

08 - Dissociative Disorders

Dissociative Disorders

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Dissociative Disorders Dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. Dissociative symptoms can potentially disrupt every area of psychological functioning. This chapter includes dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder. Dissociative disorders are frequently found in the aftermath of a wide variety of psychologically traumatic experiences in children, adolescents, and adults. Throughout this chapter, “traumatic experiences” refers to experiences that result in psychological sequelae, as opposed to the physical impact that can cause traumatic brain injury. Therefore, in DSM-5, the dissociative disorders are placed next to, but are not part of, the trauma- and stressor-related disorders, reflecting the close relationship between these diagnostic classes. Both acute stress disorder and posttraumatic stress disorder include dissociative symptoms, such as amnesia, flashbacks, numbing, and depersonalization/derealization. Dissociative symptoms are experienced as unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience (i.e., “positive” dissociative symptoms such as division of identity, depersonalization, and derealization) and/or inability to access information or to control mental functions that normally are readily amenable to access or control (i.e., “negative” dissociative symptoms such as amnesia). Across cultural contexts, risk factors for dissociative pathology include earlier onset of trauma; neglect and sexual, physical, and emotional abuse by parents; cumulative early life trauma and adversities; and repeated sustained trauma or torture associated with captivity (e.g., experienced by prisoners of war, victims of trafficking). Depersonalization/derealization disorder is characterized by clinically significant persistent or recurrent depersonalization (i.e., experiences of unreality or detachment from one’s mind, self, or body) and/or derealization (i.e., experiences of unreality or detachment from one’s surroundings). These alterations of experience are accompanied by intact reality testing. There is no evidence of any distinction between predominantly depersonalization and predominantly derealization symptoms. Individuals with this disorder can have depersonalization, derealization, or both. Dissociative amnesia is characterized by an inability to recall autobiographical information that is inconsistent with normal forgetting. The amnesia may be localized (i.e., an event or period of time), selective (i.e., a specific aspect of an event), or generalized (i.e., identity and life history). In dissociative amnesia, memory deficits are primarily retrograde and often associated with traumatic experiences (e.g., lack of recall of third grade when the individual was kidnapped and held hostage). Although some individuals with amnesia promptly notice that they have gaps or a sense

of fragmentation in their remote memory, most individuals with dissociative disorders

F44.81 are initially unaware of their amnesia or minimize or rationalize the deficits. For them, awareness of amnesia occurs when they realize that they do not recall their personal identity or when circumstances make these individuals aware that important autobiographical information is missing (e.g., when they discover evidence or are told of past events that they cannot recall). Generalized dissociative amnesia with loss of a major part or all of the individual's life history and/or identity is rare. Dissociative identity disorder is characterized by a) the presence of two or more distinct personality states or an experience of possession and b) recurrent episodes of dissociative amnesia. The fragmentation/division of identity may vary across cultural contexts (e.g., possession-form presentations) and with circumstance. Thus, individuals may experience discontinuities in identity and memory that may not be immediately evident to others or are obscured by attempts to hide dysfunction. Individuals with dissociative identity disorder experience recurrent, inexplicable intrusions into their conscious functioning and sense of self (e.g., voices; dissociated actions and speech; intrusive thoughts, emotions, and impulses); alterations of sense of self (e.g., attitudes, preferences, and feeling like their body or actions are not their own); odd changes of perception (e.g., depersonalization or derealization, such as feeling detached, as if watching themselves from outside their body); and intermittent functional neurological symptoms. Stress often produces transient exacerbation of dissociative symptoms that makes them more evident. The residual category of other specified dissociative disorder includes presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment predominate but do not meet the criteria for any of the specific dissociative disorders. Examples include identity disturbances associated with less-than-marked discontinuities in sense of self and agency, alterations of identity, or episodes of possession in the absence of a history of episodes of dissociative amnesia; identity disturbance due to prolonged and intensive coercive persuasion as may occur in sects/cults or terrorist organizations; acute dissociative reactions to stressful events that last less than 1 month; and dissociative trance, which is characterized by an acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. Dissociative Identity Disorder Diagnostic Criteria A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs

and symptoms may be observed by others or reported by the individual. B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting. C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play. E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures). Diagnostic Features The defining feature of dissociative identity disorder is the presence of two or more distinct personality states or an experience of possession (Criterion A). The overtness or covertness of these personality states varies as a function of psychological motivation, current

level of stress, cultural context, internal conflicts and dynamics, and emotional resilience, among other factors. Sustained periods of identity confusion/alteration may occur when psychosocial pressures are severe and/or prolonged. In those cases of dissociative identity disorder that present as the individual being possessed by external identities (e.g., spirits, demons) (possession-form dissociative identity disorder), and in a small proportion of non-possession-form cases, manifestations of alternate identities are readily observable. Most individuals with nonpossession-form dissociative identity disorder do not overtly display, or only subtly display, their discontinuity of identity, and only a minority present to clinical attention with discernible alternation of identities. The elaboration of dissociative personality states with different names, wardrobes, hairstyles, handwritings, accents, and so forth, occurs in only a minority of individuals with the non-possession-form dissociative identity disorder and is not essential to diagnosis. In those cases where alternate personality states cannot be directly observed, the presence of distinct personality states can be identified by sudden alterations or discontinuities in the individual's sense of self and sense of agency (Criterion A), and recurrent dissociative amnesias (Criterion B). Criterion A symptoms are related to discontinuities of experience that can affect any aspect of an individual's functioning. Individuals with dissociative identity disorder may report the feeling that they have suddenly become depersonalized observers of their own speech and actions, which they may feel powerless to stop (i.e., impaired sense of self and impaired sense of agency). These individuals may also report perceptions of voices (e.g., a child's voice, voices commenting on the individual's thoughts or behavior, persecutory voices and command hallucinations). In some cases, hearing voices is specifically denied, but the individual reports multiple, perplexing, independent thought streams over which the individual experiences no control. Individuals with dissociative identity disorder may report hallucinations in all sensory

modalities: auditory, visual, tactile, olfactory, and gustatory. Strong emotions, impulses, thoughts, and even speech or other actions may suddenly materialize, without a sense of personal ownership or control (i.e., lack of sense of agency). Conversely, thoughts and emotions may unexpectedly vanish, and speech and actions are abruptly inhibited. These experiences are frequently reported as ego-dystonic and puzzling. Attitudes, outlooks, and personal preferences (e.g., about food, activities, gender identity) may suddenly shift. Individuals may report that their bodies feel different (e.g., like a small child, the opposite gender, different ages simultaneously). Alterations in sense of self and agency may be accompanied by a feeling that attitudes, emotions, and behaviors—even the individual's own body—are “not mine” or are “not under my control.” Although most Criterion A symptoms are subjective, these sudden discontinuities in speech, affect, and behavior may be witnessed by family, friends, or the clinician. In most individuals with dissociative identity disorder, switching/shifting of states is subtle and may occur with only subtle changes in overt presentation. State switching may be more overt in the possession form of dissociative identity disorder. In general, the individual with dissociative identity disorder experiences himself or herself as multiple, simultaneously overlapping and interfering states. Dissociative amnesia (Criterion B) manifests in several major domains: 1) gaps in any aspect of autobiographical memory (e.g., important life events like getting married or giving birth, lack of recall of all school experiences before high school); 2) lapses in memory of recent events or well-learned skills (e.g., how to do one's job, use a computer, cook or drive); and 3) discovery of possessions that the individual has no recollection of ever owning (e.g., clothing, weapons, tools, writings or drawings that he or she must have created). Dissociative fugues, with amnesia for travel, are common. Individuals may report suddenly finding themselves in another city, at work, or

