

Depersonalization- Derealization Disorder and ISTDP

Matthias Michal & Michelle Brehm



Depersonalization-Derealization Disorder (**DDD**, ICD-11, DSM-5)

- 1. Persistent or recurrent experiences of either or both depersonalization or derealization:**
 - a) Depersonalization (DP) is characterized by experiencing the self as strange or unreal, or feeling detached from, or as though one were an outside observer of, one's thoughts, feelings, sensations, body, or actions. Depersonalization may take the form of emotional and/or physical numbing, a sense of watching oneself from a distance or 'being in a play', or perceptual alterations (e.g., a distorted sense of time).
 - b) Derealization (DR) is characterized by experiencing other persons, objects, or the world as strange or unreal (e.g., dreamlike, distant, foggy, lifeless, colorless, or visually distorted) or feeling detached from one's surroundings.
2. During experiences of depersonalization or derealization, **reality testing remains intact**. The experiences are not associated with delusions or beliefs that the individual is being controlled by external persons or forces.
3. The symptoms are **not better accounted for by another mental disorder** (e.g., Post-Traumatic Stress Disorder, an Anxiety or Fear-Related Disorder, another Dissociative Disorder, Personality Disorder).
4. The symptoms are **not due to the effects of a substance** or medication on the central nervous system, including withdrawal effects, and are not due to a Disease of the Nervous System (e.g., temporal lobe epilepsy), head trauma, or another medical condition.
5. The symptoms result in **significant distress or significant impairment** in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

DDD is likely if

3 months > 50% of
the time
in a state of
depersonalization-
derealization



Epidemiology of DDD

- Onset \approx age of 16 ± 6 (95% before the age of 25)
- Men : women = 1:1
- Prevalence in the **general population \approx 1%** (Yang et al. 2023)
- **Outpatients 5-20%** (Yang et al. 2023)
- **Inpatients 17.5-41.9%** (Yang et al. 2023)
- Administrative 12-month prevalence of DDD = 0.007% (Michal et al. 2010)
- **Course mostly chronic and treatment-resistant**, rarely episodic
- 15 or more years of permanent DP/DR are common
- \approx 7 years until "diagnosis" (Sierra 2009)
- **High comorbidity** (depression, anxiety disorders, obsessive thoughts, substance abuse, personality disorders)

Etiology

Genetic / temperament:

- Harm Avoidance (Cloninger, Simeon et al. 2001)

Socio-cultural:

- DP/DR highly correlated with degrees of individualism versus collectivism (Sierra 2009)

Childhood adversity (Lee et al. 2012, Simeon et al. 2001, Michal et al. 2016):

- Anxiety in school children
- **No specific association with sexual and physical abuse**
- **Attachment trauma (lack of emotional responsiveness, narcissistic abuse).**



Assessment

- Whilst doing something I have the feeling of being a "**detached observer**" of myself.
- My body feels very light, as if it were floating on air.
- **When I weep or laugh, I do not seem to feel any emotions at all.**
- I have the feeling of *not having any thoughts at all*, so that when I speak it feels as if my words were **being uttered by an 'automaton'**.
- My surroundings feel detached or unreal, as if there was **a veil between me and the outside world.**
- Out of the blue, I find myself **not feeling any affection towards my family and close friends.**

CAMBRIDGE DEPERSONALIZATION SCALE

(Sierra & Berrios, 1996)

NAME: _____

AGE: _____

SEX: male / female

(please circle as required)

SCHOOLING: primary / secondary / higher (e.g. university)

(please circle as required)

PLEASE READ INSTRUCTIONS CAREFULLY:

This questionnaire describes strange and 'funny' experiences that normal people may have in their daily life. We are interested in their: (a) frequency, i.e. how often you have had these experiences *over the last six months* and (b) their approximate duration. For each question, please circle the answers that suit you best. If you are not sure, give your best guess.

1. Out of the blue, I feel strange, as if I were not real or as if I were cut off from the world.

Frequency

0 = never

1 = rarely

2 = often

3 = very often

4 = all the time

Duration

In general, it lasts:

1 = few seconds

2 = few minutes

3 = few hours

4 = about a day

5 = more than a day

6 = more than a week

2. What I see looks 'flat' or 'lifeless', as if I were looking at a picture.

Frequency

0 = never

1 = rarely

2 = often

3 = very often

4 = all the time

Duration

In general, it lasts:

1 = few seconds

2 = few minutes

3 = few hours

4 = about a day

5 = more than a day

6 = more than a week

3. Parts of my body feel as if they didn't belong to me.

Frequency

0 = never

1 = rarely

2 = often

3 = very often

4 = all the time

Duration

In general, it lasts:

