

Depersonalization and Derealization

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Between the World and the Self: An Exploration of Depersonalization/Derealization Disorder for Healthcare Professionals

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In this week's episode of the podcast, we are joined by registered mental health nurse, Paul Molyneux, to discuss depersonalization/derealization disorder and his personal experiences and recovery from the disorder.

*"I woke up this morning
Didn't recognize the man in the mirror
Then I laughed and I said,
'Oh silly me, that's just me'
Then I proceeded to brush some stranger's teeth
But they were my teeth, and I was weightless
Just quivering like some leaf come in the window of a restroom."*

(Lyrics from the song *Pretty Pimpin* by Kurt Vile, 2015)

Introduction

Have you ever had the strange experience of looking out into the world only to question whether you were dreaming or not? Or, like the song's protagonist, have you gazed at yourself in the mirror and wondered who it was staring back at you? You certainly aren't alone.

The experiences of depersonalization and derealization (DPDR) have been considered the third most frequent psychiatric symptom, after depression and anxiety (Simeon & Abugel, 2008). Indeed, telephone surveys reflect this with 23.4% of respondents having experienced depersonalization or derealization in the last 12 months in a rural Southern US population (Aderibigbe et al., 2001). The lifetime prevalence of transient episodes of depersonalization and derealization has been reported between 26 and 74% (Hunter et al., 2004), with brief episodes often associated with fatigue, stress, and substance use (Hunter et al., 2003). It is worth noting that depersonalization is also associated with several neurological conditions, including migraine and temporal lobe epilepsy (Lambert, 2002). Depersonalization can also follow a bout of a viral infection, including COVID-19 (Simeon & Abugel, 2023).

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Whilst transient episodes of depersonalization and derealization are clearly a common part of the human experience, some individuals have more persistent symptoms. For these patients, clinicians may wish to consider a diagnosis of depersonalization/derealization disorder (DDD).

Diagnostic Criteria

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) categorizes depersonalization/derealization disorder as a dissociative disorder, alongside dissociative identity disorder, dissociative amnesia, and other specified dissociative disorder (American Psychiatric Association, 2022). Some authors have suggested that it may be better conceptualized as an anxiety disorder, given that “anxiety and depersonalization are intimately related” (Medford et al., 2005, p. 98). Nevertheless, to be diagnosed with depersonalization/derealization disorder, patients must meet the following DSM-5-TR criteria:

Criterion 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).
Criterion B	During the depersonalization or derealization experiences, reality testing remains intact.
Criterion C	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Criterion D	The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).
Criterion 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.

Adapted from “Dissociative Disorders,” by American Psychiatric Association, 2022, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), F48.1

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In a seminal 2003 paper, leading depersonalization/derealization disorder psychologist and researcher, Dr. Elaine Hunter, and colleagues, fleshed out the then DSM-IV depersonalization disorder criteria, highlighting the range of additional cognitive, affective, and physiological/perceptual symptoms individuals with the disorder might also experience:

Affective	<ul style="list-style-type: none">· Emotional numbing (for both positive and negative affect)· Lack of empathy· Sense of isolation· Depression· Anxiety· Dream-like state· Loss of motivation· Loss of a sense of the consequences for one's behavior
Cognitive	<ul style="list-style-type: none">· Impaired concentration· Mind 'emptiness' or 'racing thoughts'· Memory impairments· Impaired visual imagery· Difficulty in processing new information
Physiological / Perceptual	<ul style="list-style-type: none">· Partial or total physiological numbing· Feelings of weightlessness/hollowness· Lack of a sense of physical boundaries· Sensory impairments (e.g., taste, touch, microscopia and/or macroscopia)· Sensory distortions (e.g., sound, loss of color)· Dizziness· External world appears flat or two dimensional· Objects do not appear solid· Loss of sense of recognition to one's own reflection and voice· Changed perception of time

Adapted from "Depersonalisation disorder: a cognitive-behavioural conceptualisation," by E. C. M. Hunter et al., 2003, *Behaviour Research and Therapy*, 41(12), p. 1452 ([https://doi.org/10.1016/s0005-7967\(03\)00066-4](https://doi.org/10.1016/s0005-7967(03)00066-4)). Copyright 2003 by Elsevier Ltd.

