Late Bodily Impairment and Depersonalization: The Case of Four Cameroonian Adults with Diabetic Foot

Mengue Assila Marie Serge[1]; Ndje Ndje Mireille[2]

[1]University of Yaoundé 1, Yaoundé, Cameroon
[2]University of Yaoundé 1, Yaoundé, Cameroon

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Abstract: Depersonalization is usually reported as a manifestation in other psychiatric disorders such as psychosis, anxiety, or depression; in physical trauma; or in drug addiction. But it has been very little reported in clinical descriptions relating to bodily injuries such as diabetic foot. This article focuses on the case of four Cameroonian adults with diabetic foot and presenting clinical manifestations close to the picture of depersonalization-derealization. He tries to understand the psychic processes at play in this phenomenon of depersonalization, in the context of diabetic foot in Cameroonian adults with no psychiatric history. To achieve this, we used the case study method. The data were collected from semi-structured interviews with four participants met at the Yaoundé Central Hospital. This data was the subject of a content analysis. The results show that these participants experience intolerable psychological suffering, caused by the damage to the body in its four dimensions, in each of the participants. They then show that this attack causes the gradual rupture of the sense of identity, due to social rejection and self-exclusion. And that this rupture is reinforced by a manifest failure of the work of symbolization. And finally, that, in these conditions where the subject, due to the loss of his social roles on the basis of which he nevertheless defined himself, experiences a massive libidinal disinvestment of his body, causing the withdrawal of consciousness from the body, and producing manifestations of depersonalization. And at the same time, he experiences the withdrawal of the libido from his environment, leading to manifestations of derealization. This study therefore provides a new perspective on secondary depersonalization-derealization disorder in the context of somatic disease management.

Keywords: *Late Bodily Impairment, Diabetic Foot, Failure of Symbolization, Depersonalization-Derealization.*

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I. INTRODUCTION

Chronic diseases are currently the leading cause of morbidity and mortality globally (Houmkoua et al., 2021). It is therefore characterized by its evolutionary mode introducing moments of aggravation, appeasement, relapse or even more serious complications. It is also characterized by its therapeutic demands made up of undue hardship, limitations, and great financial expenditures. There are four main groups of priority chronic noncommunicable diseases targeted for public policy intervention: cardiovascular diseases, cancers, chronic respiratory diseases and diabetes (WHO, 2018). Insulin is a serious and chronic condition that occurs when the body cannot produce insulin, does not produce enough insulin, or cannot effectively use the insulin it produces (IDF, 2021). Diabetes is described as "*one of the world's leading killers*" according to the World Health Organization (WHO, 2018). Most worryingly, in recent decades, there has been a steady increase in the number of cases of diabetes and the prevalence of the disease.

Indeed, the phenomenon of diabetes is growing in today's society, defying all prognosis. While the International Diabetes Federation (IDF, 2019) forecast the number of people expected to be affected by diabetes in 2025 at 240 million, the latest figure from the same organization for adults affected in 2021 is 537 million (IDF, 2021), almost triple these forecasts. In sub-Saharan Africa in general and in Cameroon in particular, this phenomenon is more formidable: insufficient knowledge on the issue, poverty and lack of appropriate care provide late diagnosis and therefore complications (Dehayem & al., 2016; Abomo & Essaga Eteme, 2020; FID, 2021).

The most feared, dangerous and expensive chronic complication in our society is the diabetic foot (Qassimi Ferdaouss, 2015). It is a common pathology in Africa (Dehayem et al., 2016). This is mainly due to the late diagnosis of diabetes in this region. Recent studies indicate that about 50% of people living with peripheral vascular disease are asymptomatic while 33% have atypical symptoms (FID, 2021). These people will usually find out about their diagnosis when they were being consulted for something else, usually a persistent wound. This consequently highlights the morbidity and even mortality of diabetes, and more particularly of the diabetic foot. In particular, many people

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living with peripheral vascular disease die in hospitals as a result of a complication of diabetes: deep tissue damage associated with neurological disorders and peripheral vascular disease of the lower limbs (Dehayem et al., 2016).

The situation in Cameroon is equally worrying. Indeed, the State, often assisted by the World Diabetic Foundation and the International Diabetes Federation, has set up several initiatives aimed at combating this disease. In this sense, we can mention in particular the establishment and implementation of the National Programme for the Control of Diabetes and Hypertension, or the WHO's Packages of Essential Non-communicable Disease Interventions (PEN and PEN-Plus) adopted later. It is a set of standardized, low-cost interventions designed for resource-constrained health systems (Nkafu Policy Institute, 2026). The strategy aims to integrate NCD care into primary health care, equipping first-line health workers with the necessary tools and protocols.