1 = few seconds

2 = few minutes

3 = few hours

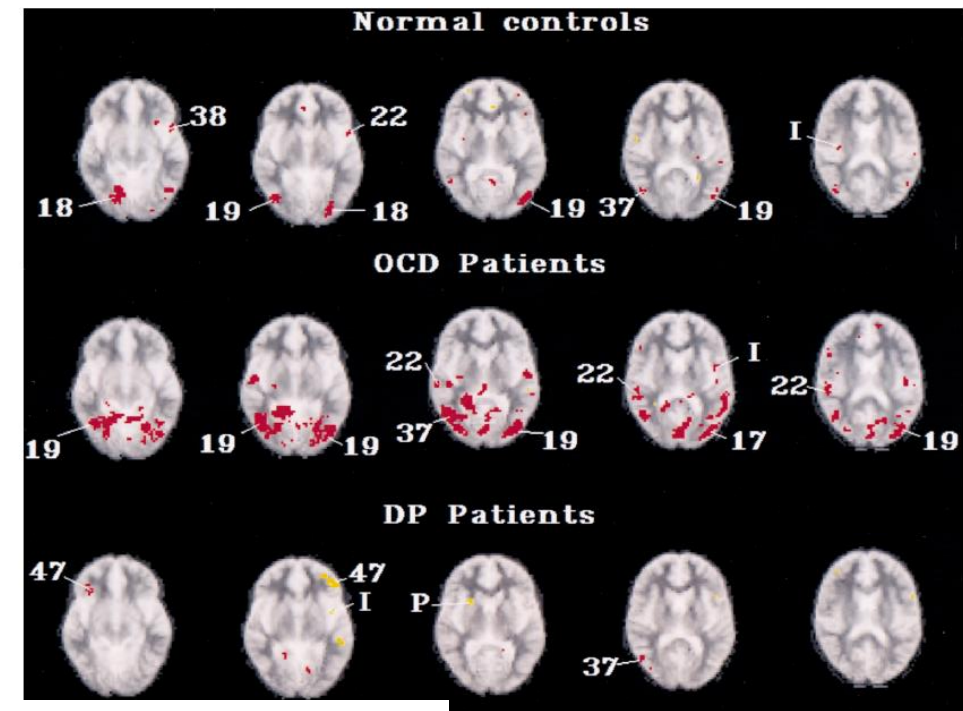
4 = about a day

5 = more than a day

6 = more than a week

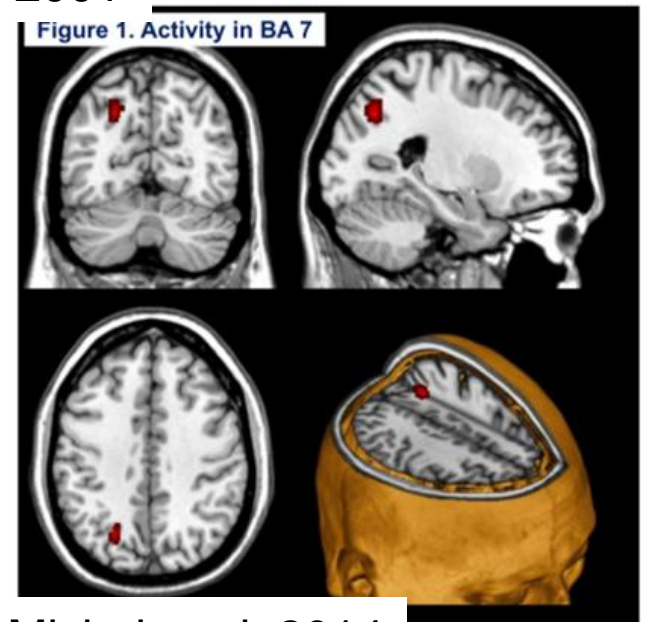
Neurobiology

- (1) ↑ prefrontal cortex hyperactivation
→ limbic system (esp. insula) ↓
- (2) Abnormal activity in the parietal sensory cortex (integration of perceptual and somatosensory information)



Phillips et al. 2001

Fig. 2.



