FEELING UNREAL: DEPERSONALISATION/ DEREALISATION DISORDER

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reversing adversity

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by Carolyn Spring

INTRODUCTION

'I don't feel real. All the time – literally all the time – I feel like I'm living life from behind a glass screen, or that I'm watching life as it's happening on TV but it's not real. I'm always ten yards removed from it. I don't cry. I don't feel things. I feel like I'm in a dream. I feel like I'm going mad. Even now, talking to you, I'm not sure if this is really happening or not or if I'm just imagining it. The GP says I'm just depressed, but I'm not.'

Eventually, a pause. He looks up at me, eyes pleading.

'Can you help me?'

I hesitate.

'Please!' he implores, as if I've already said no, even though I haven't. 'Nobody knows what to do with me or how to help me. But I can't live like this. Please can you help me?'

Of course what I want to say is a reassuring 'yes' and just smile softly and reach in my bag for my magic wand, but I forgot to pack it today, so I hesitate again, searching for the right way forwards. I do believe that he can be helped, although not by me. But I will do my best to point him in the right direction. I know what his problem is. I know what causes it. I know, as far as anyone knows, what's going in the brain. I know it can get better. But the problem right now is that very few other people do, and I'm struggling to think who I can point him towards who can work with him to help him.

And he's not the only one. I have this on a regular basis. There are a lot of people

struggling with these same symptoms, struggling to understand, struggling to contain their fear that they're going mad or they've got a degenerative brain disease, and struggling to find anyone at all who understands, let alone can help them.

On the whole, GPs don't know enough to think beyond depression or anxiety. And it's neither, although it often co-occurs with these conditions. So GPs often prescribe antidepressants despite the lack of any real evidence to suggest that they're particularly effective. Their patients, like this young man talking to me here, then fail to improve, and they fall into a vicious cycle: they are so distressed by their symptoms and the belief that they won't recover, that it makes their symptoms worse.

This young man isn't going mad, doesn't have a brain tumour, isn't suffering from clinical depression or generalised anxiety disorder, and isn't consigned to being like this for the rest of his life. He is actually presenting symptoms of a very common, but largely unknown and deeply misunderstood condition known as depersonalisation/derealisation disorder (DPD). It is the most common dissociative disorder and yet in many respects the least well known.

The general consensus is that DPD occurs when the brain attempts to protect itself from overwhelming emotion by turning the volume up on thoughts and down on feelings: in very broad and very basic terms, it involves over-thinking and under-feeling, and this has been borne out by the latest neuroscience research (see 'What's going on in the brain during DPD?'.) It's a response that was initially helpful but has become stuck and therefore unhelpful: the adaptive becoming maladaptive. But it not a sign of insanity – it's an entirely logical process, just one that has got into a vicious circle, a self-reinforcing loop. In this article we'll look at what is currently known about DPD: what it is, what causes it, how common it is, how it's diagnosed, and how it's treated.

Because this young man is not alone. DPD is actually one of the most common mental health conditions in the world and the symptoms of depersonalisation and derealisation are experienced by over half the population at one point or another. The problem, as with other dissociative disorders, is ignorance.

So let's dive in and find out what's what.

THE STRANGER IN THE MIRROR

Dr Marlene Steinberg, author of 'Stranger in the Mirror' on depersonalisation:

> *'The distinguishing characteristic of depersonalisation disorder is the feeling that one is going through the motions of life, or that one's body or self is disconnected or unreal. Mind or body may be perceived as unattached, seen*

from a distance, existing in a dream, or mechanical. Such experiences are persistent and recurrent, and lead to distress and dysfunction. Chronic depersonalisation is commonly accompanied by 'derealisation,' the feeling that features of the environment are illusory. It should be noted that characteristics attributed to depersonalisation disorder must be independent of any kind of substance abuse. It should also be noted that depersonalisation as an isolated symptom may appear within the context of a wide variety of major psychiatric disorders. For example, mild episodes of depersonalisation in otherwise normally functioning individuals have been reported following alcohol use, sensory deprivation, mild social or emotional stress or sleep deprivation, and as a side effect to medications. However, severe depersonalisation is considered to be present only if the sense of detachment associated with the disorder is recurrent and predominant.'

Source: http://strangerinthemirror.com/dissociative.html

AN OVERVIEW OF DPD

There has been limited research on DPD but there is firm consensus over how it presents. The average age of onset of symptoms is adolescence, but adult onset is also common. It can start gradually or it can be sudden (about a 50/50 split between insidious versus acute onset), and the most common triggers include severe stress, other types of mental distress, or drug use (for example marijuana). It affects both men and women equally. The majority of people with DPD experience it continually and over a significant period of time. It is not generally associated with the extreme childhood trauma which results in dissociative identity disorder, but it has strong links with emotional maltreatment. It often overlaps with depression, anxiety and so-called personality disorders, but it exists as a disorder in its own right and is often misdiagnosed for these co-occurring conditions. There has historically been little success in treating it, not least because medication is not directly effective, but this is beginning to change: recovery is possible.

SYMPTOM OR DISORDER?

Depersonalisation is both a symptom and a full-blown psychiatric disorder in its own right – an important distinction. Lots of people experience depersonalisation as a transient state, but the vast majority do not go on to develop it as a chronic condition as the symptoms generally pass within a matter of minutes or hours. Depersonalisation/derealisation disorder, as a diagnosis, is reserved for people whose experience of depersonalisation and derealisation symptoms does not go away but persists. They may experience it 24 hours a day, or they may experience it more episodically, in response to stressful events or

heightened emotions. But even when it is episodic it often persists, and quite often becomes worse over time.

DPD does sometimes resolve on its own accord, but it is a self-reinforcing feedback loop which can make it difficult for people to break out of on their own. With help, however, the prognosis for DPD is good: just as the brain has become stuck in a habit of depersonalisation, so it can be trained to become unstuck.

WHAT EXACTLY IS IT?

At core DPD is experienced as a sense of detachment or estrangement from one's self or from one's surroundings – 'feeling unreal' – alongside a heightened awareness of this detachment.

It is thought that DPD is a mental/emotional defensive strategy which is employed unconsciously to manage unmanageable emotions by shutting down from them. The result of this is that emotions and perceptions are blunted, leading to a feeling of detachment and numbness, of not being fully alive or real, and as if participating in the world at a distance.

