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DEPERSONALIZATION IN A NON-CLINICAL SAMPLE

Jean Charbonneau

Hopital St-Luc, Montreal, Canada

Kieron O'Connor

Hopital Louis-H Lafontaine, Montreal, Canada

Abstract. Twenty participants self-referred from the general population as experiencing depersonalization were interviewed to determine the qualities of the experience and possible pathology. The participants and control group were also administered a battery of questionnaires measuring different aspects of psychopathology. There were no consistent diagnostic associations with depersonalization. In the majority of cases, onset was reported after a traumatic life event, or after sexual abuse or after giving birth. The most frequent experiences were related to derealization and participants did not score high on dissociation in general. The most common strategy to alleviate the problem was concentrating on a task. We distinguish between those clients who viewed the experience as a loss of or less than normal sensation, which we qualified as negative symptoms and others who evaluated the experience as an addition to their usual perceptions and sensations, which we qualified as positive symptoms.

Keywords: Depersonalization, derealization, coping strategies, psychopathology.

Introduction

Depersonalization as a symptom is distinguished from depersonalization disorder in both ICD-10 and DSM-IV nosology. Depersonalization symptoms, even if recurrent, which do not cause serious social or occupational impairment, are not considered to constitute a depersonalization disorder. DSM-IV diagnostic criteria for depersonalization disorder include: persistent or recurrent experiences of feeling detached from and as if one is an outsider of one's mental processes or body; feeling like an automaton or as if in a dream, although reality testing remains intact. In order to meet DSM criteria, the problem must be severe and persistent enough to cause marked distress. However, depersonalization as a symptom occurs in a number of psychiatric and medical disorders including epilepsy, clinical depression and schizophrenia. But, its presence has also been widely reported in the non-clinical population (Trueman, 1984) and associated with trauma (Steinberg, 1991). The major indicator of the presence of

Reprint requests and request for an extended report to Kieron O'Connor, Centre de Recherche Fernand-Seguin, Hopital Louis-H Lafontaine, 7331 rue Hochelaga, Montreal, Quebec, Canada H1N 3V2.

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depersonalization is currently verbal report and diagnostic robustness could be improved by clarifying the relationship between subjective reports and other clinical features. Since there is very little research on the qualitative differences in depersonalization experiences an essential starting point seems to be to look at the experiences of those with depersonalization symptoms as a main complaint. There are at present no fully validated subjective measures of depersonalization, although Riley (1988) has developed a dissociative experience questionnaire, and Fewtrell (1990) has expert rated a 54-item questionnaire covering statements representative of the problem and which distinguishes between depersonalization, derealization and desomatization (Fewtrell & O'Connor, 1988). The aims of the current study were to examine the clinical characteristics of people experiencing depersonalization but not reporting to a clinic, and to describe subjective features of the experience, along with how people interpreted and coped with the experience.

Method

Participants were recruited by announcements in the local francophone media of Montreal about the nature of our research together with a description of subjective aspects of the depersonalization experience. All subjects were French speaking Quebeckers. The inclusion criteria were: depersonalization experience that occurred either continuously or sporadically and experienced at least twice in the last year. Exclusion criteria were: acute psychotic symptoms, current psychiatric medication, reported use of drugs in the past year, epilepsy and other cerebral organic disorders. We report here data on 20 consecutive participants who met the above criteria (13 F, 7 M; age range (yrs) 25–60). All participants attended for interview twice. Total interview time was about 4 hours. On the first occasion, participants received a semi-structured interview based on the DSM-III-R Schedule administered by an experienced psychiatrist (J.C.). Participants completed Riley's (1988) QED and responded to a questionnaire adapted from Fewtrell's (1990) list of statements describing the depersonalization experience and were questioned on accompanying thoughts and sensations. On the second occasion, 17 of the 20 participants completed a computerized package of standard clinical questionnaires measuring: anxiety level (Spielberger State-Trait Anxiety Inventory [STAI]), obsessionality (Leyton Obsessional Inventory [LOI] symptom scale), and depression (Beck Depressive Inventory [BDI]). The questionnaire program also elicited strategies or behaviours that reduced or augmented the depersonalization experience. The questionnaires were also administered as part of a wider survey to a control group of 20 participants with no reported psychiatric problems recruited from the general population (15 F, 5 M; age range (yrs) 24–50).

Results

None of the participants were in current psychiatric treatment and did not meet criteria for current Axis I diagnosis (except depersonalization), but two had a history of panic with agoraphobia and two had a history of past major depression. On Axis II, five participants showed evidence of obsessional, three histrionic, two narcissistic and two avoidant personality. The STAI trait anxiety level of the sample was moderately high

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Table 1. Questionnaire data

	Depersonalization group		Control group	
	[*n*]	(SD_{n-1})	[*n*]	(SD_{n-1})
Chronicity of depersonalization (yrs)	[20]	16.9 (13.7)		N/A
Age at onset (yrs)	[20]	20.8 (12.4)		N/A
QED	[19]	14.79 (4.5)		N/A
Current age (yrs)	[20]	37.8 (10.5)	[20]	33.4 (9.2)
Depersonalization items**	[20]	30.6 (9.6)	[18]	3.83 (3.2)
STAI (trait)*	[17]	52.28 (7.5)	[18]	35.22 (5.4)
LOI	[17]	17.18 (9.3)	[18]	16.30 (9.8)
BDI*	[17]	12.23 (3.9)	[18]	3.47 (3.5)

