Depersonalization disorder and anxiety: A special relationship?

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A significant association between anxiety and depersonalization has been found in healthy controls and psychiatric patients irrespective of underlying conditions. Although patients with depersonalization disorder (DPD) often have a history of severe anxiety symptoms, clinical observations suggest that the relation between anxiety and depersonalization is complex and poorly understood. Using relevant rating scales, levels of anxiety and depersonalization were assessed in 291 consecutive DPD cases. ‘High’ and ‘low’ depersonalization groups, were compared according to anxiety severity. Correlation and multivariate regression analyses were also used to assessed the contribution of anxiety to the phenomenology and natural course of depersonalization. A low but significant association between depersonalization and anxiety (as measured by Beck’s Anxiety Inventory) was only apparent in those patients with low intensity depersonalization, but not in those with severe depersonalization. Levels of anxiety did not seem to make specific contributions to the clinical features of depersonalization itself, although DPD patients with high anxiety seem characterised by additional non-specific perceptual symptoms. The presence of a ‘statistical dissociation’ between depersonalization and anxiety adds further evidence in favour of depersonalization disorder being an independent condition and suggests that its association with anxiety has been overemphasized.

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1. Introduction

It has been known for more than a century that depersonalization and anxiety states are often closely associated. Indeed, most patients complaining of ‘feelings of unreality’, originally described by Krishabber (1873), also suffered from episodes of paroxysmal anxiety, reminiscent of panic attacks. Echoing those early observations, Roth (1959) emphasised the presence of anxiety symptoms in patients with chronic depersonalization and coined the term ‘phobic-anxiety depersonalization syndrome’, to define a specific anxiety disorder, which had depersonalization and agoraphobia as its central manifestations.

Subsequent studies have also documented a significant association between anxiety and depersonalization across the severity spectrum of depersonalization. Thus, significant correlations have been found in non-clinical populations (Trueman, 1984); in psychiatric in-patients regardless of primary diagnosis (Noyes et al., 1977), and in patients with depersonalization disorder (Baker et al., 2003). In fact, of all emotional states, anxiety has been found to be the strongest predictor of depersonalization (Simeon et al., 2003). Of all anxiety manifestations accompanying depersonalization, studies have emphasised social anxiety and panic attacks (Noyes et al., 1992; Toni et al., 1996; Michal et al., 2005). Indeed, depersonalization (including derealization) has always been considered one of the constituent symptoms of a panic attack, occurring in up to 60% of patients (Swinson and Kuch, 1990). While in most such patients, the experience of depersonalization is limited to the duration of the attack, in others it outlasts its duration and can become persistent (Hollander et al., 1989). A recent study on 104 patients with panic disorder found that 20% met criteria for depersonalization disorder (Mendoza et al., 2011). In fact, a common clinical observation in patients with depersonalization disorder is the clustering of panic attacks around the time of onset of depersonalization, subsequently becoming less frequent or absent as depersonalization becomes chronic and predominant. A similar inverse association has also been found in psychophysiological studies. Thus, as compared with anxiety disorder patients, DPD patients reporting similarly high levels of subjective anxiety, show attenuation of autonomic sympathetic responses (Kelly and Walter, 1968; Sierra et al., 2002, 2006). The above observations suggest that the relation between anxiety and depersonalization is complex and poorly understood. The following is a systematic analysis of the relationship between the two conditions in a large series of patients with DPD. In particular we addressed two related questions: 1-Does the presence of comorbid anxiety impose a qualitative or quantitative change on the depersonalization experience? 2- Can anxiety account for the presence of adjunct symptoms, which often accompany depersonalization such as tinnitus, dizziness, or hallucinatory-like experiences?

2. Patients and Methods

This study was carried out on 291 consecutive cases with DPD assessed in the Depersonalization Disorder Clinic at the Maudsley Hospital, London (Baker et al., 2003). All patients underwent a semi-structured psychiatric interview which incorporated...
Methods were used throughout (Mann-Whitney U test) given that most variables with the exception of CDS scores, had a right-skewed distribution. Differences were considered to be significant at a p<0.05, and all significance tests were two-tailed.

