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Dissociative Disorders

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Dissociative Disorders

- Introduction
- Dissociative Identity Disorder
- Dissociative Amnesia
- Depersonalization/Derealization disorder
- Other Specified Dissociative Disorder
- Unspecified Dissociative Disorder

Dissociative Disorders – Introduction

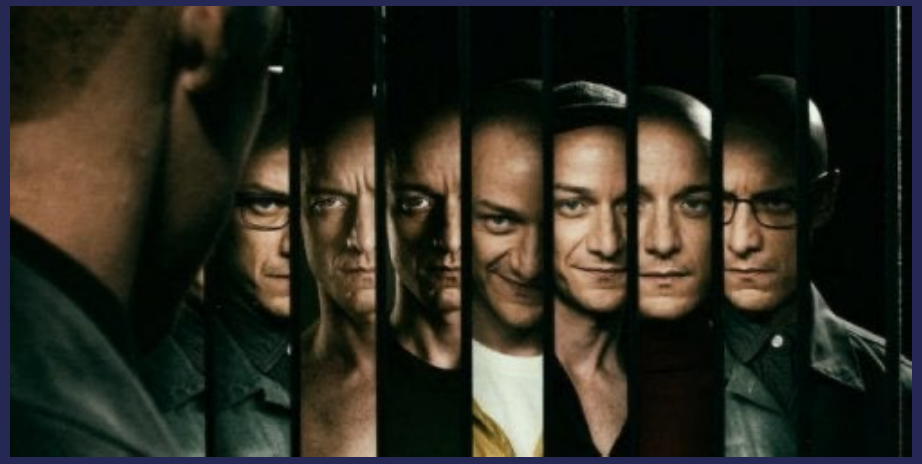
- Disruption and/or discontinuity of normal integration of:
  - Consciousness, memory, identity, emotion, perception
  - Body representation, motor control, behavior
  - Can potentially disrupt every area of psychological functioning

- Positive dissociative symptoms
  - **Unbidden intrusions** into awareness + behaviour with **losses of continuity in subjective experience**
    - E.g. fragmentation of identity, depersonalization, derealization

- Negative dissociative symptoms
  - **Inability to access information** or **control mental functions** that normally are available
    - E.g. amnesia

- Trauma → embarrassment, confusion, desire to hide (dissociative sx)
  - Sx are influenced by the **proximity** to trauma

Dissociative Identity Disorder



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Dissociative Identity Disorder – Diagnostic Criteria

A. **Disruption of identity characterized by 2+ distinct personality states** (described as experience of possession)
   - Discontinuity in **sense of self + agency**
   - **Alterations in affect, behavior, consciousness**, memory, perception, cognition, sensory-motor function
   - May observed by others or reported

B. **Recurrent gaps in recall**, inconsistent with ordinary forgetting
   - Everyday events, important personal info, traumatic events

C. Significant distress or impairment

D. Not normal part of accepted cultural/religious practice

E. Not due to substance or AMC

DSM5

Dissociative Identity Disorder – Diagnostic Features

- A) 2+ distinct personality traits, or experience of possession
  - Overtness of personality states **VARIES with psychological factors**
    - Motivation, current stress, culture, internal conflicts, resilience
    - May be sustained if severe/prolonged psychosocial pressure
  - **Possession-form cases** → usually **highly overt**
  - **Non-possession-form** → usually NOT overt
  - If alternate personality states NOT directly observed, 2 sx clusters:
    - 1. Sudden alteration in **sense of self + agency**
    - 2. Recurrent **dissociative amnesias**

- Can affect any aspect of function → may be observable by others
  - **Sense of self** → depersonalization, observing own speech/actions
    - May report perceptions of voices
    - Attitudes, outlooks, preferences may shift suddenly
    - Body may feel different → "not mine"
  - **Sense of agency** → no control over emotions, speech, actions
    - Ego dystonic, puzzling → "not under my control"
  - **Conversion sx** may be prominent (esp non-Western settings)