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Prevalence (and Paul Molyneux's story)

Once thought to be extremely uncommon, indeed, even the ICD-10 referred to the syndrome as a “rare disorder” (World Health Organization, 1993), epidemiological data from the early 2000s pointed to a prevalence rate of around 1% (Sierra et al., 2004), which has been confirmed by more recent research (Yang et al., 2022). In relation to other psychiatric disorders, the prevalence of depersonalization/derealization disorder is similar to obsessive-compulsive disorder and bipolar disorder (Simeon & Abugel, 2023).

This poses a conundrum. If transient episodes of depersonalization and derealization are common, and depersonalization/derealization disorder is not infrequent, why is this not reflected in the experiences of many clinicians? Authors have put forward a variety of explanations, ranging from professional unawareness to the difficulties patients have in describing their symptoms (Sierra, 2009). Whatever the cause, the fact remains that it can take up to 12 years until a correct diagnosis is made (Hunter et al., 2003). One can only imagine how frustrating that must be for those suffering with this disorder.

In that respect, I (Paul Molyneux) was one of the lucky ones. I'd experienced unproblematic and transient episodes of depersonalization and derealization for as long as I can remember. However, in 2007 the cumulative effects of several social stressors resulted in a panic attack with a strong dissociative element. After the panic had subsided, the depersonalization and derealization remained. I recall the extremely uneasy sense of watching the world as if it were a dream, feeling disconnected from my own hands and reflection, and experiencing a pervasive sense of woolly-headedness, amongst other symptoms. These symptoms remained with me persistently and without relent for nearly two years, which was utterly terrifying.

With an interest in psychiatry – I was studying to be a mental health nurse at the time – I was aware that my symptoms were commensurate with a diagnosis of depersonalization/derealization disorder. I sought help from both my family doctor and a counselor. Whilst well-meaning, both practitioners were clearly inexperienced with depersonalization/derealization disorder and instead chalked my symptoms up to anxiety. This only served to intensify my sense of hopelessness.

Of course, it behooves professionals to be aware of the diagnostic criteria for depersonalization/derealization disorder. However, it is probably just as useful for clinicians to have an insight into *how* individuals might describe their symptoms. Given the highly subjective and nebulous nature of the experience of depersonalization and derealization, clinicians should be alert to the use of metaphors. For me, the sense of detachment from familiar people and places left me feeling *as if I had lost my soul*, whilst the dreamlike appearance of reality felt *as though I was watching a movie of my life*. Individuals will often describe feeling as if a pane of glass has been placed in front of them or as though they might have slipped into an alternative reality.

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'It's as if' and 'it's as though' are key phrases of which to be mindful here. As per the diagnostic criteria, patients with depersonalization/derealization disorder have intact reality testing and are fully aware they aren't living in a dream, etc. This will be in clear contrast to the psychotic patient who may suggest they are *actually* living in a dream. Furthermore, patients with depersonalization/derealization disorder will often present without the high levels of distress, agitation, and disorganized thought that one might associate with something like a psychotic episode.

Predisposing and Precipitating Factors

The onset of the condition tends to be in late adolescence or early adulthood with most cases seemingly beginning between the ages of 15-19 (Sierra, 2009). That being said, it has been proposed that onset may well begin in childhood and is simply never detected by parents and professionals due to the "reduced linguistic abilities of children which would make it almost impossible for them to describe the experience" (Sierra, 2009, p. 50). Interestingly, a history of emotional abuse or neglect during childhood appears to be a significant risk factor for going on to develop the disorder, with 44 out of 49 individuals reporting having experienced emotional abuse in childhood in one 2001 study (Simeon et al., 2001). The gender distribution for the disorder leans slightly towards a preponderance of males (Baker et al., 2003; Michal et al., 2016).

