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INVITED PAPER

Ten misconceptions: CBT for depersonalisation and derealisation

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Abstract

Depersonalisation (DP) and derealisation (DR) experiences can cause clients and therapists a lot of confusion and anxiety. Therapist confusion has led to the under-recognition of DP and DR symptoms, under-confidence in working therapeutically with this client group and unequal client access to effective cognitive behavioural therapy (CBT) interventions. Client confusion has resulted in missed opportunities to engage in meaningful discussions with therapists about their DP and DR experiences and under-confidence that CBT can be of help. This article seeks to provide clarity for clinicians and clients around key misconceptions we have identified from the authors' clinical experience of using CBT to treat DP/DR, both when presenting as symptoms in the context of other diagnoses and when presenting as a primary depersonalisation derealisation disorder (DDD). In addressing symptom misconceptions, we want to increase clinicians' confidence when assessing DP and DR. We hope this will lead to productive discussions with clients and the inclusion of these symptoms in clinical formulations. We draw attention to client misconceptions in the hope that this facilitates better therapeutic dialogues about DP and DR and the potential benefit of CBT. Finally, we address therapist misconceptions about the use of CBT with this population in the hope that we can encourage more CBT therapists to work more proactively, confidently and effectively with DP and DR.

Key learning aims

(1) To help therapists better recognise depersonalisation (DP) and derealisation (DR) symptoms when in the context of another disorder and when presenting as primary depersonalisation derealisation disorder (DDD).
(2) To recognise therapist misconceptions leading to under-confidence in working with clients whose presentation includes symptoms of DP/DR and/or diagnoses of DDD.
(3) To understand misconceptions clients might hold about their DP and DR experiences and how these may impact engagement with CBT.
(4) To help therapists engage with clients in helpful discussions about the effectiveness of CBT to help with DP and DR, both when experienced in the context of another disorder and when conceptualised as DDD.

Keywords: cognitive behavioural therapy (CBT); depersonalisation; derealisation; dissociation

Introduction

Depersonalisation and derealisation are terms used to describe specific dissociative experiences (DSM-5: American Psychiatric Association, 2013; ICD-11: World Health Organization, 2022). Depersonalisation is the experience of unreality, detachment or being an observer of one's thoughts, feelings, sensations, body or actions. This can include alterations in perceptions, such as time distortion, a sense of an unreal or absent self, and emotional or physical numbing. Derealisation describes experiences of unreality or detachment with respect to one's surroundings. This can include individuals or objects experienced as unreal, dreamlike, lifeless, foggy or visually distorted. In this paper we will use the abbreviations 'DP' and 'DR' with reference to the *symptoms* of depersonalisation and derealisation. We will use the abbreviation 'DDD' to refer to the *diagnosis* of depersonalisation and derealisation disorder.

To meet criteria for the diagnosis of DDD, the symptoms must persist or reoccur, cannot be better explained by another mental health diagnosis, are not attributable to the physiological effects of a substance or other medical condition and reality testing must remain intact. The experiences must also cause clinically significant distress or impairment to an individual's functioning. One of the main challenges of DP/DR management is the accurate identification of both the symptoms and the diagnosis of the disorder. We think this is likely due to certain assumptions and misconceptions held by both clinicians and clients about the symptoms themselves, the perceived clinical prognosis and most effective treatment.

A client navigating the health system with DP/DR symptoms can find their interface with clinicians anxiety provoking, given the frequent lack of accurate knowledge held by mental health clinicians assessing DP/DR symptoms in the context of other disorders and diagnosing DDD. Clients presenting to the UK's only National and Specialist Depersonalisation and Derealisation Disorder Service at the Maudsley Hospital (www.tinyurl.com/cadatservice) tell us they worry about being able to explain themselves or articulate their symptoms to health professionals accurately due to the confusing and often terrifying nature of the symptoms. Examples of worries that clients have shared include: '*How can I explain what's going on when I don't even know myself?*', '*These symptoms feel different to anxiety and depression to me, but GPs keep telling me that's what it is*', and '*I keep getting told that these symptoms are stress-related and will resolve on their own, but they don't*'. Clinicians at both assessment and treatment levels of the system may be unfamiliar with DP/DR symptoms and the diagnostic profile of DDD, and therefore may lean towards a more familiar anxiety or trauma descriptor as an explanation of the client's presentation. Sadly, this lack of awareness and knowledge regarding the presentation has meant that clients can take an average of 7–12 years to receive an accurate DDD diagnosis (Hunter *et al.*, 2017).

