Mindfulness-Based Cognitive Therapy in Depersonalization-Derealization Disorder: A Case Report

To the editor,

Depersonalization has been described as feeling disconnected from self and derealization as feeling disconnected from the immediate environment. Transient experiences of depersonalization and derealization are quite common in the general population, with the prevalence being 46%–74%. These are dream-like states, usually associated with physical and emotional numbing and temporal distortion of time and occasionally with subjective visual and auditory distortions, often called “as if” experiences. However, the reality testing in the individual remains intact.1 The persistence or recurrence of these experiences, termed depersonalization-derealization disorder (DDD), is quite disabling. The individual tends to develop a sense of hypo-emotionality and disconnectedness from life.

Pharmacological treatment for DDD is based on case reports and small studies; except for inconsistent evidence for selective serotonin reuptake inhibitors and lamotrigine,2 there is little role for pharmacological interventions in DDD. The mainstay of treatment remains to be psychotherapy.1 Even though no randomized controlled trial (RCT) for the same has been undertaken proving its efficacy, successful outcomes have been reported with psychoanalytic technique,3 psychoanalysis combined with abreaction,4 family therapy,5 and cognitive behavioral therapy (CBT).6 There is limited literature regarding the application of third-wave therapies in DDD. We implemented mindfulness-based cognitive therapy (MBCT) of the third wave of psychotherapy in DDD. In this case report, we highlight the potential role of MBCT in alleviating the distress associated with this condition.

Case History

A 25-year-old male graduate, gainfully employed, from a nuclear family of lower-middle socioeconomic status, presented with six years history of frequent (5–6/week) episodes of experiencing a sense of unreality, dream-like state, “as if” he and his surroundings have changed. During the episodes, he would report his body to be hollow and empty, him being devoid of any kind of emotions, and feeling a sense of detachment from his surroundings, including his family members. These episodes would be variable in duration and highly distressing.

There was no history of any mood disorder, psychosis, substance use, epilepsy, or any significant organicity. There was no significant past or family history. Premorbidly, the patient was well adjusted.

His mental status examination revealed normal speech and psychomotor activity, with anxious affect, and preoccupation about the distress associated with the depersonalization/derealization experiences. He was diagnosed with DDD. He had not been treated elsewhere and we initiated him on Tab Paroxetine 25 mg/day with MBCT as the psychotherapeutic approach.

The components of the therapy included body scan, mindfulness, acceptance of thoughts and application to the surrounding, the practice of detachment of one’s body from the environment, breath focus with guidance, and nonguided breath focus with reality testing of the surrounding. These were carried out twice weekly in a step-wise manner, along with a cotherapist-assisted (family member) home-based therapy on alternate days for the entire duration of therapy. We continued sessions for three months, twice weekly, each session for two hours. The cotherapist was employed in the first week to ensure the implementation of homework tasks and for feedback which the therapist used to structure future sessions. During the first four weeks, the techniques of body scan and 3-minute breathing with guided imagery were practiced. Over the next eight weeks, the components of acceptance of thought process, practice of nonguided breathing, and improving reality testing were focused on. The patient had maximum benefit with techniques of body scan and 3-minute breathing space with guided imagery. Three more booster sessions of one hour each were conducted to ensure the maintenance of improvement. After about three months of regular MBCT, interestingly, the depersonalization/derealization experiences were completely resolved, along with improvement in attention and overall mood state. The cotherapist also observed an improvement in general functioning. Score on the Cambridge Depersonalization Scale before initiation of therapy was 92, which decreased to 32 after therapy, resulting in a 65% reduction. The patient was seen to be maintaining the improvement at the six-month follow-up.

Discussion

Even though depersonalization-derealization symptoms are common in the general population, isolated DDD is often underdiagnosed. The lack of a standard protocol of psychotherapy for DDD has led to diverse psychotherapeutic approaches adopted by clinicians.6 An open study in 2005 with 21 patients of DDD showed significant improvement with CBT.6 The cognitive-behavioral model of DDD was proposed to be similar to that of panic disorder, where catastrophic misinterpretation of initially transient symptoms occurs. Later, that leads to the perpetuation of symptoms and development of cognitive biases.7 Even though there is evidence of the efficacy of incorporating mindfulness in treatment for dissociative disorders,8 the third-wave therapies have not yet been evaluated extensively for the management of DDD.

The construct of DDD, or for that matter, any kind of dissociation, is conceptualized as a survival strategy through “mental escape” from the experience of a hostile reality. But this self-protective measure becomes pathological when it becomes generalized to other situations and ultimately becomes maladaptive.9 The phenomenon of mental escape results in diminished attention and withdrawn interest from self and environment. Mindfulness is characterized by an awareness that emerges from paying complete attention to surroundings on purpose, in the present, and to willingly and non-judgmentally accept the experience.10 Thus, a state of DDD is clearly in disparity with a state of mindfulness and
has an inverse relationship with the same. The core symptom of DDD is a deliberate lack of attention to the experiences and subjective feeling of unreality in self and environment.6 Mindfulness, on the other hand, is a process of regulating attention to increase awareness and relatedness to one’s own experiences. With this in mind, we opted for mindfulness in our patient and pondered whether it can be used as a targeted intervention for the core symptoms of DDD, and thus opted for the same alongside 25 mg of Tab Paroxetine in our patient, who showed remarkable improvement.

Conclusion
Future studies of MBCT in DDD and head-to-head trials with other psychotherapeutic approaches such as CBT might shed light on the utility of MBCT in DDD.

Declaration of Conflicting Interests
The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Declaration of Patient Consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Multimodal Augmentation Approach with Transcranial Direct Current Stimulation in Management of Obsessive-Compulsive Disorder with Depression and Comorbid Seizure Disorder: A Case Report

To the Editor,

Obsessive-compulsive disorder (OCD) is a chronic and disabling psychiatric disorder. Despite adequate trials of treatment, a significant number of patients remain symptomatic and dysfunctional. In the management of OCD, various neuro-modulation techniques such as repetitive transcranial magnetic stimulation (rTMS), transcranial direct current stimulation (tDCCS), and deep brain stimulation (DBS) have been used along with the conventional treatments.1 However, these treatments are often offered to patients with OCD who are resistant to conventional treatments.2,3 We present the case of a 21-year-old male with OCD, depression, and a comorbid seizure disorder who responded well to a multimodal augmentation approach involving pharmacotherapy, psychotherapy, and tDCCS.

The patient presented with complaints of recurrent intrusive thoughts about contamination and symmetry and doubts about sex, along with repetitive acts of cleaning, arranging, and checking, for 11 years. For the past six months, he has had persistent sadness and ideas of helplessness and hopelessness. Also, he has had multiple episodes of generalized tonic-clonic seizures in the past two years. He had been on antiepileptics and, at presentation, was seizure-free for the last three