

eventually joining a Cistercian monastery for two years. In 1981 he had become frightened by several intense meditative experiences, giving up the practice for some time. In September 1986 he entered a prolonged ecstatic state with heightened awareness, and increased attention and concentration that he believed was necessary to develop his psychic powers. It was initially pleasant and thought to be derived from spirituality and the contemplation of God.

However, as this state became a constant feature, Mr A found he could no longer control it or make it go away and he became mildly depressed with fatigue, 5 lb weight loss, and awakening from vivid dreams. During this time he had five panic attacks, lasting only a few minutes but preceded by 1–3 days of anxiety. He had one short previous episode of situational depression of moderate severity. His father is a chronic alcoholic, and both a brother and sister have been treated for depression. On presentation, Mr A's mood was mildly anxious and affect slightly restricted; there was no evidence of psychosis.

He showed mild left frontal lobe signs with decreased word list generation and perseveration with a reciprocal hand sequence test; deep tendon reflexes were increased on the right, and he showed dystonic posturing on that side with a complex gait task. The Wechsler Adult Intelligence Scale showed an above-average score (Verbal 118, Performance 105); personality testing gave evidence of general distress and interpersonal isolation.

Mr A was initially unsure whether he was willing to give up the mystical ecstasy in exchange for relief of the panics; hyperventilation on occasion had brought on a state that resembled meditation. Alprazolam helped somewhat, but increased the euphoric dissociation causing a sensation of levitation and "out of body" experiences; when phenelzine was substituted, the ecstatic state, panics, and mood change lifted in three weeks.

The predominant feature of his complaint was the feeling of strangeness or change which was initially pleasant and desired, and long preceded those akin to 'atypical' depression, or the few panic attacks. The picture resembles the syndrome of intellectual-obsessive depersonalisation with endless ruminative self-scrutiny (Torch, 1978). Depersonalisation disorder has probably the weakest description in the current DSM-III nosology, even though the symptom occurs frequently in dissociative, affective, and anxiety disorders as well as in psychosis. Attempts to define the syndrome essentially ended after the delineation of phobic anxiety-depersonalisation syndrome, although there was a slight revival with the study of meditation and 'transcendental' states. The salient features are: a subjective awareness of a feeling of change, strangeness, or unreality; a quality of unpleasantness or distress; loss of affective responsiveness; and the nondelusional quality (Ackner, 1954). Agents with sedating effects usually worsen depersonalisation; an MAOI was selected because of the class's stimulating effects and proven benefit with

mixed anxiety-depressive states, panic disorders, and atypical depression.

The phenomenology, associated conditions, and treatment of depersonalisation disorder must be better described if it is to survive as a useful diagnostic entity.

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References

- ACKNER, B. (1954) Depersonalization: I. Aetiology and phenomenology. *Journal of Mental Science*, **100**, 838–853.
 BENSON, H. (1984) The relaxation response and the treatment of anxiety. In *Psychiatry Update Vol. III* (ed. L. Grinspoon). Washington, DC: American Psychiatric Press.
 TORCH, E. M. (1978) Review of the relationship between obsession and depersonalization. *Acta Psychiatrica Scandinavica*, **58**, 191–198.

Unilateral Auditory Hallucinations

SIR: There have been a few reports of unilateral complex auditory hallucinations, and this lateralisation phenomenon has been attributed to the brain lesion contralateral to the side of the hallucinations. We report a patient with unilateral auditory hallucinations related to deafness on the same side.

Case report: A 72-year-old lady presented with a 26-year history of auditory hallucinations which had become louder and distressing over the preceding two months. The hallucinations were of complex verbal form. They were also stereotyped and repetitive in character. The voices were located in objective space and were attributed to her mother. The hallucinations were restricted to the left ear. There was associated depression, but this was in response to the persistence of the hallucinations. No other psychopathology was evident on mental state examination, and her personality was intact. She was originally seen in 1964, and was diagnosed as suffering from schizophrenia. She had consequently been treated with neuroleptics ever since. However, to our knowledge there had been no evidence of psychopathology pathognomonic of schizophrenia. She had a childhood history of otitis media with resultant deafness in the left ear since the age of seven. Her physical examination and routine blood investigations were unremarkable except for evidence of tardive dyskinesia. Recording of her EEG was normal. Hearing tests revealed that she had conductive deafness of the left ear.