Dissociative Identity Disorder – Diagnostic Features

- Dissociative amnesia manifestations in DID:
  - 1) Gaps in **remote memory** → personal life events
  - 2) Lapses in **dependable memory** → recent events, well-learned skills
  - 3) Finding evidence of **actions they don't recollect doing**
  - Not limited to stressful or traumatic events → everyday events too
  - Common to **minimize amnestic sx** → awareness/attitude varies

- Dissociative fugue → COMMON
  - Pt discovers dissociated travel → no memory of how they got there

- Possession-form → typically manifests as "spirit" taking control
  - Begins speaking/acting in distinctly different manner
  - Identities **unwanted + involuntary**
  - (majority of possession states are **normal**, part of **spiritual practice**)

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Dissociative Identity Disorder – Associated Features (1)

- Typically present with non-dissociative sx:
  - Comorbid depression, anxiety, substance abuse, self-injury, nonepileptic seizures, or another common sx
  - Often **conceal or not fully aware** of dissociative sx
- Dissociative flashbacks
  - Sensory reliving of previous event → often with **change of identity**
  - Partial/complete **loss of contact/orientation** to current reality
  - **Subsequent amnesia** of flashback content
- Typically report hx of adverse events in childhood + adulthood
  - Often report **multiple types of interpersonal maltreatments**
  - May also report multiple long, painful early-life **medical procedures**

Dissociative Identity Disorder – Associated Features (2)

- More frequent → **suicidal behavior + self-mutilation**
  - Higher levels of **hypnotisability + dissociativity**
  - May experience **transient psychotic phenomena/episodes**

- Implicated brain regions
  - **Orbitofrontal cortex (OFC)**
  - **Hippocampus, parahippocampal gyrus**
  - **Amygdala**

Dissociative Identity Disorder – Prevalence

- 12-month prevalence = **1.5%** (small US community study)
  - Males = 1.6%
  - Females = 1.4%

Dissociative Identity Disorder – Development & Course (1)

- Onset
  - Assoc with **overwhelming experiences, trauma, abuse in childhood**
  - Full disorder may manifest at **almost ANY age**

  - **Children** → problems w/ memory, concentration, attachment, traumatic play
    - Do NOT usually present with identity changes
    - Usually present with overlap and interference of mental states, **discontinuity of experience**

  - **Adolescence** → sudden identity changes
    - May appear as just **adolescent turmoil**, or **early stages of AMD**

  - **Older individuals** → may present as **AMD due to dissociative amnesia**
    - Late-life mood disorder, psychotic mood disorder, OCD, paranoia, NCD
    - Disruptive affect/memories may increasingly intrude into awareness with advancing age

Dissociative Identity Disorder – Development & Course (2)

- Triggers of psychological decompensation + identity changes:
  - **1) Removal from traumatizing situation** (leaving home)
  - **2) Individual's children reaching same age of abuse/trauma**
  - **3) Later traumatic experience** (even if minor)
  - **4) Death or onset of fatal illness in their abuser**

Dissociative Identity Disorder – Risk & Prognostic Factors

- Environmental
  - **Interpersonal physical + sexual abuse** → incr risk
    - **90% have hx childhood abuse + neglect**
  - Other traumatizing experiences reported:
    - Childhood medical + surgical procedures
    - Childhood prostitution
    - War, terrorism

- Course modifiers - poorer prognosis associated with:
  - Ongoing **abuse, later-life re-traumatization**
  - Comorbidity with **mental disorder, severe medical illness**
  - **Delay in appropriate treatment**

Dissociative Identity Disorder – Culture-Related Issues

- Many features influenced by cultural background
  - May present with prominent medically **unexplained neurological sx**
    - Non-epileptic seizures, paralysis, sensory loss

- In setting where normative possession common:
  - Fragmented identities = spirits, deities, demons, animals, mythical figures
  - Distinguishing features of **possession form-DID** (vs culturally-accepted)
    - Involuntary, distressing, uncontrollable
    - Recurrent/persistent
    - Social conflict
    - Manifests at inappropriate times/places (violates cultural norms)

Dissociative Identity Disorder – Gender-Related Issues

Males	Females
• May **deny sx + trauma histories** • May lead to high **false negative** dx • More **criminal/violent behavior** • Common triggers include **combat, prison, physical/sexual assaults**	• More common in **adult clinical settings** (not in child clinical settings) • Present more frequently with **acute dissociative states** • (i.e. flashbacks, amnesia, fugue, hallucinations, conversion sx, self-mutilation)