However, it should be noted that despite these efforts, the situation remains worrying. Thus, for the person living with diabetes, the government's action in the fight against diabetes is almost insignificant. Because, as Abomo and Essaga Eteme (2020) point out, health policies in Cameroon do not attach great importance to Therapeutic Education (TPE) for people living with diabetes. Similarly, no policy for systematizing screening has really been defined. Thus, for most people living with diabetes, the diagnosis of the disease is carried out by screening after the onset of the first attack, intervening at the onset of obvious complications. The IDF (2021) also notes that about 330,700 cases of diabetes are undiagnosed in Cameroon. The diabetic foot therefore continues to claim victims and has consequences on several levels. On the psychological level, it is a disease that affects the body. As a result, she observes difficulties with patients ranging from simple personal or relational conflicts to serious psychiatric problems such as depersonalization.

➢ *Damage to the Body in the Experience of Diabetic Foot*

In the Cameroonian context, the diabetic foot usually occurs in adulthood. The available studies do indeed report the average age of the disease at 57 ± 9 years (Dehayem et al., 2016; Tchakonte, 2005). However, this age corresponds to the apogee of man's social trajectory. Because it has proven itself by demonstrating its moral value and its ability to contribute to collective life during the period from adulthood to the end of the thirties. In particular, he or she has taken on important roles, including family responsibilities, with the entry into marriage and fatherhood, which are decisive stages in the acquisition of social adulthood (Fokwang et al., 2022). Having reached his forties, he is supposed to have fully accomplished his transformation into an accomplished social adult. Responsibilities reach their maximum here. He has family responsibilities as a husband, father and head of the family who must provide for his household and ensure the education and socialization of his children. Second, he has economic responsibilities as a worker who can generate sufficient income to support not only his nuclear family, but also his extended family. It also has a community responsibility as an influential member participating in local decisions and contributing to social cohesion.

These responsibilities are not optional. It is indeed on the ability to assume them that man is judged by his community. The adult is evaluated according to his or her ability to fulfil his or her roles, which are at the heart of social production and community cohesion. It is through the daily fulfilment of these obligations that man finds his value and maintains his status as a social adult. This period actually corresponds to the moment when he must rise to the top of society, as an intergenerational transmitter, as respectability.

The occurrence of a diabetic foot at this precise period is therefore an attack that can only be reduced to a single dimension of the body. For we can see in it the attack on the biological, subjective, social, and even unconscious dimensions of the body. The first, the damage to the body-object, is therefore an objective phenomenon, which can be diagnosed by paraclinical examinations such as imaging or biology, and which medical nosography accounts for with increasing precision. It is an attack on the body reduced to its organic, functional or mechanical materiality. It can thus take multiple forms that can be grouped into three main categories, although these are frequently intertwined in clinical reality, but which it is heuristically useful to distinguish: lesion and organic pathology, pain in its neurophysiological foundations, and disability with the functional loss it induces. In the context of this study, the involvement of the object body integrates all these forms, relating to the diagnosis of the pathology of diabetes, then of its complication, the diabetic foot lesion, with its algic and disabling characteristics.

Then, the attainment of the second dimension mentioned above, that of the lived body, appears as the loss of its transparency, of its erasure, that is to say its appearance in consciousness as an explicit object of our attention. It thus refers to an alteration of the feeling of incarnation, of the unity of the self-world, or of the evidence of inhabiting one's body (Merlau-Ponty, cited in Ancet et al., 2014). Its two fundamental modes are hyper-corporealization, that is, when it is too present; and de-corporealization, when it is not sufficiently de-corporealized (Fusch, 2005). In the context of this study, the attack on one's own body constitutes a hyper-corporeization due to its objectification and pain, which make it permanently present to the subject.

Moreover, the social body presents itself as the body invested by norms, signs, but also by the gazes of others. It is therefore the body in situation, marked by belonging, gender, status or age (Le Breton, 2016). We speak of its impairment when it ceases to be acceptable, recognizable or even legitimate in the eyes of others, what Goffman (1975, in Dargère, 2024) describes as a "stigma" or Le Breton (2016) as "bodily downgrading". It can also be symbolic sidelining or excessive social control that dispossesses the subject of his or her own self-presentation (Le Breton, 2016). The forms of its impairment refer in particular to situations of visible disability, chronic diseases, deviant bodily practices, ageing or obesity. And its main psychopathological consequence is the internalization of the stigma.