On this admission the working hypothesis was that her unilateral auditory hallucinations resulted from her deafness. She was therefore encouraged to use her hearing aid. Indeed, she had been provided with a hearing aid for a number of years and had rarely used it, because she felt it was socially embarrassing. As her compliance improved, her auditory hallucinations disappeared. She became cheerful and fit enough to discharge. She had no medication.

Unilateral complex auditory hallucinations were considered by Bergman (1965) as a reliable indication of unilateral pathology, with lesion usually on the opposite side of the brain. Tanabe *et al* (1986) reported this lateralisation phenomenon in a patient who developed auditory hallucinations lateralised to the right ear with the lesion in the left superior temporal gyrus. They also reviewed previous reports (Hecaen & Ropert, 1957; Penfield & Perot, 1963; Foerster, 1936) and came to the conclusion that unilateral auditory hallucinations could be a significant clinical sign indicating a lesion in the temporal gyrus opposite the side of hallucinations. It is also held that significant numbers of patients with late onset schizophrenia (Kay & Roth, 1961) have a hearing impairment, and therefore isolation caused by deafness seems to contribute to the aetiology. In the majority of these patients deafness was found to be associated with persecutory delusions. In our patient, deafness was associated with auditory hallucinations and there was no evidence of focal brain pathology.

Here the unilateral auditory hallucinations appeared to be associated with ipsilateral deafness.

The hallucinations were stereotyped and repetitive in character and responded to a hearing aid.

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References

- BERGMAN, P. S. (1965) Unilateral auditory hallucinations. *Transactions of the American Neurological Association*, **90**, 226–227.
- FOERSTER, O. (1936) Sensible corticale felder. In *Handbuch der Neurologie Vol 6*, 358–498. Berlin: Springer.
- HECAEN, H. & ROPERT, R. (1957) Hallucinations auditives au cours de syndromes neurologiques. *Annales Medico-Psychologiques* (Paris), **117**, 257–306.
- KAY, D. W. K. & ROTH, M. (1961) *Journal of Mental Science*, **107**, 649–681.
- PENFIELD, W. & PEROT, P. (1963) *Brain*, **86**, 595–696.
- TANABE H., SAWADA, D., ASAI, H., OKUDA, J. & SHIRAIISHI, J. (1986) Lateralisation phenomena of complex auditory hallucinations. *Acta Psychiatrica Scandinavica*, **74**, 178–182.

A HUNDRED YEARS AGO Leavesden Imbecile Asylum

On Saturday last the managers of the Metropolitan Asylums District paid their annual visit of inspection to the Leavesden Imbecile Asylum, one of the three institutions for the reception and treatment of chronic cases of harmless lunacy chargeable to the metropolis. This institution affords accommodation for 2,000 patients – 900 males and 1,100 females. The cost per head, including the purchase of land, was £90 14s 7d. The infirmaries, epileptic wards, and ordinary wards are well organised, while in the estate of eighty-five acres many of the unfortunate patients were enjoying the beautiful afternoon. The more sensible and able-bodied men and women are employed in more or less active duties, while an excellent farm with cattle and pigs, kitchen-garden and gas-works,

afforded opportunity for open-air work on the part of other patients, which was evidently enjoyed. In the course of the proceedings, Sir Edwin Galsworthy, addressing those present, defended the Metropolitan Asylums Board for the charges of extravagance, which, he said, were often made against it, and claimed that in such an excellent work as the visitors had seen carried on in the asylum that day, ample proof was given of wise and useful expenditure of public money, as well as an enormous amount of work on the part of the public's representatives for the benefit of London and the poor.

Reference

- The British Medical Journal*, 16 July, 1887, 140.