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Meghan E. Doherty
More than Unreal: Clinicians'
Practice Experiences with Clients
Affected by Chronic
Depersonalization and Derealization

ABSTRACT

Despite a growing awareness of their prevalence, depersonalization (DP) and derealization (DR) – the persistent or recurrent experience of consciously feeling detached from one's mental processes, body, and/or surroundings – are two types of dissociative experiencing that remain mysterious, if not unknown, to most clinicians and clinical researchers alike. This qualitative study was undertaken to explore how a particular group of experienced clinicians have conceptualized their clients' chronic depersonalization and derealization symptoms, and subsequently approached therapeutic treatment. Semi-structured interviews were conducted with 12 licensed clinicians that had specializations in treating trauma and/or dissociative disorders, and identified working with clients that have experienced DP/DR symptoms. Participants were asked to reflect on the source of their knowledge regarding DP/DR; to define these symptoms and their relationship to dissociation; to discuss their assessment of what contributed to their clients' symptoms; to identify both effective and ineffective interventions and modalities they have utilized; and the impact of DP/DR on the clinician in terms of countertransference.

Study results indicated that clinicians have successfully supported clients in ameliorating their depersonalization and derealization symptoms through keen attendance to alliance and rapport building, as well as consciously using transparency and use of self to mitigate the various dynamic interpersonal barriers to effective treatment. Clinicians noted that relational,

intersubjective, and psychodynamic theoretical lenses consistently informed their understanding and treatment of DP/DR, and described the influence of ego state therapy as well as somatic, body-based intervention techniques on their approach to the clinical work. These findings were in contrast with existing literature that has framed DP/DR as treatment resistant to therapeutic intervention, and suggests the need for future research of the impact of clinical encounters on experiences of DP/DR, as well as increased education and training for those in the fields of mental health and social work regarding these types of dissociative symptoms.

**MORE THAN UNREAL: CLINICIANS' PRACTICE EXPERIENCES WITH CLIENTS
AFFECTED BY CHRONIC DEPERSONALIZATION AND DEREALIZATION**

A project based on an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2014

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So many thanks also go to my dear parents, whose continual belief in me has enabled me to learn how to trust and believe in myself; to Sarah, who has helped me access my multiple self-states and feel more deeply connected to myself and the world around me; and to all the café employees who kept filling my cup with coffee, and provided a space in which I could focus on the slow construction of these chapters.

Lastly, but most importantly, to the thousands upon thousands of individuals that experience depersonalization and derealization symptoms and wonder if there is any hope for feeling real again: your resilience and support for one another, as a largely silenced community, is inspiring. As Walt Whitman stated: we are large, and contain multitudes; I hope that more and more clinicians can learn how to better support your personal work in exploring the depths of your stories and selves.

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CHAPTER I

Introduction

Despite a growing awareness of their prevalence, depersonalization (DP) and derealization (DR) – the persistent or recurrent experience of consciously feeling detached from one’s mental processes, body, and/or surroundings – are two types of dissociative experiencing that remain mysterious, if not unknown, to most clinicians and clinical researchers alike (Nuller, 1982; Simeon, 2006). Though exploration of dissociation as a concept has a written history dating back to the 17th century, there remains extensive controversy regarding the definition of DP and DR, as well as its prevalence, etiology and severity. Common parlance, which has often linked the term dissociation with dissociative identity disorder and the existence of so-called multiple personalities, has contributed to an overall misunderstanding of the complexity of dissociation as a broader phenomenon (Shilony & Grossman, 1993). As a result, dissociative symptoms such as DP and DR, which are rarely externally visible, have often been perceived to have relatively minimal impact on a person’s quality of life (Hunter, Sierra & David, 2004). Furthermore, because DP and DR can occur both as a temporary, defensive reaction to stress, as well as an unremitting disconnection from daily experience, debate has reigned as to whether it qualifies as a diagnostic entity in itself. All of these factors have affected the ability to further build knowledge as to how depersonalization and derealization symptoms present, persist, and impact the subjective experience of the self.

For the purpose of this study, the DSM-IV-TR criteria for depersonalization disorder (DPD)(300.6) will be utilized as the operational definition for DP/DR, and consists of the following:

- A. Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g. feeling like one is in a dream).
- B. During the depersonalization experience, reality testing remains intact.
- C. The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The depersonalization experience does not occur exclusively during the course of another mental disorder, such as schizophrenia, panic disorder, acute stress disorder, or another dissociative disorder, and is not due to the direct physiological effects of substance (e.g. a drug of abuse), a medication or a general medical condition (e.g. temporal lobe epilepsy)(American Psychiatric Association, 2000, p. 530).

The DSM 5, akin to the ICD 10, has included the concept of derealization in this diagnosis and has shifted its title to depersonalization/derealization disorder (American Psychiatric Association, 2013). Derealization, according to both of these manuals, is described as “experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted)” (Spiegel, et al., 2013, p. 830). Because it has been found that most clinicians avoid distinctions between depersonalization and derealization due to the belief that they actually manifestations of the same impairment, and the lack of conclusive evidence that derealization is an independent phenomenon from depersonalization, they will be inextricably linked in this study (Varga, 2012; Sierra & Berrios, 2001).

Despite statistics that chronic depersonalization/derealization is present within 0.8-2 percent of the general population, clients that suffer from these symptoms often reflect feeling misunderstood by treatment providers (Hunter et al., 2004; Johnson et al., 2006; Michal et al., 2009). Studies have shown that most clinicians inaccurately diagnose chronic DP/DR as secondary to other disorders, such as anxiety or depression (DeHoff, 2010; Simeon & Abugel,

2006). These diagnostic conclusions ring false for those who experience DP/DR as prevailing and problematic in their daily life; negation of their subjective level of suffering by mental health providers, in addition to the general population, exacerbates feelings of aloneness, alienation and difficulty with pursuing therapeutic treatment.

At present, chronic depersonalization and derealization are perceived as treatment resistant to both pharmacological and therapeutic interventions (Baker et al., 2003). However, the validity of this claim remains unclear, as the literature seems to be devoid of research regarding the impact of psychotherapy and therapeutic relationships on clients' DP/DR. In addition, there is a lack of understanding as to how clinicians do attempt to engage with clients' DP/DR in the clinical relationship, as well as their subjective perspective of treatment efficacy. The following study was designed, as a result, to engage in a wider exploration of the potential reasons that psychotherapy has been broadly perceived as an ineffective treatment method for exploring, addressing and mitigating DP/DR. The researcher conducted exploratory interviews with 12 licensed clinicians that have stated experience with clients affected by DP/DR, with the aim of addressing the following research questions: 1) How do experienced clinicians understand chronic DP and DR symptoms? 2) What challenges might these symptoms pose in clinical encounters, and how do these impact the modalities clinicians utilize? 3) What meaning do clinicians make of their subjective experience and countertransference with these particular clients, and how might this affect the treatment relationship?

The conclusions drawn from this research are relevant to the field of social work on a number of fronts. Because there is little to no research that has elucidated how clinicians assess, respond to, and develop interventions to target depersonalization symptoms, clinicians are often undertrained regarding the complexity of what these particular experiences may mean for a

client. In addition, longstanding conflict regarding the understanding and definitions of dissociation, DP and DR have impeded the ability of academic institutions to consistently and effectively train clinicians in how to approach long-term work with a patient who feels themselves and others as unreal. Research that can elucidate the ways clinicians have and do approach understanding and working with DP/DR is paramount in removing both the mystery and the stigma perpetuated against, and internalized by, those that live with these symptoms. As the foremost providers of mental health services in the country (SAMHSA, 2002, as cited in National Association of Social Workers, 2009), social workers play a vital role in both understanding the symptomatic challenges of clients in the field, and improving the quality of overall mental health service provision. In addition, the National Association of Social Workers (2008) Code of Ethics prioritizes the challenging of social injustices, as well as the valuing of human relationships; it seems evident that contributing to a greater understanding of a marginalized diagnosis, such as DP/DR disorder, can improve services to individuals in need, and is thus connected to our ethical obligation as social workers.

CHAPTER II

Literature Review

Depersonalization (DP) and derealization (DR), two modes of dissociative experiencing, are terms that have been shrouded in conceptual debate since the beginning of psychoanalysis. In the 120 years since Breuer and Freud's (1893) observations on dissociative processes in patients presenting for treatment, multiple disciplines of mental health professionals, within and outside of psychoanalysis, have contributed to the vast base of literature exploring DP and DR. This chapter will begin with some of the historical, theoretical and contextual literature that has contributed to conceptualizing dissociative disorders as a category, contrasted with literature specific to depersonalization, in order to frame the present challenges in clinical (mis)understanding of DP/DR. Major themes regarding etiology, prevalence, and treatment methods will be address. Furthermore, a brief discussion of depersonalization as defined within the social psychology field will contribute to a wider discussion of the ways DP/DR, and experiences of "unrealness", are perpetuated on systemic and institutional levels of society. In addition, discussion of the literature on countertransference in relation to dissociation and trauma will further elucidate the importance of pursuing this study on clinicians' experiences in the clinical relationship with DP/DR, and its impact on treatment. Limitations of the literature will also be discussed.

Historical and Theoretical Underpinnings of Depersonalization/Derealization

While some argue that depersonalization has only recently become the focus of clinical research, psychodynamic theorists have a long history of mulling over the meaning of dissociative experience, and DP/DR in particular. Over the 20th century, numerous psychoanalysts critically reflected on clients' experiences with these symptoms in ways that subsume any present dynamic work on the topic. The value of these older works cannot be understated, as psychodynamic literature has contributed the most in terms of quality and quantity to a foundational understanding of depersonalization/derealization in all clients, regardless of the etiology or diagnosis.

Though the term depersonalization was first coined in the late nineteenth century (Dugas, 1898), symptoms suggestive of DP/DR were described in case studies throughout the 1800s in connection with diagnoses of hysteria. The term was in fact used to refer to a broad range of psychological conditions and symptoms that today fall under more distinct diagnostic categories such as dissociative, somatization, conversion, borderline personality and post-traumatic stress disorders. Pierre Janet (1859-1947) can be credited with the realization that all of these clinical phenomena are a result of dissociative mechanisms, which he described as the “difficulty of personal synthesis” (as cited in van der Hart & Friedman, 1989, p. 6).

The development of dissociation theory in the late 1800s and early 1900s can be traced back to a battle of the minds between Sigmund Freud and Pierre Janet. Freud discussed dissociation without using this term, but instead referred to it as *repression*, and noted it was an active process. This aligned with his theoretical constructs around defense mechanisms, the purpose of which are “to stave off an instinctual danger only by putting restrictions upon its own organization” (Lynn & Rhue, 1994, p. 24). Freud described his own experience with

depersonalization in his work, “A Disturbance of Memory on the Acropolis” when, after having longed to see the famous ruin for years, he was overwhelmed by its realness in person. This experience of depersonalization, he concluded, was his mind was defending against feelings of triumph and guilt in superseding his father (Levy & Wachtel, 1978). Because Freud’s tripartite structural model of the psyche emphasized the existence of one unitary consciousness, he postulated that there was one unconscious that acted as a container for repressed material.

However, unlike Freud, Janet maintained that there existed a “double consciousness” and potentially multiple centers of mental activity in the structure of the human mind (Harrison, 1966). The key differences between their theories is the implied model of the mind, and its structure; in coining the term *subconscious*, Janet reinforced his understanding that how dissociation could manifest in both active and passive ways, the latter of which seems to resonate with descriptions of symptoms of depersonalization. In his theory, the mind is described as having two functional elements: activities that preserve and reproduce the past, and activities which are directed towards synthesis, creation and integration of the past with the present (Van der Hart & Friedman, 1999). He argued that depersonalization can occur when the internal process of merging new experiences with that which have already been experienced, in order to maintain a level of equilibrium, stops occurring automatically and prevents adaptation to reality. Others have concurred with his ideas in reflecting upon the ways conflicting states of emotion and affect can be difficult to fully assimilate an experience into a cohesive sense of self-structure (Fenichel, 1945; Rosen, 1955).

Several early theories on depersonalization discussed these symptoms as a result of biological mechanisms, such as a damaged “sensory body apparatus” which led to thinking without feeling (Simeon, 2006, p. 20). In his famous paper, “On Depersonalization”, Mayer-

Gross (1935) described his sense that depersonalization was the result of a cognitive and emotional non-attendance to reality that was supplanted by self-observation, which “disturbs the genuineness of every psychic occurrence” which he believed was a “non-specific pre-formed response of the brain” that could occur suddenly” (p. 110). Many discussions focusing on DP/DR as solely evidence of a physiological disorder have continued throughout the centuries, and have been renewed in more recent decades as neurobiology advances understandings of the brain.

Drive Theory and Depersonalization. Several early theorists also reflected on DP in connection to self-destruction or the death drive. Initially chronicled in Freud’s (1920) work, “Beyond the Pleasure Principle”, the death drive was described as both a tendency and an urge of “all organic life to restore an earlier state of things, the inorganic state from which life originally emerged (Freud & Hubback, 1922, p. 308). Reik (1927) further postulated that an individual’s lack of feeling was connected to death wishes directed against the ego, which are in lieu of attaching and destroying others with one’s aggressive drive. Lower (1971) discussed his work with a client’s depersonalization could abate her desire for self-harm and cutting by provoking expressions of her aggressive drive towards others, rather than herself. As a result, he felt that her anger was a result of denying herself of an interpersonal need or vulnerability, out of fear of interdependency, and her treatment furthered as she was able to move towards an active role in her relationships with others and shift her “withholding hostility and expectation of ridicule” (p. 586).

Ego Psychology and Depersonalization. Due to Freud’s influence, intersystemic conflict has continued to be a commonly discussed factor in the psychodynamics of depersonalization (Bradlow, 1973). Freud initially discussed the ego as synonymous with organization, and a person’s experience of himself as a whole cohesive organism. Understanding

of depersonalization, then, initially centered on ideas of a superego inharmonious with a body ego in some manner, such as an ego “split between incompatible identifications” that consist of instinctual wishes and superego demands that cannot be reconciled within, or a premature advance of ego development ahead of libido development (Searl, 1932). It has been thought that, if the ego no longer fulfills the demands of the ego-ideal, it also may lead to a sense of depersonalization through the creation of observing and participating parts so as to alienate from the non-ideal participation part (Oberndorf, 1950). In his writings, Feigenbaum (1937) discussed a client who dreamt of his mother’s suicide and, shocked at the lack of grief she felt in the dream, woke up and continued to experience a level of depersonalization and “deadness”. He extrapolated a theory from her case that when demands of the Id are experienced as overwhelming, the ego can break down and renounce its own functions, thereby altering one’s sense of, and connection to, reality.

Other drive theorists have also discussed depersonalization as symptomatic evidence of a harsh, punitive or sadistic superego that is attempting to impoverish aggressive and libidinal drives that are approaching consciousness (Stamm, 1962). In his descriptive case study, Lower (1971) reflected on a younger patient that had often received the seductive attention of her father, which stirred up intense jealousy within her mother, whom eventually committed suicide. He noted that the father often critiqued the patient severely and derogatorily, which led her to “get into a blind confusion, a panic where all my faculties desert you, and the only way I was able to handle the feeling of panic was by playing dumb” (Lower, 1971, p. 584). He concluded that her expression of femininity left her torn between an irreconcilable dilemma: she was unable to experience acceptance and love from one parent without experiencing shame and alienation from the other. Thus, the female patient began to feel depersonalized in moments that her psyche

attempted to guard against the sense of humiliation that accompanied her need to be adored and seen. This case example is similar to many that pepper the early literature in its commentary on the damaging impact of a lack of emotional recognition from primary caregivers.