Clients often tell us that they have been turned away from primary and secondary care mental health services, because their presentation is 'too complex', or there are no 'specialist clinicians' available in their local services who can effectively treat them. Our conversations with clinicians working in these services, reveals that this tends to be due to practitioner and service level beliefs such as, '*DDD requires treatment from a specialist clinician*', or '*I feel out of my depth with DDD, I don't know how to use CBT with this client group*'. There are likely many systemic reasons for this under-confidence within individual clinicians and mental health services. To our knowledge, there have been no specific clinical guidance papers published in recent years on how to best treat DDD, in addition to the fact that there are also currently no NICE guidelines for the treatment of DDD. Similarly, from personal communications with course leads, there is currently little taught about DDD on psychology undergraduate courses, clinical psychology doctorates or postgraduate diplomas in CBT in the UK.

More encouragingly, in recent years the UK-based charity for those with lived experience of depersonalisation and derealisation, "Unreal" (https://www.unrealcharity.com/) has worked to raise awareness and has taken discussions about the condition beyond academic and clinical circles. Nevertheless, based on anecdotal evidence, it is our speculation that clinicians need more investment in both developing knowledge and skills in assessing and treating these symptoms.

Within this paper, we address some common misconceptions about the presentation of DP/DR symptoms and DDD that might prevent practitioners from engaging with sufferers. We have categorised these into symptom, therapist and client misconceptions, with symptom misconceptions being applicable to both therapist and client. We acknowledge that confusion exists around the presentation, particularly given the sometimes unclear nature of the symptoms, the lack of clinical teaching and training about managing these symptoms and the paucity of clinical guidance to date.

Our views reflect our experiences, observations and reflections over several years of working in a specialist CBT service for this clinical population. Our hope is to generate discussion and invite feedback and reflections from the wider CBT community with the aim of improving the experience of psychological therapy for those whose presentation includes symptoms of DP/DR and who experience DDD.

Symptom misconceptions

1. Depersonalisation and derealisation symptoms are rare

Transient DP/DR symptoms frequently occur in the context of stress, tiredness or medical problems (Hunter *et al.*, 2017) and they can also be experienced within various psychological problems such as generalised anxiety disorder (Simeon *et al.*, 1997), post-traumatic stress disorder (PTSD; Davidson *et al.*, 1990), panic disorder (Marshall *et al.*, 2000), depression (Michal *et al.*, 2024), personality disorders (Simeon *et al.*, 1997) and psychosis (Humpston *et al.*, 2020). They form part of the DSM-V diagnostic criteria for the PTSD dissociative subtype (American Psychiatric Association, 2013). In addition, they can occur in neurological disorders such as temporal lobe epilepsy or migraines and in otherwise healthy individuals following substance abuse or prescribed medication (Lambert *et al.*, 2002; Medford *et al.*, 2003; Pikwer, 2011). DP/DR symptoms can occur along a continuum of severity from brief episodes lasting seconds to more persistent, distressing and incapacitating experiences. For some people, symptoms may present as a discrete problem in their own right, rather than a secondary problem (Lambert *et al.*, 2001).

As Medford *et al.* (2005) highlight, the general consensus indicated by the World Health Organization (1992) used to be that DDD was rare. However, it has not always been clear from the literature whether a study is referring to transient symptoms, DDD or both. Transient or not, the examples of reported prevalence rates provided below in Table 1 show that some level of symptoms appears to be relatively common for both clinical and non-clinical populations.

Sadly, DDD receives relatively limited research funding in contrast to other psychiatric disorders. However, the literature cited in Table 1 that focuses specifically on clinically significant DP/DR or DDD, suggests that the prevalence rate for this is not necessarily appreciably lower, whether it be for non-clinical populations, psychiatric in-patients or psychiatric out-patients. The 1–2% estimate of prevalence indicated in the general population for clinically significant DP/DR (Hunter *et al.*, 2004) is similar to that for obsessive-compulsive disorder, for example, a condition with a 12-month adult prevalence of 1.2% (Harvard Medical School, 2007). To put that figure of 1–2% into further perspective, the UK population currently stands at 68.3 million (Office for National Statistics, 2023), so 1–2% would equate to between 683,000 and 1.366 million people with DDD in the UK alone, a group of some considerable size. What is more, The UK Rare Diseases Framework defines ‘rare’ as a condition affecting fewer than 1 in 2000 people (Department of Health and Social Care, 2021). This would be the equivalent of a 0.05% prevalence rate, some 20–40 times lower than the figure reported for DDD.

