

Introduction

Depersonalization is a fascinating and intriguing phenomenon which becomes, for those who experience it, a significant source of distress and alienation, and poses a direct challenge to long-held, unquestioned assumptions regarding their existence and identity. Indeed, the person affected with depersonalization ‘complains spontaneously that his or her mental activity, body and surroundings are changed in their quality, so as to be unreal, remote or automatized. Among the varied phenomena of the syndrome, patients complain most frequently of loss of emotions and feelings of estrangement or detachment from their thinking, their body or the real world. In spite of the dramatic nature of the experience, the patient is aware of the unreality of the change. The sensorium is normal and the capacity for emotional expression intact’ (World Health Organization, 1992).

Since the condition was first described (half a century before it was named), during the first half of the nineteenth century, depersonalization has been found to be commonplace in psychiatric patients. For example, Schilder (1935), who wrote extensively on depersonalization believed it to be present, at some stage, in ‘almost every neurosis’. A similar view led a panel of clinicians to conclude that, after anxiety and depression, depersonalization was the most frequent symptom seen in psychiatry (Stewart, 1964), while others emphasized its frequent occurrence in association with neurological conditions (Brock and Wiesel, 1942). Such ubiquitous nature led early writers to believe that depersonalization must be related to functions relevant to the understanding of both normal and abnormal mentation: “the syndrome is related to so many urgent questions of medical and normal psychology that it is worth studying in a large number of patients” (Mayer-Gross, 1935). Coinciding with the rise of interest in the study of altered mental states of consciousness during the 1960s and 1970s, there was a significant increase in the number of publications dealing with theoretical, philosophical as well as empirical research on depersonalization. It became well established for example, that fleeting experiences of depersonalization were commonplace among teenagers, as well as in people facing life-threatening situations. In turn, empirical studies on large samples of patients

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confirmed the view that depersonalization was indeed highly prevalent among psychiatric in-patients, as well as in patients with depression, anxiety disorders and schizophrenia (Brauer *et al.*, 1970; Hunter *et al.*, 2004). However, unlike the case with equally ubiquitous symptoms such as anxiety and depressed mood, the high prevalence of depersonalization was taken to mean that it was so non-specific as to lack any clinical relevance. A profusion of literature emphasizing depersonalization in its non-specific guise, seems to have had the effect of eclipsing clinical observations, which suggested that, just as it was the case with depression or anxiety, depersonalization did become, in some cases, a chronic, distressing and incapacitating condition in its own right (Shorvon, 1946). Roth (1959, p. 587) criticized this neglecting bias with unusual clarity:

It is traditional to begin papers such as this dealing with depersonalization by paying tribute to the ubiquity and versatility of the phenomenon citing in illustration the experiences of Wordsworth, Amiel and Charles Morgan and continuing with depersonalization occurring in schizophrenia, affective disorder, obsessional states, temporal lobe epilepsy, head injury, encephalitis, carbon monoxide poisoning, hashish intoxication, and botulism....such a list is somewhat misleading ... as it appears to confer an equal status to the very rare and the common place. And a similar one could be compiled for the majority of entities known to psychiatry.

The existence of severe, chronic clinical presentations of depersonalization had been clearly described since the early nineteenth century, but became particularly well established in 1946 with the publication of an impressive series of 66 patients suffering with a distinct form of chronic depersonalization that could not be attributed to any other mental pathology (Shorvon, 1946). Two decades later similar cases were again well documented by Roth (1959), who in addition to the chronic nature of depersonalization, drew attention to the concomitant severe distress and anxiety experienced by those affected. Unfortunately, such observations suggesting a chronic and disabling form of depersonalization have traditionally been met with disbelief within mainstream psychiatry. A comment found in a fairly recent publication illustrates well this commonly held view: 'Despite a lack of convincing empirical justification, the DSM-IV and the ICD-10 contain depersonalization as a separate disorder' (Parnas and Handest, 2003).

In the last decade, however, there has been a renewed interest in the study of chronic, pathological forms of depersonalization not explainable by any other mental illness. Two large independent series of cases on both sides of the Atlantic have been systematically assessed and found to converge on clinical features, demographics and course of illness (Simeon *et al.*, 2003; Baker *et al.*, 2003). It is now known that this form of depersonalization (referred to as Depersonalization Disorder by the DSM-IV, or as Depersonalization–Derealization syndrome by the ICD-10) typically begins during mid to late teens, and tends to run a continuous, unremitting course for years and even