even at home: in the closet, under the bed, or running out of the house. Amnesia in individuals with dissociative identity disorder is not limited to stressful or traumatic events; it can involve everyday events as well. Individuals may report major gaps in ongoing memory (e.g., experiencing “time loss,” “blackouts,” or “coming to” in the midst of doing something). Dissociative amnesia may be apparent to others (e.g., the individual does not recall something others witnessed that he or she did or said, cannot remember his or her own name, or may fail to recognize spouse, children, or close friends). Minimization or rationalization of amnesia is common. Possession-form identities in dissociative identity disorder typically manifest behaviorally as if a “spirit,” supernatural being, or outside person has taken control, with the individual speaking or acting in a distinctly different manner. For example, an individual’s behavior may give the appearance that her identity has been replaced by the “ghost” of a girl who died by suicide in the same community years before, speaking and acting as though she were still alive. The identities that arise during possession-form dissociative identity disorder present recurrently, are unwanted and involuntary, and cause clinically significant distress or impairment (Criterion C). However, the majority of possession states that occur around the world are usually part of a broadly accepted cultural or religious practice and therefore do not meet criteria for dissociative identity disorder (Criterion D).

Associated Features Individuals with dissociative identity disorder typically present with comorbid depression, anxiety, substance abuse, self-injury, or another common symptom. Nonepileptic seizures and other functional neurological symptoms are prominent in some presentations of dissociative identity disorder, especially in some non-Western settings. Some individuals, especially in Western settings, may present with apparently refractory neurological symptoms, such as headaches, seizures, or symptoms suggestive of multiple sclerosis. Individuals with dissociative identity disorder often conceal, or are not fully aware of, disruptions in consciousness, amnesia, or other dissociative symptoms. Many individuals with dissociative identity disorder report dissociative flashbacks during which they experience a sensory reliving of a previous event as though it were occurring in the present, often with a change of identity, a partial or complete loss of contact with or disorientation to current reality during the flashback, and a subsequent amnesia for the content of the flashback. Individuals with the disorder typically report multiple types of interpersonal maltreatment during childhood and adulthood. Other overwhelming early life events, such as multiple long, painful, early-life medical procedures, also may be reported. Nonsuicidal self-injury is frequent. On standardized measures, these individuals report higher levels of hypnotizability and dissociative symptoms compared with other clinical groups and healthy control subjects. Some individuals experience transient psychotic phenomena or episodes. Among personality features, avoidant personality features most often rate highest in individuals with dissociative identity disorder, and some individuals with dissociative identity disorder are so avoidant that they prefer to be alone. When decompensated, some individuals with dissociative identity disorder display features of borderline personality disorder (i.e., selfdestructive high-risk behaviors, and mood instability). Many individuals with dissociative identity disorder display attachment problems but typically do not exhibit frantic activity to avoid being abandoned. Some have stable long-term relationships, albeit frequently dysfunctional and/or abusive ones, from which they may have difficulty extricating themselves. Obsessional personality features are common in dissociative identity disorder, more so than histrionic personality features. A subgroup of individuals with dissociative identity disorder have narcissistic and/or antisocial personality features. **Prevalence** The 12-month prevalence of dissociative identity disorder among adults in a small U.S. community study was 1.5%. Lifetime prevalence of dissociative identity disorder was

1.1% in a representative sample of community-based women in mid-eastern Turkey. Development and Course The disorder may first manifest at almost any age from early childhood to late life. Children usually do not present with identity shifting, instead presenting primarily with independently acting, imaginary companions, or as personified “mood” states (Criterion A phenomena).

Environmental. Genetic and physiological. Course modifiers. Dissociation in children may generate problems with memory, concentration, and attachment, and may be associated with traumatic play. In adolescents, dissociative identity disorder commonly comes to clinical attention because of externalizing symptoms, suicidal/selfdestructive behavior, or rapid behavioral shifts often ascribed to other disorders such as attention-deficit/hyperactivity disorder or childhood bipolar disorder. Some children with dissociative identity disorder can also be quite aggressive and irritable. Older individuals with dissociative identity disorder may present with symptoms that appear to be late-life mood disorders, obsessive-compulsive disorder, paranoia, psychotic mood disorders, or even cognitive disorders attributable to dissociative amnesia. Overt identity alteration/confusion may be triggered by many factors, such as later traumatic experiences (e.g., sexual assault), or even seemingly inconsequential stressors, like a minor motor vehicle accident. The experience of other major or cumulative life stressors may also worsen symptoms, including life events such as the individual’s children reaching the same age at which the individual was significantly abused or traumatized. The death of, or the onset of a fatal illness in, the individual’s abuser(s) is another example of an event that may worsen symptoms. Individuals with dissociative identity disorder are at high risk for adult interpersonal trauma such as rape, intimate partner violence, and sexual exploitation, including ongoing incestuous abuse into adulthood, as well as adult trafficking. Risk and Prognostic Factors In the context of family and attachment pathology, early life trauma (e.g., neglect and physical, sexual, and emotional abuse, usually before ages 5–6 years) represents a risk factor for dissociative identity disorder. In studies from diverse geographic regions, about 90% of the individuals with the disorder report multiple types of early neglect and childhood abuse, often extending into late adolescence. Some individuals report that maltreatment primarily occurred outside the family, in school, church, and/or neighborhoods, including being bullied severely. Other forms of repeated early-life traumatic experiences include multiple, painful childhood medical and surgical procedures; war; terrorism; or being trafficked beginning in childhood. Onset has also been described after prolonged and often transgenerational exposure to dysfunctional family dynamics (e.g., overcontrolling parenting, insecure attachment, emotional abuse) in the absence of clear neglect or sexual or physical abuse. Twin studies suggest that genetics account for around 45%–50% of the interindividual variance in dissociative symptoms, with nonshared, stressful, and traumatic environmental experiences accounting for most of the additional variance. Several brain regions have been implicated in the pathophysiology of dissociative identity disorder, including the orbitofrontal cortex, hippocampus, parahippocampal gyrus, and amygdala. Ongoing sexual, physical, and emotional trauma often leads to significant difficulties in later functioning. Poorer outcome in adults is commonly related to severe psychosocial stressors, revictimization, ongoing sexual or physical abuse or exploitation, intimate partner violence, refractory substance use, eating disorders, severe medical illness, enmeshment with the individual’s abusive family of origin, or ongoing involvement in criminal

subgroups. Poorer functioning may also be related to perpetration of child maltreatment or intimate partner violence by individuals with dissociative identity disorder. Culture-Related

