Case Conference

Primary Derealization Syndrome

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Abstract: *Depersonalisation and Derealisation constitute an interesting aspect of phenomenology where the sufferer retains his insight and reality testing during these distressing perceptions which are often described as an "as if" phenomena. Depersonalisation is characterized by a feeling that there is a change in oneself while in derealisation the environment appears to be changed. It was earlier described more commonly with psychiatric and neurological disorders. However current research, although scanty suggest that depersonalisation and derealisation as primary symptoms are not as uncommon as previously thought. We present a case of a 23 year old male, who presented with primary derealization syndrome, who was managed with sertraline 100mg/day, cognitive and behavioural techniques.*

Keywords : Primary Derealization Syndrome

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INTRODUCTION

Depersonalisation and Derealisation are psychiatric symptoms characterized by altered perception of the self and the environment respectively. However, the patient has intact reality testing and retains insight into the falsity of the perception. It is regarded as the third most frequently reported psychiatric symptom after depression and anxiety.[1] However, it is commonly reported in association with psychiatric disorders (depression, substance abuse) and neurological disorders rather than as a primary psychiatric illness. Primary depersonalization disorder classically has an onset in adolescence[2] with a chronic course and is associated with significant dysfunction and distress.

We present a case of a 23 year old male presenting primarily with derealisation symptoms and discuss the clinical features, diagnosis and management of patients with primary derealisation syndrome.

THE CASE

Mr HS, a 23 year old 12th passed, single, farmer from Sikh nuclear family of middle socio-economic status of rural background with premorbid anxious traits, with no abnormality in birth and early developmental history presented with the chief complaint of acute onset of a feeling that *'as if'* everything around him has changed for a duration of 18 months.

About 18 months back, one fine day, after waking up in the morning, he started complaining that he is feeling *"as if"* everything in his surroundings was strange and different. When asked by family members about the difference in the surrounding, he would elaborate that everything was appearing to have come closer to him by 1-2 feets from their actual position. However, he was able to appreciate that things were actually not closer and were in their normal positions. Additionally, he perceived that the lights around him were dimmer than usual and had a feeling that *'as if'* he was observing his surroundings through a 'transparent plastic'. All the above symptoms were accompanied by subjective anxiety. To overcome the above described perception, patient shook his head and

closed his eyes repeatedly, but failed to get any relief. As he could not understand what was happening to him he became very distressed. However, he did not feel that anyone had deliberately induced the symptoms in him or was trying to harm him. He refused to go to work and would request his mother to stay with him as he was filled with apprehension and fearful due to the above symptoms.

Over the next few days, the feeling that his environment had changed and subjective anxiety persisted at the same intensity throughout the day without any aggravating or relieving factor. In addition he started having difficulty in maintaining sleep. On one occasion he was persuaded by mother to visit the Gurudwara in accordance to his earlier habits. On his return from the Gurudwara he appeared even more distressed than before because in addition to the above symptoms he was not able to describe as to how he made the journey back and forth from the Gurudwara. On enquiry denied any problem in walking or responding adequately to others and was able to recall all his activities at the Gurudwara or on his way. There was no history of abnormal involuntary movements, incontinence associated with the above symptom.

As the symptoms continued for a week, he was taken to a doctor and was prescribed some medications with which with which subjective anxiety and sleep disturbance improved within 3-4 days but the other symptoms persisted. However, due to persistence of feeling of “as if” the environment around him has changed, he stopped all the medications after 1 week.

After about 1 month of onset of symptoms, in addition to the above symptoms, he started feeling suffocated on visit to a crowded market. Patient attributed this to the feeling that the people around him were coming closer to him in order to compress him. He would be distressed by the same despite knowing that it was not actually happening and would be filled with a desire to escape. Due to this he started avoiding crowded places like Gurudwara, fairs, markets, social gatherings. Later he became more and more housebound and when compelled to attend such places he would be filled with distress even before reaching the place and would try to escape from the situation as early as possible. However he did not complain of increase in anxiety or any somatic symptoms of anxiety in these situations.

About 2 months after the onset of the symptoms he consulted an Ophthalmologist and underwent complete ophthalmological examination (refraction, visual acuity, fundoscopy). He was also investigated further as per the advice of a psychiatrist, but the electroencephalogram (EEG) and non contrast computerized tomography (NCCT) of brain did not reveal any abnormality. Following this he was started on tablet escitalopram 10mg/day.

However, over the period of next 4-6 weeks, despite taking escitalopram regularly his symptoms kept on worsening and he became completely home bound, wouldn’t do any minor household work and would mostly prefer to remain in his room in company of a family member. Following this he stopped treatment. Later escitalopram was increased to 20 mg per day, with which patient reported some improvement in “as if” symptoms but dysfunction persisted. As the symptoms failed to resolve, he started feeling that he would never be able to fulfill his ambition (joining the armed forces) and would consider himself incapable of even working as a farmer and hence would frequently think of ending his life and on one occasion tried to consume organophophorous but the family members stopped him from doing so.

Over the next 1 year he was tried on various combinations of psychotropic medications which included tablet olanzapine 10mg/day, tablet mirtazapine 15-30 mg/day and risperidone 1-3 mg/

day but he did not perceive any benefit despite taking the medication regularly. Over this period he was completely home-bound.

There was no history suggestive of any feeling as if his own body has changed, substance use/ abuse, panic attacks, fear of social situations, anxiety over trivial issues, obsessive symptoms, easy fatiguability, ideas of poverty, catastrophe, delusions, hallucinations and Schneider first rank symptoms, head injury, heat or cold intolerance and fever.

No abnormality was detected on general and systemic examination.