In order to explore the predictive effect of depersonalization, and anxiety on symptomatology and course of illness, a stepwise multiple regression analysis was carried out using variables extracted from the structured interview questionnaire as the dependent variables and global scale scores on the CDS, BAI, BDI and Spielberger (state anxiety) as the independent ones. Since multiple regression assumes a normal distribution, right skewed variables (BAI, BDI, Spielberger) were ‘normalised’ by means of square root transformation. Variable correlations were also examined by means of scatter-plots to ensure they met linearity assumptions.

3. Results

The whole sample (n=291) had the following mean scores on administered scales: CDS = 125 (SD 63.2); BAI = 20.2 (SD 12.1); Spielberger (s) = 52.8 (SD 13.7); Spielberger (t) = 55.18 (SD 12.6); BDI = 20.9 (SD 11.4).

Out of the whole sample 145 and 146 patients were allocated to the ‘low’ and ‘high’ de-personalization groups respectively (See Table 1). Table 1 compares demographics and scale scores across these two groups.

As can be seen in Fig. 1, in both the ‘high’ and ‘low’ DP groups, those belonging to the ‘high anxiety’ subgroup had BAI mean scores in the range of ‘severe anxiety’ (26-63) while those in the ‘low anxiety’ subgroups had scores in the range of minimal (0-7) to mild anxiety (8-15). Those in the ‘high DP’ group had slight but significantly higher BAI scores than the ‘low DP’ group (see Table 1).

A comparison of ‘High’ and ‘Low Anxiety’ scorers within the High DP subgroup (CDS 184.7 (43.5); BAI; 36.5 (6.6) vs. CDS: 178.6 (41) BAI: 9.3 (4.3)), group did not reveal any significant differences in regards to CDS scores (Z=-0.70, p=0.48); age (Z=-0.27, p=0.78); gender (Z=0.01, p=0.97); age of onset (Z=-0.98, p=0.32); duration of de-personalization (Z=-0.12, p=0.90); specific event at onset (Z=-0.006 p=0.99); speed of onset (Z=-0.05, p=0.95); concomitant psychiatric symptoms (Z=-1.7 p=0.088).

As shown in Fig. 2, within the ‘Low DP’ group those in the ‘high anxiety’ subgroup scored significantly higher on the CDS than those in the ‘low anxiety’ subgroup (Z=-8.5 p<0.0001). There were no significant differences within the ‘high DP’ group between the ‘low’ and ‘high’ anxiety subgroups (Z=-0.70 p=0.482).

Whole sample Pearson correlations between normalized anxiety measures and CDS scores were as follows: BAI (r=0.23, p<0.001); Spielberger (s) (r=0.24, p<0.001); Spielberger (t) (r=0.19, p<0.001).

Similarly, within the ‘low DP’ group there were significant moderate correlations between the CDS and anxiety scores on both the BAI (r=0.31, p<0.001); Spielberger trait (r=0.27, p<0.001) and state (r=0.29, p<0.001). There were however, no significant correlations within the ‘high DP’ group: BAI (r=0.06, p=0.46); Spielberger state (r=0.04, p=0.57); and trait (r=0.02, p=0.72) (see Fig. 3).

Table 2. shows the results of a stepwise multiple regression analysis carried out on the whole sample using global scores of administered scales as independent variables and a number of anxiety-related variables as dependent ones (See Table 2). Only those scales finally retained by the procedure are shown with their respective Beta coefficients. Scores on the different component subscales (as per Sierra et al., 2005) were also used as dependent variables. In order to avoid inflating correlations through item overlap between the subscales and the Global CDS score, those items constituting the subscale in question were subtracted from the Global CDS.

4. Discussion

In keeping with previous observations, it was found that patients with de-personalization disorder as a whole are characterized by...
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