The specific triggers for chronic depersonalization-derealization are myriad, and even a cursory look on depersonalization online forums reflects this. It is certainly true that many posters point to a scary experience with cannabis which left them with a sense of unreality long after the effects of the drug had worn off. In studies, cannabis is the number one drug cited as having triggered chronic depersonalization and derealization, with hallucinogens, ecstasy, and ketamine also showing up in the data (Simeon & Abugel, 2008). As for other causes, studies have shown that chronic depersonalization-derealization has followed periods of severe stress, trauma, panic, and depression (Simeon et al., 2003). For some, there is no obvious trigger (Simeon & Abugel, 2008). The experience of the disorder remains remarkably similar whether induced by a substance or not, suggesting that drug-induced depersonalization/derealization disorder should not be considered a separate condition (Sierra, 2009). It is worth bearing in mind that whilst many individuals report a rapid onset of the disorder, for others it can emerge insidiously (Simeon & Abugel, 2008).

Psychotherapy

I am pleased to report that in 2009, after depersonalization and derealization that had persisted for around two years, I achieved recovery from the condition. Since then, I have had well over a decade to reflect on how my recovery got underway, leading me to a cognitive-behavioral model of the disorder. The model, proposed by Hunter et al. (2003), suggests that the difference

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between someone who experiences a transient episode of depersonalization and derealization and someone who goes on to experience it persistently, is in how they appraise the symptom. Most of the time, experiences of depersonalization and derealization are put down to situational factors (e.g., “I’m feeling this way because I’ve had a very long and stressful day at work”) and once the situational factor diminishes, so does the dissociation. People who go on to experience depersonalization and derealization as a disorder are said to insert a catastrophic appraisal of their symptoms (e.g., “this must be a sign that I’m going mad”). This sets up a loop, in which the catastrophic narrative creates increased anxiety and distress, which in turn exacerbates pre-existing depersonalization and derealization. For me, I became convinced that my depersonalization and derealization might have been a sign that I’d done some irreversible damage to my brain that there was no going back from.

Once this loop has been established, the model suggests that sufferers then engage in behaviors they think might be helpful, but that only serve to intensify their symptoms. Examples suggested are excessive symptom monitoring (i.e., when we look for something, we tend to find it), avoidance of things that might “trigger” depersonalization and derealization (avoidance reduces our ability to learn that things might not be as bad as we thought and can increase the sense of feeling detached from life), and acting “normal” (in which the very *act* of acting is itself depersonalizing). For me, once I started to experience persistent depersonalization-derealization, I retired to bed in the hopes that I might have been able to sleep the condition away. Only now do I realize how unhelpful this was given that sleep inertia might easily have been misinterpreted as depersonalization and derealization.

I managed to close these loops when a close friend took me along to a spinning class at a local gym. The intense nature of the experience – the darkened room with disco lights, loud music playing, and a trainer shouting to “go faster!” – allowed for a brief time in which I didn’t dissociate. As a psychologist once put it to me, when you exercise intensely, “you don’t have the luxury to think past your next breath, let alone to ponder about depersonalization and derealization.” Once I realized the depersonalization and derealization wasn’t fixed, my assumption that I’d done irreversible brain damage was disproven, and the spell was broken. This, together with a reduction in social stressors, allowed me to recover over a period of several months.

Psychotherapy is considered the standard of care for dissociative disorders like depersonalization/derealization disorder, as there is not convincing evidence for any particular medication (Scarella & Franzen, 2017). Research has been conducted testing the effectiveness of cognitive-behavioral therapy (CBT) for depersonalization/derealization disorder. Simeon et al. (2003) conducted interviews with patients diagnosed with depersonalization disorder about their treatment history and found that most did find psychotherapy helpful for better understanding their depersonalization symptoms and learning how to cope with them; however, only 2% experienced definite improvement in symptoms, whereas 23% felt their symptoms were slightly better, and 75% had either worse symptoms or no improvement (Simeon et al., 2003). A 2005 open study involving 21 patients treated with CBT saw significant improvement in measures of dissociation, depression, anxiety, and general functioning, with 29% of patients no longer