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Dissociative Identity Disorder – Suicide Risk

- Of DID outpatients → **>70% have attempted suicide**
  - Multiple attempts common
  - Other self-injurious behavior frequent

- May be amnesia/unawareness for past suicidal behavior
  - Presenting identity may not feel suicidal

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Dissociative Identity Disorder – Functional Consequences

- Impairment varies widely
  - Commonly MINIMIZE impact of dissociative/post-traumatic sx
  - If higher-functioning → **social/family function** may be impacted more

- Treatment → can improve occupational + personal function
  - Some remain highly impaired in most areas
  - Some may respond very slowly
  - Long-term supportive tx may decr impairment

Dissociative Identity Disorder – Differential Diagnosis (1)

- Other specified dissociative disorder
  - Repeated division of identity/conscious functioning
  - OSDD → presence of chronic/recurrent mixed dissociative sx that do NOT meet criterion A, OR are not accompanied by recurrent amnesia

- Major depressive episode
  - If not full MDE criteria → dx "other specified depressive disorder"
  - In these cases **depressed mood + cognitions fluctuate** → experienced only in some identity states

- Bipolar disorders
  - DID often misdiagnosed (esp as bipolar II)
  - DID → **more rapid shifts in mood** (vs slower in bipolar)
    - May occur across dissociative states, with fluctuating activation levels
    - May be in conjunction with overt identities

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Dissociative Identity Disorder – Differential Diagnosis (2)

Shared DID + PTSD symptoms	ONLY DID (NOT in PTSD)
• Amnesia for some **aspects of trauma**	• Amnesia for **everyday events**
• **Dissociative flashbacks**	• Dissociative **flashbacks with amnesia**
• **Intrusion + avoidance sx** • **Hyperarousal** focused on trauma	• Disruptive intrusions into **sense of self + agency**
• **Negative alterations** in cognition/mood	• **Full-blown changes** among different identity states

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Dissociative Identity Disorder – Differential Diagnosis (3)

DID	Psychotic Disorders
• Personified, internally communicative inner voices **(esp of child)** • Visual, tactile, olfactory, gustatory, somatic hallucinations	• Vs. psychotic hallucinations
• **Identity fragmentation**/possession • Perceived loss of control over thoughts, feelings, impulses, acts	• Vs. formal thought disorder
• Caused by **alternate identities** • No delusional explanations	• Vs. delusions
• Persecutory/derogatory **internal voices** assoc with depressive sx	• Misdiagnosed as MDD with psychotic features
• **Chaotic identity change** • Acute intrusions • Predominance of dissociative sx + amnesia	• Vs. brief psychotic episode (distinguish via diagnostic evaluation after cessation of the crisis)

Dissociative Identity Disorder – Differential Diagnosis (4)

- Substance/medication-induced disorders

- Personality disorders
  - Identities may encapsulate variety of severe PD features (esp borderline)
  - DID → longitudinal **variability** in personality style
    - (vs pervasive + persistent dysfunction)

- Conversion disorders
  - No identity disruption → amnesia more limited

- Seizure disorders
  - DID may present similarly to **complex partial seizures (temporal lobe)**
    - Déjà vu, jamais vu, depersonalization, derealisation, amnesia, disruptions of consciousness, hallucinations, intrusion phenomena
  - DID → normal EEG, very high dissociation scores

Dissociative Identity Disorder – Differential Diagnosis (5)

- Factitious disorder, malingering
  - Tend to **overreport well-publicized symptoms** → dissociative amnesia
    - Underreport subtle symptoms → depression
  - Tend be **undisturbed or enjoy** having the disorder
    - (vs ashamed/overwhelmed)
  - **Limited, stereotyped alternative identities, feigned amnesia**
    - Related to gain which is sought
    - "all-good" + "all-bad" identities to gain exculpation for crime

Dissociative Identity Disorder – Comorbidity

- Often present with comorbid disorder
  - Often just treated for comorbid dx → limits overall response
  - Dissociative sx may affect presentation of comorbid disorders

