PSYCHIATRY GRAND ROUNDS

“Depersonalization Disorder”

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“things feel unreal to me…”

“my voice sounds different to me…”
“something is wrong with me…”

“I feel detached from myself…”

“Depersonalization Disorder is characterized by a persistent or recurrent feelings of being detached from one’s mental processes or body that is accompanied by intact reality testing.”

Introduction
Depersonalization, as a symptom or experience, is what the majority of us encounter at some time in our lives. It occurs briefly, and has no lasting effect.

Depersonalization Disorder, however, is a chronic illness that can take a dreadful and long-lasting course.

Unlike relatively new disease phenomenon, DPD has been clearly defined for years, (though somewhat buried under the Dissociative Disorders heading) in the Psychiatric Diagnostic and Statistical Manual (DSM).

History

The word depersonalization itself was first used by Henri Frédéric Amiel in The Journal Intime. The July 8, 1880 entry reads:

"I find myself regarding existence as though from beyond the tomb, from another world; all is strange to me; I am, as it were, outside my own body and individuality; I am depersonalized, detached, cut adrift. Is this madness?"

Depersonalization was first used as a clinical term by Ludovic Dugas in 1898 to refer to "a state in which there is the feeling or sensation that thoughts and acts elude the self and become strange; there is an alienation of personality; in other words a depersonalization."

This description refers to personalization as a psychical synthesis of attribution of states to the self.
Early theories of the cause of depersonalization focused on sensory impairment. Maurice Krishaber proposed depersonalization was the result of pathological changes to the body's sensory modalities which lead to experiences of "self-strangeness" and the description of one patient who "feels that he is no longer himself".

Pierre Janet approached the theory by pointing out his patients with clear sensory pathology did not complain of symptoms of unreality, and that those who suffered from depersonalization were normal from a sensory viewpoint.

Janet (1859-1947), who began his career as a philosopher, used hypnosis to explore the dissociative propensities of the human mind. Following his doctoral dissertation in philosophy, he completed a medical degree and continued his research into the nature and treatment of dissociative conditions. Hypnosis continued to be his investigative tool and therapeutic intervention of choice because it was, in his view, a form of dissociation.

"Hypnotism may be defined as the momentary transformation of the mental state of an individual, artificially induced by a second person, and sufficing to bring about dissociations of personal memory."

Pierre Janet

Psychodynamic theory formed the basis for the conceptualization of dissociation as a defense mechanism. Within this framework, depersonalization is understood as a defense against a variety of negative feelings, conflicts, or experiences. Freudian theory is the basis for the description of depersonalization as a dissociative reaction, placed within the category of psychoneurotic disorders, in the first two editions of the DSM.
Occasional moments of mild depersonalization are normal; strong, severe persistent or recurrent feelings are not.

A diagnosis of a disorder is made when the dissociation is persistent and interferes with the social and occupational functions necessary to everyday living or causes distress.

Although depersonalization disorder is an alteration in the subjective experience of reality, it is by no means related to psychosis as sufferers are able to distinguish between reality and fantasy and do not represent a risk to society since their grasp on reality remains stable at all times.

**Symptoms**

The core symptom of depersonalization disorder is the subjective experience of unreality.

- Continuous or recurring feelings that you're an outside observer of your thoughts, your body or parts of your body; *out-of-body experiences*.
- Numbing of your senses or responses to the world around you.
- Feeling like a robot or feeling like you're living in a dream or in a movie.
• The sensation that you aren’t in control of your actions, including speaking.

• Awareness that your sense of detachment is only a feeling, and not reality.

• The sense that your body, legs or arms appear distorted, enlarged or shrunken.

• Feeling like you are observing yourself from above, as if you were floating in the air.

• Feeling emotionally disconnected from people you care about.

• Fears of going crazy, brain damage, and losing control are common complaints.

Although DSM-IV-TR does not specify a list of primary symptoms of depersonalization, British clinicians generally consider the triad of emotional numbing, changes in visual perception, and altered experience of one's body to be important core symptoms of DPD.

DSM-IV-TR notes that patients with depersonalization disorder frequently score high on measurements of hypnotizability.
The literature suggests that spontaneous dissociative phenomena, imagery, and hypnotizability are mobilized as defenses both during and after traumatic experiences. This could be the explanation why individual with DPD display high hypnotizability and high dissociative scores as measured by standardized testing.

Some factors that exacerbate dissociative symptoms are negative affects, stress, subjective threatening social interaction, and unfamiliar environments.

Factors that tend to diminish symptoms are comforting interpersonal interactions, intense physical or emotional stimulation, and relaxation.