Finally, the concept of the erogenous body designates the body as a place of drive, jouissance and the repressed, not

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being confused with the organic or with conscious experience. Its impairment manifests itself in a massive, often progressive, withdrawal of the libidinal investment of the body (Schilder, cited in Dong, 2023). It therefore constitutes a narcissistic attack. Because the body, which should be the support of the feeling of existing, becomes a source of shame, worry, guilt, pain. The unconscious image of the body is wounded, fragmented, or, on the contrary, hyper-invested and painful. Its pathological forms include conversion hysteria, hypochondria, eating disorders, psychosomatic disorders, among others.

Clearly, this analysis of attacks on the different dimensions of the body has important implications for clinical psychopathology. It invites us never to separate the body-object from the body-lived and the body-social, but to articulate them in an understanding of the subject in its totality. Thus, the erogenous body presents itself as the interface between these different dimensions: it is the place where the biological becomes psychic, where the social is internalized, and where subjective experience is embodied. It is on the strength of this that our concern in this study is focused on the psychoanalytic theory of the body.

➢ *The Construction of a Psychoanalytic Theory of the Body*

The notion of the body has undergone a long evolution in the history of both scientific and philosophical thought. It has thus evolved progressively from the dualism of body and mind to the subjective representation of the body. However, it has remained quite ambiguous in psychoanalytic theory. Indeed, the founder of this theory had a rather clear-cut position on the possibility of a theory of the body in psychology. He certainly considers the drive as a notion straddling the biological body or soma and the psyche. On the other hand, he establishes that the source of this drive being somatic, its knowledge is not necessary in psychological research. He justifies this position by the fact that research in psychology is focused on psychic phenomena and processes, and consequently the study of the body is, according to him, the responsibility of another scientific discipline, in particular anatomical physiology (Freud, 1915, cited in Dejours, 2009). By this position, the founder of psychoanalytic theory distances the body from psychoanalytic theory (Dejours, 2009). There are, however, many attempts to establish a theory of the body based on Freudian metapsychology (Anzieu, 1985; Dolto, 1984; Schilder, 1950). Unlike the founder, who had based the analysis on the clinical case of neuroses, these attempts started from the clinic of borderline states and psychoses. Following this logic, we are given the opportunity to observe the subjective experience of the body in the context of diseases affecting the body, the particular case of the diabetic foot that is of interest in the present study.

This damage to the body, in this particular case of the diabetic foot, leads to the loss of the patient's bearings. According to Lehmann (2014), the basic element of the sense of identity and security is the body's landmarks. However, it is this body that has developed this pathology, in a sneaky way. Unexpectedly and helplessly, the patient found himself with an illness that is eating away at him from the inside, which upsets all his balance. Before, a simple injury had a relatively short time to heal. He was used to a healthy and vigorous body, yet now he finds himself with a body that is sick, vulnerable, fragile and unable to heal a simple wound (Kembellec, 2017). So sometimes he experiences it as a betrayal, this body has in fact betrayed him. He can no longer rely on it. However, as Lehmann (2014) states: "*the fact of not being able to trust one's body generates anxiety, permanent doubt, a feeling of shame and powerlessness.* (p.179) We can therefore observe from this intrusive attack on the body, throbbing anguishing ones, in the form of the fear of death. Le Poulichet (2010, cited in Lehman, 2014) sums up this situation well in the context of diseases affecting the body, when she states that "*the diagnosis acts like a trauma, it deals a blow to the ego, which dislocates*" (p. 264). The imaginary and symbolic psychic construction of the patient's body is altered, the sense of identity shaken. This happens to be the bed of depersonalization states.

➢ *Depersonalization-Derealization Experience*

The experience of the diabetic foot is made up of many attacks on the body. These modifications imposed by diabetic foot wounds thus reinforce the feeling of deformity and enormity. Diabetic foot ulceration sometimes causes difficulty in blood circulation to the periphery of the affected foot. This situation leads to either excruciating pain or a loss of sensation in this limb (Kembellec, 2017). Both cases, this author tells us, often cause the patient to feel bodily disintegrated. This also often results in an image of the body marked by devitalization. Patients also usually complain of feelings of heaviness in body weight, while others often speak of the feeling of immateriality; we also often note the feeling of modification of the limit and/or volume of the body, the feeling of being outside one's own body; or the feeling of having an unsuitable body envelope (Saladini & Luauté, 2013).

