AVERAGE WING RATINGS
(Thirteen patients)

Wing scale	Pre-trial	Weeks of treatment							
		2	4	6	8	12	16	20	24
Hallucinations	2·5	2·9	2·7	2·1	1·7	1·7	2·0	1·9	2·1
Delusions	2·5	2·5	2·5	1·9	1·7	1·2	1·7	2·0	2·1
Withdrawal	2·5	2·2	2·2	1·8	1·7	1·7	1·7	1·7	1·8
Speech disorder ..	2·5	2·5	2·5	2·2	2·5	2·2	2·0	1·9	2·1
Affect disorder	3·9	3·9	3·9	3·1	3·3	2·9	3·0	2·9	3·2
Behaviour disturbance ..	3·0	3·0	2·9	2·0	1·9	1·5	1·7	1·6	1·6

FIG. 2.

these very chronic 'refractory' patients the results were excellent in that 10 patients showed a clear clinical improvement (possibly in part from a degree of 'subclinical' depression), two as stated, became manic and only one patient's rather tense and hypochondriacal behaviour did not improve.

Although this was by way of a pilot study and therefore uncontrolled, it would have been impracticable and unjustifiable in our view to use placebo in these patients. Seen in conjunction with the results reported by other workers (6) we believe ours to be clinically realistic. Fig. 2 summarizes our Wing ratings of the patients before and during the trial.

Schizophrenic patients are, of course, highly responsive to changes in their environment (9), but we doubt whether an air of expectancy alone would explain our results; indeed, our initial attitude was, if anything, one of scepticism. We feel that flupenthixol decanoate is a promising and interesting drug which, rather to our surprise, improved a group of our most chronic schizophrenics to a degree much beyond what we had been able to achieve with what we considered to be fairly sophisticated chemotherapy with other drugs, and we believe it may become not only a valuable therapy for patients suffering from schizophrenia but perhaps even the first depot antidepressant. Further trials in both schizophrenia and depression seem indicated.

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DEPERSONALIZATION

DEAR SIR,

Much of the research carried out on depersonalization has involved assessments of its incidence in a variety of psychiatric and non-psychiatric populations. Authors have not always made it clear that there are a number of factors that may affect such estimations. These include: the definition of depersonalization accepted for the study, the method of eliciting the phenomenon, the skill of the interviewer, the validity and reliability of the method adopted, the co-operation and suggestibility of the subject, and the influence of direct questioning, suggestion and contagion.

Not one of the definitions recorded in the literature is entirely satisfactory; some just comprise a list of symptoms described by depersonalized subjects. With a phenomenon so difficult to delineate this is perhaps not surprising, and Lewis (3) pointed out

that 'it is difficult to decide how much objective reality there is in the word or how much metaphor'. Ackner (1) emphasized that insistence on the phenomenon being strictly formulated in a certain way violates the facts and produces an 'arbitrary terminological frontier'.

The method of eliciting depersonalization is of considerable importance. Those psychiatrists who take an interest in it frequently find it, while others claim that they run across it less frequently. This is not just a reflection of the skill of the interviewer, but is dependent on the type of questions and the manner in which they are asked. The less structured the interview, the more likely it is that there will be inconsistencies in the frequency with which depersonalization is recognized. This produces a dilemma for the investigator, because only a rigidly structured questionnaire can have a significant degree of inter-rater reliability, while on the other hand the incorporation of non-directive probes may be necessary to increase its value as an instrument for recognizing depersonalization.

Some patients are fearful of 'going mad', and feelings of unreality may be subjectively interpreted as signifying impending insanity. Questioning about feelings of unreality by a psychiatrist seeing the patient for research purposes only can therefore lead to unfounded fears and in some instances to denial of alien experiences. Some patients are more likely to relate their experiences to one with whom they have established good rapport, rather than to the researcher taking an isolated interest in depersonalization and not in the patient as a whole. This is less likely to be the case when dealing with a population of normal subjects, especially if they are associated with the practice of psychiatry on research and if they have agreed to participate in the study. This could possibly be one of the factors accounting for the higher incidence of depersonalization found in normal subjects (5) than in schizophrenic patients (6).

Although a sizable literature has accumulated on depersonalization, little mention has been made of the influence of direct questioning, suggestion and contagion. This is surprising, because there is the occasional psychiatrist who regards depersonalization as little more than an iatrogenic phenomenon induced by over-enthusiastic questioning. Although this is possibly true for a very small proportion of cases, the weight of evidence in the literature, as well as our own clinical experience, suggests that direct questioning does little more than assist the patient to verbalize his depersonalization experiences in terms with which we are familiar. Ackner (1) has pointed out that ' . . . one has the impression that the more medical contact the patient has had, the more likely he is to formulate his complaints in terms of unreality', and quoted a case in which depersonalization was described without use of the term 'unreality', until further questioning. He also stated that, just as hysterical paralyses abound when their value as demonstration cases is high, so hysterical 'emotional paralysis', when presented in terms of depersonalization, often leads to contagion (2). Roberts (4) also wondered if suggestion was one of the responsible factors for the high incidence of depersonalization found in his study of students.

In an attempt to assess the influence of suggestion and direct questioning on depersonalization, we designed a structured questionnaire with the questions arranged in an ascending order of suggestibility. Section A of this questionnaire consisted of general questions in which suggestion could not be said to play a part. Section B repetitively sought evidence of a 'change', a 'difference' or an 'alteration' in the experience of either the self or the environment. Section C asked directly about such feelings as 'unreality', and Section D attempted to elicit whether or not the patient had been 'contaminated' by such questioning or by contact with depersonalized subjects in the past.

The questionnaire was administered to 100 newly admitted patients under our care at Bergen Pines County Hospital, Paramus, New Jersey, U.S.A. Each of us presented the questionnaire to 50 of our own patients, while the other readministered it 24 to 36 hours later, without being aware of the first observer's findings. The questionnaire was not administered to patients whose attention, concentration and grasp were so impaired, as a result of either psychotic experiences or of intellectual deterioration, that they were unable to comprehend the questions; nor to patients with formal thought disorder of such severity that it was impossible to determine from their replies whether or not they were experiencing depersonalization.

Of the 100 patients tested, 24 were found by one or the other of us to have experiences fulfilling our definition of depersonalization as part of the symptomatology of their present illness, and 8 others had experienced depersonalization in the past. The distribution of the results between the different sections of the questionnaire and between the interviewers was complicated, but it was clear that as one ascended the hierarchy of questions a greater number of positive responses were elicited, and that with certain patients the second observer tended to obtain responses at an earlier stage of questioning than did the first observer. These trends did not, however, reach statistical significance.

Although we could not be sure that direct question-

ing had not induced depersonalization in certain patients, we felt that the questions simply assisted the patients to verbalize experiences which they had formerly found difficult to put into words. We veered towards this view because of a note of authenticity which the methodology of our experiment could not measure. This note was more than just an impression or 'intuition' and was clearly confirmed by some patients who gave negative replies to Section A and B questions but when asked, for example, 'Have you ever felt unreal?', not only replied, 'Yes', but went on to describe several classical features of depersonalization in a detail which the word 'unreal' itself could not possibly have suggested.

Of course, repeating a set of suggestible questions once only may not have been sufficient to induce depersonalization. It is possible that if they had been repeated a greater number of times suggestion might have been shown to be a more potent factor. However, it was not thought justifiable to burden acutely ill patients with repetitive questions of this kind.

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