American Handbook of Psychiatry

DEPERSONALIZATION

Psychological and Social Perspectives

JAMES P. CATTELL
JANE SCHMAHL CATTELL

DEPERSONALIZATION:

PSYCHOLOGICAL AND SOCIAL PERSPECTIVES

James P. Cattell and Jane Schmahl Cattell

e-Book 2016 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 3* Silvano Arieti

Copyright © 1974 by Silvano Arieti and Eugene B. Brody

All Rights Reserved

Created in the United States of America

Table of Contents

DEPERSONALIZATION: PSYCHOLOGICAL AND SOCIAL PERSPECTIVES[1]

James P. Cattell and Jane Schmahl Cattell

This is a chapter on psychological and social theory concerning depersonalization. In the psychological analysis, we shall concentrate on solitary, individual behavior, motives and ideas which reflect rather than explain the general state of the contemporary American environment. In sociological analysis, we are interested in the process as it involves the individual in his role, and the reciprocal obligations that always come into play when two or more persons enter into relations with one another. Both levels of analysis consist of focusing on human behavior in interaction.

In our analysis, we shall tend to raise critical questions rather than attempt to provide final answers. What is depersonalization? Under what circumstances does it occur? What are some of the factors that influence the onset of an episode of depersonalization? What types of relationships with significant others during developmental years may render the person vulnerable to depersonalization experiences? Some of the answers to these questions were explored in a survey of the literature prepared for Volume 3 of this *Handbook* in 1965. That chapter, with some sixty references, was essentially a historical review.

Whether an individual will be healthy is largely out of his hands. It is influenced by the society in which he lives. A central proposition of this chapter is that depersonalization is influenced by manifestations of societal mal-integration. How does one know how society makes a person sick? What is the relationship between a particular family social structure and the society of which the family is a part? What is the relationship between an individual who depersonalizes and the general condition of the society to which he belongs? What is the relationship between a person's loss of self-identity and the state of the social environment?

These questions point to the construction of a theory of depersonalization through the careful examination of the link between psychological and social concepts and social observations. This approach has influenced the method of presentation—the case method. It is particularly useful in both psychology and sociology because many of the concepts are of such a high level of abstraction that they tend to lose their connection with observation.

This chapter will focus on the following:

1. Definition and occurrence of depersonalization, citing certain recent literature.

2. The characteristics of contemporary America that lead to anomie, alienation, and social isolation.

3. The development of the self and the miscarriage that fosters depersonalization.

4. The role of the double bind in depersonalization, schizophrenia, and society.

5. Clinical vignettes from the lives and therapies of two such patients.

Definition and Occurrence

The patient who has depersonalization experiences complains of having unpleasant feelings of unreality—of the self, the body, and the world. These feelings are not delusional, for the patient knows that reality has not changed. There is an attendant loss of affective response with complaints of no feeling for loved ones, no emotion, and no pleasure. There is loss of the ability to evoke visual imagery, to "picture" family and friends.

Depersonalization can occur in well-integrated individuals spontaneously, as well as in special circumstances or situations in which there is an alteration in the quantity and quality of input signals. In a study of fifty-seven philosophy and psychology students, Roberts found that twenty-three "showed past or present liability to brief periods of depersonalization." Contrary to the findings of others that depersonalization occurs more commonly in women, Roberts found no sex differences. Alteration of input signals can occur through sensory deprivation or sleep deprivation, time

changes with air flights, various states of altered physiological homeostasis, certain therapeutic drugs, and a number of psychotomimetic drugs,[2] thus jeopardizing reality sense.

The depersonalization experience is usually episodic, lasting from minutes to a few hours; conversely, on occasion, the condition is chronic and continues for months or years.

Depersonalization occurs frequently in association with neuroses and psychoses, as well as with organic psychiatric syndromes. It is our clinical impression that patients experience depersonalization far more commonly than is generally recognized. Only anxiety and depression occur more frequently. It is difficult to determine the incidence of depersonalization experiences because of the relative strangeness of the symptoms and the attendant problems of patients communicating them to the psychiatrist.

A major portion of the literature on this subject has been devoted to a consideration of factors that predispose to and influence the onset of depersonalization. The contributions of Arlow, Jacobson, Rosen, Sarlin, Stewart, Wittels, and others, were enunciated in the earlier article. Bychowski has chosen alienation as a term and concept that is more general and penetrating, for it also includes the way a person experiences his total reality including humanity at large. Bonime described transitory feelings of

depersonalization in a patient with personality change during the course of treatment. The patient had experienced growth and had the subjective

Characteristics of Contemporary America

In large part, the family is shaped by the industrial system. In this section, we shall examine the general state of contemporary American society to prepare the ground for exploring why the relations of family members are seen as the consequences of the dynamics of American society. First, we must look at the conditions of work and the self in America. Then, we shall examine fear in America as this refers particularly to acquiescence and conformity. Finally, we shall discuss anomie and alienation in relation to insatiability of social desires, social control and social change, loss of the self and social isolation.

Depersonalization has been defined as feelings of unreality. Thus, it is a subjective *experience.* In contrast, such behaviors as alcoholism, crime, divorce, drug addiction, psychoneurosis, and suicide are objective *actions.* They are difficulties of individuals, since we can always point to an individual alcoholic, criminal, drug addict, or divorcee. But, as has been demonstrated by Durkheim in his study of suicide, the individual and his society are never independent of one another. In the study of social disorders, it becomes clear that a particularly large number of persons who suffer from behavior

disorders are likely to appear in a society that shows certain other characteristics besides the individual incidences of the behavior disorder itself.

To further elaborate on this concept, personality development or socialization of a person occurs as a result of the interaction between the individual and his society. We cite Bredemeier's analogy which helps to clarify this relationship. On the one hand, personality needs can be likened to piano keys which have the potential for making music. Role, which refers to the way in which personality needs are organized in terms of behavior, on the other hand, can be compared with the melody (or noise) that evolves. Like the co-ordination of the potential for music and the organization of tone, the individual and his society interpenetrate through role playing.[3]

A central purpose of this chapter is to demonstrate the relationship between our institutional structures and family values. Therefore, we shall outline some of our basic institutions and values. Through them, we shall interpret patterns of family life as these pertain to avenues to behavior disorders, generally, and to depersonalization specifically.

Conditions of Work and Self

The worker does not own the product nor the tools of his production. Centralized administrative decisions determine when men work and how

fast. The product of man's labor is not a reflection of his imagination and dedication, nor is it an instrument through which he gains self-realization. People working under centralized bureaucracies are routinized, humiliated, and thereby dehumanized. The economic system prevents involvement and fosters detachment. It generates competition, creates feelings of inadequacy and fear of human obsolescence. It creates hostility and suspiciousness.

Personal Achievement. In contrast to some other societies, America's standard for personal excellence is occupational achievement. This emphasis on achievement is exclusively concerned with the objective results of man's activity, while man as a whole being is minimized or even denigrated. Merton's writing on anomie has highlighted the fact that the roots of alienation are evident in the widespread discrepancy between the universal need to achieve and the restricted means available to meet expectations of accomplishments. Consequently, there is a strong emphasis on the principle of individual competitiveness which frequently results in individual aggressiveness.

According to Beauvoir, a basic characteristic of the American value orientation is that the source of one's value and truth is perceived in things and not in oneself. Consequently, craftsmanship has low value. Conversely, material comfort has a high place in the value hierarchy. Success puts its emphasis on rewards. The success system, which William James has colorfully

described as “the Bitch Goddess success,” is comprised of money, prestige, power, and security. Mills has expanded the concept of money as a medium of exchange. He has stated: “The intermediary becomes the real god since it is the real power which a person mediates to me. Money has omnipotence—the pander between need and object, between human life and the means of subsistence. What I am unable to do—what therefore all my individual faculties are unable to do is made possible by means of money.”

The Corporate Structure and Bigness. Whyte has stated that the shift from family-owned companies to management-run corporations has been a predominant influence on the movement from individual to group activities. The need to give priority to security over risk-taking has led to the emphasis on “bigness”—big business, big government, big unions.

In view of the humiliation and dehumanization of the individual, how does management bind him to the corporate structure? Management-run corporations, where most Americans work, offer job security through the establishment of guarantees, such as wage scales, bonuses, seniority rights and privileges, tenure, health insurance, sick leave, paid vacations, and retirement plans. The bureaucratic organization thereby binds the worker who is uninvolved in his work. In Becker’s terms, the corporation has thus bought the “commitment” of the worker through these “side bets.”

Fear in America

The American man is a frightened individual. Fear, obsession, isolation, and suspicion are fostered by government, business, the press, school, the armed forces, and political reactionaries. The molding of the individual by these forces evolves from a specific concept of the human being. He must have a programmed view of the world: a national character who must be fearful and inclined to acquiesce.

There is a desire for security as opposed to risk-taking. There is a fear of becoming obsolete. The industrial system obliges too many people to devote their working hours to activities in which they have little interest. Change is rooted in obsolescence and both are basic to our industrial system.

The American is afraid of exploitation, competition, failure, and humiliation. Hence, one acts as if one were sincerely interested in others, but one is not. This "as if" behavior enables the individual to manipulate people, for he knows that manipulation is inherent in every human contact. Thus, there is a tendency to dismiss life as a dominance-submission struggle and to sacrifice tenderness and sensitivity to toughness and hardness. One result of dehumanization has been the development of countercultures. Some of these are the drug culture, drug-free communes, the "Jesus people," the worship of Satan with black masses, and the followers of gurus.

As with other cultures, the American is terrified of annihilation by unknown or foreign powers. According to Cook, the American economy rests on fear generally, and particularly on America being a juggernaut state. Another sign of fear is the obsessional concern about the future. Emphasis on security and achievement lead to placing a high value on "side bets."

Acquiescence and Conformity. To want to be accepted by one's society is a universal phenomenon. As in most other cultures, to be accepted in contemporary American society a person must adopt an uncritical attitude toward its customs and fears. For example, one must hate and fear the Soviet Union, North Vietnam, Communist China, and Cuba (at least in some years). If he does not acquiesce, he isolates himself. As has been emphasized by Henry, unthinking acquiescence results in "woolly-mindedness."

As has been noted by such foreign observers of the American social scene as Tocqueville and Beauvoir, the American values of equalitarianism, social mobility, and prestige underlie its stress on conformity. In buying patterns, fashion has acquired increasing influence over taste. By yielding to fashion, the consumer combines his need for both conformity and individuality. As analyzed by Simmel in his classic paper on fashion, the fashionable individual derives the satisfaction of knowing that he represents something striking, while he feels inwardly supported by a set of persons who are striving for the same thing.

The impact of the changing occupational structure and bureaucratization (as a result of differentiation of labor, more education, and social mobility) is depicted as the collapse of individualism. The result, according to Riesman, is movement from "inner-directed" man to "other-directed" man. He is characterized by (1) orientation toward situational rather than internalized goals; (2) extreme sensitivity to the opinion of others; (3) excessive need for approval; (4) conformity on internal experience as well as on externals; (5) loss of achievement orientation; and (6) loss of individualism.

The emptiness of values in a social system where life is lived in a mirror of how people evaluate an individual is exemplified in the Theater of the Absurd. In Arthur Miller's *Death of a Salesman,* Willy Loman refers to the endless search for approval when he says that it is not enough to be just "liked," one must be "well liked." Like Freud's and Marx's ideas of decreased individuality and dignity making man the pawn of opposing forces from within and without, Samuel Beckett's *Waiting for Godot* is primarily concerned with the basic problem of dualism whether it is psychic, religious, social, or economic. Despite Vladimir's and Estragon's knowledge that each functions better separately, they find themselves bound together.

Anomie and Alienation

According to Durkheim, there are three conditions necessary for the development of anomie: insatiability of social desires, breakdown of collective order (social control), and social change. The loss of social control is the characteristic that gave the state of this society its name: anomie, a Greek word, meaning "lack of law."

As a society, we are urban, democratic, bureaucratic, rationalized, large-scale, formal, open-class, geographically and occupationally mobile, secular, capitalistic, and technological.[4] These results of the French and Industrial Revolutions are fixed. They are irreversible. As a consequence, we propose that in various segments of contemporary America, the condition of *anomie* prevails.[5]

Insatiability, Collective Order, and Social Change. The purpose and mode of marketing is to create more and more desires, leading to an emphasis on consuming undurable goods. Durkheim has asked, "But how [do we] determine the quantity of well-being, comfort, or luxury legitimately to be craved by a human being? Nothing appears in a man's organic nor in his psychological constitution which sets limits to such tendencies." Since the "sky is the limit," as far as man's social desires are concerned, a ceiling must be put on his passions so as to keep him from exploding. This ceiling consists of society which defines and regulates goals to which man should orient his behavior. When man's shared expectations of the "rules of the game"

(expectations of the rights, obligations, and behavior of the other person) break down, it is as if the individual were stripped naked: A breakdown in collective man occurs. The shared meanings no longer serve as rules of a collective order. Action is no longer organized.

Social control breaks down under conditions of any sudden change, such as economic depression, or prosperity and extreme technological advance. Sudden change upsets the equilibrium and disturbs large numbers of people, thereby weakening the ruling forces of tradition (shared meanings and values).

To clarify these dynamics, we refer to the theoretical proposition of Strodtbeck and Short. They have postulated that to the degree roles are not clearly defined by a social structure, the needs of the individual personality take precedence over playing the role (e.g., teacher or student) in a manner that meets the requirements of the social system (e.g., the university). When there is no conventional way to meet a situation satisfactorily, those who are involved are thrown back on their own resources. The result is either idiosyncratic or psychopathological behavior.