On the psychopathological level, psychodynamic models (Anzieu, 1985; Dolto, 1984; Freud, 1936; Schilder, 1950) approach depersonalization as a disorder related to the dysfunction of the distribution of libido in the subject. Freud (1936) evokes the thesis of early trauma. For him, depersonalization can be explained by the overflow or even the overcoming of the ego and its mechanisms, the latter undergoing a form of self-dissolution, the aim of which is to escape awareness, while struggling to restore its capacity for self-observation. For Schilder (1950), depersonalization results from an alteration of the self-image and is therefore a disorder of the image of the body. For him, it appears as a disintegration of the normal synthesis that ideally unites sensations, emotions and social relations in the construction of the body image. It is therefore not an absence of consciousness of the body, but a pathological consciousness of a body that has become foreign, because it is not invested by the libido and is not integrated into a network of personal and social meanings. Dolto (1984), for her part, conceives of depersonalization as the result of the non-structuring of the body image during early somatic damage. For her, it is not a disease of the biological body, but a pathology of the image of the body, resulting from a lack of symbolization of primitive experiences. It testifies to a collapse of the narrative function that allows a subject to appropriate his or her bodily history and to emerge as a desiring and distinct being. Finally,

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for Anzieu (1985), in line with the hypothesis of the early traumatic experience evoked by Freud, postulates that depersonalization is the result of psychic envelopes that are pierced, eroded.

And even if these various models have different postulates – about the origin of the experience of depersonalization – they all seem to have the same point of departure: the developmental aporias resulting from early psychic traumas. According to this approach, the depersonalized person experiences a change in the distribution of the libido resulting from the developmental aporias caused by these traumas, which has an unfavorable impact on the capacities of the ego and hinders the process of subjectivation. The experience of depersonalization is one of the disorders related to contact with reality (Dong, 2018). These models describe this disorder as occurring essentially in the context of serious psychological pathologies affecting the subject's relationship to reality. These are pathologies that originate in a deficient psychic organization, where there is an early withdrawal of the libido in external objects, with the difficulty of reinvesting them. They therefore refer to pathologies arising from a poorly structured psychic organization. In short, everything is done as if the disorder of depersonalization is present only in the general framework of psychiatric disorders such as psychoses (Freud, 1936; Anzieu, 1985) or exceptionally in organic injuries that occurred in early bodily damage, occurring in early childhood (Schilder, 1950; Dolto, 1984).

The cases described below refer to adults who were victims of late bodily injury and who had no psychiatric history. Our interviews reported that late bodily injury even in an adult with no psychiatric history can lead to experiences of depersonalization. They especially highlighted the reorganization in the psychic functioning of such a person.

II. METHOD

The present study is qualitative research. We applied the clinical method and adopted the inductive approach. It was a question of ascertaining the facts and rigorously making punctual and repeated observations concerning the involvement of the body in the context of the diabetic foot in the Cameroonian context. We opted for a case study, thanks to its ability to provide an in-depth analysis of a phenomenon such as the personalizing experience. The Yaoundé Central Hospital hosted this research, as it is one of the hospitals that have diabetology services in Cameroon.

➢ *Procedure, Collection Tools and Analysis Technique*

We carried out this study through the prism of qualitative research; to select our participants, we used the technique of purposive sampling, to which we associated a scale of evaluation of depersonalization. Thus, before meeting the selected criteria, the participants were subjected to a scale to assess the effectiveness of the depersonalizing experience for them. For this purpose, we used the *Cambridge Depersonalization Scale* of Lopez and Elzière. (2021). Subsequently, our reasoning on the choice of the participants finally selected was driven by the definition of criteria. The inclusion criteria were: being male with diabetic foot, receiving treatment at the HCY; having knowledge of his diagnosis of diabetic foot; showing signs of depersonalization states; being available to participate in the research; being 40 years of age or older. In addition, as an exclusion criterion, we note: having interrupted the interviews; not having signed the informed consent. And finally, as a criterion for non-inclusion, we have retained: being hospitalized; have another complication of diabetes; have another psychiatric illness or disorder.

We used the clinical research interview, in its semi-directive variant, as a data collection technique. This allowed us to focus the participants' comments essentially on the themes of the experience of the attack on the body, the depersonalizing experience and the desymbolization that interested us. According to the principle of saturation, we met each of the four participants four times. This interview technique was clearly beneficial to the participants who, through the verbalization it allows, were able to evacuate their suffering. Some have also benefited from prolonged psychological support at their request.