Over time, theorists also began to reflect on the possibility of depersonalization as a defense against losses that are experienced as equivalent to loss of self/identity. In the course of normal development, an individual develops their knowledge of what is “real” through gradually internalizing the act of others’ validating experience. For example, children project un verbalized feelings onto a caretaker, who transforms them back to the child in the form of feelings, imagery, thoughts and language; if this interactive process is restricted, a person may, when confronted with an inability to validate their own experience, re-externalize the need for validation again and find themselves alone, and thus, non-existent. Similarly, Paul Schilder (1886-1940) described DP/DR as an escape from the full experience of reality through the withdrawal of interest from the outside world and the body, which he believed occurred in patients who felt excessive admiration and interest by their parents in their early years. When this inflow of energy began to lessen, the patient would then suffer a level of emotional neglect at feeling like a “showpiece” rather than a “full human being” (Michal, et al., 2006, p. 694). In more recent decades, depersonalization has been discussed as a form of regression to a primitive state in which someone yearns for a symbiotic union with mother (Stamm, 1962), while others have postulated that the symptom is more nuanced as a presentation of the constant tension all humans experience between the demand for separateness and the demand for union, between the drive towards differentiation and the drive towards non-differentiation (Gordon, 1961). In many ways, if depersonalization is viewed as a distressing dissolution of the self, it is also the inadvertent expression of a intense longing and desire for integration, wholeness and connection.

Object Relations and Depersonalization. Object Relations theory, which emphasizes the importance of experience and interpersonal relations on individuals, broadened discussions of depersonalization symptoms in the mid-twentieth century. In particular, Donald Winnicott's (1945) contribution to the literature in regards to self-regulating psychological systems is particularly helpful in understanding depersonalization. In one of his main works, "Primitive Emotional Development", he expounded upon the basic processes of early self-development, which are integration, personalization and realization. In reflecting that the primary state of all humans is *unintegration*, and differentiating it from *disintegration* as a regressive process that produces fear, he created a model in which depersonalization was an understandable result of the delay in ability to personalize. Rather than utilize terms such as ego and Id, Winnicott used the term *self* to encompass both of these concepts, and the development of both *true* and *false selves* in infancy. The sense of being alive and real in one's mind and body, with spontaneous feeling, was at the heart of one's true self; in healthier individuals, Winnicott believed that a person's false self - an imitation or mask of sorts based on introjections of others' behavior and desires that was phony, or empty to the person - would only be engaged when needing to adapt to the immediate environment. Using Winnicott's theory of object relations and developmental processes, DP may be considered a symptom of False Self syndrome, in which the true self is blocked from expression, subsumed and abandoned (Philips & Frederick, 1995). Winnicott (1945) believed that clients whom have been required, or forced, to deny aspects of their "true self", it can be a long road therapeutically to identify where aspects of the true self remains.

Another endopsychic object relations theorist that helped enunciate a dialectic, rather than unidirectional, understanding of depersonalization-type symptoms was Ronald Fairbairn (1947). In his work on those in the schizoid position, he suggested that certain individuals have a

difficulty of moving beyond an infantile relationship with a rejecting mother, and thus experience the love they bear for all objects thereafter as exhausting, devouring, and destructive to others. As a result, Fairbairn noted that schizoid individuals have patterns of moving in and out of relationships as a means of avoid dependence on objects, and prevent a potential collapse of identity when the object is lost. Fairbairn believed that these individuals would feel their only option would be to retreat into an inner world of bad internal objects, where their struggle would manifest as introversion, narcissism, loneliness, loss of self-sufficiency, and depersonalization (Pereira & Scharff, 2002). His work articulated connections between the fear of being too much, and the fear of being not enough, as potentially correlated with intense depersonalization symptoms. The language utilized by Fairbairn and other aforementioned theorists to describe the depersonalization of their clients continues to be reflected within the language chosen by individuals today when describing their own DP/DR symptoms.

Descriptive Overview of Symptoms: Lived Experience

Depersonalization has been described as a phenomenon regarding the “organization of experience” (Wachtel, 1978), and as “neither a defense nor a symptom, but rather the product and manifestation of the operation of a defense, or of the formation and maintenance of a symptom” (Stamm, 1962; Michal et al., 2007; Roscho, 1967). A comprehensive meta-analysis of 147 studies containing cases in which depersonalization was described as the primary symptom, categorized that phenomenological components of depersonalization have remained consistent over the last 100 years, and consist of: an absence or alteration of emotion, changes in body experiencing, and visual complaints of unreality and detachment (Sierra & Berrios, 2001). A depersonalized individual experiences the self as at an unbridgeable distance from their

perceptions, thoughts, emotions and actions, as though they are numb, observing themselves but not experiencing themselves with a level of identification or ownership (Steinberg, 1991).

Derealization can also be included as an experience of detachment from the external world, with perceptions of it as flat, lifeless and strange (Steinberg, 1999; Sierra & Berrios, 2001). The majority of authors writing on depersonalization phenomena do not want to separate the phenomena of derealization from depersonalization, because these symptoms often occur together; in addition, the self, the body and its environment are normally experienced as one continuous whole, and patients may struggle to really differentiate between which aspect of the self or world feels unreal (Radovic, 2002). Numerous first-person accounts exist that articulate this paradoxical experience of, over time, being familiar with feeling strangely unfamiliar:

My thoughts are separate from my body, as if my mind exists in one place and my physicality in another. I see myself doing things, like I'm in a movie. I go through the motions as if I'm in a play. How can I be inside myself while watching myself at the same time? Words come out of my mouth, but they don't seem direct by me... my arms and legs don't feel like they are mine. How do I control them? What makes them move? I look in the mirror and try to re-center myself, but I still feel like I'm in the 'twilight zone'. (Simeon, 2006, p. 80)

I seem to have no personality, as if I had no background, no future and no ties at all with anyone or anything. I feel non-existent as a personality – like a vacuum. I'm not part of anything and so nothing seems real. The part of me that is there, talking, is like part of a machine. I seem so unreal to myself. (Ackner, 1954).

Wachtel (1978) often described the experience of DP as not an “altered state of consciousness” but an “altered state of attention”, and this can be a useful way to move forward in thinking about DP. Just as the literature struggles to define and understand ambiguous philosophically-oriented key terms such as “normal consciousness” or “selfhood” or “real”, we also see this echoed in the vague language often utilized by clients to describe their DP/DR symptoms: ‘as if I were an automaton’, ‘as if I did not really exist’, ‘as if the world is not real’. These types of descriptors show that someone is giving an approximation of their experience, as

well as an uncertainty about what is happening. Though these types of comparisons to inanimate objects may lead clinicians to erroneously wonder if their clients experiencing a level of psychosis (Medford et al., 2005), DP and DR are not, by definition, “delusional” symptoms, because they always include recognition that there is something “not normal” about what is happening, often described as “intact reality testing”. This is a feature that is absent in other dissociative conditions such as Dissociative Identity Disorder, that feature components of amnesia, and more rigid splitting of self. Because individuals who experience DP and DR have a conscious awareness that their symptoms are subjective phenomena rather than objective reality, clinicians sometimes question, or doubt, the relative “severity” of their impact (Hunter, Sierra & David, 2004). This is deeply connected to the long-standing confusion about how to conceptualize dissociation and its bounds.

Prevalence and Diagnosis: Clinical Controversy

While many theorists now believe in the existence of both “normal” dissociation and “pathological” dissociation, there continues to be disagreement about whether this boundary is distinct or blurred, and what necessarily qualifies as either (Dell & O’Neil, 2009). Bernstein and Putnam (1986) were the first to describe dissociative phenomena as a “continuum” that includes the minor dissociations of everyday life, to the major forms of psychopathology. In addition, because DP/DR consists of several unique, underlying dimensions, some have suggested that DP/DR may be more suited to the classification as a “syndrome”, akin to anxiety or depression, rather than a disorder that consistently manifests with precise criteria (Sierra, Baker and Medford, 2005). In a proposed model that supports the uniqueness of depersonalization/derealization symptoms by illustrating the two categories of phenomena in

dissociative experience, detachment and compartmentalization, Brown (2008) emphasizes two different psychological mechanisms that contribute to differences in presentation between those with DP and conditions such as dissociative identity disorder. His bipartite model of thinking about dissociation is one of many, along with the structural dissociation model (van der Hart, Nijenhuis, & Steele, 2006) and the BASK dissociation model (Braun, 1988), that have helped encourage a more nuanced lens with which to view the inner workings of the mind.

More recently, research studies have estimated that approximately 23-70 percent of the general population have experienced short-lived episodes of DP at one point in their lives (Aderibigbe, Bloch, & Whaler, 2001), which has helped fuel an argument that DP and DR are experiences categorically within the scope of what is considered “normal” or “universal”. Schidler (1935) and Ogden (1997) have both described DP as being part of almost every form of neurosis or psychopathology, due to their limitations on an individual’s capacity to be fully alive as a human being. Because all human beings dissociate, and much of our dissociative responses are adaptive, clinicians may have a limited understanding of the ways in which DP/DR can manifest as reoccurring, jarring, involuntary intrusions into daily life.

Though several recent epidemiological studies have reflected that chronic DP/DR symptoms are present within 0.8–2 percent of the general population (Hunter et al., 2004; Johnson et al, 2006; Michal et al., 2009). Though this statistic may seem insignificant, it would mean that chronic DP/DR is as prevalent as more well-funded and regularly researched conditions such as schizophrenia and bipolar disorder, which have a prevalence of 1.1 percent and 2.6 percent, respectively (National Institute of Mental Health, 2005). More studies have shown that anxiety and depression, depersonalization may be the third most commonly experienced psychiatric symptom among psychiatric inpatients (Stewart, 1964; Brauer, Harrow,

& Tucker, 1970; Hunter, Sierra, & David, 2004). Despite this data, debate as to whether the prevalence of chronic DP and DR warrants an independent stand-alone diagnosis has increased over the last decade. This is unfortunate and disturbing, particularly in relation to information that links DP severity as independently associated with suicidal ideation beyond depression and anxiety (Michal et al., 2010). This further illuminates the need for continued academic and research efforts that can contribute to more widespread conviction of its clinical relevance.

Few studies have explored how clinicians outside of academia might understand DP and DR symptoms in the context of diagnosis. In a experimental study in which 231 doctorate-level psychologists were given clinical vignettes of clients that expressed DP/DR symptoms as their primary complaint, 45 percent listed the client with a depersonalization disorder (DPD) diagnosis (DeHoff, 2010). DeHoff found that the vague nature of the criteria DPD in the widely used Diagnostic and Statistical Manual IV TR may have a large effect on clinician misunderstanding and underdiagnosis. This is likely to be true for the new edition, the DSM 5, as well as the ICD-10 of the World Health Organization, as neither provide a comprehensive definition of dissociation as part of their diagnostic manuals (Spiegel, et al, 2013). In spite of the speculated infrequency with which the official DP/DR diagnosis is used, the Internet has given indirect voice to many individuals who have often self-diagnosed themselves with depersonalization/derealization disorder. Simeon (2007) noted that, in 2001, depersonalization.info, a message board dedicated to those suffering from DP/DR, received 10,000 hits within three months, or over 100 hits a day; similarly, a more recent Internet search surfaced a support site for those with DP/DR, DPselfhelp.com, with 30,000 registered members, as well as 9,700 separate video files on the video sharing site, YouTube, the majority of which are primarily autobiographic in nature.

These statistics emphasize the growing number of individuals that suffer from these symptoms, and the demand for appropriate response from those within the mental health field.

Lack of clarity around the diagnostic criteria of depersonalization/derealization disorder may also contribute to the misunderstanding and underuse of the diagnosis itself. Sierra and Berrios (2001) argue that its formulation, based on negative symptoms that allude to something missing from normal experience without being specifically about what normal experience might “feel like”, has poor explanatory value. Positive dissociative symptoms that are not tied with depersonalization disorder specifically – such as flashbacks, or the sudden interruption of conscious experience by an aspect of identity that had not been previously part of awareness – are evidence of a level of intrusion that can appear more tangible for the purpose of diagnostic clarity. Because there is no common etiology, pathogenesis, or characteristic behavioral manifestations of depersonalization/derealization, subjective complaints remain the current basis for diagnosis (Radovic, 2002).

A reluctance to articulate symptoms of DP/DR may be another factor leading to underdiagnosis. Because clients with DP/DR often express worry they are “crazy, it can be incredibly triggering to describe and explore their subjective (un)reality to others. Baker (2003) found that the mean duration of symptoms was over 12 years before the first contact with a clinician regarding DP/DR symptoms. Because shame is often at the core of dissociative dynamics, a client’s sensitivity to the way in which clinicians ask about or respond to their subjective experiences of DP/DR may be more pronounced than with other symptomology. As a result, individuals describe their lives with DP/DR as its own repetitive traumatic experience; feelings of alienation, distance and numbness can continue to be reinforced as a result of the need to create literal physical, emotional, and mental distance from those who may not

understand their “unrealness”.

The limited training that clinicians receive on the diagnostic category of Dissociative Disorders very clearly impacts the frequency of DPD diagnosis (Dorahy, Lewis, & Mulholland, 2005). However, there currently is a lack of research on the impact of clinicians’ level of education in relation to the diagnosis and treatment of dissociative symptoms. In addition, there is little information or standard regarding what clinicians do or should learn in their initial academic training in regards to particular diagnostic categories, and treatment interventions that are effective for particular symptom clusters.

The lack of a dissociative disorder section on widely used general psychiatric assessment instruments has also led to neglect of clients’ experience of dissociative phenomena (Sar and Ross, 2006). In the last decade, the development of several assessment and screening tools has contributed to an increased validity and reliability of diagnosing dissociative conditions. The 28-item self-report Dissociative Experiences Scale (DES) inspired Waller et al (1996) to attempt to create a dissociative taxon – that is, a “natural, nonarbitrary type” - to help identify individuals experiencing “pathological dissociation”. Depersonalization and derealization are measured separately on this taxon, allowing for data that can differentiate a depersonalization disorder diagnosis from other dissociative conditions that include alterations in memory (e.g. dissociative amnesia) or identity (e.g. dissociative fugue or dissociative identity disorder). The Multiscale Dissociation Inventory (MDI), and the Clinician Administered Dissociative States Scale (CADSS) are other psychometrically valid instruments that have helped parse out differences between the dissociative disorders. The only specific scale to DP/DR, the Cambridge Depersonalization Scale (Sierra & Berrios, 2000) is a quantitative tool that has been utilized in differentiating between depersonalization/derealization disorder and DP/DR symptoms as

secondary to another primary diagnosis; studies have shown individuals with DP that warrant a primary anxiety or mood related diagnosis score lower on the CDS than those who warrant a DP/DR diagnosis (Hunter, Sierra, & David, 2004). However, the literature is unclear as to how frequently these scales are utilized by clinicians, and whether they prove to be efficacious in regards to treatment.

Etiology and Differential Diagnosis of Depersonalization/Derealization:

Both Symptom and Syndrome

Challenges with determining the source of DP/DR, as well as the consistent presence of potential differential and comorbid diagnoses, has impacted the level of acknowledgment and understanding of DP/DR symptoms by mental health professionals. Because those with DP/DR symptoms can frequently experience diagnostic criteria connected to a variety of “mainstream” disorders, and DP/DR are important in many other types of psychopathology, the symptoms can often get incorporated into existing categories and misattributed as an epiphenomenon of other conditions, leading to a focusing on treating the more widely understood pathology with the hope it will affect the manifestation of DP/DR (Baker et al., 2003; Simeon, 2004; Simeon & Abugel, 2006). Though brain imaging and neural response studies have shown that there may be a neurophysiological predisposition to depersonalization in the brains of those who experience it unremittingly, a review of these findings are outside the scope of this paper. Instead, this section of the review will center on the frequently discussed psychosocial precipitants of DP/DR within the literature, and the various co-occurring symptoms and syndromes with which it frequently presents.

