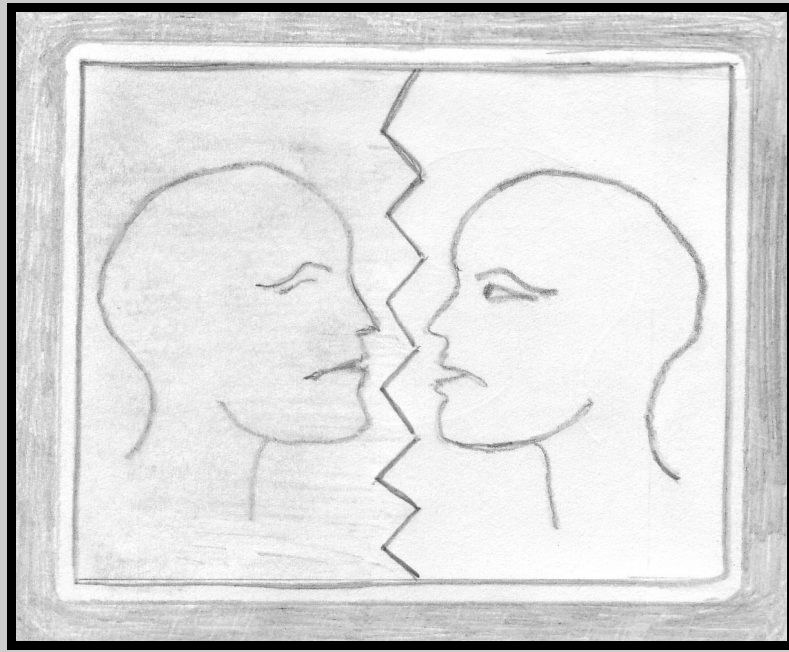


DETACHED



The Practitioner's Sourcebook
For Depersonalisation

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Detached. The Practitioner's Sourcebook for Depersonalisation
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Preface

Depersonalisation is the most common of the dissociative disorders and therefore the most likely one practitioners will come up against in private practice. Given it has been reported as the third most prevalent disorder in the psychiatric population after depression and anxiety (Gershuny & Thayer, 1999) there is surprisingly little coverage of it in psychotherapy training books and in the literature in general.

My research for a doctorate in psychotherapy at the Metanoia Institute, London, involved me interviewing eight practitioners who specialise in the field of complex trauma and dissociation. The interviews involved me asking these specialists open ended questions about their work with this client group. They were largely working in specialist centres for trauma and dissociation and were therefore immersed in this field of work and had considerable experience. They were sourced by searching the internet for the names of some of the most widely known specialists in the field. The participants came from America, Holland and the UK. The questions I asked looked at all aspects of working with clients with dissociative experiences, from initial assessment, through their entire therapy and included asking about some of the problems these

practitioners face in this work. The input from these specialists has been invaluable to me and not wanting the material to simply sit on an academic shelf, I decided to incorporate it into a series of booklets. This booklet aims to be accessible to practitioners who are working with someone they suspect may have depersonalisation disorder. However, it is also likely to be useful to practitioners working with dissociative identity disorder and dissociative disorder not otherwise specified, as well as many clients who experience anxiety and panic because frequently depersonalisation symptoms co-exist with these other conditions.

The material has also been derived from a literature review of the work published on the subject over the last thirty years, as well as being informed by my own experience of working with this client group. I hope you find it informative and would very much like to hear your comments. You can contact me via the e-mail address found on page i.

Acknowledgements

I would like to thank my clients for sharing all their experiences so bravely with me. They think I teach them but the learning and experience has come from them more than me.

Thank you too to Christine Stevens, who has been my academic adviser throughout my doctorate training and Remy Aquarone who has been my academic consultant. Both of you have helped me professionally but also personally to rise to the challenges of this work in my writing and practice.

Thanks too, to members of my cohort at Metanoia Institute but in particular, Maxine Daniels and Val Thomas who have been companions on my research journey and provided both emotional and practical support, as well as critical ears to check out my ideas.

Last but by no means least thanks to my husband, Mark, my two children, Laura and Christopher and my dear friend Julia Nadal. They have patiently listened to my accounts of the trials and tribulations whilst I have been undertaking this research and fed me love, care and enthusiasm when my resources have been depleted.

CHAPTER 1.

What is Depersonalisation?

1.1 Definition Of Dissociation & The Five Dissociative Disorders in DSM-IV-TR

The American Psychiatric Association (2000) define dissociation as;

‘a disruption in the usually integrated functions of consciousness, memory identity or perception’ (p. 519).

The DSM-IV-TR dissociative disorders category encompasses five disorders, Dissociative Amnesia (DA) Dissociative Fugue (DF) Dissociative Identity Disorder (DID), Depersonalisation Disorder (DP) and Dissociative Disorder Not Otherwise Specified (DDNOS).

1.2 Depersonalisation

The main features of depersonalisation result in the person feeling detached from their own body as if they are an outside observer, or as if operating on automaton. In the short term, depersonalisation distances the client from unpleasant situations and is the client’s way of coping and dealing with lasting anxiety (Kluft, 1984). However, long term, clients

struggle to feel fully connected with the outside world and may present with a blunting of affect. Client behaviours reflecting this may be a monotone voice and facial expressions lacking emotional expression. This may be misinterpreted as the client being bored. Initially this blunting of affect was helpful because it reduced the likelihood of the client feeling overwhelmed by negative emotions, often anxiety. However, the depersonalisation symptoms themselves can become problematic causing the client to worry about their inability to feel connected. These thoughts can then serve to fuel anxiety and the depersonalisation still further and a vicious circle can ensue with symptoms getting worse because of these thought processes.