As a data analysis technique, we made use of thematic content analysis. It aims at a second reading of a message, to replace intuitive or instinctive interpretation with a constructive interpretation (Hascoët et al., 2024). Through the latter, we proceeded by dividing the discourse and identifying the main themes that can be the subject of different analysis depending on the questions and research objectives. In concrete terms, our operation consisted of selecting, condensing, categorizing, grouping and organizing the information. This technique made it possible to examine the meaning of words and to reconstruct the meaning of the sentence.

➢ *Ethical Provisions*

In psychology, as in various other scientific disciplines, research focuses on aspects of human activity. It must therefore be conducted with strict respect for human rights, regardless of the aspects studied. We have therefore regularly obtained an ethical clearance accompanied by a research protocol and a research certificate have been filed with the General Management of the HCY. It was only after the study of this file and the formal obtaining of authorization that the data collection was carried out. The present study thus complied with the measures aimed at protecting the dignity of the participants. Because, aware of their state of vulnerability relative to their condition, all of them have previously signed the informed consent. They were also free to suspend interviews at any time. It was also up to them to deliver only what they could say. And to reassure themselves of the anonymity of these participants, pseudonyms have been assigned to them. The average duration of the interviews was on average 45 minutes each, depending on the participant's availability.

III. RESULTS

To facilitate the understanding of the results of this study, they are presented by theme. But first, a systematic presentation of the history of each case is necessary.

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A. *Case History*

- *Alex Case*

Alex is a 49-year-old man from the West (Bafoussam of the Baleng tribe). He is married and has five children. He was a Catholic Christian, the youngest of five siblings. Professionally, he is a liaison officer in a local company. Before this illness, he says that he led a more or less stable family life. Alex does not remember any psychiatric history, bodily harm or particular event since childhood. He became aware of his diabetic status when he was diagnosed with diabetic feet eight months ago. He is being followed on an outpatient basis at the Yaoundé Central Hospital. To be selected, she was administered the *Cambridge Depersonalization Scale* of Lopez and Elzière (2021) and obtained a total score of 150, with 8 severe symptoms of depersonalization and 12 moderate.

- *Boby Case*

Originally from the West (Bandjoun), Boby is a 52-year-old man. He is married and has eight children. He is a Catholic Christian who lives with one of his children, the youngest, and his wife. He is the eldest of seven siblings. Boby claims to have obtained his primary school certificate in his time and worked as a public transport driver (taximan), before his illness which was announced to him two months ago. He is an adult with no psychiatric history, as far as he can remember, any particular bodily injury since childhood. He is undergoing outpatient treatment at the HCY. After administration of the *Cambridge Depersonalization Scale* by Lopez and Elzière (2021), Boby scored 155 with 10 severe symptoms of depersonalization and 14 moderate.

- *Carl Case*

Carl is a 50-year-old adult from the Centre. He is the second youngest of four siblings, and the youngest of the men. He is married and has two children. He is a Christian believer in the evangelical church. He is a telecommunications technician who has worked in different cities in the country. He lives with his wife and children in the East, and travels to each of his appointments at the HCY. Carl claims to have no psychiatric history, just as he describes a peaceful childhood, without any particular event related to any early bodily injury. He says he was diagnosed with diabetes 10 years ago. However, the diagnosis of diabetic foot is very recent, four months ago. Carl scored 146 on *Lopez and Elzière's Cambridge Depersonalization Scale (2021), with 9 symptoms of severe depersonalization and 14 moderate.*

- *Dany Case*

Dany is a 43-year-old electromechanic and computer maintainer from the West (Bandjoun). He is a Catholic Christian, the eighth of nine siblings (the youngest man), the husband of a wife and the father of five children. It has been 14 years since he was diagnosed, and after a long period of adherence, he says he stopped his treatment. Three years ago, when he returned to the hospital with a persistent wound, he was diagnosed with diabetic foot. Since then, he has been followed on an outpatient basis, with periods of improvement in his condition and complications. On the *Cambridge Depersonalization Scale* of Lopez and Elzière (2021), Dany scored 141, with 8 symptoms of severe depersonalization and 11 moderate.

B. *Body Experience*

An analysis of the four cases reveals a clear common structure. Indeed, the serious and painful bodily injury of late onset and disabling that is the diabetic foot operates a real dispossession of the body experienced. It thus induces a total transformation of the relationship to the body, which passes from a familiar and obedient instrument to a foreign, persecuting and alienating object. More specifically, Dany experiences an upheaval of bodily boundaries according to a double modality. On the one hand, his body retracts: the foot, physically present, is experienced as "dead" because it no longer responds to the motor intention ("*I don't feel that leg anymore. Finally! I feel it, the pain, yes. But to move the toes, nothing [silence]. I command, I tell my foot to move, but nothing, it doesn't obey me. It's like he's ... [hesitates for a moment] dead. But by staying there*"). On the other hand, it is extended by his wife's arm, which has become a necessary but alienating prosthesis: "*Everything you want, we have to give you. We have to go and find out. To go to the toilet, you have to call. Wait. Let my wife come. Let her take my arm. Without it, I can't. It's as if his arm has become my arm.*" This existential dependence sends him back to an infantile regression where the other becomes an "auxiliary ego".