Loss of Self and Alienation. To be alienated is to be made alien—to be made strange and solitary, cut off from one's origin and history. Self-alienation might mean the loss of any of the three time dimensions, though

loss of the past is the most frequent and important. In Sartre's *Nausea,* when Roquentin discovers that the past does not exist for him, he almost goes mad. Previously, Roquentin says the past to him "was another way of existing" and "each event, when it had played its part, put itself neatly into a box and became an honorary event." When he discovers he has no past, he is overwhelmed by "an immense sickness," and throughout the novel, he constantly insists that he really does exist.

Social Isolation. Empirically, alienation does not constitute an all-or-none dichotomy, but rather a continuum of relatedness. Such a continuum might consist of the following dimensions : (1) alienation from the Establishment —an individual voluntarily chooses to give up the society to which he belongs, because he does not find it intrinsically rewarding; for example, he withdraws from college, leaves home, to live in a commune-subculture; (2) alienation from others—the individual still hopes to be in the social system, but he has a feeling of being lost and he flounders rather than functions. He is estranged from others as each person secretly tries to make an instrument of the other, and a full circle is made—(3) he then makes an instrument of his self and is estranged from it also. Thus, he has no sense of being and is in a state of despair.

We propose that the essence of social isolation is alienation from others and from the self. According to Fromm, isolation is "moral aloneness." In

May's terms, isolation is defined as lack of a sense of being. In isolation, a person subordinates his existence to his functioning: a man knows himself not as a man but as a thing—the assembly-line worker in an automobile factory, the advertising executive, the post office employee, and so forth. We believe that the most destructive of all abuses that society inflicts upon the self or others is isolation.

In conclusion, in human history, there is one final conflict: man versus society. As has been emphasized by Norman Mailer, "Society, which is necessary to enable men to grow, is also the prison whose walls he must perpetually enlarge." The relation between man and society is "half-wedding half-prison. Without man there cannot be a society, yet society must always seek to restrain man."

The Self

The next sections of this paper are devoted to the consideration of the development of the self, the role of identity in the individual's interpersonal relationships, and how these can influence the development of depersonalization. These concepts are the common denominators in almost every relevant psychodynamic, sociological, and literary frame of reference. Even the language differences that once characterized various points of view are fading.

The definition and development of the self have been given wide attention in the literature. For example, Cooley, Erikson, May, Mead, Shibutani, Sullivan, and Winnicott have formulated a developmental theory through which the self and identity emerge. They concur and emphasize that the self is to a large extent the product of culture, in that the individual picks up reactions of others and incorporates them into a meaningful, coherent self-structure.

Sullivan's concept of the self-dynamism has many similarities to those of Cooley and Mead. For example, Sullivan has defined the self as "the reflected appraisals of significant others."[6] This formulation closely approximates Cooley's concept of "the looking glass self"—the self is a mirror of how significant others have perceived the individual. In Mead's framework, the self is the capacity of a person to take the role of others, to see himself through their eyes. He has stated: "The individual experiences himself as such not directly, but only indirectly from the particular standpoints of other individual members of the same group or from the generalized standpoint of the social group as a whole to which he belongs."

Shibutani has described personal identity as one's only tie with society. Personal and social status are defined in terms of reciprocating relationships with people who recognize the individual as a specific being. It is this tie with society that is humanizing. According to May, self-identity is *being* (the

potentiality of a person becoming what he truly is), and being is *becoming.* Being human is self-consciousness—to be aware of the self, to be responsible for himself if he is to become himself. Selfhood (identity) means having a history and knowing what that history is. The self lives in three time dimensions—past, present, and future—though the significant dimension for human beings is the future.

Development of the Self

Winnicott has identified the main processes that take place in the emotional growth of the infant during early months as integration, personalization, and relating to objects.[7] The self comes into being in infancy through the good mother's response to the infant's gesture or spontaneous impulse. Through the mother's unconditionally meeting the infant's needs, the infant is able to identify and differentiate basic needs. This leads to the development of basic trust accompanied by satisfaction and security.[8] Any attendant anxiety is minimal. According to Winnicott, under optimal mothering circumstances, the "I" is experienced and differentiated from the "Not-Me." Add to this the basic perception: "I am seen or understood to exist by someone . . . I get back the evidence I need that I have been recognized as a being."

Erikson and Shibutani have observed that the feeling of being a distinct

person also arises from one's sense of autonomy (versus shame and doubt), competency (industry versus inferiority) and the feeling of having some measure of control over one's destiny. In addition, Erikson has stated that the central task of the adolescent era of personality development is *role identity,* in contrast to role confusion.

According to the authors of this chapter, the issue of one's sexuality is implicit in the task of achieving identity. Thus, the concept of identity raises not only the question of "Who am I?" but also, more specifically, it raises the point of "What does it feel like to be a girl?" "A boy?" "Do I like being a boy?" Lidz et al. have further commented: "Of all factors entering into the formation of personality characteristics, the sex of the child is most decisive; and security of sexual identity is a cardinal factor in the achievement of stable ego identity." As we have pointed out, probably all patients who depersonalize are seriously confused in their sexual identity. Frequently, a person may struggle to cope with a weak or lost self-identity by trying to belong to someone. Instead of resolving the problem of identity, he may shift his focus to achieving intimacy. Erikson has stated the dilemma succinctly, "You can't get your identity straightened out by trying to achieve intimacy ahead of identity."

As for the role of identity in depersonalization, Laing has illustrated this in a statement of one of his patients: "It struck me that if I stared long enough

at the environment that I would blend with it and disappear just as if the place was empty and I had disappeared. It is as if you get yourself to feel you don't know who you are or where you are . . . Then, you are scared of it (of disappearing) because it begins to come on without encouragement . . . I would get frightened and repeat my name over and over again to bring me back to life."

Miscarriage in the Development of Self

In view of the nature of the normal developmental process of the self, as well as its miscarriage, a crucial question with which this discussion must be concerned is: What is the process by which the development of the self and identity miscarry and lead to depersonalization?

Of particular relevance to our topic is the distorted message, the mixed message, or the non-message, and the relationships of the individual's perceptions of these to his concept of himself and the world. As has been pointed out by Roshco, contact with reality depends on an objective perception of the self in relation to an objectively perceived external reality, i.e., the child's perceptions in relation to his mother. To the extent that there is a disturbance in the normal separation-individuation phase of development (sense of autonomy), the perception of the mother is distorted and, therefore, perception of the self is distorted. Thus, there is interference with reality

contact—difficulty in distinguishing between self and objects.

Bettelheim has cited a concrete example of miscarriage in development. He has stated: “Artificial feeding times dehumanize the infant and prevent him from feeling that his actions, cry or smile, are what bring about his being fed . . . When we feel that we cannot influence the important things that happen to us but that they follow the dictates of some inexorable power, then we give up trying to learn how to act or change them.” The growth of the child is accompanied by the conviction that his personal efforts can influence a given chain of events providing the environment permits this. “If the infant’s caretaker is not perceived as a human being, then neither can the infant grow up to be one.”

In discussing the development of the self-system, Laing, Boszormenyi-Nagy and Framo, Shibutani, and Winnicott have emphasized that when such development miscarries, there is a split in the self. This results in two parts, the true self and the false self, or the subject and the object.

According to Laing, the true self is the unembodied self that functions as observer, controller, and critic of what the body is experiencing and doing. The true self translates into action what one wants to be. Winnicott has pointed out that in health, the true self remains dominant and perceives reality. He has emphasized that only the true self feels real.

As for the false self, both Laing and Winnicott have stressed that it is built on compliance. Laing has stated that there is a basic split in the individual along the line of cleavage between his outward compliance and his inner withholding of compliance. The false self arises in compliance with the intentions or expectations of the significant others or what one imagines these to be.

Laing has related the body to the false self. The body is perceived more as an object among other objects in the world than as the core of the individual's being. He has illustrated this perception in the following comment on one of his patients: "He found reassurance in the consideration that whatever he was doing, he was not being himself." This patient was always playing a part, usually the part of someone else but sometimes he played himself. Not that he was spontaneously himself, but he played a role depicting himself (as an intellectual, poet, or clown, for example). His goal was never to give his true self away.

In terms of perceiving the self as an object, Shibutani has stated that loss of identity means loss of humanness. The individual feels that he is a spectator observer of what his body is doing rather than a participant observer.[9] Winnicott has conceptualized the false self partly as having the function of defending the true self. When the false self becomes exploited in the extreme and is treated as real (as if it were the true self), there is a sense

of futility and despair. This is the depersonalization experience which is terrifying.

Boszormenyi-Nagy and Framo, Laing, Sullivan, and Winnicott agree that the occurrence of the "false self-system" or "weak ego" or the "not me" emerges in response to deficiencies in the mothering of the infant. They have enunciated the fact that after the early months, the father often joins with the mothering one in the unconscious conspiracy of presenting the child with distortions in perceptions, identity, and interpersonal relationships.

In this kind of total setting, the true self is sabotaged. It remains unformed, weak, easily disrupted, and not capable of moving through the evolutionary process of growth. Thus the dominating false self emerges in the child and he therefore becomes vulnerable to experiencing depersonalization at a later time in his life.

Double Bind, Depersonalization, and Schizophrenia

According to Bateson et al., the double-bind situation is a necessary condition in the development of schizophrenia. It is of particular interest to note, however, that in most of the literature on depersonalization, double bind is a central, organizing concept. The occurrence of depersonalization and double bind together has been validated in our own clinical experiences and will be illustrated in the presentation of two clinical vignettes. Concerning the

nature of the relationship between the depersonalization experience and the double-bind condition, we are faced with a critical theoretical question, namely: Does or can the double-bind situation occur in depersonalization without the development of schizophrenia?

In addressing this issue, Arieti has pointed out that ". . . all of us would agree that our schizophrenic patients have been repeatedly exposed to this double-bind situation. But I think we would also agree that many neurotics were exposed, and many normal people, and we, too."

Structure of the Double Bind

For purposes of exploring the relationship between double bind and depersonalization, it is important to review the social structure of the double bind as analyzed by Bateson et al. In this creative work, the authors have identified five interacting parts that make up the structure of the double bind:

1. Two or more persons are involved, the child-victim and the mother alone, or in combination with father and/or siblings. The double bind, far from being a single traumatic experience, is repeated so often that the double-bind structure comes to be a habitual experience.

2. There is a primary negative injunction based on avoidance of punishment. This injunction may have either of two forms: "Do not do so and so, or I will punish you," or "If you do not

do so and so, I will punish you." The authors define the punishment as withdrawal of love, expressions of hate or anger, or the kind of abandonment that occurs when the parent expresses extreme helplessness.

3. There is a secondary injunction that conflicts with the first but at a more abstract level and again threatening punishment. In contrast to the direct verbalization that characterizes the primary injunction, the secondary one is communicated by posture, tone of voice, gesture, facial expression, or an indirect allusion to the primary injunction. For instance, "Do not submit to my prohibitions." "Do not see me as a punishing agent." "Do not see this as punishment." "Do not question my love of which the primary injunction is (or is not) an example." When the double bind is inflicted by two individuals, one parental partner may negate the injunctions of the other at a more abstract level.

4. There is a tertiary negative injunction that prohibits the victim from escaping from the field. If the double binds are imposed during infancy, escape is naturally impossible. In some instances, however, escape from the field is made impossible by certain devices which are not entirely negative. For instance, capricious promises of love.

5. Finally, the complete set of ingredients is not necessary once the individual has learned to perceive the universe in double-bind patterns. Almost any part of a double-bind sequence may then be sufficient to precipitate panic or rage. The pattern of conflicting injunctions may even be taken over by

auditory hallucinations.

Even though the double-bind mode of communication has been identified as a core concept in the development of the schizophrenic process, depersonalization can occur under a wide variety of circumstances that have nothing to do with schizophrenia. However, depersonalization experiences are common among those who have schizoid personalities and schizophrenia. Many of the distortions of perception and identity during early maturation that have been associated with depersonalization also obtain in the development of schizophrenia.

Double Bind in Society

In view of our earlier question that pertained to the relationship between the individual who experiences depersonalization and the general conditions of the society to which he belongs, we raise the following question: What contributes to parents' expertise in using the double bind? Certainly, they developed some of their skills in this realm in their early relationships with their own parents. However, we suggest that in addition to such family determinants, there are cultural determinants.

Various organizations and cultural institutions disseminate double-bind messages. As an example, we shall focus on the plight of the faculty member in the university.

There are numerous illustrations of the double bind in the university setting, which may serve as a prototype for other bureaucratic organizations. The role of the university faculty member is formally defined as “teacher of students.” The primary injunction, on the one hand, is, “Get close to the students,” while on the other hand, the negative aspect of this injunction is, “Don’t get too close to students, because if you do it means you no longer identify with us as faculty members and administration.” The punishment for obeying either command is to be denied promotion and tenure. The teacher must demonstrate his loyalty to the university by doing so-called “research” and grinding out publications to the greater glory of the institution.

In another context, some universities have a policy of open admissions (every high-school graduate must be admitted, irrespective of grades). The positive aspect of the primary injunction is: “Be fair, but maintain reasonable standards of academic performance.” This calls for an “as if” performance by the teacher in the face of the negative part of the injunction that states: "You, the teacher, are forbidden to fail any student.” Thus, the administration obviates student demonstrations that might lead those in political power to question the ability of the leaders of the academic administration and the need to replace some of them. Thereby, the faculty member is encouraged to remain aloof from the student, to look down on him and to derogate him but is ordered to give him a passing grade.