* Differences between group means significant at $p < .01$.
** Differences between group means significant at $p < .001$.

with all participants scoring 40 or above. One person's current score on the BDI was in the mildly depressed range according to the Quebec BDI norms. Only two of the depersonalization sample reported high (QED > 20) dissociation scores. A majority of participants (19) first experienced the problem after negative life events, 15 of these after sexual trauma, and/or after post-partum. Only three were experiencing severe enough subjective distress to qualify for DSM-III-R/IV diagnosis of depersonalization disorder. Three out of the 20 found the depersonalization experience enjoyable. In the control group, two participants reported depersonalization experiences and were excluded. Questionnaire data for both depersonalization and control group are presented in Table 1. The main distinctions between the depersonalization and control group were in the former's higher level of depersonalization ($t[36] = 11.19; p < .001$), trait anxiety ($t[33] = 7.6;\ p < .01$) and depression ($t[33] = 6.18; p < .01$), but in neither group did the mean group STAI or BDI scores fall outside the normal range. There was no significant correlation between depersonalization scores and either level of depression or trait anxiety within the depersonalization group.

The majority of the depersonalization group responded to derealization and desomatization statements as descriptors of their experience. The most frequently endorsed statements concerned derealization: "I am frequently looking on as if not part of things" (95%); "I feel as if I am floating away from reality" (90%); "nothing seems absolutely concrete or real" (90%); "I often experience a dream like detachment" (85%); "life seems like a film played in front of me" (85%); "the outside world seems remote" (85%); "things that I am used to now begin to seem strange" (80%). There were also a number of desomatization items that were frequently endorsed: "my body is not in harmony with my being" (85%); "my body does not feel like it belongs" (80%); "my actions and feelings do not come naturally" (80%).

The most commonly experienced thoughts and sensations accompanying the depersonalization experience concerned worries of isolation and detachment from others (60%), feeling vulnerable and embarrassed (45%), worries about feeling and looking out of control (40%), loss of sense of time and space (50%), loss of coordination (50%) and difficulty breathing (35%). There was no single thought or sentiment that was experienced by everyone.

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Appraisals about the consequences of the depersonalization experience could be grouped under three categories: fears about becoming disconnected and permanently losing touch with reality (50%), fears of losing control of self or actions (30%), worries about registering stimulus information in order to know what was happening in the immediate surroundings (30%).

Strategies used to diminish the depersonalization effect also varied across participants. The following strategies were cited: going into the dark or the shade, restricting or fixating vision, concentrating on a task, using the imagination, stretching and doing physical exercise, controlling breathing. The most frequently cited strategy used to reduce depersonalization was concentrating on a task (53%). The activity most often cited as likely to worsen depersonalization was doing machine-like tasks (41%). Drinking alcohol and coffee, and keeping still, were also reported to aggravate the sensation by at least 20% of the sample.

We noted differences in the way the depersonalization was experienced in relation to the normally experienced self. Some of the sample felt the addition of new experiences and sensations, some felt the loss of normally felt sensations. We classified these phenomena as positive symptoms and negative symptoms respectively. The criterion for positive symptoms was the presence of floating sensations with sensory acuity enhanced or intensified by the depersonalization experience. Where the person reported a distancing, a diminution or a masking of normal receptiveness and sensitivity of either an emotional or sensory kind, the symptoms were classed as negative. For example, someone feeling superlight or feeling the body had extended or feeling she or he is seated and watching and speaking elsewhere at the same time, would be experiencing positive symptoms. Conversely, someone reporting that she or he had been deprived of the usual way of feeling things or had lost spontaneity in relating to people would be experiencing negative symptoms. This division into negative and positive reports was not related to whether the experience was enjoyed or not. These differences might refer to a concentration by the clients themselves on positive and negative symptoms of the experience. Seven subjects in the present sample reported positive symptoms. All the other subjects, with the exception of two, who both reported a disoriented clouded experience not easily identifiable as positive or negative, were classed as experiencing negative symptoms. This distinction had some clinical relevance in that those in whom the experience developed after reported sexual trauma focused more on the positive symptoms than did the rest of the sample ($x^2(1\ df) = 4.2, p < .05$).

Conclusion

The limitations of our study are the small number of subjects and the way they were recruited (self-referral after newspaper advertisement) which could account for an overrepresentation of anxiety traits in the sense that the sample may have been more aware and preoccupied by the problem. An important conclusion from our study is that there do seem to exist non-pathological chronic forms of depersonalization that are not directly linked to any psychiatric disturbance. Steinberg (1991), in a study comparing psychiatric patients to normal controls, reported that the chronicity of depersonalization indicated a link to dissociative disorders and that such chronic depersonalization

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lacked any associated precipitous events; this was not what we observed in our non-clinical sample. Clinicians could come across depersonalization symptoms without important co-morbidity of axis I and axis II disorders related to depersonalization disorder, such as described by Simeon et al. (1997) in their study of depersonalization disorders. In this case, it is important for the clinician to specify the quality of the experience. Derealization seemed, in our study, the most common symptom of depersonalization and this concurs with Simeon et al. (1997). However, our sample seems less severe than the cases reported by Simeon et al. (1997), the majority of whom had received multiple psychiatric treatment. Although the DSM distinguishes between derealization and depersonalization, both experiences are considered dissociative symptoms. But whereas dissociation is likely to be present with depersonalization disorders, non-clinical subjects who experience derealization may not necessarily score high on dissociative scales.

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