Carl, on the other hand, describes an even more radical disintegration. His feet "*refuse to move forward*", as if they had become hostile adversaries. In her case, the lived space contracts down to the dimensions of her bed: "*My world begins at the edge of the mattress and ends here at the door.*" In addition, the smell of his necrotic flesh precedes his entry into the rooms, reversing the natural relationship of presence in the world: "*I enter a room before entering myself*". And even pain, personified, "erases everything" and reduces existence to the sole sensation of pain.

Boby, on the other hand, experiences a confusion of tactile limits that threatens the very integrity of the ego. The hands of caregivers and relatives constantly cross the skin border, to the point that he can no longer distinguish his own touch from that of others ("*I don't even know what is about me anymore. You see, other people's hands on my skin, it's become my daily life (...) I can't even tell the difference when it's me who touches me or when it's them [silence]*"). Similarly, pain is described as "*a fire that burns from within*", a self-combustion that turns the body into a place of torture. And his feet, once a "*rooting force*", have become "chains" that nail him to bed, completely reversing their symbolism.

Finally, Alex speaks of "betrayal": his body, which once obeyed him, now dictates its law. "*Now, according to him, I live (...) My life is limited only to the reflection I make on this footing... [Silence]* ". The diseased foot becomes an invasive entity, so "huge and heavy" that Alex fears it will explode. Pain empties him of his interiority: "*only pain occupies me (...) At the hospital recently, I screamed so much while the doc [the podiatrist nurse] was doing the bandage that it alerted the whole hospital.*" The smell of putrefaction makes

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him experience the monstrous coexistence of life and death: "*How can anyone rot alive?* ".

In fact, the body ceases to be the transparent mediator of being-in-the-world for all our participants. It fragments (retraction of the limbs), prolongs itself alienating (dependence on the other), persecutes itself (pain, smell, decay) and turns against the subject. The border between oneself and the other, between the living and the dead, becomes porous and distressing.

C. Symbolization Process

The bodily alteration mentioned above clearly leads to a radical identity crisis in our participants. The four discourses testify to a major failure in the capacities of connection and symbolization, manifested by massive silences, factual thinking, a cleavage of representations and an erosion of systems of meaning. Silence is a "collapse of meaning", an impossibility of distancing anxiety through language. His inability to integrate the disease into his history testifies to a biographical rupture: "*Now it's another life. I don't know this one*." Primary guilt ("I should no longer exist") reveals an archaic superego that transforms dependence into moral fault, short-circuiting any psychic elaboration.

As for Carl, he alternates between moments of nostalgic idealization of the past body ("*my body is particularly robust*") and moments of depressive devaluation of the present body ("*the smell of my own death follows me everywhere*"). This oscillation, characteristic of a bodily cleavage, prevents any work of mourning. The broken silences, the gestures of substitution (tapping the sheet, shaking the head) testify to an associative impasse where unrelated affect interrupts the chain of representations.

Boby, for his part, presents an operative, factual thought, reduced to the enumeration of immediate sensations: "*the wound is leaking, my wife comes at 5 a.m., she changes the dressing, it's wet*." The total absence of metaphor is a sign of an extreme impoverishment of intentionality. The silences here are a "withdrawal from the shared world", a motionless and overwhelming present. The nocturnal destructive rage ("*I want to break everything*") is a desperate attempt to regain agency, immediately followed by shame, in an exhausting cycle that locks in all elaboration.

Finally, Alex expresses his distress through tears and silences every time the interview brings him up to his suffering. The "*I don't know*" returns as a leitmotif, not as a refusal, but as the observation of a void of representations. The bodily cleavage between the "front foot" (living, functional) and the "foot of today" (rot, death) maintains an idealized image but prevents any integration. The collapse of explanatory systems – neither witchcraft, nor morality, nor religion give meaning to his illness – leads to an absurd observation: "*there is no justice in this world*".

