

Depersonalization/Derealization Disorder

Code: 300.6 (F48.1)

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 the thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbings).
- 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 course of 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 better explained by a medical condition (e.g., seizures), a substance (e.g., drug abuse, medication) or another medical condition (e.g., a seizure).

E. The disturbance is not better explained by another mental disorder, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, posttraumatic stress disorder, or another dissociative disorder.

Diagnostic Features

[illegible]

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 sense of unreality or detachment from one's self. Individuals may have difficulty concentrating, vividly recalling past memories and owning them as personal and emotional. Vague or 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 if they are real). The disorder may be associated with a variety of other mental health associated features. Individuals with the disorder have been found to have physiological hypersensitivity to emotional stimuli. Neural substrates of interest include the hypothalamic-pituitary-adrenal-cortical axis, inferior parietal lobule, and prefrontal cortical-limbic system.

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 symptoms. Depersonalization/derealization disorder is more common in females than males. About 50% of individuals experience onset after age 20 years and 50% experience onset before 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 disorder is likely to have been present since childhood. Associated symptoms include irritability, seizures, sleep apnea, and depression. 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 unvarying 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.

Temperamental. Individuals with depersonalization/derealization disorder are characterized by harm-avoidant temperament, immature defenses, and both disconnected and disconnected-ambivalent attachment styles. Depersonalization/derealization is a protective strategy and acting out result of denial of reality and poor adaptation. Cognitive disconnection is a defense against affect and emotion. Depersonalization/derealization is associated with a sense of helplessness and emotional numbness and subsumes themes of abuse, neglect, and trauma. Depersonalization/derealization is also important in the context of dependency, vulnerability, and incompetence.

Environmental. There is a clear association between the disorder and childhood interpersonal trauma. The disorder is associated with the association between the past and present as or 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, sexual abuse, and incest. The disorder is also associated with a history of physical abuse, sexual abuse, parent or unexpected death or suicide of a family member or close friend. Sexual abuse is much less common antecedent but can be encountered. The most common proximal precipitant is a traumatic event, such as a natural disaster, accident, or war. The disorder is usually very (particularly panic attacks), and likeliest drug use. Symptoms may be specifically induced substances such as tetrahydrocannabinol, hallucinogens, ketamine, MDMA (3,4-methylenedioxymethamphetamine), and alcohol. The disorder is also associated with panic attacks and depersonalization/derealization symptoms, separately.

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 narratives.

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 Depersonalization/Derealization Disorder 305

Individuals often demonstrate they 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 due to the hypoemotionality with others, subjective difficulty in focusing and retaining information, and a general sense of disconnectedness from

Differential Diagnosis

illness anxiety disorder. 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.

Major depressive 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.

Obsessive-compulsive disorder. 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 unusual.

Other dissociative disorders. In order to diagnose depersonalization/derealization

honor, the symptoms should not occur in the context of another dissociative disorder. The dissociative disorder is characterized by a loss of memory and/or identity and/or functional (neurological symptom disorder) is similar to the other dissociative disorders. The symptoms of these disorders do not overlap with those of depersonalization/derealization disorder. Anxiety disorders: 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 in the context of panic attacks. Specific phobia: Depersonalization/derealization disorder is not a 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 panic attacks, and (2) the depersonalization/derealization continues after panic disorder has remitted or has been successfully treated.

Psychotic disorders. 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 rhizomatic 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.

Substance/medication-induced disorders. 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 saliva. In 306 Dissociative Disorders

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 averse to the tripton substance and do not use it again.

Mental disorders due to another medical condition. 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 such cases, it is essential to conduct a thorough medical and neurological evaluation, which may include standard laboratory studies, vital signs, 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
300.15 (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 disturbances associated with less-than-marked dissociative influences. A sense of unreality or depersonalization may be experienced or 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) might report a sense of unreality while captive. Short- to 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 symptoms: These symptoms are characterized by 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); somatization; sensory-motor disturbances (e.g., numbness, tingling, numbness); amnesia; micro-amnesia; 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.

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