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decades (Simeon, 2004). Unfortunately, the condition has been shown refractory to most conventional medications used in psychiatry, and at the time of writing there is no officially recognized treatment (Sierra, 2008). The quality and strength of the data published by three independent clinical research centres are such that the existence of a primary form of chronic depersonalization can be safely established as a clinical fact. This is indeed reflected on current official classifications, although the prevailing view is that the condition is exceptionally rare. Such a view is, for example, still enshrined in the ICD-10 definition of 'depersonalization–derealization syndrome', which qualifies it as being 'very rare'. How does this view square with current epidemiological data? A few studies in the general population have now been carried out which suggest that the prevalence of chronic, pathological depersonalization lies around 1% (Hunter *et al.*, 2004; Johnson *et al.*, 2006; Michal *et al.*, 2009). In other words, such findings would seem to suggest that depersonalization disorder is as prevalent as other well-known mainstream psychiatric conditions such as schizophrenia or manic-depressive illness. If that is the case, however, how is it that most clinicians believe it to be so rare? There may be several reasons for this: most psychiatrists are still trained to believe that depersonalization disorder is extremely rare or non-existent, and that, when present, it is usually a secondary, almost irrelevant symptom of another condition such as depression. Not surprisingly, this leads to a high rate of misdiagnosis. In fact, it is known that, from the moment patients make initial contact with a mental health service, it usually takes up to 12 years until the right diagnosis is made (Hunter *et al.*, 2003). Underdiagnosis may also stem from the fact that patients are often reluctant to divulge their symptoms out of fears of being thought mad by others or due to difficulties in describing such an ineffable experience (Simeon, 2004). In this regard, failure to ask screening questions during assessment interviews is also a known element contributing to non-detection (Edwards and Angus, 1972).

The above scenario would not be unknown in the recent history of psychiatry. For example, up until the early 1980s, the prevailing view was that obsessive compulsive disorder (OCD) was an extremely rare condition, with a prevalence not higher than 0.05% in the general population. However, the Epidemiology Catchment Area survey, and subsequent epidemiological studies across the world showed the prevalence to be 50 to 100 times more common than previously thought, being in fact 'twice as common as schizophrenia or panic disorder' (Rasmussen and Eisen, 1990; Weissman *et al.*, 1994).

The last decade has seen an unprecedented resurgence in research on depersonalization. It is indeed no exaggeration to say that, as a result of the establishment of specialised clinics and research programmes both in the US and in Europe, more has been learned about the condition in the last 10 years than in the previous 100 years. The availability of large samples of patients meeting strict criteria for depersonalization disorder has afforded a unique

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opportunity to carry out systematic research on the phenomenology, and clinical features of the condition. In fact, systematic descriptions of large series of patients with depersonalization disorder have shown striking clinical overlaps in regards to the different symptom domains that characterize the condition (Sierra *et al.*, 2005; Simeon *et al.*, 2008). A similar convergence has also been found between modern and historical cases, suggesting a degree of clinical homogeneity seldom encountered in clinical psychiatry. It is now clear that, rather than being restricted to the experience of ‘unreality feelings’, depersonalization is a complex phenomenon characterized by several symptom domains of which ‘derealization’ is only one (Sierra *et al.*, 2005; Simeon *et al.*, 2008). On a clinical level, it is also becoming clear that, in addition to its chronic, incapacitating variety (i.e. depersonalization disorder), the presence of depersonalization in patients with other primary diagnoses may have clinical and prognostic implications. It has been shown, for example, that its presence in patients with panic disorder or depression constitutes a marker of severity, and its presence in depression seems associated with poorer response to treatment (Mula *et al.*, 2007).

The emerging view places depersonalization along a spectrum of severity, which goes from the fleeting and seemingly benign depersonalization experiences of youth, moving on to depersonalization as a comorbid manifestation of other psychiatric conditions, and finally to severe, disabling cases of constant depersonalization which cannot be accounted for by any other psychiatric condition. Interestingly, patients often show a dynamic longitudinal progression of severity along the continuum. Thus, it is not rare to find patients who having experienced fleeting depersonalization experiences in their childhood and early teens, go on to develop severe depersonalization in the context of depression or an anxiety disorder, which after responding to treatment, leave depersonalization as a sole, unchallenged condition for years (Baker *et al.*, 2003). This dimensional view of depersonalization brings coherence to what used to be a set of scattered, seemingly unrelated observations. For example, it has now been shown that experiences of emotional abuse in childhood predispose to the occurrence of depersonalization in both its pathological and non-clinical forms (Simeon *et al.*, 2001; Michal *et al.*, 2007).

Recent research using psychophysiological as well as functional neuroimaging approaches are revealing distinct abnormalities, which supports the idea that the condition is firmly grounded on neurobiological mechanisms (Phillips and Sierra, 2003). The significance of such objective findings is particularly relevant for a condition like depersonalization, the clinical manifestations of which are entirely subjective, and mostly confined to the experiential domain of self-awareness.

