Depersonalization/derealization disorder: Psychotherapy

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Literature review current through: **Oct 2023.**
This topic last updated: **Sep 16, 2022.**

INTRODUCTION

Depersonalization/derealization disorder (DDD) is characterized by persistent or recurrent depersonalization and/or derealization that causes clinically significant distress. Reality testing remains intact [1].

DDD has a lifetime prevalence in the general population of approximately 2 percent and is associated with significant morbidity, but often goes undetected or misdiagnosed, leading to delays in treatment.

This topic discusses psychotherapy for DDD. The epidemiology, pathogenesis, clinical manifestations, course, and diagnosis of DDD are discussed separately. Pharmacotherapy for DDD is also discussed separately. (See "Depersonalization/derealization disorder: Epidemiology, clinical features, assessment, and diagnosis".)

DEFINITIONS

Depersonalization — Depersonalization is a persistent or recurrent feeling of detachment or estrangement from one's self. An individual experiencing depersonalization may report feeling like an automaton, as if in a dream, or as if watching himself or herself in a movie. Depersonalized individuals may report the sense of being an outside observer of their mental processes or their body. They often report feeling a loss of control over their thoughts,

perceptions, and actions. (See "Depersonalization/derealization disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical manifestations'.)

Derealization — Derealization is a subjective sense of detachment or unreality regarding the world around them (eg, other individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted). (See "Depersonalization/derealization disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical manifestations'.)

APPROACH TO TREATMENT

Our approach to selecting among treatments for depersonalization/derealization disorder, including the use of pharmacotherapy and psychotherapy, is discussed separately. (See "Approach to treating depersonalization/derealization disorder".)

PSYCHOTHERAPIES

Several psychotherapies, in our clinical experience, can help patients with depersonalization/derealization disorder (DDD), including psychodynamic, cognitive, behavioral, hypnotherapeutic, and supportive therapies. No controlled clinical trials have been performed to assess or compare the efficacy of these interventions.

Clinicians working with patients with depersonalization and/or derealization may have an excessively pessimistic view of the treatment responsiveness of DDD because they often have an opportunity to intervene only years after onset [2-4], at which point the symptoms tend to have become more constant and possibly more treatment resistant. Anecdotal evidence suggests that patients are more likely to respond if treatment is begun earlier in the course of the disorder or if the disorder has an episodic or fluctuating course.

Cognitive-behavioral therapy — A cognitive-behavioral therapy (CBT) has been developed to treat DDD, but has not been tested in controlled clinical trials.

Conceptual model — Acute DDD represents an almost ubiquitous response to extreme stress. A cognitive framework has been used to describe mechanisms that contribute to the exacerbation and maintenance of the initial symptoms after the stressor lifts, rather than their attenuation and extinction.

This cognitive-behavioral model proposes that an initial trigger (trauma, anxiety, depression, stress, fatigue, or intoxication) can induce transient symptoms of depersonalization and

derealization which are subsequently cognitively processed by an individual as either situational or catastrophic [5]. If the attributions are situational, and therefore more benign, the depersonalization symptoms will tend to fade as the situational factors lessen. However, if the attributions are catastrophic, they evoke overwhelming fears such as going mad, losing control, becoming invisible, or having a permanent brain dysfunction. In turn, such fears can lead to an increase in anxiety coupled with a paradoxical decrease in arousal, resulting in increased intensity of the depersonalization/derealization symptoms as the individual enters the maintenance phase. During this phase, individuals may start to avoid situations that they associate with symptom provocation, become preoccupied with safety behaviors (such as avoidance or "acting normal"), and develop cognitive biases so that they over-monitor their symptoms and have a reduced threshold for the perception of threat. These maintenance factors thus serve to perpetuate or exacerbate the symptoms over time.

Administration — CBT is initially undertaken as a 12- to 16-session course with weekly sessions. Progress is assessed at the end the 16 sessions, and a decision is made about whether patients should continue in once weekly CBT or can taper down to monthly booster sessions.