Michal et al. 2014

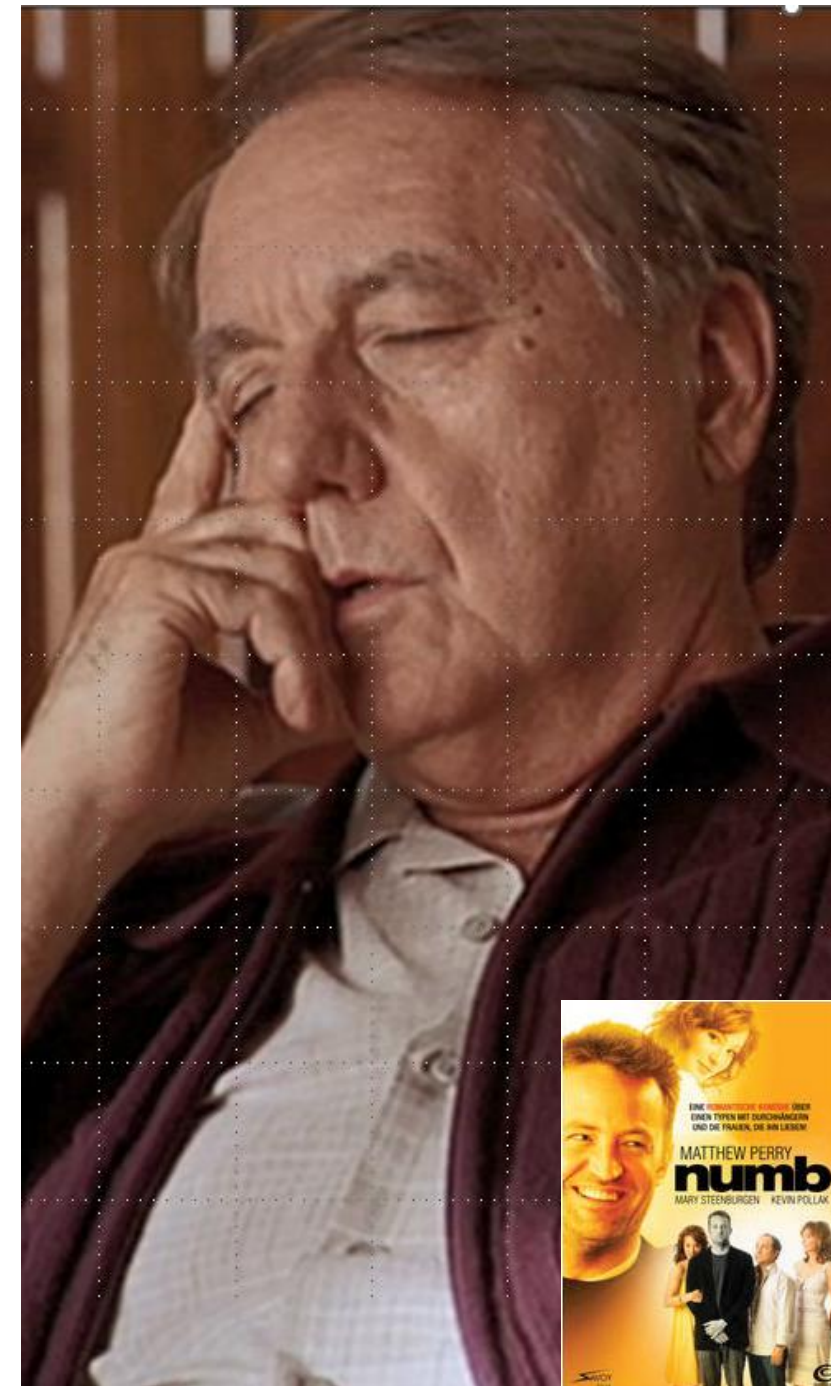
Health Care Problems

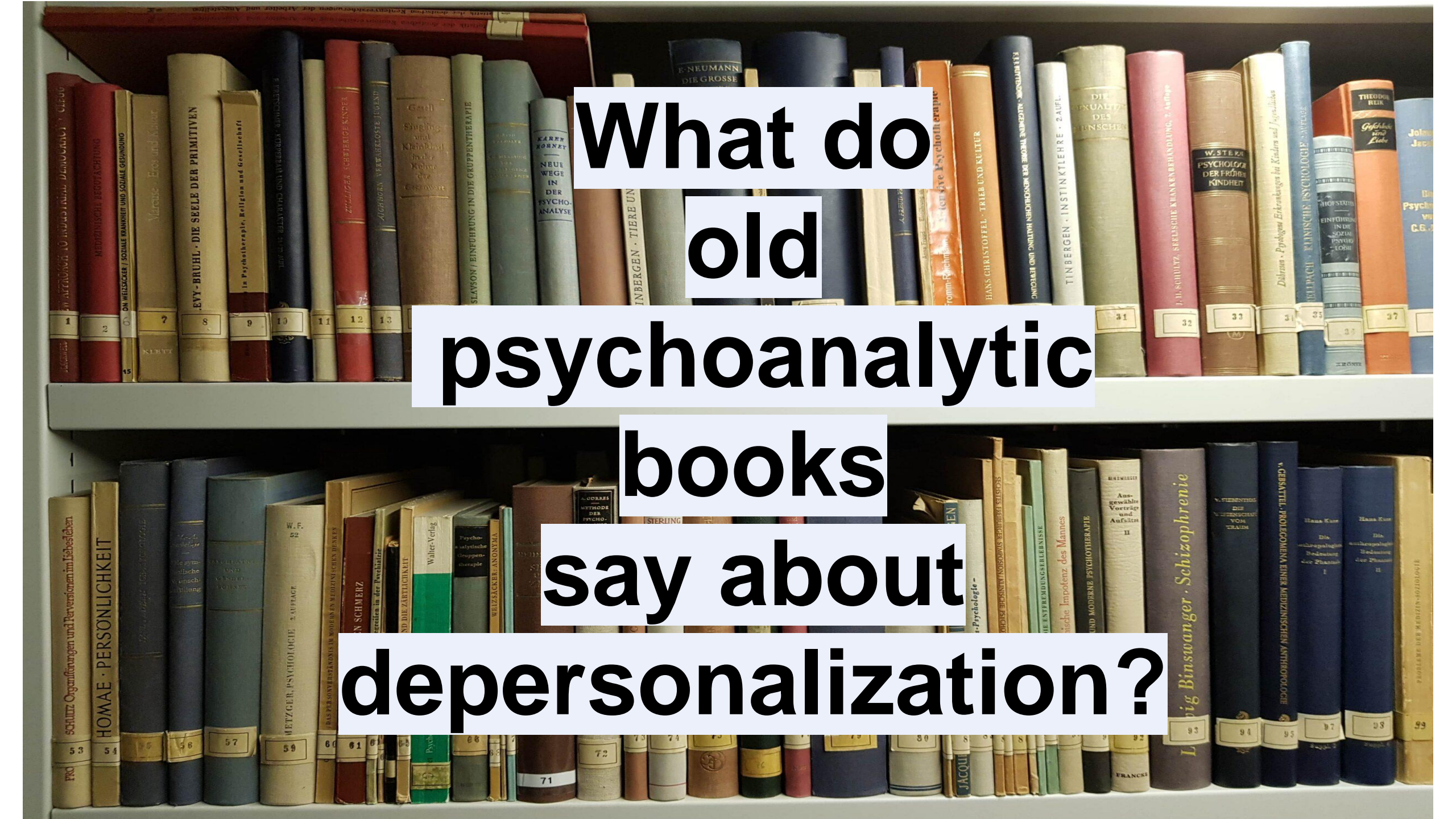


DP/DR = risk factor for non-response and chronic course of mental health problems

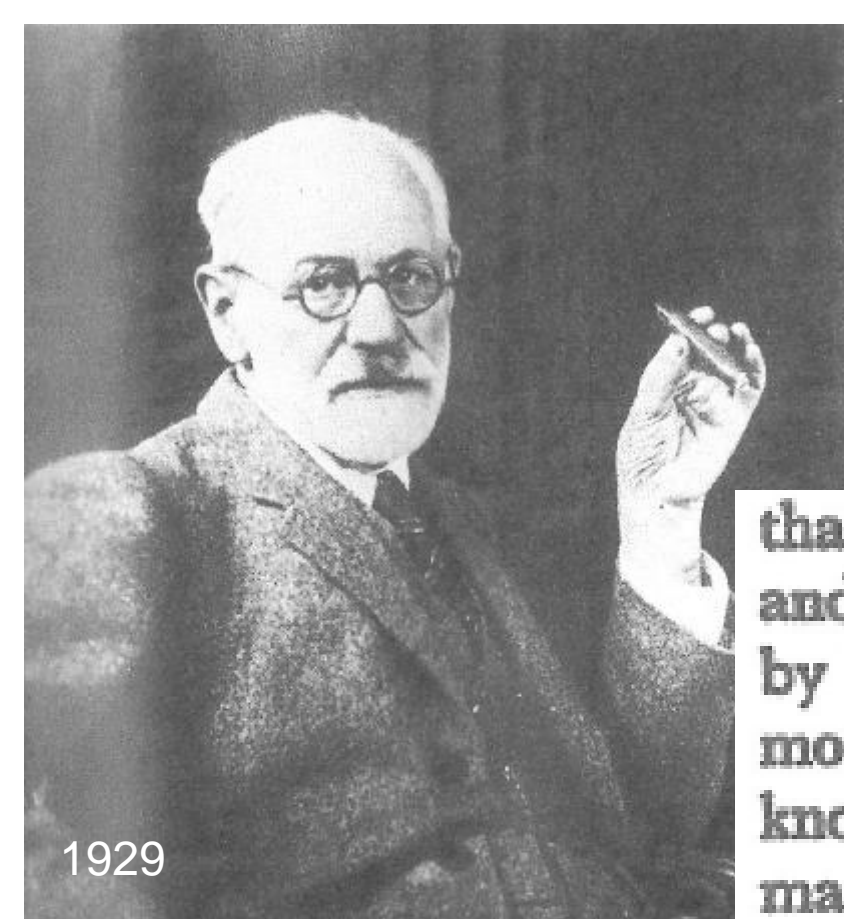
(Kleindienst et al. 2011, Spitzer et al. 2021; Lyssenko et al. 2018, Schlax et al. 2020, Michal et al. 2024)

- misperception and mistreatment as psychosis (e.g. treatment-resistant schizophrenia)
- denial of DDD
- “invisible” resistance against emotional closeness and emotional experiencing



A photograph of a bookshelf filled with numerous books. The books are arranged in two rows. The top row features books with spines in various colors like red, blue, and gold. The bottom row has books in shades of blue, green, and brown. The text is overlaid in white boxes with black text. The text reads: "What do old psychoanalytic books say about depersonalization?".

**What do
old
psychoanalytic
books
say about
depersonalization?**



1929

A DISTURBANCE OF MEMORY ON THE ACROPOLIS

AN OPEN LETTER TO ROMAIN ROLLAND ON THE
OCCASION OF HIS SEVENTIETH BIRTHDAY

My dear Friend,

I have been urgently pressed to make some written contribution to the celebration of your seventieth birthday and I

that the whole psychical situation, which seems so confused and is so difficult to describe, can be satisfactorily cleared up by assuming that at the time I had (or might have had) a momentary feeling: *“What I see here is not real.”* Such a feeling is known as a ‘feeling of derealization’ [*‘Entfremdungsgefühl’*].¹ I made an attempt to ward that feeling off, and I succeeded, at the cost of making a false pronouncement about the past.