- Usually many comorbid disorders
  - Trauma disorders → **most patients develop PTSD**
  - Depressive disorders
  - Personality disorder **(esp avoidant + borderline PD)**
  - Conversion disorder
  - Somatic symptom disorder
  - Eating disorders
  - OCD
  - Sleep disorders
  - SUDs

Dissociative Amnesia

Dissociative Amnesia – Diagnostic Criteria

A. **Inability to recall important autobiographical information**
   - Usually of **traumatic/stressful nature**
   - Inconsistent with ordinary forgetting

B. Significant distress or impairment

C. Not due to substance, AMC or AND

D. Not better explained by AMD

Dissociative Amnesia – Diagnostic Specifiers

- *Specify if*
  - **With dissociative fugue:** purposeful travel or bewildered wandering
    - Assoc with amnesia for identity or other important autobiographic info

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Dissociative Amnesia – Diagnostic Features (1)

- A) Inability to recall important autobiographic information
  - That should be **successfully stored** in memory
  - That would be **ordinarily remembered**

- Differs from permanent amnesias (due to damage/toxicity)
  - **Potentially reversible** (because memory successfully stored)

- *Localized amnesia* → MOST COMMON (of dissociative amnesias)
  - **Failure to recall** events during **circumscribed period of time**
  - May be broader than amnesia for single traumatic event

- *Selective amnesia*
  - Can recall **SOME events** during circumscribed period of time (not all)
  - May report both selective + localized

Dissociative Amnesia – Diagnostic Features (2)

- *Generalized amnesia* → RARE
  - **Complete loss** of memory for one's **life history**
  - May forget **personal identity, semantic or procedural knowledge**
  - **Acute onset** → perplexity, disorientation, purposeless wandering
    - Usually come to attention of police, psychiatric emergency services
  - More common among **ccombat veterans, sexual assault victims**
    - Individuals experience **extreme emotional stress/conflict**

- *Systematized amnesia* → for specific category of information
- *Continuous amnesia* → forgets each events as it occurs

- Usually unaware or only partially aware
  - If localized → tend to **minimize importance** of memory loss

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Dissociative Amnesia – Associated Features

- Historical features
  - Hx of **trauma, child abuse, victimization** → COMMON
  - Many have hx of **self-harm, suicide attempts, other risky behaviors**
  - May have preceding **mild TBI**

- Associated symptoms
  - Some may report **dissociative flashbacks**
  - **Depressive sx, conversion sx**
  - **Depersonalization, auto-hypnotic sx, high hypnotisability**
  - **Sexual dysfunction**

- Chronic impairment in satisfactory relationships

Dissociative Amnesia – Prevalence

- 12-month prevalence = **1.8%** (small US community study)
  - Males = 1.0%
  - Females = 2.6%

Dissociative Amnesia – Development & Course (1)

- Onset
  - Generalized amnesia → sudden
  - Localized, selective amnesias → less known, less evident
  - **May be delayed** from preceding stressful event (hours-days-longer)

- May report multiple episodes of dissociative amnesia
  - Single episode **may predispose** to future episodes
    - Between episodes → may not appear acutely symptomatic
  - **Duration of forgotten events** can range from minutes to decades
    - Some episodes resolve rapidly, some persist for long periods
    - Some may gradually recall dissociated memories year later
  - **As amnesia remits** → may be distress, suicidal behavior, PTSD sx

- Dissociative capacities → may decline with age (not always)

Dissociative Amnesia – Development & Course (2)

- Observed in young children, adolescents, adults

- May be difficult to evaluate in children
  - Understanding/formulating questions about amnesia
  - Differentiate from inattention, absorption, anxiety, opposition, learning diff

Dissociative Amnesia – Risk & Prognostic Factors

- Environmental
  - **Single or repeated traumatic experiences** → common antecedents
    - War, concentration camps internment, genocide
    - Childhood maltreatment, natural disaster
  - More likely to occur with:
    - More **adverse childhood experiences** (esp physical/sexual abuse)
    - **Interpersonal violence**
    - **Incr severity of trauma** (frequency, violence)