This response is automatic and intended to promote survival in the face of life-endangering threat: the brain adjusts its normal set of priorities. It numbs the emotions, to make sure that we are not overwhelmed by them, and it heightens mental activity. This allows us to act rationally, rather than emotionally, in the face of serious threat, unimpeded by distress and with super-charged mental alertness. It is an experience that many people have during trauma and in that context is known as 'peri-traumatic dissociation': survivors of terrorist attacks, for example, will talk about everything happening as if they were in a movie, not feeling alarmed or worried at all, and just coping with the situation very calmly and as if on autopilot. This is a typical dissociative response and is entirely adaptive while the trauma or threat is ongoing. However, once safety is restored then it should diminish. This doesn't seem to happen for people with DPD. The onset may also be more subtle rather than them being aware of a particularly traumatic triggering event.

Various theories and explanations exist to explain the experience of depersonalisation. One idea is that we have two basic ego-functions: the part of us that engages and participates in life, and the part of us that observes ourselves engaging in and participating in life. In DPD, these become segregated (or 'dissociated') from each other, rather than functioning in synchrony. It is as if a gap opens up between these two ego functions, and so the depersonalised person watches themselves do life, but from a distance. This sense of distance can be so great that it can feel like an out-of-body experience.

In DPD, this dissociation becomes not just an appropriate response to life-threatening trauma, but an inappropriate, rigid response to any increase in a sense of danger, threat, challenge or stress. It can be provoked merely by the rise of emotion itself. It has therefore stopped being adaptive and has become maladaptive. This is the point at which the brain's best intentions have gone awry and a disorder has developed.

In simple terms, DPD is a stress-response symptom: it is a way of managing emotions or stress. This explains why anxiety about the symptoms of DPD can make those symptoms worse. The more someone with DPD focuses on their symptoms of depersonalisation and derealisation and stresses about them, the more it will exacerbate those same symptoms. This seems to be the vicious cycle that leads to DPD developing as a disorder, and why, as we shall see later, successful treatment has been built on a foundation of psychoeducation to normalise the symptoms and learning to distract from them.

SIGNS AND SYMPTOMS

DPD involves a plethora of symptoms and there is a wide array of descriptions. It is very difficult to describe what 'feeling unreal' is actually like, and so people often use 'as if' language: 'as if I'm dreaming', 'as if I'm dead', 'as if I'm behind a glass partition', 'as if I'm an automaton'.

The main experience is one of emotional numbing, detachment and separation from the world and the self. Life is happening 'over there'. There is an intellectual understanding that something is upsetting, but no feelings to go with it. There may be a deep care and concern for a significant other, but no feeling of love. People with DPD talk very often about going through the motions or feeling like a robot. There is a persistent sense of not being fully alive.

As well as this sense of emotional numbing or disengagement, and that life is happening as if in a dream, there is an accompanying heightened sense of awareness of one's own thoughts, perceptions and the experience of unreality itself. This can lead to obsessive ruminating, especially about the symptoms themselves, sometimes to the point of compulsions. It is very common for people with DPD to be convinced that they have a serious brain disease or that they have become 'insane'. Anxiety and depression are common, often brought on by the relentless distress of feeling derealised.

In short, there are four main categories of experience with DPD:

- Detachment from the self
- Detachment from the world

- Lowered emotions
- Heightened thoughts (anxiety and ruminations).

PREVALENCE

DPD is a very common mental health condition, with a conservative estimate of 1–2% of the general population being affected, which would equate to 650,000 to 1.3 million people in the UK. DPD is therefore at least as common as bipolar disorder and obsessive-compulsive disorder (OCD), both of which are mainstream concepts. DPD is also at least twice as common as schizophrenia. As with other dissociative disorders, however, there is no correlation between prevalence and awareness: DPD is relatively common, but it is not commonly known about.

Depersonalisation as a temporary symptom, rather than a chronic disorder, is even more common. Conservative figures again suggest that 3–10% of the population have experienced it recently (for example in the last year), and lifetime occurrence can be as high as 50–70%. The student population is particularly prone to transient (temporary) depersonalisation, with one third to one half of students reporting at least one episode of it.

Most people experience depersonalisation and derealisation when under severe stress, when nervous or depressed, when having upsetting memories of past events, or when in danger (Aderibigbe et al, 1995). However around a third reported experience depersonalisation for no apparent reason. It is clear, therefore, that this is by no means an unusual response of the brain to a wide range of experiences, but in particular stressful or disturbing ones. What is much more unusual is for the symptoms to persist and develop into a disorder.

CAUSES

As mentioned earlier, the onset of DPD may be sudden, after a very obvious event which was particularly shocking and emotionally difficult to handle. Alternatively, it may develop more slowly and insidiously, following a prolonged period of physical or emotional stress. Marijuana and other social drugs including ketamine (Special K) and ecstasy can trigger DPD in a small percentage of users.

The main cause of DPD, according to research, seems to be subtle forms of childhood maltreatment, in particular emotional abuse and neglect. Whereas physical and sexual abuse seem to be specifically linked to PTSD, Complex PTSD and dissociative identity disorder (DID), lower intensity but chronic childhood trauma such as emotional abuse and neglect seem to more commonly result in DPD.

DIAGNOSIS ISSUES

Despite its prevalence, it is difficult to get a diagnosis of DPD, principally

because of the lack of awareness amongst medical professionals. Not knowing about DPD, the default diagnosis (misdiagnosis) is of depression or anxiety, which is both hugely frustrating for the person with DPD who knows that this is not a good fit with their symptoms, and also does not facilitate recovery, as treatments for depression and anxiety have not generally been found to be effective with DPD.

WHAT IS GOING ON IN THE BRAIN WITH DPD?

There have been a limited number of brain studies on DPD but what has so far been carried out has been both fascinating and revealing, clearly showing that DPD is not 'all in the mind' but presents readily observable phenomena in the brain, in particular showing a dysfunction in the ability to process sensory information, and a hyper-activation of the 'front brain' at the expense of a hypo-activation of the 'back brain'.

In DPD, it seems that incoming negative information is filtered away and not processed even before the person has become consciously aware of it. This was seen in a memory task using neutral and negative words. The study was carried about by the Mount Sinai team and they found that people with DPD remembered more neutral words than their 'normal' counterparts. However, at the same time, they also remembered fewer negatively-loaded words. So their memory was equal, if not superior, to other people. But their brain was pre-consciously 'choosing' not to think about or retain the words linked to negative emotions. Researchers described this as a dissociation of negatively-charged emotional information.