Trauma and PTSD. Unlike other dissociative disorders, depersonalization disorder is not exclusively linked to the presence of specific types of early traumatic experiences (Nijenhuis & Van der Hart, 2011). Though trauma has been historically defined as the presence of an “external out of the ordinary” experience, most analytic writers have written about the importance of recognizing interpsychic and intrapsychic trauma, and understanding individuals’ subjective assessment of their histories (Wachtel, 1978). Howell (2005) noted that trauma is better defined as the event, or events, that cause dissociation; this reflects an important prioritization of individuals’ subjective responses to events over the specific nature of events themselves. Though depersonalization and derealization symptoms are key symptomatic criteria of a post-traumatic stress disorder (PTSD) diagnosis, DP/DR disorder significantly differs in the absence of hypervigilance, flashbacks and physiological activation responses.

Despite this, symptoms of DP are commonly experienced during, or immediately after traumatic events, which is often referred to as “peri-traumatic dissociation”. Some have discussed that the degree to which an individual uses depersonalization as a defense during specific traumatic events in adulthood that incur acute stress, such as a sudden death, suicide, or severe role adjustment conflicts), can aggravate or modify the way that person continues to relate to and interpret the trauma. Levine (1997) adeptly notes that depersonalization may be akin to a “uncompleted action tendency” of the primitive mammalian defense system – particularly the freeze mechanism – that become trapped in the body beyond the presence of physical and psychological threat. The chronicity of depersonalization may occur when an individual actually misinterprets the state of detachment *itself* as a threat, perpetuating anxiety and inhibiting emotional response (Hunter et al., 2003, cited in Brown, 2008).

Though there has been found to be significant correlation between the experience of emotional abuse in childhood and depersonalization as an adult (Simeon et al., 2001; Michal et al., 2007), trauma has not been found to exclusively precipitate unremitting depersonalization. Unless a client has a known history of trauma, many beginning therapists are not encouraged to look for or explore the potential for a dissociative disorder as a diagnosis (McWilliams, 2003).

Mood, OCD and Anxiety Related Disorders. Though DPD is frequently comorbid with Axis I mood and anxiety disorders (73 percent and 64 percent), these disorders have not been necessarily found to have an onset prior to the depersonalization symptoms (Simeon et al., 2003). Though depersonalization and derealization are frequently reported as a key symptom in anxiety and panic related disorders, rumination regarding a disconnect from others and oneself is a key feature of depersonalization disorder, which Steinberg (2001) describes this as the anxiety-depersonalization-anxiety cycle. The internal maintenance and reproduction of the symptoms can increase an individual's fear of insanity, as the experience of the self as "unreal" begins to be the center around which one defines their identity. Unlike obsessive-compulsive disorder (OCD), the obsessional nature of DP extends over all psychic experience, and is indiscriminating in what perpetuates its perseveration, but the recollection of the former healthy personality and comparison with it has been described as a certain "hyperactivity of memory". As a result, have argued that depersonalization/derealization disorder could be better aligned with a subtype of OCD, such as "intellectual-obsessive depersonalization syndrome", in which the component of continual repetitive preoccupation with one's self is better recognized (Simeon, 2007).

DP and DR are also particular symptomatic criteria of a panic disorder diagnosis (APA, 2013). In a synthesis of 16 studies that reported the presence DP and DR during panic attacks, Hunter, Sierra and David (2004) described a prevalence range from 24.1 and 82.6 percent,

indicating that there may be a consistent casual link between the two conditions. However, in depersonalization/derealization disorder, the lack of typical physical symptoms associated with panic, such as autonomic arousal, indicates that this experience of “fright” is outside of conscious awareness. Future research that is able to differentiate between anxiety/panic that motivates depersonalization and anxiety/panic, which is consequent to depersonalization, might also illuminate more successful approaches to diagnosis and treatment.

Substance Use/Withdrawal. Transient depersonalization and derealization can occur as a chosen, or unintentional, byproduct of substance use (Simeon, 2007). However, many cases of chronic depersonalization and derealization that seem to never “wear off” have been chronicled as a result of specific chemical intoxications. Notably, recorded cases with marijuana, hallucinogens, ecstasy, ketamine, and psilocybin use have suggested that substances can trigger states that are perceived by the body as destabilizing, even if the period of intoxication does not instigate traumatic stress (Kober et al., 2005; Baker et al., 2003). Over the last decade, several pharmacological trials have been conducted with antidepressant and antipsychotic medications, none of which have been found to effectively remit or shift experiences of DP/DR (Guralnik, Schmeidler & Simeon, 2000).

Features of Personality and DP/DR. Because chronic experiences of DP/DR have often been found to begin in late adolescence and early adulthood, some have suggested there is an inborn vulnerability to the disorder that is a result of personality organization (Sierra et al., 2005). A 1930s medical textbook that first included a description of depersonalization stated a sense that it “occurred more frequently in personalities of an intelligent, sensitive, affectionate, introverted and imaginative type” and that, before the onset of depersonalization, these patients were “hyperemotional, anxious, touchy, sensitive and quick to take offense” (Nuller, 1982, p.

454). Many early theorists noted that depersonalization may be the result of “feeling one’s self as an incomplete, unachieved person” (Janet, as cited in Simeon, 2007, p. 53), or a “neurosis of the good looking and intelligent who want too much admiration” (Shidler, 1935, as cited in Simeon, 2007, p. 49). In recent years, psychiatrist Evan Torch has publically noted his assessment that depersonalization disorder is a result of a combining obsessive-compulsive sense of disappointment in one’s self with low self-esteem (Simeon, 2007). He has noted that treatment involves reducing the pursuit of perfection and the desire for control.

Bromberg (1995) noted that all the personality “disorders” are actually dissociation based; all of which include experiences with amnesia, damage to identity and relationships, and emotional dysregulation (as cited in Howell, 2005). These observations align with empirical studies that have found dissociative disorders are frequently diagnosed in those with personality disorder diagnoses, particularly those with Cluster A and Cluster B traits (Johnson et al., 2006).

Interpersonal Theory, and Understandings of Self

Though many of Janet’s theories regarding dissociation were actually assimilated into Freud’s discussion of repression, the singular model of the mind that Freud championed contributed to an extreme “dissociation of dissociation” from mainstream psychoanalytic discourse. A reinvestment in the idea that identity is not singular, but always multiple and multifaceted, has blossomed in recent decades due to postmodern, interpersonal, intersubjective and relational theorists. As a result, a multitude of treatment modalities have surfaced that honor the idea that of a multiplicity of internal self-states that can be experienced as pathological if they are non-cohesive, limiting access the full range of intra-relational flexibility (Siegel, 1999). As we move towards a broader understanding that the unity of self is an illusion for all,

depersonalization and derealization may begin to be discussed as less obscure, but rather the result of being frozen in a particular self-state.

Psychologist Philip Bromberg, a significant contributor to the literature of dissociation and the clinical process, has highlighted the importance of never assuming that any patient has a sense of continuity of self or that their past feels connected to their experience of themselves at present; the value, then, of therapeutic treatment can always be centered in facilitating a slow transition “from dissociation to conflict” as “health is the ability to stand in the spaces between realities without losing any of them – the capacity to feel like one self while being many” (cited in 1998, p. 513). The ability to be psychology capable of conflict, he thought, is a slow process that must begin with first with an acceptance of, as a valid mental state in itself, the experience of depersonalization and non-selfhood. This can then allow a patient to talk about their current state without feeling that the therapist believes this is all that is seen of them, and thus, move towards internalizing that a state of depersonalization is not all that exists.

In the last decade, several interpersonal models of dissociative experience have emphasize the ways in psychic disconnectedness is greatly connected to both longing for, and fears of, intimacy. Some have argued that interpersonal estrangement is a consequence of depersonalization/derealization, while phenomenological psychiatrists are more inclined to believe that depersonalization/derealization is precipitated by feelings of estrangement from people in their lives (Varga, 2012). Regardless, Bradlow (1973) noted that the psychodynamics of not feeling human is *always* connected to feelings of shame, and that depersonalization can be an affective response to the tension between I as me, and I as who I would wish to be that results in self-abnegation. “Like shame” he describes, “feeling non-human arises from a feeling of inferiority, later more specifically ethical and moral inferiority...many of those who

depersonalize are shame-ridden and prone to react with disgust, aversion, horror and self-contempt” (p. 490). This aligns with the focus that has been indicated in which individuals who are depersonalized have a predisposition to experience an affront when circumstances present dissimilarities between “myself as perceived as me” and “myself as perceived by others” (Hunter, 1966, as cited in Bradlow, 1973). In a quantitative study with 90 volunteers, Sorokin (1992) came to similar conclusions about the relationship between depersonalization and other self-concepts. She identified that self-consciousness, self-scrutiny and absorption in internal experiences was not a byproduct of DP but an integral part of the construct, and limited attentiveness to the self as an observable object.

Therapeutic Treatment

Much of the writing and research on depersonalization has focused on the question of why it occurs and what function it serves, rather than how to address its presence in treatment (Levy & Wachtel, 1978). Unfortunately, in the over-extension of the term “dissociation” to encompass almost any kind of symptom involving an alternation in consciousness, the fundamental differences of depersonalization and derealization has been less investigated (Brown, 2008). In the last decade, experiential and empirical studies have begun to reflect that depersonalization/derealization may require different types of treatment than other dissociative problems; despite these efforts, there is currently no evidence-based, effective treatment for DP/DR (Sierra, 2008). Since the 1990s, two medical institutions, the Institute of Psychiatry at Kings College in London and Mt. Sinai School of Medicine in New York, have been committed to building a database of empirical research on depersonalization disorder (Simeon, 2007).

Behavioral therapy (Sookman & Solyom, 1978) and directive therapy (Blue, 1979) were utilized in early empirical studies of DP/DR treatment. More recently, a two-phase cognitive-

behavioral approach to DP/DR has been proposed that mirrors the treatment for many anxiety-based disorders (Hunter et al, 2003). For the initial phase, non-specific interventions are recommended, such as activity scheduling, graded exposure to avoided behaviors and settings, and the challenging of negative automatic thoughts through the use of cognitive diaries. In the second phase, techniques are recommended to facilitate the controlled re-experiencing of emotions and the refocusing of attention away from the self and the depersonalization experience. However, general dissociative symptomatology has been found to be a predictor for poor treatment response to CBT, as well as high relapse in patients with diagnosed with panic and OCD (Michaelson, 1998). Cognitive techniques by themselves, such as intense self-observation and monitoring thoughts, may get in the way of therapeutic change for clients with DP if they become so thoroughly *observers* of themselves that they are unable to act or feel (Connor, 2012). Oberndorf (1950) believed that depersonalization was a result of anxiety that “has been corralled, is almost abstract and is not diffused and combined with common neurotic compulsions, fears and doubts” (p.3). For those that this is the case, both identifying and addressing specific thoughts that could contribute to DP would be difficult.

Depersonalization disorder has been noted to be the only dissociative disorder that refers to bodily symptoms, and it is generally understood in the trauma literature that emotional pain which is suppressed instead of experienced retains a bodily component as opposed to dissipating, resulting in tension and illness (Firestone, 2013). As a result, several clinicians (Levine, 2005; Rothschild, 2000) have reflected the ways symptoms like DP/DR can be a result of traumas trapped in the body on somatic, emotional and cognitive levels, that require working within a “window of tolerance” between hyperarousal and hypoarousal so as not to re-traumatize through the therapy relationship itself (West, 2013). The “sensorimotor” model of treatment, developed by

Ogden (2006) can be seen as useful when a narrative is difficult to formulate, and arousal must be modulated through nonverbal means such as touch and movement. Levine (1997, 2005) has, in particular, noted that connecting individuals to other action tendencies within their primitive mammalian defense system, such as fight, may be a way of empowering a counter response to depersonalization.

There are several treatment modalities that show both support and contraindication in the context of DP and DR symptoms. Mindfulness-based therapies focused on cultivating a sense of connection with the body in the present moment and paying attention without judgment, are generally thought to enhance one's well-being. However, concentrative meditation have been shown to further induce DP in those that struggle with it (Castillo, 1990), creating a paradoxical sense of "sensory deprivation" in the absence of external stimuli to distract from the unrealness (Michal et al., 2007). In addition, hypnosis has been utilized in treatment for other dissociative disorders and has been proposed as a potential way to teach depersonalized individuals, sometimes viewed as "virtuosos in self-hypnosis", a level of mastery in controlling their ability to depersonalize and "reassociate" (Gorman et al., 2002; McWilliams, 2003).

Many of the aforementioned psychodynamic contributions to understanding depersonalization reflect the strong potential of talk therapy to explore the phenomena within dynamic treatment over time. However, there has been little to no research on the benefits of psychodynamic therapy and/or analysis on symptoms of depersonalization. It has been postulated that several components of traditional psychoanalysis may exacerbate a dissociated client's emotional and psychic isolation, such as its emphasis on free association and lack of eye contact (Gorman et al., 2002), as well as a clinician's passive stance (MacIntosh, 2013). Patients that experience depersonalization may benefit more from didactic and mutual recognition, rather than

the one-way interpretations inherent in traditional analytic work (Bromberg, 1998). In addition, even early theorists believed that treatment for depersonalization could take several years, double the time it takes to treat conditions of “obsession neurosis” (Bergler & Eidelberg, 1935, as cited in Simeon, 2007, p. 172).

Macro Level Contributors to Depersonalization Experiences

Though intrapsychic experience has been the focus of much of the literature on DP in the last several decades, recent theorists have contributed to a resurgence of addressing the impact of cultural and systemic contexts on mental health. In his proposal of a three-person psychology, inner-city therapist Neil Altman (1995) explicitly discussed culture as an active third presence in the therapeutic relationship, constantly making and made by deep encounters we have in everyday life, as clients, as therapists, and as humans (Bodnar, 2004). His work aligns with what many social psychologists and sociologists always reflect: that we are individuals to the degree that we are attached to social systems, in that interpersonal and institutional relations define our personalities and become represented within us as we acquire successes and symbols that are reflected upon as valuable. Philosophers and sociologists such as Foucault (1988) and Goffman (1959) further illuminated how social organization determines the social roles in which self-experience nests. They observed how pieces of individuals that do not, and cannot, fit into social roles emerge defiantly in the form of creativity, rebellion and sometimes psychopathology, which reinforce delineated constructed categories of what is self, and what is other.

Anthropologist Jules Henry (1973) furthered these thoughts in several of his works that posed questions on whether the source of certain disease and disorder could be institutionally induced. He postulated that those who are seen as not making contributions to social systems as expected have altered relationships with individual and systemic levels that can create a sense of

“losing personality” and depersonalization (p. 22). Though he regularly differentiates this type of depersonalization from the psychic state discussed in most of this review, his work has been utilized as a categorical tool with which to assess the ways systems can contribute to depersonalization. In an extensive case study on care of the elderly in a nursing home, Kayser-Jones (1981) engaged with Henry’s material to categorically explore the high prevalence of depersonalization that her clients experienced in symbolic and material ways, as well as through the deprivation of protection and choice.

Exposure to trauma, marginalization, racism, and oppression has been thought to shape individuals’ experiences of themselves as individuals, and as parts of cultural groups. Jacobson (1959) studied the experiences of women who were survivors of the German concentration camps and noted that depersonalization was the result of an objective loss of agency while imprisoned, which often lingered after these women had regained physical freedom. His reflections have been key in thinking about depersonalization as a response to the disconcerting experience of having to hold others’ negative projections regarding their identity, and the discord inherent in fighting off the internalization of these sentiments. In other words, Jacobson made early connections between the damage of prejudice and discrimination on one’s ability to experience self-objectification. Hannah Arendt (1978), the German-American political theorist that reflected on the links between societal structures and ontological understanding, noted that no person “that had suspended all faith in the reality of its intentional objects, would ever have been able to convince him of his own reality” (as cited in Varga, 2012), articulating that a loss of faith in the humaneness of others – that which, by definition, makes us “human” - could prohibit an individual from feeling like a person themselves.

