Information Handout

Professional Version | US English

Cognitive Behavioral Model Of Depersonalization Disorder (Hunter, Phillips, Chalder, Sierra, David, 2003)

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Description

Depersonalization Disorder (DPD) is a chronic condition in which an individual experiences frequent or unremitting detachment from themselves, disrupting the normally integrated sense of self. Critically, people experiencing DPD are not delusional: they retain insight, and their awareness of the disjunction between the observing self and the embodied self causes significant distress (Hunger et al, 2003; Medford et al, 2005)

Core symptoms of DPD include:

- **Depersonalization (DP).** A sense of unreality and detachment from oneself. The normal integrated sense of self – mind and body – is disrupted so that individuals feel detached from their thoughts, their bodies and their experiences. Individuals often report watching themselves from a tunnel, behind glass or through a window.
- **Derealization (DR).** The world feels unfamiliar and artificial. The external world may appear flat or two dimensional, lack color or appear black and white. Objects do not appear solid, or appear larger or smaller than they actually are (macro and microscopia respectively), sounds are distorted or muffled.
- **Desomatization.** Estrangement from or change in one's body sensations. Individuals may report dizziness, partial or total physiological numbing, feelings of weightlessness or hollowness, inability to sense the physical boundaries of their body, or to recognize their own face and voice, and changed perceptions of the size of different body parts. They may also report impairments in their senses of taste and touch.
- **Deaffectualization.** The feeling that one's emotional responses are numbed, flattened or superficial. Individuals may report a dream like state, a sense of isolation, loss of motivation, lack of empathy, inability to feel the consequences of their behavior, depression and anxiety.
- **Cognitive changes.** Individuals might experience impaired concentration, a changed perception of time, an empty mind or racing thoughts, memory impairments, impaired visual imagery, or difficulty processing new information. They may have recurring thoughts or ruminations on the nature of reality and the self.
- **Preserved insight.** People experiencing DPD have intact reality testing are acutely aware of the disjunction and the disruption to their sense of self, which may cause them significant distress. People with DPD are not delusional, being aware that their symptoms are subjective and not due to changes in the world itself.

Assessment for DPD should be considered for people reporting symptoms in any of the categories described above (Medford et al, 2005). The most widely used clinical tool for assessment is the Cambridge Depersonalization Scale (Sierra & Berrios, 2000). DPD is classified with the dissociative disorders in DSM5, but hallmark features of dissociation are absent: people with DPD retain insight and dissociative amnesia is absent or very rare (Hunter et al, 2003; Medford et al, 2005). Clinicians should note that episodes of DP/DR can occur as part of the presentation of temporal lobe epilepsy. In these cases, it is typical for the individual to report circumscribed occurrences of DP/DR symptoms along with cognitive and behavioral changes (e.g. aura, ticks or fidgeting, acute changes in smell or taste, headache and confusion afterwards) (Medford et al, 2005).

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Description

Co-occurring symptoms of DPD often overlap with experiences of social phobia, panic and health anxiety:

- **Panic attacks.** A high proportion of those with DPD suffer from panic attacks (59%) and will experience worsened DP/DR symptoms during the attacks (40-90%: Hunter et al, 2003).
- **Social anxiety.** Simeon et al (1997) found 50% of patients with DPD had co-morbid social phobia.
- **Acute stress.** People with DPD often report being afraid to go out alone (59%, Baker et al, 2003) and avoid situations that could lead to increased anxiety or a worsening of their symptoms.
- **Healthy anxiety or hypochondriasis.** Heightened self-monitoring and self-observation for DP/DR symptoms are common in DPD.
- **Tinnitus.** Around a third of those with DPD report Tinnitus (29%: Baker et al, 2003).
- **Migraine.** Around a third of those with DPD report Migraine (31%: Baker et al, 2003).

Hunter, Phillips, Chalder, Sierra & David (2003) proposed a cognitive model to account for the maintenance of DPD, which suggests that common, transient symptoms of DP/DR (typically experienced during times of stress or threat) are catastrophically misinterpreted as signs of deteriorating or damaged mental health. This leads to feelings of anxiety and associated physiological reactions, which may then exacerbate the symptoms of DP/DR. Similar to other anxiety disorders, they propose that the cycle is maintained by avoidance, safety behaviors and heightened symptom monitoring and self-focused attention. Important components of the model include:

Predisposing factors.