Many people with DPD report having difficulties with their memory, but it seems that it is of a certain kind, and not the same at all as people suffering from dissociative amnesia. In DPD, it seems that some memories are not encoded or laid down in the first place. In dissociative amnesia, the memories appear to be recorded, but cannot be retrieved. This is connected to two different dissociative issues occurring in the brain: detachment and compartmentalisation. In DPD, there is a detachment from the self and the surrounding world, and this leads to less focus and attention on what is happening. Hence, memories are not encoded. In other dissociative disorders, compartmentalisation is more evident: information is taken in but as it is stored in 'other compartments' of the mind, it cannot be readily accessed.

One of the theories of the brain processes of DPD has been proposed by Sierra and Berrios (1998) with their concept of 'cortico-limbic disconnection'. In other words, there is

a disconnection between the cortical parts of the brain (the 'front brain') and the limbic system, responsible for emotions (the 'back brain'). The 'front brain' is over-activated, while the 'back brain' is under-activated. This results in the over-thinking and obsessive ruminating symptoms (hyper-activation of the front brain) and the numbing and emotional deadness (hypo-activation of the back brain).

Another theory has been proposed by Krystal (1998). He suggests that certain parts of the brain's cortex are failing to work in tandem with each other. He also suggested that there is a breakdown in communication between the thalamus, which is the brain's 'gatekeeper' and 'cook', and which blends the raw ingredients of experience into a kind of 'sensory soup' before feeding it to the rest of the brain. As this is a key part of how we convert the data from our senses into coherent perceptions, it would explain why a DPD person's sense of the world is distorted.

In order to have a cohesive, conscious experience of our self, we need the different parts of our brain to communicate well with each other. This is largely facilitated by the neurotransmitter glutamate, which latches onto various connection points in the brain called NMDA receptors. The drug ketamine, also known as 'Special K', works by blocking these NMDA receptor points and people taking ketamine experience profound dissociative states such as depersonalisation and derealisation. Therefore, with this disruption of communication between different parts of the cortex, we feel unreal and detached from ourselves.

There is one part of the brain in particular which seems to be the source of many symptoms of DPD, and this is the sensory cortex, specifically the rear part of it (the posterior sensory cortex, consisting of the temporal, parietal, and occipital lobes). Some people who have seizures in the left temporal and parietal lobes have dissociative symptoms, in particular depersonalisation, as well as somatosensory aurae, an alteration of body image, vertigo, and visual illusions. In fact, visual derealisation seems to be strongly correlated with the occipito-temporal areas, whilst 'body alienation' is connected to the parietal areas.

Ruth Lanius has conducted numerous brain studies on PTSD and dissociation. One of her principal findings was that trauma survivors tend to fall into one of two distinct groups when presented with traumatic reminders. One group responds with emotional hyper-activation, accompanied by flashbacks and an increased heart rate. The other group responds to traumatic reminders with emotional hypo-activation: no increase in heart rate, and a shutting down, withdrawing and numbing response instead. Their brains also show

up these distinctly different responses when scanned using functional magnetic resonance imaging (fMRI). The latter group (the 'dissociative' response, as opposed to the more typical PTSD response of the first group) show increased brain activity in the medial prefrontal cortex (part of the 'front brain') and anterior cingulate cortex, which are areas associated with cognitive processing and calming down emotional responses, also known as limbic inhibition. At the same time they also have increased activation in their sensory cortex, specifically in the temporal, parietal, and occipital lobes. These brain scan studies seem to support the two theories mentioned above.

A fascinating study was also carried out in 2001 by Mary Phillips, a neuroimaging expert, and her team at the Department of Psychiatry at the University of Cambridge. They compared people with DPD with people with OCD, alongside a 'normal' control group. Using functional magnetic resonance imaging (fMRI), the researchers were looking at activity levels in the brain when they presented the participants with both neutral and disgusting objects (things like open wounds or cockroaches). The DPD group were different to both other groups: when they saw the aversive pictures, they had more activity in their prefrontal cortex ('front brain') but not in the insula, a part of the 'back brain' responsible for the emotion of disgust. The DPD group knew intellectually that the pictures were disgusting, but they simply didn't feel any disgust. These brain scans support the cortico-limbic disconnection theory: their front brains lit up, but their back brains didn't.

Similarly, a study at the Department of Psychiatry, Mount Sinai School of Medicine, and published in the American Journal of Psychiatry, compared the activity in the cortex ('front brains') of people with DPD with 'normal' controls using PET imaging scans. The frontal part of the front brain (the anterior cortex, specifically the frontal and cingulate cortex), responsible for things like planning, executing daily tasks and inhibiting emotional responses, lit up equally for both groups. However, for people with DPD, the posterior part of the cortex (the temporal, parietal and occipital lobes) and in particular the sensory cortex was markedly different to the control group, with much less activity.

This sensory association cortex, which failed to light up, is responsible for processing sensory information such as visual and auditory stimuli – if this is affected, it leads to distorted perceptions. In particular the angular gyrus (area 39 of the parietal lobe) was significantly under-active. This part of the brain is thought to be responsible for a kind of internal map of the body, which may account for the sense of disconnection from the body

or feelings out of body experiences in depersonalisation. Other research has shown that when people have cancerous tumours in this area, they often experience depersonalisation.

Studies of the autonomic nervous system – the body's unconscious activities including heart rate and blood pressure – show again that people with DPD respond differently. There are tests called 'galvanic skin responses' which are often used in lie detectors: they detect changes in the electrical resistance of the skin in response to stress and anxiety. A study by Sierra et al in 2002 showed that when DPD people were exposed to emotionally unpleasant stimuli, they had less of a response than normal people or people with anxiety disorders. They responded exactly the same as the other groups when they were exposed to stimuli such as claps which were surprising but not emotionally charged. Therefore, at a pre-conscious level, people with DPD are under-reacting to anything emotional.

Similarly, studies looking at the noradrenergic system have shown that people with DPD differ to 'normal' people. This system uses a chemical messenger called noradrenaline and facilitates mental alertness, orienting to new stimuli, selective attention, and enhanced memory encoding under stressful conditions. In other words, noradrenaline makes us super-alert when we are faced with threat. A number of studies have shown that people with PTSD have elevated levels of noradrenaline on a chronic basis, and this is thought to contribute to the symptoms of hyperarousal and intrusive thoughts. However, people with DPD experience the opposite: in several studies they have been found to have unusually low levels of noradrenaline. In fact, the lower the noradrenaline, the higher the depersonalisation. This would account for why people with DPD are 'shut down' (hypo-aroused as opposed to hyper-aroused) and why PTSD and DPD are only very rarely comorbid.

TREATMENT PART I: DOES MEDICATION WORK?