Within psychodynamic and social work literature, there is a lack of discussion about the impacts of sociocultural factors and aspects of identity, such as race, class and ethnicity, on individuals' that have been found to experience DP/DR. Psychotherapist Olga Guralnik has described work with two depersonalized clients, an African American woman and a gay Catholic male whose families could never engage in discussions of race or sexuality, respectively. She notes that these clients eventually utilized depersonalization as an "exit strategy" to attempt and preserve their functioning when the aspects of themselves that had gone disavowed by their environments had nowhere to exist externally, resulting in existential crises (Simeon, 2007). The sense of being controlled – whether through literal or psychic imprisonment – can create a sense of internal rigidity when one feels unable to manifest their true selves over the conclusions projected upon them by society and systems. In an article on women in abusive relationships, Stein (2012) discusses the impact of "cultural demands for women to dissociate feelings that have been labeled antithetical to accepted gender norms for heterosexual behavior" (p. 34). After studying the clinical narratives of 11 abused women, Stein hypothesized that this compartmentalizing of aggression away from conscious expression was often the result of women viewing these emotions as being "gender-dystonic". Stein implored therapists to look at the ways in which they, in the therapeutic relationship, may collude with systems of oppression by ignoring the ways society impacts an individual's experience of themselves as real or unreal.

Sierra (2006) hypothesized that societal influences on how the self is constructed may explain a difference in prevalence of depersonalization amongst individuals within particular cultural systems. Interestingly, a Japanese study (Mizobe et al., 1992) reported a relatively low prevalence of DP/DR in patients with panic disorder (ranging between 9 percent and 25 percent) that indicate a potential national or ethnic variation in symptom identification. This suggests the

possibility for exploring the impact of cultural constructs around “self” and “other” could play a role in the way an individual identifies, experiences and labels pathology. It would seem that highly individualistic cultures may increase one’s vulnerability to distress by feelings of alienation and separateness (Draguns & Tanaka, 2003).

Transference/Countertransference with the Unreal

The extensive theoretical literature on the experience of transference-countertransference dynamics of patients who experience trauma and dissociation can increase clinicians’ understanding of the nature of the work with clients that are depersonalized. Transference and countertransference can be defined roughly as key components of the unconscious interactive process elicited in the relationship between therapist and client in which information is transmitted, received, and retransmitted in the form of imagery, ideation, feelings, thoughts and behavior, which are repetitions of past reactions and relationships in each individual’s history (Glucksman, 1998). In response to clients’ depersonalization, therapists may respond by means of their own denial, inattentiveness, boredom, sleepiness or dissociation (Glucksman, 1998).

Because transference-countertransference dynamics are thought to be situated on more of an “archaic” level in depersonalized clients, bodily and sensory experiences may arise within the therapist. Nonverbal transference can often go unrecognized, leading to enactments, role reversals and other situations “that make the analytic couple ‘fall ill’ of what had made the patient ill” (D’Agostino, 2011, p. 33). Reis (2013) describes this when discussing clinical interactions with someone experiencing depersonalization as “lifeless, stale, suffocating and threatening to the analyst’s own subjective experiencing”, likening these clients to “zombies” that eat the figurative “brains” of others. When he notes that “clearly, a powerful contagion exists in encountering these states clinically, and the analyst may often have to struggle to regain

a feeling of humanness” (p. 279), he articulates the struggle of therapists when they find themselves introjecting their clients’ internal states.

Tillich (1952) postulated that ontological anxiety is the inevitable consequence of man’s condition on this planet. It is reasonable to postulate that a depersonalized client may force a clinician to confront their own personal, philosophical, epistemological and spiritual concepts regarding the fragility of existence, and how we define ourselves. When Freud struggled with the possibility that his numerous patients’ reports of sexual abuse were true, he reportedly found himself unable to reconcile this possibility with the reality he knew; in shifting his theoretical lens towards conclusions that intrapsychic fantasy had caused these “delusions”, he inadvertently “dissociated” his patients’ experiences in order to maintain his own understanding of people and the world. Similarly, in the treatment room, symptoms of depersonalization may leave therapists unconsciously manifesting societal and cultural norms through the own nonverbal or verbal behaviors, such as silence or misattunement, reinforcing the client’s experience as “separate”, given that, there is always a “creation of the new and the reworking of the old simultaneously” (Lyons-Ruth, 1999, as cited in Gill, 2010, p. 267). Depersonalization requires that a therapist have a tolerance for dis-order, and a willingness to “shift through the debris in his search for lost meaning; in this way, he can help his patient re-create his own order, his world, his own experience, his feeling of being and being alive” (Resnik, 2001, p. 86).

Limitations of Existing Literature

This review of the literature has hopefully highlighted some of the potential reasons that, despite a long history of discussion around depersonalization and derealization, there remains such little consensus regarding how to engage with these symptoms in a clinical setting. Despite recent work in composing more concise definitions of depersonalization and derealization,

particularly within the context of diagnostic manuals and empirical research, there remains a lack of diversity in whom is engaging in these discussions, and how broad an audience they are reaching; the majority of articles written on the topic in the last decade have been composed by a few psychiatrists that identify it as their specialty. As a result, the literature does not give an overarching understanding of how the wider mental health community understands and conceptualizes depersonalization/derealization in their clients. In addition, it was challenging to find even one article regarding these symptoms had been authored by an individual in the social work field.

A particular void in the literature, in regards to clinicians' perceptions of clinical treatment with depersonalized clients, will be addressed in this research study. It has been theorized that this absence may be due to the challenge of clinicians openly reflecting on their contributions to dissociative therapeutic interchanges, as well as airing vulnerabilities in a manner that could risk criticism from professional peers (Rankin, 2013). Further investigation is needed to determine as to why depersonalization and derealization remain relatively dissociated from mainstream education, research and practice.

CHAPTER III

Methodology

Purpose

The intent of this qualitative study was to explore the subjective experiences of clinicians that have worked with depersonalization (DP) and derealization (DR) symptoms in their caseload. The semi-structured interview questions were designed to gather exploratory information from a sample of experts as to how they understand, treat and are affected by chronic depersonalization and derealization symptoms in their clients. Open-ended questions were based around the following topics: 1) Clinicians' training and understanding of depersonalization/derealization in their clients; 2) Beliefs regarding treatability of depersonalization/derealization, including treatment modalities and important aspects of the therapeutic relationship; 3) Personal experiences with DP/DR symptoms, and the countertransference reactions. This chapter presents the methods used in this study, including study design, sample selection, data collection, and data analysis procedures.

Study Design

The study was designed to better understand clinicians' work with depersonalization/derealization symptoms in their clients. As illuminated in the literature review, there were few pre-existing studies found on clinicians' knowledge and understanding of depersonalization and derealization, and no studies discussing how clinicians are impacted by

these symptoms in the therapeutic relationship. As a result, a qualitative methodology was chosen for its ability to identify themes and patterns in hopes of contributing to a rich, more nuanced understanding of the ways clinicians respond to these symptoms, and what impact therapy may have on their presence. Thus, an exploratory, inductive approach allowed for generating insights that could serve to acknowledge the gap in the literature, and generate hypotheses to be explored in further research (Rubin & Babbie, 2013, p. 29).

Because this study will only scratch the surface of an unexplored topic area, it has several limitations in its design. As a qualitative and exploratory study with 12 participants, this research does not attempt to be generalizable to all clinicians. In fact, some qualitative researchers have argued whether generalizability is possible within qualitative research (Cronbach, 1975), and have proposed a greater focus on transparency and researcher self-reflexivity as an equivalent (Butler-Kisber, 2010). This involves directly accounting for, and attending to, the biases and assumptions that the researcher brings to their study. Bias can include any influence that limits hearing, interpreting and reporting of data. For example, this researcher's own personal interest in constructionist and intersubjective theories could result in a greater likelihood of illuminating aspects of the data that emphasize these values. Though subjectivity, interpretation and context are interwoven into the nature of qualitative research (Auerbach & Silverstein, 2003), the researcher worked to consistently confront their opinions and prejudices of the data.

Sample

The study population included twelve clinicians who have provided mental health services to one or more clients who experience depersonalization/derealization as a primary symptom, as described in the DSM 5 diagnosis for depersonalization/derealization disorder.

Because depersonalization and derealization are secondary to many other diagnoses, it was pertinent to specify that the study was addressing experience with clients that find their DP/DR to be unremitting and distressing. Other inclusion criteria for participants were defined as: post-master's licensure in a mental health field; a self-defined specialization in treating trauma and/or dissociation. Because the literature has shown that DP/DR symptoms are relatively misunderstood, the criteria for specialization attempted to determine a more narrow community in which more participants might be identified. Exclusion criteria included clinicians who could not identify a client that had the criteria listed in the depersonalization/derealization disorder diagnosis in the DSM 5.

This researcher used non-probability convenience and snowball sampling techniques to recruit for the study. The first method included an email advertisement sent to the researcher's existing connections in the field to share with their colleagues. In emails to individuals known to the researcher, it was specifically noted that clinicians who knew the researcher personally would not qualify for the study. The second method involved recruitment messages on private mailing lists facilitated by the International Society for the Study of Trauma and Dissociation (ISSTD), New England Society for the Treatment of Trauma and Dissociation (NESTTD), and the alumnae mailing list for graduates from Smith College School for Social Work. Given that these mailing lists are primarily used for intra-organizational communication, permission to disseminate information about the study was solicited from leaders of both organizations, who then forwarded it to their members directly. Given that clinicians voluntarily become affiliated with these groups due to a level of interest and experience with trauma and/or dissociation, participants from these organizations met aforementioned inclusion criteria regarding specialization. Snowball sampling was used in both recruitment messages, as each potential

participant was encouraged to share the study announcement with any other interested colleagues that might qualify. The recruitment message outlined the aim for the study, the inclusion criteria, and the nature of participation (see Appendix C).

The sample was intended to be representative of the broad spectrum of individuals who work from a variety and/or mixture of disciplines and theoretical orientations in their treatment of clients that experience depersonalization/derealization. As such, recruitment was open to all individuals who met the above stated criteria for participation. The researcher endeavored to recruit a diverse sample in regards to gender, race, ethnicity, and age as well as practice settings. However, choosing inclusion criteria that indicated a specialization in trauma and/or dissociation, as well as recruiting through NESTTD and ISSTD, has the potential for creating a bias in the sample towards particular theoretical lenses. In addition, the means of sampling via the alumnae list of Smith College School for Social Work is likely to have contributed to a large number of participants reflecting on DP/DR through psychodynamic frameworks.

Data Collection

Procedures to protect the rights and privacy of participants were outlined in a proposal of the study and submitted to the Human Subjects Review Board (HSRB) of the Smith College School for Social Work. Approval of the proposal (see Appendix A) indicated that the study was in adherence to federal regulations and guidelines regarding the Protection of Human Research Subjects. Prior to the interview, participants were given an Informed Consent document describing the purpose of their study, their rights, as well as the potential risks and benefits of participation. Inclusion criteria for participation was also outlined again in this informed consent paperwork (see Appendix B). In agreeing to participate, clinicians masked all conversations

regarding client/clinician interactions so as to ensure confidentiality and adhere to ethical guidelines.

The semi-structured interviews were conducted in locations chosen by the participants, all of which happened to be their own private practice office. This contributed to both their comfort, as well as their participation to remain confidential. All interviews were digitally recorded lasted for approximately 45 minutes to 1.5 hours in length between January 23, 2014 and April 26, 2014. All interviews were then transcribed by the researcher, after which the recordings were permanently deleted. Prior to analysis, all transcriptions omitted or masked any information that could be used to identify the participant. Interviews began with an optional brief demographic questionnaire (see Appendix D), in which the participants were asked to identify their age, gender, years in practice, and their theoretical orientation. In addition, it asked participants to identify the age and sociocultural identities of the client population they serve. Then, the interview progressed to the open-ended questions regarding depersonalization and derealization (see Appendix E). Initially participants were requested to have a specific client in mind and the researcher intended to ask each participant to describe their therapeutic relationship with this client. However, taking into account participants' responses to this request and how the interview process unfolded, a majority of the interviews focused on more general open-ended questions pertaining to the study participant's of their own thoughts, feelings, images, and sensations while working with depersonalization and derealization, and the meaning they made of these particular therapeutic dyads.

Risk and Benefits of Participation

Risk and benefits of participation were outlined in the Informed Consent document, and reviewed with participants prior to beginning interviews. Clinicians were thought to hopefully benefit from reflecting on their successes and challenges of their clinical work, as well as sharing their experience with a new-to-the-field clinician. In terms of risks, participants could find themselves uncomfortable while conveying the experience of their clients, and describing their own subjective experience of their work. The researcher reminded participants that they had the option to ask for a break, skip a particular question, or stop the interview if they felt discomfort at any time.

Data Analysis

The data collected was examined utilizing a grounded theory approach, which serves to discover ways to define concepts through discovery, relationships, and patterns (Sherman and Reed, 1994). An important quality of grounded theory involves an emphasis on continually modifying findings through constant comparison within and across interviews. In order to engage in this approach, the data collected was processed and organized using the open coding method in which data is systematically analyzed for themes, and categorized accordingly in ways that yielded insights on the topic (Rubin & Babbie, 2010). Discoveries from the data are further reflected on in the findings chapter, and serve as a foundation for theory development on the topic. This suggestive analysis that will hopefully be further developed in future research studies on depersonalization and derealization.

CHAPTER IV

Findings

This chapter will present the findings of a qualitative analysis of interviews with twelve therapists who provide psychotherapy to clients with depersonalization and derealization symptoms. Interview questions were designed to elicit a breadth and depth of information on both their clients' experiences, as well as the clinicians' own subjective experiences of the therapeutic work with them. For clarity of presentation, the findings have been organized into the following primary thematic sections: 1) Demographics of the Sample, 2) Understandings of Chronic Depersonalization/Derealization, 3) Aspects of Treatment, 4) Clinicians' Reflexivity and Self-Reflection, and 5) Critiques of the Profession and Other Professionals.

Demographics of the Sample

Interviews began with optional questions about demographic information which included: age, race/ethnicity, gender, number of years in clinical practice post-licensure, practice setting, and descriptors of the client population served. The twelve participants ranged from 38 to 68 years of age. The mean age was 56, the mode age was 60, and the median age was 62.5. Six participants identified as female (50%) and six participants identified as male (50%). When asked their identified gender, three participants also chose to identify their non-heterosexual orientations (two lesbian participants, and one gay male participant). Ten participants identified

as Caucasian (83%), one participant identified as Asian, and participant identified as biracial (Mexican and Caucasian); three participants (25%) identified as Jewish.

Seven of the participants were Licensed Clinical Social Workers (LCSWs)(60%), three were psychiatrists (MD)(25%), and one was a licensed Marriage and Family Therapist (LMFT). Though all participants had been previously employed in a myriad of community-based settings, at present, all twelve (100%) worked with clients in private practice at the time of the interview. Their level of experience in the field post-licensure ranged from six years to 40 years, with the mean average being 21.5 years, and the bimodal average being 18 and 35. Nine of the participants (75%) solely worked with adult clients over the age of 18, while 2 participants (17%) also worked with adolescents from 11-17, and only 1 participant worked with children.

The racial homogeneity of the participant pool, which is 83% white, is a significant limitation on the study. Other limitations and their impact on the data will be further elaborated upon in the discussion chapter.

Theoretical Orientation. The demographic questionnaire also collected data on participants' theoretical orientation in their clinical work. Several participants spoke to the challenge of answering this question, and illuminated their abilities to engage with multiple modalities and lenses depending on the needs of their clients. All of the participants (100%) identified utilizing psychodynamic and/or psychoanalytic underpinnings in their work. The other orientations most often identified were EMDR (n=5, 42%), relational (n=3, 25%), ego state therapy (n=2, 17%), attachment theory (n=2, 17%) and Internal Family Systems (IFS)(n=2, 17%). The way their orientations affected treatment with depersonalized clients is further outlined in the treatment section; however, participants overwhelmingly spoke of their orientation as multifaceted and malleable, based on the client's needs in any given moment.

Several participants noted a difficulty of describing their orientation, but in actuality, elaborated on nuances within the theories that guide them. One participant noted that “within psychoanalysis there are so many orientations...within every field of therapy there is a psychoanalytic underpinning that isn’t acknowledged. For example, CBT and behavioral interventions is not something that is foreign to psychoanalysts, we just don’t call it that.”