In CBT for DDD, the focus is on developing techniques to:

- Cognitively reinterpret symptoms as less threatening
- Reduce symptom monitoring
- Diminish avoidance and safety behaviors

As an example, consider a patient with DDD who is constantly preoccupied with existential ruminations; has checking rituals to determine whether the symptoms are still present; believes that they have suffered irreversible brain damage; and avoids many activities, such as leaving home, socializing, or being in overstimulating environments out of the fear that these will worsen the symptoms.

Using thought-blocking and distraction techniques, the patient can be helped to ruminate less and resist checking rituals using a distracting task. Cognitive corrections can be used to counter catastrophic cognitions, such as the one involving irreversible brain damage. A hierarchical exposure approach can be used to help the patient gradually confront, rather than avoid, situations that worsen the symptoms. If anxiety is exacerbating the symptoms, mindfulness, grounding, and relaxation/breathing retraining can be used to keep anxiety in better check while illuminating for the patient the vicious cycle of anxiety triggering more depersonalization/derealization, and depersonalization/derealization then triggering worsened anxiety.

Efficacy — Limited evidence suggests CBT may be effective for DDD. An uncontrolled, prospective trial tested CBT in 21 patients with chronic DDD [6]. Compared with the start of treatment, reductions were seen in depersonalization, derealization, dissociation, and other psychiatric symptoms at the end of the 12-week intervention and at a follow-up assessment six months later. At the end of 12 weeks, 29 percent of participants no longer met diagnostic criteria for DDD. Seventeen of the 21 patients received medication concurrently, but only three had medication changes during the intervention period. Still, depersonalization/derealization symptoms decreased by an average by 23 percent in this study, suggesting that psychotherapy approaches beyond CBT, such as psychodynamic and trauma-informed, are often indicated. Further research on the effectiveness of CBT for DDD is needed, including larger, randomized trials.

Administration

Psychodynamic therapy — Psychodynamic psychotherapy for DDD focuses on the underlying threats to self-constancy and self-experiencing associated with emotional maltreatment, attachment disturbances, and alexithymia, and giving rise to affectively intolerable states that are perpetuated by inadequate emotional awareness and processing.

Conceptual model — Emotional maltreatment, dissociation of affect (“not feeling”), and alexithymia (difficulty identifying and verbalizing internal emotional states) are seen as core components of the condition [3,7]. Patients with DDD frequently recount traumatic or stressful life experiences in a way that is highly robotic, matter-of-fact, and without feelings. A distinct subgroup of individuals with posttraumatic stress disorder also suffers from depersonalization and derealization symptoms. (See "Dissociative aspects of posttraumatic stress disorder: Epidemiology, clinical manifestations, assessment, and diagnosis".)

According to psychoanalytic theory, a person in whom the cohesiveness and stability of self-representations is tenuous and profoundly threatened may resort to depersonalization (ie, a disconnection from the self), as a response to the overwhelming shifts in self-experiencing. Although such a response may be in some ways ubiquitous, hard-wired, and even adaptive in the short run, its persistence over time becomes maladaptive and pathological.

A psychodynamic understanding of depersonalization/derealization phenomena centers around the inability to integrate various aspects of one's self-experience due to external stressors or internal processes that pose an overwhelming challenge to an individual's "usual expected" sense of self [8]. The self can be conceptualized as having lost its cohesion, so that the "physical" self, "thinking" self, "feeling" self, or "acting" self are poorly integrated with each other leading in discontinuities of various sorts in the experience of the self.

Psychodynamic theories similarly suggest that depersonalization and derealization can be linked to various levels of character pathology:

- In psychotic-spectrum character pathology, the symptoms may be triggered by experiences of impaired self and other differentiation.
- In borderline psychopathology, unstable and switching self-representations may be associated with depersonalization or derealization experiences.
- In narcissistic pathology, when self-constancy is threatened by the loss, real or imagined, of self-objects serving purposes of object constancy, depersonalization or derealization may arise.
- In psychopathology related to mood (anxiety, depression) or cognition (obsessions or compulsions), derepressed self-representations associated with overwhelming intrapsychic conflict and associated affect may trigger depersonalization or derealization.