The double bind communicated to the faculty member is inevitably passed on to the student. As a result, each is a pawn in an unfeeling system that dehumanizes people and creates "things." Finally, students who wish to become faculty members in a university setting are told that they are most welcome but that they must have a doctoral degree to achieve this high estate. Once the degree has been earned, frequently the message is different. The secondary injunction is that there are no jobs at the university level and the candidate is advised to apply for a teaching position in a junior college in Texas (if he is in New York, but the reverse formula is applied if he is in Texas).

It appears that the concepts of double bind and anomie may be positively correlated. In the situation we have described, there is a lack of an accepted standard for judging students', teachers', and administrators' role obligations. How can one person look down on someone who has acted wrongly if there is no clear definition of "wrong"? In this kind of situation in which roles, expectations, and norms are not clearly defined, there no longer can be inner cohesion. Thus, the entire university setting is anomic. There is mass indifference and the individuals who make up the university group are demoralized.

Depersonalization and Family Structure

To illustrate the relationship between a person who depersonalizes and the small group, his family, we shall present clinical vignettes which include history, dynamics, and treatment of two patients.[10] In our presentation of the two family groups we shall scrutinize three elements of behavior: (1) individual activity—what Michelle Mahler and Nancy Cabot[11] do as members of the family group, as well as what other members of the family do; (2) feelings—the sum of internal feelings, whether physical or emotional, that a family member has in relation to what another member does; (3) interaction —the relationship which the activity of one member of the group has to do with that of other members. In addition, we also shall examine these three elements of behavior in relation to significant others outside the family group, including the therapist.

Behavior disorders and psychoses are the final outcome of all that is wrong with a society. We shall focus on the parents, not as individuals, but on the individuals in their role in the social system. It is they who are the carriers of the culture and who transmit cultural ills and strengths, and thereby lay the foundation for sanity or madness.

The Mahler Family

Michelle Mahler is a strikingly attractive girl of twenty-four. She is tall and shapely with a pretty face and finely chiseled features. She moves well

and has an aristocratic air about her. Despite her foreign birth, she speaks English fluently and clearly.

Three years prior to seeking treatment with me, Michelle had begun treatment with a psychologist who was less than ten years her senior. She discontinued when she felt that he had become too involved with her personally. Next, she saw a psychiatrist who was old enough to be her father. He told her that she was inhibited and that this could be alleviated through personal contact with him. When he invited her to sit on his lap, she left.

Michelle wants treatment because of depression, depersonalization, painful self-consciousness, anxiety in many areas of behavior, migraine, nausea, and anorexia. Her depression is characterized by feelings of deep sadness, uncontrollable crying spells, withdrawal, suicidal ideation, and self-disparagement.

Before considering Michelle's social history and personality development, a consideration of her feelings of unreality and her sense of identity is in order.

Unreality Feelings and Sense of Identity

Speaking of her feelings of unreality, Michelle describes them as follows: "If anyone gets to know me really well, they and I would find out that there is

nothing there, just hollow, rotten, crumby . . . A thing comes over me when I can't feel anything . . . As if I were living exclusively through my head with no real pleasure . . . A numb feeling, feeling really strange, as if the whole world were encompassed in a numb feeling . . .Feel there's nothing inside, a hole ... A feeling I have to be acted upon in order to react. Otherwise, there is nothing. No outline of what kind of person I am. No shape, form, texture, just an amorphous blob . . . In arguments, words come out but I don't really feel anything inside . . . I have a tendency to feel that anything I say is not being heard by anyone . . . I mean what I say but it is as if someone else is saying it.

"A good friend from Boston is in New York, but I feel that I have nothing to contribute and she has so much vitality. It bothers me that I have no definite sense of who I am. I fear she'll be disappointed and that there's no me that exists for her to like. I don't feel this when I am with Derek (an old friend from Austria with whom she is comfortable). Then I feel my own self thrown into great relief and I can see myself and what I think."

Social History

Michelle's grandparents on both sides had been wealthy Protestant or Greek Orthodox aristocrats in Central Europe, with one exception. Her maternal great-grandfather had been Jewish, and her maternal grandfather had been a judge and an owner of factories. With the advent of Hitler, the

latter was forced to give up everything because he was not pure Aryan. The maternal grandmother committed suicide.

Michelle's mother, Sigrid, grew up in a household that was run by a multitude of servants, and she had been cared for by governesses since infancy. She had never been in a kitchen until she was eighteen, when her social and economic status was devastated by the fact of her Jewish background. She had to go to work and people told her they could no longer speak to her. As long as Sigrid was married to Michelle's father, Hans, a wealthy landowner, the Jewish background was not a problem. However, the marriage was short-lived and was terminated before she brought Michelle to the United States.

Personality Development

There are no specific data about Michelle before she was five. However, Sigrid's behavior in the past, and more recently, provides no evidence that she has changed in any way since Michelle was born. Having divorced her wealthy husband, it is quite likely that she came to the United States to seek her fortune. Thus, she brought Michelle to this country when she was five years old. Sigrid wanted to work and to find a new husband, so she placed her daughter in a series of foster homes for the next year. When Michelle was six and still had German as her principal language, her mother placed her in a

boarding school for destitute children, where she remained for two years. In that setting, Michelle feels that she was dehumanized, as was the heroine of *Jane Eyre.*

When Michelle was eight years old, her mother married a second time, and the little girl lived in this household until she was sixteen and the parents were divorced. This eight-year period is the longest the patient has ever spent in any residence. For two years before going to college, she lived successively with the families of two high-school friends. The mother married her third husband during this period.

Mother-Daughter Relationship. In the following monologue, Michelle enunciates the essence of her relationship with her mother. "Mother is the key to me, not the fact of three different fathers . . . I have trouble believing she is not as nice as I thought when she does certain things. She used to say that I was the most fantastic thing ever created, beautiful, perfect. In contrast, she is opposed to another side of me and things that mean a lot to me, such as my working in the museum in the ghetto. She said I was selfish to do this, never thinking of her but surrounding myself with low-class people and dragging her down . . . I can never decide what to think of her. She says that she's the only one I can trust and that I can't trust my friends. She says she's right and my friends are wrong. Is she deliberately doing that or is it that she's just warped and can't help herself? She says things that aren't the truth.

I could cope with her better if I could decide about these things.

"If I don't get love from my parents, then nothing else matters, though it does matter. I can't believe they are unloving people. Mother used to threaten me with having a lawyer take control of my affairs (a trust fund that will eventually become hers) or to put me in an institution. There were lots of such threats."

Father-Daughter Relationship. Beginning at the age of ten, Michelle visited her father, Hans Mahler, in Germany, once a year. These are some of her impressions of him and his way of life.

"Three years ago, when I was twenty-one, he was close to being an alcoholic when I visited. I'd have to sit up with him until 2 a.m. while he drank. He seemed very sexual, sensual. He was seductive verbally and I left. Now, he's more like a very old man and he no longer frightens me. He sculpts and paints fairly well. He tries to buy the love I'm incapable of giving him. He despises himself so it's difficult to love him. He's frustrated because he doesn't know who he is and he's done nothing with his life. I don't like him but I want to. I never know what to do when he's around. He's snide."

Relationships with Men. Initially in New York, Michelle lived alone. Later, she had a dour, young Jewish schoolteacher named Jacob move in with her. She subsequently joined him in an apartment nearer their places of work,

but found their interests so far apart that, after much soul searching, she moved into her own apartment again. She expresses distress that she cannot seem to maintain a relationship with a young man for more than two months. She has continued relationships with one or two men who are her peers, such as Derek. She sees them from time to time, but does not find them attractive sexually. She has found herself attracted to emotionally unstable young men from disadvantaged backgrounds who exploit her and then repudiate her. Her sexual interests seem to focus on young black men who have had varying degrees of sociopathy. Michelle has done a kind of reversal of the Cinderella story, leaving the castle to go to the ghetto hearth and repudiating minor princes for relative paupers.

Dynamics of Feelings of Unreality and Confused Identity

Michelle's painful feelings of unreality have an "as if" quality. These feelings are not delusional for she speaks of *feeling* unreal in contrast to *being* unreal. She feels empty, numb, an amorphous blob. There is no feeling and no pleasure. These are the criteria for depersonalization that we have outlined.

She lacks the feeling of being a distinct person and of having the sense of autonomy and competency described by Erikson and Shibutani. She is a spectator observer in contrast to being a participant observer. In an argument, words come out, though she feels nothing, yet she means what she

says, but repudiates the idea she is saying it. Thus, her sense of self or identity is very shaky and, for no apparent reason, it seems to come and go.

Michelle describes a feeling that she must be acted upon in order to react. The "personalization," described by Winnicott, has never fully taken place. The experience of having been recognized as a separate being in infancy and having had her needs met unconditionally by the mothering one was deficient, and the opportunity for the development of the true self must have been less than optimal.

In addition, she notes that meeting someone she likes and respects paralyzes her functioning and she fears being judged and found wanting. Here is evidence of feeling compelled to adopt a compliant attitude, as enunciated by Winnicott, in the evolution of the self.

Interestingly enough, Michelle feels most comfortable and whole when she is with Derek, a peer and contemporary from her native land. This is one of the few such relationships she has permitted herself. He treats her with affection and respect. (This seeming paradox in her perception of herself will be considered later.)

Dynamics of Interaction

Marginal Individual

The concept of “marginal individual” was developed by Parks in the study of interethnic contacts. In the traditional sense, “marginal” means that a person stands on the border of two or more social worlds but is not accepted as a full participant in either. Marginality creates anxiety and can lead to feelings of alienation. A principal implication of marginality for this chapter is that the uprooting of the immigrant is a critical factor in determining the American character.

Marginal persons who develop emotional disturbances are those who attempt to improve their lot by identifying with the higher stratum (Michelle’s pull to Germany, where her wealthy father resides), and to rebel when rejected. However, no necessary relationship between marginal status and personality disorder has been established.

The Mother. In several respects, Michelle’s mother is a marginal woman, as this refers to being uprooted but not transplanted. First, at the age of eighteen, Sigrid was totally rejected by friends who could no longer speak to her because of her Jewish background. Second, her marriage ended in divorce, at which time she came to America. Third, she was compelled to work, though she was totally unprepared to do so.

Michelle. As Michelle grew up, she experienced a frightening quantity and quality of rootlessness, multiple identifications, and a lack of loving,

consistent role models. She grew up in what was initially an alien culture with an alien language, and she has never regarded this country as her home. She is unclear about her nationality and language of choice. She expresses preference for Germany and the German language and feels alien to middle-class America. Yet, she seems content to limit her time in Germany to the annual visits. Her life has been that of a gypsy, in the sense of her moving frequently, except for the eight-year period when her mother was married to her first stepfather.

In the traditional sense, Michelle is a marginal woman, in that she maintains one foot in Germany and one foot in America. She has suffered from the inability to find integration of herself and society, and thus she is an alienated young woman.

Parental-Daughter Interaction

The mother is self-centered; she was more interested in finding a husband than in caring for Michelle. Frequently, she acts *as if* (the need to mask real feelings) she loved Michelle, when in fact she wishes the girl had never been born. Double binds are a central theme in the mother-daughter relationship. For example, on the one hand, she tells Michelle she is "the most fantastic, beautiful thing created," while on the other hand, she humiliates Michelle by telling her how ugly she is after plastic surgery and commanding

her to cover her face with a handkerchief. Anyone who agrees to play the game of double bind can and does lose every time. Every reaction of Michelle elicits some form of punishment, rejection, further loss of self-esteem and self-reliance.

Michelle's mother uses terror as the instrument to obtain Michelle's acquiescence. To illustrate, the mother talks to Michelle about her "bad genes" and has threatened to place her in an institution if she does not acquiesce to her demands. She exploited and humiliated both her second husband and Michelle when she told her she had married a man "who was not interested in sex and was a manic-depressive" because her daughter needed a home. In conveying her dissatisfaction with this husband, she undermined his value to Michelle as a model for a love object.

Michelle was treated merely as an extension of her mother and thus was manipulated as a thing. She has had the perspicacity and detachment to question her mother's motives or illness: "Is she deliberately doing that or is it that she's just warped and can't help herself? . . . I could cope with her better if I could decide."

In infancy, Michelle did not have this objectivity and was subjected to an onslaught that wreaked havoc. This havoc could be defined in the language of any of several theoretical frameworks: Bettelheim's dehumanization,

Erikson's lack of autonomy, Roshco's separation-individuation phase, or the failure of the development of the self, as described by Winnicott and Laing, respectively.

The father, though less prominent in her day-to-day life, has been her role model of a man. Michelle speaks of him as a man who is not a man and as a person who is empty and who lacks self-respect. He is difficult to love, yet he tries to buy Michelle's love. On the other hand, he tells her to do as she pleases and to live where she chooses. However, he promises to support her and her graduate education if she lives in Europe, but not if she lives in the United States, where she has a life of near-poverty. With this "very sexual, sensual, and verbally seductive behavior," Hans Mahler breaks the generation boundaries, in that he seeks emotional support and sense of completion from his daughter, rather than from his second wife. Consequently, he confuses and humiliates Michelle and uses her as a pawn. He is impulse-driven. He is frustrated and despises himself, and so resorts to alcohol to assuage the pain of his feelings. This enigmatic man has been a very confusing influence in many areas, including Michelle's choice of men.

Michelle's penchant for selecting unstable young men has also been influenced by her need to rebel against parents and their way of life. However, her identity and conception of self are very shaky and she has doubts about her worthiness to live at a level consistent with her breeding, as

well as doubts about her ability to cope with her peers. Ironically, she has chosen to work in one of the most difficult sociological areas imaginable in today's world. She has done very well in her occupational position despite the many problems inherent in it.