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meeting the criteria for the diagnosis by the end of treatment (Hunter et al., 2005). While the evidence overall is limited by small sample sizes, several other treatment modalities have been studied, including dance/movement therapy (Millman et al., 2023), mindfulness-based cognitive therapy (Mishra et al., 2022), CBT-based group therapy (Flückiger et al., 2022), and cognitive therapy targeting social anxiety disorder (Schweden et al., 2016). Some have hypothesized that virtual reality (VR) combined with biofeedback could benefit patients with depersonalization (Patrikelis et al., 2021), although virtual reality itself has been shown to trigger depersonalization-derealization symptoms (Barreda-Ángeles & Hartmann, 2023). Whilst promising, clearly more research is required. Encouragingly, a trial investigating CBT for depersonalization/derealization disorder is due to be completed in 2024 (Hunter, 2023).

Pharmacotherapy

An interesting analysis by Simeon et al. (2003) asked 117 participants to retrospectively describe all previous treatments they had received. Although the nature of the study has significant limitations, the results did not paint a particularly optimistic picture. Among several different medications, only SSRIs and benzodiazepines showed a modest benefit, with 38% reporting slight or definite improvement in symptoms with SSRIs, and 52% reporting improvement on benzodiazepines (Simeon et al., 2003). Indeed, at the time of writing, there exists no FDA-approved medication for the treatment of the disorder, and the evidence for pharmacotherapy is very limited overall. A 2023 systematic review by Wang et al. on depersonalization/derealization disorder treatment found that both the quantity and quality of research were lacking. Despite this, when researching for this article, I asked users of a depersonalization/derealization disorder forum about their experiences of recovery from the disorder, with several responders listing medication as something that had helped them personally (Molyneux, 2023).

Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs have been used in the management of depersonalization/derealization disorder, however, there is conflicting evidence for their effectiveness. A double-blind, placebo-controlled study involving 54 patients with DSM-IV depersonalization disorder found that fluoxetine was no better than placebo (Simeon et al., 2004). However, it was found that patients with comorbid anxiety or depression did better on fluoxetine than placebo, with individuals reporting that whilst their depersonalization hadn't changed much, they were less concerned by it. SSRIs in combination with lamotrigine also have some, albeit limited, evidence of effectiveness for depersonalization-derealization, as discussed below.

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Lamotrigine

There has been significant interest in whether lamotrigine might be useful in treating depersonalization/derealization disorder, although the evidence is nuanced and limited. Whilst ketamine, an NMDA antagonist that increases glutamate release, is known to bring about dissociative symptoms (Abdallah et al., 2018; Tully et al., 2022), lamotrigine inhibits glutamate release (Gärtner et al., 2023). Pre-treatment with lamotrigine has been reported to reduce dissociative symptoms after ketamine administration (Anand et al., 2000). However, Gärtner et al. (2023) found no difference with lamotrigine pretreatment on subjective symptoms like dissociation in patients who received ketamine, though it did help with “emotional [working memory] and associated neural activity.” Additionally, a double-blind, cross-over, placebo-controlled trial involving nine patients treated with lamotrigine monotherapy failed to show any benefit for depersonalization-derealization symptoms (Sierra et al., 2003).

Despite this, further, admittedly less robust, open-label trials suggest that lamotrigine was helpful in 50-70% of patients when used as an adjunct to an antidepressant, especially an SSRI (Sierra et al., 2001, 2006, as cited in Sierra, 2009). There does exist a randomized, double-blind, placebo-controlled trial from 2011 that showed positive results for lamotrigine as a monotherapy for depersonalization/derealization disorder, however, this has since been retracted due to plagiarism (Aliyev & Aliyev, 2011). Since then, there have been some case reports describing improvement of depersonalization and derealization symptoms in patients treated with lamotrigine combined with SSRIs (Belli et al., 2014; McEvoy et al., 2015; Bout et al., 2018), lamotrigine plus sertraline and clomipramine (Rosagro-Escámez et al., 2011), and lamotrigine with venlafaxine (Salgado et al., 2012). Most of these patients also had comorbid psychiatric symptoms or disorders, including anxiety, depression, or obsessive-compulsive disorder.