Diagnostic Issues Many features of dissociative identity disorder can be influenced by the individual's sociocultural background. In settings where possession symptoms are common (e.g., rural areas in low- and middle-income countries, among certain religious groups in the United States and Europe), all or some of the fragmented identities may take the form of possessing spirits, deities, demons, animals, or mythical figures. Acculturation or prolonged intercultural contact may shape the presentation of the other identities (e.g., identities in India may speak English exclusively and wear Western clothes). Possession-form dissociative identity disorder can be distinguished from culturally accepted possession states in that the former is involuntary, distressing, and uncontrollable; involves conflict between the individual and his or her surrounding family, social, or work milieu; and is manifested at times and in places that violate cultural or religious norms. Combined dissociative-psychosis episodes may be more common in cultural contexts with marked communal violence or oppression and limited opportunity for redress.

Sex- and Gender-Related Diagnostic Issues Women with dissociative identity disorder predominate in adult clinical settings but not in child/adolescent clinical settings or in general population studies. Few differences in symptom profiles, clinical history, and childhood trauma history have been found in comparisons between men and women with dissociative identity disorder, except that women may have higher rates of somatization.

Association With Suicidal Thoughts or Behavior Suicidal behavior is frequent. Over 70% of outpatients with dissociative identity disorder have attempted suicide; multiple attempts are common, and other self-injurious and high-risk behaviors are highly prevalent. Individuals with dissociative identity disorder have multiple interacting risk factors for self-destructive and/or suicidal behavior. These include cumulative, severe early- and later-life trauma; high rates of comorbid posttraumatic stress disorder (PTSD), depressive disorders, and substance use disorders; and personality disorder features. Dissociation itself is an independent risk factor for multiple suicide attempts. Greater severity of dissociative symptom scores is associated with a higher frequency of suicide attempts and nonsuicidal selfinjury among individuals with dissociative disorders.

Functional Consequences of Dissociative Identity Disorder Some children and adolescents with dissociative identity disorder may function poorly in school and in relationships. Others do well in school, experiencing it as a respite. In adults impairment varies widely, from apparently minimal (e.g., in high-functioning professionals) to profound. The symptoms of higher-functioning individuals may impair their relational, marital, family, and parenting functions more than their occupational and professional life, although the latter also may be affected. Many impaired individuals show improvement in occupational and personal functioning over time, while some individuals with dissociative

Dissociative amnesia. Depersonalization/derealization disorder. Major depressive disorder. Bipolar disorders. Posttraumatic stress disorder. identity disorder may be impaired in most activities of living and function at the level of chronic and persistent mental illness.

Differential Diagnosis Both dissociative identity disorder and dissociative amnesia are characterized by gaps in the recall of everyday events, important personal information, or traumatic events that are inconsistent with ordinary forgetting. Dissociative identity disorder is distinguished from dissociative amnesia by the additional presence of identity disruption characterized by two or more distinct personality states. The essential feature of depersonalization/derealization disorder is persistent or recurrent episodes of depersonalization, derealization, or both. Individuals with depersonalization/derealization disorder do not experience the presence of personality/identity states with alterations of self and agency, nor do they typically report dissociative amnesia. Most individuals with dissociative identity disorder endorse a lifelong negative posttraumatic emotional state, often with childhood

onset, and their symptoms may appear to meet the criteria for a major depressive episode. Moreover, posttraumatic reactivity to times of year when trauma occurred (anniversary reactions), primarily manifesting with more despondency, distress, and suicidal ideation, may also appear to be major depressive disorder, with seasonal pattern. However, individuals with major depressive disorder or persistent depressive disorder do not experience dissociative fluctuations in self and agency and dissociative amnesia. It is important to assess if all or most identity states are experiencing the adverse mood state, since mood disorder symptoms may fluctuate because they are experienced in some identity states, but not others. Dissociative identity disorder is commonly misdiagnosed as bipolar disorder, typically bipolar II disorder, with mixed features. The relatively rapid shifts in behavioral state in individuals with dissociative identity disorder—usually within minutes or hours—are atypical for even the most rapid-cycling individuals with bipolar disorders. These state alterations are due to rapidly shifting dissociative states and/or fluctuating posttraumatic intrusions. Sometimes these shifts are accompanied by rapid changes in levels of activation, but these usually last minutes to hours, not days, and are associated with activation of specific identity states. Elevated or depressed mood may be experienced as loculated in specific identities, through overlap/interference phenomena. Usually, the individual with dissociative identity disorder does not have a classic bipolar sleep disturbance (e.g., reduced need for sleep), instead suffering from chronic, severe nightmares and nocturnal flashbacks that interrupt sleep. A majority of individuals with dissociative identity disorder will have symptoms that meet diagnostic criteria for comorbid PTSD. Dissociative symptoms characteristic of dissociative identity disorder should be differentiated from the dissociative amnesia, dissociative flashbacks, and depersonalization/derealization characteristic of acute stress disorder, PTSD, or the dissociative subtype of PTSD. Dissociative amnesia in PTSD typically manifests only for specific traumatic events or aspects of traumatic events, as opposed

Schizophrenia and other psychotic disorders. Substance/medication-induced disorders. Personality disorders. to the chronic, complex dissociative amnesia characteristic of dissociative identity disorder. Depersonalization/derealization symptoms in the dissociative subtype of PTSD are related to specific posttraumatic reminders. Depersonalization/derealization symptoms in dissociative identity disorder may occur not only in response to posttraumatic reminders, but also in an ongoing fashion in daily life, including in response to stressful interpersonal interactions and when there is overlap/interference between states. Individuals with dissociative identity disorder may experience symptoms that can superficially appear similar to those of psychotic disorders. These include auditory hallucinations and symptoms characteristic of intrusions of personality states into the individual's awareness; these symptoms can seemingly resemble some of the Schneiderian first-rank symptoms formerly considered indicative of schizophrenia (e.g., thought broadcasting, thought insertion, thought withdrawal, hearing voices keeping up a running commentary about the individual). For example, hearing different personality states discussing the individual can resemble auditory hallucinations of voices arguing in schizophrenia. The individual with dissociative identity disorder may also experience the thoughts or emotions of an intruding personality state, which can resemble thought insertion in schizophrenia, as well as experience the sudden disappearance of these thoughts or emotions, which can resemble thought withdrawal. Such experiences in an individual with schizophrenia are usually accompanied by delusional beliefs about the cause of those symptoms (i.e., thoughts being inserted by an outside force), whereas individuals with dissociative identity disorder typically experience these symptoms as ego-alien and frightening. Individuals with dissociative identity disorder may also report a range of visual, tactile, olfactory,

