THE DEPERSONALIZATION SYNDROME.*

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Depersonalization, or feeling of unreality, is a symptom which may occur as part of several psychiatric conditions, such as hysteria, anxiety and obsessional states, and some forms of schizophrenia and endogenous depression. The true derealization-depersonalization syndrome, however, in which the unreality symptom is the primary disturbance, is a quite peculiar and distinctive condition, which has received scant attention in most psychiatric textbooks and which appears to be becoming increasingly common in practice.

The first accurate descriptions of the condition were given by Mayer-Gross and Mapother, and by Guttmann and Maclay in their paper in the *Journal of Neurology and Psychopathology* (1936), in which the authors described the effects of mescaline sulphate on a series of depersonalization patients and their therapeutic response to the drug. The syndrome may be defined as a form of affective disorder in which feelings of unreality and changed personality are the most prominent symptoms.

The usual age-incidence of the condition is the 20 to 30 age-group, although one form may sometimes occur in the later years of life. The onset may be acute, following a severe emotional shock, as seen in some wartime cases, or gradual and insidious following prolonged stress or as an endogenous depressive state. It commonly occurs in personalities of the sensitive, intelligent, and affectionate type, and is much more common in the introverted imaginative than in the extraverted personality. It is never found in dull and backward individuals, and is also unusual in the inadequate schizoid personality type.

The depersonalization syndrome is characterized by five cardinal symptoms —namely, reality disturbance, affective disorder, thought disturbance, cephalic paraesthesia, and absence of projection features. To these a sixth might be added, that is, a high degree of responsiveness to anoxic therapy.

The unreality feelings, as pointed out by Mapother, are of two kinds: Depersonalization, or feeling of changed personality, and derealization, or feeling of unreality of the outside world.

The depersonalization symptom is commonly described by the patient as a feeling that his body has become changed in some peculiar way, and seems to be no longer his own, or feels as if dead. Other patients say that they feel as if turned into wood, rubber, or other such inert substance. He may also complain that his personality itself is altered, and that he feels changed into a different person, or as if he were two or more different people. He may

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state that his thoughts are strange, and of a sensation of being detached from his body, as if floating in the air; his thoughts and acts seem to him to be carried on mechanically as if he were a mere machine or automaton.

The derealization symptom is usually described as a feeling that the outside world has become mysteriously changed, so that people and objects appear to the patient to be unreal, far away, lacking in normal colour and vividness, or even actually distorted in shape. Patients often say that they feel as if they were going about in a trance or dream, or as if there was a sort of veil interposed between them and the outer world. Some patients complain chiefly of derealization, while in others the feeling of loss of personality is the principal symptom; more commonly, however, the syndrome is a combination of both derealization and depersonalization phenomena.

The affective disturbance is distinctive and rather characteristic. It is usually a quiet, depressed, apathetic state accompanied by a marked degree of perplexity and bewilderment, due to the strangeness of the unreality feelings. It is not the dull, confused, restless condition seen in katatonic and confusional patients, nor does it resemble the profoundly depressed, retarded state of the acute depressive. It differs equally from the tense and anxious misery of the anxiety neurotic, and the fearful, apprehensive state seen in the agitated depressed patient. A common complaint in derealization patients is the feeling of emotional poverty, with inability to experience the normal gradations of emotional feeling; they are no longer able to enjoy food and other normally pleasant sensations, and experiences normally charged with emotional reaction no longer evoke any normal affective feeling or response.

Of sensory features, cephalic paraesthesia is a constant and distressing symptom. It is commonly described by the patient as a peculiar and unpleasant sensation referred to the head; common terms used to describe it are "numbness," "emptiness in the head," or feeling "as if the brain was dead, or had stopped working," and it is always accompanied by great difficulty in concentrating and thinking clearly.

The thought disorder is one of slowness and difficulty in thinking, which differs from true retardation in being subjective rather than apparent to the examiner. Patients usually describe it by such expressions as "my mind feels a blank," or "my thoughts will not come." Characteristic is a marked impairment of the power of mental imagery; the patient complains that his ideas do not come to him readily and his mental imagery, both visual and auditory, lacks its normal vividness, so that he is unable to conjure up mental pictures of familiar faces, scenes, and voices in the normal way.

Projection features, such as hallucinosis, delusions, and ideas of passivity and reference, are never seen in the true derealization syndrome. Clouding of consciousness and disorder of abstract thinking are likewise absent, and memory, insight, and judgment are not impaired. Although patients sometimes find difficulty in describing the peculiar sensations of unreality in words, there is no language disorder of the schizophrenic type.

