

# EGYPTIAN NATIONAL GUIDELINES FOR CHILD AND ADOLESCENT PSYCHIATRY

## Dissociative Disorders

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## Abbreviations

**AACAP:** American Academy of Child and Adolescent Psychiatry

**CBT:** Cognitive Behavioural Therapy

**DBT:** Dialectical Behaviour Therapy

**DD:** Dissociative Disorders

**DSM-5:** Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

**ECAPA:** Egyptian Child and Adolescent Psychiatry Association

**EMDR:** Eye Movement Desensitization and Reprocessing

**GDG:** Guideline Development Group

**GRADE:** Grading of Recommendations, Assessment, Development and Evaluation

**ICD-11:** International Classification of Diseases, 11th Edition

**ISSTD:** International Society for the Study of Trauma and Dissociation

**NGOs:** Non-Governmental Organizations

**PFA:** Psychological First Aid

**PTSD:** Post-Traumatic Stress Disorder

**TF-CBT:** Trauma-Focused Cognitive Behavioural Therapy

**WHO:** World Health Organization.

## Glossary

**Dissociation:** Disruptions in consciousness, memory, identity, or perception, often in response to trauma or overwhelming stress.

**Conversion Symptoms:** Neurological-like symptoms (e.g., paralysis, seizures) without a medical basis, arising from psychological stress.

**Trauma-Informed Care:** An approach that emphasizes safety, trust, and avoidance of re-traumatization while recognizing the impact of trauma on behaviour and emotions.

**Psychological First Aid (PFA):** Immediate, supportive, non-intrusive care offered after traumatic events to promote safety, stabilization, and coping.

**Stigma:** Negative social attitudes or beliefs toward individuals with dissociative symptoms, leading to discrimination or treatment delays.

**Regression:** A return to earlier developmental behaviors (e.g., bedwetting, baby talk, clinging) in response to psychological stress or trauma, commonly observed in younger children with dissociative symptoms.

**Trance-like State:** An altered state of consciousness characterized by unresponsiveness to the external environment, fixed staring, or automatic behaviors, often observed in dissociative presentations or after traumatic events.

## Executive Summary

These guidelines provide **evidence-based recommendations** for the assessment and management of **dissociative disorders in children and adolescents**. Dissociative disorders (DDs) are often misunderstood, underdiagnosed, and stigmatized, leading to delayed care and unnecessary suffering.

The recommendations emphasize:

- **Exclusion of medical/neurological conditions** before psychiatric diagnosis.
- **Comprehensive psychiatric assessment** incorporating trauma history, family context, and developmental needs.
- **Psychotherapy as first-line treatment**, delivered within a trauma-informed, family-inclusive framework.
- **Cautious use of medication only for comorbidities** such as depression or anxiety.
- **System-level supports** including anti-stigma interventions, psychoeducation, and clinician training.

The ultimate goal is to standardize care, reduce misdiagnosis, and improve outcomes for children and families across Egypt and similar contexts.

- **Comprehensive Medical and Neurological Assessment:**

Children and adolescents presenting with dissociative symptoms must undergo a comprehensive medical and neurological evaluation to exclude organic causes such as epilepsy, syncope, metabolic disorders, migraines, and central nervous system pathology. This step is essential to prevent misdiagnosis and inappropriate psychiatric labelling. **(Strong Recommendation)**

- **Comprehensive Psychiatric Assessment:** Following medical clearance, children and adolescents with suspected dissociative disorders should receive a comprehensive developmentally informed psychiatric assessment. This should integrate information from multiple sources (child, caregivers, teachers), include trauma and attachment history, family context, and comorbid psychiatric conditions. **(Strong Recommendation)**
- **Psychotherapy as First-Line:** The first-line treatment for dissociative disorders in children and adolescents is psychotherapy. Individual psychotherapy should be developmentally tailored and trauma-informed, incorporating techniques from cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT) skills adapted for youth, psychodynamic therapy, and/or attachment-focused interventions. Family therapy should also be integrated to strengthen caregiver and relational support. Psychoeducation for the child, caregivers, and schools is essential to reduce stigma and improve coping. **(Strong Recommendation)**

