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

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 due to the hypoemotionality with others, subjective difficulty in focusing and retaining information, and a general sense of disconnectedness from life.

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 present.

Other dissociative disorders. 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 conversion disorder (functional neurological symptom disorder) is simpler, as 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 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 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 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.

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 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.

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, 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

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 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);

micro-amnesias; 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

300.15 (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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