CHAPTER

27

Depersonalization: Systematic Assessment

M. Steinberg
Independent Practice, Naples, FL, USA

OUTLINE

Definition and Characteristics 227
Etiology 228
Assessment with the Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised 229
Case Study 230
Sample SCID-D-R Psychological Evaluation 230
Conclusions 231
Glossary 231
References 231

Abstract

Depersonalization is often not the presenting complaint, making familiarity with the means for detection and assessment critical to avoiding misdiagnosis and ineffective treatment. Depersonalization occurs on a spectrum, from few/transient episodes in individuals with a variety of psychiatric disorders, to recurrent or ongoing episodes experienced in those with posttraumatic and dissociative disorders. Accurate diagnosis requires assessment of depersonalization within a context of other dissociative symptoms in order to properly characterize an underlying dissociative disorder, or to rule one out. The author reviews assessments of depersonalization in adolescents and adults using the Structured Clinical Interview for Dissociative Disorders (SCID-D) (Steinberg, 1994, DSM-5/ICD version). The SCID-D evaluates depersonalization in the context of four additional dissociative symptoms: amnesia, derealization, identity confusion, and identity alteration. Many studies have documented the SCID-D's good-to-excellent reliability and validity for detection of depersonalization and its characterization within the full spectrum of dissociative symptoms.

Depersonalization is characterized by a sense of detachment from the self. The symptom itself may manifest in a variety of axis I or axis II psychiatric disorders. The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5)[1] describes depersonalization as involving experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions. The sense of detachment itself may be experienced in various ways. Commonly it appears as out-of-body experiences giving a sense of division into a participating and an observing self, resulting in the sense of going through life as though one were a machine or robot.[2] In some cases, there exists a feeling that one's limbs are changing in size or are separated from the body.

It is important to distinguish between recurrent to persistent depersonalization that is characteristic of both, the dissociative disorders and of a subset of individuals with posttraumatic stress disorder,[3–11] versus the occasional episodic depersonalization which occurs in patients with other nondissociative axis I or II disorders,[3–6,8,9] versus the very brief or isolated episodes experienced by persons in the nonpsychiatric population (normal controls).[2,12]

DEFINITION AND CHARACTERISTICS

Although depersonalization was first described in 1872, it was not named until 1898, when Dugas[13] contrasted the feeling of loss of the ego with a real loss. In 1954, Ackner remedied the lack of clearly defined boundaries of the symptom by describing the four salient features: (1) feeling of unreality or strangeness regarding the self, (2) retention of insight and lack of delusional elaboration, (3) affective disturbance resulting in loss of all affective responses except discomfort over the depersonalization, and (4) an unpleasant quality that varies in

Stress: Concepts, Cognition, Emotion, and Behavior
http://dx.doi.org/10.1016/B978-0-12-800951-2.00027-3

intensity inversely with the patient's familiarity with the symptom.[14] For the purposes of clinical assessment, Steinberg defined depersonalization as one of five core symptoms of dissociation, the other four consisting of amnesia, derealization, identity confusion, and identity alteration.[2,15–18] Each of the five dissociative disorders has characteristic symptom profiles of these core dissociative symptoms. For this reason, it is essential that the symptom of depersonalization is evaluated within the context of the other dissociative symptoms and not as an isolated symptom.[2,15–18]

KEY POINTS

- Depersonalization is characterized by a sense of detachment or disconnection from one's self, and is commonly experienced within a variety of psychiatric conditions, as well as in nonpsychiatric populations.
- Depersonalization occurs along a spectrum, from a few transient episodes that are not associated with dysfunction or distress, to recurrent or persistent episodes which result in dysfunction or distress.
- Depersonalization as seen in both dissociative disorders and in a subset of individuals with posttraumatic stress disorder can be distinguished from depersonalization occurring in other psychiatric and nonpsychiatric samples by use of the *SCID-D Interview* to assess the frequency, nature, and context of the patient's depersonalization experiences.
- Systematic assessment of depersonalization in the context of other dissociative symptoms, as assessed in the *SCID-D Interview*, is essential for accurate diagnosis and effective treatment of an underlying dissociative disorder.