DPD reflects the shift of experiences of depersonalization and derealization from transient to chronic. Transient experiences of depersonalization and derealization are relatively common in healthy adults, between 35-70% over a lifetime (Hunter et al, 2003). Transient episodes of DP and DR are especially common during times of fatigue or transitioning from sleep to wakefulness, alcohol and drug use, extreme stress or life threat (Myers & Grant, 1972; Noyes & Kletti, 1977). For example, in a sample of people who had been subject to life-threatening danger, 72% reported a feeling of unreality during the event, 52% reported a sense of detachment, and 30% reported the world feeling unreal (Noyes & Kletti, 1977). It is common for anxiety and panic attacks to predate or accompany the diagnosis of DPD, and for a period of increased stress or a stressful life event to precede symptom onset in DPD (Medford et al, 2005).

There is a high incidence of experiencing DP and DR symptoms alongside a panic or anxiety attack, and a previous mental health diagnosis is common among people diagnosed with DPD, especially: depression (62%), anxiety (41%), Obsessive Compulsive Disorder (OCD, 16%) or agoraphobia (14%; Baker et al, 2003). However, the role of co-morbid anxiety in DPD is complex. One study found a significant association between DP symptoms and levels of anxiety when the DPD was classified as mild, but this relationship did not hold when DPD was moderate or severe (Sierra et al, 2012).

One hypothesis is that individuals may be predisposed to developing DPD if they have a reduced affective response during stressful situations. Neurobiologically, it has been demonstrated that DPD is associated with an increase in pre-frontal regulation and an inhibition of emotional responses (Sierra & Berrios, 1998). The pre-frontal systems that 'watch' and regulate cognition become highly active, leading to a state of increased alertness. At the same time, emotional responses are strongly inhibited and this "reduced physiological reaction in response to anxiety... results in an unpleasant 'unreal' state" (Hunter et al, 2003).

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Description

The development of DPD.

The onset of DPD typically begins with transient episodes that become more frequent and persistent over time, until the experience of DP/DR is "pervasive and unremitting" (Medford et al, 2005). The model proposes that, in DPD, symptoms of DP/DR are initially triggered in the same way as in healthy adults – for example, through fatigue, stress, trauma, anxiety or substance use (Hunter, Salkovskis & David, 2014). However, those who go on to develop DPD misappraise the symptoms and make catastrophic attributions about their origin, e.g. "There is something going wrong with my brain" or "I'm losing control". In contrast, healthy adults will make attributions that normalize the symptoms, e.g. "I'm really tired and stressed" (Hunter, Salkovskis & David, 2014).

In this model, appraisals made in DPD relate to mental ill health or brain dysfunction (e.g "I'm going mad", "There is something wrong with my brain"). These appraisals may be made more likely by an individual's previous concerns over their own mental health, or their personal and family history. Prior mental health diagnoses are relatively common in people who experience DPD, and one study found that around a third of individuals had a first degree relative with a diagnosed mental health condition, and a tenth had a first degree relative with a diagnosis of DPD (Baker et al, 2003). People with a history of alcohol or drug use may believe DP/DR symptoms are a sign of permanent brain damage.

Maintenance of DPD.

The model proposes that catastrophic misinterpretation of transient symptoms initiates a negative feedback cycle that exacerbates and maintains the experiences of DP and DR, until these become chronic and established as DPD.