In short, no medication has yet been found to be completely effective in treating DPD and no pharmacological treatment guidelines have yet been developed. There is therefore a lack of a consistent treatment approach, which makes it difficult to assess whether any medication is effective. Given the lack of consensus, what we know about the effectiveness or otherwise of medication comes from a small number of studies, and the clinical experience of a small number of pioneers working in this field.

However, some medication has been shown to help reduce co-occurring symptoms, such as anxiety, obsessiveness or depression. Some

leading experts, such as Dr Elena Bezzubova and Dr Evan Torch, are proponents of combining psychotherapy with a combination of stimulants and selective serotonin reuptake inhibitors (SSRIs). This approach in some cases seems to reduce symptoms of numbness and obsessiveness and, they say, can be helpful as part of an overall treatment strategy. However, it seems clear that medication is rarely effective on its own and mostly works to decrease other symptoms, and therefore psychotherapy should be the primary treatment route.

TREATMENT PART II: WHAT WORKS IN THERAPY?

Although DPD is classified as a dissociative disorder, researchers at the Institute of Psychiatry in London have had some success by treating it as if it were an anxiety disorder. Elaine Hunter's team have developed a cognitive-behavioural approach which is based around five key interventions:

1. PSYCHOEDUCATION AND NORMALISING.

The therapist educates the client on what DPD is, how it arises, what causes it, how common it is in the general population, and its protective purpose. The treatment is oriented towards the client being able to stop worrying about the symptoms and just being able to notice them as they arise, name them, and understand what is happening in the brain.

2. DIARY KEEPING.

The purpose of this is for the client to begin to observe their symptoms and see how they ebb and flow. It also helps them identify how their thoughts and behaviours can influence the symptoms, so that they can start to appreciate that their symptoms are not relentless but are in constant motion. By noticing what makes things worse, they can begin to appreciate that there are also things that will make them better, and thus gain some semblance of control over their symptoms for the first time.

3. REDUCING AVOIDANCE.

This is based on theories of graded exposure therapy which teaches clients to be able to tolerate feelings, including feelings of fear and distress, without defaulting to dissociating. With gradual exposure to situations, thoughts and feelings which would normally evoke depersonalisation, whilst operating within a window of tolerance, the client is slowly able to reduce their avoidance and safety behaviours and grow in their ability to manage their feelings.

4. REDUCING SELF-FOCUSED ATTENTION.

DPD is maintained by clients in effect being triggered by their own symptoms: their symptoms trigger more symptoms, which trigger more symptoms. The client instead is taught focusing and grounding techniques which distracts the brain's attention away from the symptoms and thereby reduces the triggering cycle.

5. CHALLENGING CATASTROPHIC ASSUMPTIONS.

This again reduces the vicious cycle of self-triggering, by reducing anxiety and distress which arises in response to anticipating overly negative outcomes. For example, the client is taught to challenge the thought that they will be like this forever, which normally results in greater distress and therefore greater symptoms. Through education, experimentation and evidence-gathering of outcomes, the client learns to self-soothe and practice optimism in order to take control over their symptoms.

The basic premise of this approach is that depersonalisation is a common transient experience. However, when people misinterpret it in catastrophic terms – 'I've got a brain tumour!', 'I've gone mad!', 'I'll never feel real again!' – then this causes levels of emotional distress sufficient to maintain the depersonalisation and prevent it from resolving. A vicious cycle is born, with people with DPD triggered into depersonalisation by the catastrophic misinterpretation of their own symptoms. Elaine Hunter's team's approach seeks to break up this cycle and has shown promising results.

A similar approach has been pioneered by Daphne Simeon and her team at Mount Sinai, New York. Their 'Brief Psychotherapy' approach consists of ten weekly psychotherapy sessions using a variety of techniques, including psychoeducation, symptom monitoring with diary keeping, identification and working through core dynamics associated with the depersonalisation, CBT interventions (such as cognitive corrections, distraction task training, thought blocking, grounding techniques and positive reinforcement), and exercises to help manage and modulate levels of physiological arousal (for example, calming down from states of anxiety, or ramping up from states of depression). In particular the therapy seeks to help the client to understand what DPD is and is not, and that with help they can learn to control their symptoms, through grounding and desisting from obsessive and compulsive symptom-checking ('Do I still feel unreal?')

Clients with DPD benefit in particular from having their fears relieved: knowing that their experience has a name and is relatively common; knowing how it typically presents and what causes it; knowing what the future holds and that recovery is possible; knowing that it does not represent a serious brain illness or disease, is not irreversible and will not deteriorate into something worse; and understanding it as a condition in its own right rather than 'just' anxiety or depression. It can also be helpful to resolve any self-blame for actions which triggered the initial symptoms, such as drug-taking. A major step forwards for clients is often

for them to come to appreciate that their symptoms fluctuate from minute to minute and day to day, and diary-keeping often facilitates this. Otherwise, symptoms can feel persistent and enduring, which contributes to the sense that there is no hope for recovery. Once a client can begin to understand that the brain is trying to protect them from danger or levels of emotion which feel dangerous, they can start to take control over their brain's responses, and the cycle of self-triggering can stop.

CONCLUSION

DPD is a common condition which historically has not been diagnosed and treated well. As a result, many people with DPD have been stuck in a cycle of unrelenting symptoms which have been exacerbated by the belief that they cannot and will not recover.

Although classified as a dissociative disorder, DPD does not appear to be the caused by the same levels of extreme trauma that result in DID. Instead, it is largely a defence mechanism for coping with chronic levels of emotional maltreatment in childhood.

It is vital that more therapy professionals are made aware of DPD and how to treat it, which principally involves training the brain out of its own self-triggering vicious cycle. This can be effective in even short term therapies based on largely cognitive-based techniques. The prognosis for people with DPD is therefore positive as long as their symptoms are accurately identified and appropriate help and psychoeducation offered.