- „too good to be true“
- unconscious guilt feelings for overtrumping his father

THE
PSYCHOANALYTIC
THEORY
OF NEUROSIS

*

Otto
Fenichel

The experiences of estrangement and depersonalization are due to a special type of defense, namely, to a **countercathexis against one's own feelings.**

... the countercathexis appears as heightened self-observation .. (i.e., comparing and observing instead of experiencing)



1897 -1946



imprisoned 1935-1938 (escaped)



Edith Jacobson
1897-1978

The defensive function of the emotional detachment was clearly evident and very successful in such situations, in as much as anxiety and other undesirable emotions had disappeared, and **a high level of ego functioning could be maintained with control and direction of aggression into the proper channels of organized thinking and behavior.**

... nothing left but a **coldly fighting brain** ...

Depersonalization thus appears to be the pathological result of a **conflict within the ego**, between the part that has accepted and the part that attempts to undo identification with a degraded object image.

Instead of a punishing superego accusing the worthless self, **we, therefore, find in depersonalization a detached, intact part of the ego observing the other -emotionally or physically dead-unacceptable part.**

Henry Krystal (1925-2015)

“If the individual's **affect tolerance** is exceeded, he may have to ward off the affect by becoming depersonalized, i.e., by developing a **massive »numbing« through isolation of affect**. Under these circumstances, the person experiences the event as an observer as if it was happening to someone else”

(Krystal, 1971, p. 17).



THE INTERNATIONAL PSYCHO-ANALYTICAL
LIBRARY

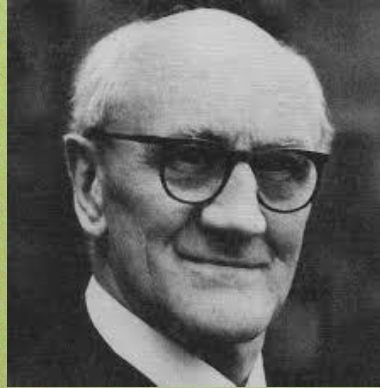
Edited by John D. Sutherland, C.B.E., F.R.C.P.E.

Associate Editor M. Masud R. Khan

No. 77

**SCHIZOID PHENOMENA,
OBJECT RELATIONS
AND THE SELF**

Harry Guntrip, Ph.D.



1901 – 1975

AND THE INSTITUTE OF PSYCHO-ANALYSIS

Paranoid-Schizoid Position

The **schizoid condition** reflects an intrapsychic state, where the individual attempts to cancel external object-relations and live in a detached and withdrawn way

The picture of the shut-in individual

- detachment, loneliness
- Regression to the paranoid-schizoid position (internal splitting-based object fantasies)
- Depersonalization (when anxiety is too deep)

Depersonalization represents a compromise between the fear of isolation and the fear of emotional closeness.

CBT treatment studies

- Psychoeducation about the disorder
- Reduction of symptom-focussed attention and catastrophizing behavior
- Reduction of safety and avoidance behavior
- Grounding strategies

15 sessions → no clinically significant symptom reduction in the CDS: 154 to 135 (effect size 0.52)

Table 2. Outcome scores, sample distribution, regression coefficients and effect sizes for completers ($n = 36$) and total sample ($n = 50$).

Outcome	n	Phase	Mean (SD)	Coefficient [95% CI]*	Effect Size (d) [95% CI] **
CDS	36	Waiting Period	154.20 (63.15)	-4.25 [-16.59 to 8.09]	-0.07 [-0.26 to 0.13]
	36	Treatment Period	135.06 (69.01)	-35.99 [-48.45 to -23.52]	-0.52 [-0.70 to -0.34]
	50	Waiting Period	151.51 (62.55)	-6.60 [-4.42 to -17.60]	-0.11 [-0.28 to 0.07]
	50	Treatment Period	132.27 (68.76)	-33.67 [-45.14 to -22.20]	-0.49 [-0.66 to -0.32]



30
Apr., 2024

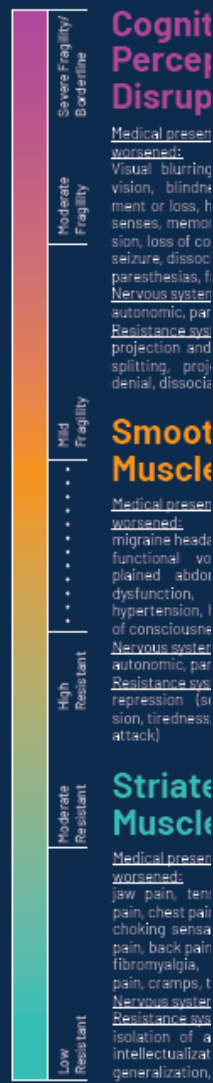
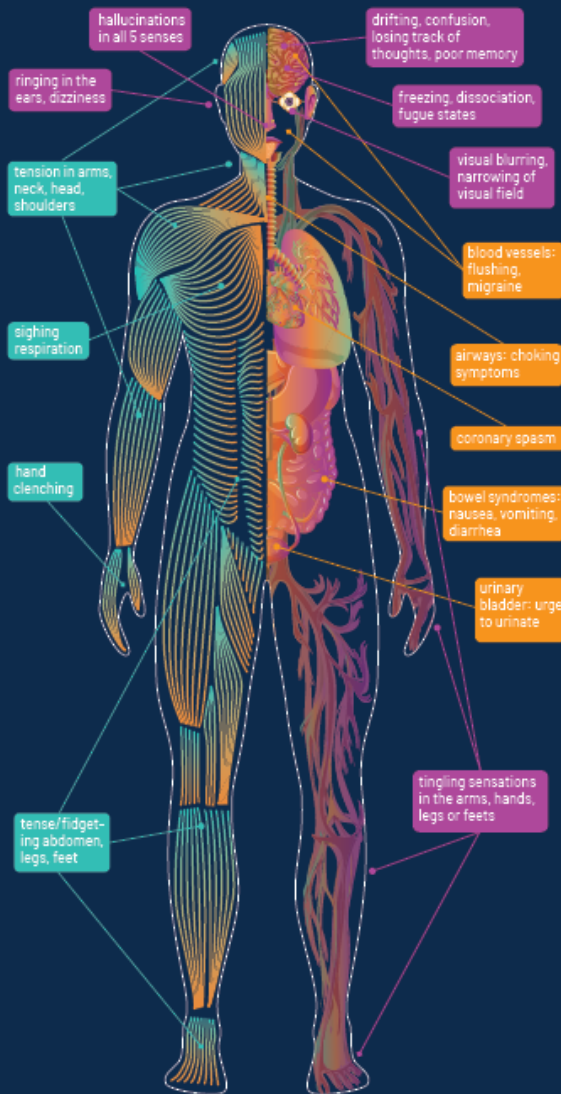
?