gustatory, and somatic hallucinations, which are usually related to autohypnotic, posttraumatic, and dissociative factors, such as partial flashbacks, in contrast to individuals with schizophrenia, whose hallucinations are primarily auditory and less commonly visual. Dissociative identity disorder and psychotic disorders are therefore distinguished by symptoms characteristic of one of these conditions and not the other (e.g., dissociative amnesia in dissociative identity disorder and not in psychotic disorders). Finally, individuals with schizophrenia have low hypnotic capacity, whereas individuals with dissociative identity disorder have the highest hypnotic capacity among all clinical groups. Individuals with dissociative identity disorder frequently have a current or past history of substance use disorders. Symptoms associated with the physiological effects of a substance (e.g., blackouts) should be distinguished from dissociative amnesia in dissociative identity disorder if the substance in question is judged to be etiologically related to the memory loss. Individuals with dissociative identity disorder often present identities that appear to encapsulate a variety of severe personality disorder features, suggesting a differential diagnosis of personality disorder, especially of the borderline type. Importantly, however, the individual's longitudinal variability in personality style (attributable to inconsistency among identities) differs from the pervasive and persistent dysfunction in affect management and interpersonal relationships typical of those with personality disorders.

Posttraumatic amnesia due to brain injury. Functional neurological symptom disorder (conversion disorder). Factitious disorder and malingering. Both dissociative identity disorder and traumatic brain injury (TBI) are characterized by gaps in memory. Other characteristics of TBI include loss of consciousness, disorientation and confusion, or, in more severe cases, neurological signs and symptoms. A neurocognitive disorder due to TBI manifests either immediately after brain injury occurs or immediately after the individual recovers consciousness after the injury, and persists past the acute postinjury period. The cognitive presentation of a neurocognitive disorder following TBI is variable and includes difficulties in the domains of complex attention, executive function, and learning and memory, as well as slowed speed of information processing and disturbances in social cognition. While depersonalization is not uncommon following TBI, the additional neurocognitive features noted above help distinguish it from dissociative amnesia that is part of dissociative identity disorder. Moreover, dissociative amnesia occurring in the context of dissociative identity disorder is accompanied by a marked discontinuity in sense of self and sense of agency, which are not features of TBI. Functional neurological symptom disorder may be distinguished from dissociative identity disorder by the absence of identity alteration characterized by two or more distinct personality states or an experience of possession. Dissociative amnesia in functional neurological symptom disorder is more limited and circumscribed (e.g., amnesia for a nonepileptic seizure). Individuals who feign dissociative identity disorder usually do not report the subtle symptoms of intrusion characteristic of the disorder; instead they tend to overreport media-based symptoms of the disorder, such as dramatic dissociative amnesia and melodramatic switching behaviors, while underreporting less-publicized comorbid symptoms, such as depression. Individuals who feign dissociative identity disorder tend to be relatively undisturbed by or may even seem to enjoy "having" the disorder, or may ask clinicians to "find" traumatic memories. In contrast, most individuals with genuine dissociative identity disorder are ashamed of and overwhelmed by their symptoms, deny the diagnosis, underreport their symptoms, and display minimization and avoidance of their trauma history. Individuals who feign the symptoms of dissociative identity disorder usually create limited, stereotyped alternate identities, with feigned amnesia related only to the events for which gain is sought, with apparent switching behaviors and

amnesia only displayed while being observed. They may present an “all-good” identity and an “all-bad” identity in hopes of gaining exculpation for a crime. Comorbidity Disorders that are comorbid with dissociative identity disorder include PTSD, depressive disorders, substance-related disorders, feeding and eating disorders, obsessive-compulsive disorder, antisocial personality disorder, and other specified personality disorder with avoidant, obsessive-compulsive, or borderline personality traits. The most common forms of functional neurological symptom disorder include nonepileptic seizures, gait disturbances, and paralyses. Most commonly, nonepileptic seizures resemble grand mal seizures or complex partial seizures with temporal lobe foci; others may mimic absence or partial seizures.

F44.0 Dissociative Amnesia Diagnostic Criteria A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting. Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history. B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. C. The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, other neurological condition). D. The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder. Coding note: The code for dissociative amnesia without dissociative fugue is F44.0. The code for dissociative amnesia with dissociative fugue is F44.1. Specify if: F44.1 With dissociative fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information. Specifiers The specifier “with dissociative fugue” applies when dissociative amnesia occurs in the context of a dissociative fugue, which is characterized by apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or other important autobiographical information. Diagnostic Features The defining characteristic of dissociative amnesia is an inability to recall important autobiographical information that 1) should be successfully stored in memory and 2) ordinarily would be freely recollected (Criterion A). Dissociative amnesia is conceptualized as a potentially reversible memory retrieval deficit. In this way, among others, it differs from the amnesias attributable to neurobiological damage or toxicity that impair memory storage or retrieval. A variety of types of dissociative amnesia may manifest. In general, the memory deficit in

dissociative amnesia is retrograde and, except in rare cases, is not associated with ongoing amnesia for contemporary life events. Retrospective memory impairments include not only lost memories of traumatic experiences but also lost memories of everyday life during which no trauma occurred. Most commonly, individuals with dissociative amnesia report localized amnesia—a failure to recall events during a circumscribed period of time; and/or selective amnesia—the individual can recall some, but not all, of the events during a circumscribed period of time. In systematized amnesia the individual fails to recall a specific category of important information (e.g., fragmentary recall of home growing up, but continuous memory for school; no recall of a violent older sibling; lack of recall of a specific room in the individual’s childhood home). Individuals rarely overtly complain of symptoms of these forms of dissociative amnesia and attempt to minimize and rationalize the memory loss. Generalized dissociative amnesia involves a complete loss of memory

for most or all of the individual's life history. Individuals with generalized amnesia may forget personal identity (e.g., a woman loses memory of her entire life history after giving in to repeated pressure from a close friend to engage in a sexual relationship), lose previous knowledge about the world (e.g., recent political events, how to use current technology), and less commonly lack access to well-learned skills (e.g., what contact lenses are and how to put them in). Generalized dissociative amnesia has an acute onset; the perplexity, disorientation, and purposeless wandering of individuals with generalized amnesia usually bring them to the attention of the police or psychiatric emergency services. Dissociative fugue is commonly associated with generalized dissociative amnesia and can be indicated by using the "with dissociative fugue" specifier. Generalized dissociative amnesia may be more common among combat veterans, sexual assault victims, and individuals experiencing extreme emotional stress or conflict. In continuous amnesia (i.e., anterograde dissociative amnesia), an individual forgets each new event as it occurs. Individuals with dissociative amnesia are frequently unaware (or only partially aware) of their memory problems. They may recall some traumatic events, or parts of traumatic events, but not others of the same type. Many, especially those with localized amnesia, minimize the importance of their memory loss and may become uncomfortable when prompted to address it. Associated Features Many individuals with dissociative amnesia are chronically impaired in their ability to form and sustain satisfactory relationships. Histories of trauma, especially child abuse, and victimization are common. Some individuals with dissociative amnesia report dissociative flashbacks (i.e., behavioral reexperiencing of traumatic events). Many have a history of nonsuicidal self-injury, suicide attempts, and other high-risk behaviors. Depressive and functional neurological symptoms are common, as are depersonalization, auto-hypnotic symptoms, and high hypnotizability. Sexual dysfunctions are common. Mild traumatic brain injury (TBI) may precede dissociative amnesia. Prevalence The 12-month prevalence for dissociative amnesia among adults in a small U.S. community