Episodes of depersonalization can accompany or even may precipitate panic attacks and/or agoraphobia; they may also be associated with dysphoria.[19] Chronic depersonalization frequently results in the patient's acceptance of the symptoms, in a manner of resignation. Patients experience difficulty putting their experience into words, but often compare their feelings to such states as being high on drugs, seeing themselves from the outside, or floating in space and watching themselves. Other descriptions of depersonalization include feelings of being unreal, or in severe cases, include the feeling of being numb or dead, or the lack of all feeling, which may be attributed to and/or misdiagnosed as depression.

Depersonalization has been reported to be a common complaint among psychiatric patients, after depression and anxiety. The assessment and prevalence of depersonalization has been impeded by (1) its multifaceted presentation and relative strangeness of the symptoms, (2) the difficulty that patients have in communicating their depersonalization experiences, and (3) the lack of widespread training in the diagnostic tools used for the systematic assessment of depersonalization.[2] Detection is further complicated by the fact that depersonalization may not be accompanied by altered observable or social behavior indicating the patient's dysfunction or distress.

ETIOLOGY

Various biological and psychodynamic theories have been advanced for the etiology of depersonalization[20–23]: (1) physiological or anatomical disturbance, with feelings of depersonalization produced by temporal lobe function and various metabolic and toxic states, (2) the result of a preformed functional response of the brain to overwhelming traumata, (3) a defense against painful and conflictual affects such as guilt, phobic anxiety, anger, rage, paranoia, primitive fusion fantasies, and exhibitionism, (4) a split between the observing and the participating self, allowing the patient to become a detached observer of the self, and (5) the result of childhood maltreatment, especially emotional abuse.

Depersonalization has been reported to be a normal reaction to life-threatening events, such as accidents, serious illnesses, and near-death experiences and was noted in 66% of 101 survivors of life-threatening experiences.[12] Depersonalization is common among victims of sexual abuse, political imprisonment, torture, and cult indoctrination. Symptoms of depersonalization are often associated with hypnosis, hypnagogic and hypnopompic states, sleep deprivation, sensory deprivation, hyperventilation, and drug or alcohol abuse.

Depersonalization, as a brief, isolated symptom, is nonspecific and not necessarily pathognomonic of any clinical disorder. Research indicates that it is the persistence, nature, and context of depersonalization that differentiates depersonalization in people without psychiatric disorders from persons with dissociative and nondissociative disorders.[2–12] Table 1 is useful for distinguishing between common mild depersonalization and pathological depersonalization. Table 2 summarizes the spectrum of depersonalization.

The differential diagnosis tree of depersonalization (Figure 1) illustrates procedures for distinguishing between depersonalization disorder and other disorders that may resemble it. The differential diagnosis of patients experiencing recurrent or persistent depersonalization should include the dissociative disorders, posttraumatic stress disorder, and possible medical disorders/organic etiology, most commonly acute head trauma, seizure disorders, and acute drug or alcohol use.

TABLE 1 Distinguishing Between Common Mild Depersonalization and Pathological Depersonalization

Common mild depersonalization	Transient depersonalization	Pathological depersonalization
Context		
Occurs as an isolated symptom	Occurs as an isolated symptom	Occurs within a constellation of other dissociative or nondissociative symptoms or with ongoing interactive dialog
Frequency		
One or few episodes	One or few episodes that are transient	Persistent or recurrent depersonalization
Duration		
Depersonalization episode is brief; lasts seconds to minutes	Depersonalization of limited duration (minutes to weeks)	Chronic and habitual depersonalization lasting up to months or years
Precipitating factors		
• Extreme fatigue • Sensory deprivation • Hypnagogic and hypnopompic states • Drug or alcohol intoxication • Sleep deprivation • Medical illness/toxic states • Severe psychosocial stress	• Life-threatening danger. This is a syndrome noted to occur in 33% of individuals immediately following exposure to life-threatening danger, such as near-death experiences and auto accidents (Noyes and Kletti[12]) • Single, severe psychological trauma	• Not associated with precipitating factors in column 1 exclusively • May be precipitated by a traumatic memory • May be precipitated by a stressful or traumatic event but occurs even when there is no identifiable stress • Results in dysfunction or distress

Reprinted with permission from Ref. 2.