We propose several reasons for the prevalence misconception. One may lie in the nature of the symptoms, which makes them difficult to articulate clearly compared with those associated with

Table 1. Examples of reported DP/DR prevalence rates by population, prevalence period and presentation*

	Population	Prevalence period	Prevalence rate (%)
DP/DR symptoms	Non-clinical samples	Lifetime	26–70[a]
	Non-clinical sample	Preceding year	23[b]
	Clinical (in-patients)	1 month or for the period of psychiatric disorder	19–42[a]
	Clinical samples with panic disorder	During previous typical/severe panic attacks and/or previous month, previous 6–12 weeks or currently	8–83[a]
Peri-traumatic DP/DR symptoms	Individuals with near-death experiences	At time of trauma	66[c]
	Individuals who had been hospitalised following traffic accidents	At time of trauma	31[d]
DDD/clinically significant DP/DR	Non-clinical samples	Previous month to current	1–2[a]
	Clinical (out-patients)	Current	5–20[e]
	Cross-cultural clinical (in-patients)	Current	18–42[f]

*This is a non-exhaustive list and more detailed references on reported prevalence rates can be found in Hunter *et al.* (2004) and Yang *et al.* (2023). [a]Hunter *et al.* (2004); [b]Aderibigbe *et al.* (2001); [c]Noyes and Kletti (1977); [d]Noyes *et al.* (1977); [e]Yang *et al.* (2023); [f]Sierra *et al.* (2006).

many other mental health problems. Another may be the relative absence of DDD teaching on therapist training courses. We speculate that these factors may lead to the condition either not being identified by, or being misdiagnosed by, health professionals. Many of our clients have described previous experiences to us of having their DP/DR treated as anxiety or psychosis, for example. In addition, we have found that clients are often reluctant to talk about or disclose their symptoms, perhaps for fear of either exacerbating them (Edwards and Angus, 1972), or being misinterpreted or further stigmatised.

This under-recognition is likely to compound the sense of isolation that people with DDD commonly already feel, whilst all too sadly echoing the formative experiences of emotional neglect that many have experienced. For that reason, it is imperative that clinicians normalise the symptoms for both clients and colleagues by highlighting the data on prevalence, thus challenging this harmful misconception.

2. Depersonalisation and derealisation symptoms are complex and pathological

DDD is also often viewed as a very complex disorder. As is the case with most mental health conditions, we have found that some DDD presentations are complex, whereas others are not. Although the words *complex* and *complicated* may sometimes be used interchangeably: '*complexity does not necessarily lead to complications*' (Murray and El-Leithy, 2022; p. 8). Quite conventional and simple solutions may be used to address each of the elements of a '*complex*' presentation. The view of DDD as complex may stem from many of the misconceptions that we are addressing here. It may also result partly from the co-morbidity seen amongst many DDD clients.

One of the more 'simple and straightforward' DDD presentations bears much resemblance to panic disorder, although here the client's catastrophic misappraisals of symptoms relate to a mental rather than a physical catastrophe. These clients may sometimes respond quite well to psychoeducation, symptom reappraisal and dropping maintaining safety behaviours or avoidance to help their symptoms subside (Hallett, in press). Knowing this, some clinicians may consequently approach DP/DR treatment within a panic framework or under the assumption that symptom remission will be a realistic goal within a brief therapy context. However, not all DDD presentations fit this kind of framework. Therefore clinicians are reminded to formulate a person's presenting problems before assuming a particular framework will capture those difficulties. Some presentations will be more depressive, some more obsessional and some more related to attachment, trauma or emotional processing difficulties. For some, the precipitating stressor will have long since passed. For others, the stressor may be ongoing and there may be no prospect of it ending anytime soon. In such contexts it may not always be realistic to expect DP/DR symptoms to subside during short-term therapy and clinicians who expect this (or indeed, communicate it to the client), may find they struggle.

Linked to this, the emphasis on protocol-driven treatment in training courses and services (Drew *et al*., 2021) may also contribute to a perception that DDD is more complex than it is. We use the term protocols to refer to standardised evidence-based disorder-specific treatments, often widely implemented, such as those used in UK Talking Therapies services (National Collaborating Centre for Mental Health, 2018). For a clinician who is used to relying on protocols, treating DDD, where no current protocol exists, may feel daunting and overwhelming (see misconception no. 7). Some clinicians might offer clients protocols for other disorders in their attempt to help. However, as outlined above, approaching DDD in this way, may be unhelpful and confusing, adding complications for both client and clinician unnecessarily.

Another misconception linked to complexity is that a detailed neuropsychological understanding of DP/DR is necessary to treat it. Sadly, this frontier in neuroscience remains far from well understood. Nevertheless, as CBT therapists, we are well equipped to share psychological metaphors to explain complex brain process (e.g. describing dissociative processes being like a helpful parachute to take the client away from the distress of a situation); these are often sufficient to help clients make therapeutic shifts.

One way to avoid some of the pitfalls outlined above is to adopt a collaboratively developed formulation-driven approach rather than prematurely opting for a protocol-driven one. Another is to keep explanations as simple and parsimonious as possible for the client. Regardless of the complexity of a presentation, there are usually identifiable unhelpful appraisals of symptoms that can be conceptualised within maintaining cycles (e.g. rumination, avoidance, reassurance-seeking, symptom checking, etc.). These can then be targeted in treatment. Identifying maintenance processes will reduce complexity for both client and clinician. This approach also has the advantage of using frameworks such as a vicious cycle or the Beckian developmental formulation (Beck *et al*., 2024) and CBT tools that will be familiar to most therapists. We also manage expectations from the outset, shifting away from aiming to ‘cure’ the problem and instead adopting more realistic aims of managing symptoms and learning how not to exacerbate them. We find it helpful to model not being fazed by complexity and being open and non-defensive about the limits of our knowledge, remaining curious even in the face of challenge.