Environmental. study was 1.8%. Development and Course Dissociative amnesia has been observed in young children, adolescents, adults, and geriatric populations. Amnesia in children younger than 12 may be the most difficult to evaluate because they often have difficulty understanding questions about amnesia, and interviewers may find it difficult to formulate child-friendly questions about memory and amnesia, especially in younger children. Observations of apparent dissociative amnesia are often difficult to differentiate from inattention, absorption, daydreaming, anxiety, oppositional behavior, and learning disorders. Reports from several different sources (e.g., teacher, therapist, case worker) may be needed to diagnose amnesia in children. Some traumatized adolescents with dissociative amnesia are less likely to come to clinical attention because of lower levels of posttraumatic stress disorder (PTSD) intrusive symptoms and less externalizing behavior. Dissociative fugue behavior in children and adolescents may be limited by the child's life space (e.g., a child in a fugue "coming to" after bicycling to an unfamiliar neighborhood, a teenager finding herself having taken public transportation to a nearby town). Onset of generalized amnesia is usually sudden. Individuals may experience multiple episodes of this type of dissociative amnesia. A single episode may predispose to future episodes. In between episodes of amnesia, the individual may or may not appear to be acutely symptomatic. Some episodes of acute generalized amnesia resolve rapidly (e.g., when the individual is removed from combat or some other stressful situation, and/or is brought to clinical attention). A substantial subgroup of individuals develop highly impairing, debilitating, chronic autobiographical memory deficits, such that even "relearning" their life history does not ameliorate the memory loss. Removal from the traumatic

circumstances generating acute, generalized dissociative amnesia (e.g., combat) may bring about a rapid return of memory. The memory loss of individuals with dissociative fugue may be particularly refractory. Later life trauma, life stresses, or losses may precede breakdown of long-standing autobiographical memory deficits related to childhood or adult trauma, with the onset of acute PTSD, mood disorders, substance abuse, and dangerousness to self or others, among other symptoms. Risk and Prognostic Factors Severe, acute, or chronic traumatization is the main risk factor for dissociative amnesia. Cumulative early life trauma and adversities, especially physical and sexual abuse, are the major risk factors for dissociative amnesia for childhood and adolescence. More severe sexual abuse, multiple episodes of childhood sexual abuse, and sexual abuse by a relative, especially with betrayal by a close attachment figure, may increase the extent of childhood autobiographical memory disturbances. Individuals with dissociative amnesia may deny recall of specific childhood traumas (e.g., sexual assault), even those documented in medical or social service reports, although the individual can recall other similar traumatic events, both before and after the amnestic event. Severe cumulative adult trauma (e.g., repeated combat, trafficking, prisoner-of-war or concentration camp

Genetic and physiological. experiences) also may result in extensive localized, selective, and/or systematized dissociative amnesia. Generalized dissociative amnesia may be more common among individuals who have recently experienced extreme acute traumas (e.g., brutal military combat, rape, torture, often in the context of inability to escape) and/or a prior history of major social dislocation, asylumseeking, or refugee status. Others develop generalized amnesia in the context of profound psychological conflict from which the individual also feels unable to escape. Virtually all individuals who develop generalized dissociative amnesia in the context of psychological conflict report past histories of severe early life and/or adult traumatization. Extreme acute traumatic experiences also may engender major psychological conflicts (e.g., a woman develops generalized amnesia after experiencing a brutal rape resulting in an unwanted pregnancy and becomes suicidal; on assessment, she reveals that her religion views abortion as murder and suicide as a major sin). Quantitative genetic studies suggest that genetics account for about 50% of the interindividual variance in dissociative symptoms, with nonshared, stressful environmental experiences accounting for most of the additional variance. Candidate gene studies suggest a gene x environment interplay with earlier and more chronic childhood traumatic experiences leading to significant increases in dissociative symptoms later in life. Culture-Related Diagnostic Issues In cultural contexts where possession is part of normative religious or spiritual practice, dissociative amnesia and fugue may be interpreted as resulting from pathological possession. In contexts or situations where individuals feel highly constrained by social circumstances or cultural traditions, the precipitants of dissociative amnesia often do not involve frank trauma. Instead, the amnesia may be preceded by severe psychological stresses or conflicts (e.g., marital conflict, other family disturbances, attachment problems, or conflicts attributable to restriction or oppression). Association With Suicidal Thoughts or Behavior Suicidal and other self-destructive behaviors are common in individuals with dissociative amnesia. The psychological forces producing generalized amnesia may be extreme, and suicidal thoughts, impulses, plans, and behavior are a risk when amnesia decreases. Case reports suggest that suicidal behavior may be a particular risk when the amnesia remits suddenly and overwhelms the individual with intolerable memories. Functional Consequences of Dissociative Amnesia Impairments in individuals with dissociative amnesia resulting from childhood/adolescent traumatization range from limited to severe. Some of these individuals may be chronically impaired in their ability to form and sustain satisfactory

attachments. Some may become highly successful in occupational functioning but often do so by compulsive overwork. Individuals with acute generalized dissociative amnesia usually have impairment in all aspects of functioning. A substantial subgroup of individuals with generalized amnesia develop a highly impairing, chronic autobiographical memory deficit that even relearning their life history does not ameliorate. These individuals experience a highly debilitated, chronic course with poor overall functioning in most