1.3 Prevalence

Short lived experiences of depersonalisation are common, particularly if the person feels under threat, is under the influence of drugs or drink, or is over tired. However, depersonalisation tends to be a chronic condition causing considerable distress longer term. Researchers typically report a roughly equal number of men and women suffering from this problem (Simeon, 2004) although some have found a greater number of men (David, 2003). In clinical populations,

depersonalisation has been reported the third most common symptom after depression and anxiety (Gershuny & Thayer, 1999) and in its chronic form, an estimated 1-2% of cases in the general population (Medford, Sierra, Baker & David, 2005). The difficulty tends to be seen in younger adults with an average age of about 23 years (David, 2003) and is more common in shy people and people with anxiety.

1.4 Symptoms

The symptoms of depersonalisation are listed in the box over the page. Clients are unlikely to report all of these symptoms but these are the most commonly spoken about.

Following this, I list the common antecedents to DP. In my experience, DP tends to follow extended periods of anxiety or trauma. I list the experiences which have been reported to me, as well as some of those found in the literature.

Summary of Symptoms

1. Feeling spaced out, numb, dreamy, dizzy, confused, foggy, distant, detached from oneself, trance-like.
2. Practitioners have reported patient descriptions of 'feeling like a robot' 'different from everyone else' and 'separate from myself' where some clients ask 'Am I really me / here?' (Medford et al, 2005).
3. There is often a tendency to focus attention on what is happening inside the body. Clients may feel compelled to check or monitor the severity of their symptoms ('How fuzzy am I today?').
4. There may also be questions about the point or purpose of life 'Why am I here?' 'What's it all about?' 'Am I real?'. These types of questions may be ruminated on and tend to exacerbate the condition.
5. Clients report catastrophic fears of physical illness, for example a brain tumour, or of 'going mad'.
6. Often there is difficulty in concentrating, where tasks may become difficult to start or complete. This may result in a reduction of work performance.
7. Poor memory and attention span.
8. Emotionally numb, or a loss of emotions.
9. The client senses they are not the one doing their own thinking, feeling, or imagining because it is like they can observe these processes as an outsider (Castillo, 1990).

1.5 Antecedents

- Living with parental or marital conflict, where there appears to be no solution.
- Feeling powerless or helpless in situations with no easy way out. A feeling of being 'Caught in the headlights'.
- Needing to find an exit route from internal conflicts or inner turmoil.
- Being in any no win situation long term. Feeling that whatever choice is made will be wrong.
- Persistent avoidance of one's own needs, or a discounting of feelings through fears of being wrong or bad.
- Illicit drug use, particularly cannabis (Medford et al, 2003; Medford et al, 2005; Simeon, 2004) and ecstasy (Mc Guire, 1984).
- A traumatic or severely stressful incident.
- Experiencing anger or sadness for protracted periods of time without it being expressed.
- Experiencing abuse in childhood (Simeon et al, 2001).
- There is an increased prevalence amongst clients belonging to a minority group, e.g. transvestites and gay men and women.
- Clients may have experienced a lack of warmth causing them to feel threatened by the advances of others who come close. This may cause the individual to depersonalise under such circumstances.

1.6 Derealisation

Derealisation is often coupled with depersonalisation, although one can be experienced without the other. Derealisation

‘is experienced as the sense that the external world is strange or unreal’ (p. 530. American Psychiatric Association, 1994).

Therefore, in derealisation the perception of the environment appears altered, whereas in depersonalisation, there is an altered perception of the person themselves. Commonly people describe the world as looking two dimensional (Baker et al, 2003) fuzzy, far away, all grey and occasionally more colourful. Objects may appear to change in shape, or size, look more alive, to shimmer or breathe (Castillo, 1990). Clients with Dissociative Disorder Not Otherwise Specified (DDNOS) or Dissociative Identity Disorder (DID) have reported further features which may or may not be exclusive to these disorders but which I have only heard from in these patient groups. These are outlined in my other booklet (‘Understanding and treating Dissociative Identity Disorder and Dissociative Disorder Not Otherwise Specified’) in more detail. However, briefly, clients have sometimes reported seeing the consulting room and all its physical features, as well as a place from their past, both at once. This has been coupled with them feeling

they are part with me but also part in the other environment. I believe these are post traumatic symptoms and therefore less prevalent amongst clients with anxiety and panic related depersonalisation, than trauma related depersonalisation. In addition, these same clients (with DDNOS and DID) often experience visual, auditory, sensory and olfactory hallucinations which are related to their trauma leaving them feeling unsure about what is real and what is imagined.

Derealisation

- In derealisation the perception of the environment appears altered.
- Common descriptions include the world looking two dimensional fuzzy, far away, all grey and occasionally more colourful.
- Objects may appear to change in shape, or size, look more alive, to shimmer, or breathe.

Depersonalisation is reported to be the third most common mental health problem after anxiety and depression. It is frequently experienced as a symptom of anxiety, panic, dissociative identity disorder and dissociative disorder not otherwise specified, as well as a disorder in its own right. This sourcebook provides all of the basic knowledge a practitioner needs in order to work with clients with this often chronic and debilitating condition.

Jo Ringrose has a clear and concise style of writing. She has made a complex disorder easy to grasp and without the need to plough through a mountain of text to get at the essential ingredients. She is a UKCP registered psychotherapist and emerging specialist in this field. Currently in her final year of doctoral research on this and other related problems, she has considerable experience from working with clients, as well as from listening to the experiences of other practitioners in her research and supervision.

Further Books:

‘Detached’ Practical Help With Feeling Detached, Dazed, Unreal & Numb. Symptoms Of Depersonalisation Disorder’

‘Understanding & Treating Dissociative Identity Disorder & Dissociative Disorder Not Otherwise Specified’