SIGNS AND SYMPTOMS

People with DPD explain their experiences in a number of ways, and the following is a summary of the most common descriptions:

Feeling as if in a dream or a trance

- Emotionally numb
- Not feeling alive
- Going through the motions
- Being like a robot
- A sense of disconnection
- An absence of feeling
- A disturbance in the sense of time
- Experiencing one's self as 'alien'
- A heightened consciousness of the self
- A feeling that the self isn't familiar
- Not feeling 'grounded'
- Detachment from surroundings
- Feeling disconnected from other people
- Struggling to concentrate and focus
- Compulsive self-scrutiny
- Preoccupation with fears of insanity or illness
- A feeling of unreality

- A lack of a sense of control over one's own body
- Feeling foggy or spacey
- A lack of emotional meaning
- Frozen feelings
- People and things seem a long way away
- Macropsia or micropsia: a perceived change in the size and shape of objects
- Obsessive rumination about the symptoms of depersonalisation, or the nature of existence or the self
- Experiencing the self as a distant 'voice'
- A split between the part of the self which experiences life and the part which observes that experience
- Being out of sync with one's self
- Feeling cut-off
- General anxiety and dread
- Objects seem lacking in colour or vividness

DEPERSONALISATION CASE STUDY #1

SHAWN, 28

'I felt like I was in a prison, but one made of frosted glass.'

When I was 17, my parents had an almighty row. They'd always argued, and things had often been difficult and tense in the house, but this was like nothing I'd ever witnessed before. I literally thought they were going to kill each other, and that if I didn't stay out of the way and keep my head down, they'd kill me too.

It went on for hours. There was violence, but nothing serious. It was the anger and the malice that was hardest to deal with. After an hour or so of listening from the top of the stairs, I couldn't deal with it any more. It really felt like my life was going to fall apart from the inside. It was just this overwhelming feeling that I had to do something to make it stop.

So I went into my room and barricaded the door shut and smoked a joint. Normally I was really careful with my drug use to make sure I never got found out, so I'd never normally smoke at home with my parents around. But I was so stressed that I didn't care. I just needed some relief. And I figured that they were too busy attacking each other to come and find me. I felt like they'd forgotten I existed anyway. In a way, when I closed

the door and pushed my desk up against it, I felt like I was cutting myself off from their world. I was sick of it, and terrified. I couldn't hack it any more.

I'd first smoked pot at a friend's house a couple of years previously. He taught me what to do and then showed me where to get it. I didn't do very much of it, but I liked the chilled feeling it gave me. After all the tension at home, it was a welcome release.

That night though, as I smoked that joint, it was different.

I wish I could describe it, but I can't do it justice. It was such a strange, powerful experience that I doubted whether it was actually pot that I was smoking, or whether someone had laced it with LSD or something. That was the only way I could explain the weirdness of the feelings I had.

It's like I floated away from myself. Everything went strange and unreal. To this day I could tell you the exact date and time that my life changed. I've spent my life since that point wishing I'd never smoked that joint. There's nothing I regret more.

My parents fought a lot when I was a kid, partly because my mother was an alcoholic (she didn't think I knew that, but it was hard to miss) and my father was emotionally remote and shut-off. He coped with her by not being around. When he was at home, he would get completely entranced in watching sport or NCIS or something and would snap at her for talking during it.

That's how this particular row started: it was nothing really. He was watching TV and she was on at him about something, and he ignored it for a while and then suddenly he snapped. He just completely lost it. And so she did too. And it got ugly really quickly.

I grew up with this constant sense of anxiety and dread that something bad was about to happen. But I wouldn't say that I had an abusive childhood. When my mother wasn't drunk, she was caring and kind and I knew she loved me. My dad loved me too, although he didn't ever really show it. But he did stuff with me. He taught me how to fix my bike and how to skateboard and he showed up to parents' evening and lots of stuff that my mates' dads didn't do. So I've got no complaints really.

As the row continued downstairs, it was like I fell deeper and deeper into a sense of unreality. I felt right on the limits of insanity, like I was on the edge of a huge abyss. I lost all sense of time. I lost all sense of where I was really. It was terrifying. I felt like I sort of detached from my body and was watching myself sit on the end of my bed, but that it wasn't really me that I was watching, and that it wasn't really me who was doing the watching. I was totally freaked out.

That was 11 years ago. The next day I woke up and still felt weird, but nowhere near as bad as I'd felt during the joint. But things weren't right. Things have never gone back to how they were before that night.

I was at college at the time but I couldn't focus or concentrate. After college, I had a series of low-paying jobs which I'd work at for 2–3 months and then give up on. I'd simply not turn up for work one day and then not go in ever again. I just got overwhelmed with anxiety really, so I couldn't handle it. And whenever my anxiety spiked it started this chain-reaction of panic in me that I'd end up feeling like I did the night of 'The Row'.

The more afraid I became of losing the plot like I did that night, the more spacey and detached I'd become. It was a self-fulfilling prophecy. Whenever I got really anxious, I'd start to feel that everything was unreal again, and that made me even more anxious.

I constantly beat myself up for having smoked that joint. I thought about that night literally all the time.

It was like the depersonalisation started suddenly, that night, but then it came and went in waves. It was sudden, but it was also slow-growing. By the time I was in my mid-twenties I felt depersonalised almost all the time. I'd wake up on a morning and feel unreal, and then I'd feel this rush of panic. And as soon as it reached a certain level, it was like a switch was flipped on the inside of me and everything went numb instead.

I had a girlfriend for a couple of years until just recently, but we split up because she felt like I was never really present. She thought I didn't care. She was always complaining at me that I wasn't listening. I was always trying to listen, but the problem was that her voice was coming from such a long way away that it was hard to concentrate on it.

Whenever she wanted to be intimate, I'd quickly feel out-of-control and I wouldn't be able to focus on her properly. This sounds stupid, but I'd become hyper-aware of how many light flecks there were in her hair. She'd get cross with me for looking at her hair rather than at her directly, but it's like I couldn't help it. I just couldn't take my attention off her hair flecks. They were strange and unfamiliar and I couldn't figure them out, even though I'd seen them and noticed them and even stared at them a hundred times. It was like I couldn't figure out if the flecks of colour in her hair were actually part of her hair or if they were separate to it. I know that sounds crazy to other people, and I can't really describe it, but it's like my whole attention got swallowed up by it and there was nothing I could do about it. I'd tell her, 'Your hair is so beautiful' to

try to cover up what was going on in my head and why I was staring at it, but she was just creeped out by me.

Whenever we had any conflict, I'd immediately feel myself drifting away from myself. So all the emotion in the room just kind of got swallowed up in a chasm between us. I knew intellectually that she was upset. I understood why she was crying. And it bothered me in my head. But it didn't touch my emotions. It sounds callous, but it was like I just didn't care. I didn't feel her upset. And the more upset she became, the further inside myself I disappeared. It used to make her really mad and she went on and on about how controlling it was of me to refuse to engage with her. But I wasn't doing it on purpose. I just couldn't stop myself.

I felt like I was in a prison, but one made of frosted glass. I could see a bit of what was going on in the outside world but not clearly, and I certainly couldn't engage with it.