If using lamotrigine, the team at the then Depersonalization Research Unit in London (now the Depersonalization Disorder Service) suggest that the starting dose should be 25 mg/day and gradually increased at fortnightly intervals (Medford et al., 2005). They recommend monitoring lamotrigine plasma levels, especially if used in combination with sertraline, due to reports of marked changes in lamotrigine levels when the two medications have been used concurrently. In one of the open-label studies, the authors noted that a greater improvement was seen with higher doses—they used up to 600 mg (Sierra et al., 2006). Simeon & Abugel (2023) propose maximizing the dose of lamotrigine, keeping in mind tolerability, if there is an insufficient response to lower dosages.

Tricyclic Antidepressants (TCAs)

There is some limited evidence for the use of tricyclic antidepressants. A case study from 1987 saw primary depersonalization disorder respond well to desipramine (Noyes et al., 1987). Furthermore, a small study found that two of seven patients treated with clomipramine showed

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significant improvement in their depersonalization symptoms, as did one of six patients taking desipramine; one of the patients who responded to clomipramine had near remission from depersonalization for 4 years, with relapsing symptoms each time she attempted to taper off of clomipramine or change to a different medication (Simeon et al., 1998). Perhaps clomipramine is useful for a subset of patients where obsessions and compulsions are present, given the established overlap between obsessive-compulsive disorder and depersonalization/derealization disorder, (Boysan, 2014; Quigley et al., 2022) and clomipramine's long-established usefulness in treating OCD ("Clomipramine in the Treatment of Patients with Obsessive-Compulsive Disorder," 1991), although the same might be said of SSRIs, which are considered first line pharmacotherapy for OCD (Paxos, 2022). Additionally, Simeon & Abugel (2023) point out that clomipramine might be a better option for patients who cannot tolerate the "numbing" effects of the SSRIs.

Monoamine Oxidase Inhibitors (MAOIs)

Sadly, there are no studies involving MAOIs and depersonalization/derealization disorder; however, one 1989 study noted an improvement in a form of depression that featured depersonalization and anxiety when MAOIs were used (Davidson et al., 1989).

Opioid Antagonists

Another class of medications that are of interest are the opioid antagonists, though as with other pharmacotherapies, the data is very limited. Thinking mechanistically, activation of the endogenous opioid system has been characterized by an amplified pain threshold and a reduced emotional repertoire (Younger et al., 2006), which can reflect the experiences of people with depersonalization/derealization disorder (Sierra, 2009). Furthermore, depersonalization/derealization disorder researcher, Mauricio Sierra, points to research in which subjects exposed to opioid agonists describe experiencing symptoms of depersonalization and derealization (Pfeiffer et al., 1986; Walsh et al., 2001, as cited in Sierra, 2009). It seems plausible that one may see a reduction in depersonalization and derealization symptoms—especially emotional numbing—if an opioid antagonist were initiated. So, what does the research say?

In 2001, Russian researchers conducted a single-blind, placebo-controlled trial involving 14 patients with persistent depersonalization who were treated with naloxone, although only six met the criteria for DSM-IV depersonalization disorder (Nuller et al., 2001). A significant reduction in depersonalization was seen in 10 of the 14 patients (71%), three of whom achieved complete remission.

Two further studies hint at a role for naltrexone, another opioid antagonist, in the treatment of depersonalization symptoms. A 2005 open-label trial on depersonalization disorder involving 14 patients saw an average 30% reduction in symptoms when treated with a mean dose of 120 mg/day (Simeon & Knutelska, 2005). More recently, German researchers Pape & Wöller (2014)

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tested the effectiveness of low dose naltrexone (2-6 mg/day, 0.06 mg/kg) in reducing dissociative symptoms in patients with severe trauma-related and dissociative disorders. Although the trial did not specifically treat patients with depersonalization/derealization disorder, the study did find an immediate reduction in dissociative symptoms in 11 of 15 patients and a lasting effect in seven (Pape & Wöller, 2014).