Dissociative identity disorder. Posttraumatic stress disorder. Neurocognitive disorders. Substance-related disorders. domains of life. Differential Diagnosis Recurrent episodes of dissociative amnesia may be attributable to dissociative identity disorder. Individuals with dissociative amnesia may report depersonalization and auto-hypnotic symptoms, as do individuals with dissociative identity disorder. Individuals with dissociative identity disorder report pervasive discontinuities in sense of self and agency, accompanied by many other dissociative symptoms. Amnesias in dissociative identity disorder, in addition to retrospective autobiographical memory deficits, include ongoing amnesia (“time loss”) for everyday events and interpersonal interactions; finding unexplained possessions; perplexing major fluctuations in skills and knowledge; and frequent, brief amnesic gaps during interpersonal interactions. Some individuals with PTSD cannot recall part or all of a specific traumatic event (e.g., a rape victim who cannot recall most events for the entire day of the rape). When that amnesia extends to events beyond the immediate time of the trauma, a comorbid diagnosis of dissociative amnesia may be warranted. Individuals with the dissociative subtype of PTSD may also report dissociative amnesia in addition to depersonalization/derealization. In major neurocognitive disorders, there is typically evidence of neural tissue damage accompanied by a decline in cognitive function with deficits in attention, executive function, learning and memory, language, and perceptual-motor and social cognition that impair capacity for independent everyday activities. Memory loss for personal information is usually embedded in cognitive, linguistic, affective, attentional, and behavioral disturbances. Generally, awareness of personal identity is spared until late in the course of the neurocognitive disorder. In neurocognitive disorders, retrograde amnesia is almost always accompanied by anterograde amnesia. Anterograde dissociative amnesia can be confused with delirium. However, medical, laboratory, toxicological, and neurological workups, including imaging studies, are normal. Careful, repeated evaluations over time will show that as in other forms of dissociative amnesia, there are no true neurocognitive deficits. In the context of repeated intoxication with alcohol or other substances/medications, there may be episodes of “blackouts” or periods for which the individual has no memory, or partial memory (“grayouts”). To aid in distinguishing these episodes from dissociative amnesia, a longitudinal history should show that the amnesic episodes occur only in the context of intoxication. However, the distinction may be difficult when the individual with dissociative amnesia also misuses alcohol or other substances, particularly in the context of stressful situations that may also exacerbate dissociative symptoms. This can be a more complex differential diagnosis when the substance use begins in childhood or adolescence, generally in the context of intrafamilial abuse, neglect, and substance-related disorders. Sequential observation of these individuals after detoxification, along with carefully taken history, usually can distinguish the memory loss attributable to long-standing substance use from dissociative amnesia. Some individuals with comorbid dissociative amnesia and substance use disorders will attempt to minimize their dissociative amnesia and attribute memory problems solely to the

Posttraumatic amnesia due to brain injury. Seizure disorders. Memory deficits associated with electroconvulsive therapy. Catatonic stupor. substance use. Prolonged use of alcohol or other substances may result in a substance-induced neurocognitive disorder that may be associated with impaired cognitive function. However, in this context the protracted history of substance use and the persistent deficits associated with the neurocognitive disorder would serve to distinguish it from dissociative amnesia, where there is typically no evidence of persistent impairment in intellectual functioning. Amnesia may occur in the context of a TBI when there has been an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull. Other characteristics of TBI include loss of consciousness, disorientation and confusion, or, in more severe cases, neurological signs and symptoms (e.g., abnormalities on neuroimaging, a new onset of seizures or a marked worsening of a preexisting seizure disorder, visual field cuts, anosmia). A neurocognitive disorder attributable to TBI must present either immediately after brain injury occurs or immediately after the individual recovers consciousness after the injury, and persist past the acute postinjury period. The cognitive presentation of a neurocognitive disorder following TBI is variable and includes difficulties in the domains of complex attention, executive function, learning and memory, as well as slowed speed of information processing and disturbances in social cognition. The patterns of memory deficits are typical of neurocognitive disorders. Mild TBI may precede acute dissociative amnesia presentations, but the dissociative memory deficits are out of proportion to the TBI head trauma and typically follow the dissociative, not the neurocognitive, patterns. Individuals with seizure disorders may exhibit complex behavior during seizures or postictally with subsequent amnesia. Some individuals with a seizure disorder engage in nonpurposive wandering that is limited to the period of seizure activity. Conversely, behavior during a dissociative fugue is usually purposeful, complex, and goal-directed and may last for days, weeks, or longer. Occasionally, individuals with a seizure disorder will report that some autobiographical memories have been “wiped out” as the seizure disorder progresses. Such memory loss is not associated with psychological trauma or adversities and appears to occur randomly. In seizure disorders, serial electroencephalograms usually show abnormalities. Telemetric electroencephalographic monitoring generally shows an association between the episodes of amnesia and seizure activity. Dissociative and epileptic amnesias may coexist. Memory deficits after electroconvulsive therapy (ECT) most commonly occur for the day of ECT administration. More extensive retrograde and even anterograde amnesia after ECT is usually unrelated to stressful or traumatic life epochs, and generally remits after the ECT series concludes. ECT in severely depressed individuals with dissociative disorders does not worsen dissociation, and memory access may improve as depression remits. Mutism in catatonic stupor may suggest dissociative amnesia, but failure of recall is usually absent. Other catatonic symptoms (e.g., rigidity, posturing, negativism) are usually present. Catatonic symptoms in children can be associated with trauma, abuse, and/or deprivation. Unlike in dissociative amnesia, the pattern of memory loss in catatonia is only for the catatonic episode.

Acute dissociative reactions to stressful events (other specified dissociative disorder). Factitious disorder and malingering. Memory changes with aging or mild neurocognitive disorder. The acute dissociative reactions to stressful events example of other specified dissociative disorder is characterized by a combination of dissociative symptoms that occur together acutely in response to stressful events and typically last less than 1 month. Amnestic episodes that occur as part of these reactions are accompanied by other prominent dissociative symptoms, have a short duration (hours or days), and tend to be circumscribed to limited periods or events in a person’s life (micro-

amnesias). There is no test, battery of tests, or set of procedures that invariably distinguishes dissociative amnesia from feigned amnesia. Feigned amnesia is more common in individuals with 1) acute, florid dissociative amnesia; 2) financial, sexual, or legal problems; 3) a wish to escape stressful circumstances; 4) a desire to seem to be a more interesting patient; and/or 5) a plan to engage in litigation for “recovered memories.” However, dissociative amnesia can be associated with those same circumstances and can coexist with deliberate feigning. Many individuals who malingering amnesia confess spontaneously or when confronted. Memory decrements in mild neurocognitive disorder differ from those of dissociative amnesia; in mild neurocognitive disorder, memory changes manifest as difficulty in learning and retaining new information. This is often measured in tests of verbal learning of word lists or a brief story with evaluation of immediate and delayed recall. With normal cognitive aging, individuals may also have similar weaknesses in immediate and delayed recall of new information, although normal aging may also affect information processing speed and other complex executive function tasks in addition to memory. Comorbidity As is common in individuals with a history of trauma, many comorbidities co-occur with dissociative amnesia, particularly as dissociative amnesia begins to remit. A wide variety of affective phenomena may surface, including dysphoria, grief, rage, shame, guilt, and psychological conflict and turmoil. Individuals may engage in nonsuicidal self-injury and other high-risk behaviors. These individuals may have symptoms that meet diagnostic criteria for persistent depressive disorder, major depressive disorder, or subthreshold depression (other specified depressive disorder). Many individuals with dissociative amnesia develop PTSD at some point during their life, especially when the traumatic antecedents of their amnesia are brought into conscious awareness. Many of these individuals may show symptoms of the dissociative subtype of PTSD. Many individuals with dissociative amnesia have symptoms that meet diagnostic criteria for a comorbid somatic symptom and related disorder (and vice versa), particularly functional neurological symptom disorder (conversion disorder). Substance-related and addictive disorders may be comorbid with dissociative amnesia, as well as feeding and eating disorders and sexual dysfunctions. The most common comorbid personality disorder is other specified personality disorder (with mixed personality disorder features), which often includes avoidant, obsessive-compulsive, dependent, and borderline features.