TABLE 2 The Spectrum of Depersonalization on the SCID-D-R

DID and DDNOS	Nondissociative and personality disorders	No psychiatric disorder
Depersonalization questions elicit descriptions of identity confusion and alteration	No spontaneous elaboration	No spontaneous elaboration
Includes interactive dialogs between individual and depersonalized self	No interactive dialogs	No interactive dialogs
Recurrent-persistent	None-few episodes	None-few episodes

Note: *DID, dissociative identity disorder; DDNOS, dissociative disorder; not otherwise specified.*
Reprinted with permission from Ref. 16.

ASSESSMENT WITH THE STRUCTURED CLINICAL INTERVIEW FOR DSM-IV DISSOCIATIVE DISORDERS—REVISED

Several self-administered tests are available which screen for the presence of depersonalization.[4] Screening tests should not be used for the purpose of diagnoses, but rather for identification of at-risk cases to be evaluated further by clinical interview or diagnostic test.

The *Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised* (*SCID-D-R*) is a diagnostic interview for the comprehensive assessment of dissociative symptoms and disorders, including the systematic identification of depersonalization. The interview can be used in adolescents and adults.[10,24] Developed in 1985 and extensively field tested, it is the only diagnostic instrument enabling a clinician to detect and assess the presence and severity of five core dissociative symptoms (amnesia, depersonalization, derealization, identity confusion, and identity alteration) as well as the dissociative disorders (dissociative amnesia, depersonalization/derealization disorder, dissociative identity disorder, other specified dissociative disorder, and unspecified dissociate disorder) as defined by DSM-5 criteria. The updated version of the SCID-D-R also allows for diagnosis based on ICD criteria.[17] The SCID-D-R is a semi-structured diagnostic interview with good-to-excellent inter-rater and test-retest reliability and discriminant validity.[3–5,10,25] Recent neuroimaging studies have validated the SCID-D-R's ability to discriminate those with complex dissociative disorders, for example, a recent study documented that SCID-D-R identified dissociative identity disorder patients had characteristic brain activity during state-switching that could not be duplicated by either fantasy-prone controls or trained feigners.[26]

Guidelines for the administration, scoring, and interpretation of the SCID-D-R are reviewed in the *Interviewer's Guide to the SCID-D-R*. Severity rating definitions were developed to allow clinicians to rate the severity of symptoms in a systematic manner and are included in the guide.[16,18]