Depersonalización
Derealización



Unconscious Anxiety

Discharge Channels



Cognitive Perceptual Disruption

Cognit Percep Disrup

Medical present worsened:
Visual blurring, vision, blindness, ment or loss, h senses, memor sion, loss of co seizure, dissociation, paresthesias, f. Nervous system autonomic, par Resistance sys projection and splitting, proj denial, dissoci

Smooth Muscle

Medical present worsened:
migraine heads functional vo plained abdo dysfunction, hypertension, l of consciousness Nervous system autonomic, par Resistance sys repression (sri sion, tiredness, attack)

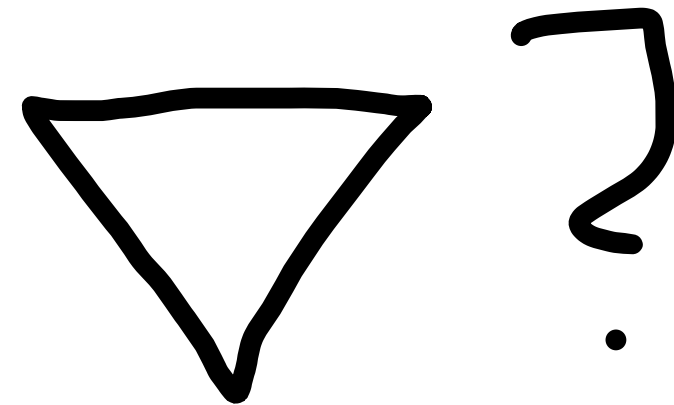
Striate Muscle

Medical present worsened:
jaw pain, ten pain, chest pain, choking sensa pain, back pain, fibromyalgia, pain, cramps, t Nervous system Resistance sys isolation of a intellectualizat generalization,

Medical presentations caused and or worsened:

Visual blurring, visual loss, tunnel vision, blindness, hearing impairment or loss, hallucination in all five senses, memory loss, mental confusion, loss of consciousness, pseudo-seizure, dissociation, dizziness, paresthesias, fainting

Nervous system:
autonomic, parasympathetic
Resistance system:
projection and splitting (projection, splitting, projective identification, denial, dissociation, acting out)



DP/DR =

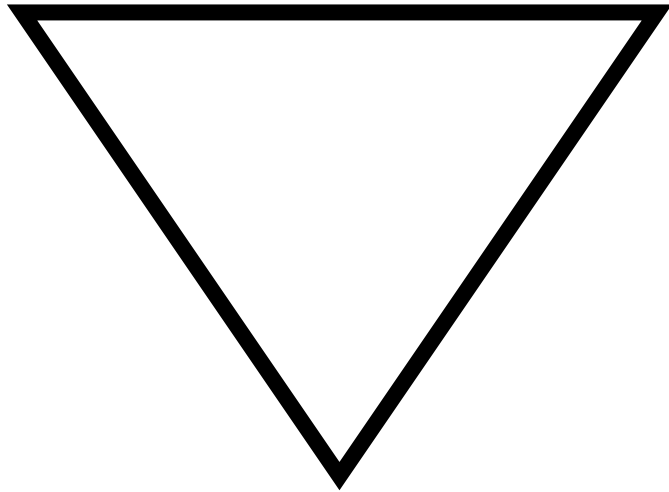
CPD?

Defense?