- Genetic & Physiological → no genetic studies

- Course modifiers
  - Removal from traumatic circumstances underling dissociative amnesia
    - May bring about **rapid return of memory**
  - **Dissociative fugue memory loss** → may be particularly refractory
  - **PTSD sx** → may DECREASE localized, selective, systematized amnesia
    - Returning memory may be experienced as **flashbacks (± amnesia)**

Dissociative Amnesia – Culture-Related Issues

- Asia, Middle East Latin America
  - **Non-epileptic seizures, other conversion sx** may accompany amnesia

- In cultures w/ highly constrictive social traditions:
  - Precipitant usually **severe psychological stress or conflict**
    - Marital, family, attachment, restriction, oppression
    - (not usually frank trauma)

Dissociative Amnesia – Suicide Risk

- Suicidal + self-destructive behavior → COMMON
  - Particular risk if **amnesia remits suddenly**
    - May overwhelm individual with **intolerable memories**

Dissociative Amnesia – Functional Consequences

- Localized, selective, systematized amnesia
  - Impairment varies from **limited to severe**
- Chronic generalized amnesia
  - Usually impairment in **ALL aspects of functioning**
  - Even if re-learn life history → **autobiographic memory still impaired**
  - Most become vocationally + interpersonally disabled

Dissociative Amnesia – Differential Diagnosis (1)

- Dissociative identity disorder
  - Dissociative amnesia → relative stable
  - DID amnesia → **everyday events, finding unexplained possessions**
    - Sudden fluctuations in skill/knowledge
    - Major gaps in life history, amnestic gaps in interpersonal interactions

- PTSD
  - May not recall part/all of **specific traumatic event**
  - If extends beyond immediate time of trauma → consider additional dx

- Neurocognitive disorders
  - Memory loss embedded in cognitive, linguistic, affective, attentional, behavioral disturbances
  - (vs deficits in autobio info with preserved intellectual/cog abilities in DA)

- Substance-related disorders
  - May be **"blackouts" with no memory** → whether etiologically related

Dissociative Amnesia – Differential Diagnosis (2)

- Post-traumatic amnesia due to brain injury
  - Amnesia may occur in context of **TBI**
    - Associated w/ loss of consciousness, disorientation, confusion
    - If severe → **neurological sx** (neuroimaging, seizures, vision, anosmia)
  - **Neurocognitive disorder due to TBI**
    - Immediately after brain injury or recovery of consciousness
    - Deficits persist past acute post-injury period, impact:
      - Complex attention, executive function, learning, memory
      - Processing speed, social cognition

- Seizure disorders → may coexist
  - May have complex behavior during seizures, post-ictally (with amnesia)
    - **Non-purposeful wandering** → limited to period of seizure activity
    - (vs. dissociative fugue → behaviour is purposeful, complex, goal-directed, may be days to weeks)
    - Memory loss in sz d/o NOT assoc with trauma, **occur randomly**
  - Serial EEGs → abnormalities, association btw amnesia and sz activity

Dissociative Amnesia – Differential Diagnosis (3)

- Catatonic stupor
  - **Mutism** may appear like dissociative amnesia → NO failure of recall

- Factitious disorder, malingering
  - No definitely distinguishing tests for feigned amnesia
  - During **hypnotic or barbiturate-facilitated interviews**
    - → Factitious disorder/malingering may continue deception
  - Feigned amnesia more common in:
    - **Acute, florid dissociative amnesia**
    - **Financial, sexual, legal problems**
    - **Wish to escape stressful circumstances** (can be true amnesia)
  - Malingering → may confess

- Normal + age-related changes in memory
  - Not assoc with stressful events → less specific/extensive/complex

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Dissociative Amnesia – Comorbidity

- Affective phenomena (as dissociative amnesia begins to remit)
  - Dysphoria, grief, rage, shame, guilt
  - Psychological conflict + turmoil
  - Suicidal + homicidal ideation, impulses, acts
  - May meet diagnostic criteria for mood or anxiety disorders
- Many develop PTSD at some point
  - Esp when **traumatic antecedents** brought to conscious awareness
- Many have comorbid somatic symptom or related disorder
  - **Somatic symptom disorder, conversion disorder**
- Many have comorbid personality disorder
  - Esp **dependent, avoidant, borderline PD**

