DISSOCIATIVE DISORDERS

Depersonalization/Derealization Disorder

DPDR

DSM-5-TR 300.6 | ICD-10-CM F48.1

Persistent unreality of the self or the surrounding world, experienced with fully intact reality testing, often chronic and severely disabling.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1-2%; transient in ~50%	Mean age 16; rare after 25	~1:1 female:male	Continuous in about 2/3

CLINICAL PICTURE

- Depersonalization is experienced as observing one's own thoughts, body, or actions from outside, with emotional numbing and a sense of not being real.
- Derealization renders surroundings dreamlike, foggy, flat, or visually distorted, with familiar people and places feeling artificial or stage-set.
- Reality testing stays intact throughout: patients say it is as if they were unreal, which cleanly separates the condition from psychosis.
- Subjective memory and concentration complaints, distorted time sense, and a feeling that one's own past belongs to someone else are frequent.
- Onset is often abrupt after cannabis, ketamine, or hallucinogen use, a panic attack, or severe stress, and patients recall the exact moment it began.
- Patients describe the state as indescribable, fear they are going insane, and typically see several clinicians over years before it is correctly named.

DIAGNOSTIC CRITERIA AT A GLANCE

- Persistent or recurrent experiences of depersonalization, derealization, or both, which may occur separately or together in the same person.
- Reality testing is preserved during the experiences, distinguishing the disorder from psychotic conditions in which unreality is held as delusional belief.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Not attributable to a substance, medication, seizure disorder, or another medical condition, requiring history, toxicology, and sometimes EEG to exclude.
- Not better explained by schizophrenia, panic disorder, major depression, acute stress disorder, PTSD, or another dissociative disorder.

NEUROBIOLOGY & PHYSIOLOGY

- The fronto-limbic model holds that ventrolateral and dorsolateral prefrontal cortex over-inhibit amygdala and anterior insula, stripping experience of emotional coloring.
- Autonomic reactivity to aversive stimuli is reduced, with attenuated skin conductance responses despite normal or elevated subjective anxiety.
- Anterior insula hypoactivation disrupts interoceptive awareness, plausibly generating the disembodied, numbed quality that patients struggle to describe.
- NMDA antagonism reproduces the syndrome, since ketamine reliably induces it, and cannabis and hallucinogens are the most common clinical precipitants.
- HPA axis findings include blunted cortisol reactivity and altered feedback sensitivity, a pattern distinct from that seen in PTSD and major depression.
- Temporoparietal junction dysfunction in multisensory integration links the disorder to out-of-body phenomena and is the target of rTMS research.

PSYCHOLOGICAL MECHANISMS

- Catastrophic appraisal of ordinary dissociative sensations drives the maintenance cycle, as symptom monitoring and threat interpretation amplify unreality.
- Depersonalization begins as an evolved defense that dampens overwhelming affect to preserve function under threat, then persists past any usefulness.
- Safety behaviors such as checking oneself in mirrors, avoiding crowds or bright light, and constant self-scrutiny maintain symptoms much as in panic disorder.
- Childhood emotional neglect and verbal abuse are the adversity types most consistently associated with the disorder, more than physical or sexual trauma.
- Rumination about the nature of self and existence consumes attention and correlates with severity on the **Cambridge Depersonalisation Scale**.

DIFFERENTIAL & COMORBIDITY

- Panic disorder commonly includes depersonalization during attacks; a separate diagnosis applies only when unreality persists outside panic episodes.
- Substance-induced states from cannabis, ketamine, hallucinogens, or withdrawal resolve with abstinence, while persistence supports the primary disorder.
- Temporal lobe epilepsy, migraine, vestibular disease, and traumatic brain injury all produce derealization and warrant EEG or imaging when features are atypical.
- Depression and anxiety disorders are the leading comorbidities, present in the majority, and depersonalization predicts poorer antidepressant response.
- Suicidal ideation is common and driven by intolerable emptiness rather than depressed mood, so screen even when the mood exam looks unremarkable.

Treatment

EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No agent is FDA-approved; **SSRIs** alone did not outperform placebo in controlled trial and are reserved for comorbid depression or anxiety.
- **Lamotrigine 100-250 mg/day** added to an SSRI carries the most supportive open-label and small controlled data, presumably through glutamate modulation.
- **Naltrexone 50-100 mg/day** produced modest benefit in open trials, consistent with an endogenous opioid contribution to dissociative numbing.
- Clonazepam combined with an SSRI may help when anxiety drives symptoms, but benzodiazepines deepen dissociation and should not become standing therapy.
- Full cessation of cannabis, stimulants, and hallucinogens is non-negotiable, since continued use sustains symptoms and defeats every other intervention.

PSYCHOTHERAPY

- **CBT** targeting catastrophic appraisals, symptom monitoring, and safety behaviors is the best-supported psychotherapy, with meaningful gains in open trials.
- Psychoeducation and normalization alone reduce distress substantially, because much of the suffering comes from fear of insanity or brain damage.
- Behavioral experiments drop reality checking and self-scrutiny, while attention training redirects focus outward onto external tasks and sensory detail.
- Trauma-focused work is indicated when childhood emotional neglect or abuse is prominent, sequenced after stabilization and appraisal work.
- **Mindfulness and acceptance-based** approaches teach non-judgmental observation of unreality, reducing the struggle that perpetuates the state.

ADJUNCT & SUPPORTIVE

- Quantify severity and change with the **Cambridge Depersonalisation Scale** or the depersonalization subscale of the **DES-II** at regular intervals.
- **rTMS to the right temporoparietal junction** reduced symptoms in small open studies and remains investigational rather than routine care.
- Regular aerobic exercise, consistent sleep, and reduced caffeine lower baseline autonomic arousal and measurably lessen symptom intensity.
- Correct fatigue, dehydration, and hyperventilation, all of which acutely intensify unreality and often explain day-to-day fluctuation in severity.
- Peer support and accurate patient resources counter the isolation of a condition patients cannot describe to family or to previous clinicians.

CLINICAL PEARLS

- Intact reality testing separates this from psychosis: it feels as if, it is never believed to be.
- Ask directly; patients rarely volunteer symptoms they fear will sound insane.
- Cannabis is the most common trigger and the most common reason it persists.

References

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NOTE

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