

## Interoceptive Cue Exposure for Depersonalization: A Case Series

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*Cognitive-behavioral treatment for panic disorder relies heavily on interoceptive exposure. Specifically, therapists induce physical symptoms associated with panic in order to produce habituation to those sensations. Many common symptoms of panic are easily induced, such as increased heart rate and dizziness. However, depersonalization is a difficult symptom to induce in the office. Three uncontrolled cases are presented here where a novel intervention, the use of 3D glasses, was used to successfully induce depersonalization with positive effect. The application of the procedure resulted in rapid habituation within session, and all three patients had significant reductions in panic following treatment. Additional research is necessary to examine the application of this, and other, novel methods for inducing depersonalization as part of a comprehensive approach to treating panic and other psychiatric conditions where depersonalization is present.*

**D**EPERSONALIZATION (DP) is the experience of feeling separated from one's self (American Psychiatric Association [APA], 2000). Individuals may feel a sense of being disconnected from their bodies or their cognitive processes, as if they were in a dream or watching themselves as outside observers. Derealization (DR) can be described as the feeling that an individual's surroundings are unreal or strange. While experiencing DR, a person might perceive that others in the environment are unfamiliar or mechanical (APA, 2000). Brief occurrences of DP/DR seem to be common among the general population and, in the absence of other psychiatric conditions, are typically associated with fatigue or drug use. Hunter, Sierra, and David (2004) reviewed the available epidemiological literature and found lifetime prevalence rates of DR ranging from 26% to 74%. DP and DR, however, are also associated with a variety of psychiatric diagnoses, including panic disorder.

Patients diagnosed with panic disorder frequently experience DP/DR during panic attacks. Hunter et al. (2004) reviewed 16 available studies on the prevalence of DP/DR among panic disorder patients and found that reported rates varied widely. Two of the studies reviewed, conducted in Japan, found quite low figures for DP/DR

during panic attacks, with both studies reporting the prevalence to be less than 10%. However, the remainder of the studies reviewed found higher prevalence rates for DP/DR during panic, ranging from 24.1% to 82.6%.

Hunter, Philips, Chalder, Sierra, and David (2003) developed a cognitive behavioral conceptualization of the relationship between DP/DR and anxiety. This model is based on the premise that when some individuals have a transient DP/DR experience, they misinterpret the event as a sign that they are going insane or about to lose control. These catastrophic misinterpretations of DP/DR then lead to increased anxiety. The anxiety associated with experiencing DP/DR and its feared consequences is maintained through phobic avoidance of particular situations, safety behaviors, and increased hypervigilance toward symptom monitoring. From a physiological standpoint, Hunter et al. (2003) suggested that the feelings of DP/DR might stem from finding that patients who experience DP/DR demonstrate *reduced* physiological arousal in response to high anxiety (Sierra et al., 2002), possibly as a protective mechanism when the system is overwhelmed by anxiety and therefore blocking habituation (Foa and Kozak, 1986). This paradoxical bodily reaction in conjunction with increased anxiety may serve to enhance feelings of being detached from physical and mental processes.

There is some empirical evidence that patients who experience DP/DR during their panic attacks can be distinguished from patients who do not experience these symptoms and, in fact, may have a more severe disorder. Márquez, Seguí, García, Canet, and Ortiz (2001) found

that patients with DP/DR symptoms reported more panic attacks, greater phobic avoidance, and were judged to be at a lower level of functioning. Patients with DP/DR also endorsed significantly higher levels of some common panic attack symptoms on a self-report measure, including feelings of choking, sweating, dizziness, nausea, hot flushes, trembling, and fear of going crazy. *Katerndahl (2000)* found that DP during panic attacks was a significant predictor of the subsequent development of agoraphobia, providing further evidence that DP/DR during panic attacks is a poor prognostic indicator. Furthermore, the presence of DP was the sole predictor of the progression from mild avoidance to severe agoraphobia among panic patients. Despite this evidence that DP/DR is a critical symptom associated with panic attacks, there has been very little research conducted in terms of developing effective treatments to target this symptom.

