Individuals with dissociative identity disorder usually exhibit a large number of comorbid disorders. In particular, most develop PTSD. Other disorders that are highly comorbid with dissociative identity disorder include depressive disorders, trauma- and stressor-related disorders, personality disorders (especially avoidant and borderline personality disorders), conversion disorder (functional neurological symptom disorder), somatic symptom disorder, eating disorders, substance-related disorders, obsessive-compulsive disorder, and sleep disorders. Dissociative alterations in identity, memory, and consciousness may affect the symptom presentation of comorbid disorders.

Dissociative Amnesia

Diagnostic Criteria **300.12 (F44.0)**

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 **300.12 (F44.0).** The code for dissociative amnesia with dissociative fugue is **300.13 (F44.1).**

Specify if:

300.13 (F44.1) With dissociative fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for 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 readily remembered (Criterion A). Dissociative amnesia differs from the permanent amnesias due to neurobiological damage or toxicity that prevent memory storage or retrieval in that it is always potentially reversible because the memory has been successfully stored.

Localized amnesia, a failure to recall events during a circumscribed period of time, is the most common form of dissociative amnesia. Localized amnesia may be broader than amnesia for a single traumatic event (e.g., months or years associated with child abuse or intense combat). In *selective amnesia,* the individual can recall some, but not all, of the events during a circumscribed period of time. Thus, the individual may remember part of a traumatic event but not other parts. Some individuals report both localized and selective amnesias.

Generalized amnesia, a complete loss of memory for one's life history, is rare. Individuals with generalized amnesia may forget personal identity. Some lose previous knowledge about the world (i.e., semantic knowledge) and can no longer access well-learned skills

(i.e., procedural knowledge). Generalized 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. Generalized amnesia may be more common among combat veterans, sexual assault victims, and individuals experiencing extreme emotional stress or conflict.

Individuals with dissociative amnesia are frequently unaware (or only partially aware) of their memory problems. Many, especially those with localized amnesia, minimize the importance of their memory loss and may become uncomfortable when prompted to address it. In *systematized amnesia,* the individual loses memory for a specific category of information (e.g., all memories relating to one's family, a particular person, or childhood sexual abuse). In *continuous amnesia,* an individual forgets each new event as it occurs.

Associated Features Supporting Diagnosis

Many individuals with dissociative amnesia are chronically impaired in their ability to form and sustain satisfactory relationships. Histories of trauma, 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 self-mutilation, 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 may precede dissociative amnesia.

Prevalence

The 12-month prevalence for dissociative amnesia among adults in a small U.S. community study was 1.8% (1.0% for males; 2.6% for females).

Development and Course

Onset of generalized amnesia is usually sudden. Less is known about the onset of localized and selective amnesias because these amnesias are seldom evident, even to the individual. Although overwhelming or intolerable events typically precede localized amnesia, its onset may be delayed for hours, days, or longer.

Individuals may report multiple episodes 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. The duration of the forgotten events can range from minutes to decades. Some episodes of dissociative amnesia resolve rapidly (e.g., when the person is removed from combat or some other stressful situation), whereas other episodes persist for long periods of time. Some individuals may gradually recall the dissociated memories years later. Dissociative capacities may decline with age, but not always. As the amnesia remits, there may be considerable distress, suicidal behavior, and symptoms of posttraumatic stress disorder (PTSD).

Dissociative amnesia has been observed in young children, adolescents, and adults. Children 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. Observations of apparent dissociative amnesia are often difficult to differentiate from inattention, absorption, 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.

Risk and Prognostic Factors

Environmental. Single or repeated traumatic experiences (e.g., war, childhood maltreatment, natural disaster, internment in concentration camps, genocide) are common ante-

cedents. Dissociative amnesia is more likely to occur with 1) a greater number of adverse childhood experiences, particularly physical and/or sexual abuse, 2) interpersonal violence; and 3) increased severity, frequency, and violence of the trauma.

Genetic and physiological. There are no genetic studies of dissociative amnesia. Studies of dissociation report significant genetic and environmental factors in both clinical and nonclinical samples.

Course modifiers. Removal from the traumatic circumstances underlying the 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. Onset of PTSD symptoms may decrease localized, selective, or systematized amnesia. The returning memory, however, may be experienced as flashbacks that alternate with amnesia for the content of the flashbacks.

Culture-Related Diagnostic Issues

In Asia, the Middle East, and Latin America, non-epileptic seizures and other functional neurological symptoms may accompany dissociative amnesia. In cultures with highly restrictive social traditions, the precipitants of dissociative amnesia often do not involve frank trauma. Instead, the amnesia is preceded by severe psychological stresses or conflicts (e.g., marital conflict, other family disturbances, attachment problems, conflicts due to restriction or oppression).

Suicide Risk

Suicidal and other self-destructive behaviors are common in individuals with dissociative amnesia. Suicidal behavior may be a particular risk when the amnesia remits suddenly and overwhelms the individual with intolerable memories.

