An Experiential Approach to Dissociative Phenomena

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5.1 A Clinical Vignette

Eduard is a 22-year-old Portuguese male, single, Caucasian, with no children, born in Lisbon, and living in Lisbon. He performed outstandingly during high school in a science-based curriculum where he had "enjoyed my life as a student being an extroverted, warmhearted, enjoying and fostering a strong group of friends." At the age of 18, after a problematic breakup (a 2-year relationship), he became help-seeking for the complaints that are described next and started psychotherapeutic and psychiatric treatment. During the following 2 years, he underwent treatment with antidepressants (SSRI and SNRI) and benzodiazepines as well as completed a year of weekly psychoanalytical psychotherapy and a year of weekly cognitive behavioral therapy. He had no past medical diagnosis and no substance abuse or forensic history. There were no formal psychiatric diagnoses in any of his family members though he referred that his father had been diagnosed with psychotic episodes (with paranoid and persecutory delusions) but did not entertain any psychiatric assistance other than acute prescription at emergency department and his mother showed anxious and an anankastic personality traits.

Our initial contact with Eduard occurred 2 years after his original complaints through a visit to our emergency department in North Lisbon Hospital Centre. His main complaint was "I have lost contact with reality. The best way to translate it is in recognizing my face as familiar in the mirror or, in case of not having that notion of reality, I just do not recognize myself. I need to recover the notion of reality and myself." In his first psychopathological assessment, he showed restless behavior and general distress, syntonic contact, clear reference in time and space and also an auto-psychically, euthymic mood slightly unhinged, physical and psychic anxiety,

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severe depersonalization and derealization (d&d), no apparent thought disturbances other than pressure of speech and rumination about his d&d experiences (no formal thought disorders), and no eating or sleeping disturbances. After an initial psychiatric follow-up, he commenced weekly client-centered psychotherapy treatment, which lasted for a year, and 3 years of psychiatric treatment. We attempted most psychopharmacological drugs from antipsychotics (including clozapine), antidepressants (including clomipramine), and mood stabilizers (including carbamazepine) with no consistent improvement. Despite enduring continuous symptoms and experiencing them as severe, restricting and disabling his performance fluctuated dramatically irrespective of the symptom burden ranging from (1) periods of loss of contact with reality, severe social isolation, and being restricted to home care (once he admitted to an in-patient unit and he spent 1 month at a day-hospital) to (2) average to good functioning with good social life and being esteemed worker and good student. Extensive neuropsychiatric tests were performed twice and suggested normal executive functions and no other disruption.

Eduard sent emails spontaneously, almost as a log of his daily activities referring mostly to anxious and d&d phenomena. The phenomena listed here (providing a glimpse into Eduards subjective world) and in Sect. 5.3 refer to those presented in (1) psychotherapeutic sessions (client-centered psychotherapy) which were taped for supervision purposes (tutoring) and (2) over a thousand detailed emails in the past 3 years.

> "I'm getting crazy, for times this is just anxiety but then I start being saturated and destroyed, losing pleasure in the things that I do"…"I don't feel time passing by, I can feel space, I can't feel my body. There are so many everyday life things that I cannot feel. I'm not available to reality. And this state is progressive a fact which always brings me down. Sometimes I feel that someone should open my chest with a machine-gun. I just can't "let it be", the lack of pain and feeling is not a good thing of course"…"I do not allow myself to become close to others, I've lost my inner center, I even fear of being homosexual, it is really as if I'm living a parallel history of my life, and the worse is that in this story I'm a bystander—I don't feel anything. You've led to try and see "how I feel" but that's just too vague and I don't feel much anything besides emotional distance and apathy"…"Sometimes I think this represents my lack of mental health while many other moments I feel I just lack disposition to do whatever"… "I'm worried with my emotional apathy. I see my girlfriend crying and I cannot cry, not even sadness, not guilt nor anything. I'm very worried because I'm becoming rigid. This rigidity is very worrying because it takes away my power"…"I think this is the lack of mental well-being and it is because I have suffered too much. I feel like I always have a cloud in my head"… "I feel as if I had suffered so much that I cannot believe that such amount of suffering could exist and it was more plausible that reality didn't exist" "I cannot stand this anguish, I can't stand this. This is sick. I can find a solution and I spend all days in my room. I can't feel this anymore. I already finished with her why am I left in this state, why? Enough. I'm not suicidal. But I cannot stand this suffering anymore"…"I can't feel sorry or shame. I can't feel anything. I have no identity, I feel no connection to others, everyone is a stranger to me, I feel no shame, I have no self concept"…"my head is going berserk, everything is just a mess, I'm all mixed up inside, fantasy gets mixture with reality. Yes I did get to some conclusions but today I got worse for staying home. My thoughts have become diffused and I can no longer separate things, I don't know why I keep making these associations"…"Everyone says I'm