Michelle's mother, who has lived in America for twenty years, her father, and her stepfathers manifest American personality characteristics that are widespread. These are detachment, pathological "as if" behavior, a tendency to humiliate others, criticalness, and pecuniary motivations. Finally, there is the demand for acquiescence (through the threat of abandonment), which we have emphasized as the ultimate in conformity. Hand in hand with the use of terror is the illusory promise of forthcoming gratification. But whoever utilizes terror has no intention of gratifying anyone or anything but himself. The Mahlers have overtly terrorized Michelle and, to a point, she has acquiesced.

Perhaps the most remarkable aspect of this clinical vignette is that Michelle has not succumbed completely to her mother's domination or to a paralyzing schizophrenic reaction. It is a triumph for Michelle and a tribute to her that she has the strength and persistence to find the emerging potential of a true self and an identity. In addition, she has been able to make a significant contribution in her work, despite her talent for sabotaging her personal life.

The Cabot Family

Nancy Cabot is a blonde beauty of twenty. Her almond-shaped eyes are blue and she has the attractive figure of a young woman but the shyness and naiveté of an early adolescent. These are evident in her need to wear a trenchcoat on even the hottest days to hide herself, and in her frequently expressed wish to be a little girl and not a woman.

She had been referred by one of the deans at the college in New York City where she is a second-year student. Frequently, she is dominated by pervasive anxiety, depersonalization, obsession, phobias, depression with suicidal ideation and self-disparagement, as well as feelings of inadequacy and helplessness.

Unreality Feelings and Sense of Identity

Depersonalization feelings are recurring strands in the fabric of Nancy's symptomatology and are enunciated here for purposes of illustrating the phenomena. Her own descriptions of depersonalization gives us an additional perspective on her experiences. Her account is relatively characteristic and demonstrates the difficulties patients encounter in describing these strange and uncanny feelings.

"Sometimes, I feel foggy. Now, I feel disconnected, not foggy . . . At times,

I know where I am but don't feel I'm really there . . . My head feels all cloudy. At times, I get so I can't think clearly or do my work. It is as if there's a big mass stuck in my head . . . Off and on during the past week I didn't feel real. Wherever I was, I just didn't feel I was there, just no place . . . Sometimes, on a bus, I feel like a stick, lose my balance . . . I get peppy and laugh but it doesn't feel like me laughing. It feels like something inside me is doing it . . . About half the time I feel real but with some blurring of vision . . . I'll sit for a long time doing nothing and just staring. It's as if someone had put Novocain in my brain."

Nancy's experiences become more meaningful when viewed in the context of her own symptoms and the interpersonal situation in which they occur.

If Nancy is in a public setting among strangers, the unreality feelings are accentuated. For example, she went to the library of the Academy of Medicine to prepare a paper for school but was very fearful. She felt awkward, bumped into things, feared the bookshelves would topple over on her—but once there she was afraid to leave. On her second visit there, she felt in a daze, was unable to concentrate and felt she was being watched all the time. "Every time I would look up, someone had their eyes on me." There probably is a reality basis for this perception, because attractive young women are conspicuous in such a setting.

When she was alone on the boardwalk in Atlantic City, she felt frightened of the crowds. “It was like a wall was there stopping me. I couldn’t go on. This happened two times in Barbados. I couldn’t go through the hotel gate to the street. My feet were like lead and I had to turn back.”

These experiences of encountering a “wall,” feeling paralyzed and unable to move forward and having to turn back, are disabling. However, her preoccupation with being watched by dead people is more pathological. When alone, she feels that dead people she has known are watching her. These include grandparents, friends of her mother, and others. At times, she feels they are judging her critically and at other times she feels they are neutral. This experience seems to vary between obsession and delusion. “They’re watching you but you don’t know they’re there. They make you behave as you should and there’s never any privacy. If they turn off, I wouldn’t know what to do. They’d be pleased if I didn’t do certain things, mainly go against my parents. When I die, I’ll be able to see people on earth.”

On many occasions when she feels depressed, she has obsessive thoughts about harming herself with medication or by cutting or burning herself. “Last night I called you because I felt futile and self-destructive, but less so now . . . This past week I’ve been feeling unreal much of the time. I made these cuts on my left wrist to hurt myself and I feel a little better when I do it. The cuts are not over the vein. I made some last week and some this

week. I have to do it. I get so mad at myself for causing my parents concern. The feeling lifts several times a day and I'm able to function better than normally." On another occasion, she speaks of burning herself with a cigarette for that hurts more than a razor blade and would be less easy for her roommate and her friend Ruth to detect, though they have discovered it.

Social History

The social climate of the Cabot family is one of severe emotional deprivation and massive impoverishment. Nancy not only has numerous depersonalization experiences but also has had a schizoaffective episode for which she had to be hospitalized.

Nancy's mother, Elizabeth Whitney Cabot, comes from a wealthy, Social-Register family. She puts much emphasis on social position. Mrs. Cabot has had all the better things of life as defined by the American high-rising living standard. Her parental family is responsible for the trust funds that have been provided for her and her daughters. Nancy lives in an atmosphere of material indulgence.

Arthur Cabot, the father, was born in the South. He works in New York City, where he maintains a small apartment for himself; he commutes to the family home in exurbia only on weekends. Mr. Cabot drinks heavily, is frequently intoxicated, and regularly yields to uncontrolled impulse.

Nancy's two sisters, six and eight years her senior, are married, and each has a husband who is completing his professional training. One sister was taken to see a psychiatrist during adolescence, but there was an early termination of treatment by the parents whose opposition to psychiatric care persists in the present. Since Nancy is six years younger than the second daughter, one wonders if she may have been an unwanted child.

Ruth, whom the parents deeply resent, is a crucial figure in Nancy's life, filling the role of surrogate mother. She is the housemother of the boarding school that Nancy attended in New York City. Since the number of boarders was small, Ruth was able to give many of them a lot of individual attention and they, in turn, became attached to her. Nancy was one of several of these "poor little rich girls" who continued to see her after they had gone on to college and to spend all or parts of their holidays with her. Ruth was in her mid-thirties when Nancy came for treatment. Her personal life had been scarred by a number of tragedies, both in interpersonal relationships and physical health. During the period of Nancy's treatment, Ruth's time was devoted primarily to her job of caring for her "lost sheep."

Personality Development

The parental home is in an exclusive section of exurbia where the married sisters and their families gather for Christmas each year. Details of

Nancy's early developmental history are fragmentary, in view of the parents' aversion to psychiatrists and their reluctance to visit the senior author who treated Nancy. A good deal of material has been provided by Nancy's recollections and the parents' ongoing interactions with each other and with Nancy.

Nancy's developmental years have been marked by episodes of exposure to sexual stimulation and to periodic domestic violence. Both kinds of scenes continue to be familiar in current contacts with her parents.

Sexual Stimulation. When Nancy Cabot was young, theirs was a "nude household." She recalls having taken baths with her father when she was four and seeing him and others in the family running around nude. When she was five or six, her parents came home drunk one evening and got into a fight after they had taken their clothes off. Mother picked up a poker and the teen-aged daughter called the police. No one was seriously injured but some bruises were sustained.

Even then, Nancy feared the dark and would sleep with a sheet over her head. However, she rarely slept alone. Until she went to boarding school in her teens, she would sleep with her mother at times, but more often with her father. When they were in bed together, he would hold her in his arms, so she made him wear shorts under his pajamas. Occasionally, he would leave the

bed and go to her mother's room for a half hour. When Nancy was ten, one of her sisters told her something about sexual intercourse. She then realized that this was the reason for her father's visits to her mother's bedroom. Subsequently, Nancy would feel angry and go to her own room.

From time to time, during the period of treatment, her father continued to touch her breasts, as well as those of her sisters and make a snide joke about it. A brother-in-law ignored or criticized Nancy on the one hand, while on the other hand he would grab her, kiss her, and grope at her breasts. Her mother and sisters tacitly disapproved of this behavior on the part of the men, but tolerated it.

Thomas, a sixty-two-year-old black, is the man of all work in the parental household. He lives in a small house on the grounds with his young wife and small child. Nancy was devoted to them, felt safe with them, and enjoyed visiting their home and playing with the child. She was perplexed and alarmed that when they were alone together, Thomas grabbed her buttocks and breasts. He derided her by saying, "You've been asking for it." She was afraid to tell anyone and resolved never to be alone with him. Somehow, her mother found out. She told Nancy that Thomas' feelings were hurt because she was afraid of him and that he had cried. Her mother demanded that Nancy write to Thomas and apologize to him.

School Years. Nancy had been more assertive during childhood and preadolescence and there were frequent spankings for "talking back." She feels she may have been indulged by her mother, who defended her from her sisters' wrath when she teased them.

In school, Nancy's talkativeness provoked the teacher, who applied Scotch tape to her mouth and sent her to the principal's office for such misbehavior as kicking and scratching other children. The teacher kept a card on Nancy's desk and would paste a gold star on it in recognition of a week of good behavior. She fought a lot with peers and had few friends. Her two main playmates were younger than she.

After attending public school for five years, she was sent to a private day school for three years. She spent two of her high school years in a boarding school in a near-by state, and the final two years in the boarding school in New York City where she met Ruth. Following graduation, she went to a college in Florida, but left after two months, for she was lonely, frightened, and withdrawn. Subsequently, she entered the college she was attending at the time she began treatment.

Shortly after psychiatric treatment was initiated with the senior author, therapy became an area of controversy between Nancy and her parents, particularly the issue of three sessions a week. In addition, they were opposed

to her spending time with Ruth, which limited Nancy's visits home to one or two weekends a month. It was not that they were eager to see her, but that they were jealous of her relationships with Ruth and the therapist.

A few months after starting treatment, Nancy earned an associate arts degree in June. She wished to return to college in the fall for a third year. However, her parents wanted her to spend a year living with a family in France and then return to the United States to work. Such a plan would effectively terminate both relationships they so vehemently opposed.

Family Violence. The Friday after graduation, Nancy returned home. After her parents' guests had left, she heard her intoxicated father yelling at her mother. When Nancy entered the room, the father turned on her and blasted her for not "controlling" her behavior and said there was no need for her to have treatment. He shouted that there was no hope for her amounting to anything and that she could leave home. He sneered, "As far as I'm concerned, you can go kill yourself." In addition, he accused her of not loving her mother because of her affection for Ruth. The mother defended Nancy, whereupon the father slapped his wife's face twice. Nancy slapped her father's face, then he grabbed her arms and bruised them. Elizabeth picked up a fireplace poker and threatened to call the police, but Nancy persuaded her to calm down. Arthur threatened to drive to the city, but since he was not sober enough to drive safely, Nancy hid the car keys.

The next day, Arthur behaved as if nothing had happened. Nancy felt her father had become angry at her in part "because he felt guilty that I am the way I am." It was not clear just how he felt responsible. He cried and reminded her he had given her things that should help solve any problem; he referred to a car he had given her for Christmas, even though she had not asked for it. He accused her of not enjoying anything he did for her and told her she was "driving him nuts."

Double-Bind Messages. Her parents had taken an adamant stand on Nancy's going to France in the fall. Then came a series of mixed messages and double binds.

If she wished to continue treatment, she must move out of the house, get a job, and live on her own. If she wished to return to college, she must live in her father's one-room apartment in the city, rather than in the college dormitory. Finally, permission was given for her to return to college for the fall semester, and the trip to France was postponed until the spring semester. This plan was contingent on Nancy's coming to treatment only once a week and seeing Ruth only once a month.

She was surprised at her parents' acquiescence. "They go along yet it seems like they never will. At times, they seem to give up on something like forbidding me to see Ruth, then they suddenly get mad about it. It's odd that

they don't find out I see her more than once a month and you more than once a week. I don't understand why they never check up on me, but they never have. They just don't want to find out."

Dynamics of Feelings of Unreality and Confused Identity

Nancy's symptoms illustrate the occurrence of depersonalization in association with schizophrenia. By contrast, Michelle, who was not schizophrenic, nevertheless had depersonalization experiences.

In one sequence, Nancy speaks of feeling fuzzy and as if she did not have a head. "I get peppy and laugh, but it doesn't feel like me laughing. It feels like something inside me is doing it." These experiences have the "as if' quality and are alien to the self, thus representing depersonalization, not delusion. Her "as if" feelings develop further into ideas of reference and being influenced by some force outside herself (dead people). These feelings are held with conviction and are delusional.

Then, there are the somatic components of her unreality experiences, among which are blurring of vision, feeling like a stick, losing her balance, bumping into things, and feeling unable to bend her knees. There is a culmination in her "wall" experiences. Are we dealing with a continuum ranging from mild fleeting feelings of unreality to paralyzing catatonia? The literature notes that developmental experiences that precede and seem to

predispose one to depersonalization experiences are similar to, or the same as, those antedating schizoid personality structure and schizophrenic reactions.''

Nancy's obsession-delusion that she is being watched by dead relatives becomes more meaningful in terms of Winnicott's formulation of the capacity to be alone. He has stated that the basis for the ability to be alone is the experience of being alone in the presence of the ego-supporting mother during infancy. Gradually, the maternal support is incorporated and there develops the capacity to be alone. Nancy never had an adequate opportunity to develop this capacity, so she calls on beneficent spirits to be with her when no one else is around. This obviates her being alone.

Suicidal Ideation. Depression and thoughts of harming herself have been common in Nancy's life, particularly when she feels frustration and the threat of abandonment. However, on only a few occasions has she tried to damage herself. These occasions were overdetermined and represent a cry for help, expiation for sins, and ritual suicide, as well as the need to feel real pain and thus alleviate the pain of unreality feelings.