- **Emotional responses** which maintain DPD include increased anxiety, and possibly panic. Physiological arousal follows the appraisal that the DP/DR symptoms are a threat. If individuals are already prone to experiencing DP/DR symptoms during times of stress, these emotional and physiological responses can make the symptoms worse or prolong the DP/DR episode.
- **Cognitive responses** which maintain DPD include increased self-monitoring and attention toward symptoms. Such monitoring reduces the threshold at which symptoms are detected and therefore increases their frequency. Worry and rumination may also play a role in the maintenance of DPD. Medford and colleagues (2005) note that the distressing feelings of detachment underpin a pattern of recurring thoughts about the nature of reality and the self that may become "repetitive and intrusive", helping to exacerbate and maintain self-monitoring.
- **Behavioral responses** which maintain DPD are conceived as following threat appraisals, and can include avoidance of situations which the person predicts will worsen symptoms, as well a safety behaviors intended to help prevent feared outcomes (Hunter et al, 200; 2014). These behaviors can result in threat appraisals failing to be challenged. If behavioral responses are linked with socializing, individuals may feel even more alienated from themselves, as they must now play a role during social situations.

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There are not yet any robustly evidenced treatments for DPD (Medford et al, 2005). The cognitive-behavioral model of DPD proposes a series of interventions for DPD which draw from existing treatments for anxiety. A preliminary study applying these techniques showed improvements across all outcome measures, though the improvements appeared to be driven by reductions in anxiety and depression (Hunter et al, 2005).

Cognitive behavioral treatments for DPD include:

- **Psychoeducation to explain symptoms:** This phase of psychoeducation focuses on reducing the distress that is common for sufferers of DPD (Hunter et al, 2014). Clinicians can provide information and education on the common occurrence of transient DP/DR symptoms, and the situations in which these might arise (e.g. fatigue, acute stress). This can make the symptoms less alarming by providing non-catastrophic interpretations of DP/DR, rather than interpreting them as signs of deteriorating mental health. It may help to discuss neurobiological mechanisms which are triggered by stress, in which the 'watchful' part of the brain is highly active, but emotional responses are inhibited.
- **Psychoeducation to facilitate lifestyle change:** Fatigue is a known trigger for DP/DR symptoms for some individuals, so discussion of sleep habits, sleep hygiene, routine, exercise and diet is valuable.
- **Diary Keeping:** Individuals often feel that their symptoms are continuous and unremitting. A symptom diary can provide evidence against this, and highlight cycles in symptoms that are linked to particular triggers, patterns of avoidance, or activity.
- **Graded exposure and/or behavioral experiments to target avoidance:** Identify situations or contexts that the individual avoids due to fear of their condition worsening. These may be external, such as social situations or particular environments (e.g. busy places, or those with particular lighting or sound) or internal. Such environments can be gradually constructed or introduced, with the individual making predictions for feared outcomes and then reflecting on what actually happened. Interoceptive exposure can be used to explore how DP/DR symptoms can be manipulated in a controlled fashion or induced in other people. Example activities for interoceptive exposure include prolonged staring at a blank wall, or at one's face in the mirror.
- **Role play or video of interactions to counter safety behaviors during social interactions:** Individuals struggling with symptoms of DPD may report avoidance of social situations and anxiety that they appear 'weird' or not 'normal' when socializing. In response to such fears it is common to have developed safety behaviors such as avoidance of eye contact, or staying quiet and passive. Videos of interactions with the therapist when using or dropping such behaviors can be used to explore how these may have unintended consequences.
- **Reducing self-focused attention:** A common cognitive response in DPD is increased self-focused attention and monitoring of DP/DR symptoms. Attention training may help individuals to redirect attention when they find themselves self-monitoring their symptoms. When DPD is mild, grounding techniques can be used to reconnect with the external world (e.g. controlled breathing, use of scent with essential oils). Moderate to severe DPD may benefit from more intense attention training, such as completing challenging tasks (such as mental arithmetic or a dual task) so that attention is redirected away from symptoms.

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- **Challenging catastrophic assumptions:** Thought records can be used to capture the catastrophic appraisals and predictions of feared outcomes of the DP/DR symptoms. Hunter et al (2003) recommend attention on this after some experiences of exposure.
- **CBT interventions for symptoms of anxiety and depression:** If the individual has co-morbid anxiety and/or depression it may be prudent to direct treatment toward those symptoms.

