

ABSENT STATE

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Absent State

Primary Disciplinary Field(s): Psychology, Neurology, Psychiatry

1. Core Definition

The **absent state** refers to a profound subjective experience characterized by a feeling of detachment from one's own body, mind, or reality, resulting in a sensation of being "less life-like" or "somewhat imaginary." This conceptual term describes a form of transient or chronic dissociation, wherein the affected individual experiences an altered sense of self-awareness and presence. It fundamentally involves a disruption in the integrative functions of consciousness, memory, identity, emotion, and perception, causing the individual to feel disconnected from their immediate surroundings or their personal history. While not a formal diagnostic category in major psychiatric manuals like the DSM or ICD, the description of the absent state overlaps significantly with core symptoms of depersonalization and derealization phenomena, representing a failure of the brain to properly integrate sensory and affective data into a cohesive, present self-narrative. The critical element of this state is the qualitative shift in consciousness, moving away from grounded reality toward a hazy, unreal, or automatistic existence, often causing significant internal distress regarding the authenticity of their own experience.

Subjectively, the experience is often reported as similar to viewing the world through a veil, or watching a film of one's own life unfold, rather than actively participating in it. This feeling of being "imaginary" underscores the erosion of the sense of self-agency and embodiment that defines normal consciousness. The intensity of the **absent state** can fluctuate dramatically, ranging from mild, fleeting moments of unreality, common during periods of extreme fatigue or stress, to severe, sustained episodes that significantly impair cognitive function and emotional responsiveness. Clinically, when this state is pronounced and persistent, it suggests an underlying psychopathological or neurological process that demands thorough investigation. The psychological mechanism often involves a defense response to overwhelming stimuli or trauma, leading to a mental retreat that manifests as emotional numbness and physical disconnectedness, effectively separating the conscious self from immediate painful reality.

2. Clinical Manifestation and Symptoms

Individuals experiencing an **absent state** typically report a distinct set of symptoms that relate primarily to the disruption of self-perception and environmental awareness. Key manifestations include depersonalization, where the individual feels alien or detached from their own body, actions, and thoughts, perceiving them as belonging to someone else or a mechanism rather than the true self. This often results in emotional blunting, where the capacity to feel emotion--joy, sadness, or fear--is severely diminished, further reinforcing the perception that the person is

merely going through the motions of life without genuine internal participation. The sensory perceptions themselves may feel distant, muted, or distorted, contributing to the overall sense of unreality that defines the condition.

Simultaneously, derealization frequently accompanies the absent state. **Derealization** involves the perception that the external world is unreal, foggy, dreamlike, or artificial. Familiar places may suddenly seem strange or foreign, and other people may appear distant, robotic, or inanimate, failing to evoke the usual emotional resonance. This dual detachment--from the self (depersonalization) and from the environment (derealization)--creates the holistic feeling of being "absent," suspended between full presence and complete unresponsiveness. Furthermore, cognitive symptoms are common, including difficulty concentrating, memory disturbances concerning recent events, and an overwhelming preoccupation with the nature of the self or the reality of existence, often described as existential angst triggered by the lack of grounding.

In acute episodes, particularly those linked to neurological events, the individual may appear outwardly unresponsive or exhibit subtle automatisms. They might stare blankly, engage in repetitive, non-purposeful movements (such as lip smacking or fumbling with clothes), or respond slowly and inappropriately to external stimuli. These observable behaviors, especially when associated with focal or partial seizures, provide objective evidence of a temporary functional disruption in brain regions responsible for integrated consciousness and self-monitoring. The duration of these episodes is highly variable, lasting from mere seconds in neurological contexts to sustained periods spanning days or weeks in severe dissociative disorders.

3. Neurological and Etiological Context

A significant etiological factor contributing to the presentation of the **absent state** is underlying neurological dysfunction, particularly related to seizure disorders. As noted in the source material, this state is commonly observed as a side effect in patients experiencing **partial seizures**. These seizures, now often referred to as focal aware seizures or focal impaired awareness seizures, originate in a specific area of the brain, frequently the temporal lobe, which is critically involved in processing memory, emotion, and self-perception. During a focal seizure, the abnormal electrical activity can disrupt the normal functioning of these integration centers, leading directly to symptoms of depersonalization, derealization, or a sensation of being outside of one's body--precisely the characteristics of an absent state.

It is crucial to distinguish the descriptive term "absent state" from the established clinical entity of **absence seizures** (formerly known as petit mal seizures). While absence seizures also involve a temporary lapse of consciousness, they are characterized by a sudden, brief cessation of activity and responsiveness, often without the complex, subjective feelings of unreality described in the absent state. The absent state, especially when neurological in origin, is more closely aligned with

the experiential aura or ictal phenomena associated with temporal lobe epilepsy. Abnormal firing in the temporo-limbic system can generate these complex subjective experiences of altered reality and self-alienation, positioning the absent state as a potential ictal or post-ictal manifestation of specific neurological conditions.