On the motor side, there is generally some degree of underactivity and lack of spontaneity, but katatonic motor symptoms and true psycho-motor retardation are absent.

Other symptoms include insomnia, which is not, as a rule, severe, loss of appetite, and some deterioration of physical health in the severer cases. Anxiety symptoms, functional pains, and agitated states are not common in derealization patients, although they sometimes occur as symptoms secondary to the distressing unreality feelings. Fears of insanity, again due to the strange and terrifying derealization feelings, are not uncommonly found.

The derealization state is a condition which causes great suffering and incapacity, and in all but the mildest cases the patient is usually completely unable to work, on account of the difficulty in thinking and distressing mental and bodily sensations. In the severest cases the appearance of perplexity and bewilderment in combination with the marked depression and lack of volition may give the impression at first of a confused, almost stuporose condition, which, however, is in marked contrast to the degree of insight and rapport revealed on closer examination.

Suicidal tendencies are not as a rule common in derealization patients, but they may occur sometimes in the severer forms of the condition.

A rather different form of the syndrome is sometimes seen in patients in the involutional period of life. In this form, the unreality feelings are not nearly so marked, and are associated with a variety of bizarre somatic paraesthesias and hypochondriacal complaints, the thought disturbance being absent and the emotional reaction one of querulous anxiety. This type has, on the whole, a worse prognosis and is much less responsive to electroanoxia than the form just described.

The course of the untreated derealization-depersonalization syndrome is apt to be prolonged, usually of several months to a year or more. The ultimate prognosis, however, is generally good, as it tends to clear up completely in time, recurrence being uncommon, while personality deterioration of the schizophrenic type is never found.

As regards its nature and pathology, the derealization reaction may be regarded from the psychopathological point of view as a form of withdrawal from reality and a means of escape from an intolerable situation in a sensitive and intelligent personality. The unreality sensations would appear to be the expression of a subconscious renunciation by such a personality of the outer world and its realities which have become unbearable. It would seem that this does not involve such a radical personality upheaval as the typical schizophrenic reaction or such a profound degree of dissociation as in the latter condition.

From the organicist point of view the syndrome belongs to the dysoxic group of metabolic brain disorders, since it exhibits typically the dysoxic features of depression, slowing of cerebration, unpleasant mental and bodily sensations, and marked responsiveness to anoxic therapy with non-response to hypoglycaemia. It may be considered as a special form of dysoxic reaction in which the thalamic centres and their cortical connections are chiefly involved, particularly those systems which subserve the functions of conscious awareness and interpretation of somatic sensations and relation of the self to the external world. The higher association systems, acoustico-psychic and visuo-psychic areas, and frontal lobe motor systems are spared ; hence the absence of features

such as disorder of association, aural and visual hallucinosis, and katatonic disturbances. The absence of mental deterioration would appear to indicate that the dysoxic process is of the reversible or benign type, as in the case of the depressive states.

Physiologically, the unreality state may occur in certain conditions of acute emotional crisis—for instance, acute grief reactions and ecstatic religious experiences in mystics and suggestible subjects. These conditions may be due to a temporary and reversible upset of the cerebral oxidation processes. Derealization feelings may also be found in states of severe physical exhaustion, due to overwork or physical stress, as in soldiers under battle conditions. A more severe form sometimes occurs as part of a post-infective exhaustion state.

Of specific toxins which produce a derealization syndrome, the best known are the dibenzopyran or cannabis drugs, and the phenylethylamine or mescaline compounds, of which the last-named was employed by Guttmann and Maclay in their experiments on the therapy of derealization states.

In dosage of 0·1 to 0·2 gm. mescaline produces in the normal human subject a condition strikingly similar clinically to the derealization-depersonalization-syndrome. The symptoms include feelings of unreality as already described, slowness and difficulty in thinking with alterations in mental imagery, and peculiar sensations in the head. The affective reaction may be one of apathy and mild depression, but is more often one of euphoria, the only respect in which the intoxication differs from the endogenous syndrome. With this dosage, clouding of consciousness, hallucinosis, and other gross symptoms are not found, so that the condition induced is clinically almost identical with the derealization state seen in psychiatric patients.

It has been found by Quastel and others that the drug has a specific depressant effect on the oxidation mechanism of the brain cells, and this and the characteristic response of the endogenous unreality state to anoxic therapy would suggest that the physiological mechanism in this condition is similar to that of mescaline intoxication, that is to say, a disorder of the cellular oxidation processes. This, of course, does not necessarily mean that the endogenous syndrome is caused by the action of a toxic amine on the brain-cells; there is no clinical evidence to suggest that such toxins are present in the blood of derealization cases. It would rather appear that the pathological basis of the derealization syndrome is a metabolic upset of the cerebral oxidation processes occurring as a response to psychological or other stress in a constitutionally predisposed personality.