**Diagnosis**

The diagnosis of DPD is usually a diagnosis of exclusion. Diagnosis is based on the self-reported experiences of the person followed by a clinical assessment by a Psychiatrist, psychologist or other mental health professional. Psychiatric assessment includes a psychiatric history and some form of mental status examination.

**Differential diagnosis are:**

- Temporal lobe epilepsy.
- Panic disorder.
- Acute stress disorder.
- Schizophrenia.
- Migraine.
- Drug use.
- Brain tumor or lesion.
No laboratory test for depersonalization disorder currently exists but the PCP should get detailed medical history, physical examination, and blood and urine tests to rule out depersonalization resulting from epilepsy, substance abuse, medication side effects, or recent periods of sleep deprivation.

The diagnosis of DPD can be made with the use of the following interviews and scales:

The Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) is widely used, especially in research settings. This interview takes about 30 minutes to 1.5 hours, depending on individual's experiences.

The SCID-D is a semi-structured interview, which means that the examiner's questions are open-ended and allow the patient to describe experiences of depersonalization in some detail (distinct from simple "yes" or "no" answers).

The Dissociative Experiences Scale (DES) is a simple, quick, self-administered questionnaire that has been widely used to measure dissociative symptoms. It has been used in hundreds of dissociative studies, and can detect depersonalization and derealization experiences.
The Dissociative Disorders Interview Schedule (DDIS) is a highly structured interview which makes DSM-IV diagnoses of somatization disorder, borderline personality disorder and major depressive disorder, as well as all the dissociative disorders. It inquires about positive symptoms of schizophrenia, secondary features of dissociative identity disorder, extrasensory experiences, substance abuse and other items relevant to the dissociative disorders. It can usually be administered in 30–45 minutes.

In addition to these instruments, a six-item Depersonalization Severity Scale (DSS), has been developed to discriminate between depersonalization disorder and other dissociative or post-traumatic disorders, and to measure the effects of treatment in patients.

**DSM-IV-TR criteria:**
- Longstanding or recurring feelings of being detached from one's mental processes or body, as if one is observing them from the outside or in a dream.
- Reality testing is unimpaired during depersonalization

- Depersonalization causes significant difficulties or distress at work, or social and other important areas of life functioning.
- Depersonalization does not only occur while the individual is experiencing another mental disorder, and is not associated with substance use or a medical illness.
The DSM-IV-TR specifically recognizes three possible additional features of DPD:

- Derealization, experiencing the external world as strange or unreal.
- Macropsia or micropsia, an alteration in the perception of object size or shape.
- A sense that other people seem unfamiliar or mechanical.

Etiology

The exact cause of depersonalization is unknown, although biopsychosocial correlations and triggers have been identified. In some cases, it starts suddenly without an apparent cause.

The symptom of depersonalization can also occur in normal individuals under such circumstances as sleep deprivation, the use of certain anesthetics (nitrous oxide, ketamine), experimental conditions in a laboratory (experiments involving weightlessness, for example), and emotionally stressful situations (such as taking an important academic examination or being in a traffic accident).

Depersonalization disorder, like the dissociative disorders in general, has been regarded as the result of severe abuse in childhood. This can be of a physical, emotional, and/or sexual nature.
Findings in 2002 indicate that emotional abuse in particular is a strong predictor of depersonalization disorder in adult life.

Analysis of one study of 49 patients diagnosed with DPD indicated much higher scores than the control subjects for the total amount of emotional abuse endured and for the maximum severity of this type of abuse.

Depersonalization disorder can be conceptualized as a defense mechanism as the core symptoms of the disorder are thought to protect the victim from negative stimuli.

Depersonalization disorder is often comorbid with anxiety disorders, panic disorders, clinical depression and bipolar disorder.

Other severe traumatic lifetime events including accidents, war, and torture are well known causes.

The most common immediate precipitants of the disorder are severe stress, major depressive disorder and panic, ecstasy (MDMA), LSD, marijuana (Delta-9-Tetrahydrocannabinol) and other hallucinogen ingestion.
One cognitive behavioral conceptualization is that misinterpreting normally transient dissociative symptoms as an indication of severe mental illness or neurological impairment leads to the development of the chronic disorder. This leads to a vicious cycle of heightened anxiety and symptoms of depersonalization and derealization.

Not much is known about the neurobiology of DPD; however, there is converging evidence that the prefrontal cortex may inhibit neural circuits that normally form the substrate of emotional experience.

A PET scan found functional abnormalities in the visual, auditory, and somatosensory cortex as well as areas responsible for an integrated body schema.

In an fMRI study of DPD patients, emotionally aversive scenes activated the right ventral prefrontal cortex. Participants demonstrated a reduced neural response in emotion-sensitive regions, as well as an increased response in regions associated with emotional regulation.