Administration — In our experience, psychodynamic psychotherapy needs to be conducted at a minimum of once weekly, and often more frequently, to facilitate breaking of the dissociation and working with the underlying affects and dynamics. Results may be seen within weeks or months, or may require a more prolonged treatment.

In psychodynamic psychotherapy, the therapist has the opportunity to observe and analyze, often in a microprocess, moment-to-moment fashion, such dynamics as they occur inside the session or as they are described by the patient. This microanalysis of symptoms as they wax and wane during psychotherapy sessions can be most effectively utilized with an affect-phobia psychodynamic model in mind. This model implies that the hypoemotionality, emotional numbness, and alexithymia (inability to name or describe feelings) stem from a need to "dissociate" unbearable affects and their accompanied cognitions, relational structures, and historical origins.

The goal of an affect-based, trauma- and attachment-informed psychodynamic psychotherapy is to uncover, experience, label, own, and verbalize intolerable emotions and experiences, and to process such emotions in the context of underlying conflicts and disavowed self-representations and self-states (ie, poorly integrated components of identity). Eventually, such emotions can be gradually integrated with the core sense of self, so that the individual can transition from an "unreal" self to a more "real" owned self.

The affects needing to be dealt with can vary greatly depending on each person's history and sense of self, ranging from the negative to the positive, and can include anger, grief, sorrow,

shame, guilt, excitement, and love. In a simple sense, this approach counters the defensive aspect of the depersonalization by mobilizing affect rather than detaching from it. This is consistent with exposure-based and cognitive restructuring treatments for trauma-related conditions such as posttraumatic stress disorder or dissociative identity disorder, as the goal in therapy of DDD is to activate and experience rather than to better temper and regulate intense affects [9,10]. (See "Depersonalization/derealization disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical manifestations' and "Posttraumatic stress disorder in adults: Psychotherapy and psychosocial interventions", section on 'Trauma-focused therapy as first-line treatment'.)

At times when patients visibly experience, or report, an acute heightening of their depersonalization/derealization outside of or inside the treatment, a microanalysis is undertaken in order to determine what the intolerable affect is that is being defended against (eg, anxiety, shame, rage, guilt, excitement, hope) and the external and internal contexts (cognitions, dynamics, traumatic memories, threats to attachment) that acutely activated the peaking of symptoms. Conversely, when a patient reports moments of lessened depersonalization and/or derealization, in or out of session, the circumstances that facilitated the containment and awareness of difficult affects are explored.

Efficacy — No clinical trials have been conducted on psychodynamic psychotherapy for DDD. In our clinical experience, psychodynamic psychotherapy can be very helpful, especially in patients who have fluctuating symptoms, affect intolerance, and are more psychologically minded. Case reports describe such an approach [3,11]. The continuation and frequency of psychotherapy should be reassessed at the conclusion of each course of treatment.

Hypnosis — Hypnosis, a state of focused concentration, may be useful in helping patients reconceptualize and control their symptoms of depersonalization or derealization [12,13]. Patients are shown how to practice cognitive control over the symptoms through self-hypnosis. They learn how to modulate symptoms by making a controlled connection to emotional memories, past self-states, and/or interactions causing different degrees of dissociative symptoms, including pleasant or less threatening forms of depersonalization or derealization. Data are limited on hypnotizability in individuals with depersonalization/derealization disorder. Some experts report limited hypnotic capacity in a subset of depersonalization/derealization disorder patients.

Pretreatment assessment — Not all patients have the capacity to undergo hypnosis, and therefore measures of hypnotizability, such as the Hypnotic Induction Profile [14], can first be used to determine eligibility for hypnotic techniques. These should be employed by trained clinicians and are typically incorporated into the broader treatment.