DP/DR symptoms are often regarded as pathological yet there are times when a detached response can help an individual get through a challenging situation. For example, a driver might be better enabled to safely steer a car out of a skid if they are able to dampen down their emotional response and detach from the situation rather than becoming overwhelmed by fear and panic. These considerations suggest that DP/DR symptoms are functional and protective in nature, rather than pathological. A better way to view them is as the sign of a healthy but overloaded, tired, anxious or stressed brain – a brain that is doing exactly what it is supposed to, protect the person from full awareness of something that would feel intolerable and may otherwise impair functioning.

Viewing the symptoms of DP/DR as pathological is likely to lead to a focus on trying to eradicate them, which can be counterproductive. Instead, addressing maintaining behavioural cycles, reviewing unhelpful symptom appraisals or processing memories from the past make for a better therapeutic focus.

3. Depersonalisation and derealisation symptoms are always PTSD symptoms

One of the more widely held assumptions amongst clinicians and clients is that DP/DR symptoms are always part of a bigger picture of PTSD symptomatology. The presumption is that a client has most likely experienced a traumatic event(s) and DP/DR symptoms are best conceptualised as post-traumatic sequelae. Therefore, treatment of the DP/DR should follow a PTSD protocol. From our clinical experience, this can sometimes be true, but not always.

DSM-5 (American Psychiatric Association, 2013) recognises a dissociative subtype of PTSD, which mentions depersonalisation/derealisation as a prominent symptom. A review of this subtype (Lanius *et al*., 2010) argues that depersonalisation serves as a protective mechanism against the emotional impact of trauma memories, resulting in an altered perception of reality and the self. King *et al.* (2006) found that depersonalisation symptoms are frequently reported amongst combat veterans with PTSD and suggest that depersonalisation may be associated with more severe symptoms of PTSD.

However, the argument that depersonalisation is a coping mechanism to disconnect from overwhelming emotional experiences (Cardeña *et al*., 2012; Simeon *et al*., 2001; Spiegel and Cardeña 1991) can be true for those with or without PTSD. Research suggests that the traumatic experiences of emotional abuse and neglect in childhood are most likely to correlate with adult DP/DR symptoms (Simeon *et al*., 2001), but not all the survivors will have PTSD. In addition, a low lifetime prevalence rate of 5% for PTSD has been reported in individuals with DDD (Simeon and Abugel, 2023). Simeon and Abugel suggest that this may reflect the traumas experienced by clients with DDD being less severe and life-endangering compared with other dissociative disorders, although this needs more empirical investigation.

If clinicians assume a link between DP/DR symptoms and PTSD, there is a risk of narrowed conceptualisation of the client and subsequent choice of intervention. Indeed, qualitative research has shown that when discrepancies between client's and clinician's understanding of dissociation exist, this can lead to misunderstandings and ruptures in the therapeutic relationship (Pierorazio *et al*., 2024). The clinician, and by association the client, may miss opportunities to be curious and see the possibility of alternative explanations for the symptoms beyond PTSD. This therapist assumption might well relate to the emphasis within CBT training of treating dissociation only within a PTSD context. This dissociation–PTSD pairing might have shaped an understanding of dissociation, and therefore by association, depersonalisation/derealisation. For some CBT clinicians the context of PTSD may be their only point of reference for dissociative symptoms. DP/DR experiences can occur for a range of idiosyncratic reasons as a transdiagnostic symptom, as well as a disorder in its own right, independent from PTSD.

In our experience, this misconception is commonly held by clients too. Many have told us how they have tried to pinpoint a singular traumatic event to explain their symptoms. Some may pinpoint a specific precipitating incident (e.g. cannabis use), while others report they are unable to. In our experience, both personal accounts can lead to rumination on the hypothesised cause of DP/DR and a self-blaming stance (e.g. '*I have done this to myself, I've broken my brain*'). Such assumptions add anxiety to an already upsetting condition.

We encourage clinicians to maintain curiosity when exploring the relationship between DP/DR symptoms and traumatic events in both childhood and adulthood. A thorough assessment of whether a PTSD-dissociative subtype diagnosis is the right fit for the client's DP/DR symptoms needs to be conducted, rather than assumed. An idiosyncratic formulation incorporating developmental trauma experiences is likely going to best guide treatment.