Depersonalization/Derealization Disorder

Depersonalization/Derealization – Diagnostic Criteria

A. <u>Depersonalization, derealization, or both:</u>
   1. **Depersonalization** → experience of unreality, detachment, or being outside observer to one's thoughts, feelings, sensations, body or actions
   2. **Derealization** → experience of unreality or detachment to surroundings

B. **Intact reality testing**

C. Significant distress or impairment

D. Not due to substance or AMC

E. Not better explained by AMD

Depersonalization/Derealization – Diagnostic Features (1)

- A1) Depersonalization
  - Unreality/detachment/unfamiliarity with
    - **Whole self** → "I am no one"
    - **Whole body or body parts**
    - **Feelings** → hypoemotionality
    - **Thoughts** → "thoughts don't feel like my own"
    - **Sensations** → touch, proprioception, hunger, thirst, libido
  - May be **diminished sense of agency**
    - Feeling robotic, automaton, lacking control of speech/movements
  - **"Out of body experience"** → split-self (observing + participating)

- Unitary sx of "depersonalization" consists of several sx factors:
  - **1) Anomalous body experience**
  - **2) Emotional/physical numbing**
  - **3) Temporal distortions with anomalous subjective recall**

Depersonalization/Derealization – Diagnostic Features (2)

- A2) Derealization
  - Unreality/detachment/unfamiliarity with world
    - Includes individuals, inanimate objects, all surroundings
    - May feel like in **fog, dream, bubble** → veil or glass wall in between
    - May experience surroundings as **artificial, colorless, lifeless**
  - Commonly accompanied by **subjective visual distortions**
    - Blurriness, heightened acuity, wide or narrowed visual field
    - 2-dimensionality/flatness, exaggerated 3-dimensionality
    - Altered distance or size of objects (macropsia, micropsia)
  - **Auditory distortions** may occur
    - Muted or heightened voices or sounds

Depersonalization/Derealization – Associated Features

- May have difficult describing their sx → "going crazy"
  - Fear of **irreversible brain damage**
  - Subjectively **altered sense of time** → too fast or too slow
  - Subjective **difficulty recalling past memories vividly, or as personal**

- Associated symptoms
  - **Vague somatic symptoms** → not uncommon
    - Head fullness, tingling, light-headedness
  - **Extreme rumination or obsessional preoccupation**
    - Constant obsessing about whether they exist, whether perceptions real
  - **Varying degrees of anxiety + depression** → common
  - **Physiological hyporeactivity** to emotional stimuli

- Neural substrates of interest:
  - HPA axis, inferior parietal lobe, prefrontal cortical-limbic circuits

Depersonalization/Derealization – Prevalence

- Transient depersonalization/derealization → common
  - 50% of adults have **at least one lifetime episode**
- Lifetime prevalence of DISORDER → **2%** (0.8 – 2.8%)
- Gender ratio = **EQUAL**

Depersonalization/Derealization – Development & Course

- Onset
  - Mean age at onset → **age 16**
    - Can start in early childhood → minority cannot recall not having sx
    - After age 20 → <20%
    - After age 25 → <5%
    - After age 40 → very unusual (consider underlying AMC)
  - Onset may be **sudden or gradual**
  - Duration varies → hours to days, week to months to years

- Course → often persistent
  - One-third → **discrete episodes**
  - One-third → **continuous sx** (wax/wane or constant intensity)
  - One-third → **initially episodic, then continuous**
  - Exacerbating factors
    - Stress, mood/anxiety, new/overstimulating settings, lack of sleep

Depersonalization/Derealization – Risk & Prognostic Factors

- Temperamental
  - Harm-avoidant temperament
  - Immature defenses → **idealization/devaluation, projection, acting out**
    - Result in denial of reality, poor adaptation
  - ***Cognitive disconnection schemata*** → defectiveness, emotional inhibited
    - Themes of abuse, neglect, deprivation
  - ***Overconnection schemata*** → impaired autonomy
    - Themes of dependency, vulnerability, incompetence