obsessive-compulsive, as I don't show a critical appraisal the contents of my thoughts. But that critical stance exists thought only projected because I'm restless, it is an appraisal that reminds me that before it wasn't like this and the tendency is to vanish as I'm reinforcing my state and each time less my healthy readings of reality"…"I'm becoming paranoid, I feel that my friends talk to my girlfriend behind my back"…"My previous therapist just destroyed the rest always asking questions like "do you ever feel that persons in the newspaper are spying you?" For 3 months I felt that everyone was a spy by always testing myself. Convincing myself otherwise was almost impossible, made tests to myself lose the test I always lose the test and feel that I do feel that."

5.1.1 Appraising His Clinical Record

Despite a 5-year follow-up, Eduard has been challenging from the standpoints of diagnosis and treatment. At symptom level he displayed trait features of psychical and physical anxiety, derealization, and depersonalization experiences and states of psychomotor agitation and retardation, dysphoric, euphoric, and depressed moods with times of mood instability. His thought disturbances included experienced and observed thought pressure as well as overvalued, obsessive, and quasi-delusional ideation. A disturbing feature of his emails was the perseverance of ideas, as they seemed, from time to time, to recapitulate themselves on examples (he had little insight for such persistence). Along the 5 years there were no disturbances in appetite, sleep-wake rhythm, or suicidal ideation. According to ICD-10 classification system, there were periods where criteria were present for the diagnosis of general anxiety disorder, obsessive-compulsive disorder, dissociative fugue, psychotic episode, bipolar disorder, major depressive disorder, substance abuse, and several traits of borderline and anxious personality disorders.

His psychopharmacological treatment was decided largely to address anxiety and also, at times where diagnoses (nosology) were implied, for direct treatment of each diagnostic impression. Large arrangements of prescriptions were attempted along the years comprising most antipsychotics (including clozapine), antidepressants (including most tricyclic antidepressants), mood stabilizers (including lithium), and benzodiazepines. No improvement was acknowledged with exception of the reduction of anxiety through diazepam and other benzodiazepines. Indeed his enduring and severe symptomatic presentation seemed to improve and worsen across his life events. These comprised (1) a breakup form a long-standing relationship, (2) a rehousing process (left for a period from his parents' house), (3) voluntary and involuntary unemployment, and (4) permanent change of his friendships.

Eduard presently considers psychopharmacological treatment noneffective and psychiatric follow-up as negative to his recovery, and yet he accepts them both. He takes that psychodynamic and cognitive behavioral therapies were both prejudicial to his recovery by increasing or adding more elements to the intricateness of his chain of thoughts and increasing his cognitive strain. Along the 2 years where he decided just for sole psychiatric treatment, he described that the year of weekly client-centered therapy "was fruitful in decision-making and clarifying difficult

moments in his life" moreover it allowed him to focus and explore his experiential features. . .there were times in the sessions where he felt he was "in contact with reality and himself." Recently he decided to resume his weekly therapy sessions. An interesting take on his experiences arising from the last therapy sessions includes "I think it is my creativity and my intelligence that makes me this way, they took hold and I came to be in this state of everlasting diffidence, there is no proof for the things I doubt, the things I lack we all take for granted, but there are moments, there are always moments, I take it as happiness but they are also ecstatic where I can get a peek into experiencing reality—this state of well-being is really rare this time. This is what I want to achieve."

Therapist and psychiatrist agree with Eduard that his symptom constellation was unaffected by most treatments and that the patient remained help-seeking for the last 5 years. Despite the extreme suffering experiences and important fractures in his performance, the features of his personal contact, including his empathy, warmheartedness, and care, countered the possibility of the diagnosis of schizophrenia and to some point suggested to us that his restlessness might be hypomanic. Also his most relevant subjective distress was permanent depersonalization and derealization, features that were expressed in rich metaphorical language and some of which are described along the discussion of this chapter.