### Interoceptive Exposure for Panic Disorder

The cognitive behavioral treatment (CBT) of panic disorder includes interoceptive exposure (IE) (see *Barlow & Craske, 1994*, for a detailed description of the treatment of panic disorder). Originally proposed by *Goldstein and Chambless (1978)*, IE involves inducing the feared bodily sensations associated with panic attacks through various exercises in order to reduce the fear associated with these physical sensations through habituation. IE exercises are designed to mimic the physiological sensations that patients experience during panic attacks (i.e. dizziness, heart palpitations, and sweating) through such activities as brief vigorous physical exercise, hyperventilation, and spinning. *Craske, Rowe, Lewin, and Noriega-Dimitri (1997)* demonstrated that IE is a more powerful component of CBT for panic disorder than breathing retraining.

Though the therapeutic value of IE has been widely documented, there has been very little research on which IE exercises are the most effective for producing the symptoms of panic. *Antony, Ledley, Liss, and Swinson (2006)* evaluated the symptom response of participants with panic disorder to commonly utilized IE exercises. They instructed participants to complete 13 IE exercises and three control exercises and assessed the participants' level of anxiety and severity ratings of specific panic attack symptoms for each exercise. Antony et al. found that breathing through a very thin straw for 2 minutes, while making sure not to breathe through the nose, was the most potent IE exercise. It produced at least moderate fear in over half of the study's participants. Three other IE exercises also brought on anxiety for a significant portion of the sample. Spinning around while standing for 1 minute, hyperventilation for 1 minute, and pressing a tongue depressor down at the back of the tongue for 30 seconds each produced at least moderate levels of fear in over 30% participants.

### Induction of Depersonalization/Derealization

DP and DR have traditionally been difficult to re-create through exposure exercises. In an early study, *Miller, Brown, DiNardo, and Barlow (1994)* investigated ways of re-creating sensations of DP and DR among participants with panic disorder and non-anxious controls. These authors found that staring at a dot on the wall and staring in a mirror both successfully elicited feelings of DP/DR among the study participants, while silently repeating one's own name did not produce DP/DR. In a more recent study, *Antony et al. (2006)* found that the only IE exercises to produce feelings of DP/DR (described as "feeling as if you were unreal or in a dream") were staring at a light for a brief duration before attempting to read a paragraph, staring at mirror, and staring at a spot on the wall. These exercises, however, elicited only mild sensations of DP/DR and also produced mild feelings of dizziness. Notably, one of the control exercises ("imagine being in a peaceful place") also elicited the symptom of "feeling as if you were unreal or in a dream." *Schmidt and Trakowski (2004)* conducted a trial of the nature and effects of IE exercises among patients with panic disorder, testing numerous IE exercises, including shaking one's head from side to side, running in place, spinning, and hyperventilation. They reported that 16% of panic disorder patients experienced DR during hyperventilation. None of the other IE exercises tested induced sensations of DR.

Despite the evidence that DP/DR is prevalent among patients who suffer panic attacks, there is a lack of research on how to reliably produce these symptoms as part of IE. Indeed, a survey of the randomized controlled trials conducted for panic disorder revealed that none assessed depersonalization severity at posttreatment. The importance of direct exposure for depersonalization is highlighted by research suggesting that, when depersonalization is present, there are frequently more severe symptoms of panic (*Márquez et al., 2001; Segui et al., 2000*). Further, it has been found that a significant number of panic sufferers report depersonalization, with estimates as high as 69% (*Ball, Robinson, Shekhar, & Walsh, 1997*). Finally, in a large study of individuals with primary depersonalization disorder, over 30% met criteria for panic disorder (*Simeon et al., 2003*). Therefore, direct therapeutic efforts to alleviate this component of panic disorder appear essential for any comprehensive treatment of the disorder. This paper outlines a novel approach to producing feelings of DP/DR through the use of 3D glasses in three uncontrolled cases. Presently, 3D glasses are available as novelty toys or as promotional items for certain movies. When worn as a novelty toy, the effect is often a hazing of visual perception. In some instances the glasses lead to perceptions of prismatic light in the periphery. Since glasses are, in general, unobtrusive when worn, the application of 3D

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