I felt like I'd caused it all by smoking the joint, so it took a long time before I told anyone what was happening to me. I eventually talked to my GP and he suggested medication but I was terrified of how it would make me feel, so I refused. We went around in circles for a while. One appointment he asked me to tell him again how it had first started, and I told him about the joint, but he said, 'And why did you smoke a joint at that point?' and I told him about the row between my parents. He seemed to think this was really relevant. He referred me to see a counsellor based in the surgery and she said straightaway that she thought I had depersonalisation disorder. Obviously, I'd never heard about it before. I guess I was really lucky that the first person I saw knew about it – I know from other people I've met online that it's not everyone's experience.

My counsellor gave me some stuff to read about it and it was like a major epiphany. 'That's it! That's what I've got!' It was such a relief. The best thing she did to help me was to normalise it. She explained that it's actually really common but hardly anyone talks about it. We worked on some stuff about getting grounded in my body for a few weeks and then with the GP's help I was referred to the Maudsley in London who have a specialist unit. I had 12 weeks of therapy there and at the end of it I felt like I was beginning to come back to life again. I felt like I was getting back to the person I was before the row and the joint. I had to do a lot of work in therapy to get there, but it was worth it.

Things can get better. I'm not 100% sorted but I'm improving all the time and I now know what to do when I'm feeling depersonalised. I've made the connection with my anxiety and feeling overwhelmed and I work on settling that rather than panicking even more

because of the feelings of unreality. It seems to have broken the vicious cycle and has really worked for me, although I know that everyone's different.

DEPERSONALISATION CASE STUDY #2

SHEILA, 53

'I kept wondering if really I was dead and I would eventually realise that I was.'

I started experiencing depersonalisation and derealisation about 3 years ago. I've only just been diagnosed with depersonalisation/derealisation disorder (DPD).

It all started suddenly when I witnessed a terrible road traffic accident. I don't want to go into details, but suffice to say that it was traumatic and those images will never leave me. I have never felt so helpless in all my life.

While the scene was unfolding, I immediately felt like I wasn't 'there'. I felt like I was watching a film and that what was happening wasn't real. It felt make-believe. Time seemed to slow down so everything happened in slow motion and took an age. There was just this overwhelming sense of horror and that I couldn't do anything about it. I felt frozen, both physically, mentally and in time. All I could do was watch, but it was like I wasn't even in my body while I was watching. It was the strangest thing.

The sense of horror was palpable, but it was as if it was swallowed up in some way and really I felt like I knew that it was horrible, but I didn't feel it. It was like someone had thrown a switch on the inside of my brain and cut off all my feelings all of a sudden.

Up until that point I would say that I'd had a reasonably happy, normal life. Not perfect, but no worse than anyone else's. I had divorced about ten years previously but that was my choice (although it was still painful). I have a grown-up daughter and son and I see both of them regularly. I don't have a partner and quite frankly I'm not interested. I just know I wouldn't be capable of it since the accident. Nobody wants to be with someone who's dead on the inside, do they?

The paramedics at the scene told me that I was in shock and I was taken to hospital but it was all a blur at the time. I went home with some sleeping tablets and literally slept for about 48 hours solid. But when I woke up, I still didn't feel real. I thought maybe it was the tablets, but by the end of the week it was no different. All I did all day was sit in the chair and stare at the fire. I would rouse myself from time to time to do things like going to the toilet or getting a meal ready. I wasn't hungry, but nor was

I un-hungry, so I was eating normally. When anyone came around, I made a huge effort to appear normal. But really on the inside I felt dead. Years ago I saw the Bruce Willis film *The Sixth Sense* and I kept wondering if really I was dead and I would eventually realise that I was. That's how weird it felt.

My daughter was worried about me and nagged me to go to see the GP, who thought that I was still in shock but suggested that I just do my best to get back to normal routines and that in a day or two the feeling should pass. So I did what I was supposed to do: I went through the motions. I wasn't having flashbacks of the accident or anything like that, but I could find myself having spent a couple of hours or more on an evening just thinking about it and replaying the scene over and over in my head. I think what I was actually trying to do was to feel something. Because I saw this horrible scene, but I didn't have any emotions. I knew that wasn't right. I kept hoping that the next time I thought about it, I'd suddenly become upset. It felt like there was a kink in the hosepipe of my emotions and that if I could just find where it was, I could be free of the blockage.

But nothing worked and after a couple of weeks or so I began to doubt that I was 'in shock' and that something actually was wrong with my brain. I went back to the GP. She also thought it strange that I was still feeling so detached and numb but tried to reassure me that all was okay. This time, though, I refused to be fobbed off. She agreed to do some blood tests, just to be on the safe side.

Within a few days I felt even worse. It was like I had totally lost contact with my body, that I was just free-floating in space somewhere above it. It was the strangest feeling. I was completely convinced at one level that I was dead, like Bruce Willis' character, but at another level I knew that I wasn't. Part of me was floating over there in this corpse of a body, while another part of me was watching. I couldn't figure out which part was 'me'. I felt like I'd put myself down somewhere, and couldn't remember where.

I went back to the GP and saw a locum. He was a young trainee. He was alarmed at what I was telling him and started wondering if I'd had some sort of stroke, brought on by the stress of the accident. He referred me immediately to the hospital and within a few days I had had an MRI scan and a CT scan. The experience of being in the scanner made everything worse. I literally couldn't remember where I was supposed to be and it was like I'd fallen down a hole into myself and I didn't know how to come back out.

I was having really strange visual experiences. Sometimes it would be

as if all the colour had been bleached from my sight. Although intellectually I knew the sky was blue, it didn't seem blue. It seemed no-colour, not even grey. I had an itch on my arm at one point, and looked down to see if there was a mosquito bite, and was shocked to find that my arm suddenly looked huge. The only way I can describe it is that it was as if I had a giant's arm. Another day, I couldn't figure out why my television and my phone both seemed so tiny. I've since discovered that the technical term for these is micropsia and macropsia but I don't really understand it.

The brain scans had come back as normal, so I hadn't had a stroke. I was worried about my vision though, so I asked for a referral to an opthalmologist. My eyesight also came back as 'normal', or at least normal for my age. There was no explanation for what I was seeing. The ophthalmologist was really rude and she bluntly suggested that I see a psychiatrist – I think she thought I was just a time-waster.