The main purpose for writing this book has been to pull together all the different research threads of the last decade, and to relate them to the larger canvas of more than 100 years of research and thinking into this enigmatic condition.

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A history of depersonalization

Introduction

The term and concept depersonalization appeared during the late nineteenth century to name a cluster of apparently related experiences usually described as ineffable feelings of disembodiment, loss of feelings and a sense of unreality regarding the self and surroundings. During the early part of the twentieth century, the term derealization was introduced to refer to the latter aspect of depersonalization but it has since been reified into another concept. Depersonalization is currently defined in DSM-IV as: “an alteration in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of”, one’s “mental processes or body (e.g. feeling like one is in a dream)” and derealization as “an alteration in the perception or experience of the external world so that it seems strange or unreal (e.g. people may seem unfamiliar or mechanical)” (American Psychiatric Association, 1994).

This chapter will trace the history of depersonalization as it gradually evolved from early scattered descriptions, their subsequent convergence under the new term ‘depersonalization’ at the end of the nineteenth century, and the ensuing attempts to understand and relate the condition to the landscape of ‘mental faculties’ known at the time. A historical understanding of how depersonalization came to be construed would in itself constitute a good introduction to the condition, as all its nuances are still as relevant today as they were a century ago (Sierra and Berrios, 1997).

Early historical descriptions

Early descriptions of experiences redolent of ‘depersonalization’ can be found in the medical literature since the early nineteenth century. For example, as early as 1845, Griesinger quoted a letter written by a patient to Esquirol, the prominent French psychiatrist:

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I continue to suffer constantly; I don't have a moment of comfort, nor experience human sensations. Even though I am surrounded by all that can render life happy and agreeable, in me the faculty of enjoyment and sensation is wanting or have become physical impossibilities. In everything, even in the most tender caresses of my children, I find only bitterness, I cover them with kisses, but there is something between their lips and mine; and this horrid something is between me and the enjoyments of life. My existence is incomplete. The functions and acts of ordinary life, it is true, still remain to me; but in every one of them there is something lacking. That is, the sensation which is proper to them ... Each of my senses, each part of my proper self is as if it were separated from me and can no longer afford me any sensation. This impossibility seems to depend upon a void which I feel in the front of my head and to be due to a diminished sensibility over my whole body, for it seems to me that I never actually reach the objects that I touch. I no longer experience the internal feeling of the air when I breath ... My eyes see and my spirit perceives, but the sensation of what I see is completely absent (Griesinger, 1845, p. 157).

Griesinger seemed well acquainted with such descriptions as he had commented earlier:

We sometimes hear the insane, especially melancholics, complain of a quite different kind of anaesthesia ... I see, I hear, I feel, they say but the object does not reach me; I cannot receive the sensation; It seems to me as if there was a wall between me and the external world' (my italics) p. 67.

However, rather than just being an accompanying symptom of depression, Griesinger seemed aware that at times such symptoms seemed to lead an independent course: *'This very remarkable state, which the patients themselves have much difficulty in describing, and which we also have ourselves observed in several cases as the predominant and most lasting symptom ...'* (Griesinger, 1845; my italics p. 157).

In a similar way, Zeller (1838) reported five patients, all of whom *"complained almost in the same terms of a lack of sensations ... to them it was a total lack of feelings, as if they were dead ... they claimed they could think clearly, and properly about everything, but the essential was lacking even in their thoughts ... A criminal is better off in that he dreads the scaffold. At least he can experience fear of death and they might envy him for that"* (my italics), pp. 524–525.

At around the same period, in France, Esquirol (1838) described similar experiences in patients: *"An abyss, they say, separates them from the external world, I hear, I see, I touch, say many lypemaniacs, but I am not as I formerly was. Objects do not come to me, they do not identify themselves with my being; a thick cloud, a veil changes the hue and aspect of objects"* (p. 414). Another great French psychiatrist, Billod (1847) described a patient who complained of similar experiences: *"she claimed to feel as if she were not dead or alive, as if living in a continuous dream ... objects [in her environment] looked as if surrounded by a cloud; people seemed to move like shadows, and words seemed to come from a far away world"* (p. 187).

The first systematic account of such experiences was provided by Maurice Krishaber (1873), a Hungarian ENT specialist working in France who, under the category ‘Névropathie Cérébro-Cardiaque’ reported 38 patients showing a mixture of anxiety, fatigue and depressive mood. Krishaber noted that over one-third of these patients complained of a baffling and distressing mental experience, characterized by the loss of a feeling of reality. He went on to suggest that these phenomena resulted from sensory dysfunction (see below).

