DEPERSONALIZATION

I. AETIOLOGY AND PHENOMENOLOGY

By

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I. Introduction

Depersonalization remains a subject whose fascination for psychiatric investigators shows no sign of waning. That this is so may partly be due to the striking nature of the symptomatology, though for many the philosophical problems it poses cannot fail to exercise much thought (Lewis, 1949). Numerous aetiologies have been advanced, but there exists no common agreement, even amongst those of similar psychiatric discipline, as to the origin of the condition.

It is the purpose of this paper to examine some of the reasons why depersonalization remains such a problem. An attempt will be made to demonstrate how the disagreements on aetiology have partly arisen on a semantic basis, due to the phenomena accepted as those of depersonalization being such that no clear-cut boundaries can exist for the condition. In a second paper the basis on which depersonalization type of phenomena may arise will be discussed, and the value of considering depersonalization as a generic term for a number of syndromes, often related only by a loose similarity of complaint, will be examined.

II. Aetiology

The various theories which have been advanced to account for the aetiology of depersonalization may conveniently be grouped as follows:

1. Theories which regard depersonalization as originating from the disturbance of a particular psychological function.
2. Theories which regard depersonalization as originating from a cortical dysfunction, which itself is specific, but which may be set in motion by a number of different factors.
3. Theories of psychoanalytic origin, relating depersonalization to various disturbances occurring at different stages of the early developmental period and psychic organization of the individual.
4. Theories which regard depersonalization as a form of schizophrenia.

The above four groups of theories have thus attempted to relate depersonalization respectively to a single disturbance of psychological function; a single common pathway through which the disorder manifests itself; a single disturbance of the developmental period; or a single disease process. Some of these theories will now be considered in more detail.

Theories which regard depersonalization as originating from the disturbance of a particular psychological function

Amongst the earliest theories of depersonalization were those of Krischaber (1872), Ribot (1882), and Taine (1870) who considered the disturbance to be

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one of sense perception. This approach was later pursued by Pick (1904). Oesterrich (1910) and Loewy (1908) both regarded the emotional disturbance as primary, the former emphasizing the loss of feeling and the latter postulating loss of specific feelings accompanying action. Janet (1903) regarded the hyperactivity of the memory, contrasting the present state with the recollection of the healthy state, as the important factor, while Heymans (1911), taking a somewhat similar view, incriminated the loss of feeling of familiarity. Schilder frequently stressed the importance of increased self-observation.

Most theories of the above type are based on the now unacceptable assumption that the mind is composed of a collection of different functions, any of which may separately become disturbed. Furthermore, such concepts are merely *ad hoc* theories derived from the over-emphasis of a particular feature or symptom isolated from the whole structure. In view of the fact that the particular features from which the concepts were derived are certainly not present in every case diagnosed as suffering from depersonalization, their absence must either have been overlooked by the authors, or insufficient cases examined to allow the development of more caution in the universality of their approach. Störring (1932) attempted to overcome this difficulty by postulating a disturbance of a number of different psychological functions in various combinations, but this does little to remove the objections on general grounds raised above.

Theories which regard Depersonalization as being the result of a cerebral dysfunction, which itself is specific, but which may be set in motion by a number of different causes

Schilder (1935), L'Hermitte (1939) and others have attempted to relate depersonalization symptoms to a disturbance of the "body scheme". The central representation of the latter is now known to be localized in the region of the inferior parietal, angular and marginal gyri of the brain. Tumours in these regions of the brain can cause body-image disturbance, often expressed by the patient in depersonalization terms. However, in the majority of patients suffering from depersonalization symptoms there is no evidence of structural change in these areas. Nevertheless both Schilder (1935) and Bychowski (1943) have pointed out that the integration of the body image proceeds on a psychobiological basis and its disturbance may thus be the result of organic brain disorder, psychodynamic disturbance or a combination of the two. On the other hand we have the fact that the complaints of patients commonly labelled as suffering from depersonalization often do not relate to their body at all. When further questioned such patients may deny any alteration in their experience of their body. To attempt to explain all feelings of change of the self and the outside world by deriving them from a disturbance of the "body scheme" would seem not only to be a doubtful hypothesis, but one which, if accepted, would stretch the concept of the "body scheme" to such extremes as to render it valueless.

Others have regarded the symptoms of depersonalization as resulting from a less localized cerebral dysfunction. Mayer-Gross (1935) considered the condition to result from a "preformed functional response of the brain", which he regarded as being in the same category as other non-specific preformed mechanisms such as the epileptic fit, delirium, states of semi-consciousness, catatonic states, etc. While allowing a non-specific origin, Mayer-Gross insisted on the specificity of the phenomena, being led to this conclusion by his impression that the varied utterances of depersonalized patients describe essentially the

same experience and by the fact that depersonalization often occurs in normal people in states of marked fatigue. However, as will be discussed in more detail below, the "essential similarity" of the experiences of patients complaining of depersonalization symptoms is often more apparent than real, and is partly grounded in the basic limitations of our language.