**Acute Stress and Conversion Symptoms (First Month Post-Trauma):**

For children and adolescents presenting with symptoms of dissociative (conversion) disorders within the first month after exposure to a potentially traumatic event, clinicians are not advised to initiate specialized psychological interventions, as evidence does not support their effectiveness. Instead, we advise that early management includes the following:

- Exclusion of physical and neurological causes
- Provision of Psychological First Aid (PFA) focusing on comfort, stabilization, and safety
- Psychoeducation for the child and caregivers, explaining that symptoms may occur after extreme stress
- Respectful, culturally appropriate engagement, including safe collaboration with traditional/community supports
- Avoidance of reinforcing secondary gain from symptoms. **(Conditional Recommendation)**

- **Pharmacological Management:** Pharmacological treatment is not indicated for dissociation itself in children and adolescents. Medications should only be considered for comorbid conditions such as depression, anxiety, or severe behavioral dysregulation. Benzodiazepines should be avoided, as they may worsen dissociative symptoms. (**Strong Recommendation**)

## Introduction

Dissociative disorders (DD) in children and adolescents are a complex group of psychiatric conditions marked by disruptions in consciousness, memory, identity, perception, and behaviour. These symptoms often develop as involuntary coping mechanisms in response to trauma or overwhelming stress, and they frequently impair a child's social, academic, and emotional functioning (1, 2). Although primarily psychological, dissociative symptoms may resemble or coexist with neurological or developmental conditions, making careful assessment and exclusion of physiological causes essential (2).

DDs may present early in life, sometimes from the age of three, and their manifestations can vary widely across developmental stages. In young children, symptoms may take the form of regression, trance-like episodes, or imaginary companions that appear unusually vivid or controlling. In school-aged children, dissociation may emerge through unexplained amnesia, abrupt changes in behaviour or identity, or somatic complaints without a medical basis. During adolescence, presentations often become more structured, with clearer episodes of amnesia, identity disturbance, depersonalization, derealization, or trance states (2, 3). Because presentation may overlap with normal developmental behaviour, careful attention to features that are inconsistent with developmental expectations—such as loss of control, memory gaps, or functional impairment—is essential for timely recognition. The ICD-11 framework identifies Dissociative Identity Disorder, Dissociative Amnesia, Depersonalization-Derealization Disorder, and trance or possession states as part of this spectrum (1).

These Egyptian Guidelines aim to provide practical recommendations for doctors working with children and adolescents. They recommend evidence-based and culturally

appropriate interventions, with particular focus on early recognition, accurate differentiation, and trauma-informed care. In Egypt, where family bonds and community traditions strongly shape children's development, clinicians should consider cultural meanings of distress and use family-engaged, school-linked pathways to ensure care that is both effective and respectful.

## Scope and Purpose

This chapter provides guidance on psychotherapeutic interventions for Dissociative disorders in children and adolescents to be used by policymakers, mental health professionals, and primary health care providers to offer better treatment strategies.

The objective of this chapter is to standardize practice to decrease variation of practice and improve outcomes for affected children and their families.

## Target Audience

This guideline targets child and adolescent psychiatrists, psychiatrists, general practitioners, mental health professionals (clinical psychologists, social workers), family physicians, pediatricians, policy makers, as well as non-governmental organizations (NGOs) and other stakeholders to offer the most appropriate treatment guidelines for children with reactive attachment disorder.

## Methodology

A comprehensive search for guidelines was undertaken to identify the most relevant guidelines to consider for adaptation.

Inclusion/ exclusion criteria were followed in the search and retrieval of guidelines to be adapted:

- Selecting only evidence-based guidelines (guidelines must include a report on systematic literature searches and explicit links between individual recommendations and their supporting evidence)
- Selecting only national and/or international guidelines
- Selecting peer-reviewed publications only

- Selecting guidelines written in the English language
- Excluding guidelines written by a single author, not on behalf of an organization, to be valid and comprehensive, a guideline ideally requires multidisciplinary input
- Excluding guidelines published without references, as the panel needs to know whether a thorough literature review was conducted and whether current evidence was used in the preparation of the recommendations