5.2 A Conceptual History of Dissociation

Eduard's main complaint is of suffering from dissociative phenomena (DP) particularly depersonalization and derealization (DD). By its nature, the distress of depersonalization experiences refers to the subject of complexity of human subjective experience suggesting the possibility of suffering not only through the presence of a feeling but also by the lack of feelings. Derealization implies that the meaning of experiences is not immediate but a process of inner attribution of meaning (and conceptualization) in which if disturbed can lead to different amounts of perplexity (or even loss of natural evidence). Most of Eduard's descriptions are made by metaphors adding to the overall idea that these changes in engagement with the world, enactment of meanings, and periods of loss of awareness are not easily transmittable. As a group, DP are complex as they involve (1) a large range of phenomena and (2) they occur in a large number of psychiatric and neurologic disorders as well as in healthy persons. The idea of dissociation in psychiatry has had various inputs and such is expressed in symptomatology (conceptual halo) and nosology, as in the different stances about dissociative disorders expressed in DSM-5 and ICD-10 (APA 2013; World Health Organization 1992). As with other psychiatric symptoms, DP are in need of increased conceptual and phenomenological inquiry. Dissociative disorders as a broad category raise criticism on the "lack (of) a single, coherent referent . . . that all investigators in the field embrace" [chapter by Cardena in Lynn and Rhue (1994)], and yet some of its central categories have shown phenomenological consistency [as is the case of depersonalization (Sierra and Berrios 2001)]. Dissociative amnesia,

depersonalization (and derealization), conversion symptoms (somatic symptoms), pseudo-hallucinations, trance, and self-disturbances are taken as classic dissociative phenomena.

Our up-to-date manuals including the ICD-10 (World Health Organization 1992) and the DSM-5 (APA 2013) use mainly an epistemology of changes of consciousness and the separation of "mental functions" (Hilgard 1973). The ICD-10 takes dissociative phenomena as a partial or total loss of (1) an integrated memory system, (2) a conscious awareness of identity or sensations, and (3) the control of bodily movements, and DSM-5 details it as a "separation of mental functions usually integrated and consciously accessible" comprising both/either memory, identity, perception, emotions, and/or will (Hilgard 1973). The DSM-IV was reorganized in the DSM-5 to increase the homogeneity of the categories—depersonalization/derealization disorder instead of depersonalization and accepting dissociative amnesia as encompassing dissociative fugue. Overall the clinical use of both classifications involves intense criticism as patients are frequently assigned with the diagnosis of "dissociative disorder not otherwise specified" (Saxe et al. 1993; Kihlstrom 1994).

An historical review of the conceptual models for dissociation is out of the scope of this chapter and can be found in a comprehensive review by Onno van der Hart and Martin Dorahy (Rosenthal 2009). From their analysis we retrieve some important ideas. First the conceptualization of dissociation is driven from the very start as (1) a detachment of parts of personality in Puysegur, Moreau de Tours, Gros Jean, and Taine or (2) the occurrence of double consciousness described in Charcot, Feinkeind, Janet, and Binet (see more in the previous reference). The former suggests a disorganization of the incorporation of personality elements. The latter proposes a behavioral override by an independent mental structure that the subject is unaware and that bursts directly as a response to a stimulus.

An important epistemological quarrel included dissociation being considered a phenomenon, a neurological explanation, or a psychological understanding. As an explanation dissociation is seen as the mechanism of the conversion symptoms in psychiatry and of functional symptoms in neurology. The latter has provided dissociation another delicate aura—functional symptoms stand for absence of an organic explanation that neurologists would claim real (dissociation = absence of a real cause). As a psychological explanation (e.g., psychoanalytical inputs), dissociation stands as the most relevant conceptualization of hysterical symptoms by the separation of psychological elements under the light of preceding stressors (traumatic experiences). Further studies have suggested a consistent psychological and biological correlation between trauma and dissociative phenomena [see seminal work by Ferenczi Putnam (1989)]. As a phenomenon, dissociation is also represented in the ideas of depersonalization, fugue state, and dissociative amnesia. Dissociative phenomena as a group are troubling as each phenomenon occurs in contrasting situations (e.g., depersonalization in anxiety disorders and dissociative amnesia arising in patients that do not express clear anxiety symptoms and can sometimes show "la belle indifference"). Linking the previous considerations leads to even more intricate possibilities as depersonalization is being considered as a

dissociative phenomenon with an anxious explanation (Baker et al. 2003; Sierra et al. 2012) or as a mechanism (detachment) of dissociative phenomena (Holmes et al. 2005).