A few participants eschewed categories, as much as possible, and highlighted the ways that adherence to particular methods of doing clinical work can a common way of finding guidance and structure as an early clinician. One noted that:

You know, I just really use myself. I remember many many years ago I got sort of expert training in hypnosis because I thought I needed it to work with really dissociative clients. And I realized it was just a way to bind my own anxiety...when EMDR came along, I didn’t even bother, because it made no sense to me. You have to be able to sit with people and have them feel like they can do what needs to be done to help them....find their way. Would you call that eclectic?

Specialty in Trauma/Dissociation. Because the inclusion criteria necessitated a clinician to self-identify as having a self-defined “specialization” in working with trauma and/or dissociation, participants were asked to describe how they had acquired the information that had led them to feel skilled with these types of symptoms. Overwhelmingly, all participants noted that their work with clients is what ultimately has shaped them into “specialists”; in particular, they discovered the impact of trauma and dissociation in their pre-private practice years in their work with veterans (n=4), sexual abuse and incest survivors (n=3), and those with chronic illness (n=2).

Many spoke, with a level of matter-of-factness, that the specialization *chose them* because their clients demanded to be understood. One participant described his experience as similar to a lot of therapists’ experiences in which he “didn’t know that there were dissociative clients that I was already practicing with. Until one day they show up. And they aren’t who they

usually are.” Though many participants spoke to their budding awareness of dissociative identity disorder specifically, this exposure began their overall ability to engage in an understanding of, and attunement to, dissociative symptomatology such as depersonalization.

Many of the interviews reflected on the historical shifts in the field of trauma treatment, particularly in relation to ways to respond to dissociative identity disorder (DID) in clients. One participant summed up what many reflected: “we thought we knew a lot, and we didn’t know anything”. They contributed this wider acknowledgment of the impact of trauma, and symptoms like depersonalization, to two factors: the increase in numbers of veterans’ returning home from conflicts that are decade-long with no end in sight, and advances in neurobiology that have begun to reflect the impact of experience on brain functioning. One participant reflected on the ways diagnostic understanding has shifted over the course of his time in the field:

The issues that came up in one case discussions of this particular client were issues of depersonalization and how he seemed to lose himself, and this is really before we understood dissociative process very well... and I think we ended up calling him some kind of very strange combination of you know, a latent schizophrenic, we tacked on so many diagnoses.... we had the words but we didn’t have all the stuff to pull it together.

Though some participants incorporated new knowledge and modalities into their clinical toolbox, a few spoke to a sense that they “rode the waves” of change within the field and have continued to come out more adept at the work by focusing on the building of the clinical relationship. This will be discussed further in the treatment section of the chapter.

Understandings of Chronic Depersonalization/Derealization

Conceptual Definitions through Case Discussions. This section will focus on participants’ understanding of chronic depersonalization symptoms. When asked to define depersonalization, the majority of participants reflected that conflicting schools of thought and

theory have led to the lack of common language about dissociative processes, even amongst self-defined “experts” such as themselves. In the study interviews, participants themselves universally (n=12) interchanged dissociation and depersonalization in their responses to questions; frequently, the terms would be mentioned in sequence, separated by “and”, or “or”, reflecting a sense of the two conditions as being the same, if not similar, in essence. In other cases, participants attempted to differentiate depersonalization from derealization from dissociation, but these explicit attempts at delineation showed few if any similarities from one participant to the next. A few discussed depersonalization using figures of speech to visualize its complicated nature. One noted, “you can look at it as a long continuum or you can look at it as a bush. A continuum begins at one position of being mild and goes to a more severe kind of thing. But a bush, it’s kind of an evolution, we don’t see it as a linear process, we see it as something that pops up relative to lots of different circumstances and lots of different entities in terms of diagnostics and terms of various human conditions.”

Many general themes emerged during discussions of the nature of depersonalization symptomatology, as well as in the descriptions of particular client cases. The data is grouped together below:

Detachment from One’s Self. Akin to the literature, participants noted that their depersonalized clients struggle with finding language to explain their symptoms, but commonly denoted feeling a lack of feeling, or a “separateness” from themselves, with such words such as numb, not real, unreal, in a fog, detached, or distant. Their clients’ own awareness of their detachment, and their ability to talk about it, was a primary factor in determining its difference from other dissociative conditions.

Several participants (n=5) described the ruptured relationships that clients' have with their bodies as a distinct part of their difficulties. Whether it involved the physical failure of their bodies betraying them or not being able to literally control them, such as the experience of many patients in hospital settings, or a judgment of their bodies that manifested in a sense of physical disconnection, it was clear that challenges to embodiment was a distinct part of the depersonalization experience.

Lack of Developed Sense of Self/Agency. Outside of conversations about diagnosis, it was common for participants to think about a personality-based structural disposition or an inner "sensitivity" that contributes to the presence of depersonalization symptomatology. One participant stated her belief that "depersonalization episodes for someone who is in a neurotic range are a lot shorter, and we can stabilize much quicker", which reflects a sense that those who experience them regularly, and for extended periods of time, are in line with other personality structures. Several noted their clients' obsessive qualities as they manifested in difficulties with managing and maneuvering through tasks of daily living. Often these moments would lead to a questioning of their capacity for living and life itself. One participant noted that:

I see a university professor and she will hit something, like a trigger, but it's not really a trigger because it doesn't activate the whole trauma process but it does activate the depersonalization process. And she begins this long litany of what she can't do. "I can't pay my taxes, I can't grade my papers, I can't sleep, I can't clean my house, I can't clean my car" I can't do all these things. And then she starts talking about how she begins to feel like it's not real anyway. Even though she knows it's all too real. And at that point she begins to say, "well, I'm going to be dead anyway." And the self has just about... gone all the way down to the floor.

In a similar vein, participants discussed their clients' depersonalization as the result of subtle affronts to their personhood, and intricately connected to difficult developmental and relational histories. In reflecting on a particular case, one participant reflected:

I will never forget in play how he represented depersonalization for himself, which was showing this character with his head detached from his body. Which I felt was kind of representation of dissociation and depersonalization as a subset of that, I guess you could say, with one's thoughts away from their body. And by the way, this kid, no one had ever sat down and talked with at one of these clinics that were a disciple of this particular program really sat down with him and talked with him about anything. They never sat with him, spoke with him, and he told me that his father would beat him with a spatula and a belt and stuff like that, so I thought it was PTSD... complex trauma, whatever you want to call it.

While several participants noted believing their patients had PTSD or a trauma based disorder, they noted seeing many clients in which depersonalization symptoms existed long after the trauma, and in the absence of other clear threats to their clients' well-being. Some reflected the difficulty of treating traumas that become incorporated into parts of a person's self-understanding, "because you are interrupting and meddling with who they are: depersonalization is ego-syntonic for them, even if it is cognitively causing them distress, sometimes it is not causing them any other kind."

Limited Affect. All of the participants spoke to their clients' subjective experiences of themselves as being the primary indicator of depersonalization; that is, few noted witnessing any particular criteria that signaled the presence of depersonalization in their clients. Though many discussed cases in which clients had overt incidents of losing time, and the presence of an "amnesiac barrier" in their day-to-day lives, a few noted that depersonalization did not have these components, but rather a more subtle presentation than other types of dissociation. One participant discussed it in the following way:

There's an affect associated with it. It's generally not full range. There's some either depression or anxiety component in the affect. The person's capacity to relate is somewhat compromised in the sense that they are having a difficult time gauging or interpreting their own sense of self, it's very difficult for them to recognize another person, so the whole idea of reciprocity is significantly compromised, I think.

Some noted that a client's inability to tolerate affect itself can cause depersonalization, and that strong emotions can create a sort of "trauma from within". As one participant described, "there is something about the affect that is mobilized that feels threatening and dangerous and that's when the person has a dissociation of it. So if this person has any kind of anger...most strong feelings, but particularly any kind of rage... it is a kind of source of impetus for dissociation."

Defense against Threat. Over half of the participants (n=7) discussed depersonalization as a defensive structure, reflecting the physiological underpinnings of depersonalization as the result of an autonomic response of the nervous system. Often, the "fight, flight, and freeze" terminology was utilized, and participants frequently contextualized their clients' chronic depersonalization as something that had been initially useful, but transformed itself into a distressing symptom when it continued to be "deployed" beyond a moment of clear usefulness. Some emphasized its presence as "regressive" or a means of "playing dead". However, the majority of participants reflected a deep appreciation for depersonalization as a means of self-protection. The majority of clinicians (n=10) spoke to the normative dissociative processes in all individuals, and frequently normalized the depersonalization experiences of their clients when discussing particular cases, and the ways in which it, as one participant noted, "it becomes an operating system, a way of navigating the world."

Almost all of the participants (n=10) reflected that developing an understanding of the potential source(s) of threat for their clients is key in comprehending the etiology of depersonalization symptoms for their clients. While several (n=7) utilized trauma-informed language, such as "trigger", to describe the impetus of depersonalization symptoms, there was no consensus about a uniform type of experience that led to such symptoms. The data showed that

“triggers” to depersonalization can often be less visible or explicit than with other trauma-based disorders, such as PTSD. One participant noted “the damnedest things can trigger you, it’s not always bad triggers, it can be very benign, it can be smelling gardenias or jalapenos, or the remnants of a song, it can be anything, it can be the way in which you are seated at a table, we don’t always know ... what sets that thing off that makes a person go away...”

When asked to reflect on a particular client case in which depersonalization was a primary symptom, most participants directly linked their clients’ depersonalization as defenses first enabled during explicit experiences of trauma, frequently explicit physical or sexual abuse. In some cases, this abuse had occurred in the past, while others were presently in tumultuous relationships, or, in some cases, both. One participant noted his work with a client who had both been abused as a child, and in her current relationship: “She has a abusive huge husband, who she is afraid of, and her major defense will be pretending she is not actually a person until he’s done. But sometimes it lasts much longer than that. I mean... her mother would lock her in a closet and forget about her, naked in a closet. She would have to utilize depersonalization then, she certainly would never call it that, but she wasn’t actually present...”

Similarly, other participants postulated that depersonalization was a defense that had often been engaged in early in their clients’ lives, and that the experience of it as a pathological symptom indicated that its defensive function was beginning to *fail*. Some noted that their clients may have never been able to develop an inner sense of themselves because depersonalization had been needed during the periods of development; however, as this incorporated defense began to become ineffective later in their lives, clients’ lack of connection to their uniqueness of self, opinions, and identity seemed to become more evident and ever-present. One participant elaborated on the psychodynamic underpinnings of this process:

[The symptoms] are diagnostic in my opinion but they are telling us that you are dealing with very very early material around disruptions in being able to metabolize experience. You're hearing about what it is like to be in a little body.... we know that Freud literally thought about the ego developing in the body, and that wasn't hyperbole, that was *literal*...and that's really accurate for these symptoms. This is a little tiny body with a very inchoate ego that could **not** take in and metabolize whatever was happening to them. So the body became...something other than the flesh and blood that we inhabit, it became what could actually do in those moments, the symptom then of feeling tin or wooden or not real or frozen or a statue suddenly make a whole lot more sense, they are much less crazy, right? And from an interpretation standpoint, "I imagine you must have felt very much like a statue *when*... fill in-the-blank at such and such an age...", that that can become a framework in which they can begin to think about what otherwise is just craziness.

Though many participants reflected that not all who experience trauma have depersonalization symptoms, only three participants reflected a level of skepticism about whether trauma is always at the root of chronic depersonalization. Simultaneously, participants seemed to utilize the interview space to work through their understanding of what may or may not have constituted "traumas" for their clients, in terms of difficulties in developing a sense of individual identity:

My first experiences in working with depersonalization and derealization per se happened with a young woman [who] had a twin sister and really doting parents. And I never found any evidence for trauma. Which is very interesting. Everyone suspected that there had to be trauma but it never became clear that there was any trauma. But the trauma, it seems to me, had to do with her experience of being a twin and having all this anger at feeling like her envy and her competitive feelings with her twin.... It was a tough case and I didn't understand depersonalization or derealization then and everybody assumed trauma was the reason, but it wasn't the case.

While the majority of participants discussed depersonalization as, what one participant described, an "experiential based pathology", one participant pondered the possibility of, like schizophrenia and other psychotic disorders, depersonalization disorder being a "genetically loaded brain disorder" to which clients may be predisposed. They elaborated on this by stating:

If it were really a trauma based or situational based disorder, psychodynamic therapy would help and it really doesn't. But I don't know anyone who has done it. It would be interesting to know about patterns in treatment history, and how long in the mental health

system, what they've tried, what's worked, where they have been referred... if you could talk with [Daphne Simeon, depersonalization specialist] she will tell you that people do get better than this but there isn't a specific regime that helps everybody...

Interpersonal and Relational. Several clinicians spoke to the relational and interpersonal nature of depersonalization for the clients, and the great impact of object relatedness on their sense of themselves. They noted having clients who have struggled to understand who they are as distinct from others' identities, and separate from others' perceptions of who they are. In particular, relationships with early caregivers and intimate partners were emphasized as being tied up in the existence, and perpetuation, of depersonalization symptoms. One participant discussed his work with a mother who felt that she was "nothing but her mother", and their work of differentiating her narrative of herself through factually looking at the ways in which his client provided her children love and appreciation that was in direct opposite to his client's childhood. Another person described her client's depersonalization as directly connected to the ways in which she was not treated as a "person" in childhood: "This client was absolutely exploited and objectified in her family and I guess if you had to use identity terminology... she certainly would identify herself as unlovable, worthy of hatred and self-hatred, abuse, neglect... and she is beginning to believe that isn't true, because, as the feeling of not being alone with one's overwhelming affects increases, then feelings of attachment increases, and then, the corollary of that, dissociation decreases."

Many participants were able to speak to an understanding of a common duality in relationships with depersonalized clients that experience a yearning for, and intolerance for, understanding and empathy from others. Participants noted the experience of isolation, and its self-perpetuating nature within their clients' relationships, as both contributing to and maintaining the depersonalization symptoms. One interviewee described her long-term work

with a client whom struggled to directly communicate about aspects of his history and life, but would often read passages from books to her:

The hard part about him was that if I asked any questions about him he started treatment saying he wouldn't tell me anything about himself. Of course, he was telling me a lot by saying that. He used to read a lot of psych books and everything. In fact, he couldn't talk to me about himself but he would select pieces out of books and he would talk to me about them... Karen Horney... Shapiro... you know, the neurotic style or something like that... When I asked him questions about himself, he said "I do tell you about myself." And I said "through the readings?" and he said "yeah! I tell you about my condition through these books!"

Interestingly, this client seemed to equate sharing things about himself with this clinician by talking about his condition from the third person; he not only felt that he *was* his condition, but that it was the only accessible part of his self that he could discuss because, as the participant noted, "he didn't want to say more than he could tolerate... it made him feel more depersonalized when he talked about himself."

Some participants noted their clients' depersonalization would become exacerbated in the context of perceived judgment from others. They reflected that working through their fears, which often were externalized through projection, were actually the result of an intense internal critic. One participant noted the depersonalizing effect that a male's gaze could have on her female client in the following way: "She blitzed out, she would go into this fog, that she wasn't seeing well. And internally she has this feeling that she is ugly, the feelings of others get into the ugliness... I tried to explain to her that when she feels depersonalized it is the anxiety that causes her to dissociate from herself in this way... she just used to go to the bathroom several times a day, so she knew what she looked like."

