DEPERSONALIZATION-DEREALIZATION SYNDROME

Depersonalization

- Persistent or recurrent experiences of feeling detached from one's mental processes or body, as if an observer
- Depersonalization causes significant distress or impairment in social, occupational, or other functioning
- During the experience of depersonalization, reality testing remains intact, one is aware of his/her experiences are unusual
- The depersonalization experience does not occur during the course of another mental disorder and is not due to the physiological effects of a substance or a general medication

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Depersonalization vs. Derealization

- Depersonalization refers to an altered perception of oneself.
- Derealization refers to alteration of the environment as it is perceived.

Cont.

- In the case of **depersonalization**, the individual may feel detached from his or her entire being
- (e.g., "I am no one," "I have no self").
- He or she may also feel subjectively detached from aspects of the self, including feelings (e.g., hypoemotionality: "I know I have feelings but I don't feel them"),
- thoughts (e.g., "My thoughts don't feel like my own," "head filled with cotton"), whole body or body parts, or sensations (e.g., touch, proprioception, hunger, thirst, libido).
- There may also be a diminished sense of agency (e.g., feeling robotic, like an automaton; lacking control of one's speech or movements).

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Derealization is described as the experience of the external world as strange or unreal.

(e.g.one's vision may be distorted so that objects appear larger or smaller than they really are,

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- objects in the environment may seem like they are somehow not the same as they are known to be,

- as though they are not the right size/shape, or alien in some other way).

Desomatisation

- Diminution, loss or alteration of bodily sensations, sense of disembodiment; there may be a raised pain threshold

Epidemiology

- Depersonalisation may occur as a transient phenomenon in healthy individuals, particularly in the context of fatigue, during or after intoxication with alcohol and/or drugs, or in situations involving serious danger
- May affect 1–2% of the general population
- Gender ratio of about 1:1
- Depersonalisation might be the third most common psychiatric symptom after anxiety and low mood. (Stewa
- rt, 1964; Simeon *et al*, 1997)

Etiology

- **Neurological factors-**neuroimaging and psychophysiological studies have found objective evidence of an abnormal response to emotional stimuli, consistent with patients' reports of loss of emotional reactivity.
- The neural substrate for the 'shutting down' of emotional responses is hypothesised to be a combination of prefrontal regions inhibiting limbic areas (particularly the amygdala) and reciprocal actions of the right dorsolateral prefrontal cortex and anterior cingulate cortex

CONT

- The anterior cingulate cortex is thought to play an important role in the regulation of normal emotional responses

Endocrinology

- Endocrine studies of patients with depersonalisation have found a striking negative correlation between severity of depersonalisation
- there are conflicting data on the relationship between depersonalisation and cortisol levels
- two studies reporting low salivary cortisol, but another finding raised plasma cortisol (Morozova *et al*, 2000; Stanton *et al*, 2001)

Symptoms

Main Feelings of Depersonalization

- *"Auto-pilot"* - one may feel as if an unknown force has taken control of their body and that their body acts independently of their brain.
- *Mental and Emotional Numbing* -Individuals with DPD report that they use a limited percentage of their brain during daily activities or that they do not feel any true emotional connection in their relationships, even to their spouse or children.
- *"Gone Blank"* - Individuals with DPD may have difficulty concentrating, their thoughts may be jumbled or confused, or they may have difficulty retaining new information.

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- Individuals with DPD may describe their feelings and thoughts as “foggy,” “fuzzy,” “numb,” or “dream-like.”
- They often say that they feel as though they are out of their own bodies, disconnected from their actions or feelings,
- People with DPD may feel that they are about to lose control or “go crazy”

CONT.

- feel hollow inside
- feel like you lost your sense of self
- feel like you are observing yourself from the outside, looking inside
- feel like a robot
- unable to feel emotions

Cont.

- Many people with DPD obsess about the possibility that symptoms are evidence of some neurological condition (e.g. Alzheimer's, exposure to neurotoxins, or some other form of brain damage).

Behaviors, Feelings, and Thoughts Associated with DPD

- Sensory Changes
- Perceptual Changes
- Mood Changes
- Changes in the Way One Thinks
- Behavioral Changes

Sensory Changes

- Feeling Unreal
- Feeling as if one is living in a dream world
- Decreased sensations (things may not taste or smell the way they used to)

Perceptual Changes

- Objects appear to be further or nearer
- Colors may appear more vivid (e.g. the world seems brighter)
- One's voice may appear as if it were altered

Mood Changes

- Feeling anxious
- Feeling depressed
- Feeling numb
- Feeling emotionally detached

Changes in the Way One Thinks

- Thoughts appear foreign (e.g. one's thoughts seem to belong to someone else other than the self)
- Confusion
- Self-focus (attempts to figure out what has happened to one's brain and way of thinking)

Behavioral Changes

- Disorganization
- Difficulty completing a task
- Detachment and distancing oneself from others or during interactions with others

Triggers of DPD

- Trauma
- Marijuana
- Extreme family dysfunctionality
- Extreme and prolonged stress
- Extreme and uncontrollable emotions

Trauma

- Common traumas that results in DPD include, physical, sexual, and/or emotional abuse, neglect, rape, and victimization among others.

Substance Abuse

- Marijuana may trigger panic attacks, dissociative states, a combination of the two.
- Individuals have reported that marijuana use makes them more introverted, more aware of perceptual changes,
- While marijuana is the most common trigger of depersonalization, any drug could serve as a trigger.

