesize that stress-induced changes in brain function, particularly involving areas related to memory integration, self-awareness, and emotional regulation (such as the prefrontal cortex and the limbic system), may predispose individuals to dissociative states. Furthermore, socio-cognitive models suggest that high levels of hypnotizability or suggestibility, combined with cultural exposure to possession narratives, can influence the manifestation and phenomenology of the disorder. In vulnerable individuals, exposure to culturally validated ideas of possession can provide a template through which psychological distress is expressed.

6. Differential Diagnosis

Diagnosing DTD requires careful differentiation from several other psychiatric, neurological, and cultural conditions. This is often the most challenging aspect of clinical practice regarding DTD.

Dissociative Identity Disorder (DID): While both involve alterations in identity, DID features the presence of two or more distinct, enduring personality states (alters) that recurrently take control. DTD, in its classical form, typically involves transient, discrete episodes of trance or possession, not the establishment of separate, complex personality systems.

Psychotic Disorders (e.g., Schizophrenia): Psychotic symptoms involve a fixed loss of reality testing (delusions and hallucinations). While possession states may resemble delusions of control, DTD patients generally maintain reality testing outside the trance episode, and their altered state is typically episodic rather than chronic or pervasive.

Epilepsy: Complex partial seizures, particularly those involving the temporal lobe, can sometimes mimic dissociative states, presenting with altered consciousness, automatisms (repetitive, non-purposeful movements), and post-ictal confusion. A comprehensive medical workup, including EEG, is essential to rule out neurological causes.

Malingering or Factitious Disorder: Clinicians must determine whether the presentation is intentional (malingering, driven by external incentive) or feigned (factitious disorder, driven by the desire to assume the sick role). The involuntary nature and associated distress of genuine DTD help distinguish it from intentional deception.

7. Treatment Approaches and Prognosis

Treatment for Dissociative Trance Disorder is fundamentally similar to treatment for other trauma-related dissociative conditions, prioritizing stabilization, emotional regulation, and trauma processing.

The initial stage of treatment focuses on establishing a therapeutic alliance and ensuring the patient's safety. Psychoeducation about **dissociation** is critical, helping the patient understand

their symptoms as reactions to trauma rather than indicators of spiritual or demonic influence. Techniques focusing on grounding, such as mindfulness and sensory awareness exercises, are employed to help the patient remain connected to the present reality and regulate the intensity and frequency of dissociative episodes.

The core therapeutic work involves trauma-focused psychotherapy. Approaches such as **Cognitive Processing Therapy (CPT)**, Dialectical Behavior Therapy (DBT), and Eye Movement Desensitization and Reprocessing (EMDR) are often utilized to process the underlying traumatic memories that trigger dissociation. The goal is to integrate these experiences into the patient's conscious narrative, reducing the need for the involuntary defense mechanism of trance.

While there are no specific pharmacological treatments for DTD itself, medications are frequently used to manage high rates of comorbidity. Antidepressants, mood stabilizers, and anti-anxiety agents may be prescribed to treat associated symptoms such as major depressive disorder, anxiety disorders, and post-traumatic stress disorder, which often contribute to the severity and frequency of the dissociative episodes. A crucial component of effective treatment often involves incorporating cultural competency, collaborating with cultural healers or spiritual leaders where appropriate, to bridge the gap between biomedical and traditional understandings of the patient's experience.

Further Reading

[Dissociative Trance Disorder - Wikipedia](#)

[American Psychiatric Association: What Are Dissociative Disorders?](#)

[World Health Organization \(WHO\) International Classification of Diseases \(ICD-11\)](#)

[Dissociation and the Dissociative Disorders: A Review of Epidemiology, Clinical Aspects and Treatment](#)