THE DEPERSONALIZATION SYNDROME: REPORT OF A CASE.

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INTRODUCTION.

THIS paper presents an example of the depersonalization syndrome as experienced and described by an intelligent patient. Considering the frequency of its occurrence, this syndrome has not been as often recognized nor as adequately described as would be expected. The syndrome was first described by Mayer-Gross (1935), later by Gordon (1936), Shorvon (1946, 1947) and Tayleur Stockings (1947). The psychopathology of depersonalization was given in analytical terms by Oberndorf (1935, 1936) and Feigenbaum (1937); Galdston has recently discussed this aspect (1947). As a symptom of organic brain disease, depersonalization offers an interesting field in the long-disputed question of body-mind relationship. Reidl (1942) described this symptom in a case of carbon monoxide poisoning, and Brock and Weisel (1942) discussed its occurrence in organic cerebral disease. Guttman and Maclay (1936) described the interesting relationship between mescaline intoxication and depersonalization. Cerebral anatomical localization was discussed in an anatomico-clinical study by Dide (1938).

The case described here is so classical an example of the syndrome that a record of the patient's symptoms in her own words was considered to be of value in aiding recognition of this peculiar condition. Depersonalization needs no introduction as a symptom of psychiatric disorder. It is found commonly enough in depressive states, hysteria, obsessional-ruminative neuroses, and sometimes in schizophrenia. However, in the condition about to be described, depersonalization is viewed as a distinct disease entity with a peculiar group of symptoms which together form a well-demarcated syndrome.

SYMPTOMATOLOGY.

In his paper in this Journal,* Tayleur Stockings classified the symptoms of the syndrome under the following headings:

(1) Depersonalization.
(2) Derealization.
(3) Emotional poverty.
(4) Cephalic paraesthesiae.
(5) Thought disorder.

* *J. Ment. Sci.*, 1947, **93**, 62.

By depersonalization is meant a feeling that one is no longer oneself—i.e. one no longer believes fully in one's own existence.† Derealization is the term applied to the feeling that one's environment is unreal, or has changed in quality. The affective disturbance is characteristically a poverty of emotional feeling towards objects that normally provoke an emotional response, e.g. one's own children. To the observer the patient appears to be quietly apathetic. Cephalic parasthesiae are the effect of depersonalization applied to the head. The head feels "numb, dead, empty, or solid." Thought disorder is characterized by difficulty and slowness in thinking, with marked impairment of mental imagery, e.g. the inability to recall a face or a melody.

Case History.

The patient, a housewife, aged 57, with no children, had had two previous nervous illnesses, the last of which was an agitated involutional depression at 43. Her present illness, however, differed considerably from the others. She was normally a cheerful, capable person until her illness commenced in January, 1948, with insomnia, which came on while she was in the throes of buying a house and furniture. This persisted until May, 1948, when she suddenly awoke in the middle of the night with the feeling that her body was numb and "cut off" from her surroundings. Next day her head seemed cloudy, and she described her surroundings as appearing unreal to her. She was admitted to hospital a few weeks later. The patient's symptoms are now described in her own words, and classified under the characteristic symptoms of the syndrome.

Depersonalization.—"I feel as though I'm not alive—as though my body is an empty, lifeless shell. I seem to be standing apart from the rest of the world, as though I'm not really here. Is there something wrong with my ears? I hear you clearly, yet your voice sounds far away—distant and unreal. Whatever has deadened my feelings has deadened my hearing too. It's the same with my eyes. I see but I don't feel. I taste but it means nothing to me. I'll eat anything put before me. We had walnut cake which I normally adore—but it might have been a piece of dry bread. I eat, not for pleasure, but only to live. Perfume doesn't smell pleasant any longer. I'd have no preference for the smell of these roses over the smell of the cabbage cooking."

Derealization.—"The wireless is playing, but there's no response in me. Music usually moves me, but now it might as well be someone mincing potatoes. I really love music, but now I can't bear it because it doesn't stir me. I hear it with my ears in a rather distant way, but there's no pleasure attached—it might be someone speaking rather than singing.

"It's the same with flowers. I should feel deep pleasure from these roses my husband sent me, but they mean nothing to me. I was an expert at arranging flowers, but not now. They all look drab to me no matter how they are placed. I can't admire a painting—it affords me no pleasure.

"I seem to be walking about in a world I recognize but don't feel. I saw Big Ben alight last night, normally a moving sight to me, but it might have been an alarm clock for all I felt. It all makes me feel so lonely and cut off. It's the terrible isolation from the rest of the world that frightens me. It's having no contact with people or my husband. I talk to them and see them, but I don't feel they are really there. When I close my eyes I no longer feel their presence."

Emotional shallowness.—"My husband and I have always been happy together, but now he sits here and might be a complete stranger. I know he is my husband only by his appearance—he might be anybody for all I feel towards him. That's what worries me most of all. How can my feelings for him have changed after all these years?