One of the worst things was that my daughter had recently had a baby and I used to see them about twice a week. Before witnessing the accident, I absolutely loved seeing Eva. It was the highlight of my week. Afterwards, it was just something to do. It was literally a chore to be ticked off the list. I had absolutely no enjoyment while I was with her. In fact, I didn't even really recognise her. I knew intellectually that this was my grand-daughter, but every time I met her it was as if it was for the first time and I had no emotional connection to her at all. It all felt numb and empty and distant.

A lot of the time I feel like I'm not awake. Like I'm in a dream. I can see everything that is happening, and I know that it's happening, but it's happening in a dream. I speak, words come out of my mouth, and yet it's as if I'm an actor reciting a script. I keep waiting for the scene to come to an end, for the Director to shout, 'Cut!' and then to wake up or come round or switch back to 'me', but it never happens. Hours can go by but it feels like it's only been seconds. Or other times it can feel like everything has been slowed down and the day stretches ahead of me like a decade. It feels interminable.

Eventually after all the different referrals a psychiatrist diagnosed me with DPD. Everything then made sense, but of course it didn't make any of the symptoms any better. But at least I have a label. It was also reassuring to realise that what I was experiencing had a name and that it wasn't 'serious'. By that I don't mean that the symptoms aren't awful and debilitating, but just that it's not going to get any worse and I'm not going to die of it. For months I'd been convinced that I had a brain tumour or was suffering some rare brain disease.

It's a relief to find out what it is. Now I am on a waiting-list for treatment. I hope that one day with help I'll find who I am again.

DEPERSONALISATION CASE STUDY #3

ALICE, 42

'Everyone else just seems to take it for granted that they exist and they get on with their lives. For me, it's become a bit of an obsession.'

I can't tell you when the depersonalisation started. In a sense, it's always been there. And yet I also know it's not normal, so there must have been a time when it wasn't like this.

My mother was highly critical and highly strung. She would get into a frenzy and shout and scream at me for doing anything 'wrong'. And it could be literally anything. Once she started screaming at me because I wasn't smiling properly. The slightest thing could set her off, and you never knew what would. Looking back, I now realise that she wasn't well, mentally, but at the time I just thought it was normal. If I didn't come straight to the dinner table, or if I spilled something down my top, she would become a whirling dervish shrieking at me.

I want to say that it didn't used to bother me, but I know now that that's the depersonalisation talking. I would just float away from myself while it was going on. Or I imagined that I was a tree trunk and I would climb down within myself and sit in the roots while she was screaming somewhere up near the branches. I could hear it all going on but I was a long way away from it. That's how I coped, I suppose.

I was asked once if I was abused and I said no, and I still believe that. It doesn't seem to me that there was anything abusive about it at all. I didn't get hurt. My mother just had these funny turns, that's all. The person who asked me thought that it was abuse, but I guess the way I saw it was that my mother didn't mean to become like this. It wasn't malicious. I never thought she hated me. It was just something that happened, and I climbed down my tree trunk inside myself and later on it was all okay.

What's not okay, I suppose, is the way that it affects me now. I feel like I'm floating away from myself a lot of the time. I feel detached from my body. It's a bit like an out-of-body experience, but not quite. It's like my body is one thing and my mind is another. I don't feel in control of my actions. I feel like a robot that's been put onto autopilot. It always amazes me that I manage to walk because I don't have any conscious sense of how I'm doing it. It just happens.

My memory is very hazy. If someone asked me if I can remember my

childhood, I'd say yes of course. But that's not quite true. I can tell you where I lived and where I went to school and who my friends were and where we went on holiday. But it's like I'm telling you someone else's history. It's like I just watched it all – it feels like I'm telling you about me in the same way I'd tell you about Scott and Charlene getting married on *Neighbours*. I'm not sure that my life is real and that *Neighbours* isn't.

It can be like that when I've had a dream. I wake up the next morning and often I can't remember if what I dreamt happened or not. My memories often seem fake. I could be making them all up.

I sometimes wonder if I even really exist, or if I'm in something like *The Matrix*. I get stuck asking myself, 'Why do I exist? Do I even exist?' I don't know anybody else who does that. Everyone else just seems to be take it for granted that they exist and they get on with their lives. For me, it's become a bit of an obsession. I have to keep checking out that I exist.

Sometimes my body feels so far away and distant, so disconnected, that I hurt it just to make sure it's still there. Sometimes, especially when things are bad, I can hurt myself and in my head I know there's pain, but it's like it doesn't really hurt. It doesn't bother me. I can go on hurting myself and there's nothing in me that tells me to stop. It's actually quite comforting, because at least I'm feeling something. But even pain can seem a long, long way away.

Lots of times I think I've gone mad, that this is what insanity is. I'm afraid of being locked up if I tell anyone what life is like for me, so mostly I keep it to myself. I tell people a lot of the time that I'm 'just tired'. In fact mostly it feels that I'm going through life asleep, or as if my brain is only minimally awake. I'm sure I could achieve all sorts of things if I were really conscious. But I'm so numb and dead that I barely exist.

One doctor told me that I had depression, and I thought that was what it was for a while. But the more I read and talked to other people on a mental health forum, the more I realised that this isn't depression. People who are depressed don't wonder if they exist. They don't watch themselves and hear themselves talk and feel like it's not them doing the listening or talking. It's completely different.

DEPERSONALISATION CASE STUDY #4

RAY, 55

'It feels as if life is happening too far away for me to be involved in it.'

I don't actually have DPD, but I wanted to talk about what depersonalisation is like, as a lot of the time it's my

main symptom. I have actually been diagnosed with dissociative identity disorder (DID) and I'm in therapy for it. After years going round in circles and feeling that life will never improve, I'm making some progress now. We've been doing a lot of work on identifying my emotions and putting them into words. This is completely new to me. It's not that I didn't ever feel anything, but generally I wouldn't. Most of the time I was numb and I'd feel like I didn't exist. Then out of the blue everything would erupt out of me and I'd go on a rampage. Not hurting anyone, but hurting myself, and smashing things up. I always made sure I did it in a way that no-one else would be affected by it, because I didn't want to get in trouble and I didn't want to go to prison or get put in a mental ward. But emotions would just explode out of me suddenly and I'd lose the plot. And I never saw it coming, because most of the time I didn't feel anything.

I know now that that's a switch to another part of me. So in a way it's reassuring, because it shows that my brain is capable of doing feelings. But it's like the volume switch goes from zero to ten – all or nothing. As me, I'm no good at feelings. When I switch to that other part, the feelings come out in a mad rage.

Normally, when anything emotional or negative happens, I feel like I'm withdrawing into myself. Everything goes still and numb and calm. I feel like I'm not there. It feels an awful lot like I'm dreaming with my eyes open.