Clearly, in all four cases, the symbolizing function is seriously attacked. Silences are "holes" in the psychic fabric, stopping points where unbound affect interrupts speech. The bodily cleavage preserves a "good object" (the body passes, idealizes) but prevents the integration of present reality. Explanatory systems collapse, leaving the subject to face the absurdity of his suffering. Thought is reduced to the factual, to the immediate sensation, for lack of being able to metaphorize.

D. Manifestations of Depersonalization-Derealization

The above developments show an experience made up of a double loss: bodily and identity, among our participants. And in the face of this double loss, the capacity for symbolization collapses. In conjunction with this reality, all our participants describe experiences of splitting the ego and altering reality, close to the picture of depersonalization-derealization. Indeed, Dany experiences a progressive disembodiment: "*I have become a bit like air, like wood smoke*". He floats "*on the ceiling*", reduced to a disembodied consciousness that watches, powerlessly, the spectacle of his own inert body. The voices reach him "from very far away, as in a dream". The alteration of the consciousness of the psychic ego reaches its highest level when he watches his daughter cry without feeling anything: "*It wasn't my hand. It was like the hand of a stranger*." Derealization is expressed in the perception of the world as "*a film*" from which it is excluded, enclosed in a "*bubble*". Carl, for his part, describes an alteration of the consciousness of the bodily ego or the diseased foot, experienced as a "*big stone*" that "*carries downwards*", becomes autonomous as a persecuting object. The psychic ego is also affected: it observes its own smile as that of a stranger, asking itself "*who is this man who is pretending?* ". The derealization reaches its peak in the confusion between dream and wakefulness: he no longer knows whether the illness is real or "*a long dream*", whether the shadows seen at night were his children or hallucinations.

Boby, for his part, describes a body exit characteristic of heautoscopy: "*I have the impression that I am flying, as if I were hovering above the bed. I see the man lying downstairs, with his big foot. I know it's me, but it's not me* ." The question "*who really suffers?* reveals that even pain, an intimate sensation, can be put at a distance. The alteration of the psychic ego manifests itself in the feeling of having become a "*burden*", a "*mouth to feed*", a "*hole in my place in the world*". The derealization is expressed in the loss of confidence in language: the words of the doctor and his wife "*don't seem true*"; only the stinky foot, the pain that doesn't go away, are real. Finally, Alex describes an alteration of the bodily ego where the diseased foot becomes "*enormous*", "*heavy*", "*invasive*", to the point that "*the rest of my body no longer* exists". The alteration of the psychic ego is revealing: it opposes a "before" where he was "someone", "a man, a real man", to a "now" where he is no longer "nothing", "*a completely empty shell*". Derealization is expressed by the loss of taste (food no longer has any flavor) and by the smell of putrefaction that makes him experience his own death in life.

Our four participants present, finally, a picture close to depersonalization-derealization. The alteration of the bodily ego manifests itself in the fragmentation, strangeness and autonomy of the parts of the body. The alteration of the psychic ego results in a biographical rupture, a feeling of

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becoming someone else, a loss of identity landmarks. Derealization affects the perception of the world that has become a "film", a "bubble", a "dream"; and even fundamental sensations such as taste and smell. These experiences testify to a significant withdrawal of the libidinal investment of the body and the world, giving way to a disembodied consciousness, a powerless spectator of its own decline, starting from social isolation and a painful questioning of the family or community role.

IV. DISCUSSION

Many studies prior to this study have reported the manifestations of secondary depersonalization in severe psychiatric disorders (Birmes et al., 2000; Cassano et al., 1989; Hollander et al., 1992; Murphy, 2024; Saladini & Luauté, 2013), physical trauma (Saladini & Luauté, 2013), and substance abuse (Yang et al., 2023). Very few have really addressed the issue in the context of somatic diseases (Dong, 2023).

It is true that the work of Bouvet (cited by Ribas, 2020) associated the experience of the body with the manifestations of depersonalization-derealization at the time. This author has indeed been very interested in the Ego-body and its disinvestments. In this work, he distinguishes, following Husserl (cited in Ancet et al., 2014) and Merlau-Ponty (cited in Ancet et al., 2014), two sides of bodily experience: the body experienced as a support for the ego's sense of identity and unity, and the body as an object perceived from the outside, comparable to other objects in the world. For this author, mental health is thus based on the harmonious articulation of these two aspects. In this logic, depersonalization appears as their disarticulation, as if the subject ceased to inhabit his body and perceived himself as a spectator foreign to his own manifestations, what he calls a "retreat of the ego in relation to the body."