Winnicott has stated that if the balance between the true self and the false self is such that the true self cannot be realized, the outcome is suicide. The total self is destroyed in preference to annihilation of the true self. In

Waltzer's formulation of depersonalization, the individual acts as both participant and observer and responds as if his behavior were being carried out by another person. Thus, unacceptable impulses, such as suicide, often to escape panic, are more easily permitted partial or complete expression. Laing has mentioned suicide as one outcome of the vicissitudes in the struggle between the real self and the false self. One is defensive: "If I'm dead, I can't be killed." The other is punitive, in the sense that one has no right to be alive because of one's guilt.

Dynamics of Interaction: The Family as a Social System

In exploring the dynamics that led to Nancy's futile attempts to cope, it is critical to view her as one part of the social system of the family. Although she was labeled as the "primary patient," her behavior cannot be understood outside the context of her family. From a theoretical point of view, the family is defined as a social system in which each member acts upon another. The various combinations and permutations of behavior define the social structure of the family.

The Mother

Elizabeth Cabot has serious difficulty in differentiating Nancy from herself. She displays indifference. She is cold, detached, and uninvolved, despite the fact that on occasion she defends Nancy from her father.

Elizabeth's defense of Nancy, rather than being an expression of love, is a way of retaliating against the husband. It is difficult for her to make decisions and she has seriously scattered thinking. Often, she is confused and vague. She, like her husband, drinks heavily and frequently is intoxicated.

Absence of Nurturance. The concept of "nurturance" or mothering is defined as *creating a climate for growth.* In Nancy's life, there was no real mothering. In the absence of nurturance, Nancy missed many of the child-centered rituals, such as those carried out at bedtime: bathing and playing in the water; being hugged and cuddled as she is being wrapped, mummy fashion, in a towel; a bedtime drink, a story, a song; and a goodnight kiss. These bedtime rituals are functional for both child and parent, for they coax the child to go to bed and make separation easier for parents and child. "Any erosion or decay in ritual symbolizes a decay in the culture," and by this definition, the Cabot family is in decay, or worse, it has disintegrated.

"As If" Behavior. Elizabeth Cabot's relationship with Nancy is dominated by her need to mask reality through "as if' behavior. She acted *as if* she did not know of her husband's sexual exploitation of Nancy, but she does know. The mother has been aware of the father's behavior toward Nancy and her sisters throughout the years, since it was evident which beds had been slept in, but there was never any attempt to hide the wandering hands. From time to time, she voiced disapproval but never really intervened or tried to

protect Nancy. Instead of being mothered and nurtured, Nancy was offered to her father as a kind of sacrificial lamb. The result has been that Arthur's attention to Elizabeth has been minimized. Accordingly, when Nancy was sexually molested by Thomas, the houseman, Mrs. Cabot acted *as if* it was not Nancy who was suffering but rather the hired man.

Mrs. Cabot talked to Nancy *as if* she knew what she was talking about, but she did not know. With all of these *as if* behaviors, Elizabeth forces Nancy to deny her own perceptions, thereby adding to her confusion about her identity and about her worth as a person.

Violence and Humiliation. Mrs. Cabot apparently associated love with physical violence. She is a woman who feels dead. Thus, she has married a violent man who needs constantly to defend his own image as a male, perhaps because he is the only kind who can make her feel alive and arouse her sexually.

This is a household marked by massive humiliation. For example, when Nancy was humiliated by her brother-in-law's sexual advances, Mrs. Cabot never intervened. She thereby further humiliates Nancy, adding to her anguish. She ignores Nancy's emotional disturbance yet exaggerates trivia. Through humiliation, Mrs. Cabot saps any belief Nancy has in her self and thereby distorts her perceptions. Through this process, the mother turns

Nancy into a *thing.*

The Father

On the one hand, Arthur Cabot seeks admiration and attention that he has been unable to get from his wife. On the other hand, he has not maintained generation boundaries when he looks to Nancy for sexual and emotional support, rather than to his wife. He has used Nancy as a pawn to purposely foster his wife's jealousy. Thus, Nancy has never been sure whether Arthur was father or lover. Consequently, she could not be clear about her own identity. Was she child, daughter, wife, lover? Or was she none of these and regarded merely as a sexual object?

Mr. Cabot is paranoid, inasmuch as he is suspicious and feels persecuted by one family member or another much of the time. He shows open contempt of his wife in front of Nancy. At the same time, he pits Nancy against her mother when he flails her with the accusation, "You don't love your mother because you spend so much time with Ruth."

Double Binds, Violence and Humiliation. Nancy is exposed to constant double binds and humiliation. For example, the father requires Nancy's admiration and adulation and yet in an outburst of uncontained rage, he says, "You can go kill yourself." He is tough, violent, and insensitive, as illustrated when he blasted Nancy and slapped Mrs. Cabot in the face. He

constantly tries to buy Nancy's love, while at the same time he is impervious to her emotional needs. He is bent on sacrificing tenderness to hardness.

He has weakened his role as a father through emotional withdrawal and physical absence from home. Although there are brief periods of affection (sexual), as when he holds Nancy in his arms, more often he is violent and humiliating.

Marital Schism

Lidz et al. speak of the modes of interaction within a family that seem to lead to one member becoming schizophrenic. In particular, their discussion of the nature of the relationship of the marital pair has relevance for understanding Nancy's behavior and personality development.

Of the two types of marital relationships, they have characterized one as "marital schism." It is this mode of marital interaction that helps to clarify how and why Nancy became ill. According to Lidz et al., marital schism is a chronic, severe disequilibrium and discord in a couple's relationship. They have spoken of one partner's chronically "undercutting" the worth of the other in the eyes of the children and their competing for the children's affection and loyalty. One member of the couple may try to make a child a substitute to replace the affection missing from the spouse, or the motivation may be just to spite the marital partner. This description fits the relationship

between Nancy's parents, including the father trying to substitute daughters as sources of affection. He received little from his wife.

In the marital schism situation, the husband is said to retain little prestige in the home, for none is warranted by his behavior. "He becomes an outsider or a secondary figure who cannot assert his instrumental leadership and when he strives to dominate in tyrannical fashion, he eventually forces the family to conspire to circumvent him." When Nancy's father could not make his point by shouting, he would resort to muscular action that required police intervention or the threat of it. His subsequent petulant efforts to drive to the city were usually aborted by some family member making the car keys unavailable to him.

In the study of Lidz et al., communication between the partners was impeded by reciprocal withdrawal, as well as by scattered thinking by the wives and the husbands' rigidity and paranoid thinking. As has been emphasized, some of the mixed messages that Nancy received from her mother may well have been scattered. The father's wild accusations about Nancy's adversely affecting his health were certainly paranoid.

The Cabot couple falls into the category of the "woman-dominated competitive axes." "The outstanding feature is the wife's exclusion of the passive and masochistic husband from leadership and decision-making. She

derogates him in work and in deed and is emotionally cold and distant to him. Her attention is focused on her narcissistic needs for competition and admiration. These wives are extremely castrating and their husbands are vulnerable. The husband withdraws from the relationship in an effort to preserve some integrity when defeated in the struggle, and may find solace in alcohol. The wife does not fill an expressive, supportive role to her husband and her expressive functions with the children are seriously distorted."

This is a reasonably accurate description of Nancy's parental household. Her father's retreat to living in the city during the week was based on the withdrawal described above, not on the inconvenience of commuting. The same is true for his having a separate bedroom from his wife. This was withdrawal or banishment, not the fact of his snoring that was officially credited as the reason. He certainly sought solace in alcohol, but it is doubtful that he found it.

Lidz and his colleagues have stated that they do not seek to demonstrate a direct etiological relationship between marital discord and the appearance of schizophrenia in an offspring. However, the two phenomena occur together with striking frequency.

Nancy never knows how her parents will behave toward her. They are inconsistent and unpredictable. Nancy has always wondered whether they

really care about her. She is puzzled that the only time they show emotion is when they are angry and condemnatory and that at other times they are more or less indifferent. They will continue to see her as a thing or as some extension of themselves and not as a person in her own right. To the extent that she has a relationship with Ruth or with the psychiatrist, the parents forbid such relationships, and having done so they refuse to see that any exist. Though they exercise denial on the one hand, they are capable of citing the relationships at any time for scapegoating purposes and as a basis for threats to demand that Nancy acquiesce to their wishes.

In conclusion, we will point out certain other dynamics of interaction that appear to have been operating in the Cabot household. We have previously mentioned that in the anguish of being unable to feel her self, Nancy slashes and burns her wrists. However, there is the problem of Nancy's repressed rage toward her mother. In addition to the above dynamic, does Nancy hurt herself *instead* of her mother?

Nancy tries to bridge the gap between her mother and father by playing the role of pseudo-wife and thereby gets caught in the schism, as for example, when she slapped her father's face. Despite all the violence in the Cabot household, both parents frequently acquiesce to Nancy's requests, e.g., they permitted her to return to college.

We have emphasized that the American characteristics of conformity and acquiescence are based on fear. What were Nancy's mother and father afraid of? Were they afraid they would lose her to the two most important people to Nancy—Ruth and the psychiatrist? Since Nancy was the scapegoat in this divisive marital pair, were the parents afraid that they would lose control with each other if they permitted Nancy to find her true self?

In view of another American characteristic, namely humiliation, it is critical to note that Nancy learned to enjoy the pleasures of humiliation. She found that humiliation brought some of its own reward. It was better for her to have her existence recognized even as a sexual plaything than not to have had her existence recognized at all.

Treatment

Obviously there is no specific treatment for depersonalization any more than there is for any other constellation of psychiatric symptoms. However, there are special considerations in both the psychotherapeutic and the somatic approaches to patients who experience the depersonalization phenomena.

The Task of Therapy

The task of therapy is to help the patient recognize his stereotyped,

anachronistic attitudes, concepts, and patterns of behavior, with their attendant anxiety and defensive maneuvers against anxiety. Then, alternative, flexible, contemporary reactions can be tested and facilitated and a dynamic growth process reinstituted.

Vulnerability to depersonalization comes about through deficiencies and distortions of the patient's experiences with nurturance in infancy and in subsequent stages of personality development. These include exposure to the double bind, rejection of the true self and fostering of the development of the false self. In essence, the infant is programmed to deny satisfaction of his needs, including the expression of his emotions, in order to avoid extreme anxiety. Such repudiation leads to repression so that the unacceptable needs and emotions are not consciously recognized. This is the intrapsychic programming that must be dealt with in treatment.

Why do depersonalization phenomena occur only episodically in the patient's daily living and why does a particular episode come about when it does? Some aspect of a present interpersonal relationship catalyzes the intrapsychic programming in such a way that depersonalization results. There is a meaningful sequence, of which the patient is unaware or only vaguely aware. The patient has an interpersonal experience that provokes anger, sexual interest, helplessness, or loneliness. Any one or all of these being unacceptable, it remains unrecognized. The effort to keep these feelings

repressed is such that all feeling is nullified. Then, the patient reports that he feels nothing, that he feels unreal and that the world is unreal.

Psychotherapeutic Technique

Utilization of the couch is usually contraindicated in these patients. Their feelings of unreality about themselves and the world are such that lack of visual contact with the therapist can underline the symptomatology to the point of panic. It is very important for the patient to feel and see that he is "touching" the therapist with his eyes and his words. He perceives this through watching the therapist's eyes and facial expression and correlating these with the words that are spoken by therapist, as well as by patient.

Some of these patients are not able to free associate on request or demand. To the extent that they are dominated by the depersonalization experiences, there may be lapses in their ability to free associate or even to verbalize at all. There may be true blocking. In this kind of situation, it is not enough for the patient merely to see the therapist. It is incumbent on the therapist to "touch" the patient with appropriate verbalizations and to begin to bring the patient out of his paralysis of unreality and associated blocking.[12]

Does one really touch the patient in an effort to introduce a physical dimension of warmth and reality? Probably not, or only under unusual circumstances. Ordinarily, it is simpler to set the limit at no touching. Once

touching is initiated, the patient may want more and more, and a line has to be drawn at some point. It is better to obviate physical touching in the beginning.

Neither Michelle nor Nancy has had much experience in being touched by someone who wanted to convey warmth and affection. Each has had her body used by men who wanted to titillate or satisfy their own lust. Each was extremely confused about her own sexual needs and their satisfaction; each was bewildered about the role of sex in love and love in sex. Each has attempted to arrange for recognition and affection by giving over her body to men. Michelle has had the wisdom twice to veto the possibility of this happening in an allegedly psychotherapeutic setting. Touching either of these girls, beyond the initial handshake, could have frightened them, on the one hand, and led to unconscious wishes for more contact, on the other hand. Such a development could have led to depersonalization experiences in the treatment session, or precipitated by the treatment. The complex transferential situation would have been further complicated.

Inasmuch as these patients have been subjected to manipulation and to the double bind for most of their lives, they in turn are usually expert in manipulation and in giving double-blind messages. Though scarcely aware of it, they enter treatment expecting the therapist to use the familiar, stereotyped parental techniques for controlling them. The patient more or

less automatically responds with his own repertory of manipulative and double-binding techniques. Anticipating the likelihood of these developments, the therapist is better able to recognize them when they appear and to obviate the otherwise inevitable game-playing.

One must also be aware of parental efforts to manipulate the therapist or the therapy. Michelle's mother tried the former unsuccessfully. She called the therapist and tried to make him an instrument in her efforts to control Michelle. Once parents recognize that the therapist is an ally of the patient and of health, they try to sabotage treatment. This can be done by withholding or withdrawing financial support or by fostering plans that remove the patient from the city. Both ploys were undertaken by Michelle's and Nancy's parents, and Michelle's treatment was terminated because of lack of funds. Nancy used private income and her parents did not interfere though they voiced disapproval.