Benzodiazepines likely not helpful for depersonalization

In the retrospective study mentioned earlier, trials of benzodiazepines were reported in 35 of the 117 subjects, with eight reporting a slight improvement and 10 reporting a definite improvement (Simeon et al., 2003). This tallies with the findings of a small survey of online depersonalization forum participants suggesting that clonazepam, alone or in combination with sertraline (or sertraline alone), might be helpful in treating depersonalization (Lambert et al., 2000), as well as case reports reporting improvement with clonazepam during inpatient hospitalization (Weber et al., 2018) or citalopram combined with clonazepam (Sachdev, 2002). Additionally, a 2013 systematic review by Bredlau et al. found that patients taking ketamine for refractory cancer pain experienced adverse effects including depersonalization and derealization, but these were not reported when the ketamine was combined with benzodiazepines.

Simeon & Abugel (2008) indicate that benzodiazepines might be useful in treating patients with depersonalization-derealization and concomitant anxiety. It appears that the benefits of benzodiazepines may be related more so to relieving underlying anxiety that may be triggering depersonalization and derealization, rather than acting directly on these symptoms. However, benzodiazepines should only be used cautiously in patients with depersonalization and derealization. There may be a role for benzodiazepines, particularly for relief of short term panic and anxiety in these patients, but depersonalization is a known adverse effect of certain benzodiazepines, including alprazolam, clonazepam, and temazepam (Lexicomp, 2023a, 2023b, 2023c). Depersonalization and derealization have also been associated with benzodiazepine withdrawal (Lader, 1984; Marriott & Tyrer, 1993; Mintzer et al., 1999).

Antipsychotics: more research needed

Unsurprisingly, the literature on antipsychotics is similarly thin, with a notable absence of randomized-controlled trials investigating the efficacy of this class of medications. A 2014 case report pointed to antidepressant therapy with adjunctive aripiprazole being effective in relieving depersonalization-derealization symptoms in three patients with depersonalization disorder and either comorbid OCD or major depression (Uguz & Sahingoz, 2014). This tallies with a prior report in which, after various failed medication trials and combinations, aripiprazole combined with clomipramine and diazepam successfully treated a 23-year-old female with depersonalization disorder and comorbid panic disorder, major depressive disorder, and generalized anxiety disorder, as well as a history of anorexia nervosa between ages 13 and 14 (Janjua et al., 2010).

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Whilst some reports do point to a possible role for antipsychotics in depersonalization and derealization treatment, contrary reports suggest that antipsychotics are ineffective (Simeon et al., 2003) or have the potential to make depersonalization and derealization worse (Medford et al., 2005; Sarkar et al., 2001).

Stimulants

More recently, a 2020 case report by Weber about a 35-year-old female with depersonalization/derealization disorder, generalized anxiety disorder, and unspecified depressive disorder (but who did not meet criteria for attention-deficit/hyperactivity disorder [ADHD]) taking venlafaxine saw improvement in the frequency and intensity of dissociative symptoms with the addition of extended-release mixed amphetamine salts.

Scarella & Franzen (2017) report the case of the effects of stimulant medication on dissociative symptoms in another 35-year-old female with an extensive psychiatric history, including major depression, panic attacks, bulimia nervosa, dissociative amnesia, depersonalization, derealization, suicidal ideation, and self harm, but not attention deficit disorder. The authors also surmise that she likely experienced chronic childhood trauma related to parental misattunement. She had previously been trialed on at least ten different psychiatric medications, as well as several different psychotherapy modalities, with no sustained improvement in symptoms, and she was currently taking desipramine and lorazepam (~3 times per week, for insomnia or anxiety) but continued to have persistent symptoms. With the addition of extended-release mixed amphetamine salts, she experienced brief improvement of depression symptoms but a more sustained decrease in dissociative symptoms, including depersonalization and derealization, which was beneficial in her everyday life and also, notably, facilitated her ability to participate in psychotherapy sessions, ultimately leading to more frequent “periods of relative euthymia” (Scarella & Franzen, 2017).