On the basis of above history and examination differential diagnosis between Depersonalisation - Derealisation syndrome versus Agoraphobia with derealisation syndrome was entertained initially. Further clarification of phenomenology was done. From the description of the patient it was evident that he avoided crowed places because of *"as if"* feeling of things coming closer to him and this leading to secondary fear of being compressed. He was aware of the fact that this is not possible and happening, but because of the *"as if"* feeling he would avoid such situations. Further exposure to such situations was not associated with panic attacks. Hence a final diagnosis of primary Depersonalisation - Derealisation syndrome was made.

All the previous medications were withdrawn and he was started on tablet sertraline 25mg/ day which was gradually increased to 100mg/ day. Patient and mother were psycho-educated about the diagnosis and plan of treatment. Relaxation exercises were taught. Distraction techniques like listening to music, spending time with friends and attending household chores like caring for the animals were advised in order to help patient shift attention from derealization symptoms. As patient agreed that his surrounding items could not actually come closer to him cognitive strategy like repeated reassurance to oneself about the improbability of such a thing happening was advised. Behavior Therapy in the form of hierarchical exposure to the avoided situations was started. Over the period of next 9 months patients socio-occupational functioning improved significantly although the derealisation symptoms persisted at a lower intensity.

DISCUSSION

In depersonalization the individual feels that his or her own feelings and/or experiences are detached and not his or her own.[3] Fish describes it as a change in the awareness of one's activity where patient feels that he is no longer his natural self. Derealization is characterized by a feeling of unreality so that the environment is experienced as flat, dull and unreal.[4] The subject may perceive objects, people and/or surroundings as unreal, distant, artificial and colorless.[3] The core feature of these symptoms are the acceptance that it is a subjective and spontaneous change and is not imposed by outside forces or other people and the subject is aware of the .unreality of disturbing change in their experience of themselves and/or their surroundings.[5]

Nosological status

The nosological status of this disorder is disputed and shrouded in controversy. In the International Classification of Mental and Behavioural Disorders (ICD–10)[3] the diagnostic category of Depersonalisation – Derealisation syndrome is placed under the vague heading of 'other neurotic disorders'. It explicitly links depersonalisation with the related phenomenon of derealisation, as diagnosis can be made by the presence of either or both symptoms. However, Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM–IV)[6] includes Depersonalisation under

Dissociative disorders NOS and does not include derealisation symptoms as part of the criteria. This classification under dissociative disorders is controversial as depersonalization is not associated with a 'lack of subjective awareness of change' which is the hallmark of true dissociation.

Epidemiology

Depersonalisation can occur as a transient phenomenon in healthy individuals during fatigue, intoxication with alcohol and/or drugs, or in situations involving serious danger.[7] On the other hand it can occur as a chronic, disabling and clinically significant phenomenon, either as a primary disorder or secondarily in a range of neuropsychiatric settings. The common causes of secondary depersonalization are neurological conditions (temporal lobe epilepsy), head injury, depression, anxiety disorders, post traumatic stress disorder, schizophrenia and marijuana abuse[8].

Initially it was suggested that primary depersonalization syndrome is rare but epidemiological research suggest that it not as uncommon as previously suggested. In a survey of 204 patients with a putative diagnosis of depersonalization disorder, Baker et al found that 71% of these cases met DSM-IV criteria for primary depersonalization.[9] Primary depersonalization syndrome is reported in 1–2% of the general population, with a gender ratio of about 1:1.[10] On the other hand pure derealization syndrome is rare. In a study using self-report questionnaire scales on 42 patients with primary or secondary depersonalization only 4 had pure derealization syndrome.[8] Studies suggest that it runs a chronic course little or no fluctuation.[9]

Clinical features

They can present with various types of alteration in subjective experience. These may range from a disturbing sense of being "separate from oneself", "observing oneself as if from outside", feeling like a robot or automaton to a threatening sense of unfamiliarity or unreality in the environment" or perceptual anomalies and feeling that other people are like actors in a play. They may also present as a diminution, loss or alteration of bodily sensations, sense of disembodiment, a raised pain threshold or diminution or loss of emotional reactivity.[5]

Management

A thorough clinical assessment including a full psychiatric and general medical history and mental state examination is mandatory. Further neurological evaluation may be appropriate if the history is suggestive of epilepsy or other organic disease.[11]

There are several case reports suggesting a good response with Selective Serotonin Reuptake Inhibitors.[12-14] However, a large randomised placebo-controlled trial of fluoxetine showed little specific anti-depersonalization effect.[15] The efficacy of lamotrigine as monotherapy or in conjunction with an SSRI is not yet firmly established. It was shown to produce substantial benefits in 4 cases.[16] But a placebo-controlled cross-over study of 9 patients failed to show significant benefits with Lamotrigine.[17] Another study suggested significant but transient beneficial effect with naloxone infusion in 10 out of 14 patients with depersonalization syndrome.[18]

There are no recognised psychological treatments for depersonalization syndrome. Case reports describing successful treatment using psychoanalytical therapy[19], behavioural therapy[20] and directive therapy[21] are available. Hunter et al proposed a Cognitive model which explained the depersonalization syndrome. According to this model psychological stressors, low mood, anxiety, drug use induce depersonalisation symptoms. Catastrophic attributions like fear of 'madness', losing control lead to increase in

anxiety symptoms. Finally maintenance behaviours like avoidance of symptom provoking situations, safety behaviours like acting 'normal', cognitive biases like symptom monitoring tend to perpetuate symptoms. Cognitive behaviour therapy strategies like psycho-education and normalizing, diary keeping, reducing avoidance, reducing self-focussed attention and challenging catastrophic assumptions may be helpful in reducing symptoms.[22]

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