The differential diagnosis of the derealization-depersonalization state rests upon the characteristic association of symptoms already described, namely, unreality feelings, cephalic paraesthesia, affective disorder, thought disturbance, and favourable response to anoxia, with absence of hallucinosis and delusions, and good insight.

The commonest condition for which the syndrome is mistaken is the dysoxic form of schizophrenia. The distinguishing features of the true derealization state are the absence of the projection symptoms, disorder of language and thinking, and mental deterioration, with the presence of good rapport and insight. An important point is that the affective reaction of the derealization

syndrome is always appropriate, and shallowness, fatuity and incongruity of thought are never found.

It is distinguished from the acute depressive states by the absence of true psychomotor retardation, guilt ideas and delusions of unworthiness. As already pointed out, the typical depersonalization syndrome is not common in the involutional period.

In psychoneurotic conditions, feelings of unreality may sometimes occur, but they are, as a rule, not nearly so prominent as the other symptoms, and the characteristic combination of the five principal derealization features is not found in these conditions. Obsessional thoughts and actions or hysterical sensory and motor phenomena are, again, not symptoms characteristic of the depersonalization syndrome.

The severer depersonalization states on superficial examination often strongly suggest an acute confusional or stuporose katatonic state. In the former condition, however, clouding of consciousness and memory disorder are absent, as are also the other features commonly associated with confusional states, namely, hallucinosis, impaired comprehension, and habit disorders. Katatonic conditions may be distinguished by the presence of such features as motor rigidity, impulsiveness, negativism, and hallucinosis.

Of organic conditions, the only common one which might be mistaken for a severe derealization state is the Parkinsonian syndrome. In the more severe depersonalization reactions the apparent apathy, volitional poverty, lack of spontaneity, and facial expression may produce a clinical picture strongly resembling the post-encephalitic state. Careful neurological examination and the absence of true derealization symptoms in the last-named condition, however, should readily settle the diagnosis.

The response to drugs in the depersonalization syndrome is very characteristic. It is one of the most difficult of psychiatric conditions to influence with drugs of any type. Sedation and continuous narcosis are largely ineffective in alleviating the symptoms, while sympathetic stimulants of the benzedrine class either have no effect or render the patient tense and agitated without relieving either the depression or the unreality feelings. Powerful euphoriants, such as mescaline and cannabis, are likewise either without effect or actually intensify the symptoms. In Guttmann and Maclay's series of cases it was found that in the great majority of cases tested with the drug (mescaline), the feelings of depersonalization and depression were made worse. In a small number of patients, whose symptoms were mainly those of derealization rather than depersonalization, some improvement both in the power of visual imagery and the derealization feelings was apparent. On the whole, it would appear that drugs of this type have little or no practical applications in the treatment of this disorder.

Hypoglycaemic therapy is, on the whole, also ineffective in the derealization syndrome, as it is in the great majority of dysoxic states.

The treatment of choice in the depersonalization syndrome is electroanoxia. A course of six to seven applications administered twice weekly is often sufficient to effect a complete remission in the milder forms of the disorder. In severe cases, however, a total of ten to twelve treatments may be required.

Relapse, although by no means unknown, is much less frequent than with the katatonic and pure depressive states.

The secondary symptoms, such as sleeplessness and loss of appetite, may be relieved by the usual symptomatic measures, such as barbiturates in full doses at night and bitter tonics to promote appetite. Usually, however, these symptoms clear up rapidly on inception of anoxic therapy. Psychotherapeutic methods alone are of little avail in the active phase of the disease, but may be of value in the recovery stage when remission of the acute features has been effected by means of electroanoxia.

Residual symptoms usually include a slight degree of loss of concentration and impaired memory, mild spells of depression, and persistence in a very attenuated form of the unreality feelings. These may be treated by appropriate occupational and psychotherapy, and usually tend to resolve spontaneously in the course of a few weeks. In tense and anxious patients mild sedation, such as bromide in doses of 20 grains *t.d.s.*, or luminal, ½ grain *t.d.s.*, is often of help; while for those in whom lack of energy and mild depression are the principal residua, benzedrine 10 mgm. twice daily usually gives relief.

Summary.

1. The derealization-depersonalization syndrome and its clinical features are described.

2. Its relation to the dysoxic brain disorders and the mescaline encephalopathy is indicated.

3. The course, pathology, and treatment of the conditions are described.

References.

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