The construction of depersonalization

It was the psychologist Ludovic Dugas who first introduced the word depersonalization into the psychiatric literature. Dugas (1894) first came across ‘depersonalization’ whilst exploring the psychopathology of déjà-vu and related experiences, which at the time were designated by the generic name of ‘false memories’. Thus, Dugas wrote: “In 1894, when dealing with false memories, I had not yet knowledge of depersonalization. Not realising its novelty, I missed [the phenomenon] when I first met it” (1898a) p. 424. Soon enough, however, Dugas published a series of papers on the subject (1898b, 1912, 1915, 1936) and wrote a monograph entitled *La Dépersonnalisation*, which he co-authored with the French neurologist Maurice Moutier (Dugas and Moutier, 1911).

Dugas defined depersonalization as “A state in which there is the feeling or sensation that thoughts and acts elude the self (*le moi sent ses pensées et ses actes lui échapper*) and become strange (*lui devenir étranger*); there is an alienation of personality (during the nineteenth century the term personality referred mainly to the subjective experience of self); in other words a depersonalization” (Dugas and Moutier, 1911, p. 13). In fact, he thought of the condition as resulting from a dysfunction of a putative mental faculty, which Dugas termed ‘personalization’, whose function was to ‘personalize’ mental events: “Personalization is the act of psychical synthesis, of appropriation or attribution of states to the self” (Dugas and Moutier, 1911).

Dugas acknowledged that he had taken the term depersonalization from an intriguing paragraph found in H. F. Amiel’s *Journal Intime*. The Swiss philosopher (1821–1881) had written in his personal diary: “All is strange to me; I am, as it were, outside my own body and individuality; I am *depersonalised*, detached, cut adrift.” (Amiel, 1933; p. 275). This seems to have been interpreted by Dugas as a literal description of Amiel’s mental experiences. However, contextualized reading makes it unclear to what extent his descriptions of alienation were metaphorical rather than full-blown depersonalization experiences. For example, a few paragraphs later, Amiel clarifies: “It seems to me that my mental transformations are but *Philosophical experiences*.” (my italics) p. 275.

10 Chapter 1: A history of depersonalization**Early theories of depersonalization****The sensory theory**

One of the earliest views of depersonalization stemmed from a literal interpretation of those depersonalization complaints, which suggested a sensory distortion. One of the earliest writers to suggest that feelings of unreality might stem from pathological changes in the sensory apparatus was Krishaber himself. He believed that “multiple sensory distortions led to experiences of self-strangeness” (Krishaber, 1873, p. 171).

In his *Les maladies de la Personnalité*, Ribot (1895) endorsed a sensory dysfunction view and reported patients (some taken from Krishaber) who seem to describe anomalous body experiences ‘of being separated from the universe, of feeling their bodies as if wrapped with an isolating substance interposing between themselves and the external world’ (Ribot, 1895, p. 106). According to Ribot such experiences were caused by ‘physiological abnormalities whose immediate effect is to produce a change in coenesthesia’ (Ribot, 1895, pp. 105–106). The latter term commonly referred to a general sense of bodily existence, not reducible to any of the known sensory modalities (Berrios, 1981; Schiller, 1984). In the same vein, Ségla indicated that “*troubles de la perception personnelle des sensations internes, cénesthétiques*” might underlie typical depersonalization feelings. He described, for example, the case of a female patient with agoraphobia who ‘lost awareness of body’ every time she walked down the road: “it seems to me as if I am split into two, I lose the awareness of my body, which feels as if it is in front of me, I walk, and I am aware of it but I do not have awareness of my own identity, that it is actually me who is walking” (Ségla, 1895, p. 131). In a similar guise, Sollier brought attention to complaints of disturbing and baffling sensations in the head, which he ascribed to loss of ‘cerebral coenesthesia’ (Sollier, 1907, 1910). The conceptual roots of such ‘sensory hypotheses’ can be traced to eighteenth century beliefs on an association between bodily sensations and the ‘feeling of the self’. For example, Lamarck (1820, p. 191) wrote: “it is an internal sensation, a very obscure feeling, that provides the individual with his consciousness of being”.

In German-speaking psychiatry, Wernicke conceived of body awareness (*Psomatopsyché*) as related to muscle proprioceptive sensations (*Muskelsinn*). *Somatopsychosen*, according to Wernicke, were disorders characterized by distortions of body awareness such as Cotard’s syndrome and depersonalization. One of his patients complained: “that her body had become stiff, and that she had to keep touching herself to feel the heaviness of her body. She felt as if it was dead and numb, as if it was bereft of circulation, even though she could feel her pulse and the beats of her heart. Such feelings also involved her sensory organs: she could hear, but felt that her eyes were fixed to her head, and couldn’t