The following characteristics of the retrieved guidelines were summarized in:

- Developing organization/authors
- Date of publication, posting, and release
- Country/language of publication
- Date of posting and/or release
- Dates of the search used by the source guideline developers

All retrieved Guidelines were screened and appraised using AGREE II instrument ([www.agreetrust.org](http://www.agreetrust.org)) by at least three members. The panel decided on a cut-off point or ranked the guidelines (any guideline scoring above 50% on the rigor dimension was retained). The GDG decided to adapt the Guidelines for the management of conditions specifically related to stress by the WHO and the Guidelines of the International Society for the Study of Trauma and Dissociation (ISSTD) .<sup>4,7</sup>

### **Evidence assessment**

According to WHO Handbook for Guidelines, we used the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) approach to assess the quality of a body of evidence, develop and report recommendations. GRADE methods are used by WHO because they represent internationally agreed standards for making transparent recommendations. Detailed GRADE information is available on the following sites:

- GRADE working group: <https://www.gradeworkinggroup.org/>
- GRADE online training modules: <http://cebgrade.mcmaster.ca/>

Table 1 Quality and Significance of the four levels of evidence in GRADE:

Quality	Definition	Implications
High	The guideline development group is very confident that the true effect lies close to that of the estimate of the effect	Further research is very unlikely to change confidence in the estimate of effect
Moderate	The guideline development group is moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate
Low	Confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the true effect	Further research is very likely to have an important impact on confidence in the estimate of effect and is unlikely to change the estimate
Very low	The group has very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of the effect	Any estimate of effect is very uncertain

**Table 2 Factors that determine How to upgrade or downgrade the quality of evidence**

Downgrade in presence of	Upgrade in presence of
Study limitations -1 Serious limitations -2 Very serious limitations	Dose-response gradient +1 Evidence of a dose-response gradient
Consistency -1 Important inconsistency	Direction of plausible bias +1 All plausible confounders would have reduced the effect
Directness -1 Some uncertainty -2 Major uncertainty	Magnitude of the effect +1 Strong, no plausible confounders, consistent and direct evidence
Precision -1 Imprecise data	+2 Very strong, no major threats to validity and direct evidence
Reporting bias -1 High probability of reporting bias	

### **The strength of the recommendation**

The strength of a recommendation communicates the importance of adherence to the recommendation.

### **Strong recommendations**

With strong recommendations, the guideline communicates the message that the desirable effects of adherence to the recommendation outweigh the undesirable effects. This means that in most situations the recommendation can be adopted as policy.

### **Conditional recommendations**

These are made when there is greater uncertainty about the four factors above or if local adaptation should account for a greater variety in values and preferences, or when resource use makes the intervention suitable for some, but not for other locations. This means that there is a need for substantial debate and involvement of stakeholders before this recommendation can be adopted as policy.

### **When not to make recommendations**

When there is lack of evidence on the effectiveness of an intervention, it may be appropriate not to make a recommendation.

## Recommendations:

- **Comprehensive Medical and Neurological Assessment:**

Children and adolescents presenting with dissociative symptoms must undergo a comprehensive medical and neurological evaluation to exclude organic causes such as epilepsy, syncope, metabolic disorders, migraines, and central nervous system pathology. This step is essential to prevent misdiagnosis and inappropriate psychiatric labelling.

***Strong Recommendation***

**High Quality Evidence**<sup>2,4,5</sup>

- **Comprehensive Psychiatric Assessment**

Following medical clearance, children and adolescents with suspected dissociative disorders should receive a comprehensive developmentally informed psychiatric assessment. This should integrate information from multiple sources (child, caregivers, teachers), include trauma and attachment history, family context, and comorbid psychiatric conditions.