4. Depersonalisation and derealisation symptoms are fixed and static

Another misconception that we speculate as problematic, is that DP/DR symptoms are fixed, static and not amenable to change. When held by clients, this belief often contributes to a sense of hopelessness or stuckness, and for some is key to catastrophic misinterpretations of symptoms. For clinicians, the view could contribute to unhelpful conclusions regarding the treatability or manageability of DP/DR-related distress and interference with functioning or quality of life. In combination with the absence of established treatment protocols, this could steer therapy focus away from DP/DR, even where service users identify DP/DR as their main difficulty. The view that symptoms are fixed may even influence decisions of whether psychological treatment is offered at all. If therapists operate under the assumption that DP/DR symptoms are static, they risk overlooking relevant environmental, emotional and cognitive processes.

As outlined above, epidemiological studies (e.g. Hunter *et al*., 2004) report common and transient DP/DR experiences linked to fatigue, trauma, and substance use, which contrasts with the view of DP/DR as static. Experience sampling studies show that dissociative symptoms, including DP/DR, are linked to stress (Stiglmayr *et al*., 2008) and that DP/DR symptoms are associated with embarrassment in social interactions (Čolić *et al*., 2020) in both clinical and non-clinical groups. Tibubos *et al*. (2018) found that in a general population sample, fatigue and DP/DR symptoms were positively correlated. This relationship was influenced by preferred emotion regulation strategies; individuals who suppressed emotions and scored low on reappraisal strategies experienced a greater increase in DP/DR as fatigue increased.

Together, these observations suggest that DP/DR symptoms vary. Established CBT tools can help reduce stress, re-evaluate unhelpful appraisals of social situations and improve emotion regulation. This highlights the role of CBT in moderating factors that contribute to DP/DR experiences across different populations.

In our experience, a proportion of service users diagnosed with DDD report episodic symptoms. Those who describe their experience as constant usually do observe fluctuations in intensity or distress associated with DP/DR if this is monitored using jointly developed diaries, in-session experiments (for example, varying focus of attention) and standardised self-report measures such as the Cambridge Depersonalisation Scale (Sierra and Berrios, 2000). Such collaborative observations in treatment can facilitate helpful conversations about the symptom-related beliefs and the impact of attempts to achieve an idealised 'normal' state that can come with these beliefs. Combined with psychoeducation about DP/DR, monitoring can be a powerful tool in shifting people's hopelessness about change.

Therapist misconceptions

5. There is no empirical evidence that CBT for DDD is effective

We recognise that there is still relatively little high-quality research into treatments for DDD. There is no widely accepted CBT protocol for addressing the impact and distress associated with the condition, but there is an emerging literature. A recent review (Wang *et al*., 2024) considered all available pharmacological treatments, neuromodulations (repetitive transcranial magnetic stimulation, electroconvulsive therapy) and psychological therapies for DDD highlighting that different approaches in combination or sequence may be helpful. However, conclusions are limited by the low number of often heterogeneous studies, often with small sample sizes and variable methodological quality.

This situation leaves many services and clinicians discounting CBT as a valid approach for treating DP/DR symptoms. Many of our clinic's service users have been unable to access CBT in primary or secondary care for this reason, while others receive interventions focusing on anxiety or depression only, ignoring at times what may be most distressing for the person.

While we recognise that such clinical decisions are usually made with the best intentions of offering evidence-based treatments with proven effectiveness, we would argue that there is also a need to draw on existing practice-based evidence as well as clinical and experimental data, which together, in our mind, justify a sense of cautious optimism for a role of CBT in effectively alleviating the distress and impact on functioning associated with DP/DR symptoms.

Hunter *et al*. (2023) published a self-controlled crossover design study drawing on a clinical audit and evaluating CBT for patients with chronic DDD, comparing waiting list with active CBT focusing on DP/DR symptoms. CBT was associated with significant improvements in DP/DR symptoms, anxiety and depression scores, with medium effect sizes, replicating an earlier report (Hunter *et al.*, 2005). In a small sample of service users with psychosis and DDD, a brief 6-session CBT intervention was evaluated in a single blind randomised controlled design and indicated high acceptability as well as evidence of effectiveness in terms of clinical outcomes (Farrelly *et al.*, 2024). While limited by small sample sizes and a lack of randomisation or protocol-based intervention, these results indicate that CBT can be helpful in reducing DP/DR symptoms in those with DDD diagnoses.

As discussed above, symptoms of DP/DR present across varying diagnoses and adapted, disorder-specific or general CBT formulation-based interventions have successfully reduced DP/DR symptoms and their impact in different groups of people. A brief CBT-based group intervention targeting DP/DR in students with test anxiety was associated with significantly reduced DP/DR in the treatment group, compared with an active control group (Schweden *et al.*, 2020); the alteration of unhelpful patterns of attention and altering negative appraisals of depersonalisation were proposed as mechanisms of change in this piece of research. A randomised controlled trial of standard CBT for social anxiety demonstrated that the intervention reduced symptoms of DP/DR in treatment responders during social stress (Schweden *et al.*, 2016), with the authors hypothesising a change in catastrophic misinterpretation of bodily and mental symptoms, including those of DP/DR, as a possible mechanism leading to symptom reduction, despite the intervention not specifically addressing DP/DR symptoms.

