Old and New Derangements

Table of Contents

Legacy Articles from Sanguinus Curae (1999-2010)

About This Resource

presented by
Kismet's World of Darkness

Layout by Kismet Rose

File -> Download or Make a copy will allow you to save your own copy.
View -> Show document outline or use the table of contents to navigate.

Thank you for reading and supporting my work, and happy gaming to you!

Derangements

by Kismet Rose

In the World of Darkness, anyone can go mad, and given the horrible things that go on in the night, a lot of people see and do things that cause their minds to reel. Sometimes, sanity simply breaks down and derangements are the result of a strain too great to bear. Other times, the mind bends in order to protect itself and has difficulty healing. But stress and genetics are not the only causes of mental illness. For some beings, madness is magically induced and forced upon them. It is whispered that some creatures embrace lunacy when they give themselves over to the service of infernal beings and other creatures from beyond.

Derangements are not meant to completely and continually disable a character; if they do, chances are the player will have a deeply dissatisfying experience. In most cases, afflicted characters should have periods of calm and normality. The trouble with derangements is that their symptoms keep coming back and tend to show up at inconvenient times or in inconvenient ways. Some derangements, like delusions of grandeur, are ongoing problems with perception and thus are the status quo: most times, the character knows they're the best, but every now and then, they find out they're not.

Derangements are meant to add struggles and nuances to character, as well as opportunities for deeper roleplaying, but they must be used carefully. It is generally a bad idea for Storytellers to simply choose derangements for player characters without consulting them first. Some players might not feel they are able to play certain illnesses, or they might be opposed to or disinterested in the idea. Those who have had difficult personal experiences with mental illness might want nothing to do with such things when they game. Players might also be disturbed if derangements are treated casually or disrespectfully. Players and Storytellers should work together to choose derangements that will not throw the game into chaos or give all of the spotlight to one player, so the entire group will have fun.

Derangements have been replaced by Conditions in the latest iteration of the World of Darkness, but they can easily be converted into Conditions if the Storyteller and players want something different.

Below, I have compiled a list of derangements from as many books as I could. I have given the name of the derangement, the name of the book where it can be found, and the relevant page numbers. Some derangements, like paranoia, were printed in multiple books. When I have found a derangement in more than one place, I have noted it. For example, amnesia showed up in three places and is listed three times, each time with different book information. These derangements can be used for just about any character, whether Kindred or not, but some are specifically tailored for vampires or ghouls. Although a player can work with their Storyteller to make up a unique derangement, those listed in the books are there to help.

New World of Darkness Derangements

A full list of derangements, with brief descriptions and locations, can be found at WoD Codex.

Old World of Darkness V:tM Derangements

Derangement	Book	Page #
Amnesia (I)	V:tM 2nd	202-203
Amnesia (II)	V:tDA	204-205
Amnesia (III)	Book Wyrm 1st	25
Animalistic Hysteria	Ghouls	26-28
Berserk	Guide Sabbat	161-163
Berserker	Book Wyrm 1st	25
Blood Sweats	Guide Sabbat	161-163
Bulimia	V:tM 3rd edition	222-224
Choromania	Book Wyrm 1st	25
Compulsion (I)	V:tM Player's 2nd	35
Compulsion (II)	Libellus 4	107-108
Delusions of Grandeur (I)	V:tM 2nd	202-203

Delusions of Grandeur (II)	V:tDA	204-205
Delusions of Grandeur (III)	Book Wyrm 1st	25
Dependent Personality Disorder	Ghouls	26-28
Desensitization	Malkavian (rev)	55-58
Disassociative Blood Spending	Malkavian (rev)	55-58
Fantasy (I)	V:tM 2nd	202-203
Fantasy (II)	V:tDA	204-205
Fits	V:tM Player's 2nd	35
Fugue	V:tM 3rd edition	222-224
Gluttony	Guide Sabbat	161-163
Habromania	Book Wyrm 1st	25
Hallucinations	Book Wyrm 1st	25
Hierarchical Sociology Disorder^	Tremere (rev)	68-69
Homocidal	Book Wyrm 1st	25
Hysteria	V:tM 3rd edition	222-224
Insecure	Book Wyrm 1st	25
Klazomania	Book Wyrm 1st	25
Lunacy	Libellus 4	107-108
Manic	Book Wyrm 1st	25
Manic-Depression (I)	V:tM 2nd	202-203
Manic-Depression (II)	V:tM 3rd edition	222-224
Masochism (I)	Book Wyrm 1st	25
Masochism (II)	Malkavian (rev)	55-58
Megalomania (I)	Libellus 4	107-108
Megalomania (II)	V:tM 3rd edition	222-224
Melancholia	V:tDA	204-205
Memory Lapses	Malkavian (rev)	55-58