Dissociative phenomena must also be distinguished if they occur (1) as a lifelong trait as in patients with schizoid, borderline, and anxious personality disorders or (2) in particular states as in depressive episodes, panic attacks, or epilepsy (Krüger and Mace 2002). Trait dissociation also appears to be phenomenologically related to the idea of schizophrenic autism and other basic symptoms. This discussion renders some troubles in the conceptualization of other dissociative phenomena as, for instance, amnesia in its anterograde form (inability to encode while in the situation) appears as a state, while retrograde amnesia (inability to retrieve elements of past situations) might occur as trait.

Another input is that dissociative phenomena could also accept lighter deviations of consciousness (e.g., daydreaming) suggesting that it is dimensional with non-pathological states (e.g., meditation). This discussion is age-old and materialized in the seminal quarreling by (1) Pierre Janet who supported that true dissociation only occurred in mental patients, specifically in hysteric subjects (Janet 2012) and (2) William James (James 1950) and Morton Prince (Prince 2012) who suggested it was dimensional occurring in adaptive and useful experiences (e.g., during stressful events) or in pathological situations. Some empirical studies support that a class of dissociation is pathological (Waller et al. 1996) and yet still with no nosological bearing as it occurs indistinctively in diverse taxonomical categories such as dissociation, schizophrenia, or PTSD (Waller and Ross 1997).

5.3 Dissociative Phenomena Through the Prism of Subjective Experience of Self

The idea that changes in the self are linked with dissociative phenomena is not new in psychiatry, but recently the research on this topic has increased (Parnas et al. 2003; Fuchs and Schlimme 2009; Stanghellini et al. 2012; Sass et al. 2013). Of all the conceptualizations, the idea of three interdependent levels of subjective experience of self seems to us useful to grasp differences between dissociative phenomena. In standard subjective experience of the self, the levels are attuned leading to a coherent narrative, effortless cognitive introspection, and a readily accessible body. Disturbances of the subjective experience of oneself take place when any of these levels are disturbed or there is a disconnection between them. The latter represents the dissociative mechanism that in this model would prime classic dissociative phenomena. Yet this model also accepts various phenomenological mimics due of these phenomena (e.g., derealization occurring due to a cessation of pre-reflexive level or due to its disconnection).

5.3.1 The Minimal Self

This first level, portrayed in the idea of a minimal self (Cermolacce et al. 2007; Legrand 2007), encompasses pre-reflexive experiential involvement with oneself and the world (and its pre-reflexive meaning). It incorporates the (multifaceted) notions of "myness" (the feeling of oneness with experience), "ipseity" (a nonpropositional acquaintance with oneself), "agency" (and the experience of embodied intentionality), self-awareness (ecological awareness of being in the world and awareness of the environment), vital feelings [see more in Scheler (1992)], "self-affection" and affective resonance (possibility for interpersonal synchronization), and self-continuity (retentional-protentional unity of internal consciousness and temporal coherence). Important attributes of the experience of the minimal self include (1) its nature of being implicit and involuntary and the subject oblivious to its existence under ordinary circumstances and (2) bearing hierarchical importance to other levels and edifying their foundations (its disturbances leading to devastating consequences on other levels of self-experience). So when fully operational, the pre-reflexive level allows effortless relatedness to (and understanding of) reality leading to an intuitive and transparent activity in the world. Disturbances in this level make the subject aware of being separate from oneself or of a sense of unfamiliarity or unreality of the environment. Also such immediate understanding allows the subject to act upon his perceptual experiences without cognitive effort. So beyond the experiential feature (which is discussed in Sect. 5.4), the minimal self refers to an immediate, pre-reflexive, or experiential meaning that imbues experience before any cognitive enterprise.

A disturbance in the minimal self could be conceptualized in Eduard's complaints including having to think more on what occurred ("I cannot stop thinking about what is happening to me, thinking it's a necessity as I feel that I'm always at risk of becoming perplexed"), losing the understanding about the other's behaviors ("I freeze in front of others as if I cannot understand usual gestures"), or even loss of familiarity ("my house doesn't seem my house, I feel I had never been here"). In descriptive psychopathology, these experiences refer to derealization experiences and yet also might refer to different phenomena including the (1) loss of the ability for ordinary undertakings (labeled as enacting and affordances), (2) loss of common sense and the manifestation of perplexity and a permanent struggle by introspection and cognitive reasoning, (3) attendance of new and private meanings about life, and (4) loss of a sense of acquaintance to one's world. The possibility of the subject accessing an embodied meaning (and its disturbance) is key to understanding situations where patients feel derealized while, at the same time, keeping on performing fine in their everyday functions.

