An atypical relationship between depersonalization/derealization symptoms and self-harming behavior: A case study

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Case presentation

The patient is a 22-year-old Caucasian male who was diagnosed with bipolar disorder I, obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, and borderline personality disorder. Significantly, patient does not have a diagnosis of posttraumatic stress disorder and denies any history of verbal, emotional, physical, and sexual abuse. He also denies ever being in any life-threatening situations. Patient began self-harming one year prior to initial appointment at our clinic. At initial appointment, patient had approximately 100 shallow linear cuts in a grid-like pattern on his left forearm. Patient denied feeling emotional release associated with self-harming. After patient stopped self harming for one month, he started to develop depersonalization/derealization symptoms for the first time. He stated that "time feels weird". He stated that it felt like a few minutes had passed when in fact five hours had passed. He stated that the world felt flat, lifeless, and dreamlike. Sometimes he felt like he was watching himself from a distance or from above. He would tell people autobiographical details, such as his birthdate, and feel like he was lying to them. Patient was extremely distressed by the symptoms. During the course of treatment, patient's depersonalization/derealization symptoms would either improve or resolve after episodes of self-harming and would then re-emerge when patient did not engage in self harming. This pattern occurred several times during course of treatment. Etiologies of the depersonalization/derealization symptoms include borderline personality disorder, past history of use of sensory deprivation tanks, hours-long meditation sessions, and marijuana use. Interestingly, being in a deprivation tank or meditating for hours did not result in distressing dissociative symptoms. When asked how the depersonalization/derealization symptoms were different from the dissociative symptoms associated with meditation and sensory deprivation tanks, patient was unable to articulate the difference.

Sadock, Benjamin J., Virginia A Sadock and Pedro Ruiz. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 10th ed. Philadelphia: Wolter Kluwer/Lippincott Williams & Wilkins, 2017.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington 2013.

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Discussion

Typical presentation: According to Kaplan and Sadock, depersonalization/derealization symptoms induce a patient to self-harm in order to relieve the dissociative symptoms. A highly prevalent cognitive distortion among patients with dissociative symptoms is that, since they will suffer no matter what they do, they would like to control the timing and intensity of the harm. According to Kaplan and Sadock, "Chronic depersonalization, closely associated with emotional numbing in PTSD patients, is thought to promote a sense of detachment from self that fosters risky and self-destructive behavior, such as self-mutilation. Self-mutilation has been strongly associated with increased dissociation in numerous studies. Dissociative patients often describe self-inflicting pain in attempts to break through profound states of depersonalization. At other times, they report feeling nothing as they cut or burn themselves."

Patient atypical presentation: Patient did not have depersonalization/derealization symptoms one year ago, when he began self-harming. Instead, the depersonalization/derealization symptoms started after he stopped self-harming. In other words, the absence of the coping skill (self-harming) led to the dissociative symptoms.

Conclusion

Depersonalization/derealization symptoms can be highly distressing to patients and are often underdiagnosed or completely undetected. Patients with these symptoms often have great difficulty putting their symptoms into words, which makes diagnosis more challenging. Patients with these dissociative symptoms often exhibit a flat, robotic affect, which conceal the extent of the distress caused by the symptoms. Treatment consists of cognitive behavioral therapy or psychodynamic psychotherapy. SSRIs, such as sertraline, can treat comorbid depression and anxiety, which often improve dissociative symptoms. Lamotrigine and naltrexone have shown some benefit as well. Antipsychotics are typically not used in treatment.