Misomania	Book Wyrm 1st	25
Multiple Personalities (I)	V:tDA	204-205
Multiple Personalities (II)	Book Wyrm 1st	25
Multiple Personalities (III)	V:tM 3rd edition	222-224
Nymphomania/Satyriasis	Guide Sabbat	161-163
Obsession (I)	V:tM 2nd	202-203
Obsession (II)	V:tM Player's 2nd	35
Obsession (III)	V:tDA	204-205
Obsession (IV)	Book Wyrm 1st	25
Obsessive/Compulsive	V:tM 3rd edition	222-224
Overcompensation (I)	V:tM 2nd	202-203
Overcompensation (II)	V:tDA	204-205
Overcompensation (III)	Book Wyrm 1st	25
Overcompensation (IV)	Guide Sabbat	161-163
Paranoia (I)	V:tM 2nd	202-203
Paranoia (II)	V:tDA	204-205
Paranoia (III)	Book Wyrm 1st	25
Paranoia (IV)	V:tM 3rd edition	222-224
Perfection (I)	V:tM 2nd	202-203
Perfection (II)	V:tDA	204-205
Phagomania*	Book Wyrm 1st	25
Phobia (I)	V:tM Player's 2nd	35
Phobia (II)	Book Wyrm 1st	25
Phobia (III)	Guide Sabbat	161-163
Power-Object Fixation	Malkavian (rev)	55-58
Regression (I)	V:tM 2nd	202-203

Regression (II)	V:tDA	204-205
Regression (III)	Malkavian (rev)	55-58
Sadism	Book Wyrm 1st	25
Sanguinary Animism	V:tM 3rd edition	222-224
Sanguinary Cryptophagy^	Tremere (rev)	68-69
Schizophrenia	V:tM 3rd edition	222-224
Self-Annihilation Impulse	Malkavian (rev)	55-58
Self-Defeating Personality Disorder	Ghouls	26-28
Severe Dysmenorrheic Psychosis (SDP)**	Ghouls	26-28
Synesthesia	Malkavian (rev)	55-58
Thaumaturgical Glossolalia^	Tremere (rev)	68-69
Visions	Libellus 4	107-108

Real Derangements

by: Belladonna A Legacy Article from Sanguinus Curae

Playing derangements can be a tricky business, and there is little guide to be found for acting insane (at least none that can be trusted - who said that?). A well-played derangement can add spice and realism to your portrayals, so here are more than twenty real derangements with their clinical definitions and behavioral symptoms.

Acute Stress Disorder

The person has been exposed to a traumatic event in which both of the following were present:

- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person's response involved intense fear, helplessness, or horror
- Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
- a subjective sense of numbing, detachment, or absence of emotional responsiveness
- a reduction in awareness of his or her surroundings (e.g., "being in a daze")
- derealization
- depersonalization
- dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggeratedstartle response, motor restlessness).

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

Adjustment Disorder

The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

These symptoms or behaviors are clinically significant as evidenced by either of the following:

- marked distress that is in excess of what would be expected from exposure to the stressor
- significant impairment in social, occupational or educational functioning

Agoraphobia

Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.

Bereavement

A reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as "normal," although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement vary considerably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present 2 months after the loss.

However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include:

- guilt about things other than actions taken or not taken by the survivor at the time of the death
- thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person
- morbid preoccupation with worthlessness
- marked psychomotor retardation
- prolonged and marked functional impairment
- hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.

Brief Psychotic Disorder

Presence of one (or more) of the following symptoms:

- delusions
- hallucinations
- disorganized speech (e.g., frequent derailment or incoherence)
- grossly disorganized or catatonic behavior

Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

Delusional Disorder

This disorder is characterized by the presence of non-bizarre delusions which have persisted for at least one month. Non-bizarre delusions typically are beliefs of something occurring in a person's life which is not out of the realm of possibility. For example, the person may believe their significant other is cheating on them, that someone close to them is about to die, a friend is really a government agent, etc. All of these situations could be true or possible, but the person suffering from this disorder knows them not to be (e.g., through fact-checking, third-person confirmation, etc.).

People who have this disorder generally don't experience a marked impairment in their daily functioning in a social, occupational or other important setting. Outward behavior is not noticeably bizarre or objectively characterized as out-of-the-ordinary.

Depersonalization Disorder

Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).

During the depersonalization experience, reality testing remains intact. The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Dissociative Amnesia

The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

Dissociative Fugue

The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.

Confusion about personal identity or assumption of a new identity (partial or complete).

Dissociative Identity Disorder (Formerly known as Multiple Personality Disorder)

The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

At least two of these identities or personality states recurrently take control of the person's behavior.

Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

Exhibitionism

Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger.

Fetishism

Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).
The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).

Frotteurism

Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person.

Gender Identity Disorder

A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

The disturbance is manifested by symptoms such as:

- a stated desire to be the other sex
- frequent passing as the other sex
- desire to live or be treated as the other sex
- or the conviction that he or she has the typical feelings and reactions of the other sex
- persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex · preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

Editorial note: This article was written long ago and is based on a prior version of the DSM; the latest version classifies this as Gender Dysphoria. It is considered a disorder when it is significantly distressing and disruptive, generally for an extended period. Gender nonconformity, however, is *not* classified as a disorder.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day. It's chronic and exaggerated worry and tension, even though nothing seems to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work. Sometimes, though, the source of the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

People with GAD can't seem to shake their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. People with GAD also seem unable to relax. They often have trouble falling or staying asleep. Their worries are accompanied by physical symptoms, especially trembling, twitching, muscle tension, headaches, irritability, sweating, or hot flashes. They may feel lightheaded or out of breath. They may feel nauseated or

have to go to the bathroom frequently. Or they might feel as though they have a lump in the throat.

Many individuals with GAD startle more easily than other people. They tend to feel tired, have trouble concentrating, and sometimes suffer depression, too.

Usually the impairment associated with GAD is mild and people with the disorder don't feel too restricted in social settings or on the job. Unlike many other anxiety disorders, people with GAD don't characteristically avoid certain situations as a result of their disorder. However, if severe, GAD can be very debilitating, making it difficult to carry out even the most ordinary daily activities.

GAD comes on gradually and most often hits people in childhood or adolescence, but can begin in adulthood, too. It's more common in women than in men and often occurs in relatives of affected persons. It's diagnosed when someone spends at least 6 months worried excessively about a number of everyday problems.

Intermittent Explosive Disorder

Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.

The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating stimuli.

Kleptomania

Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.

Increasing sense of tension immediately before committing the theft. Pleasure, gratification, or relief at the time of committing the theft.

Obsessive-Compulsive Disorder

Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
2. the thoughts, impulses, or images are not simply excessive worries about real-life problems
3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

1. repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
2. the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

Panic Disorder

People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. They can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike. In between times there is a persistent, lingering worry that another attack could come any minute.

When a panic attack strikes, most likely your heart pounds and you may feel sweaty, weak, faint, or dizzy. Your hands may tingle or feel numb, and you might feel flushed or chilled. You may have chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control. You may

genuinely believe you're having a heart attack or stroke, losing your mind, or on the verge of death. Attacks can occur any time, even during nondream sleep. While most attacks average a couple of minutes, occasionally they can go on for up to 10 minutes. In rare cases, they may last an hour or more. Panic disorder strikes between 3 and 6 million Americans, and is twice as common in women as in men. It can appear at any age--in children or in the elderly--but most often it begins in young adults. Not everyone who experiences panic attacks will develop panic disorder-- for example, many people have one attack but never have another. For those who do have panic disorder, though, it's important to seek treatment. Untreated, the disorder can become very disabling.

Panic disorder is often accompanied by other conditions such as depression or alcoholism, and may spawn phobias, which can develop in places or situations where panic attacks have occurred. For example, if a panic attack strikes while you're riding an elevator, you may develop a fear of elevators and perhaps start avoiding them.

Some people's lives become greatly restricted -- they avoid normal, everyday activities such as grocery shopping, driving, or in some cases even leaving the house. Or, they may be able to confront a feared situation only if accompanied by a spouse or other trusted person. Basically, they avoid any situation they fear would make them feel helpless if a panic attack occurs. When people's lives become so restricted by the disorder, as happens in about one-third of all people with panic disorder, the condition is called agoraphobia. A tendency toward panic disorder and agoraphobia runs in families. Nevertheless, early treatment of panic disorder can often stop the progression to agoraphobia.

Posttraumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is a debilitating condition that follows a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. PTSD, once referred to as shell shock or battle fatigue, was first brought to public attention by war veterans, but it can result from any number of traumatic incidents. These include kidnapping, serious accidents such as car or train wrecks, natural disasters such as floods or earthquakes, violent attacks such as a mugging, rape, or torture, or being held captive. The event that triggers it may be something that threatened the person's

life or the life of someone close to him or her. Or it could be something witnessed, such as mass destruction after a plane crash.

Whatever the source of the problem, some people with PTSD repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They may also experience sleep problems, depression, feeling detached or numb, or being easily startled. They may lose interest in things they used to enjoy and have trouble feeling affectionate. They may feel irritable, more aggressive than before, or even violent. Seeing things that remind them of the incident may be very distressing, which could lead them to avoid certain places or situations that bring back those memories. Anniversaries of the event are often very difficult.

PTSD can occur at any age, including childhood. The disorder can be accompanied by depression, substance abuse, or anxiety. Symptoms may be mild or severe--people may become easily irritated or have violent outbursts. In severe cases they may have trouble working or socializing. In general, the symptoms seem to be worse if the event that triggered them was initiated by a person--such as a rape, as opposed to a flood.