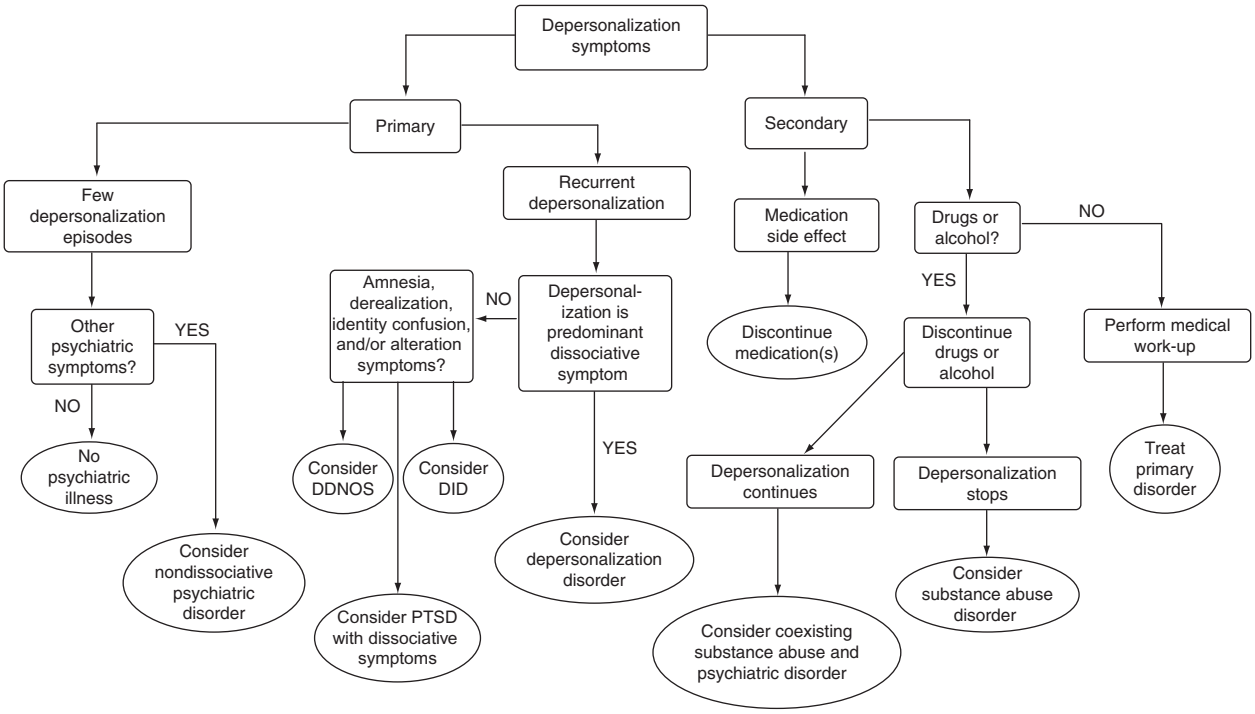

FIGURE 1 Differential diagnosis decision tree of depersonalization. Adapted with permission from Ref. 16.

The SCID-D-R can be used for symptom documentation for psychological and forensic reports.[25,27] Early detection of dissociative disorders, including depersonalization disorder, can be realized from the use of this specialized instrument, the format of which includes open-ended questions designed to elicit spontaneous descriptions of endorsed dissociative symptoms. The SCID-D-R has been demonstrated to be a valuable tool in differential diagnosis with patients of different ages (adolescents, as well as adults), backgrounds, previous psychiatric histories, and presenting complaints. It also plays a useful role in treatment planning, patient follow-up, and symptom monitoring.[28]

Correct diagnosis is vital to proper treatment of depersonalization. If the depersonalization is a symptom of a dissociative disorder, the symptoms can be alleviated by treatment of the underlying dissociative condition. The presence of depersonalization disorder itself is characterized by recurrent depersonalization. In instances in which the patient experiences only occasional episodes of depersonalization in the context of other nondissociative symptoms, the clinician should consider a diagnosis of a nondissociative psychiatric disorder.

CASE STUDY

The process of differential diagnosis of depersonalization may best be illustrated by presenting a case study. The study demonstrates the utility of the SCID-D-R in diagnostic assessment, patient education, and treatment planning. For space reasons, conventional formatting and content have been abbreviated.

Sample SCID-D-R Psychological Evaluation

Demographic information and chief complaint: Susan Walker is a 31-year-old administrative assistant at a community college who presented with the complaint of feeling detached from herself since adolescence. Past psychiatric history: Although the patient had no history of hospitalization for psychiatric disturbance, she began treatment for an episode of depression that interfered with her employment and social relationships. Although admitting to past casual use of marijuana, she had never been in treatment for substance abuse disorder.

Family history: Susan had a younger sibling; both children grew up in an intact but emotionally unsupportive family. Patient reported that both parents suffered mood swings and unpredictable temper outbursts.

Mental status exam: Susan answered questions with relevant replies; although she seemed slightly depressed, her affect appeared full range. She denied hallucinations, both auditory and visual, and evidenced no psychotic thinking. She denied acute suicidal or homicidal ideas.

SCID-D-R evaluation: The SCID-D-R was administered to systematically evaluate the patient's dissociative symptoms and was scored according to prescribed guidelines. Significant findings from the SCID-D-R interview

follow. Susan denied experiencing severe episodes of amnesia, but endorsed a persistent sense of depersonalization, resulting in distress and interference with occupational and personal functioning. This feeling of depersonalization had been chronic and occurred all the time rather than episodically. Although the feeling varied in intensity with her overall stress level, the experience of depersonalization was always characterized by a general sense of detachment from life, rather than by disturbances in body image or a split between participating and observing parts of the self. Only a single isolated out-of-body experience had occurred. Susan experienced feelings of derealization that varied in intensity with the depersonalization, but she reported the depersonalization as the most distressing symptom. She described recurrent anxiety and panic episodes triggered by the depersonalization; it was the combination of depersonalization and panic attacks that led to the depression that brought her into therapy. Susan reported that the depersonalization has eroded her sense of control over her occupational functioning and other significant areas of her life, but she did not attribute feelings of loss of control to identity confusion or alteration. She denied having internal dialogs, feelings of possession, or acquiring unexplained possessions or skills. Her descriptions of internal struggle were focused on her feelings of unreality, not on conflicts between different aspects of her personality or different personalities within herself.