However, his work is marginal to our results for at least two reasons. The first is that it does not directly deal with bodily injuries resulting from somatic diseases that appear late, as in our case. The second reason is the specificity of the Cameroonian context, which shows a slightly different source of distress leading to the appearance of manifestations of depersonalization-derealization. While his work evokes the disarticulation between the lived body and the object body, our results emphasize the progressive rupture of the sense of identity, particularly of collective identity. In fact, this nuance can be understood by the difference in social structure between the society in which he carried out his work (Western society), horizontal and individualistic; and the one in which we achieved our results (African society), vertical and community-based. And so, differently from its position, the distress related to social marginalization (by rejection for some and by self-exclusion by others) appears in our work to play the decisive role in the progressive rupture of identity, leading to these manifestations.

As for Dong (2023), he is interested in the onset of depersonalization-derealization disorder in young adults with a severe and painful late-onset somatic disease (sickle cell anemia). It therefore aims to decipher the specific psychopathology of depersonalization-derealization in the context of sickle cell anemia, a chronic genetic disease that manifests itself in childhood by vaso-occlusive pain crises, hemolytic anemia, and multiple complications affecting different organs. And unlike our patients, who experienced a period of bodily integrity before the late onset of diabetic foot (after 40-50 years), Dong's sickle cell patients (2023) grew up with the disease. Bodily damage is precocious, often in the first years of life, and is part of psycho-affective development from its beginnings. Thus, some convergences appear in our two studies. Indeed, they are due in particular to the proximity of our populations. Like the participants in Dong (2023), ours are contemporary Cameroonians, suffering from chronic somatic disease constituting an attack on the body. Similarly, similar mechanisms can be observed in the two studies, in particular cleavage. For its participants, this cleavage takes the form of an opposition between periods without crisis, when the body can be positively invested, and periods of crisis during which the body is experienced as an enemy. In our patients, the cleavage opposes the past body (idealized, healthy, functional) to the present body (devalued, sick, failing).

However, the divergences between the two populations are even more instructive, because they shed light on the impact of the temporality of the attack on the psychic organization. So, the first divergence is the presence or absence of an idealized "before". Among our participants, who have experienced a period of bodily integrity, the divide opposes an idealized "before" and a devalued "now." Whereas in Dong patients, this "before" does not exist, because they have never known a healthy body. The second divergence is due to the biographical rupture. In our participants, the disease occurs late, after a well-established adult life. It causes a brutal biographical break, a before and an after. The participants tell their lives in two stages: before the disease and after the disease. This rupture is at the heart of their complaint and their suffering for their identity. While in the participants of Dong (2023), the disease has been present since childhood. There is no clear biographical break, but a painful continuity. Their life story is not marked by a break, but by a repetition.

The third divergence concerns social and cultural inclusion. Indeed, in our patients, the late onset occurs at the height of social responsibilities, the moment when the adult man is supposed to be at the peak of his power, his status, his functions. The loss of this position is experienced as a social catastrophe, because it touches the very essence of what it means to be a man in Cameroonian society. Yet, in Dong (2023) patients, early attainment occurs before these responsibilities are acquired. So, they don't have to lose a position they never really held. Their social suffering is different: it is linked to the impossibility of fully accessing these positions, to the difficulty of building oneself as a young adult with a sick body. Clearly, the results of Dong's (2023) study converge with ours to a certain extent, due to bodily injury in the context of chronic somatic disease in the Cameroonian context. But they diverge from ours on several points that boil down to the temporality of the attack.

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V. CONCLUSION

Moreover, the objective of the present study was to understand the phenomenon of depersonalization in the context of a serious and disabling bodily injury, of late onset such as diabetic foot, through the failure of symbolization. It made it possible to understand the conditions in which manifestations of depersonalization-derealization appear among our four participants, men aged 43, 49, 50 and 52, from three of the four cultural areas of Cameroon. These manifestations were observed in particular in a context of serious and disabling bodily harm, of late onset. Our results allowed us to observe bodily injury in all its four dimensions.

The results show us that they are adults from a society in which identity is built through and in action. And that, foot disease constitutes a major impairment that is not limited to the physical dimension alone but integrates all the other dimensions of their life: social, subjective and symbolic. The participants describe a bodily injury that occurs at a time when, logically, they must access the responsibilities of society, at the social, family, cultural and spiritual levels. But this attack is an obstacle to this social ascent, the result of a hard-built reputation. With this attack, a progressive rupture of identity begins, reinforced by a failure of the work of symbolization, thus leading to manifestations of depersonalization-derealization.

This study thus offers a new look at secondary depersonalization in the context of a serious and disabling bodily injury of late onset, in a socio-cultural context of precariousness, and where identity is strongly influenced by the status occupied.

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