In a similar test of emotional memory, DPD patients did not process emotionally salient material in the same way as healthy controls.
In a test of skin conductance responses to unpleasant stimuli, the subjects showed a selective inhibitory mechanism on emotional processing.

A group of American researchers concluded that DPD may be associated with dysregulation of the hypothalamic-pituitary-adrenal axis, the area of the brain involved in the "fight-or-flight" response. Patients demonstrate abnormal cortisol levels and basal activity (significant hyposuppression to low-dose dexamethasone administration and significantly elevated morning plasma cortisol levels).

Other tests by the same research team showed that patients with DPD can be clearly distinguished from patients with major depression or PTSD by tests of the functioning of the HPA axis.

No specific genes have been associated with susceptibility to DPD. It is hopefully possible in the future, however, that a genetic factor will be identified since clearly not every patient who suffers either childhood or adult trauma exhibit symptoms of DPD.

Other neurobiological studies involving PET measurements of glucose metabolism in different areas of the brain found that patients with DPD appear to have abnormal functioning of the sensory cortex (enhanced recognition for overtly emotive words, no enhancement of memory for neutral words encoded in an emotive context, no activation of emotional processing areas during encoding, no substantial difference in their neural responses to emotional and neutral material in the encoding and emotional word recognition tasks).
Neuropsychological testing has shown deficits in attention, short-term memory and spatial-temporal reasoning.

Depersonalization disorder is associated with cognitive disruptions in early perceptual and attentional processes.

**HISTORICAL**

DPD may be a reflection of changes in people's sense of self or personal identity within Western cultures since the eighteenth century. Historians of psychiatry have noted that no instances of the dissociative disorders were recorded before the 1780s.

The emphasis on individualism and detachment from one's family is a mark of adult maturity in contemporary Western societies that appears to be a contributing factor to the frequency of dissociative symptoms and disorders.

**Epidemiology**

The lifetime prevalence of DPD in the general population is unknown, possibly because many people are made anxious by episodes of depersonalization and afraid to discuss them with a PCP.

A 2008 review of several studies estimated the prevalence between 0.8% and 2%.
One survey done by the National Institutes of Mental Health (NIMH) indicates that about half of the adults in the U.S. have had one or two brief episodes of depersonalization in their lifetimes, usually resulting from severe stress. About a third of people exposed to life-threatening dangers develop brief periods of depersonalization, as do 40% of psychiatric inpatients.

DPD is diagnosed about twice as often in women as in men. It is not known, however, whether this sex ratio indicates that women are at greater risk for the disorder or if they are more likely to seek help for its symptoms, or both.

Little information is available about the incidence of the disorder in different racial or ethnic groups.

This disorder is episodic in about one-third of individuals, with each episode lasting from hours to months at a time.

Onset is typically during the teenage years or early 20s, although some report being depersonalized as long as they can remember, and others report a later onset. The onset can be acute or insidious.
Treatment

To date, no treatment recommendations or guidelines for depersonalization disorder have been established, and it remains largely resistant to treatment.

Depersonalization disorder sometimes resolves on its own without treatment.

Specialized treatment is recommended only if the symptoms are persistent, recurrent, or upsetting to the patient.

A variety of psychotherapeutic techniques have been used to treat depersonalization disorder, such as insight-oriented psychodynamic psychotherapy, cognitive-behavioral therapy and hypnosis have been demonstrated to be effective with some patients.

There is, however, no single form of psychotherapy that is effective in treating all patients diagnosed with DPD. An open study of CBT aimed to help patients re-interpret their symptoms in a non-threatening way, which lead to an improvement on several standardized measures.
Clinical pharmacotherapy research continues to explore a number of possible options, including SSRI, anticonvulsants, anxiolytics and opioid antagonists.

Benzodiazepines

In a retrospective report of 117 subjects with DPD, 18 of 35 benzodiazepine subjects, reported slight or definite improvement with benzodiazepines and clonazepam in particular. Benzodiazepines are not known to reduce dissociative symptoms; however they do target the often co-morbid anxiety and stress experienced by those with DPD, and thus lead to global improvement. To date no clinical trials have studied the effectiveness of benzodiazepines.

SSRI's

A series of small studies have suggested a possible role of SSRI in treating primary DPD. However, a placebo-controlled trial failed to show benefit with fluoxetine in 54 patients with depersonalization disorder.

SSRI treatment created an overall improvement in participants, but only by reducing anxiety and depression.

TCA's

Clomipramine is a tricyclic antidepressant that is helpful with both depression and obsessional disorders. In a study of four subjects treated with clomipramine, two showed clinically significant improvement of DPD. Other tricyclic antidepressant tried have included amitriptyline, doxepin and desipramine.
Anticonvulsants

A combination of an SSRI and a benzodiazepine has been proposed to be useful for DPD patients with anxiety. SSRIs have also been used in combination with lamotrigine.