5.3.2 The Cognitive Self

A second level is conceived as cognitive and includes the voluntary and semi-voluntary effort to cognitively introspect on experiences. The phenomena involved in this level include (1) judgments and beliefs on oneself and the world (self-

reflection); (2) body image, the reflexive concept of oneself; and (3) perspective taking—possibility to assess reality through different perspectives. As described, commotions in the previous level can lead to major disturbances in this level, and examples include (1) compensatory and primary forms of hyper-reflexivity, (2) delusional interpretation of reality, and (3) abstract idealization—"a kind of spiritual or intellectual utopian ideology, detached from concrete daily interpersonal life" (Stanghellini 2004).

Together with the derealization feeling, Edward complained that a part of his suffering was due to being restlessly thinking about experiences aiming to regain "contact with reality" through "thinking about reality," a straining cognitive effort in which, for times, he risked reaching farfetched conclusions against his actual objective and cultural milieu. This painful, frustrating and involuntary process of introspection had become out of control and was now imposed upon him—he felt that thoughts arose independently of his own will. In descriptive psychopathology symbols, these phenomena would be quoted as thought pressure, obsessive and compulsive ideas, and hyper-reflexivity. He also complained of losing the capacity to "think clearly" both by feeling that other person's ideas were saturating his way of seeing the world or as if he wasn't the author of his thoughts. Some of these disturbances that are well represented in other chapters of classical descriptive psychopathology (obsessive ideation, ruminations, passivity experiences) seem also to constitute d&d experiences by a felt sense of losing control of the frequency, proprietorship, and presentation of thoughts as well as a feeling of loss of control of the contents of thoughts. Such changes (together with insight) lead the patient to an overall strangeness and loss of harmony of his way of thinking. These disturbances have a close relation with other categories (discussed in Sect. 5.2 in the epistemology of subjective self-disturbances) as they are conceived as referring to a primary loss of other faculties (cognitive disturbance is the endpoint of other processes). Becoming derealized through changes in cognition could turn out to be (1) disturbances of the form of thoughts (see classical formal thought disorders), (2) hyper-reflexivity (as involuntary thinking processes), (3) disturbances of the cadence of thoughts (acceleration or slowing of thoughts), or an (4) altered hierarchical relation between thoughts and one's consciousness (the feeling that thoughts are not originated in oneself).

5.3.3 The Biographical Self

The third level of self-experience entails the cohesive judgment over one's own attitudes and memory arrangements that add up to the experience of having a biography and to the possibility of portraying oneself through a story (Gallagher and Shear 1999). The experience of oneself includes a coherent narrative for one's life that is different from all experiential, physical, or cognitive milieus. Such is portrayed in Proust "the corporeal envelope of our friend had been so well stuffed with all this (narrative details), as well as with a few memories relating to his parents, that this particular Swann had become a complete and living being, and I

have the impression of leaving one person to go to another distinct from him, when in my memory, I pass from the Swann I knew later with accuracy to that first Swann whom I rediscover the charming mistakes of my youth and who in fact resembles less the other Swann than he resembles the other people I knew at the time, as though it were the same in life as in a museum where all the portraits from one period have a family look about them, one tonality." (in The Way by Swann's, Proust, 1913) The author alludes to the idea that narratives (both autobiographical and of others) are part of one's identity. Disturbances at this level entail the (a) incongruence between one's autobiographical narrative and one's experience (experiencing experiential features that no longer adapt to previous narrative) and (b) periods of life to which one has experienced but cannot find a narrative for. Dissociative fugue and borderline personality disorder could be taken as examples of a disturbance of the narrative level of self-experience (Gallagher 2013; Bennouna-Greene et al. 2012).