Disturbances in the region of the temporal lobe of the brain are well known to produce feelings of unreality and this has been commented upon by a number of authors, particularly by Penfield and Jasper (1947). Those cases reported have commonly been the result of tumour, epilepsy or direct stimulation of the cortex. The unreality feelings in such cases may be of brief duration or appear as the aura of a more generalized seizure with loss of consciousness. If more prolonged there is usually some associated alteration of consciousness, such as mild clouding and confusion, or a dream-like state. To invoke the temporal lobe as the seat of disturbance in all cases complaining of depersonalization symptoms one would have to postulate a functional disorder which left consciousness intact. However, there is no doubt that, if any one area of the brain is to be held more responsible than another, the organization of the temporal lobe is such that it has the highest claim to consideration. The implication of this will be examined in more detail later.

Theories of Analytical origin relating Depersonalization to various disturbances occurring at different stages of the early developmental period and psychic organization of the individual

One of the earliest analytic writers on the subject was Nunberg (1924) who considered that depersonalization originated from the threat of physical punishment resulting in narcissistic wound and withdrawal of libido from the object. Federn (1928) agreed with Nunberg that a shock causing loss of object-libido was the essential factor and was convinced of a specific aetiology for the condition, saying:

> "All feelings of alienation have something so specific in common that we must assume for all of them one and the same specific cause, whichever psychical function the alienation may attack. Now since we have ascertained that the cause of the external perceptions lies in the loss of a normal narcissistic cathexis, we are bound to assume a loss of narcissistic cathexis in every case where alienation occurs and therefore even in the alienation of feeling, thinking, remembering, etc."

Other analytic writers appear to have been equally convinced of the specificity of cause but manifest a remarkable lack of agreement on the subject. Sadger (1928) thought that depersonalization was an attempt to escape psychic castration, and Searl (1932) considered that there was an attempt to achieve this end by possessing the immunity of inanimate objects. Schilder (1942) considered that the child's dissatisfaction with the amount of admiration and erotic interest spent upon him resulted in a concentration of the libido in the scrutinizing tendency which became turned in. Withdrawal of libido from the body image resulting from disruptive sado-masochistic tendencies was also considered by Schilder to be an important factor. Oberndorf (1934, 1935, 1939) stressed erotization of thinking and identification of such thinking with the parent of the opposite sex, with resulting clash of homosexual and heterosexual striving. Wittels (1940) found in his cases identification with a large number of phantom images which resulted in insufficient ego-libido being invested in any one of the phantoms. The ego was left in a perplexed state due to super-ego condemnation of the phantoms, this latter springing from a disturbed father-child relationship. Freud (1937), Fenichel (1928) and Sadger (1928) agree that in depersonalization there is a defence against affects and sensations.

More recent analytic authors, some of whom will be mentioned in the next section, have been impressed particularly with disturbances of ego development as being the prime factor in the aetiology of depersonalization.

The foregoing represent only the more important analytical views on the subject and a more detailed examination of the literature would illustrate further divergent views. Clinical findings have included sado-masochism, erotization of thought, voyeurism and exhibitionism, ambivalence, strong fears of castration and annihilation. Some authors note paranoid tendencies kept in check by depersonalization, and others stress the importance of anal tendencies, especially anal exhibitionism and voyeurism. Unconscious trends towards self-castration, oedipal fixations and homosexuality have been reported. Oral sadism has been stressed by some, while others have found this rare.

Attempts by some analytic writers to differentiate between "genuine depersonalization" or "depersonalization neurosis" and symptomatic depersonalization have not resulted in an appreciable uniformity of opinion as to the aetiology of the former, and consequently the justification of its status as a clinical entity is still lacking.

The theories of analytical origin are largely constructions based, in most cases, on the analysis of a few patients, and, as has been demonstrated above, a disturbance of almost every stage of psychic development has been incriminated as the essential cause by one author or another. If all the theories are valid, then depersonalization should be one of the features of every neurosis. Perhaps it was this realization that led Schilder to write:

> "Almost every neurosis has in some phase of its development symptoms of depersonalization."

The above statement, however, should be accepted as an allegation rather than a demonstrated fact.

Recently, Oberndorf (1950), one of the leading analytic writers on depersonalization, having changed his ground by deciding that depersonalization is a defence against anxiety arising from threats to the ego from the id or super-ego, writes:

> "Why and how depersonalization and unreality occur in such apparently widely different conditions as depression, schizophrenia, obsessional neurosis and as an almost separate entity still remains unexplained . . . Depersonalization still remains a challenging problem in the field of psychic phenomena and the earlier literature, to which every new writer on the subject dutifully refers, is inconclusive and contradictory."

It must therefore be accepted that a psychopathology specific for all cases of depersonalization has yet to be demonstrated.

Theories which regard Depersonalization as a form of Schizophrenia

Depersonalization has been considered to be rooted in schizophrenic disorder, and Nolan Lewis (1949) is still apparently inclined to regard most depersonalization symptoms as being the prodromata of a schizophrenic illness. He writes:

> "All such expressions such as 'my head feels hollow, my brain seems to move towards my nose'; 'I seem to make three or four hidden meanings out of things instead of the obvious'; 'I have been in a state of mind—everybody is in a state of mind, but my mind seems too big for my body'; 'thoughts come almost like physical sensations—they pass up and down in my head' are schizophrenic in nature and pattern and are only a step away from mind reading ideas, more bizarre expressions and hallucinations."