Assessment: Susan's symptoms are consistent with a primary diagnosis of a dissociative disorder based on DSM-5 criteria and ICD-10 criteria. Specifically, in the absence of substance abuse disorder or other organic etiology, her severe chronic feelings of unreality toward herself and the accompanying dysfunction (in the absence of other dissociative symptoms such as identity confusion and alteration) are consistent with a diagnosis of depersonalization disorder.

Recommendations: Although detailed discussion of treatment for depersonalization disorder is beyond the scope of this article, it would be standard practice to conduct a follow-up interview to review the findings of the SCID-D-R evaluation, to educate the patient regarding her symptoms, and to begin the process of individual psychotherapy.

CONCLUSIONS

Recent advances in the development of reliable diagnostic tools allow for early detection and accurate differential diagnosis of depersonalization. Research based on the SCID-D-R indicates that depersonalization occurs in individuals without psychiatric illness who experience few brief episodes following high stress, as well as in individuals with dissociative disorders who experience recurrent to ongoing episodes. In addition to the frequency of the depersonalization, the nature, severity, and context also distinguish cases of dissociative disorder from other nondissociative disorders.[1–10,15–18] To date, no double-blind trials of medication have found pharmacotherapy to be effective in the treatment of depersonalization. Further research is necessary in the form of controlled double-blind studies evaluating psychotherapeutic and/or pharmacotherapeutic agents. As the SCID-D-R allows for the assessment of the severity of depersonalization based on operationalized criteria, psychotherapy and pharmacotherapy trials can be systematically performed and can evaluate baseline and post-treatment severity levels of depersonalization. Given the frequency of misdiagnosis in patients suffering from depersonalization and other dissociative symptoms, earlier detection of dissociative symptoms and disorders using the SCID-D-R can allow for rapid implementation of effective treatment.

Glossary

Amnesia A specific and significant block of time that has passed but cannot be accounted for by memory.

Depersonalization Detachment from one's self, for example, a sense of looking at one's self as if one were an outsider.

Derealization A feeling that one's surroundings are strange or unreal. Often involves previously familiar people.

Dissociation Disruption in the usually integrated functions of conscious memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient, or chronic.

Identity alteration Objective behavior indicating the assumption of different identities or ego states, more distinct than different roles.[2,15–18]

Identity confusion Subjective feelings of uncertainty, puzzlement, or conflict about one's identity. Note: Identity confusion and identity alteration are defined as listed above by Steinberg for the purpose of Steinberg for the purpose of clinical assessment.[15–18]

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. (DSM-5) Arlington, VA: American Psychiatric Association; 2013.
2. Steinberg M. *Handbook for the Assessment of Dissociation: A Clinical Guide.* Washington, DC: American Psychiatric Press; 1995.
3. Steinberg M. Advances in the clinical assessment of dissociation: the SCID-D-R. *Bull Menninger Clin.* 1995;59:221–231.
4. Mueller-Pfeiffer C, Kaspar Rufibach K, Wyss D, Perron N, Pitman R, Rufer M. Screening for dissociative disorders in psychiatric out- and day care-patients. *J Psychopathol Behav Assess.* 2013;35(4):592–602.
5. Mueller C, Moergeli H, Assaloni H, Schneider R, Rufer M. Dissociative disorders among chronic and severely impaired psychiatric outpatients. *Psychopathology.* 2007;40(6):470–471.
6. Ginzburg K, Somer E, Tamarkin G, Kramer L. Clandestine psychopathology: unrecognized dissociative disorders in inpatient psychiatry. *J Nerv Ment Dis.* 2010;198:378–381.
7. Steinberg M, Schnall M. *The Stranger in the Mirror: Dissociation—The Hidden Epidemic.* New York, NY: Harper Collins; 2001.