Proposed mediators of change also overlap with processes that are addressed in a wide range of CBT formulations (Hunter *et al.*, 2014). Together, these findings suggest that a CBT approach can be effective in reducing DP/DR in clinical populations. Thus, there is undoubtedly a pressing need to expand the evidence base for psychological therapy services to better serve people with DP/DR and DDD, but findings to date do suggest that a CBT approach can be effective.

6. Depersonalisation and derealisation should only be treated by clinicians with highly specialist expertise

CBT therapists are all too aware that holding untested assumptions can hold us back from trying things out and can lead to missed opportunities to gain information that might provide us with more helpful alternative perspectives. The assumption that DP/DR should only be treated by highly specialist clinicians can lead practitioners into this trap.

The assumptions we hold as therapists can impact our willingness to engage with clients and also our choice of therapeutic strategies (Giesen-Bloo *et al.*, 2006). In the case of this assumption, it is perhaps driven less by a fear of the nature of the client group, but more by an under-estimation of clinicians' generic competence. Thus, clinicians may look beyond their own service to a more specialist one for treatment for clients with DP/DR or DDD.

Current demands and financial pressures on mental health services means that there are not enough DDD specialist services to meet the needs of all DDD clients. Hunter *et al.* (2017) share an infographic suggesting DDD treatment in the UK's NHS should follow the same stepped-care approach as other mental health conditions. Holding the assumption in primary care services that DP/DR symptoms in the context of other disorders need treatment from a specialist can result in premature discharge or onward referral to a specialist service without any CBT treatment being offered in primary care if their workforce is not deemed 'highly specialist' enough. This delays client access to CBT treatment and perpetuates the client's belief that they have a condition that can only be treated by highly specialist clinicians. We believe that DP/DR symptoms, either as part of another primary anxiety/depression disorder or when it is a disorder in its own right can be treated by CBT therapists, who hold sound CBT expertise.

In order to increase clinician knowledge, skill and confidence in working with this client group, our clinic is developing up-to-date teaching and training resources for effective use of CBT for DP/DR, in addition to signposting to resources already available (see 'Further reading' section).

Addressing the assumption that clinicians must be highly specialist, can encourage them to consider their existing and relevant competencies, to be open to supporting patients with DDD and to be curious about developing more clinical skills. Clients with DP/DR have a broad range of clinical needs that are amenable to CBT. CBT therapists with experience of clients with complex problems already possess relevant skills for working with DDD clients, namely: the ability to develop formulations capturing multiple key maintenance processes and an ability to identify interventions that best target these processes. In addition, most CBT therapists will have the tools of grounding techniques and mindfulness interventions in their therapeutic toolkit, which there is emerging evidence to say can be applied usefully to this population (Mishra *et al*., 2022). For CBT therapists who find themselves aligning with this misconception, we encourage making good use of clinical supervision to address some of these potential therapy interfering beliefs.

7. I need to follow a protocol to know how to effectively treat depersonalisation and derealisation

Standardised protocol-driven treatments are widespread in psychological therapy services today (Wakefield *et al*., 2021). Consequently, when clinicians encounter a disorder with which they are unfamiliar, they might seek out a protocol upon which to base their treatment. However, as mentioned previously, for DDD this is currently non-existent. Instead, a series of core evidence-based CBT principles guide our treatment approach.

Each presentation of DDD is different with idiosyncratic symptoms and diverse developmental pathways. For example, some DDD sufferers have experienced significant emotional neglect or an absent parent in childhood, others have not. Some have taken drugs or have experienced chronic stress as adults, others have not. Some have multiple co-morbidities or problems related to neurodivergence, others do not. Their symptom appraisals, maintaining cycles and goals are similarly varied. Whilst we apply a structured formulation-driven approach to treatment, using basic CBT skills in therapy, the goals and interventions can nevertheless look quite different for each client. This degree of variation suggests that attempts at protocol development may prove somewhat futile, as in order to encompass all of the above, the protocol may become so broad as to no longer be disorder-specific.

Whilst there are undoubtably advantages to using protocols (Asnaani *et al*., 2018), one drawback is they might not accommodate clinical idiosyncrasies, and services that over-rely on treatment protocols can struggle to achieve a balance between rigorous practice and personalised treatment (Drew *et al*., 2021). This tension is especially pertinent with DDD.

Given the long wait for treatment that many DDD clients endure and their experiences of feeling dismissed or misunderstood, we find that they frequently need to be heard and validated as they share their narrative. A standardised protocol might not necessarily accommodate this, which could be counter-therapeutic. For someone who feels unheard or disconnected from themselves, and who is looking to become ‘personalised’, it is essential to minimise the possibility of delivering treatment that might feel impersonal.