DP/DR in ISTDP

Defense

Anxiety



Feeling/Impulse

Paul Troendle
Psychotherapie
dynamisch – intensiv – direkt
Lehrbuch zur
Intensiven Dynamischen
Kurzpsychotherapie



Psychosozial-
Verlag

Co-Creating
Change

*Effective Dynamic
Therapy Techniques*

JON FREDERICKSON

Co-Creating
Safety

*Healing the
Fragile Patient*

JON FREDERICKSON

DP/DR

- a regressive defense
- sign of fragility
- primitive denial (intact reality testing)

Experiences with ISTDP treatment of DDD patients

Transient DP/DR symptoms on the psychodiagnostic spectrum

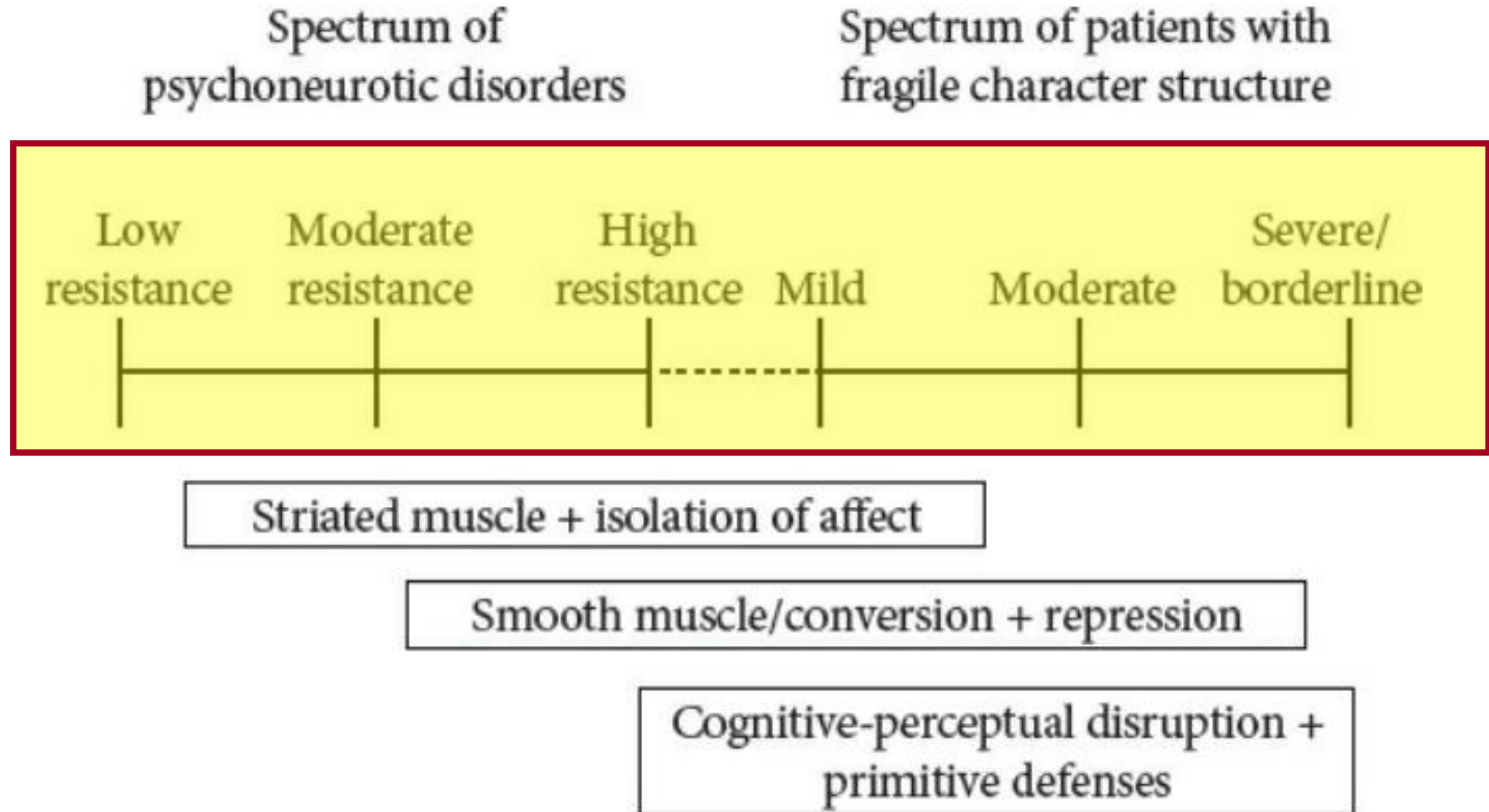


Figure from Abbass, Reaching through Resistance

DDD patients on the psychodiagnostic spectrum

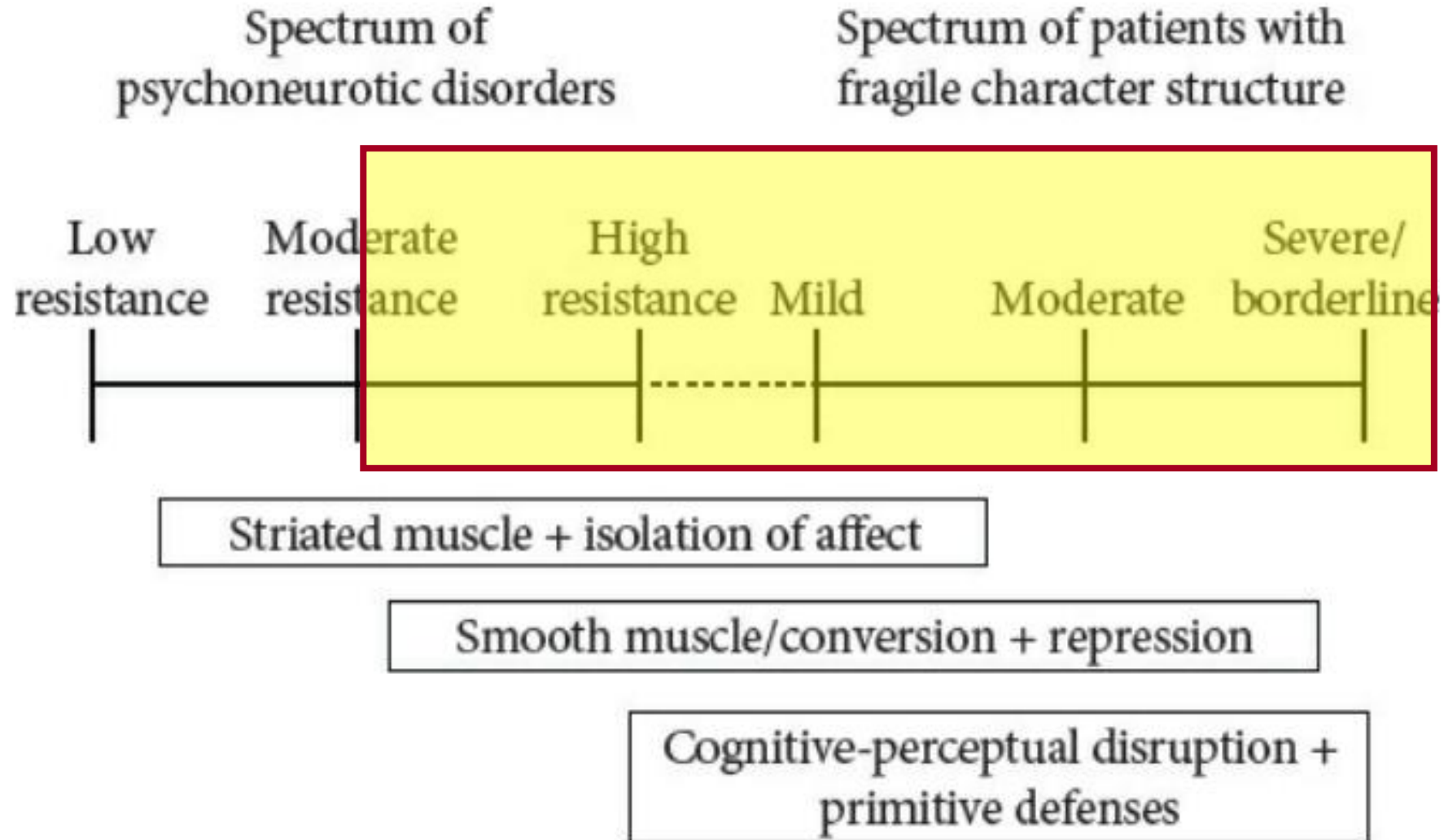


Figure from Abbass, Reaching through Resistance



Signaling and DDD

sighing indicates that (Nat Kuhn, 2014)

- **anxiety is below the threshold**
- **complex feelings are activated**
- absence of defenses that block signaling (etc. primitive defenses such as dissociation and projection)
- unconscious anxiety is not going into CPD or smooth muscles.

Final thoughts on our ISTDP experiences with DDD pat.

ISTDP with “non-perfect” breakthroughs is helpful for the patients

- illuminates the roadmap to the unconsciousness of the patient (experiential insight into the triangles)
- help the patient to experience his true feelings
- improve his feeling of identity (instead of false self)
- reduce anxiety & increase the structural capacity of the patient
- increases the feeling of agency

Final thoughts on our ISTDP experiences with DDD pat.

Shame dynamics play an important role in addition to guilt