Michelle's Treatment. In treatment, it is crucial to delineate the sequences of events that lead to depersonalization experiences. For instance, Michelle would speak to her mother in a near-by city about once a week by telephone, the mother usually initiating the calls. She actively avoided any show of interest in Michelle's health and welfare. Rather, she criticized Michelle for the life she was leading because it was soiling the family escutcheon and also ruining her heath. Michelle would try either to endear

herself to her mother, or become tearful, or both. Recognition and expression of rage, appropriate to the situation, never occurred to her. Each phone call was usually succeeded by depersonalization and an attack of migraine.

Conversely, her meetings with Derek, the contemporary and peer who had comparable European background, were marked by calm, comfort, and pleasure. There was never a hint of unreality feelings. However, she could not bring herself to allow the relationship to develop.

One of the focuses of Michelle's treatment was an ongoing review of her interpersonal encounters and her associated emotional reactions or their absence. Initially, Michelle regarded the therapist as a critical parent, a demanding authority, and an unfamiliar man who might have ulterior motives, as had her earlier therapists. On occasion, she would report having felt anger at the therapist after leaving a session, but she was not able to feel it, much less express it "on the spot." The therapist liked Michelle from the time she began treatment and felt warmth and compassion for her. It was important that he be her ally in pursuit of health, rather than in condemning the "enemy," i.e., her mother, boyfriend, and others, who exploited her and demanded compliance to their wishes. The therapist's role was to emphasize the fact that she had alternative responses in a given situation to her usual stereotyped response that led to depersonalization. As therapy continued, she was gradually able to report feeling less unreal at the end of a treatment

session. She began to experience positive feelings, including trust and warmth, in the treatment situation. Feelings of self-trust and self-respect began to emerge, i.e., a true self.

As the therapist became more familiar with her history, her attitudes, and patterns of behavior, it was possible to point out sequences leading to depersonalization. She began to recognize the appropriateness of a feeling in such a situation and then to identify the feeling itself.

The young man with whom she was living when she began treatment was remarkably like her mother in temperament and disposition, despite polar differences in background and breeding. Each had a remarkable talent for petulance, narcissism, and for demanding constant emotional feeding. Michelle came to recognize that living with him was some kind of replication of living with mother and that his presence was meant to obviate anticipated feelings of loneliness and helplessness. Realizing the price she was paying for this destructive companionship, she came to the point of challenging his demands and expressing her anger. Eventually, she developed the courage to move into her own apartment and to discontinue the relationship with him. In addition, she was able to be more assertive and to express anger in her daily work, which was filled with frustrating experiences.

Michelle's relationship to the therapist never had the depth and breadth

of Nancy's. Several factors contributed to this difference. Nancy's three sessions a week permitted such a development. In contrast, Michelle had one or two weekly visits with increasingly numerous broken appointments, until she ceased coming. Nancy, as child-woman, was more able to accept nurturance and warmth from the therapist with less inclination to sexualize these than Michelle was. Most important, perhaps, was the fact that Nancy had grown up in a home and a family—however disruptive and chaotic. Michelle had never really had either.

Throughout most of her treatment, Michelle reiterated her concern that she would meet the therapist on the street and have no idea as to how to behave. She really preferred that the therapist have no existence, except during her hour in the office. She came to be able to report feeling anger at the therapist during a treatment session, but not to express it.

Over the two-year period of treatment, she was able to forego the need to dramatize the relationship with her parents in her day-to-day living and to obviate the development of depersonalization experiences in these relationships. Her terror of her mother persisted, however, and the sequence of unreality feelings followed phone calls and direct meetings. Anger toward the mother could be recognized more readily, but not expressed directly.

Michelle interrupted treatment because she barely had enough to live

on. Characteristically, the mother had facilitated Michelle's entering treatment and had promised to pay all or half of the cost. She gave a series of double-bind messages that raised and lowered Michelle's hopes over some period of time. The ultimate message was that she and her third husband could not afford to provide financial assistance unless she (mother) obtained a job. However, her health was not sufficiently good for her to work and she attributed her ill health to concern about Michelle's way of life and need for treatment. Thus, Michelle was told that her need for treatment was the reason that her mother could not work and support treatment, a classical double-bind situation.

It is ironic that one of the principal areas of Michelle's growth—moving from Jacob's apartment where she lived rent-free—was the situation that made it financially unfeasible to continue treatment. Other substantial gains have been mentioned. However, there were many unresolved problems that made the interruption of treatment premature.

Nancy's Treatment. Though she was twenty years old when she came for treatment in the spring of 1963, Nancy was an early adolescent in many respects. Particularly in the earlier sessions, she was frightened and would sit and look at me wide-eyed as if she wanted to run away. She volunteered nothing, and on questioning she would respond by nodding or shaking her head as if that could suffice. If verbalization was necessary, her speech was so

rapid and so low in volume that it was difficult to understand her. She was not accustomed to having adults pay any attention to what she said, or if they did, it was to respond with criticism or ridicule. The one exception was Ruth, her surrogate mother, who at times was interested and attentive.

The information in the clinical vignette about her feelings and fears, her family and developmental history, and her ongoing relationships, was gradually elicited. Treatment sessions were devoted to a review of her activities between visits: classes in school, her interpersonal contacts with her roommate, with Ruth, and two or three visits a month with her parents. In addition, we talked about her daytime fears and fantasies and her nightmarish dreams. She came to perceive the therapist as consistent and predictable and the office as a safe place where she would not be ridiculed, criticized, or ignored.

Treatment was interrupted during the summer when Nancy went as a junior counselor to a camp where Ruth was a senior counselor. Despite fears about coping with campers and with other counselors, and petulant demands on Ruth's time and attention, she survived the summer. After many mixed messages from her parents, they presented her with a package deal which allowed Nancy to resume college in the fall, but restricted her contacts with Ruth and the therapist. As already noted, Nancy did not abide by these restrictions. Parental quarreling continued during succeeding months, as did

pressure on Nancy with threats that treatment would be discontinued.

Efforts to have her understand the role of unrecognized feeling in her depersonalization experiences met with success part of the time. However, on one or two occasions the content of treatment sessions had a negative impact. She would remain in the waiting room for up to an hour after her session because she could not penetrate the "wall" at the street exit. She found safety in being in the waiting room and in proximity to the therapist, though she knew that he was with another patient. She was jealous of other patients, particularly young women, and wanted to be "the one and only and the favorite." After a period in the waiting room, her courage increased, or her fear of the street and possible loneliness in the dormitory decreased, and she was able to leave.

One evening, the therapist found her in the entrance foyer as he was leaving about an hour after she had finished her session. She was terrified of the "wall." He told her that he was going to attend a meeting near her dormitory, about ten blocks north of the office, and that they could walk together. She was grateful and relieved and, in contrast to Michelle, welcomed this opportunity to walk on the street with the therapist. They chatted as they went along and he invited her to look into shop windows and at the upper stories of buildings. She looked around a bit and seemed to like the experience. This was in sharp contrast to her usual pattern of scurrying along

the avenue with downcast eyes that saw nothing and no one. When they reached the vicinity of her dormitory, she felt more calm and composed and able to travel the final half-block alone.

The therapist was fond of this girl and felt a good deal of compassion and protectiveness for her in her day-to-day living and her confrontations with her parents. He was the first male she had ever known who was attentive to her as a person and respected her. Other men had groped at her body, as if she were a toy or a thing for their pleasure. In contrast to her father, whose seductiveness helped maintain her infantile dependency on him, he was a surrogate who provided a growth-facilitating atmosphere. He provided a model for a male and a father that she could focus on in finding her way to individuation and a life and family of her own. In this setting, she could gradually dissolve the symbiotic relationship with her mother and realize that her own growth in no way meant the simultaneous liquidation of mother.

During the course of treatment, there were inroads in these realms. However, at times the therapist despaired at Nancy's episodes of petulance with parents or with Ruth, and her inability or refusal to be as assertive as she might and to take a more active role in running her own life.

Ruth was a transitional object for Nancy. On the one hand, she repeated

the mother's pattern at times by manipulating Nancy for her own needs. On the other hand, she was not Nancy's mother and thus was a positive resource in several ways. In addition, she shepherded other young women, as well as Nancy, on weekends to Nancy's chagrin. She would provoke Ruth by verbalizing her jealous feelings or by sulking.

There was a culmination of unpleasant experiences with her parents and with Ruth. Nancy's depersonalization and depression became more oppressive and she cut her wrist several times with a razor blade. Her condition was such that psychiatric hospitalization was required. Only then would the parents agree to discuss her illness and welfare with the therapist.

Following discharge from the hospital, Nancy resumed therapeutic sessions and undertook a typing course in a business school. Attendance and progress were impaired by her fears, shyness, and difficulties in concentrating. She lived in a YWCA residence facility for several weeks but spoke to no one and was afraid to enter the dining room. Subsequently, she found an apartment with another emotionally disturbed girl through Ruth. Despite the obstacles, the arrangement was somehow workable.

That summer, she again went to camp, this time as an arts and crafts counselor. She began writing letters, addressing the therapist as "Daddy Cattell." The content of the letters was not unlike that of her therapeutic

sessions. The therapist's responses were intended to provide support and encouragement, and evidence of his interest in her and concern for her welfare. He typed his letters on his professional letterhead and signed them with his usual signature.

In the fall, she resumed courses in typing and shorthand. She lived with her roommate, saw Ruth as frequently as possible, and spent occasional weekends at her parents' home. Treatment sessions dealt with her feelings about herself, her relations with her parents and responses to their concocted crisis situations, to her feelings about Ruth, and about the therapist. Thus, the year passed, and she made little progress in business school. On her parents' initiative, there was discussion about Nancy's living away from the New York area. She was acquainted with the Stevensons, a family who operated summer cottages on the Jersey shore and lived in Florida during the winter. These people were Ruth's friends and Nancy had spent time with them at the shore. The Stevensons visited the therapist's office to discuss the feasibility of Nancy joining their family. He concurred. Therefore, in the summer of 1965 she joined the Stevenson family and helped in the summer cottage operation. She returned for a few weeks of treatment sessions in the fall and then went to Florida with them. She wrote about missing Ruth and the therapist, about her unhappiness, her lack of direction, and her collisions with Mrs. Stevenson. The latter was somewhat tyrannical in running her home and family. The therapist replied promptly and as helpfully as he could, pointing out her

ambiguous position in the household—a combination of foster daughter, guest, and boarder. He noted that she had a choice to remain a rebel in the Stevenson family or to make other living arrangements. Unreality feelings were less marked at this time and she was aware of her anger and could express it in noisy temper tantrums and silent temper tantrums—periods of quiet sulking. The therapist suggested that these further incurred Mrs. Stevenson's displeasure and made Nancy's life that much more difficult.

She obtained work in a flower shop, where she showed a special proficiency in Styrofoam creations and flower arrangements, but had little awareness of her own ability and minimum pleasure in utilizing it. Through 1967, the therapist kept abreast of developments through two or three sessions a year, when Nancy was in town, and occasional letters. Her devotion and trust were very real and she seemed to gain a kind of sustenance from the relationship.

Her contact with men had been minimal throughout this time. A young man's call for a date was a burden to her and she avoided social engagements when she could. In Florida, she began to have some social life. In 1967, she met a lawyer who was about to begin his judicial clerkship. He was a devoted member of a Protestant religious sect, which Nancy joined. This meant that she had to repudiate alcoholic beverages, cigarettes, coffee, and obey certain rules. They married and in due time had a son and a daughter. Nancy has been

active in philanthropic organizations in the community where they are now living. Her endurance at jogging is greater than that of men her age. In all, she seems to be functioning in a healthy fashion consistent with her age.

Relevance of Family Therapy

It is important to re-emphasize that the family is more than a collection of individuals, it is a social system with a life, structure, and institutions of its own. Lidz et al., alluding to the contributions of several sociologists, have enunciated that within the family, the action of any member affects all, producing reactions, counter-reactions, and shifts in the family's equilibrium. Furthermore, the member labeled as the primary patient is a profile or mirror of the various intricate interrelationships within the family. To treat one member of the social system outside the context of that system (the family) can be useful, but the alternative of treating the entire family is more relevant.

Theoretically, the treatment of the primary patient only leaves him with two options: to stay in the family or to remove himself from the family. In actuality, the third possibility is a combination of these two, as illustrated by Michelle and Nancy. That compromise is to remove oneself from the family, yet remain within it in spirit and through ongoing contact with the family and responding to its influences.

Family therapy in the case of Michelle would have involved two natural

parents and three stepparents on two continents. Actually, the therapist was not in touch with her mother, who lived a few hundred miles away. She called him once and tried to engage him in her efforts to manipulate Michelle. He did not co-operate. Nancy's parents were hostile to psychiatric treatment, as already noted, and tolerated their daughter's therapy only because the college insisted. Following Nancy's hospitalization, each parent was seen individually on one or two occasions. They were disinclined to come together, since each one relegated responsibility for Nancy's problems to the other and to Ruth. They feared that joint sessions would disclose their own emotional problems.

Whatever the problems of logistics and cooperation in these families, family therapy was not indicated in the treatment of either patient. Family therapy is most relevant when the primary patient is living in the home and has no alternative possibility. Both Michelle and Nancy were living away from parents and joined them only for brief visits. The goal of therapy was to expedite each patient's living in the world, rather than to try to neutralize familial internecine warfare.

