A CASE OF DEPERSONALISATION SYNDROME PRESENTING AS SOMATOSENSORY DISTORTION IN A 20 YEAR OLD GIRL
SURTI GANURANGKUMAR MANHARLAL
Department of PSYCHOLOGICAL MEDICINE, MADRAS MEDICAL COLLEGE AND GOVERNMENT GENERAL HOSPITAL

Abstract: Depersonalisation disorder (DPRD), renamed depersonalisation-derealisation disorder in the DSM-5, and Depersonalization-derealization syndrome in ICD-10, is an alteration in the perception or experience of the self and the environment. It is a persistent, pervasive phenomenon, causing subjective distress and functional impairment and is more common in women as compared to men. Even though depersonalisation symptoms are the third most commonly reported psychiatric symptoms after depression and anxiety and frequently occur secondary to many neurological and psychiatric conditions, primary depersonalization as such is thought to be a rare phenomenon. Here we present the case of a 20 year old female with primary depersonalisation disorder who presented with somatosensory distortions in the form of feeling as if sand and water are passing from the chest to the abdomen.

Keyword: Depersonalisation, Somatosensory distortion, DPRD

INTRODUCTION: Depersonalisation disorder (DPRD), renamed depersonalisation-derealisation disorder in the DSM-5 (1), and Depersonalization-derealization syndrome in ICD-10 (2), is an alteration in the perception or experience of the self and the environment. Individuals with depersonalisation feel uneasily estranged and separated from their selves (depersonalisation) and their surroundings (derealisation), experiencing what was also described as a sense of disembodiment (desomatisation) and a diminution or loss of emotional reactivity (de- affectualisation). Depersonalisation occurs as a persistent, pervasive phenomenon, causing subjective distress and functional impairment (3). Depersonalisation symptoms can occur in many neurological (e.g. migraine and epilepsy) and psychiatric conditions (e.g. major depression, panic disorder, posttraumatic stress disorder, schizophrenia, stress and fatigue) (4), or it may occur as a primary phenomenon, in which case it is classified as depersonalisation-derealisation disorder (5). DPRD is frequently a chronic disorder, affecting between 1% and 2.4% of the general population, although its co morbidity with depression and anxiety falls between the percentage ranges of 20–40 (6, 7, 8). Depersonalisation and derealisation symptoms seem to be more common among women (26.5%) than men (19.5%) (9). They are the third most commonly reported psychiatric symptoms after depression and anxiety and usually occur in association with other mental and substance-use disorders although some authors conceptualize depersonalization disorder as a distinct disorder with a characteristic course that is independent of mood, anxiety and personality(10). However, primary depersonalization is thought to be a rare phenomenon (11). We report herein a case of a 20 year old unmarried female who presented primarily with complaints of feeling as if sand and water are passing into her abdomen from the chest and as if the body is made up of skeletons when the clothes are on.

CASE REPORT: Miss S. 20 year old female, hailing from Vyasarpadi, unmarried, completed her B.Sc, unemployed, came with her mother with complaints of feeling as if sand and water passing from her chest to her abdomen on wearing her clothes, feeling as if the body is only made up of skeletons when she has her clothes on, sleep disturbance, decreased appetite and suicidal ideas for the past 4 months. It was only when she removed her clothes that the sensation of sand and water passing and her body being like a skeleton went away. These changes were especially noticed by her while she was having a bath. Patient also complained of difficulties in falling asleep. Even while eating she felt that the sand and water passed to her abdomen faster. She, who was a regular to the church decreased going to the church and decreased interacting with others and preferred being preoccupied in her thoughts. She would even be crying frequently owing to the distress caused by these thoughts and had even harboured suicidal ideas to get rid of these thoughts. There was history of psychiatric illness in the father’s aunt. On Mental Status Examination, she was alert, ambulant, co-operative. Her psychomotor activity and speech was normal. She was preoccupied with the changes that she experienced. She experienced somatosensory distortions in the form of feeling as if sand and water passing from her chest to her abdomen and feeling as if the body is only made up of skeletons. Her mood was euthymic and affect was reactive and appropriate. Insight was present. Routine blood investigations done were found to be normal. Neurological and Gastroenterology opinion was obtained and nothing significant was found. On psychological assessment, IQ was 96 and not suggestive of psychotic disorder. On HAM-D, she was found to be having mild depression. On Dissociative Experiences Scale (DES), she scored high on the depersonalization subscale and on Cambridge Depersonalization Scale, scores were significant. Patient was given psychotherapy and behavioural therapy (daily relaxation exercises) and was started on C. Fluoxetine 40mg in divided doses and
T. Clonazepam 0.5 mg. On follow-up patient’s symptoms had reduced and she was able to function well.

DISCUSSION:
According to Ackner (12), positive features of depersonalization include that it should always be a subjective disorder of experience; this experience should be that of an internal or external change characterized by a feeling of strangeness or unreality; it should be unpleasant; affect should invariably be involved and insight should be preserved. In our case, the strange and unpleasant experience described by the patient was associated with certain features of depression and insight was present. According to Sims, depersonalization is difficult for the Doctor to portray; more importantly, it is extraordinarily difficult also for the patient to describe (13). We faced a similar situation with regard to our case where the uniqueness of the patient’s symptom and her inability to explain it made us think in terms of a psychotic disorder initially. Amongst the various components of depersonalization given by Sierra & Berrios 2001, our patient’s symptoms could be classified under changes in body experience (14, 15, 16). Our patient had features of depression like low mood, sleep disturbance, decreased appetite and suicidal ideas but these features were secondary to the somatosensory distortions she was experiencing; therefore primary diagnosis is of depression was not made. We report this case for the uniqueness of the presenting symptom as well as for the fact that it is a primary depersonalization disorder. There is as yet no definitive established treatment for depersonalization derealization syndrome. There is some systematic evidence that antidepressants (SSRIs) may be helpful (3). Depersonalization was significantly more likely to improve if co morbid disorder improved (17). Some studies report that certain patients with depersonalisation disorder respond at best sporadically and partially to usual groups of psychiatric medications, singly or in combination. (18) Our patient was started on 40 mg of fluoxetine in divided doses along with Clonazepam and she responded to it well. Reduction of symptoms and functional improvement was noted on follow up 2 months later.

CONCLUSION:
As primary depersonalization derealization syndrome is a rare presentation with poor prognosis, very few studies have been done on this subject especially in the Indian setup. It is hoped that further studies will enable us to know more about this in future.

REFERENCES: