DEPERSONALIZATION

II. CLINICAL SYNDROMES

By

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I. The Experiential Basis of Depersonalization

In an earlier paper (Ackner, 1954) various aetiological approaches to the problem of depersonalization were examined and no common agreement was found. The salient phenomena of depersonalization were examined and found to be so lacking in precision that no clear-cut boundaries could be considered to exist. This explained the lack of any truly adequate definition of depersonalization and suggested that some of the past disagreements had been the result of failure to make explicit the phenomena under discussion.

How then are the disorders in which patients formulate their complaints in terms of unreality, strangeness, etc. to be regarded? For such disorders are not uncommon. Indeed, in view of the fact that every mental disturbance must be accompanied by an altered experience of the self and/or the outer world, it is somewhat surprising that such disorders are not more common. Now, though it is probably not true to say that "almost every neurosis has some phase of depersonalization" (Schilder), it is probably true that almost every mental disturbance is capable of being expressed by the patient, to a greater or lesser degree, in terms commonly accepted as being those of depersonalization. The problem of the nature and aetiology of depersonalization thus resolves itself into the question as to what are the conditions which must obtain in any mental disturbance before a patient's feeling of change is formulated in terms of unreality or in some other way indicating a peculiar strangeness of the experience.

Experience of change, whether arising from within or coming from the external world, normally becomes organized within the framework of accepted experience. The person who feels limp or full of aches and pains, or for whom the outer world seems dull and others unfriendly, may perhaps accept this change as being the result of fatigue, disease or injury. The new experiences have been accepted and organized within the framework of normal or comprehensible experience.

It may be, however, that such experience of change is evaluated falsely and maintained irrationally to the extent that it becomes delusional in nature. Similar experiences to the above may be misinterpreted, the patient regarding himself as changed into a stone, or his body as twisted or rotting, or the world as devastated, its inhabitants strangers from another planet. The experience of change has been accepted, but only in virtue of having been organized within a delusional framework. (In psychopathological terms, it has been completely projected.)

In both the above examples, experience of change has occurred, organized in the first case within the framework of normal experience, and within a delusional framework in the second. In both cases the individual has felt changed

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in relation to either his inner or his outer world, but to apply the term depersonalization to the complaints of either would seem to allow an extension of the term to cover any altered experience of the self or the outside world, thus making it applicable to the whole range of mental disturbances.

Consider, however, the patient who feels like an automaton, with no personality, whose body feels dead and unresponsive, or for whom the outside world appears strangely flat and still, and who feels that everything seems so unreal that he fears he must be going mad. He is not able to accept his experiences of change within his normal experiential range, nor has he organized them within a delusional framework, The experiences, in fact, remain partially outside, peculiar, foreign, strange, unreal and inexplicable except in terms of incipient madness. If there is then a delusional development, the new experiences will tend to be included within the delusional system and, to the extent that they acquire a position within the latter, they will be transformed, with accompanying reduction of the feeling of strangeness and unreality. If, however, the experiences can eventually be accepted as within the normal experiential range, then their strangeness and unreality will again be reduced and they will be formulated in other terms. The former transformation is essentially the one to which Mayer-Gross (1935) refers when discussing the occurrence of depersonalization at the stage of "minor intensity" of a psychosis, the condition disappearing as the psychosis develops. Examples of the latter transformation have already been given above when discussing patients whose attitude to and formulation of their symptoms changed with time.

Depersonalization experiences can thus best be regarded as occupying a position somewhere between the delusional and the non-delusional. There is a failure to integrate new experiences into the total organization of the psychic functioning, and at the same time the latter remains relatively intact. As a result, the experiences are viewed as something partially outside, and remain strange, peculiar, foreign and unreal. Any increased tendency to integration will be in the direction either of the delusional or of the non-delusional, and to that extent the complaints will change in form and the term depersonalization will be less applicable. The occurrence of depersonalization complaints may thus be considered to originate from the relative failure of integration of such new experiences as give rise to a change in the relationship of the individual to his world, his body, or his own psychic functioning.

This lack of integration may affect all, some or only one modality of experience. Furthermore, where this lack of integration affects a number of different experiences, the degree of lack of integration may vary between the particular experiences, as may also the tendency to organization in the direction of reality or delusion. It is apparent, therefore, that any complaint can vary between an understandable feeling of change, an "as if" formulation, a complaint of unreality or a frankly delusional conviction. It is also apparent that various such complaints can, in certain circumstances, all exist at the same time in the same patient, being variously applied to different fields of experience.

Depersonalization thus cannot exist as an entity, for the concept is only an artificial isolate within the field of failure of integration of experience. There are all degrees of such failure, there are numerous varieties of experience which may be affected by such failure, and the failure may affect all or only a limited part of an experience so affected. All attempts, therefore, to define rigidly the boundaries of depersonalization are bound to be fruitless, for so many continua of experience may be involved.

It follows that patients complaining of depersonalization symptoms are

not always having "essentially the same experience", as has been alleged by Mayer-Gross (1935). The feeling of change may affect many different experiences, but in common they all have a particular failure of integration of experience characterized by a lack of complete organization within the framework of reality or delusion. The actual experiences may be widely dissimilar, only the lack of integration gives them a common flavouring of unreality or strangeness.

It is now proposed, in future discussion in this paper, to include under the heading of depersonalization those complaints of a change in the relationship of the patient to his world, his body or his own psychic functioning which are formulated in terms which indicate that, to the patient, they have the quality of unreality, strangeness, foreignness, etc. and which, whilst not accepted by the patient as within his normal range of experience, are yet not expressed in frankly delusional terms.

As depersonalization complaints are not necessarily based on similar experiences, there can be no common aetiology. But is there a common origin for the particular failure of integration postulated above?

II. The Capacity for Integration of Experience

The capacity to integrate various data, whether originating from within or without, into a meaningful whole accepted by the individual as part of his own experience is probably not present at birth. It appears to develop slowly and to accompany the gradual differentiation of the original dual unity of the ego and non-ego. Presumably an adequate biological substrate must exist for the effective organization of experience. Presumably, also, the environment of the individual must be such that the experiences to which he is subjected at any given stage of development are not so overwhelming as to render them incapable of being organized on a reality basis. From this it would follow that, developmentally, the capacity for integration can be impaired either by inadequacy of the biological substrate, or by the milieu in which development is taking place being unfavourable. Having regard to the dynamic inter-relationship of the individual and his milieu, it is apparent that the development of the capacity for integration must proceed on a psychobiological basis. It follows, therefore, that both fields must be considered when attempting to assess the effects of particular defects in one. For example, a favourable environment may effectively compensate for the disruptive tendencies of the effects of a severe cerebral birth injury; any threatening experience may be disintegrative if the relationship to reality is still in a tenuous stage.

An individual may thus develop without ever achieving a capacity for integration adequate for full reality adjustment. He may, to a greater or lesser extent, be aware that his relationship to the outside world, to his body or to himself as a personality has always lacked a certain quality of reality. More commonly the relationship to reality may be merely an insecure one. Areas of vulnerability may exist enabling an adequate stress, either psychic or biological to have a disintegrating tendency. A toxic illness, cerebral disease, the death of a parent, unacceptable feelings or urges, and so on, may thus be capable of producing depersonalization complaints in some patients and yet not in others.

The origin of the failure of integration of experience is thus rooted in the psychobiological development of the individual and although early psychic factors, environmental stress and innate or acquired cerebral dysfunction have all been invoked, in the majority of cases the condition is likely to be the product of the interaction of many such factors.

III. Depersonalization Syndromes

If it is true that depersonalization type of complaints occur as the result of the product of the interaction of various factors which lead to a certain type of failure of integration of experience, then it is likely that conditions will exist in which certain of these factors are more important than in others. If this is true, then it should be possible to delimit various different depersonalization syndromes on the basis of the particular factors chiefly concerned. Such different depersonalization syndromes, however, would essentially be convenient isolates. In practice the majority of conditions, although more nearly approaching the characteristics of one syndrome, would be likely to have some features in common with others. This, however, would be no objection if it led to greater understanding, and, in fact, would merely parallel a now accepted attitude to many psychiatric syndromes. The syndromes described below appear to the author to be those of most significance.

Organic Depersonalization Syndrome

That depersonalization symptoms can have an undoubtedly organic cerebral basis is well accepted, and Schilder (1935), Brock and Wiesel (1942), Bychowski (1943) and others have described cases in which similar symptoms may be determined either predominantly by an organic or by a psychogenic disorder. Such symptoms have been reported in a number of conditions, which include encephalitis, epilepsy, chorea, toxic and delirious states, head injury, tumour, carbon monoxide poisoning, mescalin intoxication, etc. That they should occur in such a variety of conditions is not surprising when one considers that anything which leads to an altered state of consciousness or interferes with the final associative integration is bound to result in some change in the relationship of the individual to his world, his body or his own psychic functioning.

This failure at the highest functional level of cerebral activity may occur as a result of some of the normal components of experience being altered in such a way that their final integration is rendered difficult. For example, in vestibular disorders, abnormal afferent stimuli may give rise to sudden changes in the individual's experience of his body or the outside world (Schilder, 1935). It is likely, therefore, that any marked alteration in the stream of information which is being blended into the normal state of continuous awareness will, to a greater or lesser extent, affect the quality of that awareness as a whole.

On the other hand, the failure of integration may be the result of disorder through disease, tumour or abnormal discharge of the highest level integrating systems of the brain. The latter function is now believed by many authorities to be performed by thalamo-cortical circuits involving an intimate relationship between sub-cortical centres and frontal, temporal and parieto-occipital projection areas of the cortex. From this it follows that disorder at either the cortical or sub-cortical level can lower the integrative capacity of the brain. It has for long been recognized, however, that disorder in the temporal region of the cortex, especially epilepsy, is particularly liable to give rise to states of altered awareness, dreamy states and depersonalization phenomena. The work of Penfield on the temporal lobe has shed much light on these phenomena and Penfield and Rasmussen (1950) have commented:

> "Certain mental states produced by temporal stimulation and also appearing in epileptic dreamy states are difficult to classify. Take for example the patient who says he feels as if he were not here, as though he were going away, as though he were out of this world, as though he were in some other place from which he could contemplate his own person in its actual surroundings. Sometimes this may be an illusion of vestibular sensation. At other times it

is a feeling that the ego is removed from the body. In this case it is not an illusion in regard to sensory perception so much as it is an alteration in the individual's opinion regarding his relationship to his environment or his relationship to his body. It might be considered an illusion of introspection instead of an illusion of sensory perception.

"It is difficult to interpret these abnormal states so as to throw light upon normal function within the temporal cortex. It is evident, however, that there is localization here of neurone processes that are essential (*a*) to judgment of intensity of visual and auditory sensations, and (*b*) to comparison of present perceptions with past experience."

It would seem, therefore, that depersonalization phenomena involving various modalities of experience may occur as a result of disorder in many areas of the central nervous system. However, the thalamo-cortical system, in virtue of its integrating function, is probably of the highest importance, and, within this system, the temporal cortex, closely connected with visual and auditory impressions and memory functions, has the greatest claim to be significant.

It is, perhaps, necessary to emphasize again that mental phenomena such as depersonalization symptoms can never be entirely organic in origin for, being concerned with changes in experience, they are indivisably related to the mental functioning of the individual. Thus, in cases with a large organic factor, not only may the form of the symptoms be partly psychogenetically determined, but often their occurrence will be related to periods of emotional stress which make manifest a latent deficiency in the biological substrate for integration.

Schizoid Disturbance of Identity. (See Appendix I—Case 1.)

Cases occasionally occur in which a patient alleges that he has never felt real, that his present symptoms have, to a lesser degree, always been present. One sometimes suspects that this is a retrospective judgment, and that such patients are, in fact, essentially similar to those who state that they now see that they have never experienced things as real, but have never realized it before. The "onset" of the symptoms in these cases may thus be a spurious onset, it being merely the point at which the patient becomes acutely aware of his underlying difficulties. A close study of such patients usually indicates that their inability to make genuine contact in their relationships has, in fact, been lifelong but never fully apparent to them.

This inability may, however, manifest itself in a number of ways, all of which have in common an inner poverty of genuine experience. Nearest to those expressing themselves in frank depersonalization terms are those patients in which there is a chronic state of lack of conscious pleasure. Glauber (1949) has named such a state "Primary anhedonia". He considers that the manifestations of this emotional state are described in many terms, which include withdrawal, detachment, isolation, alienation, chronic aloofness, listlessness, emotional block, etc. However, it obviously merges with those "schizoid" personalities who have always felt more or less isolated from their fellow creatures, somewhat separate from events, detached from their own activities or unable to experience deep feeling in their interpersonal relationships.

Eisenstein (1951) discussing what he calls the borderline category of narcissistic neuroses, describes similar patients:

"Superficially, patients of this type appear to function at a neurotic level, They hold jobs or attend school, enjoy musical or artistic interests, socialize or engage in sexual relations, yet suffer from deficient emotional contact and from a seriously impaired sense of reality. Clinically they complain of varying degrees of boredom, depressions or free anxiety and present abortive paranoid features, transient feelings of reference or depersonalization—often with acute exacerbations—that are dynamically rooted in serious psychopathology."

From the danger of the awareness of their lack of genuine feeling some patients seem to be protected by the spurious validity of experience given to

them by satisfactory identifications within their environment. Such identifications, however, are on the basis of infantile dependence, mature differentiation between the self and the object never having fully been achieved. Deutsch (1942) has described such cases, naming them "as if" personalities and considered that they were related to depersonalization, "differing from it in that they were not perceived as disturbances by the patient herself". In these patients their whole relationship to life had something about it which was lacking in genuineness and yet outwardly ran along as if it were complete.

> "It is like the performance of an actor who is technically well-trained but who lacks the necessary spark to make his impersonation true to life."

Deutsch considered that the loss of affect was not identical with the coldness of the repressed individual whose disturbance was a defence against the realization of forbidden instinctual drives. There was instead

> "a real loss of object cathexis due to a failure to synthesize the various infantile identifications into a single integrated personality. The apparent normal relationship to the world corresponds to a child's imitativeness and is the expression of identification with the environment."

Deutsch states that, whereas the objects with which hysterics identify themselves are the objects of powerful libidinal cathexes,

> "In 'as if' patients an early deficiency in the development of affect reduces the conflict, the effect of which is an impoverishment of the total personality which does not occur in hysteria."

This early disturbance of affect, described by Deutsch, may perhaps be similar to that discussed by Klein (1946) when describing the processes underlying identification by projection as a combination of splitting off parts of the self and projecting them onto another person. This defensive splitting of the infantile ego was considered by Rosenfeld (1947) to be the basis of depersonalization.

However, one cannot ever assume that psychopathological explanations, whether valid or not, are necessarily of prime genetic significance. The early deprivations and other traumata to which patients of this type may have been subjected are often no more severe than those to which others have made a satisfactory or different adjustment. It may be, as Fairbairn (1941) has suggested, that in the determination of the form of mental reactions some part may be played by factors such as the relative strength of the inborn tendencies to sucking and biting. In the presence of a disturbed infant-mother relationship, exaggeration of the former would lead, according to Kleinian theory, to schizoid tendencies and exaggeration of the latter to depressive tendencies. The external factor, in the form of the mother, would thus be non-specific. It may be, in the cases under discussion, that there is some disturbance of the biological substrate resulting in an exaggeration of primitive needs and urges which renders their normal integration more difficult. Or there may be an inherently low capacity for integration itself, or this capacity may be late in maturing.

Whatever the origin, the fact remains that, in the patients under discussion, the individual never appears to have developed an identity clearly enough defined to be able to relate himself fully to experiences coming from within or without. The depersonalization complaints of such patients appear to be related to varying degrees of failure within the ego structure itself. Their complaints of feeling unreal thus have some substance for, in fact, to a greater or lesser extent, they have never established an adequate relationship with reality.

Cases appearing to have this early weakness of ego development have therefore been considered together under the heading of "schizoid disturbance

of identity". Their common characteristic appears to be a lifelong failure to develop a genuine affective relationship with external objects, this impoverishment never being really overcome, though often masked or compensated for by various measures. Of those cases of this type, studied by the author, only one was treated extensively on analytical lines. In this case material emerged which often indicated disturbed oral mechanisms and recalled that described by the Kleinian authors. However, there were many schizophrenic features and one has the impression that all those cases in which this early disturbance of ego formation is alleged are either gross schizoid personalities, or potential, borderline or actual schizophrenics. Explanations of depersonalization symptoms in terms of early disturbance of ego development or in terms of a relationship to schizophrenia may well be valid for this "schizoid" group of patients. However, to extend such explanation to all patients suffering from depersonalization symptoms seems far from justified.

The prognosis for this schizoid group is without doubt bad in the absence of treatment, and treatment, to be successful, needs to be intensive and prolonged. Though symptomatic improvement may be achieved by treatment which does not involve widespread modification of the underlying personality, only a long-term analytical approach can be expected to have any influence on the fundamental ego weakness, and even with this there is little certainty of success.

Hysterical Disturbance of Identity. (See Appendix I—Case 2.)

At a later stage of psychological development disturbed identifications appear to lead to depersonalization symptoms. Wittels (1940) expressed the view that

"the cause of depersonalization is an unusually great number of phantom figures leaving the ego in such a position that it cannot decide which one of the figures has to be acknowledged as its representative."

He considered that in all cases something was wrong with the infantile relation between the patient and the father with the result that

"the super-ego is responsible for the disintegration of personality by condemning all the phantoms without exception as unreal."

Whatever may be the validity of the above theoretical interpretation, cases do seem to occur in which depersonalization symptoms manifest themselves after the loss or devaluation of an important identification object, or alternatively as the result of confusion over multiple identifications. The latter confusion may be due to some environmental factor or occur during the course of psychotherapy which has resulted in increased awareness of the multiple identifications. In these cases the ego disturbance appears to have occurred at a later stage of development compared to the schizoid group previously considered and the objects of identification (commonly the father) are invested with a strong emotional charge. There is no tendency to projective or disintegrative reactions, and the personality usually manifests a number of hysterical features.

Other Hysterical Depersonalization Syndromes. (See Appendix I—Case 3.)

Many analytical writers have considered depersonalization symptoms to serve as a defence against forbidden or unacceptable urges and feelings. Certainly in many cases it does seem that a more or less satisfactory solution to the conflicts and difficulties with which the individual is faced has been achieved by states of depersonalization based upon the mechanism of denial and repression.

It is, however, only too easy to explain away most depersonalization symptoms by regarding them as defences and there is no doubt that this facile approach is too often used. Nevertheless, there are many cases in which the symptoms only appear capable of being satisfactorily understood in terms of hysterical mechanisms, and the cases considered below have been included for a number of what appear to be valid reasons. Firstly, many of the cases presented a striking immaturity of appearance, independently remarked upon by many of the psychiatrists with whom they had come into contact. This immaturity, equalled only by those patients in the two groups previously considered, did not appear to be of such common occurrence in cases of depersonalization arising on a different basis. Secondly, an understandable and apparently adequate relationship appeared to exist between the protective function of the symptoms and the life situation of the patient. Thirdly, in common with many hysterical personalities, a number of these patients were able to formulate the mechanism of their complaints at an intellectual level whilst maintaining such a capacity for emotional dissociation that effective insight was impossible for them to achieve. Some, when questioned as to how they thought their symptoms had arisen, spontaneously described their complaints in terms of escape from difficulties. As far as could be ascertained this was not the result of previous medical suggestion. Fourthly, although affective symptoms occurred in a number of patients in this group, they occurred episodically and were not usually a persistent feature. In fact, what was usually so striking about this group of patients was the ease with which outwardly they often conducted their activities. There was a frequent disproportion between their complaints and the evident enjoyment which they derived from the social life of the hospital, many of them entering with apparent enthusiasm into all the recreations and entertainments provided. Some admitted to being symptom-free in hospital but suffering from unreality feelings when having to make journeys outside the grounds.

The depersonalization complaints of these patients appear to be the consequence of the relative lack of integration of unacceptable feelings and experiences. Denial of the reality of the outside world will enable the individual to detach himself from its dangers. Denial of the reality of the body will effectively banish dangerous needs and urges, and, by denial of the self, they can be disowned. Forbidden or unacceptable feelings can be held at bay by repression of affect, and the resulting emotional dissociation from the outer world may be expressed in depersonalization terms. Furthermore, states of affective unresponsiveness occurring initially on a depressive basis may be perpetuated hysterically long beyond the disappearance of the depressive element and expressed also in depersonalization terms.

Whilst a few cases in this group who have been under the author's care have recovered or improved, the therapeutic results are far from satisfactory. It is not difficult to see why this should be so. The state of depersonalization can be a very effective solution to various conflicts and difficulties. It is true that these patients often complain bitterly of their lot, but their behaviour usually belies their words and the relative absence of manifest anxiety is a measure of the success of the protective mechanism. There is here something in common with the hysterical motor conversion symptom, a condition notoriously intractable when the physician has nothing more attractive to offer the patient in exchange for his symptom. Furthermore, in many states of depersonalization the lack of recognition of the hysterical factor, together with a preoccupation by the unwary with the wealth of introspective description which these cases frequently produce, often contributes much to the intractability of the condition. Hysterical

motor paralyses abounded when their value as interesting demonstration cases was high. Hysterical "emotional paralyses" presenting their complaints in terms of depersonalization often stimulate much psychiatric interest and in some hospitals the condition is recognized to be highly contagious at times when medical interest is running high!

At this stage it may be pointed out that the "pure" depersonalization neurosis of many writers, in which the depersonalization symptoms occur in the absence of any other symptomatology, by definition, can correspond to either the schizoid or hysterical syndromes described above. The distinctions between these two syndromes are enough to demonstrate the lack of value in the concept of "pure" depersonalization neurosis.

Depressive Depersonalization Syndrome. (See Appendix I—Case 4.)

The symptomatology of depressive illnesses may conveniently be considered from two aspects. There is the "positive" symptomatology associated with the unpleasant affect and expressing itself in terms of misery, hopelessness, remorse, guilt, suicidal feelings, etc. There is also the "negative" symptomatology associated with the emotional and physical inertia and expressing itself in terms of lack of feeling, lifelessness, lack of interest, loss of affection for others, feelings of heaviness, easy fatiguability, etc. It is probable that most depressive illnesses contain both these "positive" and "negative" aspects in their symptomatology, but in the majority the former overshadow the latter. Occasionally, patients present with entirely "negative" depressive symptomatology. The milder forms include those cases who, without appearing depressed or admitting to depression, are considered to be suffering from a depressive state. Their complaints are usually those of a "lack of" something—"lack of life", "lack of energy", "lack of feeling", etc. When the condition is more severe the marked change in the affective state consequent upon the lack of capacity for emotional response may be formulated in various ways. Sometimes patients may describe themselves as "flat", "emotionally blocked", "suffering from death of the emotions". Lewis (1934) discussing the relationship of such complaints to feelings of unreality comments:

". . . . it is difficult to decide how much of objective reality there is in the words or how much metaphor."

In more severe depressive states the emotional unresponsiveness, memory impairment, altered time appreciation, biological disturbances, and general state of bewilderment may result in the experience of change being ill-comprehended and expressed in depersonalization terms. That this failure of integration of changed experience occurs in some depressive cases and not in others is probably dependent on factors discussed earlier. When it does occur, the manner of its formulation is no doubt related to the quality of the changed experience, the intelligence and verbal facility, and the psychopathology of the individual. As discussed earlier, with delusional development the unreality feeling tends to recede.

Sometimes, where the depressive affect is not marked, it may be difficult to decide whether the patient really belongs to this depressive group or whether the emotional unresponsiveness is on the basis of hysterical repression of affect. However, the setting of the illness, thought content of a depressive type, consistency of the affective picture, congruity of complaint and behaviour and lack of hysterical personality will all tend to indicate the depressive basis for the condition. The distinction is an important one, for in the depressive cases the depersonalization symptoms will usually clear, along with the other depressive

symptoms, following treatment with E.C.T. In the hysterical cases, treatment with E.C.T. will often clear up some of the depressive symptoms whilst leaving the depersonalization symptoms unchanged or worse.

"*Tension*" *Depersonalization Syndrome.* (See Appendix I—Case 5.)

The presence of a state of marked emotional tension, either arising acutely or chronically sustained, appears to have a direct relationship to the occurrence of depersonalization complaints in some patients. The emotional tension in such cases commonly appears to be the consequence of strong but unexpressed hostile feelings and aggressive urges. These feelings and urges are usually wholly or partially within the awareness of the patient, or if repressed, they nevertheless remain near consciousness. Precipitating environmental factors can usually be demonstrated, but the strength of the aggression aroused seems more related to factors within the individual. Depressive symptoms, affective unresponsiveness and depersonalization complaints are commonly present when the state of emotional tension is chronically sustained and not extremely marked. When the emotional tension occurs acutely or there is a sudden increase in tension already present and a threat of the underlying aggression breaking through, further depersonalization symptoms, often associated with a subjective disturbance of bodily awareness, may occur. It is this subjective disturbance of bodily awareness which is often so striking in this group of patients. There may be disturbance of appreciation of the body image, subjective feelings of unsteadiness and inability to control the limbs, subjective disturbances of sensory appreciation in various parts of the body including the viscera, and perceptual disturbances relating to the outside world.

The basis of this syndrome is not at all clear and it is probable that a variety of disorders may contribute to it.

In those cases where there is repeatedly a recognizable emotional stress immediately preceding the acute onset of affective loss, unreality feelings and disturbed bodily awareness, it is difficult to avoid a teleological approach. Sometimes the symptomatology, and especially the tendency to run an autonomous course beyond the disappearance of the stressful factor, suggest a disturbance occurring at a biological level. But whether one talks in terms of central inhibition, homeostasis or in terms of protective hysterical mechanisms is perhaps determined largely by one's predilection for a physiological or a psychological approach to mental phenomena.

In a number of patients recurrent depressions often associated with affective unresponsiveness commonly occur following periods of mounting aggressive tension. These depressions do not appear to be of the manic-depressive variety. There is usually no family history of manic-depressive illness, but sometimes a history of marked irritability or explosive temper in one of the parents or near relatives. There is usually an obvious precipitating factor and an absence of retardation, ideas of guilt, manic episodes and other features usually associated with the manic-depressive variety of depression. On the other hand, such depressions, once started, often appear to run their course for some time beyond the disappearance of the original stressful factor. It may be that emotional factors initiate some endogenous process which then proceeds autonomously for a while. Some tension depersonalization syndromes seem to be related to such conditions, some of the depersonalization symptoms arising on the basis of the affective unresponsiveness and others being more related to disturbances produced in the motor and autonomic systems by the general increase in tension.

In other cases it is possible that schizoid mechanisms may be involved. The threat of the sudden breaking through of overwhelming destructive tendencies which cannot be dealt with adequately by other psychic mechanisms may lead, in a predisposed individual, to a temporary disintegrative reaction resulting in loss of feeling and breaking up of the "body ego" into part objects.

Some of the above factors appeared to be significant in those cases falling into this group studied by the writer. All the cases in this group, however, had marked obsessional features in their personality and it seems likely that this facet of their personality was contributory to their tendency to sustained emotional tension.

Multiple Depersonalization Syndrome. (See Appendix I—Case 6.)

The depersonalization syndromes described above and the accompanying case histories illustrate relatively "pure" examples of each particular syndrome. In a large number of patients presenting with depersonalization symptoms there, however, appears to be a mixture of more than one syndrome. Thus, for example, depressive and hysterical factors, or acute emotional tension in a loosely integrated schizoid personality may appear to be associated. Some cases may be partly determined or coloured by obsessional rumination or hypochondriacal preoccupation. Indeed, it might be argued that the syndromes described above are really artificial isolates, ad hoc constructions derived by overemphasizing one facet and neglecting another. That this is not so is strongly suggested by the occurrence of what can best be described as "multiple depersonalization syndromes". These are not particularly common but their lack of adequate previous recognition appears to be due to insufficient attention having been paid to the detail of the nature and setting of the particular depersonalization symptoms. They are quite distinct from the mixed syndromes and have the following characteristics. The patient is subject to two or more depersonalization syndromes, distinct from each other in characteristics and time of occurrence. Furthermore, the precipitating factor or underlying dynamics of the attack of each separate syndrome can often be clearly distinguished.

The separate occurrence of more than one depersonalization syndrome in the same patient is a strong argument in favour of the right of each syndrome to be considered separately under the generic heading of depersonalization.

IV. Discussion

Depersonalization is a term loosely applied to various complaints made by patients in respect of certain experiences giving rise to feelings of change in relation to the self, the body, or the outside world. Common to all such feelings of change included under the heading of depersonalization is a feeling of unreality, strangeness or similar complaint indicating the foreignness or relative incomprehensibility of the experience. There are no clear-cut boundaries to such feelings of unreality or strangeness, for they merge at the one extreme with reality-interpreted feelings of change, with delusionally-interpreted feelings of change at the other, and a change towards either extreme will result in a reduction of the feelings of unreality or strangeness of the experience.

It is suggested that it is the relative failure of integration of an experience and not the experience itself which gives rise to the feeling of unreality or strangeness. As such failure of integration may originate from more than one source and as many different experiences may be affected, depersonalization complaints may have many different origins. Depersonalization types of com-

plaint merge imperceptibly into the complaints of patients suffering from certain cerebral diseases, some forms of epilepsy, body image disturbances, toxic states, dreamy states, perplexity states, confusional and delirious states, memory disturbances, depressive unresponsiveness, hysterical dissociation, schizophrenic disintegration and so on. The term depersonalization is thus commonly applied to phenomena often aetiologically dissimilar, but related by a certain similarity of complaint. This similarity is often the result of a number of the factors discussed above, but to these must now be added the very important factor of communication. Many writers have failed to take into account the fundamental limitations of our language as a means of differentiating experiences, often dissimilar in nature, but which may be unique or ill-comprehended and communicable sometimes only in the currency of analogy and metaphor. Similar terms may thus be used to describe a variety of experiences whilst similar experiences may be described in a variety of terms. Intelligence, verbal facility, cultural background, psychopathology and medical contact will all be determining factors in the final selection of the terms actually used.

It is suggested that a number of depersonalization syndromes exist, each with a different basis, and, although superficially often similar, distinguishable by the setting in which the complaints occur. Many intermediate forms exist, having features found in more than one such syndrome, and in fact such syndromes are the result of the convenient isolation of those cases with unmixed causation. Nevertheless, the existence of multiple depersonalization syndromes in which more than one type of syndrome can, in the same patient, occur on different occasions and precipitated by different factors, provides strong grounds for the view that such syndromes are really separate and are not merely artificial isolates. The differentiation of such depersonalization syndromes (as with other syndromes in psychiatry) is of value if it leads to a greater understanding of the dynamics, the treatment and the prognosis of the complaint.

The various syndromes described above, namely, the organic, schizoid, hysterical, depressive, tension and multiple, have been so differentiated because they have appeared to the writer to be the most significant. Although further experience may later lead to modification, cases falling clearly into these groups do appear to be distinct from each other and early recognition can be of much clinical assistance.

In the organic and depressive groups the prognosis and treatment is that of the underlying central nervous system disease and depressive illness respectively. The schizoid and hysterical groups may both present with depersonalization symptoms alone in the absence of any other symptoms and for this reason may appear alike. Their distinction, however, is important, for whereas the former is based on a relatively intractable personality disorder, the latter, although therapeutically far from satisfactory, is more accessible to psychotherapy. The tension group appear to have precipitating environmental factors which are often modification and, in the writer's experience, the prognosis with abreaction or with psychotherapy is usually good. The multiple group is a mixed one and follows no clear pattern. (See Appendix II.)

V. Summary

The conditions necessary for the formulation of a complaint of change in depersonalizaton terms have been examined and it has been concluded that depersonalization types of complaint arise as a result of the relative failure of integration of experience into the total organization of psychic functioning, whilst the latter remains relatively intact. Such failure of integration may affect different experiences and originate from a number of different causes. Depersonal-

ization complaints thus merge with the complaints of many other conditions which involve a change in the relation of the individual to his self, his body or the outer world. They are related often only by a loose similarity of the terms used to describe the feelings of change. Many factors contribute to the terms actually used, not the least amongst which is the fundamental limitation of our language as a means of communicating changes in experience.

It is suggested that depersonalization should be used as a generic term for a number of different syndromes which, although sometimes overlapping, are yet quite distinct.

Case histories illustrating different depersonalization syndromes are presented.

APPENDIX I

Illustrative Case Histories

Case 1. Schizoid disturbance of Identity

Miss E. H. 30.

According to the patient she had always felt apart from people and somewhat separate from events. "I was never quite in things," she said. Severe depersonalization symptoms had however only been present for a year prior to admission and followed the termination of an unfortunate love affair. These symptoms were present without relief and were associated with intermittent free-floating anxiety and depressive spells. She described her feelings as follows:

"The part of me that is there talking is like part of a machine, then it breaks down and I can't cope with others . . . In essence this is a feeling of unreality and sometimes I lie in bed and feel so unreal that I move just to see if I am . . . I seem so unreal to myself, everyone else seems to have ideas and purposes, but I do not—I'm not part of anything and so nothing seems real."

The patient's home background had been an extremely unsettled one. Her father was not married to her mother and her parents separated when she was young. Until the age of 8 she was brought up by a kindly grandmother who had little understanding of her needs. She was visited occasionally by her mother and step-father but was uncertain of her position thinking she was an adopted child. Her own father was known to her as a friend, but around the age of 14 he revealed himself to her as her real father. The subject was taboo in the family and although she tried to discuss it no one helped her. Her mother was a neurotic, self-centred woman, demanding affection from the patient, but giving little in return. The patient was always of a melancholy, retiring nature, found all human contacts extremely difficult, had wide literary and poetic interests and grew up surrounded by the nihilistic ideas of the Ouspensky movement. She was frightened of sexual matters but during adolescence developed a passionate attachment to a female friend of her mother. The latter always rebuffed her and this rejection hurt the patient considerably. She did well at school, though she had few friends. After leaving school, she travelled abroad with her mother and later did various secretarial jobs.

Three years prior to admission she began a sexual affair with a man 25 years older than herself. This man had for some time had a fatherly relationship towards her. At first the affair was a success, though always flavoured with anxiety for her. Gradually the man's sadistic character became apparent and finally, a year ago, after a visit to Paris, the affair came to a catastrophic end. From then on the patient became increasingly depressed, terrified of all social contacts and complained increasingly of depersonalization symptoms.

The patient presented as a highly intelligent cultured girl, depressed in appearance, hopeless in outlook and "terrified of everything". Her depression increased and a short course of E.C.T. brought only temporary benefit. Continuous narcosis for a week, followed by modified insulin, gradually reduced her apprehension, but her hopelessness and depersonalization symptoms remained. For the next 18 months she was given twice weekly psychotherapeutic interviews of an analytically orientated nature. However, little real progress was made for little material was produced and she was unable to approach the transference problem. She remained dependent on her therapist and, except for one or two other "safe" figures in the hospital, was filled with an all-pervading anxiety when having to make contact with others. The only feelings of hostility she would admit to were towards her mother and this was only in relation to the apprehension that the emotional demands of the latter caused. She remained in her room as much as she could, avoided all contacts and tried to occupy herself with reading poetry and foreign literature, though with little success. After a change of therapist it was decided to institute a more directive superficial type of psychotherapy designed to provide more support and reduce anxiety. To this the patient responded with increased activity and some improvement in socialization. Later, while still in hospital she took a clerical job and, on her discharge, 21 months after admission, she had already been working in a secretarial capacity for 3 months. Her depression had considerably lessened, but she was still uncertain of herself and her depersonalization symptoms remained. Over the next 18 months she remained at work, even flying to Italy for a few weeks holiday in the summer. She still, however, felt isolated and unreal, had difficulty in making social contacts and needed the support of the hospital.

Comment

In this patient the unreality feelings appear also to have evolved from a life-long feeling of detachment on the background of a schizoid personality. As a child she lacked her mother and was uncertain as to whom she should accept as her father. Her later contact with her

mother was merely anxiety provoking and further emotional rejection in adolescence increased her insecurity. To the confusion over her father's identity caused by his later revealing himself was added the final trauma when her lover, a later father figure, proceeded to destroy the identity she had built around him. Unable to relate to others and with all her parental identifications removed she became increasingly depersonalized, withdrawn and overwhelmed by primitive anxiety. Only by a forceful approach which provided a safe dominant figure was it possible to reduce anxiety and restore her finally to a limited social activity and adequate working adjustment. Her underlying feelings of isolation and unreality however remained.

Case 2. Hysterical disturbance of Identity

Miss H.G. 22.

Three months prior to admission to hospital the patient had had a sudden attack in which she felt strange, "as if I didn't exist". This feeling remained, increasing in intensity and causing her distress to the extent that she eventually had to give up work. After attending as an outpatient for some time with no improvement in her symptoms it was finally decided to admit her.

The patient's father was a successful business man who had never had much contact with his daughter. The mother was an active woman fully occupied in various social pursuits. There was one sister 5 years older than the patient with whom she had always had a very close relationship. The patient's childhood and early development were uneventful. She was an average scholar, mixed little with other children and after leaving school did a commercial course, finally becoming a shorthand typist. She had been sexually enlightened by her elder sister, was shy of the opposite sex and had high moral standards. She was described as a rather serious-minded girl, conscientious and socially somewhat ill at ease. She depended much on her elder sister for making decisions and her interests and activities appeared to follow those of her sister.

On admission she presented as a shy but good-looking girl who appeared younger than her years. She did not appear particularly depressed, but had an anxious, rather bewildered manner. Describing her symptoms she said:

"Things just seem to go on, as though they are not happening to me. In fact I don't seem to be here at all. I seem different, as though something has gone. I feel changed, lacking something I used to have, as though I had no personality and was only existing."

During psychotherapy it emerged that her elder sister was for her an ideal figure on whom she had always modelled herself. Her sister was a more active and socially successful individual than she and it was apparent that the patient had derived vicarious satisfaction from the sister's successes and achievement. One day she had learnt to her astonishment and horror that her sister was going to have an illegitimate child. This was so out of keeping with her conception of her sister that she found it impossible to reconcile the new situation with her old attitudes. "It was as though my sister had gone and someone strange had come in her place," she said "and I seemed to have disappeared with my sister." And in fact it transpired that her depersonalization symptoms had first made their appearance shortly after she had heard of her sister's pregnancy.

Further discussion of her past attitudes, her dependency on and identification with her sister resulted in her becoming more relaxed and able to engage more freely in the hospital social activities. Her depersonalization symptoms gradually receded and on discharge from hospital 4 months after admission she was symptom-free.

Comment

It appeared likely that it was the remoteness of both parents that had resulted in the patient's overdependence on her elder sister. She had used the latter successfully as her model until the occurrence of the illegitimate pregnancy. The devaluation of her identification object then appeared to disintegrate her own identity with the resulting emergence of depersonalization symptoms.

Case 3. Hysterical depersonalization syndrome

Miss Z.I. 24.

In March, 1948, the patient went to stay at her fiancé's home. They had become engaged some months previously, but the patient was never satisfied that she was really in love and had made a number of half-hearted attempts to break it off. She was however persuaded by her fiancé to spend the night in bed with him although by mutual agreement, sexual intercourse did not take place. In the morning her fiancé's mother had come into the bedroom and found them together. The mother created a scene and the patient was very upset. In order to allay her distress and help her to forget the incident her fiancé offered to hypnotize her (he had had some amateur experience in this field) and the patient willingly agreed. The first two attempts were not fully successful but during the third attempt the patient made a remark about wanting to kill her fiancé, and the latter then attempted to bring her round. However, the patient complained that she could no longer see things clearly. "Things seemed unreal, as though there was something shutting me off from reality, as though I could not look at a thing and grasp it or see it as a whole." She complained that her body felt light as though she was walking on air, she had difficulty in grasping things, she felt dead inside and, when her fiancé kissed her, she felt nothing. Further attempts to rouse her were unsuccessful and her symptoms

continued unchanged. She was finally admitted to hospital 5 months after the onset of her symptoms.

The patient's father was an anxious, somewhat morose schoolmaster who had always been a somewhat distant figure. She was more attached to her mother, a restless, over-active woman who ran a prep. school. There was a sister five years the patient's senior and with whom she did not have very close contact. The home had not been a very happy one, being frequently disturbed by parental quarrels and having scholastic standards which the patient felt were always too high for her. As a child she was shy and rather retiring. She did well at school, took Higher Certificate and then went to University to start training as a medical student. She found difficulty with the preclinical subjects, became discouraged, gave up almost immediately and quickly changed to English studies. After two years she took an Arts degree and was very disappointed at only obtaining 3rd class honours, Subsequently in 1945 she joined the A.T.S., became a Sgt. librarian and was demobbed in 1947. She worked for a short times as an assistant nurse in a nearby private mental home and shortly after the onset of her present illness she began a course of secretarial training, but soon had to abandon this. Sexually she had never been well informed, had always been fearful of the subject and her fiancé was the first member of the opposite sex with whom she had ever had any close contact. She had always regarded herself as unattractive, felt inferior in relation to others, and was timid and oversensitive in public. She had few social outlets, was interested in literature of an introspective type and was given to private day-dreaming. In outlook she was somewhat anxious and pessimistic and tended to mild depressions under difficulties.

On admission, she presented as a shy, anxious and mildly depressed girl of immature appearance. At interview she was reticent and hestitant, but if required would write pages of introspective description of her past history and present feelings. Her talk largely centred around her recent experiences and her symptoms. Her complaints centred on her emotional unresponsiveness, the feeling of unreality of the outside world and the dulling of visual, auditory, tactile and visceral impressions. She felt that her illness was protective and expressed herself as follows:

"Before the hypnosis I was feeling very unhappy. Afterwards it was as though the unhappiness I had been feeling had been shelved, as though I was protected from it. I think I felt dead inside. I seemed to do things automatically—I didn't have to do anything about it. I lost the power to feel pain but also to feel happiness. I am in a mid-state all the time. Underneath I know the unhappiness is still there. I believe that the sort of unhappiness I escaped from is mainly guilt, but I also know that Reg got on my nerves." She stated that in hospital things seemed more real but her symptoms increased as soon as she went outside. "In my bad moments here I would prefer the former unhappiness—in my good moments I'd prefer this. On the whole I'd prefer the former unhappiness as this is ruining my health and looks . . For about two days after my hypnotism I think I used it at a conscious level. I felt it was a good thing. I felt unhappy no longer. I think I let myself go and now I can't get back."

Despite her measure of "insight", repeated psychotherapeutic approaches involving elaboration of childhood and present phantasies, the patient continued to intellectualize her difficulties and her depersonalization symptoms remained unaltered. On the ward and in the various hospital social activities she however manifested little anxiety and appeared fairly cheerful. On discharge, 6 months later, the picture was unchanged and she left to take a post at a library. She later started an analysis but became too disturbed to continue, finally returning home. Later she started treatment again with another analyst and 3 years after discharge from hospital she reported that she was still continuing with this analysis but her former symptoms were still present.

Comment

In this patient the protective nature of her symptoms is clearly formulated by her. Her relative freedom from anxiety and distress in hospital indicated the success with which she had managed to dissociate the feelings associated with an unacceptable memory and contrasted with her prolific written accounts of her sufferings. It was this intellectualization of her problems that made it so impossible to obtain from her any free emotional expression and despite numerous attempts by various therapists she retained this defence intact.

Case 4. Depressive depersonalization syndrome

Mrs. N.P. 42.

During the 18 months prior to admission the patient had been becoming increasingly depressed. She was worried over her work and her marriage was unsatisfactory. She began to feel "automatic". Everything seemed "detached and apart" and her brain seemed to be "bursting up". Two weeks before admission she had made an unsuccessful suicide attempt by walking on railway lines. Following this the "depression seemed to go but I felt empty and dead inside". Superficially she was able to make a social effort and appeared brighter, "but my brain seemed scooped out and it seemed that everything was going from me—all ideas and everything else."

The patient's father was unknown and her mother, a flighty children's nurse, died suddenly when the patient was 2. Her foster parents were strict and domineering and she regarded her childhood as an unhappy one. As a child she was jealous of her foster brother, had frequent temper tantrums and a number of anxiety symptoms. She was an average scholar, but made few friends at school. Later she did a number of clerical jobs, followed by various domestic

posts, and for the last 6½ years had been a shop assistant. From the age of 15 onwards she had had many boy friends. After the age of 24 she became sexually promiscuous. She married at the age of 29 but the marriage was an unhappy one. The husband was an unstable labourer given to sexual exhibitionism. The patient was always frigid with him and there were frequent quarrels between them. The patient had always been a shy, self-conscious, unsociable individual, oversensitive to criticism. She was easily prone to worry and subject to mood swings. When well she was energetic, "athletic" and a keen reader. She had been an in-patient at the age of 20 at the Maudsley Hospital following a suicidal attempt preceded by a 10 months depression. She was discharged "relieved" after 7 months. She never made a full recovery and 2 years later was readmitted with a recurrence of suicidal feelings. She was discharged after 7 months with a diagnosis of "recurrent depression in a psychopathic personality". Her symptoms during both these admissions were essentially similar to those in the present admission.

The patient presented as a rather untidy looking woman with a somewhat expressionless face. She was tense, was somewhat aggressive in manner, answered questions slowly and appeared a little bewildered. She discussed her suicidal thoughts and ideas of hopelessness with no change of expression and little show of feeling, She was preoccupied with her feelings of change, especially with feelings related to her head and she described these repeatedly in vivid terms:

"Things look the same and my body is all right, it is the brain that is the trouble. I'm conscious of myself but I'm a vacuum. When I went out recently I felt like a bag of skins with a vacuum inside . . . There's a jammed up feeling in my head—it feels split in two as if my brain was peeling off. Nothing comes into my head. There's an emptiness there . . . I don't seem to think unless anyone says anything to me . . . I don't respond to anything, everything seems to have gone, it started going some time ago. Now I've no feelings for anyone. Nothing would affect me. I can't get disturbed or upset over things though I worry and can't see any future. Things just go on and I'm not a part of them. I know things have happened, but I can't picture things vividly or recall them properly."

Her condition continued unchanged for some weeks and a course of E.C.T. was begun. She was given a total of 9 treatments and made a complete recovery. On discharge 14 weeks after admission she was cheerful and symptom-free.

Three years later the patient attended the out-patient department again. She had recently become depressed, was feeling suicidal and had had a return of the feeling of "things breaking up inside my head". She was admitted to a mental hospital as a voluntary patient.

Comment

The central feature in this woman's complaints appeared to be her depression and widespread loss of affective responsiveness. This she referred to her head ("a jammed up feeling"), her brain ("as if my brain was peeling off") and elaborated it in various other "as if" terms.

Case 5. Tension depersonalization syndrome

Mr. E.U. 26.

The patient first experienced attacks of feeling "strange" 5 years before admission. He was at that time a Captain in charge of a Commando Unit in North Africa, and during a talk to his Unit he suddenly felt as though he was talking like an automaton. The attack lasted a few minutes, but took a few hours to disappear completely. He recalled that he was feeling tense and angry at the time as a result of recent disputes amongst his fellow officers. Subsequently he experienced two or three attacks a week, lasting a few hours, often sudden in onset, and always preceded by a period of mounting emotional tension. Initially, he only suffered a feeling of lifelessness and automatic-like activity, but later disturbances of bodily experience appeared. He put his symptoms down to the stress of military life, but after leaving the Services and beginning a university course his symptoms further increased in duration and severity. He had increasing difficulties with his studies, became progressively more depressed and was finally admitted to hospital.

The patient's father was a successful barrister, a driving and rather rigid individual, fond of his children but demanding very high standards from them. The mother was overanxious, rather possessive and emotionally over-demanding from her children. There were two older brothers, both of whom were intellectually brighter than the patient. The home was a comfortable and superficially fairly happy one. Both parents suffered from severe migraine. The patient's birth was a forceps one on account of protracted labour. His subsequent childhood development was uneventful and he was a cheerful, active boy until the age of 10. At that time he had an obscure febrile illness following which he became less active, more solitary and rather over-sensitive. His school career was not up to the family standards, and he failed to matriculate. He was undergoing private coaching at the outbreak of the war and he broke this off to join the army. He was described as an over-conscientious and rather oversensitive individual, even-tempered, rather solitary, idealistic in outlook and serious in his interests. He liked the company of the opposite sex, but was shy of making any approaches.

The patient was a tall, rather awkward individual, ill at ease initially but gradually able to relax. He appeared moderately depressed but his depression cleared in the first week after admission to hospital. His attacks of depersonalization continued however. They varied in severity but a fully developed attack had the following characteristics:

There was marked loss of affective response for external events accompanied by a feeling

of increased irritability and a tendency to rumination. Things looked dull, flat and lifeless. He claimed that his experience of bladder and rectal fullness seemed diminished and other sensations such as taste, tickle and pain were reduced. There was usually a singing sensation in his head. His hands and feet felt detached, as though they did not belong to him and sometimes seemed to disappear altogether. He felt clumsy in his movements and unsteady at times. His mouth seemed like "an empty cavern" and when he chewed it sometimes felt as though he was biting powdered glass. Of himself he said, "I seem to have no personality, as if I had no background, no future and no ties at all with anyone or anything. I feel non-existent as a personality—like a vacuum."

During psychotherapy it emerged that his illness at the age of 10 had resulted in an overdependence on his mother and a need to control his usual active and somewhat aggressive tendencies. His scholastic failure and fear of rejection had further resulted in a need to control any aggressive manifestations. His underlying aggression was, however, brought to the surface during his army career by frequent disputes with his fellow officers. These disputes usually centred around his excessive zeal and his tendency to take unnecessary risks. The connection between the onset of his attacks and preceding feelings of hostility was very apparent and the patient was soon able to relate his present attacks to stresses in the immediate environment. During psychotherapy his disturbed parental attitudes, sexual conflicts and perfectionist trends were worked through. His depersonalization attacks which had been occurring weekly and lasting a few days, gradually became less severe and less frequent. On discharge four months after admission his attacks were infrequent and fleeting.

A follow-up enquiry a year after discharge revealed him to have remained well and to be continuing with his studies.

Comment

This patient's attacks of affective unresponsiveness and disturbance of bodily experience proved to be related to preceding periods of emotional tension with underlying feelings of hostility. Resolution of his emotional conflicts led to a reduction and later a cessation of his attacks.

The suddenness of onset and severity of the subjective symptoms were suggestive of a disturbance partly at a physiological level. The forceps delivery may have caused a birth injury, the obscure febrile illness at 10 may have been an encephalitis. On the other hand, vasomotor factors might have been important. Both parents suffered from severe migraine and although the patient himself was not a migraine sufferer he commented that under stress he frequently blanched for a long time. However, this must remain speculative.

Case 6. Multiple depersonalization syndrome

Mr. M.Q. 30.

In the August of 1945, about one month after his second child had been born, the patient began to have feelings of tension and anxiety and a sensation of choking. Anxiety attacks continued daily until early in 1946 when attacks of unreality began and partially took their place. These attacks always occurred when going out but other attacks of unreality also occurred at other times which at first appeared inexplicable. The patient became increasingly fearful of going out alone for fear that he might suddenly collapse and die and by the time he attended the out-patient department of the Maudsley Hospital in November, 1946 he was unable to go out more than a hundred yards or so on his own.

The patient's childhood had been an unhappy one. His father used to drink regularly at week-ends and often stayed away from home or threatened to leave. There were frequent financial crises and quarrels between the parents. The patient was nevertheless very attached to his father, though later he developed an increasing sympathy for his mother. There were two younger sisters and a younger brother, all of whom were of an anxious disposition. During childhood the patient had manifested much jealousy towards his younger brother.

As a child he was anxious, lacked confidence in public and stammered easily. He did well at school but was timid with other boys. After leaving school he worked as a toolmaker's assistant and then later became a clerk in a firm of accountants. He did well in this firm and steadily improved his position. Sexually he had been ill-informed, masturbated with guilt and was shy of the opposite sex. He married at 21 a girl of his own age. Sexual adjustment took some time to achieve and was never fully complete, as his wife was variably frigid. The marriage was a fairly happy one, though temperamentally the pair were not very suited. There were 2 children. The patient was described as a shy, overconscientious individual, easily worried under stress. He easily reacted to frustration with anger though he had difficulty in expressing these feelings, suffering often as a result from mounting tension and intermittent moods of depression. He suffered from periodic headaches and was subject to Raynaud's syndrome at times

The patient presented as a tense asthenic individual anxious in appearance and tending to stammer badly. He appeared intelligent, was anxious for help and described his various symptoms freely. Close enquiry revealed that his unreality feelings appeared to be of three different varieties.

Attacks of derealization type would occur when he was alone outside and feeling anxious, particularly when far from home. These he described as follows:

"I feel isolated from the world, as though it is not interested in me at all. Nothing seems

to make an impression on my brain. It is as though I was looking through the world through frosted glass. Voices sound different and distant."

Attacks of a different nature would also occur either after a sudden shock or after having to bottle up considerable anger. These would always begin with a gradual blocking up of his nasal passages making it difficult for him to breathe through his nose and giving rise to a feeling of fullness in his head. Then would follow various feelings of bodily change which he described as follows:

"My hands do not seem to be mine, sometimes I have pins and needles in them. My eyes feel as if they were full up with sand and feel as if they were trying to diverge. The top part of my head often seems to disappear. I often have a feeling of swaying to and fro or of spinning round very slowly in a clockwise direction. I feel as if I have been drugged, my face often becomes hot and flushed and I stammer very badly."

Often at night just before retiring to bed, particularly after a tiring day he would have feelings of complete bodily absence described as follows:

"I feel as though I am not here at all, my mind appears to be here, but the rest of me seems to have gone. I have to touch things to make sure I am still here."

During the course of psychotherapy as an out-patient the following facts emerged. Prior to the birth of his last child in July, 1945 he had been worrying about his wife's health and what would happen to his family if he was killed in the bombing. Around that time his family moved into a larger house and his wife had increasing difficulty in dealing with the children and new household. He himself became increasingly irritable but realizing his wife's difficulties tended more and more to bottle up his feelings and contained his aggressive urges. His wife became more frigid and he began to be increasingly aware that for a long time he had been indulging in an extensive life of sexual phantasy. He felt very guilty about this but owing to his lack of sexual outlet it gained an increasing hold upon him. His anxieties in this respect were further added to by the fact that on a number of occasions when out he had been solicited by women. He began to fear that he might yield to sexual temptation, made further attempts to give up his sexual phantasies, but was unsuccessful.

With increasing understanding of the nature of his difficulties and reduction in his feelings of guilt, he was able to venture from home with lessening anxiety and reduction in the frequency of his derealization attacks. During psychotherapy he was able to discharge much aggressive feeling and his attacks of bodily unreality became less severe. No attempt was made to deal with deeper material or effect a widespread personality change but over the next 3 years or so he was seen in a supportive relationship at increasing intervals. During this period, though subject from time to time to anxiety symptoms, he gradually gained more confidence and lost all his depersonalization symptoms. He started studying for his accountancy exams and 5 years after being first seen he had passed his final exams, was a fully qualified accountant and about to become a partner in his firm.

Comment

In this case there were three different depersonalization syndromes, distinct in their phenomena and precipitation. One was of a derealization type and appeared to serve as a defence against sexual anxiety and gradually disappeared as the latter was resolved. Another was associated with feelings of bodily unreality and changed function, was related to the inhibition of strong emotion and disappeared when free expression of aggressive feelings was encouraged. It corresponded to what has been described above as the acute tension depersonalization syndrome. A third type was associated with a state of relaxation corresponding to what is quite a common phenomenon in normal people.

APPENDIX II

Analysis of 54 Psychiatric Patients Manifesting Depersonalization Symptoms, seen Consecutively

Syndrome	Total	Recovered	Improved	Unimproved
*Schizoid disturbance of identity ..	5	0	0	5 (100%)
Hysterical disturbance of identity ..	4	3 (75%)	0	1 (25%)
Other hysterical depersonalization syndromes	10	2 (20%)	3 (30%)	5 (50%)
Depressive depersonalization syndrome	8	6 (75%)	1 (12·5%)	1 (12·5%)
Tension depersonalization syndrome ..	5	5 (100%)	0	0
Multiple depersonalization syndrome	4	2 (50%)	1 (25%)	1 (25%)
Mixed depersonalization syndrome ..	18	5 (27·7%)	6 (33·3%)	7 (39%)

* Does not include cases manifesting depersonalization symptoms and later progressing to a frank schizophrenic illness.

BIBLIOGRAPHY

ACKNER, B., *J. Ment. Sci.*, 1954, **100**, 838.
BROCK, S., and WIESEL, N., *Dis. Nerv. System*, 1942, **3**, 139.
BYCHOWSKI, G., *J. Nerv. Ment. Dis.*, 1943, **97**, 310.

DEUTSCH, H., *Psychoanal. Quart.*, 1942, **11,** 301.
EISENSTEIN, V. W., *Psychiat. Quart.*, 1951, **25,** 379.
FAIRBAIRN, W. R. D., *Int. J. Psychoanal.*, 1941, **22,** 250.
GLAUBER, I. P., *Psychoanal. Quart.*, 1949, **18,** 67.
GUTTMANN, E., and MACLAY, W. S., *J. Neurol. Psychopathol.*, 1936, **16,** 193.
KLEIN, M., *Int. J. Psychoanal.*, 1946, **27,** 99.
LEWIS, A. J., *J. Ment. Sci.*, 1934, **80,** 277.
MAYER-GROSS, W., *Brit. J. Med. Psychol.*, 1935, **15,** 103.
PENFIELD, W., and RASMUSSEN, T., *The Cerebral Cortex of Man*, 1950. New York.
ROSENFELD, H., *Int. J. Psychoanal.*, 1947, **28,** 130.
SCHILDER, P., "The Image and Appearance of the Human Body", *Psyche Monog.*, 1935, No. 4, p. 139. London.
WITTELS, F., *Psychoanal. Rev.*, 1940, **27,** 57.