The loss of autobiographical coherence reports to a feeling of having become someone else—again seeing oneself from a subjective third-person perspective and feeling that something has changed." These ideas report to the "narrative dimension" of patients' self-concept and how one can endure the loss of this autobiographical sketch, including the memory of personal life and existential determinations. In the case of Edward, he felt that ever since the loss of "contact," he was no longer himself—"I'm no longer myself, I can't recognise myself as if my narrative was stolen from me, what I'm living now doesn't make any sense, and there is no meaning possible for his existence in the world, I don't have a sense of a present or a future"; "I'm no longer myself—I don't act the way I did before"; "I feel as I must follow the rules and I cannot escape society dictatorship", "sometimes I have empty blocks in my life, as if nothing was attributed to them nor I feel to have lived them." Such autobiographical dimension of self-experience covers different experiences including (1) having autobiographical distinctiveness (e.g., a specific role in the world), (2) the consistency of autobiographical memories (e.g., if subject feels that his past makes sense as a whole), (3) continuity (there are no gaps in one's history), (4) personal consideration on how the narrative account develops, and (5) social integration (relation with personal and social norms). The first category refers to the presence or absence of the feeling he has a role in the world whether it is in micro-sense with his family/friends or macro-sense—that he has world importance. The second category characterizes the insight to a loss of (or an increased) contact with past moments in life (e.g., struggling to remember recent or distant occurrences in life as in dissociative amnesia) and has to do with the feeling that when one is portraying his life, he struggles for the description or he feels that such description is strange. The third category refers to the patients "Present" and to the feeling that there appear to be gaps in it, parts which the patient cannot explain (e.g., being aborted to a point of losing contact to what he is doing just to feel lost a moment after that). The fourth and fifth categories include various idiomatic expressions which have been put forward previously in the EASE interview (Parnas et al. 2005) by Tellenbach (see the discussion by Giovanni Stanghellini (Stanghellini et al. 2006), which refer to how the person stands on his stance toward

social norms (follows norms, even crushed by norms or has his own personal rules) and his overall existential inclination (stances toward reality). Having insight into changes of this dimension leads the subject to feel that he is autobiographically disengaged or desynchronized with himself or the world—which will fall under the ideas of dissociative fugue, depersonalization, or derealization.

Interestingly Edward's case illustrates that the relation between these levels of experience of the self might not be unidirectional (primacy of the pre-reflexive) as he considered that the disturbances of the minimal self started at the narrative level—through the breaking up with his girlfriend "I could not hold up to my ideas and through pain and suffering I had to depersonalize. . . I had to lose a part of me so that I could bear discussions with her but then, after the breakup, I didn't know how to turn-on the button to feel again. It was forever ruined."

5.4 Dissociation Through the Prism of Perceptual Experience

In this section we follow a parallel discussion of dissociative phenomena under the prism of anomalous perception of oneself and the world. Perception is here regarded as different from sensation as (1) being contingent to intentionality (e.g., humans attach relevance to items to which they are related to), (2) for times disregarding real objects (as in hallucinations) and (3) pre-reflexively meaningful and so not really a raw experience (Merleau-Ponty 1980). As in the case of the self, we consider human perception as having three moments that are weaved implicitly (which the subject is unaware). If these moments become disjointed, the subject experiences a disturbance of the perception of the world. Such disruptions we take here to be associated with dissociative forms of experiencing (loss of connection between different parts of experience). For understanding purposes, we discuss separately the disturbances of the perception of reality, of the lived body, and of the physical body.

5.4.1 Perception of Reality

Following the ideas of the previous section, for perception we consider that there is also an immediate meaning which allows the subject to live without experiencing the "effort to understand what he is living" (and only if that fails does the subject exerts a cognitive effort to value what he is experiencing). Cognitive understanding is only one of the facets of understanding experience, and the vast majority of the meaning of experience is readily available before the subject is able to cognitively portray it. Such "pre-theoretical realm meaning" appears to be as original as experience itself, and such primacy could mean either (1) that experience is already meaningful (meaning imbued in experience) or (2) that there is a previous translational effort which comprises an implicit pre-theoretical/precognitive understanding of the world. The first advocates that symbolization and thoughts are built over another type of meaning—a meaning that is immediate to experience (e.g., when understanding someone extending his hand to invite us to shake it, the meaning

comes with us seeing the hand). The second reports to the fact that the acquisition of meaning of concepts is mainly practical (hands on appraisal). Indeed, most of the concepts we use for building cognitive judgments are founded in an applied knowledge (e.g., we know exactly what "time" means although it might be hard to define it). So not only the understanding of reality has little to do with "thinking about experiences," even when attending to such cognitive form of meaning we are bound to practical knowledge imbued in our concepts.

The experiential access to the world and to others can become disturbed referring to a disturbed perception of the world. In the case of Eduard, such had changed and he indicated that "the world is no longer as it was, I cannot feel the realness of reality—it all seems a part of my imagination", "I lost my ability to feel in contact with others", "sometimes I think that everything around me is menacing, as if I was the target of some evil plan", "I can't act according to my ideas as I am forced to act according to others", "It is not only as if I'm not present, but also that the world appears simulated or feigned", "I'm always in an introspective world, thinking about what is happening within me, trying to make sense of it, I cannot contact the world as if I was cut off from it." Such portrays (1) experiences of detachment or invasiveness of reality (saliency, loss of the feeling of realness), (2) becoming overwhelmed by its features (some which might constitute true hallucinations), and (3) disturbance of the interpersonal dimension of experience (the possibility of willing or unwilling synchronization for others).