Ordinary events can serve as reminders of the trauma and trigger flashbacks or intrusive images. A flashback may make the person lose touch with reality and reenact the event for a period of seconds or hours or, very rarely, days. A person having a flashback, which can come in the form of images, sounds, smells, or feelings, usually believes that the traumatic event is happening all over again.

Not every traumatized person gets full-blown PTSD, or experiences PTSD at all. PTSD is diagnosed only if the symptoms last more than a month. In those who do have PTSD, symptoms usually begin within 3 months of the trauma, and the course of the illness varies. Some people recover within 6 months, others have symptoms that last much longer. In some cases, the condition may be chronic.

Occasionally, the illness doesn't show up until years after the traumatic event.

Social Phobia

Social phobia is an intense fear of becoming humiliated in social situations, specifically of embarrassing yourself in front of other people. It often runs in families and may be accompanied by depression or alcoholism. Social phobia often begins around early adolescence or even younger.

If you suffer from social phobia, you tend to think that other people are very competent in public and that you are not. Small mistakes you make may seem to you much more exaggerated than they really are. Blushing itself may seem painfully embarrassing, and you feel as though all eyes are focused on you. You may be afraid of being with people other than those closest to you. Or your fear may be more specific, such as feeling anxious about giving a speech, talking to a boss or other authority figure, or dating. The most common social phobia is a fear of public speaking. Sometimes social phobia involves a general fear of social situations such as parties. More rarely it may involve a fear of using a public restroom, eating out, talking on the phone, or writing in the presence of other people, such as when signing a check.

Although this disorder is often thought of as shyness, the two are not the same. Shy people can be very uneasy around others, but they don't experience the extreme anxiety in anticipating a social situation, and they don't necessarily avoid circumstances that make them feel self-conscious. In contrast, people with social phobia aren't necessarily shy at all. They can be completely at ease with people most of the time, but particular situations, such as walking down an aisle in public or making a speech, can give them intense anxiety. Social phobia disrupts normal life, interfering with career or social relationships. For example, a worker can turn down a job promotion because he can't give public presentations. The dread of a social event can begin weeks in advance, and symptoms can be quite debilitating.

People with social phobia are aware that their feelings are irrational. Still, they experience a great deal of dread before facing the feared situation, and they may go out of their way to avoid it. Even if they manage to confront what they fear, they usually feel very anxious beforehand and are intensely uncomfortable throughout. Afterwards, the unpleasant feelings may linger, as they worry about how they may have been judged or what others may have thought or observed about them.

Trichotillomania

Recurrent pulling out of one's hair resulting in noticeable hair loss.
An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior.

Pleasure, gratification, or relief when pulling out the hair.

Voyeurism

Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

Legacy Articles from Sanguinus Curae (1999-2010)

Sanguinus Curae started in 1999 as a gathering place for articles about the old World of Darkness and Vampire: the Masquerade, in particular. The site was the brainchild of Belladonna and Benedira (a.k.a. the Bloodsisters), and it started with their excellent sense of taste and their well-written content. From there, it grew with user submissions and quickly became the kind of resource I wanted my own gaming site to be. Their sleek presentation and meaty articles set the bar high - just the way I liked it. Their performance enhanced mine.

They say that you don't know what you've got till it's gone, but that's not always the case. I kept an eye on Sanguinus Curae over the years and was glad to be able to refer to it. As World of Darkness web sites seemed to dwindle away and links started to go dead, it reassured me to see an old internet neighbor was still kicking. Imagine my surprise and dismay on New Year's Day, 2010 -not long after the stroke of midnight - when I went to look something up and found that Sanguinus Curae had shut its doors. Being a Hitchhiker's Guide fan, I knew that "So long, and thanks for all the fish!" was final. So the first thing I did was send an email, because I didn't want their work to fade away from the internet.

And imagine my happy surprise when I was able to get permission from Belladonna and Benedira to repost their considerable content here! It took more time than I'd hoped, but I was able to integrate all of their articles and I was proud to put my own work among them. I have edited the Sanguinus files for basic spelling, grammar, and readability issues, as well as what's needed to weave them into the style of this site. I have left their author information intact. I am thrilled to be able to keep their work available and I hope you will enjoy reading it.

Just recently, I was reminded that Sanguinus Curae once offered HTML character sheets for Masquerade that were sleek and well-loved. When asked if I had them, I found that I did but that they had been misplaced in a distant folder so they hadn't been uploaded here. I have made them available at last to complete the archive and to inspire people to post their characters proudly, in whatever fashion they wish.

I will never claim to have created anything that I did not make. I respect the people who were behind Sanguinus too much for that. I left links to the old email addresses of the authors whenever I had them; you can always see if those addresses still work. If you wish to send questions to me, please do, but if I don't have the answer I will let you know.