F48.1 Depersonalization/Derealization Disorder Diagnostic Criteria A. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:

1. Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one’s thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).
2. Derealization: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted). B. During the depersonalization or derealization experiences, reality testing remains intact. C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures). E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative

disorder. **Diagnostic Features** The essential features of depersonalization/derealization disorder are persistent or recurrent episodes of depersonalization, derealization, or both. Episodes of depersonalization are characterized by a feeling of unreality or detachment from, or unfamiliarity with, the individual's whole self or from aspects of the self (Criterion A1). The individual may feel detached from his or her entire being (e.g., "I am no one," "I have no self"). He or she may also feel subjectively detached from aspects of the self, including feelings (e.g., hypoemotionality: "I know I have feelings, but I don't feel them"), thoughts (e.g., "My thoughts don't feel like my own," "head filled with cotton"), whole body or body parts, or sensations (e.g., touch, proprioception, hunger, thirst, libido). There may also be a diminished sense of agency (e.g., feeling robotic, like an automaton; lacking control of speech or movements). The depersonalization experience can sometimes be one of a split self, with one part observing and one participating, known as an "out-of-body experience" in its most extreme form. The unitary symptom of "depersonalization" consists of several symptom factors: anomalous body experiences (i.e., unreality of the self and perceptual alterations); emotional or physical numbing;

and temporal distortions with anomalous subjective recall. Episodes of derealization are characterized by a feeling of unreality or detachment from, or unfamiliarity with, the world, be it individuals, inanimate objects, or all surroundings (Criterion A2). The individual may feel as if he or she were in a fog, dream, or bubble, or as if there were a veil or a glass wall between the individual and the world around. Surroundings may be experienced as artificial, colorless, or lifeless. Derealization is commonly accompanied by subjective visual distortions, such as blurriness, heightened acuity, widened or narrowed visual field, two-dimensionality or flatness, exaggerated three-dimensionality, or altered distance or size of objects (i.e., macropsia or micropsia). Auditory distortions can also occur, whereby voices or sounds are muted or heightened. In addition, Criterion C requires that the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, and Criteria D and E describe exclusionary diagnoses. **Associated Features** Individuals with depersonalization/derealization disorder may have difficulty describing their symptoms and may think they are "crazy" or "going crazy." Another common experience is the fear of irreversible brain damage. A commonly associated symptom is a subjectively altered sense of time (i.e., too fast or too slow), as well as a subjective difficulty in vividly recalling past memories and owning them as personal and emotional. Vague somatic symptoms, such as head fullness, tingling, or lightheadedness, are not uncommon. Individuals may experience extreme rumination or obsessional preoccupation (e.g., constantly obsessing about whether they really exist, or checking their perceptions to determine whether they appear real). Varying degrees of anxiety and depression are also common associated features. Individuals with the disorder have been found to have physiological hyporeactivity to emotional stimuli. Neural substrates of interest include the hypothalamic-pituitary-adrenocortical axis, inferior parietal lobule, and prefrontal cortical-limbic circuits. **Prevalence** Transient depersonalization/derealization symptoms lasting hours to days are common in the general population. The 12-month prevalence of depersonalization/derealization disorder is thought to be markedly less than for transient symptoms, although precise estimates for the disorder are unavailable. In general, approximately one-half of all adults have experienced at least one lifetime episode of depersonalization/derealization. However, symptomatology that meets full criteria for depersonalization/derealization disorder is markedly less common than transient symptoms. One-month prevalence in the United Kingdom is approximately 1%-2%. **Development and Course** The

mean age at onset of depersonalization/derealization disorder is 16 years, although the disorder can start in early or middle childhood; a minority cannot recall ever not having had the symptoms. Less than 20% of individuals experience onset after age 20 years and only 5% after age 25 years. Onset in the fourth decade of life or later is highly unusual.

Temperamental. Environmental. Onset can range from extremely sudden to gradual. Duration of depersonalization/derealization disorder episodes can vary greatly, from brief (hours or days) to prolonged (weeks, months, or years). Given the rarity of disorder onset after age 40 years, in such cases the individual should be examined more closely for underlying medical conditions (e.g., brain lesions, seizure disorders, sleep apnea). The course of the disorder is often persistent. About one-third of cases involve discrete episodes; another third, continuous symptoms from the start; and still another third, an initially episodic course that eventually becomes continuous. While in some individuals the intensity of symptoms can wax and wane considerably, others report an unwavering level of intensity that in extreme cases can be constantly present for years or decades. Internal and external factors that affect symptom intensity vary between individuals, yet some typical patterns are reported. Exacerbations can be triggered by stress, worsening mood or anxiety symptoms, novel or overstimulating settings, and physical factors such as lighting or lack of sleep.

Risk and Prognostic Factors Individuals with depersonalization/derealization disorder are characterized by harm-avoidant temperament, immature defenses, and both disconnection and overconnection schemata. Immature defenses such as idealization/devaluation, projection, and acting out result in denial of reality and poor adaptation. Cognitive disconnection schemata reflect defectiveness and emotional inhibition and subsume themes of abuse, neglect, and deprivation. Overconnection schemata involve impaired autonomy with themes of dependency, vulnerability, and incompetence. There is a clear association between the disorder and childhood interpersonal traumas in a substantial portion of individuals, although this association is not as prevalent or as extreme in the nature of the traumas as in other dissociative disorders, such as dissociative identity disorder. In particular, emotional abuse and emotional neglect have been most strongly and consistently associated with the disorder. Other stressors can include physical abuse; witnessing domestic violence; growing up with a seriously impaired, mentally ill parent; or unexpected death or suicide of a family member or close friend. Sexual abuse is a much less common antecedent but can be encountered. The most common proximal precipitants of the disorder are severe stress (interpersonal, financial, occupational), depression, anxiety (particularly panic attacks), and illicit drug use. Symptoms may be specifically induced by substances such as tetrahydrocannabinol, hallucinogens, ketamine, MDMA (3,4-methylenedioxymethamphetamine; "ecstasy"), and salvia. Marijuana use may precipitate new-onset panic attacks and depersonalization/derealization symptoms simultaneously.