8. Steinberg M, Rounsaville B, Buchanan J, Raakfeldt J, Cicchetti D. Distinguishing between multiple personality and schizophrenia using the Structured Clinical Interview for DSM-IV Dissociative Disorders. *J Nerv Ment Disord*. 1994;182:495–502.
9. Steinberg M, Siegel H. Advances in assessment: the differential diagnosis of Dissociative Identity Disorder and Schizophrenia. In: Moskowitz A, Schafer I, Dorahy M, eds. *Psychosis, Trauma and Dissociation: Emerging Perspectives on Severe Psychopathology*. 3rd ed. London, UK: John Wiley & Sons; 2008.
10. Sar V, Onder C, Kilincaslan A, Zoroglu S, Alyanak B. Dissociative identity disorder among adolescents: prevalence in a university psychiatric outpatient unit. *J Trauma Dissociation*. 2014;15(4):402–419.
11. Bremner D, Steinberg M, Southwick S, Johnson DR, Charney DS. Use of the Structured Clinical Interview for DSM-IV Dissociative Disorders for systematic assessment of dissociative symptoms in posttraumatic stress disorder. *Am J Psychiatry*. 1993;150(7):1011–1014.
12. Noyes Jr. R, Kletti R. Depersonalization in response to life-threatening danger. *Compr Psychiatry*. 1977;18:375–384.
13. Dugas L. A case of depersonalization [Un cas de depersonalization]. *Rev Philos*. 1898;45:500–507.
14. Ackner B. Depersonalization I: aetiology and phenomenology. *J Ment Sci*. 1954;100:838–853.
15. Steinberg M. *The Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised (SCID-D)*. 2nd ed. Washington, DC: American Psychiatric Press; 1994.
16. Steinberg M. *The Interviewers' Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised*. 2nd ed. Washington, DC: American Psychiatric Press; 1994.
17. Steinberg M. *The Structured Clinical Interview for Dissociative Disorders (SCID-D) (DSM/ICD Version)*. Washington, DC: American Psychiatric Press; 1994.
18. Steinberg M. *The Interviewers' Guide to the Structured Clinical Interview for Dissociative Disorders (DSM/ICD Version)*. Washington, DC: American Psychiatric Press; 1994.
19. Simeon D, Gross S, Guralnik O, Stein DJ, Schmeidler J, Hollander E. Feeling unreal: 30 cases of DSM-III-R depersonalization disorder. *Am J Psychiatr*. 1997;154:1107–1113.
20. Somer E. Evidence-based treatment for depersonalisation-derealisation disorder (DPRD). *BMC Psychol*. 2013;1:20. http://dx.doi.org/10.1186/2050-7283-1-20.
21. Simeon D, Guralnik O, Schmeidler J, Sirof B, Knutelska M. The role of childhood interpersonal trauma in depersonalization disorder. *Am J Psychiatry*. 2001;158:1027–1033.
22. Bowman ES, Markand O. Psychodynamics and psychiatric diagnoses of pseudoseizure subjects. *Am J Psychiatr*. 1996;153(1):57–63.
23. Lambert M, Sierra M, Phillips MD. The spectrum of organic depersonalization: a review plus four new cases. *J Neuropsychiatry Clin Neurosci*. 2002;14(2):141–154.
24. Carrion V, Steiner H. Trauma and dissociation in delinquent adolescents. *J Am Acad Child Adolesc Psychiatry*. 2000;39:353–359.
25. Welburn K, Fraser G, Jordan S, Cameron C, Webb L, Raine D. Discriminating dissociative identity disorder from schizophrenia and feigned dissociation on psychological tests and structured interview. *J Trauma Dissociation*. 2003;4(2):109–130.
26. Reinders A, Willemsen A, Vos H, den Boer J, Nijenhuis E. Fact or factitious? A psychobiological study of authentic and simulated dissociative identity states. *PLoS ONE*. 2012;7(6):e39279.
27. Steinberg M, Hall P, Lareau C, Cicchetti D. Recognizing the validity of dissociative symptoms and disorders using the SCID-D-R: guidelines for clinical and forensic evaluations. *South Calif Interdiscip Law J*. 2001;10(2):225–242.
28. Steinberg M, Hall P. The SCID-D diagnostic interview and treatment planning in dissociative disorders. *Bull Menninger Clin*. 1997;61:108–120.