We propose that it should be clarified if the person feels derealized as he feels that the world is distant and lacking authenticity [e.g., Truman symptoms (Fusar-Poli et al. 2008)] and or if he feels that the world is menacing or invading him [e.g., Conrad's trema phase of delusional atmosphere as in Mishara (2010)] or if there are new and fearful elements as true hallucinations.

5.4.2 Perception of the Lived Body

In perceiving one also finds a subjective awareness of the body (Leib) which is in nature different from the corporal dimension (Korper) and has been an extensive study of phenomenological authors of the last century [see more in Sartre (1993)]. It represents the cenesthetic indulgence of this-body-I-am—what one experiences while occupying the first-person perspective and being conscious of oneself. It is the prerequisite to the experience of belongingness and to the particular relation one has with the world. The presence of this dimension of perception of the body is greatest in intensity when fully involved in an activity and when devoid of any cognitive effort (meaning arising is pre-reflexive). This experience is not a physical occurrence and so when there are only phatic inputs to perception the body and reality feels immaterial.

In Eduard's case (along with the increased feeling that his body had become physical), the most prevalent experiential feature was the loss of the experiential features of his living body. He portrayed an unwilling detachment from the world, a "feeling of not being himself," "feeling he was not the one acting in the world," and

"feeling total absence of pleasure or having become callous by a total lack of affection for other's experiences" (lack of first-person perspective empathy). These experiences are similar to depersonalization and derealization but also to other extensively described phenomena such as anedonia and blunting of affect. We present here that the experience of the lived body (leib) includes subjective awareness of oneself (ipseity, vitality, pleasure, agency, engagement), the changes in the structure of lived time and temporality and also some cenesthetic experiences. These concepts are complex and discussing them is not the aim of this chapter. They are idiomatically bound to ideas coming from phenomenological psychiatry such as (1) ipseity [descriptions in Gallagher et al. (2004)]; (2) changes in temporality including the ideas of intra-, ante-, and post-festum [see Stanghellini and Fuchs (2013) and Kimura (2003)]; (3) cenesthopathic changes and pain-like experiences [see Stanghellini et al. (2012)]; or (4) Tellenbach's despair and remanence (Stanghellini et al. 2006). In descriptive psychopathology, patients experiencing a disturbance of such lived body dimension would be classified as suffering from passivity experiences, depressive mood, or general derealization and depersonalization experiences.

5.4.3 Perception of the Physical Body

Lastly, perceiving the body is also experiencing it as materialized, objective, or physical (we take our body not as an experience but as reality due to the fact that perception involves a corporal/physical dimension). By "resisting" us, our body leaves the experiential dimension and appears to us as real—as when I hit a maple while moving in a house—or if my body cannot attend what is requested (as when I fall ill with the flu). In everyday routine, our awareness to such corporal dimension is a small part of its perception, and yet we can become hyperaware of their physical dimension (e.g., the flu or when experiencing shame). When falling ill as in the flu, our body cannot attend what is requested, and the corporal experience of self-world becomes manifest as a "resistance." In shame, the experience of external reification of oneself gives rise to objective apprehension of one being physical.

Many of Eduard's complaints focused on his body becoming "as flesh" when (1) his body became explicit, resisting movement, or estranged (increased awareness, materialized in flu-like syndromes), (2) his body became strange or changed in the mirror (here referred as mirror-related phenomena), and (3) the perceptualization of his thoughts which became similar to his own speech (here perceptual thoughts). This dimension has been present in seminal phenomenological (and philosophical) literature and psychiatric literature with respect to different psychiatric disorders from depression to schizophrenia (Fuchs and Schlimme 2009; Ratcliffe and Stephan 2014; Stanghellini et al. 2012). As pointed out previously, coining depersonalization and derealization can cloud rich phenomenological descriptions of (1) uncanny experiences of objectification or (2) immateriality of body or mind and disturbances of the experiential features of specific parts of the body or increased awareness of properties of movement. This section groups

15 different experiences and distributes them across 5 different categories: (1) intensity of body expressiveness, (2) change in the manifestation of mind, (2) change in the manifestation of the body, (4) change in the appearance of the body, and (5) changes in bodily movements. All seem to correspond to a feeling that the corporal dimension of experience is disturbed either by becoming ever-present (e.g., flu-like experiences) or by disappearing all-entirely (e.g., feeling of immateriality or passivity).

