ORIGINAL RESEARCH PAPER

Psychiatry

KEY WORDS:

CANNABIS INDUCED PERSISTENT DEPERSONALISATION DEREALISATION DISORDER

Dr. D. Vijayanand Senior Resident, Saveetha Medical College, Chennai

Depersonalisation is **a disturbing** sense of being 'separate from oneself', observing oneself as if from outside, feeling like a robot or automaton .Derealisation is a **threatening** sense of unfamiliarity or unreality in the environment **where the patient may perceive as if they are actors in a play.**

Depersonalization disorder is thought to be caused largely by severe traumatic lifetime events, including childhood abuse, accidents, natural disasters, war, torture, panic attacks and bad drug experiences.

Management includes lamotrigine with SSRIs. Cognitive behavioral technique has been proven to be effective.

Here we report a young male who presented with persistent depersonalisation following cannabis use.

CASE REPORT:

A 24 year old male presented to the psychiatry OP with c/o feeling strange about his surroundings, altered perception of time, confused of the time (what day/what time etc.), feeling cut off from the world, unable to experience emotions for the past 1 month and secondary to that his occupational life was disturbed and developed secondary depressive features like anhedonia, suicidal ideas. These symptoms were triggered after he consumed cannabis by smoking and had a 'bad trip'. There were other life events worsening the symptom presentation. He experienced significant jamais vu phenomenon. There was no evidence of anxiety states, depressive disorder, adjustment disorder or psychotic illness. Only his perplexity and vague symptoms was mimicking prodromal psychosis. When he presented he had panic attacks, fear of going insane and fear of leaving home alone. **Family history was not significant and no deviant personality traits.**

He was given adequate trial of all SSRIs, SSRI+Modafinil, Naltrexone, Lamotrigine, Antipsychotics like Quitiapine, Arpiprazole etc were tried but he showed little response to these drugs. He showed moderate response to LamotrigIne and Desvenlafaxine with improvement in his occupational functioning but the improvement was not sustained and patient started complaining of altered time perception , self awareness and jamais vu. Numerous strategies were tried with CBT. His depressive symptoms reduced as he learnt to live with the symptoms and developed insight on the disorder. The total duration of the symptoms including the period of treatment lasted for more than 10 months thus becoming persistent and chronic. Cambridge depersonalization scale was applied showing significant reduction in the scores to (27) falling within anxiety spectrum when compared to his scores in the first visit (103) fulfilling the criteria for depersonalisation disorder. Further follow up showed chronic remission and partial relapses lasting for few minutes to hours. The final diagnosis given was cannabis induced persistent depersonalization- derealization disorder with secondary depression.

DISCUSSION:

This case report highlights the importance of substance use (use of cannabis once) inducing a persistent depersonalisation state which has been documented in western studies **(Dawn Baker2003, BJP)**. There are two case studies and one report of cannabis induced persistent depersonalisation after abstinence in the western literature (Thomas 1993). The patients were found to experience flashbacks during the drug free period and the symptoms mimic cannabis induced psychosis like the presentation in our patient.

Pharmacological evidence exists for SSRI, Lamotrigine and Benzodiazepines **(Somer et al 2013)**. Our patient can be labeled as poor responder and his response was fair and adequate only to clonazepam which has been documented in the literature. CBT model for depersonalisation suggests that there are various ways in which depersonalisation may initially arise, related to some external psychological stressor and/or as a consequence of a change in mental state (e.g. low mood, anxiety, drug use) **(Nick Medford et al 2005)**. Based on this model, patient was psychoeducated, taught reduction of avoidant 'safety behaviours' (such as avoiding social situations) and excessive self- observation (e.g. looking in the mirror to see if one has changed), and challenging the 'catastrophic' attributional style (e.g. ideas such as 'My brain is not working').

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