Functional Consequences of Dissociative Amnesia

The impairment of individuals with localized, selective, or systematized dissociative amnesia ranges from limited to severe. Individuals with chronic generalized dissociative amnesia usually have impairment in all aspects of functioning. Even when these individuals "re-learn" aspects of their life history, autobiographical memory remains very impaired. Most become vocationally and interpersonally disabled.

Differential Diagnosis

Dissociative identity disorder. Individuals with dissociative amnesia may report depersonalization and auto-hypnotic symptoms. Individuals with dissociative identity disorder report pervasive discontinuities in sense of self and agency, accompanied by many other dissociative symptoms. The amnesias of individuals with localized, selective, and/or systematized dissociative amnesias are relatively stable. Amnesias in dissociative identity disorder include amnesia for everyday events, finding of unexplained possessions, sudden fluctuations in skills and knowledge, major gaps in recall of life history, and brief amnesic gaps in interpersonal interactions.

Posttraumatic stress disorder. Some individuals with PTSD cannot recall part or all of a specific traumatic event (e.g., a rape victim with depersonalization and/or derealization symptoms who cannot recall most events for the entire day of the rape). When that amnesia extends beyond the immediate time of the trauma, a comorbid diagnosis of dissociative amnesia is warranted.

Neurocognitive disorders. In neurocognitive disorders, memory loss for personal information is usually embedded in cognitive, linguistic, affective, attentional, and behavioral

disturbances. In dissociative amnesia, memory deficits are primarily for autobiographical information; intellectual and cognitive abilities are preserved.

Substance-related disorders. In the context of repeated intoxication with alcohol or other substances/medications, there may be episodes of "black outs" or periods for which the individual has no memory. To aid in distinguishing these episodes from dissociative amnesia, a longitudinal history noting that the amnestic episodes occur only in the context of intoxication and do not occur in other situations would help identify the source as substance-induced; however the distinction may be difficult when the individual with dissociative amnesia may also misuse alcohol or other substances in the context of stressful situations that may also exacerbate dissociative symptoms. Some individuals with comorbid dissociative amnesia and substance use disorders will attribute their memory problems solely to the 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, but 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.

Posttraumatic amnesia due to brain injury. Amnesia may occur in the context of a traumatic brain injury (TBI) when there has been an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull TBI. Other characteristics of TBI include loss of consciousness, disorientation and confusion, or, in more severe cases, neurological signs (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 post-injury 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. These additional features help distinguish it from dissociative amnesia.

Seizure disorders. Individuals with seizure disorders may exhibit complex behavior during seizures or post-ictally 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 earlier autobiographical memories have been "wiped out" as the seizure disorder progresses. Such memory loss is not associated with traumatic circumstances and appears to occur randomly. Serial electroencephalograms usually show abnormalities. Telemetric electroencephalographic monitoring usually shows an association between the episodes of amnesia and seizure activity. Dissociative and epileptic amnesias may coexist.

Catatonic stupor. Mutism in catatonic stupor may suggest dissociative amnesia, but failure of recall is absent. Other catatonic symptoms (e.g., rigidity, posturing, negativism) are usually present.

Factitious disorder and malingering. There is no test, battery of tests, or set of procedures that invariably distinguishes dissociative amnesia from feigned amnesia. Individuals with factitious disorder or malingering have been noted to continue their deception even during hypnotic or barbiturate-facilitated interviews. Feigned amnesia is more common in individuals with 1) acute, florid dissociative amnesia; 2) financial, sexual, or legal problems; or 3) a wish to escape stressful circumstances. True amnesia can be associated with those same circumstances. Many individuals who malinger confess spontaneously or when confronted.

Normal and age-related changes in memory. Memory decrements in major and mild neurocognitive disorders differ from those of dissociative amnesia, which are usually associated with stressful events and are more specific, extensive, and/or complex.

Comorbidity

As dissociative amnesia begins to remit, a wide variety of affective phenomena may surface: dysphoria, grief, rage, shame, guilt, psychological conflict and turmoil, and suicidal and homicidal ideation, impulses, and acts. These individuals may have symptoms that then meet diagnostic criteria for persistent depressive disorder (dysthymia); major depressive disorder; other specified or unspecified depressive disorder; adjustment disorder, with depressed mood; or adjustment disorder, with mixed disturbance of emotions and conduct. 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 individuals with dissociative amnesia have symptoms that meet diagnostic criteria for a comorbid somatic symptom or related disorder (and vice versa), including somatic symptom disorder and conversion disorder (functional neurological symptom disorder). Many individuals with dissociative amnesia have symptoms that meet diagnostic criteria for a personality disorder, especially dependent, avoidant, and borderline.

Depersonalization/Derealization Disorder

Diagnostic Criteria **300.6 (F48.1)**

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, one'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 one's 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 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 the presence of clinically significant distress or impairment in social, occupational, or other important areas of functioning, and Criteria D and E describe exclusionary diagnoses.

Associated Features Supporting Diagnosis

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 suffer 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. Lifetime prevalence in U.S. and non-U.S. countries is approximately 2% (range of 0.8% to 2.8%). The gender ratio for the disorder is 1:1.

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. 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

Temperamental. 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.

Environmental. 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 religions and cultures 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.

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