Lastly, the models we discussed here can interact, and there can be various assortments of disturbances of the experience of self and of perception leading to distinctive accounts of dissociative experiences. Therefore, we conceive mixed forms over a spectrum of two poles: (1) a full experience of selfhood that is disturbed due to the loss of relevant parts of perceptual experiences to (2) a disturbed experience of self while perception is preserved or amalgam disturbances both of self and perception.

The proposed models and the conceptual background presented for dissociative experiences stresses the complexity of their status as mental symptoms. Also, and irrespectively of these considerations finding or not further empirical validity, it should be added how artificial (and nonnatural/man-made) may turn to be their organization into classifications.

5.5 Discussion on Diagnostic and Therapeutic Implications

This essay was established on an unpretentious clinical issue—the feeling that writing "depersonalization" and "derealization" in Eduard's clinical file did not make justice to phenomenological detail we were achieving. Also, such detail appeared to us as relevant for clinical decision-making as all other symptomatic features revealed to be fluctuating and unreliable. Therefore our endeavors were to analyze these phenomena both from (1) their past and present epistemological understandings and (2) the phenomenological inputs that literature provided on the assortment of phenomena. In Sect. 5.2, we presented the theoretical ground of dissociation and the heterogeneity of inputs that fall under such topic. We found an assortment of inputs that seemed tomake dissociative experiences a complex field—even with some ideas being at odds—stressing that the inexistence of adequate diagnosis and consistent treatment plans could be due to conceptual and phenomenological impreciseness. Also we suggest that the tying bond of the whole group is not up-to-date with neuroscience research. Therefore we draw two present-day paradigms that are used for schizophrenia and depression to discuss them—disturbances of subjective self-experience and of the perception of reality, the lived, and corporal bodies. These are presented over Sects. 5.3 and 5.4.

Such parallel understanding can stimulate new research tracks that distance themselves from the age-old concepts on dissociation (e.g., separation of mental functions). Moreover, we suggest that exploring the presence or absence of singular experiences would help distinguish clusters that could account for depersonalization in specific psychiatric disorders (e.g., major depression, borderline personality

disorder, depersonalization disorder, and schizophrenia). It is stated here that we can feel (and be considered) depersonalized because (1) we lack engagement in the world, (2) experience reduced vitality, (3) are absorbed in our minds, or even (4) that we are plighted to social rules and tasks and lost the ability to experience our present (post-festum). Indeed keeping with umbrella terms is not helpful to current translational efforts of dissociative disorders as brain mapping relies (1) on the clarity of the phenomena in study and its closeness to a natural category and (2) the possibility that these phenomena have meaning for charting a disorder. And reiterating it, the possibility of different classes of depersonalization phenomena is key to understand which of those occur in psychosis and schizophrenia and which are mainly happening in anxiety disorders. Our effort to depict the conceptual and phenomenological ground of dissociative experiences is nevertheless partial (incomplete or unsatisfactorily categorized) and in need of empirical substantiation.

We would like to emphasize two important intersecting premises raised in our appraisal, that subjective phenomena should be inquired and that phenomenologically based semi-structured interviews seem relevant for its psychopathological investigation. Many of the topics regarded in this chapter are subjective phenomena which have for long been absent in our diagnostic textbooks (Stanghellini et al. 2013). Also, there are increasing evidences that the validity of psychopathological inquiry is greatest when we use semi-structured interviews (Nordgaard et al. 2012) even for objective signs and symptoms. By the use of the phenomenological method, phenomena are untouched (provide the interviewer plain access to the persons way of experiencing), and there is space for a discussion of meaning being presented so that the interviewer clarifies the phenomena. Also here is stressed that person-centered phenomenologically based interviews share fundamental features with various schools of psychotherapy including person-centered and experiential schools adding the possibility that the inquiry itself might be therapeutic (Thorne and Lambers 1998). To Eduard such person-centered interview allowed him (1) "increased control about such experiences" as well as, for times, (2) even "reducing the occurrence of depersonalization and derealization phenomena."

All together, it seems to us that a more detailed inquiry about these experiences, allowing for phenomenological unpacking, including subjective phenomena, and keeping up with a semi-structured person-centered interview, might allow us to better clarify them. In the future we aim that dissociative phenomena have increasing diagnostic properties as well as suitable psychiatric and psychotherapeutic managements.

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