Although many patients making complaints similar to the above will develop a schizophrenic illness, it is a fact that many patients can for years make such complaints without any evidence of the development of a schizophrenic

disorder. If the schizophrenic nature of such symptoms is insisted upon, then the benign cases must be regarded as "formes frustes". This latter solution, in the absence of definite evidence, is never a very satisfactory one.

More recently, some analysts have attempted to link depersonalization to the same disorder of ego development which they postulate as a basis for the development of schizophrenia. Klein (1946) considers that states of depersonalization and of schizophrenic dissociation are a regression to infantile states of ego-disintegration at, what she calls, the paranoid and schizoid positions. Rosenfeld (1947) considers that there is only a quantitative difference between depersonalization and schizophrenia and that both result from the defensive splitting off from the ego of destructive impulses felt to be alien. Galston (1947) regards depersonalization as a benign form of schizophrenia. Winnik (1948) who views "depersonalization neurosis" as resulting from a uniform disturbance of the ego and its functions, has the impression that the condition is a disturbance "arrested somehow in the way to schizophrenia".

Those analysts who regard depersonalization as related in its development to schizophrenia do not fully agree as to the type of disturbance responsible. Furthermore, until more is known about schizophrenia and whether it itself is an entity, the relationship between it and depersonalization must remain speculative.

III. Problems of Definition

The foregoing study of the various aetiological approaches to the problem of depersonalization has revealed marked disagreement, not only between those of different psychiatric discipline, but often between those who have studied the subject from a common approach.

One possible reason for this confusion appears to be the fact that, although the territory occupied by depersonalization has repeatedly been described, its boundaries have never been successfully defined. It may be, therefore, that the contenders, without realizing it, have been fighting their battles over different ground. A consideration of the "definitions" which have been advanced by a few of the leading investigators of the subject will illustrate this point.

Attempts by Previous Authors

One of the most frequently quoted authors on the subject is Paul Schilder, and, as his descriptions of the condition have been amongst the most comprehensive, they will be quoted in some detail.

In 1914 Schilder wrote that depersonalization was

"a state in which the individual feels himself changed throughout in comparison with his former state. This change extends to both the self and the outer world and leads to the individual not acknowledging himself as a personality. His actions seem to him automatic. He observes his own actions like a spectator. The outer world seems strange to him and has lost its character of reality."

Later, Schilder (1928) gave a more detailed account:

"To the depersonalized individual the world appears strange, peculiar, foreign, dream-like. Objects appear at times strangely diminished in size, at times flat. Sounds appear to come from a distance. The tactile characteristics of objects likewise seem strangely altered. But the patients complain not only of the changes in their perceptivity, but their imagery appears to be altered. The patients characterize their imagery as pale, colourless and some complain that they have altogether lost the power of imagination. The emotions likewise undergo marked alterations. The patients complain that they are capable of experiencing neither pain nor pleasure, love and hate have perished with them. They experience a fundamental change in their personality, and the climax is reached with their complaints that they have become strangers to themselves. It is as though they were dead, lifeless, mere automatons. The objective examinations of such patients reveals not only an intact sensory apparatus, but also an intact

emotional apparatus. All these patients exhibit natural affective reactions in their facial expressions, attitude, etc., so that it is impossible to assume that they are incapable of emotional response . . . In states of depersonalization it is not only the body which appears to be alienated, but also life as a whole, thoughts, impressions, feelings. The depersonalized patient characteristically speaks of the impression that his own thinking is not carried on by himself. The alienated subjective life appears to have been robbed of its personal character and removed into the outside world. The outer world from which the individual has turned away and withdrawn his libido is only capable of alteration in the direction of the unreal. It no longer possesses the full character of reality. The world appears as a dream, objects as though they belonged to the planet Mars."

Subsequently Schilder (1935) again commented:

"All the (depersonalized) patients complain about hypochondriacal sensations, noises in the ears, choking sensations, bubbles in the head, and sensations in the heart."

In 1939 he repeated his 1914 definition, and his 1942 descriptions added little to his former statements.

Federn (1928) comments on depersonalization as follows:

"From our practice and from the literature on the subject we all know the earnest and somewhat uncanny complaints with which severe cases of depersonalization describe their condition, or rather their changing conditions. The outer world appears substantially unaltered, but yet different, not so essentially, so actually, near or far, clear, warm, friendly and familiar, not really and truly existing and alive, more as if in a dream and yet different from a dream. At heart the patient feels as if he were dead, and he feels like this because he does not feel. His feeling, wishing, thinking and memory processes have become different, uncertain, intolerably changed. And yet the patient knows everything correctly, his faculties of perception, of intellect, and of logic have not suffered at all. He knows too how his capacity for feeling is diminished. As Schilder in conjunction with Husserl so rightly says 'The actuality' or as Janet plastically calls it 'Le sentiment du réel' is lacking. In still more severe cases even the unity of the ego has become doubtful: in its continuity the ego is only perceived, not felt. Time, place and causality are recognized and properly applied to find one's bearings, but they are not possessed spontaneously and self-evidently. It is only in the very worst cases that the core of the ego, which as Herman rightly pointed out is connected with the sense of equilibrium, is lost."

In the above examples, quoted from two eminent authorities, it can be seen that, although the descriptions are particularly comprehensive, each author stresses some features which the other neglects. Schilder mentions self-observation, imagery disturbance, distortion of space perception and hypochondriacal sensations, none of which are mentioned by Federn. Federn, while making no reference to the feeling of bodily change, stresses the disturbance of thinking, of memory and of time experience, and comments on the preservation of insight.

Other investigators have not often been so comprehensive in their descriptions as those quoted above, have frequently stressed only those aspects consistent with their own particular approach, or have failed entirely to make any attempt to define or describe what they were discussing. But however admirable the above comprehensive descriptions may be, in fact they are no more than an omnibus collection of complaints made by patients accepted as suffering from depersonalization and hardly even hint at the variability in the fields in which the disturbance may manifest itself.

Malamud (1930) gave an indication of this variability:

"The reaction can best be described under the term that most patients themselves apply to it, namely, that of a sense of unreality. Most patients when asked to describe it more fully say that they have the feeling that some or all contents in their environment have changed; that they are not as they used to be, or as they are perceived by normal persons; they feel unreal. This change may affect certain objects or contents in the outside world or in the patient himself. It may affect everything; the outside world—different parts of the patient's body and even his thought and imagery."

Later, Malamud (1935) described this variability further:

"This phenomenon (depersonalization) may in certain cases be manifested only as regards things actually existing outside, whereas the person himself, his own body, and thoughts

remain unaffected; it may concern mainly contents within the person, leaving the outside unaffected, or finally it may affect the whole situation. Usually the involvement includes both of these factors to a greater or lesser degree."

Mayer-Gross (1935) advocated the retention of the term depersonalization for changes of the self, and the application of the term derealization, created by Mapother, to feelings of unreality and alienation of the outer world. He also emphasized that depersonalization and derealization were commonly, but not necessarily, associated together. He commented too on the fact that a loss of feeling was complained of by all his patients.

Henderson and Gillespie (1944) follow Mayer-Gross's suggestion, separate depersonalization and derealization, and discuss both under the heading of "Unreality feelings". In addition they comment as follows on the non-delusional quality of the experience:

"Ideas of unreality are probably sometimes psychologically related to nihilistic delusions, but they are not usually delusional, the patient recognizing their abnormality and complaining of the distress which they occasion."

Shorvon (1946) admits the difficulty of defining the boundaries of depersonalization and places the emphasis on feelings of unreality accompanied by retention of insight and lack of delusional quality. He comments as follows:

"One of our difficulties has been the description of what we mean by depersonalization. Since the mechanism is not known, the definition can only be descriptive. Short definitions can only be insufficient, and a complete one would include aspects to which attention has been drawn by many different workers. However, the experience is distressing and seems to be essentially one of unreality; the world feels unreal; the subject feels that he is unreal, totally or partially; the symptom never seems to have a delusional quality in the type of case discussed in this paper. The patients have insight. They do not say 'I am unreal', but 'I feel that I am not real, although I know I am'. When they speak of a change in their personality, they seems always to refer to a sense of loss."

From the foregoing, it would appear that no clear criteria for the diagnosis of depersonalization have been laid down. Those authors who have attempted to define the concept under discussion have usually resorted to statements containing a mixture of generalization, descriptive remarks and verbatim examples of the complaints of patients concerning their subjective state. Thus, while authors sometimes give a fairly good description of the disturbances experienced by the patients under discussion, there is such an overlapping of the aspects treated that descriptively no clear-cut entity emerges. One is left with the impression that the various disturbances are sometimes related only by an acquired name, and not by similar physiognomy, let alone common parentage.

Lewis (1935) has commented on the relative infrequency with which are found together all the important features of depersonalization in the same patient, and one might be prepared to accept a number of the manifest difficulties as being merely the inevitable product of a loosely organized syndrome were one fully satisfied as to the validity of the individual components of the syndrome. There is, however, much that renders the latter doubtful. It will, therefore, be instructive to examine the salient phenomena which, commonly though not necessarily, are associated together under the heading of depersonalization; and furthermore to consider to what extent each phenomenon in itself possesses a clarity which, as has been indicated, appears to be lacking in the concept as a whole.

IV. The Salient Phenomena of Depersonalization

The most prominent feature in states of depersonalization appears to be the statement by the patient of a subjective awareness of a feeling of change. This feeling of change can extend both to the outer and inner world, and the

two aspects may be associated together or occur separately. This statement, however, is inadequate to delimit the condition, for a person may feel a better man after a good meal, and the world may appear a pleasanter place when the sun is out. In both there is the subjective experience of internal or external change, yet both are aspects of normal experience.

In addition, therefore, to the mere subjective awareness of a feeling of change, must be added a further necessary quality of experience, namely that of unreality or strangeness. Subjects considered to be depersonalized usually experience their personalities as changed, unreal and lacking in their former qualities. The outer world seems strange and has "lost its character of reality". Yet even this formulation is inadequate so far, for a pleasant state of detachment in which the subject feels different and in which the outer world appears separate and unreal can again be an aspect of normal experience, being achieved by the employment of various ceremonials and rituals, and by the use of common agents such as alcohol, tobacco and narcotics. Such states are not usually included under the heading of depersonalization, for, lacking an unpleasant quality, there is usually an absence of complaint.

The quality of unpleasantness thus emerges as a further important feature of depersonalization; it is, in fact, the feature which brings the patient to the doctor, for those experiences of unreality, commonly designated as depersonalization are usually unpleasant and at times very distressing.

But what of the patient who insists that his body is not the same as formerly, that his organs are rotting or have disappeared, and that the world in which he is living is a strange one peopled by demons? His is certainly a distressing experience of unreality. In this case, however, the patient has no insight into the purely subjective nature of his experience, and, convinced of the reality of his unreal feelings, he must be considered as deluded. The depersonalized patient, however, is often considered to recognize the abnormality of his feelings of unreality, and, in fact complains of it as something foreign in his experience.

Another important feature, in addition to the above, is a particular type of affective state, often characterized by a complaint of lack of capacity for emotional response, variable in degree and extent.

Other disturbances, such as difficulty in thinking and concentration, impairment of memory, difficulty in time appreciation, poor imagery, subjective sensory abnormalities, etc., are often associated with conditions discussed under the heading of depersonalization, but, for the purposes of definition, they do not occur sufficiently frequently to be considered essential features.

The leading features, then, are a subjective feeling of internal and/or external change, experienced as one of strangeness or unreality; an unpleasant or even highly distressing quality to the experience; the retention of insight and lack of delusional elaboration of the experience; and an affective disturbance characterized often by the complaint of loss of affective responsiveness.

These leading features will now be considered in more detail, the data being largely derived from the intensive study of over fifty patients, all of whom had been diagnosed independently by a number of experienced psychiatrists as suffering from a state of depersonalization. The depersonalization symptoms of these patients either occurred in the course of a depressive illness, or were associated with neurotic symptomatology, or presented as the predominant complaint. States of depersonalization arising on the basis of an organic cerebral disorder or occurring in the course of a schizophrenic illness were also studied, but are not considered in any detail for the purpose of this section. All these cases were examined and studied personally by the author, the treatment of the

majority was under his supervision and seven of the cases were treated personally by him.

Feelings of Unreality

"Unreality" is a term which may be employed by patients to describe all varieties of changed experience outside their accepted range of normal variation. Frequently, however, they describe their various feelings of change without at the same time labelling them as feelings of unreality, though they may well agree to do so in direct questioning. Furthermore, one has the impression that the more medical contact the patient has had the more likely he is to formulate his complaint in terms of unreality. It is somewhat similar to the situation in depressive illnesses. In the latter, the patient, ill for the first time and uncontaminated by medical terminology, does not always complain of depression but often says that he is "miserable", "lifeless", "wretched", "lacking in interest", "has lost the joy in living", etc. It is sometimes only later that he says "I'm depressed", or "I'm suffering from depression". In the same way, psychiatrists having enquired of the patient if he feels unreal, what was formerly experienced as a sense of detachment, isolation, lifelessness, etc. may later be expressed as a feeling of unreality.

Miss W.D., aged 54, on being asked how the outside world appeared to her, replied:

"Trees seem to be stark and staring and ugly, not attractive any more. I used to see people nice and attractive, now even those that are nice look ugly. Even fair people look dark to me now . . . Rooms seem to be smaller . . . my eyes don't seem to focus . . . People's faces seem behind a sort of smoke. Familiar streets seem different."

In all her statements she did not use the expression "unreal". and, on being asked if things appeared at all unreal, she replied:

"I suppose you might say that things do look unreal in a sort of way, not seeing them as I used to."

In subsequent enquiries as to how the outside world appeared she always employed, amongst others, the expression "unreal". It can thus easily be seen that any attempt to ascertain how frequently the expression "unreal" is used to describe the feelings of change will have little value unless the effect of previous medical contact is taken into account, and the latter assessment presents obvious difficulties. However, an indication of the infrequency with which the expression "unreal" may in practice be used is given by the fact that of twenty consecutive patients diagnosed as suffering from depersonalization and who complained of feelings of external change, ten did not *spontaneously* use the expression. In respect of feelings of change of the personality and of bodily change the expression "unreal" was spontaneously used even less frequently.

Any but a cursory study of patients complaining of feelings commonly included under the head of depersonalization soon reveals that, although the expression "unreal" is often used by patients to describe feelings of change which they do not accept as being within their normal range of experience, to confine the term depersonalization strictly to patients complaining only of "unreality" feelings would be to exclude many whose manner of complaint leaves little doubt that their feelings do, in fact, transcend their normal accepted range. "Strange", "unfamiliar", "dead" and many other terms often are used in the attempt to describe similar feelings. It therefore appears that, unless a specific complaint of unreality is made or admitted to by the patient, it must be left to the psychiatrist to decide whether, in fact, he is justified in regarding

the complaint as equivalent to one of unreality. This, in practice, is done by considering the quality of the patient's complaints, his attitude and his reaction to his experience of change.

However, as soon as one discards objective criteria in the statements of the patient in making the diagnosis of depersonalization, one is confronted by the fact that the experience of unreality, or its equivalent, is not sharply delimited from the normal, but that there is a gradual transition from the normal to the abnormal.

Mrs. E., aged 39, describing her experiences, said:

"I looked in the glass and said 'Can that be me?' I looked so haggard and senile. I think that if I had had a couple of pints of blood it would have done me good. I felt as if I had entered on another phase of my life, a miserable, horrid stage. I felt as if I'd never be as I was before, something seemed to have gone for good and I was no longer the same."

Although the first part of the statement appears to attribute the changed appearance and function to poor physical health (e.g. the improvement expected after two pints of blood), the latter part contains complaints of personality change and loss, which, though no doubt in this case expressing the patient's feeling of depression, yet differ not so much from similar complaints made by patients expressing themselves in more definite terms of unreality. It sometimes appears as though the more striking the contrast between the appearance and function in health and illness, the more likely is the patient to formulate his experience in terms of unreality or strangeness.

This leads to a further consideration, namely, to what extent metaphor, rather than experience, must be held responsible for the unreality quality of certain expressions used by patients. Lewis (1934) has commented on this aspect in relation to affective disorder:

"There is the possibility of there being in some no more than a verbal difference between expressions of loss of interest and inability to enjoy, and the feelings of unreality; when a patient says 'Everything looks as black as black can be', or 'Everything seems empty and dull and dead and I don't care about anything', or 'There is no love in me, my heart is dead', it is difficult to decide how much of objective reality there is in the words, or how much metaphor."

Not only, however, may there be variations within the individual in his attitude to the degree of abnormality of his experiences, but what one patient may consider as abnormal may well be considered as within his normal range of experience by another, or by the same patient on a later occasion.

It appears that the degree with which a patient regards an experience as unreal or strange is often in inverse relationship to his familiarity with it. Thus, one patient suffering from a depressive illness who, only on direct questioning admitted to a feeling of being isolated and detached from the outside world which seemed lifeless, made the following reply when asked if she or the outside world appeared unreal:

"No, it is much the same feeling as I get when I am drunk, I've often had it before, I think."

Mrs. S., who for the past twenty years since adolescence had suffered frequent attacks in which her body felt completely absent, when asked if she felt unreal or strange, replied:

"I may have done so once. But I have got so used to my attacks that I just put them down to my nerves and hardly notice them."

Clearly, she had become so familiar with her disturbance of body image that, for her, it was part of her normal experience. Miss C., aged 39, who had suffered a number of attacks since their onset at the age of 14, described her experiences as follows:

"Everything has gone, I've no desires, joys, or feelings of affection. My conscious mind has stopped working, it seems to be controlling the back part. I've come to a standstill. I feel I don't seem to exist. The soul part seems to have stopped living. My brain feels as though it is ripped in two."

When asked if she felt at all unreal she however replied:

"I felt unreal when it first came on at 14, but after a time I got used to it and found that it was just a sort of emotional block. After that I did not seem to feel so unreal."

In this case also, frequent repetition and the partial "insight" had enabled the patient to accept her experiences of change as no longer so foreign to her.

We are thus confronted with the highly individual quality of the feeling of unreality, and it is difficult to see how the actual complaint of unreality or other equivalent complaints can usefully be used for defining clearly a state of depersonalization. Any attempt to insist that the feelings of change must be formulated by the patient strictly in certain terms before the disturbance can be accepted as coming under the heading of depersonalization would do violence to the facts, and could at best only produce an arbitrary terminological frontier, sometimes having little relation to the terrain of the country. "Unreality", therefore, can be considered only as a useful generic term, having, when considered as a complaint produced by the patient, too narrow a value in itself for the purposes of definition.

The Unpleasant Quality

It has already been pointed out that, in a number of common conditions (e.g. alcoholic intoxication) there may be a feeling of detachment accompanied by a feeling of change of the self or the outside world. Furthermore, this feeling, far from being a distressing one, may in fact be pleasant. Such conditions have not usually been considered under the heading of depersonalization owing to the lack of unpleasantness in the quality of the experience. Mention has also been made of patients in whom the depersonalization experience had largely lost its distressing quality owing to familiarity through repetition. It is perhaps, however, insufficiently appreciated that the unpleasant quality with which the experience of depersonalization may be invested is related not only to the immediate setting in which the experience occurs, but also to the previous psychopathology of the patient.

In a series of fifteen consecutive patients, all of whom complained of depersonalization experiences, particular attention was given to their insight, attitude to and reaction towards their symptoms. Enquiry was also directed towards relevant fears and preoccupations which might have been in existence before the first onset of their symptoms. The most distressed patients appeared to be those who feared that they were going insane, would die, or suddenly pass away.

Of the eight patients who complained of fears of going insane, three had a family history of psychosis in a parent and one of psychosis in a grandparent. All these four patients had been preoccupied for some time before the onset of their symptoms with the fear that they too would become insane. Of two of the remaining four patients, one had for some time previously feared that as a result of her husband's spiritualistic activities her reason would become deranged; the other had since childhood feared the confirmation of her mother's warning that masturbation would lead to madness. In only two of the eight patients complaining of fears of insanity was there no apparent evidence of preoccupation with insanity before the onset of their symptoms.

One patient expressed mild fears that she might disappear and pass away.

No relevant preoccupations could be discovered in her previous history, and she herself formulated her condition as due to wanting to run away from things that frightened her. Another patient, however, who was extremely disturbed during his attacks by fears that he might die, had been preoccupied for years previously with fears of bodily illness or of dying suddenly of cerebral haemorrhage as had his grandmother.

The remaining five patients all considered that their condition was a form of nervous disorder which would ultimately clear up. None expressed any particular fears in relation to the significance of their symptoms, and in none could any relevant preoccupations (e.g. fears of insanity, illness, death, etc.) be discovered in their past history. Of the whole group of fifteen patients their symptoms appeared to cause them the least distress.

The above examples clearly indicate the degree to which the unpleasant quality of the depersonalization experience is dependent upon the facility with which it reactivates fears, particularly those of insanity and dying, previously held by the patient. The quality of unpleasantness, therefore, cannot be considered as a very reliable feature when considered for the purpose of definition of depersonalization.

The Non-Delusional Quality

Lewis (1934) included amongst his examples of depersonalization associated with depressive states a number which were unmistakably delusional in nature. Thus M.S. (Case 52) said:

"I have no soul, I have killed myself."

Lewis states that several patients, observing some change, thought they were being tricked. Thus A.H. (Case 27) denied the identity of her sister, declared that she was in a strange ward in a strange hospital, that her sister's letters were actually from an impostor. M.C. (Case 15) after sending in great haste for a priest to make a confession, declared that he was only a bogus priest when he came; she denied that she was in hospital and said:

"Queer people, queer things here. People seem to come and go in a flash like."

L.W. (Case 61) also denied that he was in hospital or that the physician was what he purported to be, insisting that everyone was acting.

Mayer-Gross (1935) considered that some of the delusional changes of the perceived world or of the personality occurring in early schizophrenic states should not be included under the heading of derealization and depersonalization. He, however, admitted the close relationship between delusional ideas and depersonalization and considered that this relationship needed to be cleared up. He further commented on the relationship between somatic depersonalization and hypochondriacal delusions, quoting Schilder's view that somatic depersonalization was the germ of such delusions. He further suggested that the fact that only young people appear to be affected by depersonalization probably accounted for the infrequency of delusional development, and that "the hypochondriacal delusional psychosis of middle-aged persons (e.g. the nihilistic ideas of involutional melancholia, the *délire de negation*, etc.) is a sort of equivalent to depersonalization in younger persons".

Mayer-Gross thus left the problem undecided, for, while rejecting the right of some of the unreality states of schizophrenia to be included under the heading of depersonalization, he admits that in other conditions delusional development, although infrequent, can occur. He does not, however, commit himself as to

whether, when the latter condition has occurred, the symptoms should be considered under the heading of depersonalization or not.

Henderson and Gillespie (1944) state, in this connection:

"Ideas of unreality are probably related to nihilistic delusions, but they are not usually delusional, the patient recognizing their abnormality and complaining of the distress which they occasion."

The non-delusional nature of the cases described by Shorvon (1946) appears to be largely the result of selection:

". . . the symptom never seems to have a delusional quality in the type of case discussed in this paper."

Galston (1947) arrived at much the same position, arguing by definition:

"The differential diagnosis between depersonalization as a definite psychic disease and depersonalization as the component of other psychiatric disorders is not difficult. It is made entirely on the basis of exclusion on the score of the very definite insight into his condition shown by the depersonalization patient. The true case of depersonalization never loses contact with reality, and no matter how fantastic may be the perceived changes within himself or the outside world which he reports, these changes always remain incredible to the patient."

The problem of the delusional quality in depersonalization states can probably best be appreciated by considering those cases in which the delusional element presents in a variable or fluctuating manner. In a consecutive series of twenty patients complaining of depersonalization symptoms, four such cases occurred.

Miss W.D., aged 54, suffering from an involutional illness in which feelings of change occurred in the setting of depression, made the following comments on herself:

"It's as if I am living in a world of horror all on my own, I feel cut off. I'm a sort of horror people would not want to be near . . . Trees seem to be stark and staring and ugly, not attractive any more. I used to see people nice and attractive, now even those that are nice look ugly. Even fair people look dark to me now. The rooms seem to be smaller. My eyes don't seem to focus, familiar streets seem different and people's faces seem behind a sort of smoke . . . My body does not seem any shape or form. There's a hollowness, like a 'sack tied up in the middle' sensation. I *know* my head has shrunk, I think my legs must have shrunk, in fact everything has shrunk. My feet seem to lose themselves at times, and I feel as though I have no neck. I've got a terrible appetite and yet I feel empty all the time . . . Now that I'm wicked, I'm just horrid. I *know* I look horrible and I feel that other people don't want to look at me for the same reason."

The above complaints are so varied, both in form and content, that the terms depersonalization, derealization, hypochondriacal sensations and bodily delusions are all applicable. The case illustrates well the co-existence of the "as if" formulation and the frankly delusional idea, and in this case the former was not in the immediate process of developing into the latter.

Mrs. M.G., aged 45, suffering from agitated depression, complained:

"This is a living death, I have no self, it is gone and nothing is left."

Later, when less depressed, she described herself as "detached and apart"; objects seemed "distant and different".

