

Depersonalization Disorder/Derealization Disorder

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Depersonalization/derealization disorder (DPD) was first described around the turn of the nineteenth century and it is listed today among the dissociative disorders in the *DSM-5* (American Psychiatric Association, 2013). Other dissociative disorders include dissociative amnesia, dissociative fugue, dissociative identity disorder (formerly called multiple personality disorder), and unspecified dissociative disorder (UDD). Depersonalization/derealization disorder shares with the other dissociative disorders disruptions or discontinuities in consciousness, memory, identity, motor control, or perception.

Depersonalization is marked by a persistent or recurring feeling of being detached from one's body, often accompanied by derealization, the feeling that the world and other people appear unreal. Symptoms of depersonalization include perceptual alterations, distorted sense of time, feeling as though one is an outside observer of one's body, or feeling as though one is an automaton or living in a dream or a movie. The *International Classification of Diseases (ICD-10)*, World Health Organization, (1992) aggregates the two conditions as depersonalization-derealization syndrome, and *DSM-5* combines depersonalization and derealization into depersonalization/derealization disorder. In this entry, the abbreviation DPD is used to refer to this

latter syndrome, and *depersonalization* is understood to encompass symptoms of both depersonalization and derealization. Research suggests that individuals with derealization alone do not differ from those with depersonalization accompanied with derealization in any respect (e.g., demographics, precipitants, illness characteristics, and comorbidity).

Estimates of the prevalence of DPD consistently fall in the range of 1–3% (Lynn et al., 2012). It is the most common of the dissociative disorders, and may be as prevalent as, or more prevalent than, schizophrenia and bipolar disorder. Approximately 50% of adults on average have experienced transient episodes of depersonalization/derealization in their lifetimes, usually in adolescence, so a single episode is not sufficient to meet criteria for the disorder. According to the *DSM-5*, DPD should be diagnosed only if symptoms are persistent (at least 1 month) and severe enough to cause distress, impairment in functioning, or both. The distress associated with DPD may be extreme, with sufferers reporting that they feel robotic, unreal, or “unalive.” They may fear becoming psychotic, losing control, or suffering permanent brain damage. Individuals with DPD may perceive an alteration in the size or shape of objects around them. Other people may appear mechanical or unfamiliar, and affected individuals may experience a disturbance in their sense of time (Simeon & Abugel, 2006). To meet diagnostic criteria for DPD, symptoms must be accompanied by intact reality testing, such that individuals are aware that their disturbing experiences do not mirror reality and that they are not suffering from a psychotic reaction. A diagnosis of DPD requires that the symptoms do not occur exclusively in the course of another mental disorder, and they cannot be attributable to substance abuse or dependence or to a general medical condition. Furthermore, DPD should not be diagnosed solely in the context of meditative

or trance practices. Certain self-report scales may be helpful in screening for DPD (Lynn et al., 2012).

The onset and course of DPD are variable. The onset of symptoms may be sudden or gradual and appear on an episodic basis or on a chronic basis. In about two thirds of people with DPD, the symptoms are present most of the time, if not continually. Episodes of depersonalization range from hours to weeks or months, and may persist for years or even decades in rare cases.

Episodes of depersonalization are commonly triggered by intense stress. They are often associated with high levels of interpersonal impairment; reports of a history of emotional, physical, or sexual abuse; unfamiliar environments; perceived threatening social interactions; out-of-body experiences; and the ingestion of such hallucinogens as ketamine, LSD, and cannabinoids (Lynn et al., 2012). Symptoms of other disorders, including anxiety disorders, substance use disorders, major depression, somatoform disorders, and avoidant, borderline, and obsessive-compulsive personality disorders, may also be present in DPD (Simeon et al., 1997). Depersonalization symptoms are often integral to acute stress disorder—often a precursor to PTSD—in which significant depersonalization is evident in as many as 30% of cases (Michal et al., 2009). When DPD is present in conjunction with other disorders, it is associated with a higher level of severity. The prevalence of DPD in depression is as high as 60% and it is as high as 82.6% in panic disorder (Hunter, Sierra, & David, 2004). Although many European authors have classified DPD as an anxiety disorder, the special relationship between depersonalization and anxiety has recently been called into question (Sierra, Medford, Wyatt, & David, 2012). Additionally, DPD is associated with alexithymia (i.e., difficulty in identifying feelings), cognitive disruptions in early perceptual and attentional processes, and memory fragmentation in the context of otherwise unremarkable memory functioning (Giesbrecht, Merckelbach, van Oorsouw, & Simeon, 2010).

Perhaps the most widely held view of dissociation—the posttraumatic model—holds that enduring dissociative symptoms are a manifestation of a coping mechanism that serves to defend against the deleterious impact of highly aversive or traumatic events (Dalenberg et al., 2012). Accordingly, DPD has been associated with childhood adversities and, most prominently, childhood interpersonal trauma, such as emotional abuse and neglect. Another hypothesis, increasingly supported by scientific studies (van der Kloet, Merckelbach, Giesbrecht, & Lynn, 2012), is that a labile sleep-wake cycle and unusual sleep experiences (e.g., hypnagogic hallucinations) engender intrusions of sleep phenomena (e.g., dreamlike experiences) into waking consciousness, which in turn foster depersonalization. Depersonalization is also associated with impairments or abnormalities in areas of the sensory cortex and cortical areas responsible for the integration of body schemas. Depersonalization may represent a mismatch or lack of integration between multisensory inputs (e.g., visual, proprioceptive, vestibular), which produces an altered sense of self and reality in combination with decreased or inhibited activity in areas responsible for affective processing (Lynn et al., 2012).

The nontrivial prevalence of depersonalization, the copresence of depersonalization with other disorders, and the distressing nature of the symptoms all point to the fact that DPD is an important clinical and public health problem. However, pharmacological and nonpharmacological treatments of DPD and dissociative disorders more generally, have received scant attention, arguably less than for any other major class of disorders. No well-controlled study has demonstrated the efficacy of a pharmacological or psychological intervention for DPD, although cognitive-behavioral therapy focusing on the catastrophic assumptions of DPD patients might be promising. The few existing treatment studies do not permit researchers to exclude alternative explanations for symptom reduction including regression to the mean, the

passage of time, placebo effects, or other artifacts. Other methodological problems include variability in treatments offered to patients, lack of controls for nonspecific effects, drop-out rates that approach 70%, and the failure to document clinically meaningful pre-to-post treatment changes (Lynn et al., 2012). These facts underline the pressing need for investigators to develop and implement effective treatments and evaluate these interventions with rigorously controlled and well-executed research.

SEE ALSO: Acute Stress Disorder; Dissociative Disorders; Posttraumatic Stress Disorder

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Further Reading

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