Administration — Three to five sessions are usually sufficient to determine whether or not treatment involving hypnosis is likely to help. Treatment with hypnosis principally involves teaching the patient self-hypnotic strategies for modulating the symptoms, such as [15]:

- Inducing physical comfort (imagining floating or other physical sensations)
- Modulating depersonalization and derealization symptoms (feeling more or less detached from one's body)
- Managing triggering stressors differently
- Imagining oneself in a physical setting where depersonalization and derealization rarely occur, such as a room at home

Efficacy — There are no clinical trials of the efficacy of hypnosis in patients with DDD; however, in our clinical experience, hypnosis can be helpful, at least temporarily, in alleviating symptoms of depersonalization.

There is a general perception among clinicians who treat dissociative disorders that, as a group, patients with DDD are not as hypnotizable as those with dissociative identity disorder and related disorders.

Supportive psychotherapy — Some severely impaired patients with chronic DDD and extreme distress may require long-term supportive psychotherapy. These are patients whose educational, occupational, or social lives have been significantly impaired by the disorder, but whose chronic, continuous course of unrelenting intensity and minimal fluctuations limits the therapist's ability to apply psychodynamic or CBT techniques.

In providing supportive psychotherapy for these patients, the clinician should be acutely aware of the patient's interpersonal sensitivity, distress, and sense of hopelessness about the condition.

There are no published data evaluating the efficacy of supportive psychotherapy; in our clinical experience, it can be helpful in maintaining or improving occupational and social functioning, and in lessening the severe distress often associated with the disorder by cultivating an attitude of acceptance within the context of striving for change.

Additional information about supportive psychotherapy is provided in the context of treating depression. (See "Unipolar depression in adults: Supportive psychotherapy".)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Dissociative disorders".)

SUMMARY AND RECOMMENDATIONS

- Our approach to selecting among treatments for depersonalization/derealization disorder (DDD), including the use of pharmacotherapy and psychotherapy, is discussed separately. (See "Approach to treating depersonalization/derealization disorder".)

- Several psychotherapies are used to treat DDD, including psychodynamic, cognitive/behavioral, hypnotherapeutic, and supportive therapies. No controlled clinical trials have been performed to assess or compare the efficacy of these interventions. (See 'Psychotherapies' above.)

- A cognitive-behavioral therapy (CBT) developed to treat DDD focuses on the development of techniques to reinterpret symptoms as less threatening, reduce symptom monitoring, and diminish avoidance and the use of safety behaviors. An uncontrolled clinical trial in DDD patients and our clinical experience suggest that CBT can reduce symptoms of depersonalization/derealization. (See 'Cognitive-behavioral therapy' above.)

- Psychodynamic psychotherapy for DDD focuses on underlying threats to self-constancy and self-experiencing that give rise to affectively intolerable states. The goal of the therapy is to uncover, experience, label, own, and verbalize intolerable emotions, and to process such emotions in the context of underlying conflicts and disavowed self-representations and self-states. No clinical trials have been conducted on psychodynamic psychotherapy for DDD. In our clinical experience, the therapy can be very helpful for patients with the disorder, especially patients who have fluctuating symptoms, affect intolerance, and are more psychologically minded. (See 'Psychodynamic therapy' above.)

- Hypnosis, a state of focused concentration, may be useful in helping patients reconceptualize and control their symptoms of depersonalization or derealization. Patients are shown how to practice cognitive control over the symptoms through self-hypnosis. There are no clinical trials of the efficacy of hypnosis in patients with DDD; however, in our clinical experience, hypnosis can be helpful, at least temporarily, in alleviating symptoms of depersonalization. (See 'Hypnosis' above.)

- Some severely impaired patients with DDD may benefit from long-term supportive psychotherapy. Primary goals of the therapy are to maintain or improve occupational and social functioning, and to attenuate the severe distress often associated with the disorder. (See 'Supportive psychotherapy' above.)

Topic 14695 Version 22.0