A lot of the time I don't feel anything at all even though I want to. Once I was watching my team play in the Champions League final. I'm a huge football fan so this was a big deal for me. And we won on penalties. And I cheered – that's what you do when you're a football fan, right? And I was really pleased. But the weird thing was that I suddenly found that I had tears running down my cheeks. I assume that means that another part of me was really happy but I'm too depersonalised, too switched-off, to really know. It's weird.

It feels as if life is happening too far away for me to be involved in it. It's like watching a training video on life, or a reconstruction. I feel like someone could say at any point, 'In this clip, Ray is played by an actor.' I am surprised every time I see myself in the mirror. 'Is that really me?' I wonder. I avoid looking because it's such a strange thing to see your own reflection and not to recognise it.

I have quite a high-level, high-paying job as a project manager. Nobody at works knows that anything is wrong. I keep myself to myself. Work is an escape. I like the routine. It's a mental exercise all day to achieve things, to tick them off my list, like it's a series of steps across a board and I just have to take one after another to get to the other side. It's an

intellectual game. But there's no sense of enjoyment.

My health is in poor shape, largely because I don't look after myself. I know I should but I can't find it in me to care. It doesn't feel like my body, so although I understand intellectually that what I eat affects my weight, it really doesn't feel like it does. Most of the time I'm not even conscious when I'm eating. It's like if anything goes anywhere near my mouth, I can't be conscious of it. It's a blind-spot. I don't understand it yet, but my therapist has some ideas about it and says we'll talk about it when I'm ready.

From what I understand, I don't have DPD as such because I have DID, so the diagnosis of DID takes priority. But the psychiatrist who diagnosed me says that I have a lot of depersonalisation symptoms. She said that my brain has shut down from emotions. I remember her saying it and she was all serious and trying to sound clever. And it nearly made me chuckle, because I wanted to say, 'No shit, Sherlock!'

One day I'd like to feel things. But the possibility of that also feels really scary. What if I won't be able to cope with feeling stuff? Maybe I won't be any good at it. Maybe I'm too old to learn how to do feelings. My therapist says we're never too old and that the brain is learning and changing all the time. Certainly I'd like to think that I'll be able to live before I die. Living like this is like being a zombie. I feel like I'm the walking dead. That's not right, is it?

DIAGNOSTIC CRITERIA

DSM-V CRITERIA: 300.6 DEPERSONALISATION / DEREALISATION DISORDER

Parent: dissociative disorders

1. The presence of persistent or recurrent experiences of depersonalisation, derealisation or both:
   - Depersonalisation: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).
   - Derealisation: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).
2. During the depersonalisation or derealisation experiences, reality testing remains intact.
3. The symptoms cause clinically significant distress or impairment in social, occupational, or other

important areas of functioning.

4. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or other medical condition (e.g., seizures).
5. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative disorder.

ICD-10 CRITERIA: F48.1 DEPERSONALISATION-DEREALISATION SYNDROME

Parent: F40-F48 Neurotic, stress-related and somatoform disorders

A rare disorder in which the patient complains spontaneously that his or her mental activity, body, and surroundings are changed in their quality, so as to be unreal, remote, or automatised. Among the varied phenomena of the syndrome, patients complain most frequently of loss of emotions and feelings of estrangement or detachment from their thinking, their body, or the real world. In spite of the dramatic nature of the experience, the patient is aware of the unreality of the change. The sensorium is normal and the capacity for emotional expression intact. Depersonalisation-derealisation symptoms may occur as part of a diagnosable schizophrenic, depressive, phobic, or obsessive-compulsive disorder. In such cases the diagnosis should be that of the main disorder.

PROPOSED ICD-11 CRITERIA: 6B66 DEPERSONALISATION-DEREALISATION DISORDER

Parent: dissociative disorders

Depersonalisation-derealisation disorder is characterised by persistent or recurrent experiences of depersonalisation, derealisation, or both. Depersonalisation is characterised 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. Derealisation is characterised by experiencing other persons, objects, or the world as strange or unreal (e.g., dreamlike, distant, foggy, lifeless, colourless, or visually distorted) or feeling detached from one's surroundings. During experiences of depersonalisation or derealisation, reality testing remains intact. The experiences of depersonalisation or derealisation do not occur exclusively during another dissociative disorder and are not better explained by another mental, behavioural or neuro-developmental disorder. The experiences of depersonalisation or derealisation are not due to the direct 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 or to head trauma. The symptoms result in

significant distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

PRINCIPAL STUDIES

To date there have been two major centres of research into DPD, one based in New York and one in London.

- Department of Psychiatry, Mount Sinai School of Medicine, New York (2003): published study of 117 patients suffering from primary depersonalisation disorder in the *Journal of Clinical Psychiatry*
- Simeon, D., Knutelska, M., Nelson, D. & Guralnik, O. (2003). Feeling unreal: a depersonalisation disorder update of 117 cases. *Journal of Clinical Psychiatry*, 64, 990-997.
- Institute of Psychiatry, King's College, London (2003): published study of 204 patients with chronic depersonalisation in the *British Journal of Psychiatry* (participants had depersonalisation symptoms, of whom 71% actually suffered from primary DPD)
- Baker, D., Hunter, E., Lawrence, E., et al. (2003). Depersonalisation disorder: clinical features of 204 cases. *British Journal of Psychiatry* 182, 428-433.

BOOKS

- *Feeling Unreal: Depersonalisation Disorder and the Loss of the Self* by Daphne Simeon and Jeffrey Abugel: https://amzn.to/2w5mVzZ
- *Overcoming Depersonalisation and Feelings of Unreality* by Dawn Baker, Elaine Hunter, Emma Lawrence and Anthony David: https://amzn.to/2MEBIZn
- *Overcoming Depersonalisation Disorder: A Mindfulness and Acceptance Guide to Conquering Feelings of Numbness and Unreality* by Fugen Neziroglu and Katherine Donnelly: https://amzn.to/2MirTn8
- *Stranger in the Mirror* by Dr Marlene Steinberg: https://amzn.to/2P65c4d

YOUTUBE VIDEOS, LINKS AND WEBSITES

- BBC News Clip: https://www.youtube.com/watch?v=DZvJeFT2ivw
- The Maudsley Depersonalisation Disorder Service: https://www.youtube.com/watch?v=o7Dr8jt_lxg
- Steinberg Depersonalisation Test: http://strangerinthemirror.com/questionnaire.html