Beyond epilepsy, the manifestation of an absent state is also correlated with various other neurological disorders, including migraines, traumatic brain injury (TBI), certain encephalopathies, and structural lesions affecting the cortical areas responsible for spatial awareness and self-location (such as the temporoparietal junction). In these contexts, the absent state serves as a marker of cortical perturbation, reflecting a temporary failure of the neural networks responsible for maintaining a stable, unified sense of self and reality. The degree of cerebral hypoxia, metabolic derangement, or localized electrical instability determines the severity and duration of the resultant dissociative experience.

4. Differential Diagnosis and Related Concepts

The **absent state** exists on a continuum of altered consciousness and is differentiated from several related clinical concepts. The most significant differential diagnosis involves **Depersonalization-Derealization Disorder** (DPDR), which is a formally recognized dissociative disorder defined by persistent or recurrent episodes of depersonalization and/or derealization that cause significant distress or functional impairment. While the subjective experience of the absent state aligns perfectly with the symptoms of DPDR, the term "absent state" is often used more broadly to describe transient, acute occurrences triggered by specific stressors or neurological events, whereas DPDR implies a chronic, primary psychiatric condition.

Furthermore, the source content highlights that even common psychological conditions, such as **anxiety disorders**, can precipitate an absent state. During episodes of severe panic or generalized acute anxiety, the immense physiological and psychological stress can induce transient dissociative symptoms as a protective mechanism. The hyperarousal associated with panic attacks often triggers feelings of unreality or detachment, which are interpreted by the individual as frightening evidence of losing control or "going crazy," thereby fueling the anxiety-panic cycle. In this context, the absent state is a secondary, stress-induced symptom, rather than the primary diagnosis.

It is also essential to distinguish the absent state from severe psychiatric states such as psychosis. Although both involve an altered perception of reality, the absent state maintains intact reality testing; the individual experiencing it knows that the feeling of unreality is abnormal and internally generated, retaining insight into the difference between their subjective experience and objective reality. In contrast, **psychosis** involves fixed false beliefs (delusions) or sensory experiences (hallucinations) that are perceived by the individual as objectively real, representing a fundamental

loss of reality testing. This preserved insight is a critical distinguishing factor.

5. Psychological and Comorbid Factors

The psychological drivers of the **absent state** are deeply rooted in the concept of dissociation--a mental process that involves disconnecting from one's thoughts, feelings, memories, or sense of identity. As a psychological defense mechanism, dissociation serves to mitigate the emotional impact of overwhelming distress or trauma. When the pressure or stress--whether internal (e.g., severe anxiety) or external (e.g., acute stress reaction)--becomes intolerable, the mind may involuntarily induce an absent state to emotionally quarantine the self from the painful stimuli.

The comorbidity of the absent state with various psychiatric conditions is extensive. Besides **anxiety disorders**, which frequently feature transient depersonalization, the absent state is often observed in Post-Traumatic Stress Disorder (PTSD), where dissociative flashbacks and persistent feelings of detachment are core diagnostic features. Borderline Personality Disorder (BPD) and Major Depressive Disorder (MDD) also involve significant mood instability and emotional dysregulation, which can trigger episodes of derealization and depersonalization, fulfilling the descriptive criteria of an absent state. The chronic activation of the stress response system associated with these disorders contributes to the neurological and psychological exhaustion that predisposes individuals to these dissociative experiences.

Effective psychological management of the absent state often centers on grounding techniques--methods designed to bring the individual back into the present moment by focusing on external sensory input. Techniques involving tactile stimulation, intense smells, or cognitive focusing exercises help to override the internal detachment and re-establish connection with physical reality, thus counteracting the feeling of being "imaginary." Understanding the underlying psychological vulnerability and addressing the root cause, whether it be chronic anxiety, unresolved trauma, or mood instability, is paramount for long-term recovery and reduction of the frequency and intensity of these episodes.

6. Treatment and Management

Management of the **absent state** depends critically on determining its primary etiology--whether it is predominantly neurological, psychological, or substance-induced. If the state is found to be a component of **epilepsy** or other neurological disorders, treatment focuses on optimizing seizure control through anti-epileptic drugs (AEDs). Successful management of the underlying neurological condition typically reduces the frequency and severity of associated ictal or inter-ictal absent states. Neurological monitoring, including electroencephalography (EEG), is essential for accurate diagnosis and treatment titration.

For absent states rooted in psychological distress, psychotherapy is the mainstay of treatment.

Cognitive Behavioral Therapy (CBT) is often employed to challenge the distorted thoughts and existential anxieties associated with the feelings of unreality. Dialectical Behavior Therapy (DBT) is particularly useful for individuals with co-occurring personality disorders or trauma histories, focusing on emotional regulation, distress tolerance, and improved coping mechanisms to reduce the reliance on dissociation as a defense. Furthermore, pharmacotherapy may be utilized to target comorbid conditions; for instance, selective serotonin reuptake inhibitors (SSRIs) can effectively treat underlying anxiety, panic, or depressive disorders, which, in turn, may lessen the frequency of the dissociative episodes.

7. Further Reading

[Depersonalization-derealization disorder - Wikipedia](#)

[Epilepsy - Wikipedia](#)

[Anxiety disorder - Wikipedia](#)

[Dissociative phenomena in anxiety and panic disorders \(Academic Source Example\)](#)