Culture-Related Diagnostic Issues Volitionally induced experiences of depersonalization/derealization can be a part of meditative practices that are prevalent in many religious, spiritual, and cultural contexts and should not be diagnosed as a disorder. However, there are individuals who initially induce these states intentionally but over time lose control over them and may develop a fear and aversion for related practices. Cultural frameworks may affect the level of distress or perceived severity associated with uncontrolled depersonalization/derealization experiences by providing explanations for them (e.g., spiritual/supernatural causes), which may alleviate individuals' fears

Illness anxiety disorder. Major depressive disorder. Obsessive-compulsive disorder. Other dissociative disorders. Panic attacks. that they are "losing their mind." Functional Consequences of

Depersonalization/Derealization Disorder Symptoms of depersonalization/derealization disorder are highly distressing and are associated with major morbidity. The affectively flattened and robotic demeanor that these individuals often demonstrate may appear incongruent with the extreme emotional pain reported by those with the disorder. Impairment is often experienced in both interpersonal and occupational spheres, largely as a result of the hypoemotionality with others, subjective difficulty in focusing and retaining information, and a general sense of disconnectedness from life.

Differential Diagnosis Although individuals with depersonalization/derealization disorder can present with vague somatic complaints as well as fears of permanent brain damage, the diagnosis of depersonalization/derealization disorder is characterized by the presence of a constellation of typical depersonalization/derealization symptoms and the absence of other manifestations of illness anxiety disorder. Feelings of numbness, deadness, apathy, and being in a dream are not uncommon in major depressive episodes. However, in depersonalization/derealization disorder, such symptoms are associated with further symptoms of the disorder. If the depersonalization/derealization clearly precedes the onset of a major depressive episode or clearly continues after its resolution, the diagnosis of depersonalization/derealization disorder applies. Some individuals with depersonalization/derealization disorder can become obsessively preoccupied with their subjective experience or develop rituals checking on the status of their symptoms. However, other symptoms of obsessive-compulsive disorder unrelated to depersonalization/derealization are not present. In order to diagnose depersonalization/derealization disorder, the symptoms should not occur in the context of another dissociative disorder, such as dissociative identity disorder. Differentiation from dissociative amnesia and functional neurological symptom disorder (conversion disorder) is simpler, as the symptoms of these disorders do not overlap with those of depersonalization/derealization disorder. Depersonalization/derealization is one of the symptoms of panic attacks, increasingly common as panic attack severity increases. Therefore, depersonalization/derealization disorder should not be diagnosed when the symptoms occur only during panic attacks that are part of panic disorder, social anxiety disorder, or specific phobia. In addition, it is not uncommon for depersonalization/derealization symptoms to first begin in the context of new-onset panic attacks or as panic disorder progresses and worsens. In such presentations, the diagnosis of depersonalization/derealization disorder can be made if 1) the depersonalization/derealization component of the presentation is very prominent from the start, clearly exceeding in duration and intensity the occurrence of actual panic attacks; or 2) the

Psychotic disorders. Substance/medication-induced disorders. Traumatic brain injury. Dissociative symptoms due to another medical condition. depersonalization/derealization continues after panic disorder has remitted or has been successfully treated. The presence of intact reality testing specifically regarding the depersonalization/derealization symptoms is essential to differentiating depersonalization/derealization disorder from psychotic disorders. Rarely, positive-symptom schizophrenia can pose a diagnostic challenge when nihilistic delusions are present. For example, an individual may complain that he or she is dead or the world is not real; this could be either a subjective experience that the individual knows is not true or a delusional conviction. Depersonalization/derealization associated with the physiological effects of substances during acute intoxication or withdrawal is not diagnosed as depersonalization/derealization disorder. The most common precipitating substances are the illicit drugs marijuana, hallucinogens, ketamine, ecstasy, and salvia. In about 15% of all cases of depersonalization/derealization disorder, the symptoms are precipitated by ingestion of such substances. If the symptoms persist for some time

in the absence of any further substance or medication use, the diagnosis of depersonalization/derealization disorder applies. This diagnosis is usually easy to establish since the vast majority of individuals with this presentation become highly phobic and aversive to the triggering substance and do not use it again. Depersonalization/derealization symptoms are typical in traumatic brain injury (TBI) but are distinguished from depersonalization/derealization disorder by onset of symptoms following TBI and the lack of other symptoms of depersonalization/derealization disorder. Features such as onset after age 40 years or the presence of atypical symptoms and course in any individual suggest the possibility of an underlying medical condition. In cases with dissociative symptoms, it is essential to conduct a thorough medical and neurological evaluation, which may include standard laboratory studies, viral titers, an electroencephalogram, vestibular testing, visual testing, sleep studies, and/or brain imaging. When the suspicion of an underlying seizure disorder proves difficult to confirm, an ambulatory electroencephalogram may be indicated; although temporal lobe epilepsy is most commonly implicated, parietal and frontal lobe epilepsy may also be associated. Comorbidity In a convenience sample of adults recruited for a number of depersonalization research studies, lifetime comorbidities were high for unipolar depressive disorder and for any anxiety disorder, with a significant proportion of the sample having both disorders. Comorbidity with posttraumatic stress disorder was low. The three most commonly co-occurring personality disorders were avoidant, borderline, and obsessive-compulsive. Other Specified Dissociative Disorder

F44.89 This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class. The other specified dissociative disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific dissociative disorder. This is done by recording "other specified dissociative disorder" followed by the specific reason (e.g., "dissociative trance"). Examples of presentations that can be specified using the "other specified" designation include the following:

1. Chronic and recurrent syndromes of mixed dissociative symptoms: This category includes identity disturbance associated with less-than-marked discontinuities in sense of self and agency, or alterations of identity or episodes of possession in an individual who reports no dissociative amnesia.
2. Identity disturbance due to prolonged and intense coercive persuasion: Individuals who have been subjected to intense coercive persuasion (e.g., brainwashing, thought reform, indoctrination while captive, torture, long-term political imprisonment, recruitment by sects/cults or by terror organizations) may present with prolonged changes in, or conscious questioning of, their identity.
3. Acute dissociative reactions to stressful events: This category is for acute, transient conditions that typically last less than 1 month, and sometimes only a few hours or days. These conditions are characterized by constriction of consciousness; depersonalization; derealization; perceptual disturbances (e.g., time slowing, macropsia); microamnesias; transient stupor; and/or alterations in sensory-motor functioning (e.g., analgesia, paralysis).

4. Dissociative trance: This condition is characterized by an acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. The unresponsiveness may be accompanied by minor stereotyped behaviors (e.g., finger movements) of which the individual is unaware and/or that he or she cannot control, as well as transient paralysis or loss of consciousness. The dissociative trance is not a normal part of a broadly accepted collective cultural or religious practice. Unspecified Dissociative Disorder

F44.9 This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class. The unspecified dissociative disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific dissociative disorder and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

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