- split of the self into an observing and a devaluated part (Jacobson, 1959)
- focus on the relationship of the patient with himself.

Final thoughts on our ISTDP experiences with DDD pat.

The intensive video analysis taught us

- that we had missed many UTA messages because of the assumption of an “ideal process”
- i.e., it is important to overcome idealization for the sake of “realization” (“without memory and desire” Bion)

It is important to be tolerant for the effects of projective identification on T (countertransference enactments) as a precondition for digesting the projected elements of the patient (projective Identification as the earliest form of communication)

Final thoughts on our ISTDP experiences with DDD pat.

1. patients appreciate the directness and the focus on feeling the feelings (especially if they had experiences with other treatment modalities)
2. deep insight into structural problems of patients
3. Duration of DDD correlates with the time for freeing the emotional pathways.

Caveats:

- not seeing the severity of projective mechanisms – including DP/DR as a sign of regression to a schizoid position
- not seeing the façade of the false self (submissiveness, etc.)
- difficulties with locating the patients on the spectrum due to the parallel of high functioning and fragility.



More Literature

<https://seafire.rlp.net/f/6b24d69430de420b85fa/>

<https://seafire.rlp.net/f/3b5867ff4dc94d7aa859/>

<https://seafire.rlp.net/f/cffffce3c8c348fc922d/>

<https://seafire.rlp.net/f/5745fce60ff64110a756/>

<https://seafire.rlp.net/f/076093c2455f4bd989c1/>

more questions: michal@uni-mainz.de