Some Limitations of Individual Psychotherapy

The patient who has depersonalization experiences may be inclined to isolate himself from the world of human relationships. Depersonalization can lead to divorcing oneself from reality and thus to underlying feelings of

unreality. This fact, that in a sense depersonalization begets depersonalization, can be pointed out in therapy, as described above. The patient may agree to the correctness of the observation but, at the same time, be paralyzed to initiate any action to block or reverse the vicious cycle.

While Nancy was in college, much of her day was structured and she followed the schedule reasonably well, without too much discomfort. It was the unstructured time that panicked her. Ruth filled some of this time by having Nancy with her one evening a week and on most weekends. Nancy thrived on this, but was unhappy when she was not included or when she had to share Ruth with one or more other girls. Then, she became jealous, unhappy, panicky, and symptoms were exacerbated.

There were several disadvantages in this approach. Ruth was functioning as recreational director for these girls, rather than as leader and role model. She was entertaining them, rather than demonstrating to them how they could learn to entertain themselves through the use of more initiative. It is not our intention to criticize Ruth. She served a vital function to Nancy and to many girls in similar straits. Rather, we wish to point out some of the subtle difficulties and possible pitfalls in this kind of situation.

Though Ruth was providing structure for Nancy's leisure time, she was also providing structure for herself. She needed Nancy and the other girls at

least as much as they needed her. When there is such need and dependency, the emotional involvements develop on a family level, rather than on a therapeutic level. Failing to realize countertransference phenomena, Ruth becomes the mother and reacts to her daughters as such, rather than as a therapist who maintains objectivity.

The extended amounts of time Ruth spent with Nancy made it extremely difficult for her to be objective, especially when she had no special training in therapy or psychiatric nursing, and all the clinical and dynamic insights that are included.

Co-therapy

Both Michelle and Nancy have suffered from severe deprivation of parental nurturance. With certain selected patients whose overwhelming symptom is depersonalization, the authors recently have begun to collaborate as co-therapists. Our therapeutic model is based on Durkheim's *Division of Labor* (the function of the division of labor is social, namely, *integration*) and on the social structure of the American family, as has been emphasized and clarified by Parsons and Bales.

In applying concepts from these two frameworks, several critical principles will be enunciated. First, it is through the gender-linked roles that parents transmit "the basic instrumental ways of their culture" to the child.

Second, each child requires two parents: "A parent of the same sex with whom one can identify and who functions as a model to follow into adulthood and a parent of the opposite sex who becomes a basic love object." And third, there is a division of labor between the parents: They maintain their gender-linked roles. For example, the father's role is to provide masculine instrumental leadership; his concern is with solving problems, completing tasks, setting directions and long-term goals which may conflict with giving immediate gratification to family members; and he paves the way for meeting the goals. The mother's role pertains to the expressive-affective functions : she provides nurturance to family members; she tends to be more concerned with immediate goals and gratification.

Implications of Theory. We have emphasized that the goal of therapy in situations of depersonalization is to help the individual to recognize his defensive maneuvers against the feelings of anger, sexuality, loneliness, and helplessness. In Laing's and Winnicott's frameworks, the task is to assist the patient to find his true self by building up his self-esteem. In more operational terms, the objective is to help the patient develop a pleasure economy so that he can *act* in terms of taking care of and giving to himself.

The assumption that underlies co-therapy is that a particular patient requires the therapist's participation in his whole life. The treatment of patients who are seriously disabled by depersonalization experiences

requires more than the traditional, individual psychotherapeutic session. Rosen, for example, has gone shopping with patients and has spent up to ten hours a day with them. Sechehaye's only patient lived with her. Gertrude Schwing, a psychiatric nurse, worked in co-therapy with Federn.

As in the case of the American nuclear family, the two therapists in co-therapy should be of a different sex. The therapy ("labor") is divided so that the female therapist takes the expressive-affectional role and the male therapist takes the instrumental-leadership role. To illustrate how we have applied the principles from the division of labor and the family structure to co-therapy, we shall give several illustrations that focus almost exclusively on the female expressive role of the therapist, simply because less has been written about it than about the traditional instrumental role in individual psychotherapy.

Alice Foster is twenty-five. She is very attractive, intellectually bright, and a skilled physiotherapist. She has had depersonalization experiences of a degree that have partially or totally incapacitated her episodically for several years. Her therapy schedule with the authors consists of seeing each of us individually once a week and, from time to time, seeing us together. The senior author sees her in his office, where she sits in a chair facing him. However, I conduct my therapy sessions with Alice mostly on the streets of New York.[13] My goal and function is to *reintroduce* Alice to the world.

For our first session together, I had planned to take Alice to Central Park. I had prepared two packages of bread and some nuts for us to feed birds and squirrels. When Alice arrived at my office, she slumped in a chair and said in an almost inaudible voice, "I don't want to go out." (I heard "I *won't* go out.") "I'm scared. I like it better here." As I put on my coat, I said "I know and that's just why we have planned this kind of therapy for you." As we walked into the park, she was very rigid, her head was down, her face was blank as if she were miles away; and she walked several steps ahead of me. After a long silence, I asked, "What are you feeling?" She responded, "Nothing." "Do you know where you are?" I asked. "Doesn't make any difference," she mumbled.

We walked for at least fifteen minutes in silence. Then, we came to a massive, magnificent oak tree. As I pointed to the tree, I asked, "Can you experience the tree?" She responded in a flat voice, "Nothing is real. I'm not real." I suggested that we go over to the tree and touch it. She walked beside me. I ran my hand up and down the trunk and described the texture. She made a motion with her hand as if to touch the tree. Gently, I took her hand, placed it on the bark and with my hand over hers, guided it up and down. Then, I took my hand away, but she continued to "feel" the tree. We walked away in silence. Suddenly she turned full face to me and said, "It's all right now. I'm back. I don't feel numb and empty like I did. I wonder why?" I withheld any interpretation, namely, that perhaps the fact that I had "touched" her physically and emotionally had brought her back to reality.

Operating on the principle that the development of the infant and young child is organized largely around feeding, I took Alice to a restaurant for lunch. Before she ordered, I told her, “Today, I am paying the check, so order whatever you like.” Our luncheon “session” lasted for two hours, during which she poured out problems concerning her former therapist (she had begun the same discussion in her latest session with the senior author), who came from the same mold as her mother. After lunch, we visited several small art galleries for three hours. I shared some of my favorite artists with her. She mentioned one who has been her favorite. It was touching and exciting to observe Alice reaching out to a new world; to hear her laugh and set free her delightful sense of humor. Later, as she waited with me at the bus stop to return home, she told me, “You know this is the very first time in my life that I have looked into a shop window in the city. I always walk with my eyes on the sidewalk, because I feel people are staring at me and making odd remarks about me. But today this didn’t happen.”

After a few months of co-therapy, she blurted out to me, “I hate my mother; I could kill her.” One or two sessions later, we were in my office, because it was raining. Alice sat in her usual chair and I sat on the sofa next to it, as I do when I am with her, rather than in my chair across from the patient. In this session, Alice stared blankly at the bookshelves and smoked continuously. I waited. She straightened up and became rigid. “What is it?” I asked. She nodded her head and shrugged her shoulders, which told me she

did not know. More silence. She said, “I feel so bad; I’ll never get any better. I don’t know what sends me into these spells.” I responded, “You know you told me about hating your mother and wanting to kill her. I wonder if this might be bothering you now.” She stared straight ahead, put down her cigarette, and for the first time I saw tears come to her eyes. I asked, “What is it?” She put her head in her lap over her hands and sobbed as her whole body shook. I said, “Give me your hand.” She extended her hand and I held it in mine. She squeezed so hard that the ring on my finger dug into my flesh. I stroked her head with my free hand and said, “Go ahead. You have been keeping these feelings and tears bottled up for years.” A lump stuck in my own throat and my eyes felt misty.

After some time, the sobs abated. With her head still in her lap, she said, “I feel calmer now.” She lifted her head, looked at me squarely and asked, “Will you be my mother?” I felt like taking her in my arms. Instead, I responded, “Alice, I can’t be your mother but I think I can give you the kind of *mothering* you need.” She nodded with understanding.

The senior author and I have had two planned joint sessions with Alice. The first was at the time of her initial visit. About six weeks later, we had another. When, in our individual session, I asked Alice how she had felt about it, she spontaneously replied, “I felt you two had ganged up on me.” The senior author and I discussed the matter and we agreed that we had been

premature. Alice first had to identify with both of us individually. In many ways, I have served as a bridge to the senior author for Alice. For example, when she told me that she feels stupid when she cannot answer his questions, I urged her to discuss the matter with him. She did.

We have had several unscheduled joint sessions in our kitchen. On one particular occasion—it was a hot sticky day—I offered her a cold drink. We sat at the kitchen table across from each other. She acted as if she really belonged there. I asked her to help me repot a plant. "But I've never done it before," she replied. "So that makes two of us," I responded. I showed her how to break up some crockery with a hammer to use for drainage in the larger pot. I directed, "Hit harder—it's great for the hostility." She gritted her teeth and her eyes narrowed as she struck hard several times in obvious enjoyment. The senior author walked into the kitchen to get a cold drink. Alice beamed at him as he put an arm on my shoulder. The three of us chatted for about ten minutes. The family structure had been recreated, but in a different way than Alice had ever known. She saw her doctor relate affectionately to her female therapist. Neither the senior author or myself detected any jealousy—only unabashed pleasure in being part of the circle.

Alice has grown, particularly in using initiative and experiencing pleasure. She and two friends planned a camping trip over a three-day weekend. Until that time, we had never seen her register sheer joy, pleasure,

and excitement. When she told each of us about this first camping trip, her face was radiant. She said, “I am really *excited,* so *excited* I can hardly wait.” The trip went well and when she described it the words tumbled out. Another camping trip is pending.

She almost “lives” in Central Park and goes to concerts there with friends. She had become interested in art and sculpture and has visited several galleries. From time to time, we have talked about bicycling together, but Alice has never ridden a two-wheeler. I offered to get the name of a bicycle instructor for her. She readily accepted. Several weeks later, she bounced into my office and announced, “Guess what? I learned to ride a bike by myself. I just practiced with all the little kids in an empty parking lot.”

It is important to point out that my role has not been limited to helping Alice experience the world and thus to find her true self solely through activities. Like the senior author, I have worked with Alice’s transference to me and her various resistances.

To work effectively in co-therapy, just as in a marriage and a family, it is imperative for the co-therapists to have worked through problems of competition. Perhaps for one of the few times in her life, Alice has not been exploited and used as a pawn. Her gradual development of autonomy, initiative, and self-identity are emerging, because we have provided her with

a new kind of “family setting” which has allowed her to grow.

Somatic Treatments as Adjuvants to Psychotherapy

The person who is dominated by depersonalization, anxiety, and depression, is unable to perceive the experiences of living in the world and is thus not able to really participate in psychotherapy. Freud alluded to anxiety as the motor that keeps treatment going, but a racing motor is useless unless the gears mesh.

The considered use of selected medications can obviate suicide, panic, and hospitalization, successively or simultaneously. Hospitalization for acute psychiatric conditions serves a most important role. However, in many instances, the essence of dynamic growth occurs in psychotherapy that takes place in a setting of day-to-day living. As we mentioned earlier, today’s vicissitudes activate yesterday’s programming of the individual. The problems are much more likely to be solved in the arena of everyday living than in some confined cloister.

We recommend the use, in selected cases, of a phenothiazine—chlorpromazine or prochlorperazine—in spansule form every twelve hours for twenty-four-hour coverage. Dosage should be tailored to the individual patient’s needs and tolerance of side-effects. If side-effects outweigh therapeutic effects, as happens in a minority of patients, a minor tranquilizer,

such as chlordiazepoxide or diazepam can be substituted in therapeutic doses consistent with the tolerance of the patient.

The combination of dextroamphetamine with amytal tends to neutralize the depersonalization experience in many instances. The twelve-hour extended release capsule taken upon arising provides coverage through the day. This in combination with one of the tranquilizers mentioned can facilitate the patient's coming to grips with his problems in psychotherapy.

To the extent that electric treatment is indicated for depression, associated depersonalization will be relieved along with the depression. The outcome of such treatment of depressive patients is the same, whether depersonalization is present or absent. In those instances in which depersonalization phenomena represent microcatatonic phenomena or alternate with delusional thinking, electric treatment can often be equally successful.

In all instances, depersonalization must be dealt with, finally, by psychotherapeutic means.

Conclusions

We have presented some of the psychological and sociological determinants of depersonalization and related psychopathology. To the

extent that anomie exists in society, and adults are alienated from themselves, they are more inclined to treat their children as things and to demand their compliance. This is in contrast to providing nurturance and fostering their individual growth and development. Such children are rendered vulnerable to depersonalization and to schizophrenia.

Michelle and Nancy both complain that everything they do is incomprehensibly dead, empty, and meaningless, or even that it is not their own action but that of a stranger. This absence of meaning, lack of involvement (never developing feeling for anybody), is the essence of Meursault's existence in Camus' *The Stranger.* He just allows things to happen to him because everything is the same; nothing matters. It is only when he is sentenced to death that he is compelled to take a look at himself. Kafka also portrays the despairing dehumanized situation in society.

In this chapter, we have illustrated that there are many avenues to emotional illness— the final consequence of all that is wrong with society. In both the families presented, the parents are withdrawn from the children and engage in transforming them into nonhuman objects, and there is massive humiliation.

The central issue, however, is why does one child become psychotic and another not? Why did Nancy have a schizophrenic reaction and Michelle not?

It is never a single episode or one ongoing abuse that results in a child's becoming psychotic. Rather, it is a climate of living, an accumulation of abuses, especially, *social isolation,* which we see as being the most destructive. The parents who inflict these abuses have several characteristics: They are disoriented in terms of being adrift in time, unable to differentiate one's self from the person acted upon; they mask reality (as-if behavior) and give double-bind messages.

And what are the future prospects for Michelle and Nancy? Both young women have physically extricated themselves from their parents. Michelle is still emotionally tied to her mother and has many other unresolved problems. Her life chances are less favorable than Nancy's. She certainly needs more treatment. Nancy will continue to have her ups and downs. However, her growth has led to what appears to be a stable marriage and she seems to thrive on the responsibility of caring for two children.

Bibliography

Ackner, B. "Depersonalization: I. Aetiology and Phenomenology," *Journal of Mental Science,* 100 (1954), 838.

Ackner, B., and Q. F. A. R. Grant. "The Prognostic Significance of Depersonalization in Depressive Illnesses Treated with Electro-Convulsive Therapy," *Journal of Neurology, Neurosurgery and Psychiatry,* 23 (1960), 242.

Arieti, S. *Interpretation of Schizophrenia.* New York: Brunner, 1955.

Bateson, G., D. D. Jackson, J. Haley, and J. H. Weakland. "Toward a Theory of Schizophrenia." *Behavioral Science,* 1 (1956), 251-264.

Beauvoir, S. de. *America Day by Day,* P. Dudley, transl. New York: Grove Press, 953.

Becker, H. S. "Notes on the Concept of Commitment," *American Journal of Sociology,* 64 (1960), 32.

Beckett, S. *Waiting for Godot.* New York: Grove Press, 1954.

Bettelheim, B. *The Empty Fortress.* New York: The Free Press, 1967.

Bialos, D. S. "Adverse Marijuana Reactions: A Critical Examination of the Literature with Selected Case Material," *The American Journal of Psychiatry,* 127 (1970), 81.

Bonime, W. "Orientational Perception," *The American Journal of Psychiatry,* 125 (1969), 1609.

Boszormenyi-Nagy, I., and J. L. Framo, eds. *Intensive Family Therapy.* New York: Hoeber, 1965.

Bychowski, G. "The Archaic Object and Alienation," *International Journal of Psycho-Analysis,* 48 (1967), 384.

Camus, A. *The Stranger.* New York: Knopf, 1946.

Cappon, D. "Orientational Perception: III. Orientational Percept Distortions in Depersonalization," *The American Journal of Psychiatry,* 125 (1969), 1048.

Cappon, D., and R. Banks. "Orientational Perception: IV. Time and Length of Perception in Depersonalized and Derealized Patients and Controls under Positive Feedback Conditions," *The American Journal of Psychiatry,* 125 (1969), 1214.

Cattell, J. P. "Depersonalization Phenomena," in S. Arieti, ed., *American Handbook of Psychiatry,* Vol. 3. New York: Basic Books, 1959.

Cattell, J. P., and S. Malitz. "Revised Survey of Psychopharmacological Agents," *The American Journal of Psychiatry,* 117 (1960), 449.

Cook, F. J. *The Warfare State.* New York: Macmillan, 1962.

Cooley, C. H. *Human Nature and the Social Order.* New York: Scribner's, 1902.

Durkheim, E. *The Division of Labor in Society,* G. Simpson, transl. New York: Macmillan, 1933.

----. *Suicide,* J. A. Spaulding, and G. Simpson, transl. New York: The Free Press, 1951.

Erikson, E. H. "Youth, Fidelity and Diversity," *Daedalus,* 5 (1962), 27.

----. *Childhood and Society,* 2nd Ed. New York: W. W. Norton, 1963.

Fromm, E. *Escape from Freedom.* New York: Rinehart, 1941.

----. *The Sane Society.* New York: Rinehart, 1955.

Hartung, F. "Behavior, Culture and Symbolism," in G. E. Porle, and R. L. Carneiro, eds., *Essays in the Science of Culture.* New York: Crowell, 1960.

Hendin, H. Personal Communication. Henry, J. *Culture Against Man.* New York: Random House, 1963.

Homans, G. C. *The Human Group.* New York: Harcourt, Brace, 1950.

Jacobson, E. "Depersonalization," *Journal of the American Psychoanalytic Association,* 7 (1959), 581.

Kafka, F. *The Trial.* New York: Knopf, 1937.

Katona, G. *The Powerful Consumer.* New York: McGraw-Hill, 1960.

Keeler, M. H. "Motivation for Marihuana Use: A Correlate of Adverse Reaction," *The American Journal of Psychiatry,* 125 (1968), 386.

Laing, R. D. *The Divided Self.* Baltimore: Penguin Books, 1965.

Lidz, T., S. Fleck, and A. R. Cornelison. *Schizophrenia and the Family.* New York: International Universities Press, 1965.

Ludwig, A. M. "Altered States of Consciousness," *Archives of General Psychiatry,* 15 (1966), 225.

McGlothlin, W. H., and D. O. Arnold. "LSD Revisited," *Archives of General Psychiatry,* 24 (1971), 35.

McLuhan, M. *Understanding Media: The Extensions of Man.* New York: McGraw-Hill, 1964.

Mailer, N. "What I Think About Artistic Freedom," *Dissent,* 2 (1955), 98.

Marcuse, H. *One-Dimensional Man.* Boston: Beacon Press, 1964.

May, R., ed. *Existence.* New York: Basic Books, 1958.

Mayer-Gross, W. "On Depersonalization," *British Journal of Medical Psychology,* 15 (1935), 103.

Mead, G. H. *Mind, Self and Society.* Chicago: University of Chicago Press, 1934.

Melges, F. T., J. R. Tinklenberg, L. E. Hollister, and H. K. Gillespie. "Temporal Disintegration and Depersonalization During Marihuana Intoxication," *Archives of General Psychiatry,* 23 (1970), 204.

Merton, R. K. *Social Theory and Social Structure.* Glencoe: The Free Press, 1949.

Miller, A. *Death of a Salesman.* New York: The Viking Press, 1949.

Mills, C. W. *White Collar.* New York: Oxford University Press, 1953.

Mirlin, S. M. et al. "Casual Versus Heavy Use of Marijuana: A Redefinition of the Marijuana Problem," *The American Journal of Psychiatry,* 127 (1971), 1134.

Packard, V. *The Hidden Persuaders.* New York: McKay, 1957.

Parsons, T., and R. F. Bales. *Family, Socialization and Interaction Process.* Glencoe: The Free Press, 1955.

Potter, D. M. *People of Plenty: Economic Abundance and the American Character.* Chicago: The University of Chicago Press, 1954.

----. "The Quest for the National Character," in J. Higham, ed., *The Reconstruction of American History.* New York: Harper and Row, 1962.

Riesman, D. *The Lonely Crowd.* New Haven: Yale University Press, 1950.

Roberts, W. W. "Normal and Abnormal Depersonalization," *Journal of Mental Sciences,* 106 (1960), 478.

Rosen, J. N. "The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy." *Psychiatric Quarterly,* 2 (1947), 3.

Rosen, V. H. "The Reconstruction of a Traumatic Childhood in a Case of Derealization," *Journal of the American Psychoanalytic Association,* 3 (1955), 211.

Roshco, M. "Perception, Denial and Depersonalization," *Journal of the American Psychoanalytic Association,* 15 (1967), 243.

Sarlin, C. N. "Depersonalization and Derealization," *Journal of the American Psychoanalytic Association,* 10 (1962), 784.

Sartre, J.-P. *Nausea.* New York: New Directions, 1959.

Schmahl, J. A. *Experiment in Change.* New York: Macmillan, 1966.

Schwing, G. A *Way to the Soul of the Mentally Ill.* New York: International Universities Press, 1951.

Searles, H. F. *Collected Papers on Schizophrenia and Related Subjects.* New York: International Universities Press, 1965.

Sechehaye, M. A. *Symbolic Realization. A New Method of Psychotherapy Applied to a Case of Schizophrenia.* New York: International Universities Press, 1951.

Shibutani, T. *Society and Personality.* Englewood Cliffs: Prentice-Hall, 1961.

Simmel, G. *The Sociology of Georg Simmel.* Translated and edited by Kurt Wolff. Glencoe: The Free Press, 1950.

----. "Fashion," *American Journal of Sociology,* 62, (1957), 541-548.

Stanton, A. H., and M. S. Schwartz. "The Management of a Type of Institutional Participation in Mental Illness," *Psychiatry,* 12 (1949), 13.

----. "Observations on Dissociation as Social Participation," *Psychiatry,* 12 (1949), 239.

Stewart, W. A. "Panel on Depersonalization, 1963," *Journal of the American Psychoanalytic Association,* 12 (1964), 171.

Strodtbeck, F. L., and J. L. Short, Jr. "Aleatory Risks versus Short-Run Hedonism," *Social Problems,* 12 (1964), 127.

Sullivan, H. S. *Conceptions of Modern Psychiatry.* Washington: The William Alanson White Psychiatric Foundation, 1947.

----. *The Interpersonal Theory of Psychiatry.* New York: W. W. Norton, 1953.

Tocqueville, A. de. *Democracy in America,* Vol. 1. New York: Knopf, 1948.

Waltzer, H. "Depersonalization and Self-destruction," *The American Journal of Psychiatry,* 125 (1968), 399.

Weber, M. *The Protestant Ethic and the Spirit of Capitalism,* T. Parsons, transl. New York: Charles Scribner's Sons, 1958.

Whyte, W. H., Jr. *The Organization Man.* New York: Simon and Schuster, 1956.

Winnicott, D. W. *The Maturational Processes and the Facilitating Environment.* New York: International Universities Press, 1965.

Wittels, F. "Psychology and Treatment of Depersonalization," *Psychoanalytic Review,* 27 (1940), 57.

Notes

1 We gratefully acknowledge the constructive suggestions provided by: Sidney S. Goldensohn, M.D., Bernard Goldstein, Ph.D., Professor of Sociology, Rutgers University, and Esther Haar, M.D.

2 The use of mind-expanding drugs has increased significantly in the past several years. Depersonalization is not a desired effect when one smokes marijuana, but is anticipated as part of the experience with psychotomimetic drugs. sensation that his personality was unfamiliar. Searles also has noted that any change, even if it is clinically favorable, is an intense threat to the sense of identity and thus to one's perception of reality.

3 This dynamic analogy of the socialization process was given in a graduate course on contemporary sociological theory when the junior author was a doctoral student in sociology. The course was taught by Harry C. Bredemeier, Department of Sociology, Rutgers University, in 1965.

The term "role," as used in this chapter, represents a pattern of behavior of an individual by virtue of his *position* within a clearly defined division of labor, such as mother in a family, daughter, sister, wife, teacher, customer in a supermarket, or patient in a hospital. Shibutani has stated, "The concept of role refers to the way in which the group norms apply to each of the participants. Each person is able to locate himself in the cast of the drama of which he is a part and thereby develops a working conception of what he should do."

4 The term "rationalization," as has been defined by Max Weber, is a process of the conversion of social values and relationships from the primary communal and traditional shapes they once held to the larger, impersonal, and bureaucratic shapes of modem life. The concept of rationalization serves Weber exactly as equalitarianism serves Tocqueville. In each, we see the historical tendency that can be understood only in relation to what happens to traditional society. Much of the emptiness of modern life is not so much a function of "commodity" production as of rationalization of life which has been developing at least since the seventeenth century.

5 Since Durkheim has related the incidence of suicide to the state of anomie, it is of interest to note that the United States has had essentially the same incidence of suicide since 1900. It falls in the middle of frequency of suicide in any consideration of world figures. The incidence is

10.5/100,000 and it has varied from 10.3 to 11—the extremes of the range. The incidence in the United States is about the same as in Great Britain. Sweden, Denmark, Japan, Austria, West Germany, and Hungary have an incidence of 15 to 23/100,000 that persists throughout the years

6 The term "significant others" refers to those persons who play a major role in the socialization process from infancy to maturity and to whom an individual relates in a meaningful manner, whether positively or negatively.

7 The term "personalization," as used by Winnicott, describes the process of ego development, based on body ego, evolving as the self of the baby starts to be linked with the body and body functions, with the skin as limiting membrane. He has chosen this term because he defined "depersonalization" as a loss of firm union between ego and the body.

8 Sullivan clearly differentiates between needs which result in satisfaction and in security. He limits the term "satisfaction" to the infant's response to having his biological needs (feeding, bathing, and so forth) met. In contrast, he uses the term "security" to refer to the infant's need for the relief of anxiety. This need is met by the mother's unconditional nurturance, acceptance, recognition, tenderness, and support.

9 The term "participant observer," as used and defined by Sullivan, refers first to the fact that a large part of mental disorder results from and is perpetuated by inadequate communication and that the communication process is being interfered with by anxiety. Second, the term means that each person in any two-person relationship is involved as a portion of an interpersonal field, rather than as a separate entity in processes which affect and are affected by the field. To illustrate, "participant observer" requires that one person not only observe the total behavior of the other person(s) in interaction, but also observe his own behavior—feelings, reactions, attitudes, thoughts, and so forth—and the impact of these on oneself and on whomever one is interacting with.

10 Both patients were treated by the senior author.

11 The names used are fictitious. The fact that both patients are women is fortuitous and is not meant to be a commentary on sexual incidence. Roberts found no sex differences in depersonalization. In our study, it just happened that each of these patients was in treatment for more than two years and pertinent data could be collected.

12 Laing has noted that the need to be perceived as a person is not purely a visual affair but extends to a general need to have one's presence confirmed by another. It includes the need to have one's total existence recognized and ultimately the need to be loved.

13In the discussion of co-therapy, use of the personal pronoun refers to the junior author.