Diagnosis. Though all participants could speak about depersonalization in the clients they have worked with, thereby qualifying for the study, only two (17%) had ever utilized the actual depersonalization/derealization disorder diagnosis in their careers. Both those who had and had

not used the official diagnosis reflected a sense that it is “relatively rare”. Among the ten participants (83%) that had never utilized a depersonalization disorder diagnosis, five (42%) reflected that they had not known a depersonalization disorder diagnosis existed prior to this study. The majority (n=8) described using a DDNOS diagnosis most frequently with clients that experience depersonalization. Though no participant had ever officially reported a depersonalization disorder diagnosis to an insurance company, several (n=3) noted that they had never had an insurance company reject diagnoses of DID or DDNOS when asked about depersonalization disorder specifically. As one participant described:

I think because of the cultural shift and because of the new understanding of the neurology, [DID and DDNOS] have become much more widely accepted. I also experienced doing insurance reviews and new authorizations and I will still get a call now and again from a reviewer from an insurance company saying, “I don’t recognize this diagnosis. What do you mean when you say dissociation? And what do you mean when you say you are trying to maintain present orientation for this client on an ongoing basis?” and I think that goes back to the earlier point that there is no common language yet, there really isn’t, and I don’t see that shifting for a long time.

One participant reflected that the historical skepticism regarding DID may be akin to the current lack of information and awareness about depersonalization/ derealization disorder as a diagnosis, and that the perception of its rarity may be a result of clinicians not knowing they are encountering it. They elaborated further:

I bet it will be like some of the other dissociative disorders several years ago, that everyone is going to have this long history of very unsuccessful treatment. Because when they were first describing DID in the late 1980s the length of time between entering treatment and the correct diagnosis was 11 years or something like that. And that is no longer true, but if you track these things I bet you that would be the profile you’re going to see. It is phenomenologically very different than anything else and it doesn’t respond to treatment of anything else.

Just as several participants discussed the lack of utility they found in dissociative measurement scales, a similar number noted that diagnosis is not a means by which they shape their methods of working with depersonalized clients. One participant reflected that:

Over time, I've realized essentially that I work with everyone in the same way. I help them figure out what their beliefs are about themselves, and how they relate to what happened to them, and how they come to terms with...the idea that they might not have deserved it. And, you know, with different diagnoses you might take different turns...some people benefit from medication, some people are more resilient than others, or braver, and... some people have a harder time with their reliance on me. But with these kind of diagnoses, without being able to depend on somebody or grow to trust somebody, they aren't going to get well.

Similarly, participants spoke to the futility in fully “understanding where [depersonalization] comes from” in terms of diagnostic categories or etiology. Active listening and open-ended questioning seemed to be the primary means through which clinicians attempted to tease out whether their clients' depersonalization is primary or secondary to other conditions, such as depression or anxiety. One participant made the following comparison:

Depersonalization is... like saying you have “cough” syndrome. And eighteen million things could be causing your cough and when you're talking about individuals with these phenomena, you can't understand what it all means. And you can't ever understand exactly what it all means anyway, but you can try to approximate that by careful listening and people are not afforded the time to listen.

Frequency. Just as most participants struggled with the act of defining depersonalization/derealization as generalizing a complex and variable experience, almost all (n=11) could not precisely quantify how many clients they had encountered with depersonalization symptoms. “That is very impressionistic”. Most reflected that it was “many” clients, and, in particular, upwards of half to all of the clients they worked with that had any history with trauma. One participant noted that, for trauma therapists, symptoms of depersonalization are just “part of the landscape” that they work with in their daily practice. Almost all participants (n=10) maintained that it is more prevalent than it is discussed, and only one spoke directly to the fact that it can be easy to misdiagnose as another condition, reflecting that, “If you don't know anything about dissociative disorders you will probably misdiagnose it

as anxiety or depression. If you do know something about dissociative disorders, you may diagnose it as some other trauma related dissociative disorder.”

Diagnostic Measurement Scales. Nine out of 12 participants (75%) noted that they never used any diagnostic measurement scale with their clients that experience depersonalization. Overall, such scales were thought to not only negatively affect the clinical relationship with clients, but seen as relatively “useless” in the actual treatment with their clients. A few of these participants reflected a sense that empirical measures have a tendency to privilege diagnostic categories over the clinical relationship, and speculated that particular agencies and, in particular, psychologists may be more interested in the quantitative data. It was also noted that insurance companies have encouraged participants (n=2) to use scales as a means of quantifying client improvement over time and limit payment for treatment. One participant in particular described a concern that such measures could be experienced by a client as hurtful:

... I just think it would be a *breach*, it would be a narcissistic injury that somebody else applied to a person I *know*. Maybe this is the wrong thing to say, but I just don't... it's the connection that heals. You don't get more of a connection... sometimes there are things I might miss, but I'll get it eventually. So no, I never use them. Maybe psychologists are more comfortable with them, too. And think there is more value. And there probably is, but not for me.

Some had contradictory feelings about the use of assessment tools with their clients. One participant reflected the conflicting nature of the measure in that it can be “very specific and clarifying”, while also later stating that “it's often not accurate...it doesn't show the level of actual dissociation because people are negating it when they are filling it out”. Another who stated they prefer to go on “intuition” rather than utilize measurement scales described avid support for a non-dissociative measure, the Adult Attachment Inventory, in her work with all clients, speaking to her understanding of the relational nature of dissociative symptoms.

Only three participants, all male-identified licensed social workers, noted that they believed that diagnostic measurement scales had significant things to offer both the client and the treatment. All three primarily utilized the Dissociative Experiences Scale (DES) over other particular measures, and used them at the beginning of treatment, as well as periodically over time to identify shifts in the patients' experience of specific symptoms. One of the three participants also reflected on the overall bias against them in the field, and having internalized this message at some point, despite his sense that they can be "grounding" and "very comforting" for a client:

My one bias I guess, I am not sure where I picked it up, that the tests are ultimately limiting and the discussion becomes "Why am I taking this test?" And I have actually never found that to be the case. I have found that, especially the DES, is liberating for someone. It can be revealing but... that's what you want to do, you want to be shedding light on this particular problem which of course governs the way this particular person operates throughout their life, or since trauma ensued. Because very often this is the first formal mention that any of these people have ever had of this thing called dissociation that they just think is their operating system.

The other two participants that utilized measurement scales described a constant level of judiciousness in assessing the vulnerability and readiness of their clients to open up about their dissociative symptoms, illuminating their awareness of a potential for explicit questioning about dissociative symptoms to cause their clients to feel too exposed, too soon. In such cases, one clinician mentioned his tendency to use a more roundabout measure, the Impact of Events scale, to assess for the presence of depersonalization symptoms in the context of specific life experiences.

Ideas about Treatment

This section focuses on participants' experiences with clients that experience DP/DR, as well as the particular approaches and modalities that contributed to their clinical work. When

asked about treatment interventions, a common theme was to support clients in assessing the aspects of their daily routine or interactions that could be contributing to their depersonalization symptoms. Overwhelmingly, participants noted a sense that particular treatment modalities and approaches to working with other dissociative disorders, particularly DID, could be equally effective the treatment of depersonalization/derealization. In particular, several clinicians mentioned a primary treatment goal of supporting their clients in beginning to think about their internal world differently. This included an emphasis on one's self as having multiple components, or parts, that make up their whole identity. One participant eloquently described how they have worked with clients in understanding themselves as being *much more than* their present state of "disconnected":

Before I knew about structural dissociation and parts work, I would approach it as them, a singular person or an adult, that I am sitting with who is basically integrated. But now I have a sense of it being a **part of them** that feels that way. Now, when I hear a client say this I will be curious about three things. One is "Wow, I wonder if there was a trigger to feeling this way recently." And ask what tells you you have no sense of history or body. And that is to elicit some sort of response about... is it coming from their emotions or lack of feeling, is it coming from the body or numbness, or is it coming from thoughts about themselves. So separating out cognition, somatic experience and emotion is really helpful. Then I'll ask how long they've experienced it. And when did it start. And that helps, those three questions help to ground it in the present. Because folks who feel depersonalized and derealized are not in the present. And then, once they just give me the basics around present feeling, then I go to the structural dissociation model and we talk about, "oh wow that conversation with your father was a huge trigger. And your submit part probably got triggered. Or your freeze part." So then they start to differentiate from their regular adult self that is going on with life and basically okay, and the part of their personality that got triggered and went into depersonalization/derealization. And that is really empowering because they are no longer identifies as being unreal or having no self. They're realizing, "Oh, this just a part of me that feels that way. And I actually went to the library and checked out a book and went grocery shopping and I was okay." So it's very helpful to differentiate the adult part from the triggered emotional part based on a structural dissociation model. Most of the time it is a helpful way for clients to think about their experience, but people who are phobic of their parts, especially if it goes beyond fight, flight, freeze, submit and attach parts.

In elaborating about the concept of parts, and treatment with parts in mind, many participants noted their usage of the structural model of dissociation (Van der Hart, Nijenhuis, & Steele, 2006), as well as the importance of using Internal Family Systems¹ and Ego State Therapy². Some of the principles inherent in these models, and in their interventions with clients, involved universalizing the internalized presence of mean and judgmental perspectives that harm our internal sense of self-structure and existence. One participant said, “I think lots of people that don’t have a formal dissociative disorder are very much affected by introjects that are very critical of them. I worked for years with someone around lots of day to day issues, she can’t access parts of her childhood, but early on she talked about a committee in her head, and she’s not dissociative, but she has a lot of internal voices. I think it’s really common.” Some framed it in terms of having many identities as an adult, like the following participant:

I introduce it by talking about roles. That I’m a husband and a father and a gardener and a therapist... that these are all using different neural pathways of the brain... sometimes I share the story that I would accidentally drop a dish and break it, and I would yell, “you idiot!” and that was my father interject. And after about ten years, my wife started to say “stop talking to my husband that way.” And it doesn’t happen anymore that I yell at myself in that way. It’s often pretty easy to use people’s own experience of self-critical voices to get them to understand ego states and parts.

Participants noted a theme of their clients as unconsciously hiding away aspects of their identity from themselves internally, and that this act could manifest as depersonalization symptoms. One participant reflected on his work with a particular client:

Part of his depersonalization is that there are no parts ...typically represented parts of self... He is an artist and that is his great love... it is profoundly disturbing and expressive of his pain... but that isn’t who is in the conference room. It’s Sir, and Guilt, and four men who say these distorted powerful negative hostile interjects but they control

¹ Internal Family Systems (IFS) is a model of treatment focused on establishing “Self leadership” in which clients work towards cultivating a curious, compassionate stance towards their inner experience (Schwartz, 1995).

² Ego-State therapy is based on a “parts” model of personality, which emphasizes reflecting on how different aspects of self, which are totally unique within each person and do not necessarily fall into archetypal categories, can better communicate with one another to acknowledge the complex internal system (Van der Hart, Nijenhuis, & Steele, 2006).

him like a puppet and there is no himself there. That in my experience is pretty unusual and the clearest indications of his depersonalization.

In discussion with how one to engage in the idea of an individual as having parts, or multiple aspects to their inner selves, one said that they do not do so in a direct manner, but with curiosity:

I only do that with a couple of people because it seems to help them. But I think it reifies the separateness of parts, and that isn't what I want to be doing. I want leakage, leakage and more leakage. I was never one to do an "integration"... like it was up to me! (laugh) What often happens is, I would prefer somebody **to tell me** about a part... because I want her to communicate inside .. I don't want to be doing "hocus pocus" and "I know things she doesn't know or is not ready to know".

The two participants that identified using depersonalization disorder as an actual diagnosis noted difficulty in identifying ways to approach clinical work that could shift their clients' symptoms, uncertainty in their particular skill sets, as well as ethical discomfort. In their separate interviews, both worked through their doubts that psychotherapy could help those with DP/DR symptoms, while also noting that he did not have enough data or experience with any individuals that supported the foundation of their doubt. One participant reflected on their confusion on how to work with the client as directly related to a struggle to differentiate it from other types of dissociative experiencing:

With depersonalization/derealization, they could better talk about what it was like for them, that was a strong thing. They would talk about it... this first person, when she first started talking about it, I realized I don't know anything.. I didn't have any clarity about what made it different than any other diagnostic criteria. And I wasn't sure if I could ethically work with her because I wasn't sure I knew what I was talking about or what would be helpful.

Both participants that noted a difficulty in the idea of treating depersonalization reflected a sense that their clients were "attached to not being attached", or invested in their symptomatology as a deeper part of their narrative or experience of themselves. When they

sensed their clients' experienced feelings of powerlessness to shift their symptoms, clinicians responded in differing ways:

There is a *type* of client who feels very savvy about the literature or the diagnosis and who come in self-diagnosed...whereas most people come in feeling "what the hell is the matter with me?" I have *never* had anybody say they have depersonalization disorder. But I know if I have anyone come in saying they have studied the DSM or been googling a lot, I know I am in trouble. Many years ago I started seeing a person...she came in wanting the boil lanced, and I said "I'm sorry, you're lovely, but I don't work that way. You should really see somebody else." And she tried to get me to come over to her side about this. And I said "professionally I can't do that. I'm doing harm to you if I did that." Anyway, she found other people who would do it. But she decided there was something about what I was saying that... might mean something, might be true for her.

Body Work. Engaging the body seemed to be a primary way that participants helped support clients with depersonalization symptoms. While sensorimotor and psychomotor therapy were mentioned as specific modalities, several participants noted ways they may choose to engage in more active interventions in any given moment, based on the client's presentation. Questions regarding the client's awareness of time and space were important in assessing, or reality testing, their level of presence in their body. When his clients experience depersonalization in the room, one participant noted engaging with patients in exploring safely throwing pillows back and forth in the room, and checking in about any shifts in feeling; another noted asking individuals about specific recent memories in which any of their senses had been ignited, in order to recreate the feeling of "feeling". A few participants spoke of being more unconventional in their use of touch, while also noting their rigorous attunement to the client's own openness to, and desire for, such intervention. One noted, "I saw someone for the entire first year of the therapy, the only thing we could manage is sitting knee to knee with me and me holding her head in my hands. And sometimes talking to her." Overall, understanding the ways the body struggles to be in touch with itself seemed very key in working through depersonalization symptoms, such as described by this participant's work with a forest ranger:

I'm working with a guy right now...he's been in one accident after another in his job...when he did a body map, I had him lay down on the ground, I drew the outline of his body, I told him to take that full length thing home, and go through almost a timeline of his body telling the story...he had broken almost every bone in his body at one point or another. He is really struggling right now, because he doesn't *feel* anything...he's just one big ...trauma...repository...he's so connected to the pain that he can't feel connected to anything else. If I could do an x-ray, he would just be one big scar. So we do a lot of breathing and a lot of core... work. And I tell him, as we do this work it will hurt. But it's sort of like when you're pouring water over a wound and it burns. I'm not trying... I've gone away from that method of therapy where you just have them reenact their trauma. It really wasn't helpful. But it's also helpful for them to have a narrative for it, and as they do they will feel it, but you're contextualizing it so that they have an idea that they're being... this is the big thing, just that they know in being able to have a witness to it there is in fact a way to be soothed by it as opposed to more traumatized.

The Clinical Relationship. Participants overwhelmingly discussed the necessity of avid attention to the interpersonal aspects of the treatment process in their work with depersonalized clients. The majority (n=10) believed that depersonalization could shift as a result of ongoing dynamic therapy, and could attest to this having happened in their years of clinical experience. Though they explained the ways they engaged in treatment in various ways, there were many themes present when discussing their work with their clients, as outlined below.

Affective Engagement. Almost all noted the importance of being affectively present with their depersonalized clients, and that emotional or clinical neutrality could be incredibly threatening and damaging to the clinical relationship. A few were able to note experiences with clients in which their own affective distance in the treatment room had caused their clients to experience deep depersonalization, such as the following participant:

[My client's] depersonalization happened around this nightmare, she would get so anxious and so frightened by it in the room that she couldn't get a grip, she was very agitated and hyperventilating, and this is after years of connection. So [depersonalization] happened for those few minutes and in processing with me she was able to come back... in that moment depersonalization for her was a reaction to all of these feelings to being out of control. I think it was a death dream, a fear of death, she is getting older and she doesn't feel like she has enough connection with me anymore. But the depersonalization can come and go like that with a relationship, but it can also be chronic like it was with

her for years. When I was trying to be what I thought it was to be analyst, when I started out, I thought the way to help people go deeper was to have this neutral stance... she said to me recently, “you used to do this to me all the time.”