Miss P., aged 28, suffering from a depressive state, was so struck by her strange reflection in the mirror that for a short while she was convinced that she appeared peculiar and that other people must be laughing at her and talking about her.

Mrs. P., aged 30, suffering from a depressive state, was so disturbed by her feeling of bodily strangeness and the unreality of the outside world, that for a while she was, in spite of all reassurance, convinced that she was either mad or a different person and begged to be certified to avoid further uncertainty.

It appears that feelings of bodily or external change or disturbance occurring

in a totally delusional setting have been accepted by many authors as arising from the delusional state or perceptual disturbance of a schizophrenic, depressive or organic disorder, the question of depersonalization not therefore arising. Cases of the type quoted above, however, which have either a partial or fluctuating delusional quality, again raise the problem of the boundaries of depersonalization. While the majority of cases met with clearly fall either into the delusional or the non-delusional group, there remains a group of cases which cannot be so categorized. The feelings of change of this group may be delusional in some respects but not in others; there may be a fluctuation between a complaint having an "as if" formulation and a frankly delusional conviction; or, as may commonly occur in a schizophrenic state, the whole picture may be progressively delusional in its development and remain so.

It is apparent, therefore, that the presence or absence of a non-delusional quality to the complaint of a feeling of change may offer little help in the decision as to whether or not a condition should be classed under the heading of depersonalization.

Loss of Affective Response

Mayer-Gross (1935) found that "lack of feeling" was present in all the twenty-six cases of his series. He mentioned, however, a patient with the opposite state, namely, loss of emotions without any disturbances of the self. The complaints of this patient were as follows:

> "My self is the same as before, but feeling seems gone away altogether. My body is not changed, not unreal. Lying down I tried to force the feeling back to me. Feeling of remorse, passion, everything has gone. I have only the feeling of being alive."

Lewis (1934), who also comments on the presence of loss of affective response in the absence of feelings of unreality, suggests the possibility of there being no more than a verbal difference between expressions of loss of interest and inability to enjoy on the one hand and feelings of unreality on the other. In the light of what has already been discussed above concerning the use of the term unreality by patients, this possibility appears to be a very likely one.

Both Mayer-Gross and Lewis, as well as others, comment on the apparent paradox of the complaint of loss of feeling in patients who obviously experience suffering from the alleged death of their feelings. In order further to study this phenomenon, 26 consecutive cases presenting depersonalization symptoms were investigated with particular reference to the affective features. It was found that in all cases there was a complaint of loss of interest in the outside world, and in 19 cases a complaint of loss of affection towards those previously held dear to them. In 18 cases there was increased self-concern and anxiety about their present condition and future. In 18 cases there was a complaint of loss of capacity to worry over outside events which previously would have been anxiety provoking. In 20 cases there was a complaint of increased feeling of irritability. Fourteen cases exhibited a combination of lack of capacity to worry over outside events together with increased self-concern. It was such cases that demonstrated best the apparent paradox of manifest suffering associated with the complaint of lack of feeling. Patients would explain how traffic, the sight of blood, meeting strangers and other situations and objects were no longer anxiety-provoking as formerly, how they had lost all affection for their dear ones and could raise no interest in anything. At the same time they would describe vividly the distress which they were suffering as a result of their lack of feeling together with various preoccupations and anxieties about their present state and the future. The apparent paradox resolved itself into a problem

of contrast when greater emphasis was placed on the fact that there appeared to be an increased responsiveness for anxiety of internal origin, whereas that of external origin was reduced. The commonest affective pattern was that found in 12 of the 26 patients, namely, increased irritability and self-concern associated with reduced capacity for interest, affection and concern for outside events.

It appears then that states of depersonalization may sometimes exhibit a characteristic affective pattern. On the other hand, this latter pattern can sometimes be present unassociated with the complaints commonly accepted as being those of depersonalization. It may be that this latter occurrence is the result of a difference in the attitude of the patient, or a difference in the verbal formulation of the complaint; but in either case the definition of depersonalization is in no way rendered easier.

V. Conclusion

The four salient features of states of depersonalization namely, the feeling of unreality, the unpleasant quality, the non-delusional nature and the affective disturbance have now been examined in some detail. It has emerged that not only is depersonalization a loosely organized syndrome, but that the criteria of the salient features themselves are often in doubt or lacking in the clarity necessary sometimes for the establishment of their presence. It is now understandable why it is that the boundaries of depersonalization have never been clearly defined. The nature of the territory is such that any attempt to do so would only produce an arbitrary frontier, often including within it inhabitants essentially dissimilar, while excluding many others having a good claim to admission. Why the territory should be of such a nature will be considered in more detail in a second paper. It is apparent, however, that there can be no certainty that various authors have been dealing with exactly the same phenomena, and it may well be that, if the latter condition could have been achieved, a greater measure of agreement would have emerged. For some have treated depersonalization as though it was a clear-cut clinical syndrome, others as though it was merely a symptom; but what is quite clear is that the phenomena know no boundaries. Much of the confusion appears to have originated from the faults which Lewis (1949) has claimed are common to both psychiatry and philosophy, namely:

"Schematization without sufficient evidence, uncritical trust in the adequacy of language, and contention because the contenders do not agree about their axioms or fail to make them explicit."

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