Client misconceptions

8. This is a dangerous condition: symptom increases are a sign of physical/mental threat and are to be avoided

Many clients we see are alarmed by their symptoms and may go to significant lengths to avoid focusing on, triggering or exacerbating them. Often there is an underlying belief that they will cause physical or mental catastrophe, whether that be going insane, losing control or doing something dangerous. However, there is no evidence that DP/DR symptoms are intrinsically dangerous and, on the contrary, researchers have posited that they serve a fundamental protective function (Shilony and Grossman, 1993).

It is true that clients suffer. For instance, some report poor concentration, brain fog, emotional numbing, high anxiety and low mood. Whilst symptoms are distressing, the prognosis is rarely catastrophic. People with DDD do not become psychotic, or suffer neurological or physical damage (Simeon and Abugel, 2023). However, it is of note that suicidality has been associated with DP/DR (Campbell, 2023; Michal *et al*., 2010) and clinicians should of course remain attentive to risk.

Often those with DDD worry that they will lose control and do something dangerous or socially unacceptable. In our experience, this is not the case: clients do not usually report causing accidents to themselves or others because of the DDD symptoms. Similarly, in therapy behavioural experiments testing fears of committing social transgressions show that symptoms do not typically generate negative feedback from others. Those who disclose experiencing symptoms to family and friends often discover that the symptoms were not even noticed.

Misconceptions about the symptoms being dangerous might arise through the lack of understanding of them amongst the public and professionals. Limited neurological insights may distress those who fear their symptoms are neuropathological. This is understandable when DDD and neurological conditions (such as dementia, acquired brain injury, Parkinson's disease or epilepsy) share features such as brain fog, absences, physical numbness and visual or cognitive changes. Similarly, psychosis and other dissociative disorders such as dissociative identity disorder, can present DP/DR symptoms, which might lead some to fear that their symptoms imply a more severe mental health problem. In addition, a lack of information to explain DP/DR can exacerbate upset in those who find it difficult to tolerate uncertainty.

Reflecting on, or avoiding, symptoms is likely to increase focus on the symptoms and concerns about them. Over time, avoidance may become more of a problem than the symptoms themselves as it leads to excessive restrictions, and reflecting on the symptoms can increase their perceived frequency and severity. Often clients can simply test out their beliefs about symptoms by deliberately triggering them without using avoidance or safety-seeking behaviours to see what unfolds. Overall, perceiving DP/DR as a protective mechanism and symptom increases as experiences to be managed, rather than avoided seems to be helpful for most people we see.

9. All I need is for these symptoms to go away. Without them, life will be better

Clients presenting for treatment frequently want their DP/DR sensations to disappear. This hope is common across mental health disorders and the desire to be symptom-free is understandable, if we see it through the lens of the previous misconception. Those with a sense of urgency to be rid of symptoms, often identify a moment where they shifted to their current 'detached life' and now hold a dichotomous (often idealised) sense of 'all was well and good' before. Their hope that effective therapy will mean life will be symptom-free drives many suffers to persevere in finding a cure for their symptoms, sometimes over years (Hunter *et al*., 2017).

The problem with the goal of symptom eradication is that clients may be reluctant or intolerant of therapeutic conversations that do not provide a 'total fix' solution. They may disengage or become impatient in the assessment and formulation sessions as they feel time is 'being wasted' and could be better spent on simply learning what they need to do to eliminate symptoms. Early suggestions by the therapist that treatment may involve moving towards acceptance of DP/DR sensations can lead to client drop-out unless therapy is carefully stage-managed. Empathic conceptualisation and gentle psychoeducation in early sessions can sow hopeful seeds that a client can expect to take charge of their symptoms and regain a life worth living. Once engaged, CBT can help clients generate a less threatening alternative explanation of what is going on. It is important, however, not to dismiss the client's hope of radical relief too soon, and not to invalidate their distress.

The solution lies in achieving a therapeutic balance between understanding the client's desire to be DP/DR-free whilst providing information about the benign and functional nature of their experiences. The aim is to help the client develop an accepting relationship with the DP/DR sensations by sharing a psychological explanation (a CBT conceptualisation) as to what is maintaining the symptoms. Typically with CBT conceptualisations for mental health difficulties, we see the upset caused by the initial symptoms trigger anxious and/or hopeless thoughts that can exacerbate psychological and/or physiological reactions that then fuel the symptoms. These responses need to be considered idiosyncratically for each client, as advised by Beck and Haigh (2014), and a CBT assessment and conceptualisation is always informed by existing theory, research and proposed models (e.g. Hallett, in press; Hunter *et al*., 2003), which help to shape the hypotheses that the therapist explores.