NEUROLOGICAL CONDITIONS

- Neurological conditions that may be associated with depersonalization:
- epilepsy
- migraine
- mild TBI
- Lesions have been localized in parietal lobes
- PET scans show patient with DP have abnormal uptake in parietal, temporal, occipital lobes.

ICD 10 (F48.1)

- In ICD-10, this disorder is called depersonalization-derealization syndrome F48.1. The diagnostic criteria are as follows:
- 1. one of the following-depersonalization symptoms, i.e. the individual feels that his or her feelings and/or experiences are detached, distant, etc.
- derealization symptoms, i.e. objects, people, and/or surroundings seem unreal, distant, artificial, colourless, lifeless, etc.
- 2. an acceptance that this is a subjective and spontaneous change, not imposed by outside forces or other people (i.e. insight)

DSM 5

- " A. The presence of persistent or recurrent experiences of depersonalization, derealization or both:
- Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing)
- Derealization: "Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted.“
- B. During the depersonalization or derealization experiences, reality testing remains intact.

CONT.

- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or other medical condition (e.g., seizures).
- E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative disorder

Differential Diagnosis OF Depersonalization/Derealization Disorder

Dissociative symptoms due to a general MEDICAL CONDITION

Require the presence of an etiological medical condition, such as a seizure disorder, and would be diagnosed as Other Specified Mental Disorder Due to Another
Medical Condition, With Dissociative Symptoms.
Depersonalization/ Derealization Disorder is not diagnosed if the symptoms are all due to the direct physiological effects of a general medical condition on the central nervous system

Major Depressive Disorder

May be characterized by feelings of numbness, deadness, apathy, and being in a dream along with the other characteristic
symptoms of depression during Major Depressive Episodes. In Depersonalization/ Derealization Disorder, feelings of numbness are associated with other symptoms of the disorder (e.g., a sense of detachment from one's self) and occur
when the individual is not depressed

PANIC ATTACKS

- Panic Attack symptoms have an abrupt onset and reach a peak within minutes. In contrast, episodes of depersonalization or derealization in Disorder typically last for hours, weeks, or months.

- Depersonalization/Derealization Disorder is not diagnosed if the symptoms occur only during a Panic Attack.

Acute Stress Disorder

May be characterized by dissociative Acute Stress Disorder symptoms that develop in response to exposure to a traumatic stressor (and for Posttraumatic Stress Disorder, would be indicated by using the specifier With Dissociative Symptoms). Depersonalization/ Derealization Disorder is not diagnosed if the symptoms are better explained by Posttraumatic Stress Disorder

Psychotic Disorders

May be characterized by delusions in which the individual believes that he or she is dead or that the world is not real. In contrast, reality testing about the depersonalization/derealization is intact
in Depersonalization/Derealization Disorder (i.e., the person knows that he or she is not really dead and that the
world is real).

Dissociative Identity Disorder

May be characterized by symptoms of depersonalization or derealization accompanying the pervasive discontinuities in sense of self and agency. Depersonalization/ Derealization Disorder is not diagnosed if the symptoms are better explained by Dissociative Identity Disorder.

ASSESSMENT

- Dissociative Experiences Scale
- Cambridge Depersonalization Scale

TREATMENT

Pharmacological Options

- Naltrexone, an opioid antagonist, has been shown to reduce sensations of depersonalization in certain individuals.
- However, other medications typically treat the peripheral psychological complaints (e.g. depression and anxiety) associated with DPD
  - SSRIs Such as fluoxetine,
  - Tricyclic antidepressants
  - Benzodiazepines
  - Mood stabilizers (e.g. lamotrigine)

SSRI

- Simeon *et al*(1995) found that the partial serotonin agonist metachlorophenylpiperazine induced depersonalisation in healthy volunteers, and there are case reports of depersonalisation being apparently precipitated by initiation (Black & Wojcieszek, 1991) and discontinuation (Hollander*et al*, 1993) of an SSRI, the drugs involved being fluoxetine and clomipramine respectively.

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- A small study by Hollander *et al*(1990) found some evidence of therapeutic benefit for SSRIs, although the patients in this study were a heterogeneous group with high levels of psychiatric comorbidity.
- Simeon *et al*(1998) studied the effects of clomipramine in seven patients with primary depersonalisation, but found significant benefits in only two cases

CONT

- A large randomised placebo-controlled trial of fluoxetine showed little specific antidepersonalisation effect (Simeon *et al*/2004).

Lamotrigine

Clinical experience has been that many patients referred to our clinic have been on an SSRI for prolonged periods with little or no impact on their symptoms, and this has led us to investigate other potential pharmacotherapies.

- Lamotrigine acts at the presynaptic membrane to reduce the release of glutamate, and it has been shown to reverse depersonalisation-related phenomena induced by the *N*-methyl-D-aspartate (NMDA) receptor antagonist ketamine in healthy individuals (Anand *et al*, 2000).

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- Lamotrigine should be initiated at a starting dose of 25 mg/day, with the dose gradually increased at fortnightly intervals.
- Patients should be monitored for haematological and dermatological side-effects
- When lamotrigine cannot be tolerated or is ineffective, clonazepam may be useful, although the usual caveats regarding prescription of benzodiazepines apply.

Psychological approaches

- **Cognitive Behavior Therapy-** CBT has been found to be effective in reducing symptoms of depersonalization
- **Relaxation techniques-**progressive muscular relaxation do not appear to be of benefit in depersonalisation. Indeed, it has been noted that patients with depersonalisation may actually experience an increase in symptoms after using progressive muscular relaxation
- techniques aimed at refocusing attention away from introspection and self-observation may yet prove to be of benefit

THANK YOU