- Childhood interpersonal trauma (environmental)
  - Clear assoc → but **not as prevalent/extreme** as other dissociative d/o
  - **Emotional abuse/neglect** → most strongly + consistently associated
  - Other stressors
    - Physical abuse, witnessing domestic violence
    - Growing up with seriously impaired, mentally ill parent
    - Unexpected death or suicide of family member/close friend
    - Sexual abuse → much less common

Depersonalization/Derealization – Risk & Prognostic Factors

- Most common precipitants
  - **Severe stress** → interpersonal, financial, occupational
  - **Depression, anxiety** → esp panic attacks
  - **Illicit drug use**

- Drug use (specifically induce sx) → 15% of cases of disorder
  - **THC** (marijuana can precipitate panic attacks too simultaneously)
  - **Hallucinogens**
  - **Ketamine**
  - **MDMA**
  - **Salvia**

Depersonalization/Derealization – Culture-Related Issues

- May be part of **meditative practices** (volitionally induced)
  - Some may eventually lose control, develop fear + avoidance

Depersonalization/Derealization – Functional Consequences

- Highly distressing + major morbidity
  - **Appear affectively flattened w/ robotic demeanor**
    - Appears incongruent with extreme emotional pain
  - Experience interpersonal + occupational impairment, due to:
    - **Hypoemotionality** with others
    - Subjective difficulty **focusing + retaining** information
    - General **sense of disconnectedness** from life

Depersonalization/Derealization – Differential Diagnosis

- Illness anxiety disorder
- Major depressive disorder
- OCD
- Other dissociative disorders → cannot dx both
- Anxiety disorders
  - Depersonalization/derealization = **symptom of panic attack**
  - Do NOT dx → if only during panic attacks part of anxiety disorder
    - Can worsen as panic disorder progress/worsen
  - CAN dx → if very prominent from start, exceeding sx of actual panic attack
    - If continues after panic disorder remitted/treated
- Psychotic disorders
  - **Reality testing** → specifically about depersonalization/derealization
  - **Nihilistic delusions** → individual is dead, world not real
    - Whether individual knows is **true vs delusional** conviction

Depersonalization/Derealization – Differential Diagnosis

- Substance/mediation-induced disorders
  - 15% of all cases precipitated by substances
    - Marijuana, hallucinogens, ketamine, ecstasy, salvia
    - Usually become **phobic to triggering substance**, do not use again

- Mental disorders due to AMC
  - **Onset after age 40, atypical symptoms/course**
  - Medical + neurological evaluation
    - Labs, viral titres, EEG, vestibular/visual testing, sleep studies, imaging
  - Underlying seizure disorders
    - **Temporal lobe epilepsy** → MOST COMMON
    - May also be parietal lobe or frontal lobe epilepsy

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Depersonalization/Derealization – Comorbidity

- High lifetime comorbidity
  - **Unipolar depressive disorder**
  - **Any anxiety disorder**
  - Many with both
- Low comorbidity with PTSD
- Personality disorders (top 3)
  - **Avoidant**
  - **Borderline**
  - **OCPD**

Other Specified Dissociative Disorder

Other Specified Dissociative Disorder

- Does not meet any full criteria
- Clinician CHOOSES to specify reason

- Chronic + recurrent syndromes of mixed dissociative symptoms
  - Minor discontinuities in sense or self/agency, **no** dissociative amnesia
- Identity disturbance due to prolonged + intense coercive persuasion
  - Brainwashing, thought reform, indoctrination while captive, torture
  - Long-term political imprisonment, recruitment by sects/cults, terrorists
- Acute dissociative reactions to stressful events
  - Less than 1 month (may be few hours-days)
- Dissociative trance
  - Acute narrowing or complete loss of awareness of immediate surroundings
  - Profound unresponsiveness to environmental stimuli
  - May have minor stereotyped behaviors → unaware, not under control
  - May have transient paralysis, loss of consciousness

Unspecified Dissociative Disorder

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Unspecified Dissociative Disorder

- Does not meet any full criteria
- Clinician chooses NOT to specify reason