***Strong Recommendation***

**Moderate Quality Evidence** <sup>2,4,5</sup>

- **Psychotherapy as First-Line:** The first-line treatment for dissociative disorders in children and adolescents is psychotherapy. Individual psychotherapy should be developmentally tailored and trauma-informed, incorporating techniques from cognitive-behavioural therapy (CBT), dialectical behaviour therapy (DBT) skills adapted for youth, psychodynamic therapy, and/or attachment-focused interventions. Family therapy should also be integrated to strengthen caregiver and relational support. Psychoeducation for the child, caregivers, and schools is essential to reduce stigma and improve coping

***Strong Recommendation***

**High Quality Evidence** <sup>2,4,6</sup>

- **Acute Stress and Conversion Symptoms (First Month Post-Trauma):**

For children and adolescents presenting with symptoms of dissociative (conversion) disorders within the first month after exposure to a potentially traumatic event, clinicians are not advised to initiate specialized psychological interventions, as evidence does not support their effectiveness. Instead, we advise that early management includes the following:

- Exclusion of physical and neurological causes.
- Provision of Psychological First Aid (PFA) focusing on comfort, stabilization, and safety.
- Psychoeducation for the child and caregivers, explaining that symptoms may occur after extreme stress.
- Respectful, culturally appropriate engagement, including safe collaboration with traditional/community supports
- Avoidance of reinforcing secondary gain from symptoms.

***Conditional Recommendation***

**Very Low-Quality Evidence** <sup>7</sup>

- **Pharmacological Management:**

Pharmacological treatment is not indicated for dissociation itself in children and adolescents. Medications should only be considered for comorbid conditions such as depression, anxiety, or severe behavioural dysregulation. Benzodiazepines should be avoided, as they may worsen dissociative symptoms.

***Strong Recommendation***

**Moderate Quality Evidence** <sup>2,6</sup>

## Implementation Considerations

Several barriers may hinder the effective implementation and scale-up of these recommendations for dissociative disorders in children and adolescents:

- **Stigma and misinterpretation:** Families and schools may mislabel dissociative symptoms as behavioural problems or attention-seeking, which delays care.
- **Cultural beliefs:** In many settings, dissociation may be explained through spiritual or supernatural frameworks, leading families to seek non-medical care first.
- **Resource limitations:** There is a shortage of trained child psychiatrists, psychologists, and allied professionals skilled in trauma and dissociation.
- **Access inequities:** Rural areas and refugee populations often lack specialized services.
- **Financial constraints:** Psychotherapy and long-term care may not be accessible due to cost and specialized training gaps.

By addressing these barriers through awareness campaigns, training programs, tele-supervision, and integration of dissociation management into national child mental health policies, implementation can be strengthened.

## Research Needs

During the review of evidence and development of recommendations, several research gaps were identified for dissociative disorders in children and adolescents:

1. **Long-Term Effectiveness:** Conduct follow-up studies to evaluate the long-term outcomes of trauma-focused therapy, play therapy, family interventions, and attachment-based approaches.
2. **Tailoring Interventions:** Examine how personal traits (e.g., temperament), cultural factors, socioeconomic status, mental health literacy, and stigma influence treatment outcomes.
3. **Cost-Effectiveness:** Assess the economic impact of psychotherapeutic and adjunctive programs, weighing cost against clinical and functional improvements.
4. **Service Delivery Models:** Evaluate the effectiveness of tele-mental health and task-sharing models for dissociative disorders in resource-limited settings.

## Monitoring and Evaluating the Impact of the Guideline

**Potential indicators for evaluating the success of dissociative disorder interventions include:**

1. **Early Identification:** Equip GPs and non-specialist clinicians with the tools and confidence to recognize dissociative symptoms.
2. **Appropriate Referral Pathways:** Encourage timely referrals to specialized services, reducing delays in treatment.
3. **Reduction in Misdiagnosis:** Differentiate dissociative symptoms from other psychiatric or neurological conditions (e.g., epilepsy, psychosis, ADHD).
4. **Integrated Care:** Promote collaboration between GPs, psychiatrists, psychologists, pediatricians, and educators.
5. **Reducing Stigma**  
Raise awareness and provide education to reduce fear, shame, or misunderstanding about dissociative disorders. Reducing stigma helps people feel safer asking for help and improves their recovery.