"I was always soft and feminine, but now I feel hard, as though nothing could shock me any longer. I'm beyond feeling. Meeting a friend I say the conventional things, but feel nothing and don't mean what I say.

"A comedian on the wireless I normally like immensely just doesn't amuse

† *Textbook of Psychiatry*, 1946, Henderson and Gillespie.

me now. I laugh politely with everyone else, but feel neither joy nor sorrow. I hear the birds singing in the morning, but my hearing of pleasant sounds is affected as badly as all my other feelings."

Cephalic parasthesiae.—" I call my head my pound of cocoa. It feels as though my skull is packed solid with sawdust—it's solid and heavy—it doesn't think any more. My head is very queer. It feels distinctly heavy on my neck, and it seems divorced from the rest of my body. I feel very conscious of my head."

Thought disorder.—" I can't argue with people because I can't collect my thoughts sufficiently. My thinking isn't clear and I forget the trend of a conversation. I don't think I'm able to concentrate accurately on one subject. I don't feel able to put over my ideas or to make people understand what I mean."

Discussion.

The suddenness of onset of the disorder in this case is a common feature of this illness. It will be noted that many of the symptoms are referred to the special senses of hearing and seeing—so much so that the patient saw an otologist and an oculist for imagined defects. Her special senses, in fact, were quite normal, but the lack of emotional response normally accompanying sensations gave the impression of disability in these organs. Awareness of the external world through hearing, seeing, touching, tasting and smelling is qualitatively distorted when the normal concomitant emotional response to these sensations is diminished. It is, in fact, the projection of one's emotional feelings out on to objects in the external world that gives these objects their quality of reality. One must look, not merely see; listen, not merely hear; feel, not merely touch; savour, not merely taste; sniff, not merely smell. Lack of projection of one's emotions produces an unreal world. And it is this phenomenon that underlies the depersonalization syndrome. It is a tentative withdrawal from reality.

Depersonalization as a symptom of other psychiatric disorders takes second place to the other gross symptoms, e.g. of hysteria or depression. In the true syndrome, however, the five prominent symptoms of depersonalization, derealization, emotional shallowness, cephalic parasthesiae and thought disorder are outstanding. Furthermore, the absence of hallucinations, delusions and ideas of reference is a prerequisite of the diagnosis. For it is the very absence of the process of projection that underlies depersonalization and derealization.

There is no evidence of intellectual deterioration. On the contrary, intelligence is usually above average, and insight is well maintained.

The syndrome is particularly to be differentiated from depressive states, which it may superficially resemble. Though the patient may on first examination appear to be mildly depressed, it is soon clear that lack of feeling rather than feeling of depression is the prevailing mood. Apathy rather than sorrow describes the patient's affective state. Slowness of thinking may be complained of, but this differs from the retardation of depression by being purely subjective. There is no objective evidence of retardation of thought, speech or movement. The agitated state frequently found in non-retarded depressions is not seen in the depersonalization syndrome. Similarly, delusions of unworthiness, poverty and disease are never found in the syndrome, though they are, of course, common in psychotic depressive states. Finally, insight is usually

very limited if not completely absent in a depressive state severe enough to produce nihilistic delusions, whereas in the depersonalization syndrome insight is always well maintained. Nihilistic delusions and depersonalization are obviously closely allied symptoms. And it must be remembered that depersonalization is a not uncommon symptom of both mild and severe depressive states. However, the differentiation between the syndrome and depressive states is not very difficult when one considers the positive and negative features of both these disorders.

E.C.T. is the treatment of choice for this syndrome. The majority of cases appear to clear up completely, but often rather prolonged treatment is required, e.g. 15 E.C.T. sessions. Five cases followed up for a minimum period of one year have not had a relapse.

Summary.

The depersonalization syndrome is described. A description of the symptomatology is given in a patient's own words. The psychopathology and diagnosis are discussed.

References.

Brock and Weisel (1942), *Dis. Nerv. Syst.*, **3**, 139.
Dide (1938), *Ann. Med. psychol.*, Pt. 2, **96**, 95.
Feigenbaum (1937), *Psychoanalyt. Quart.*, **6**, 4.
Galdston (1947), *J. Nerv. and Ment. Dis.*, **105**, 25.
Gordon (1936), *ibid.*, **84**, 628.
Guttman and Maclay (1936) *J. Neurol. and Psychopath.*, **16**, 193.
Henderson and Gillespie (1946), *Textbook of Psychiat.*, p. 121.
Mayer-Gross (1935), *Brit. J. M. Psychol.*, **15**, 103.
Oberndorf (1936), *Arch. Neurol. and Psychiat.*, **36**, 322.
Idem (1935), *Internat. J. Psychoanalysis*, **16**, 296.
Riedl (1942), *Wien. med. Wchnschr.*, **92**, 796.
Shorvon (1946), *Proc. Roy. Soc. Med.*, **39**, 779.
Idem (1947), *Lancet*, ii, 714.
Tayleur Stockings (1947), *J. Ment. Sci.*, **93**, 62.