In the case of DP/DR, a typical CBT conceptualisation is one where their DP/DR symptoms, rather than being seen as a sign of something sinister or malfunctioning in the brain, can be reappraised through Socratic dialogue as a catastrophic misinterpretation of the bodily sensations of dissociation. Fear of these sensations can be reduced using psychoeducation about the function of DP/DR as an emotional coping response. Rather than relating to the symptoms through a lens of fear or hopelessness, we encourage clients to view them as understandable and as a behavioural cue to intentionally re-attach to the present if it feels safe enough for them to try and do so.

In the same way we would not assure anxious clients that they will never experience anxiety again by the end of treatment, we also would not promise clients they will be DP/DR-free, given the useful function that it can serve. What we do anticipate is that quality of life can improve once they have an understanding and an explanation for their symptoms, have reduced their symptom pre-occupation and re-engaged in important areas of their life. Once a client has shifted from a place of seeking symptom eradication, they and their therapist can work towards realistic quality of life improvement goals.

10. There is little that CBT can do for me – only the latest medication or new therapeutic model will work

Frequently, service users may have been left with the impression that contemporary CBT has little to offer them. This may be the result of being rejected by mental health services or being offered CBT-based interventions that did not focus on their experiences of DP/DR. Those seeking advice and information online, may feel their presenting problems are not recognised or understood well enough by mainstream services. Alongside a range of informative resources that can help people name and understand symptoms of DP/DR, the internet appears to offer a range of misleading ‘quick fix’ solutions. Some of these, often for a price, promise rapid and effective relief or a ‘cure’ from DDD, which government-funded mental health services cannot deliver.

Those who are sceptical, even dismissive towards CBT, may not access treatment that could be of benefit in managing their DP/DR symptoms. Therapists offering a CBT approach may be faced with an uphill battle when working to engage the pessimistic person in treatment. Indeed, clients’ negative expectations can create a self-fulfilling prophecy where the treatment belief interferes with genuine engagement in therapy.

As patients’ treatment expectations are significantly associated with therapy outcomes (Constantino *et al*., 2018), we recommend paying close attention to beliefs about the usefulness of CBT-based interventions for DP/DR. Such beliefs and expectations need to be identified as soon as possible, with particular attention paid to how these beliefs may differ cross-culturally. For example, research has shown that Colombian in-patients with DDD report statistically lower DP/DR symptoms than UK and Spanish counterparts. The authors hypothesise that this may be to do with differences in individualism-collectivism between cultures, with cultures higher in individualism potentially having a higher vulnerability to DP/DR (Sierra *et al*., 2006). Once idiosyncratic beliefs about treatment are identified, they can inform the conceptualisation, which will enhance both therapist and client understandings, and enable the exploration of the costs and benefits of holding pessimistic beliefs versus allowing an open mind. We find it helpful to combine a sense of therapeutic optimism with transparency about the current evidence base for both CBT and/or medication options for DP/DR. In the spirit of 'collaborative empiricism' (Beck *et al.*, 2024), it can be useful to set up a therapy contract agreeing a review of the helpfulness (or otherwise) of the CBT approach. This can be revisited after 4–6 sessions, as a way of allowing collaborative review of the value of CBT.

The course of therapy is rarely smooth or easy: small steps are hard-won, and set-backs occur. This so often can seem to confirm a client's low expectations. Also, in moments of feeling overwhelmed, people hope and long for simpler solutions to their suffering and their outlook can again become unrealistic. Thus, conversations about therapy expectations need to be regularly revisited so that the client's perspective can be validated and a shared perspective considered as appropriate, progress can be recognised, and skills deficits can be identified. Case formulations can also be revisited and updated, thus moving the client towards a more constructive and realistic framework.

Conclusion

Depersonalisation and derealisation are common, often benign experiences that play a part in everyday life and in a range of psychiatric presentations including anxiety and dissociative disorders. DP/DR symptoms are sometimes, but not necessarily, trauma-related, and symptom management is very possible. Careful assessment can help ascertain whether DP/DR symptoms warrant treatment as part of other clinical diagnoses or are best conceptualised and treated as DDD. Often, this does not require input from a highly specialist therapist or adherence to a specific protocol – there is much that the competent and capable CBT therapist can achieve.

Key practice points

(1) CBT can be effective for treating DP/DR symptoms in the context of other diagnoses and DDD. CBT does not need to be provided by a highly specialist 'expert only' and therefore we should be treating more DP/DR presentations in general mental health services.
(2) Wrongly held assumptions by clinicians about working with this client group can unnecessarily limit the effective pool of practitioners available to treat these clients, so there is a need to reflect and address any clinician-held assumptions in supervision so as not to withhold evidence-based CBT treatment for these clients.
(3) Addressing client assumptions in a culturally attuned way is key to effective therapeutic relationship development, which will be key to the efficacy of the CBT delivered.

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