Several interviewees noted that they were deeply informed by trauma literature, which is “unambivalent” about the need to be active in moments that clients seem most depersonalized while in session. One participant noted that “clients can further experience depersonalization when they are going into things that they hesitate to say, and as an analyst you need to step in and throw them a line rather than let them flounder... There is a place for neutrality and silence, but you need to help people get from Point A to Point B.” The participants’ affective and emotional presentation often seemed to have a distinct impact on their clients’ abilities to feel more able to access themselves and have their therapists’ witness this process.

Empathy. The importance of acknowledging the symptoms of depersonalization directly is an important step in the process of the work. A few therapists noted that denying, negating, or not treating the symptoms as though they are something to be concerned about can actually *reinforce* and strengthen the existence and frequency of depersonalization symptoms themselves – that is, further depersonalizing a depersonalized client. A participant elaborated further, stating:

I mean, we have growing evidence that they are getting worse because they are, on a neurologic level, because there is a confusion about whether or not they are **being** retraumatized, whether the horrible things that have happened to them are *still* happening, it’s not just a cognitive problem, but neurologically their body thinks it still *is* happening. And it’s not. And so, in some ways, when their ego is incapable of functioning in those moments, they need, as the analysts have been saying for over 100 years, they need an auxiliary ego, they need *us* to sort of function for them. No, it’s 2014. We’re safe. I can put this coffee table between us if that would feel better for you. Yeah, I’ll do that. Should I back my chair up? Okay, we’ll do that now. They’re able to calm down, they’re able to be more present, and they have an experience of a caregiver. Which we think is probably part of what is curative.

One clinician noted the temptation of having sympathy, as opposed to empathy, for “these people that lose themselves”, but that empathy is “the only effective way that I know how

to get in, and sympathy cuts of empathy at the knees.” As noted later in the chapter, participants who were able to identify their own experiences with depersonalization also seemed more able to maintain a level of empathy as they sat with their clients.

Reframing. Several participants emphasized the value of reflecting on depersonalization symptoms as a strength or skill set that is effective at keeping their clients safe. These interventions seem to involve some normalizing of the presence of depersonalization processes in the context of their clients’ histories, as well as psychoeducation about their symptoms not being their “fault”. One participant described:

I have a woman that I work with who can’t drive from point A to point B because she doesn’t feel real enough, she is so depersonalized and derealized that she doesn’t have a sense of having traveled the distance, or that her self traveled, her body went from point A to point B, and there is no sense of history between the points... but when we look at it as a part of her, and explore which part of her was triggered by driving... or is there a way that this part, the going on with normal life you, can help the part of you that is freaked out about being alone with driving. So it’s an integrative model where you help people mindfully, with curiosity, and with respect for each part, notice themselves in a new way. And it’s *unbelievable* how empowering it is, it’s depathologizing.. I mean, some people weep because it is the first time that they’ve *welcomed* the symptom as sort of hero who’s helped them out through devastating circumstances, as opposed to blaming it or judging it or being crazy or weird.

Attunement. Several participants noted the tendency of depersonalized individuals to feel completely out of touch with themselves as well as others, and that the work demands a level of alertness to “shifts in energy”, “a dropping out of affect”. They almost universally (n=11) expressed their impulse to be directly curious about these shifts with the clients, and intervene regularly with exploratory reflections that expressed a curiosity about what their clients and interest in what their clients may be experiencing, giving words and language to nonverbal states.

Time and Pacing. There was a consistent sense that work with depersonalization symptoms requires a very slow pace, and most successfully happens over a time frame of several years. Many noted not even realizing their clients had depersonalization symptoms until months

or years into treatment. Participants seemed to believe that connected to the time it can take for depersonalized clients to challenge their own internal barriers regarding their inability to connect to others, and others to connect to them; it was overwhelmingly reflected that these could not be dismantled quickly. One participant noted a client she had seen for sixteen years, and that “some people fly into the work, and other people just go kicking and screaming into it”, because “people who are severely traumatized are by nature not going to be trusting, it’s hard to sort out how much that experience of not being understood is related to their own transference to the situation. They may be producing the experience of not being understood...it’s very complicated.”

Only one participant noted the challenge of moving too slowly in the work, which seemed surmountable if and when the clinician develops an understanding of the client as a person over a significant period of time in order to “be ready to shift to deepening the process and not be so supportive that you prevent from doing the work that you need to do.”

Authenticity. A level of openness to being effected and touched by their clients, as well as showing their clients their impact on them, was noted by several participants as being incredibly important in the treatment. As described in the following anecdote, one participant illustrated that their own emotional transparency had helped their client feel more “real” within the relationship:

[My client] said that the first time she began to trust me was when I was moved to tears by some miracle that her son had accomplished. And there have been a couple times with her in my narrative work in differentiating her from her mother that I have been teary and she has found that tolerable and has said, “you see me, I felt it. We were beginning this work a few weeks ago, and I felt like you saw me.”

In addition, authenticity meant that clinicians needed to be sincere in their engagement with their depersonalized clients, as one noted: “Safety is not the same thing as comfort, but it is

definitely based in the relationship, and that is the razor's edge, which a lot of therapist's don't get, between boundaries and connection.”

Looking Inward: Therapist Reflexivity and Self-Reflection

Participants in the study overwhelmingly presented a strong sense of themselves as being able to engage with clients and do work that not all therapists are capable of handling. Several (n=4) participants noted that they were frequently referred clients who had previously been in treatment with other clinicians that had reached a stand still, or made little progress; they often attributed this sense of being a clinician of “last resort” to their level of perseverance in the face of either intense affect or a lack of it. Some noted this internal strength – or, as one participant described it, “unflappability” – as necessary for working with survivors of trauma.

Coupled with this sense of their abilities, participants also expressed their deep gratitude and awe for the opportunity to be clinicians, to share in others' stories and offer opportunities for healing. Several reflected a dethroning of themselves as expert while in the treatment room with clients. One stated, “I just have a humble understanding that you can't fix people. There's no cures here. We're just trying to help them, do you know what I mean?” while another participant echoed that “healing...doesn't happen like lancing a boil.” Their humility regarding their role in treatment was also connected to participants' interest in embracing the unknown in the treatment room, using multiple lenses with which to look at their clients, and developing an intuition about “how healing happens”.

Though participants did do work with clients regarding the potential causes of the depersonalization symptoms, they overwhelmingly placed more weight on the way they were in the treatment room with their clients, and a thoughtfulness of their role. They noted their efforts

to, as much as possible, approximate an understanding of their patients, their needs and their fears. They emphasized the fact that this was an effort – they were vulnerable, imperfect clinicians, who wouldn't and couldn't always do this perfectly. Furthermore, it was noted that the ability to successfully work with clients that suffer from depersonalization wasn't an intellectual process, but a skill developed through working to understand the depths of their own souls, and being able to note the darker places within themselves. As one participant eloquently described:

It's old fashioned, but you have to have done deep work on yourself. To not be afraid of what you are facing. Because...this is really hard. And you have to be open to advice. I think that it used to be, maybe this isn't true, I'm going to say it anyway, people go right from college to graduate school and have not had a certain kind of life experience... I mean, the only thing that forces you into therapy really is pain... a friend of mine, I was grieving 30 years ago over a breakup, she said to me she's never had that kind of pain because she knows how to cope. And I said to her.... "life hasn't brought you to your knees yet." Because I am not any different from my clients. I'm not better, I don't do it better.

Whether participants had engaged in their own therapeutic treatment or not, they had done a lot of reflecting about what brought them to be interested in work with dissociative clients in general, and some level of relatedness to their clients' sense of disconnect and difference. One participant reflected:

It took me many years to figure out why I personally was interested in these types of patients... I finally figured it out, is that one of the effects of interpersonal trauma is the sense that there is something that is wrong with me. It serves the purpose of making you feel, because there is something wrong with me, the matter with me, it leaves you this sense of alienation, of not belonging to a sense of community, being on the outside looking in. Why am I interested in this, it took me a long time to figure out. I grew up as part of the only non-white family in an upper middle class suburb and gay, so guess who identifies with alienation? (laugh). So that is the personal answer.

Others reflected a profound sense that they were no different than their clients, and that remembering this enabled them to avoid a sense that there is "fancy footwork" or treatment modalities that can do more than what many described as "simple" ways of helping: being

present, trying to understand, and trying to help their clients understand themselves. In addition, a few noted that clients' desires for the clinician to be the "fixer" or the "magician" can shift over time as auxiliary ego in supporting their clients' work in trusting their own.

Personal Experiences with Depersonalization

Few participants (n=2) divulged having their own re-occurring experiences with chronic depersonalization, but those whom did noted it as a significant contributing factor to their pursuit of work with traumatized and dissociative clients. In fact, one noted that the work itself with depersonalized individuals was what led them to recognize depersonalization in their own daily experience. Finding her way towards her own healing is what brought her a level of conviction in shifting her professional work "to start being in touch with how easily people can be out of their own bodies, looking functional and ...maybe not always knowing it but sort of knowing it, like walking around with a rubber glove on the whole body, almost like they are wrapped in latex."

When asked about their ability to imagine what depersonalization feels like, the majority (n=9) could recall specific scenarios in which they had felt unreal or disconnected from themselves and the world. Many of these were brief, episodic experiences after receiving news that had shocked them, or during events that were particularly difficult emotionally, in which depersonalization enabled them to move through the moment without their system being overwhelmed. Though these moments passed quickly for the majority of participants, there was a distinct correlation between having had an experience that had created a depersonalization response and participants being able to imagine what chronic depersonalization might feel like for their clients. In addition, this correlation led to participants having more confidence in their ability to work with these symptoms in the long-term with a sense of how the therapeutic relationship could help their clients. The two participants that could not identify having had their

own experiences with depersonalization/derealization, brief or otherwise, were the same participants reflected a hesitation to take on clients with these symptoms. One of them struggled to express what it was, or why it felt mysterious to her, with a sense of frustration with herself, “I’ve tried, but I don’t feel like.. I don’t think I quite get it. I’ve worked so hard to be present... I don’t have a felt body attuned experience of what that is like. *I want to get it*, but it’s not part of my experience.”

A few noted the ways that the medical model of care depersonalizes individuals in order to quickly provide treatment, often sacrificing a full understanding of each individual; this observation most often was present in those that had personal experiences with the medical system in which they had not felt fully seen or heard, such as the following participant’s story:

I’ve had a lot of surgery in my life, and one, in 1985, I woke up afterwards and I didn’t feel so bad. And there was a nurse in the room and I said “oh, I’m awake” and she said “you’ve been awake for hours. You’ve been throwing up for the last four hours” and I thought, yes.... dissociation and defense of the ego here. There’s no reason in the world that I needed to remember four hours of vomiting. So, you know, and I’ve had the experience first hand of the way caregivers... create derealization because... I had a brain tumor, I’m fine.. but before they knew it was a brain tumor I had felt like crap for a long time, but I had to keep going...and eventually I started to go blind in one of my eyes, and I had to go to an ophthalmologist and I saw eight specialists over hours, and one of them did some special thing and said, “okay, what do you see?!” and I said, “nothing...” and she said, “you aren’t trying hard enough!” ...and I was a mature woman, and I thought, wow, people really do this shit. And do people take them seriously? And I said, “I think we’re done here.” I just think.. I’m really able to say, you jerk, and move on, most of the time... but I think that when you are a patient, it’s much more common... I don’t know if doctors recognize it because they’re too busy creating it....

One participant noted that his own involvement with medical care had led him to notice more broadly the ways all systems can reinforce and recreate experiences of depersonalization:

And I’ve been through [discrimination], as someone with a neurological condition, and I don’t like that. I actually call it dehumanization. and that line between dehumanization and depersonalization is **so** thin... as one of the neurologists said that I was working with, “one of the things you have to watch for is to not get demoralized. Cause demoralization actually contributes to depersonalization.” I don’t know how you could not include (oppression) as a part of a conversation about depersonalization. I think discrimination

against children, discrimination against the ill and the disabled, the elderly, you name it. That... is enough to... make anybody feel crazy.

Countertransference

Most participants (n=9) reflected on the importance of countertransference in their work with depersonalized clients. Overwhelmingly, they spoke of utilizing their countertransference as a source of communication and information about the client and the clinical relationship, and consistently prioritized curiosity and exploration of their feelings over self-judgment about their contents. One participant speculated about the meanings behind her emotions in the following way:

Feeling things is my biggest tool... Sometimes I get angry and.... I think that... some of it has to do with, a perceived on my part... that.... She, the client, chose to disconnect from me. I don't know that this is accurate but... that that's her power. And it's good she has some power. And I assume my anger... mimics what would happen with an abuser who wasn't getting to see the effect she was having on the person they were abusing. I'm making this up but it's where it goes for me. Or I get this mushroom soup type feeling where I'm wading through mushroom soup, and then I have to stop focusing on the client and try and get myself more present, because I'm really no good in that mushroom soup place.

Many noted the difficulty in accessing depersonalized clients within the treatment relationship, with varying levels of response to this level of interpersonal distance. One person noted a desire within her to preserve the distance, which she described as a "twinship experience": "sometimes I'd be saying to myself... "There are two people in this room, one of us has cancer, thank god it's not me", trying to separate as opposed to join....this tells you a lot about me". A few participants (n=3) reflected that a sense of distance from their depersonalized clients have caused them discomfort, leading to concerns that they the clinician themselves are "the problem":

I start to feel myself getting anxious because the person is not connecting with me affectively since they don't pick up on what I'm experiencing... they don't, what they

experience as not real they don't experience me as being particularly real either... and I've actually asked one or two "are you upset or irritated with me?" because I was getting no response. And I would get "no, no I'm not!" but because they weren't responding on some sort of emotional level I thought they were just getting mad at me for something. When they would say no, I would know it wasn't me... that was the problem, they feel so disconnected.

When reflecting on her difficulty with understanding depersonalization symptoms, one participant reflected that dissociation seemed to centered around the "leaking" of affect in the room that she could feel, whether her clients are hypoaroused or hyperaroused; in contrast, depersonalization seemed to be an "absence of affect" that she said she "does not get". Though this participant did not directly express her sense of helplessness in reaching depersonalized clients who lack affect, her reflection aligns with another participant who more directly elaborated the difficulty in struggling to do work with these symptoms: "I would say that depersonalization used to affect me in feeling helpless... feeling like, "what did I do?" Somehow knowing that I might have made it worse... the term is iatrogenic... or feeling like I can't access this person because they are so shut off." In further reflection, he discussed the ways that his helplessness were connected to his own narcissism - wanting his clients to feel connected to him, and helped by him.

Consultation and Supervision

An overall theme that participants (n=5) emphasized in their individual interviews was the value of both consultation with their colleagues, and supervision with experienced clinicians, as key in doing work with depersonalized clients. They consistently noted the potential for missteps in this work, and that misjudgment in treatment was ameliorated and prevented through regularly connecting with others in the field and processing their interventions and treatment

goals. One participant noted their regular encouragement of her peers to consult with others, and the potential harm in not doing so:

I had a [clinician] friend... and she was very excited...that she had gone deeper with this client who was afraid to have the memories, which to me automatically says “not ready”... but, so she told me she tied the client to a bed in her spare bedroom so the client wouldn’t hurt her... and there’s my lunch sitting there. And that was the end of eating it. And I had to say to her “you can’t do it. You’re *repeating the injury*.” And she said, “oh no, this wasn’t one of her traumas.” And I said, “how the fuck do you know?” Of course it was. I said, “you can’t see her anymore. You have to get into consultation right away and move her.” She thought I was crazy...