Further, Foguet et al. (2011) present a case report on a patient with a history of anorexia nervosa and generalized anxiety (but not ADHD) who was admitted to the hospital following a suicide attempt and started on clomipramine and clonazepam, but she experienced persistent depersonalization, depressive symptoms, and suicidal ideation after discharge. It is unclear whether she continued clonazepam as an outpatient, but she did continue clomipramine. In addition, she began taking lamotrigine, with reduction in depersonalization symptoms but not depression, as well as reboxetine (a selective norepinephrine reuptake inhibitor or sNRI, not to be confused with serotonin–norepinephrine reuptake inhibitor or SNRI), with no symptom improvement, and ultimately, methylphenidate, resulting in improvement in mood and resolution of suicidal ideation after 2 months, and after 4 months, she experienced depersonalization symptoms only sporadically, rather than daily (Foguet et al., 2011).

Perhaps psychostimulants may be useful in depersonalization/derealization disorder patients where there are pronounced cognitive symptoms such as brain fog (Simeon & Abugel, 2023).

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However, the evidence for stimulants in this condition is certainly limited and has been primarily in combination with other psychopharmacotherapy and involving patients with multiple psychiatric comorbidities. Additionally, Liebowitz et al. (1980) reported two cases of mania induced by treatment of depersonalization with stimulants and antidepressants. As with benzodiazepines, an individualized approach and caution are warranted if prescribing stimulants for depersonalization/derealization disorder.

Art or Science?

In the absence of established prescribing guidelines, the practice of prescribing for depersonalization/derealization disorder may feel like guesswork – more art than science. The *science*, as described in this article, points to tentative evidence suggesting that medication can play a role in the management of depersonalization/derealization disorder. The *art* is perhaps in matching a particular patient with a subset of symptoms to a specific medication, such as an SSRI where there is comorbid depression or an opioid antagonist where there is pronounced emotional numbing. In doing so, practitioners should also carefully consider how medication might *worsen* depersonalization and derealization. Directly, some medications are reported to cause depersonalization, for example, antidepressants broadly (Healy, 2022), quetiapine (Sarkar et al., 2001), clomipramine, and buspirone (Joint Formulary Committee, 2023). Indirectly, some medications have the potential to worsen underlying depersonalization and derealization by increasing agitation or anxiety, including aripiprazole, naltrexone, and lamotrigine (Joint Formulary Committee, 2023). Finally, discontinuation or withdrawal from some medications may trigger episodes of depersonalization, for example, SSRIs (Henssler et al., 2019), other antidepressants, benzodiazepines, and mood stabilizers (Cosci & Chouinard, 2020). With this in mind, perhaps the most skilled clinician will be the one who not only knows when to prescribe, but also when *not* to.

Conclusion

With patients often expressing a strong desire for disorder-specific interventions (Michal et al., 2016) and robust evidence for effective treatments in short supply, those working in general psychiatry may be left feeling unsure as to how to help patients with depersonalization/derealization disorder. Given the typical length of time to diagnosis, perhaps one of the most therapeutic interventions is in simply *making* the diagnosis, demonstrating that depersonalization/derealization disorder is a well-established condition with a clearly defined diagnostic framework. For some, realizing that they are not alone in experiencing such a bewildering collection of symptoms may be very comforting. Additionally, writing in the British Medical Journal, Hunter et al. (2017) advise that in all cases of depersonalization and derealization, whether transient or persistent, clinicians should normalize the experience and highlight the common connection with acute stress and fatigue. Furthermore, they recommend that practitioners give hope to the possibility of recovery. Fortunately, the internet is replete with

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depersonalization/derealization disorder recovery stories that professionals can point to. And to that end, I am delighted to add my own recovery story to the compendium.

Connect with Paul Molyneux (Registered Nurse – Mental Health):

www.theDPguidancecentre.co.uk

Twitter: [@DPguidance](https://twitter.com/DPguidance)

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