## Update of the Guideline:

This guideline will be updated whenever there is new evidence

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## **Annex: Dissociative Disorders – DSM-5 and ICD-11 Criteria**

**Table 1: DSM-5 Dissociative Disorders (core criteria, summarized)**

### **1. Dissociative Identity Disorder (DID) Code 300.14**

- Disruption of identity with two or more distinct personality states (in some cultures described as possession).
- Discontinuity in sense of self and agency, with alterations in affect, behaviour, consciousness, memory, perception, cognition, or motor function.
- Recurrent gaps in recall of everyday events, important personal information, or traumatic events, inconsistent with ordinary forgetting.
- Symptoms cause clinically significant distress or impairment.
- Not a broadly accepted cultural/religious practice.
- Not attributable to a substance or another medical condition.

### **2. Dissociative Amnesia Code 300.12**

- Inability to recall important autobiographical information, usually traumatic or stressful, inconsistent with ordinary forgetting.
- Disturbance causes clinically significant distress or impairment.
- Not due to substances or medical/neurological conditions.
- Not better explained by DID, PTSD, acute stress disorder, somatic symptom disorder, or neurocognitive disorder.
- Specifier: with dissociative fugue – purposeful travel or wandering associated with amnesia.

### **3. Depersonalization/Derealization Disorder Code 300.6**

- Persistent or recurrent experiences of:
  - Depersonalization: feeling detached from one's mental processes or body.
  - Derealization: experiences of unreality or detachment from surroundings.
- Reality testing remains intact.
- Symptoms cause clinically significant distress or impairment.
- Not due to substances, medical conditions, or other mental disorders.

#### **4. Other Specified Dissociative Disorder (OSDD) Code 300.16**

- Symptoms cause significant distress/impairment but do not fully meet criteria for a specific dissociative disorder.
- Clinician specifies the presentation (e.g., chronic mixed dissociative symptoms, identity disturbance without overt switching, dissociative trance).

#### **5. Unspecified Dissociative Disorder (UDD) Code 300.15**

- Symptoms characteristic of a dissociative disorder that cause distress/impairment but do not meet full criteria for a specific disorder.
- Used when clinician chooses not to specify, or insufficient information is available.

*Adapted from:* American Psychiatric Association (8).

**Table 2: ICD-11 Dissociative Disorders (6B codes)**

#### **6B64 Dissociative Identity Disorder**

- Characterized by two or more distinct personality states with discontinuity in sense of self and agency.
- Recurrent episodes of amnesia for everyday events, personal information, or traumatic events.
- Not explained by cultural or religious practices.
- Causes significant distress or impairment.

#### **6B61 Dissociative Amnesia**

- Inability to recall important autobiographical information, usually of a traumatic or stressful nature, inconsistent with ordinary forgetting.
- May present as localized, selective, or generalized amnesia.
- May include purposeful travel or wandering (fugue).
- Causes significant distress or impairment, not attributable to substances or neurological/medical conditions.

#### **6B66 Depersonalization-Derealization Disorder**

- Persistent or recurrent experiences of depersonalization, derealization, or both.
- Reality testing remains intact.

- Causes significant distress or impairment.
- Not explained by another medical or mental condition.

#### **6B60 Dissociative Neurological Symptom Disorder (Functional Neurological Disorder)**

- Altered voluntary motor or sensory function (e.g., paralysis, convulsions, anesthesia, sensory loss) inconsistent with recognized neurological or medical disease.
- Symptoms not explained by another mental/medical disorder.
- Causes significant distress, impairment, or warrants medical evaluation.

#### **6B6Y Other Specified Dissociative Disorder**

- Clinical presentations where dissociative symptoms cause distress/impairment but do not fully meet criteria for another specific disorder.
- Clinician specifies the reason (e.g., partial symptoms).

#### **6B6Z Dissociative Disorder, unspecified**

- Dissociative symptoms causing significant distress/impairment but insufficient information to make a more specific diagnosis.

#### **6B62 Trance Disorder**

- Characterized by trance states in which there is marked alteration in the individual's state of consciousness or a loss of the individual's customary sense of personal identity, in which the individual experiences a narrowing of immediate surroundings or unusual narrowing or selective focus on environmental stimuli. The trance state is involuntary and unwanted and is not accepted as a part of collective or religious practice.

*Adapted from:* International Classification of Diseases 11th Revision (1).