Opiates antagonists

Naloxone was used in a pilot study in 11 patients with chronic DPD. Of the 11 patients, three experienced complete remission, and seven had marked improvement of depersonalization symptoms.

The study only reported immediate treatment results, which makes the efficacy of continued treatment unknown. Naloxone can only be administered IV, which makes long-term treatment difficult.

Naltrexone was used in a preliminary study in 14 individuals with DPD. Participants were treated for 6–10 weeks, at a dose of 120 mg per day. Three individuals were very much improved, another one was much improved, and on average a 30% decrease in DP symptoms were reported.

In another study in borderline personality disorder, doses of 200 mg/day of naltrexone was reported to decrease general dissociative symptoms over a 2-week period of treatment.

Unfortunately, there have been very few well-designed studies comparing different medications for depersonalization disorder.
Other treatments:

Because depersonalization disorder is frequently associated with trauma, effective treatment must include other stress-related symptoms, as well.

Relaxation techniques have been reported to be a beneficial adjunctive treatment for persons diagnosed with depersonalization disorder, particularly for those who are worried about their sanity.

Prognosis

The prognosis for recovery from DPD is good. Many patients recover completely, particularly those who developed the disorder in connection with traumas that can be explored and resolved in treatment. A few patients develop a chronic form of the disorder; this is characterized by periodic episodes of depersonalization in connection with stressful events in their lives.

Prevention

Preventive strategies could include the development of screening techniques for identifying children at risk, as well as further research into the effects of emotional abuse on children. It is also hopeful that further neurobiological research will lead to the development of medications or other treatment modalities for preventing, as well as treating, depersonalization.
Medicolegal Pitfalls

Two types of lawsuits have occurred involving dissociative disorders:

In the first type, the therapist allegedly reinforces memories of abuse reported by the patient, suggesting that they must be true and that the alleged perpetrators must be confronted. Because third parties are being accused of socially unacceptable crimes, lawyers may encourage them to sue the therapist for their role in the case.

The second type of lawsuit involves a patient pursuing a suit against the therapist for allegedly using suggestive techniques or improper diagnoses.

Even though science supports clinical practice in the field of dissociative disorders, the legal field has not been properly educated.

Clinicians should learn to practice defensively in cases involving memory or dissociative disorders by keeping careful notes and by more frequent use of informed consent forms.

Chart notes should be qualified as to the nature and source of the information.

Society and culture

The director of the autobiographical documentary *Tarnation*, Jonathan Caouette, suffers from depersonalization disorder.

The screenwriter for the 2007 film *Numb* suffers from DPD, as does the film's protagonist played by Matthew Perry.
Literary depictions of depersonalization, panic, depression, phobias, and other disorders have threaded their way through most cultures throughout history…

“Notes From Underground.” by Dostoyevsky.

“The Aleph” by Borges.

In print, the novel *The Stranger* by Albert Camus has a protagonist who displays an emotional deadness and views the world as absurd, which is reminiscent of DPD.
Apparently one who wrote about it and felt it was French philosopher Jean Paul Sartre. While he reputedly scorned the term existentialism, his first novel *Le Nausea* (Nausea), published in 1938, portrays true DPD with bone-chilling accuracy.

“...Little Lucienne was raped. Strangled. Her body still exists. Her flesh bleeding. SHE no longer exists...her hands... The houses. I walk between the houses, I am between the houses, on the pavement; the pavement under my feet exists, the houses close around me, as the water closes over me, on the paper the shape of a swan. I am. I am. I exist, I think, therefore I am; I am because I think, why do I think. I don't want to think any more. I am because I think that I don't want to be, I think that I....because....ugh! I flee.

Jean Paul Sartre

**Why Now?**

Why explore into Depersonalization Disorder at length when it has been clearly defined as an illness, or an offshoot of other illnesses in medical literature?
There is evidence that more people are experiencing DPD, and making it known, than ever before. The prevalence of DP has also impressed several seats of medical learning enough to establish clinics singly devoted to its study. These include the Depersonalization Research Unit at the London Institute of Psychiatry, and the Depersonalization and Dissociation Research Program at the Mt. Sinai School of Medicine in New York. These clinics are devoted to offer relief to those who find it an unbearable mental condition...

When your world seems strange and you've lost your sense of self, you'll be hard pressed finding a name for your affliction. But there is one "Depersonalization Disorder", and it's nothing new.

• Thank You!
• Special thanks to Dr Thomas Schacht
• References available at murillo@etsu.edu

Questions or comments?