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Instructions

This is a Psychology Tools information handout.
Suggested uses include:

- Client handout – use as a psychoeducation and skills-development resource
- Discussion point – use to provoke a discussion and explore client beliefs
- Therapist learning tool – improve your familiarity with a psychological construct
- Teaching resource – use as a learning tool during training

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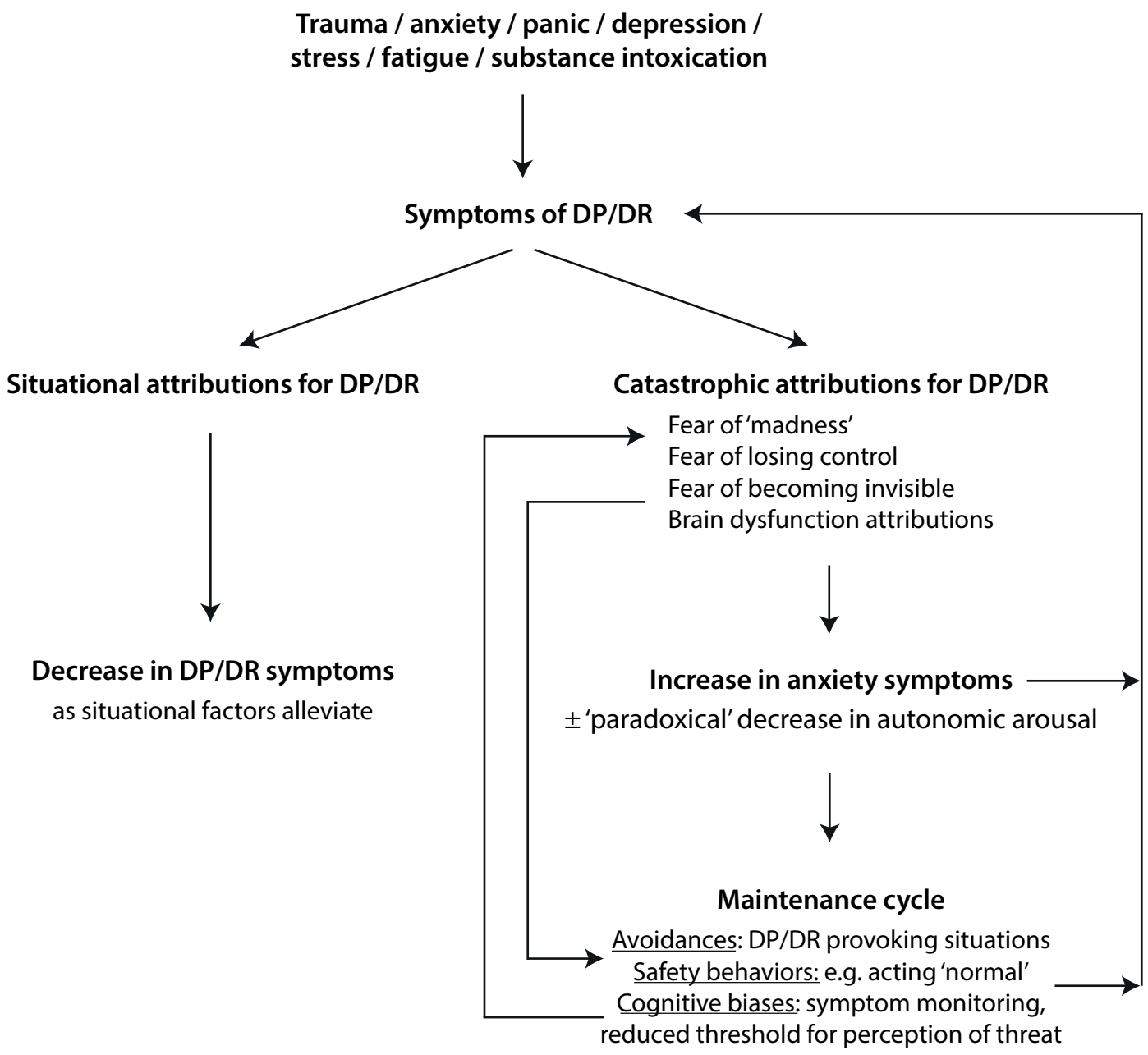

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