Those that had consulted with others about their countertransference described it as necessary, while also painful and risky. They attributed this to an internalization of historic bias towards a “blank slate” approach, resulting in clinicians’ divorcing themselves from acknowledging the thoughts and feelings that come up for them in their clinical role. One participant described the way in which his colleagues criticized him when he attempted to process a case and its countertransference, and his sense that their shaming of him was a result of their own emotional avoidance:

I am emotionally holding her and paying attention to her and working very hard to understand her but I also feel so drawn to her, physically...and it’s scary... so I actually decided to do a risk management program where I presented some of my material, and it was amazing because people started to supervise me on my own material, which was traumatic for me because I was trying to be open in sharing a moment in which I was dissociated, One of them actually said, “you know better than that”, whatever I said to the client in my dissociated state. But that wasn’t the point, I was trying to share the material as a way to say “don’t we all struggle with this?” and no one talks about it. If we don’t understand our own blind spots, how can we help someone else?

The vulnerability inherent in consultation with others seemed apparent in other anecdotes. One participant noted having a colleague who, if they mentioned the word “countertransference” to their supervisor, would be immediately asked to terminate the case without any information about the context. Another participant outlined her ability to hold tight

to the belief that her countertransference could be utilized in understanding un verbalized information that could greatly benefit the forward momentum of the client's treatment:

I remember taking the opportunity in a consultation group to talk about some difficulty I was having. And the difficulty was that a particular client who had been horribly abused, that when she would talk about the abuse sometimes I would get aroused. And I knew that had some meaning. But at the time I wasn't as experienced as I am, but I still *knew*, and I wanted to know how other people were dealing with it. And all these other top-notch people looked at me as though I was the sickest puppy they'd ever seen. And I just thought to myself, "those poor clients. That they're not taking the information that they're getting about what goes on in the room to be able to help them." I mean, what was happening for me I later figured out, she was trying to tell me that she was aroused sometimes by the abuse and she felt horrible about it. And that I had to *feel it* to be able to get it.

No matter how their countertransference disclosure was received in consultation with others, these experiences seemed to reaffirm participants' commitment to work with depersonalized clients. Their ability to be honest with themselves about what they experienced in the treatment room indicated a level of resistance to becoming depersonalized *alongside* their clients. These realizations were used as further evidence that participants were fit for the task of providing the type of treatment relationship that could lead to shifts in their clients' self-understanding.

Commentary on Not-Me: Criticisms of the Profession and Other Professionals

Unexpectedly, participants reflected extensively on their colleagues in the field and the roadblocks that may be affecting a more widespread understanding of depersonalization symptoms within the field. In particular, they mused about the reasons why depersonalization and derealization symptoms may go misunderstood, or misinterpreted, by clinicians other than themselves. These responses illuminated a level of discontent with the ways that the changing

landscape of mental health care limits the ability to always give deserved time and attention to fully pull apart the nuanced nature of a client's symptoms. One participant reflected that:

I think clinicians don't understand these symptoms because we don't have enough information. I think we try and pigeon hole people, and I think one of the great problems in private practice that is if a clinician doesn't get enough referrals or get enough base that they will take on anybody and then they'll try to shove that person into their knowledge base instead of saying "I need to refer this person out." I think that's very true in the private practice world, and probably true in any kind of hospital inpatient setting too. We get really locked into our particular perceptions and it can be bad for people, or not fair to them.

Similarly, a few clinicians also noted how the "medical model" of care has compromised the quality and accessibility of the mental health services they can provide. Participants noted the pressure of insurance companies on their clients, and the expectation for treatment to focus on changing people rather than understanding them, as hindering the ability for many clinicians to effectively treat depersonalization. As one noted, "I can't tell you how many psychiatrists I've had to explain to what dissociation is to over the phone. This all comes out of this disconnect between biologically based illnesses and what was called "diseases of the mind", right? If we can't locate it, if we can't do a blood test, if we can't pinpoint it *scientifically*, then it doesn't exist." Similarly, another participant elaborated further in the ways disconnection from one's experience is sometimes utilized as a form of treatment when a symptom, like depersonalization, is confusing to treatment providers:

I can imagine there are people who live constricted lives completely dissociated from others and the extent to which our culture and healthcare system support people in getting treatment is pretty paltry. Within the mental health culture and healthcare, you could even make the argument that certain forms of CBT promote people's dissociation. There may be some way in which that telling people to minimize their strong feelings is an institutionalized attempt to promote dissociation. There are numerous examples where that might work in healthcare alone, never mind culture at large. People could argue that attachment to technology is a form of a dissociated life...a lack of connection to real emotions, a superficiality.. I consider it kind of a virtue to be connected to yourself and others, in all of what that means... their true and authentic emotions...and that is not a cultural value for everybody....the whole idea about behavioral health instead of mental

or emotional health sends the message “I don’t care what you feel as long as you are behaving yourself.”

Similarly, when participants reflected upon the fact that they had not received any training about depersonalization or other dissociative disorders as part of their graduate level clinical education, they often attributed this to misconceptions about the frequency with which depersonalization symptoms occur. They noted how their clinical understanding is deeply interconnected to the larger ebb and flow of funding, research, and new “evidence” that can sometimes prove, or disprove, the existence of a “disorder” or “symptom”. In terms of depersonalization, one participant noted that “it’s something that the current faculty of institutions that run the show don’t understand and don’t consciously treat, so they don’t think it’s important to treat...the false memory syndrome sent the [dissociative disorders] field back 20-30 years, and there’s a lot of forces against it. And it doesn’t easily fit into the models that most schools teach so doing so would mean recognizing different theories and modalities.”

Reenactments and Secondary Gain

A few participants reflected a concern that mental health clinicians re-traumatize their patients unintentionally in their roles as clinicians. There were a variety of explanations as to why this might be the case, but an underlying theme centered around clinicians’ own conscious and unconscious reasons for going into the field that can impact the nature of their relationships with their clients. One participant briefly noted that “A lot of therapists are so afraid to be in the room with their clients and as a result, their clients can’t trust them on some deeper level. The therapist is a borderline, and the client is re-enacting old relationships with them”, while another dived further into the complex, intersubjective nature of clinical work with depersonalized clients in the following way:

A lot of people in this field are invested in not seeing themselves as having any problems. People want to see themselves as less vulnerable than that... there's a lot of traumatized people in this field who aren't dealing with their trauma, if you ask me, and are not concerning themselves with how their experience impacts the work that they do. And that's the value of psychoanalytic training, if you ask me, is that that's addressed whereas in any other training you're not required to really explore how your own struggles manifest in the work. People in this field have rescue fantasies trying to master some trauma of having an impaired parent or parents or sibling... and.... And so.... They... that may be where the helplessness comes from, situations like this where they could not enact change, so they come into this field with a repetition compulsion to master that experience. And luckily when people come to you for help they are more helpable. If you're stuck with them in your family they don't want help. But there are people who are ambivalent about change, it isn't conscious. But I think what people can experience is a re-experiencing of their own helplessness to affect change with their own family member.

Two participants noted that clinicians' pursuit of work with dissociative clients in particular is sometimes reflective of an interest that is not about the client but the clinician. They recommended, in particular, that clinicians thoroughly assess what brings them to work with clients that experience depersonalization, derealization and other dissociative conditions. As one clinician reflected, "The question goes unasked too often in our field: why are you wanting to do this work? What is it about this work? I think that there are many therapists that are too guarded, and their boundaries are too rigid, and that they follow certain rules too fervently... and that, it keeps them from being real. So, clichéd as it is, you have to be present and a real, authentic person."

Conclusion

These findings represent the perspectives of twelve mental health providers who work with clients that experience depersonalization and derealization symptoms. Participants' reflection on their subjective experience of this work has been categorized into the major themes of: 1 Within these overarching themes, a variety of subthemes have been identified and described. The following Discussion chapter will address the major themes and subthemes in

greater depth, analyze relationships between the themes, and highlight the significance of unaddressed topics. The relevance of these findings in connection to previously reviewed literature will also be considered. In addition, limitations of the study, implications of the data for clinical social work practice, and future areas of research will be addressed.

CHAPTER V

Discussion

The purpose of this qualitative study was to explore the ways in which clinicians' understand depersonalization (DP) and derealization (DR) symptoms. The overarching research questions grew from a review of both theoretical and empirical discussions that have looked at DP/DR, and identified significant gaps in the literature. As noted in Chapter 2, there exists over a century of theoretical works reflecting on the potential intrapsychic and interpersonal geneses of chronic depersonalization and derealization. Though the last decade has led to the development of several research centers dedicated to DP/DR, which have contributed to a strong foundation of empirical research that has shifted knowledge about prevalence rates, chronic DP/DR remains generally removed from larger discussions of mental health conditions by professionals. In addition, despite the lack of empirical research studying the impact of clinically-based treatment on DP/DR over time, it is frequently presented as a rare condition resistant to therapeutic intervention. These conflicting truths furthered the need for increased insight from the experience of clinicians that are not only familiar with chronic DP/DR, but have engaged in therapeutic relationships with clients for whom unrealness is reality.

With these factors in mind, this study explored the explicit and implicit ways 12 clinicians conceptualize DP/DR and how this impacts their treatment approach. This chapter will discuss the findings of the study in relation to the literature reviewed, with the hopes of more broadly exploring the implications of the study for broader practice. Then, the limitations of the

study will be highlighted, with an eye to what questions and ideas can be explored rigorously in future research.

Examination of Findings

Unlike the research that has been previously reviewed, this qualitative study elicited responses from 12 participants with training in trauma and dissociation about their own work with clients that have DP/DR. This section will outline and further discuss the significance of the study's findings in the following areas: 1) Definitions and Diagnosis, 2) Aspects of the Treatment Process, 3) Reflexivity, Self-Reflection, and Countertransference, and 4) Critiques of the Field.

Definitions and Diagnosis. As stated in the findings, participants struggled to precisely define depersonalization and derealization, particularly in its similarities or differences from dissociation as a phenomenon. This aligns with the literature, and the lengthy debate that has frequently conflated these terms while debating the definitions. Most interestingly, participants reflected a sense that differentiation between the terms, and determining the exact ways to define their clients' dissociative symptoms in terms of external diagnostic language, was not just unnecessary for treatment, but somewhat irrelevant. In fact, a few participants noted that clients who brought their own diagnostic self-assessment into the treatment room and described themselves as having a depersonalization/derealization disorder diagnosis posed a level of difficulty in the therapeutic relationship. This reflection may be the result of a fear that the client will challenge the therapist's knowledge on the subject, or that the client themselves have built a sense of self-understanding around having a diagnostic condition that currently offers little hope for remission or change.

However, those participants whom affiliated their clients' depersonalization and derealization to a diagnosis of depersonalization/realization disorder, distinct from other dissociative disorders, felt less prepared to work with their clients in addressing their symptoms through therapeutic treatment. This response seems to mirror the literature, which reflects the confusion and uncertainty regarding the potential benefits of therapy on DP/DR clients. Alternatively, it could just be affiliated with an expected anxiety with regards to treating less-diagnosed and distinct dissociative conditions dissimilar than those with which they are more familiar. Regardless, it could be argued that these findings reflect the social construction of depersonalization/derealization disorder, though important for future empirical research and understanding of the condition, limits the abilities of both clinicians and clients to conceptualize possibilities for healing.

The sense that a DP/DR diagnosis is a hurdle to be surmounted rather than a useful category aligns with the participant-initiated topic regarding the medical model as shifting the notion of therapeutic treatment in their own practices, as well as the larger conversations about mental health. As the field is impacted by financial and insurance-based systems and moves towards emphasizing therapy as product oriented rather than process oriented, some participants noted the challenge of working with, as one participant described, clients' "desire to lance the boil".

Another important point for discussion is the consistent reflection that depersonalization/derealization symptoms are almost always a post-traumatic response. This finding is in contrast to the literature, and more clearly reflects theories regarding the genesis of dissociative identity disorder (DID). However, it clearly shows evidence for one cause of underdiagnosis, as clinicians may assume their depersonalized clients have post-traumatic stress

disorder (PTSD). As one participant noted, “If you don’t know anything about dissociative disorders you will probably misdiagnose it as anxiety or depression. If you do know something about dissociative disorders you are going to diagnose it as some other trauma related dissociative disorder....and it gets complicated because...in some cases there are traumatic backgrounds and in some cases trauma does seem to have triggered the episodes, except that it is not a trauma based disorder.” However, participants that didn’t label depersonalization as evidence of PTSD reflected a deeper, more nuanced understanding of what might constitute trauma. They were informed by theories regarding the self, its creation and destruction. Furthermore, they asked questions regarding what the symptom may be communicating about their clients’ limited inner communication and organization.

When discussing depersonalization/derealization, numerous participants (n=9) were compelled to reference specific theorists that formed the basis of their understanding. This feels like a notable pattern, and it deserves thoughtful reflection. The most explicit conclusion to draw is that participants’ belief that psychodynamic formulations of DP/DR have been significant in helping build a framework with which to understand their clients. Bringing this up within the context of the study, however, may be communicating the real need participants had to ground themselves, and their ideas for treatment, in the literature. This seemed to help limit their own level of uncertainty and doubt when navigating the vaguely charted territory that is effective DP/DR treatment. Similarly, it may be evidence of intellectualization on the part of the participants as a means of remaining removed or detached from the intensity, or seemingly emotional void, in the treatment room. The findings have indicated that the possibility for both enactments and parallel process is high between clinicians and depersonalizing clients.

Aspects of the Treatment Process. The findings strongly reflected aspects of the therapeutic alliance are as important, if not more so, than specific treatment modalities. This is a new finding in relation to the existing literature. Most participants expressed curiosity, and conviction, that DP/DR symptoms serve specific purposes for each individual client. Unearthing the stories behind DP/DR was universally described as difficult, intense work, based on their nature as unmetabolized, unverbilized, embodied expressions of (non)self. They recognized the interpersonal nature of these symptoms, and the ways in which relational traumas impact clients' capacity for connecting, being seen and being known. After a certain period of work together, they were able to identify and express empathy for their clients' microtraumas to the self and self-system that may be reinforcing DP/DR symptoms.

Every participant noted the extreme importance of not just depathologizing DP/DR symptoms for their clients, but engaging in discussions about the ways that they have been served and supported by them, even if they have caused some distress. As one participant reflected emphatically, "it's unbelievable how empowering it is, it's depathologizing. I mean, some people weep because it is the first time that they've *welcomed* the symptom as sort of hero who's helped them out through devastating circumstances, as opposed to blaming it or judging it or being crazy or weird." The importance of this act alone can not be overstated; therapeutic treatment with depersonalization/derealization symptoms cannot gain traction without a lessening of clients' implicit and explicit self-punishment for their feelings of numbness and disconnection. Reframing seems to have helped these participants' encourage an opening up to the idea that they are not wholly damaged or dead to the vibrancy of life and living. It is also evident from the findings that body based interventions are an important component of treatment

as a means of embodying and re-personalizing individuals that are disconnected from their physical essence.

Lastly, it is important to reflect on participants' frequent discussion of clients with dissociative identity disorder (DID) in the study. Though these clients have conditions distinctly different from depersonalization/derealization disorder in many criteria, most participants were able to acknowledge the difference in presentation between DPD and DID, ensuring that the study maintained some level of validity. The most important conclusion to draw from their lack of distinction between DID and DPD lies within a hope and belief in the potential for treatment of DPD. Many were able to draw parallels between the historical denial of DID as a condition with DPD. This ability to perceive diagnostic and treatment knowledge as existing within an ever-evolving mental health field allowed for an openness to addressing the unknown trajectory for their clinical work with depersonalization/derealization.

Reflexivity, Self-Reflection and Countertransference. Participants' tendency towards the perspective that all individuals have multiple parts to their identity was not just a means of normalizing depersonalization for their clients, but an act of reintegrating them back into belonging with humanity. Though this itself is not necessarily a radical notion, their level of *witness* in their treatment relationships was seen as the primary tool with which they contributed to their clients' healing. Those participants whom could not just sympathize or empathize but *identify* their own personal experiences with DP/DR was strongly correlated with any sense of remission of the client's DP/DR. In terms of self-awareness, clinicians that saw themselves as multifaceted and a composite of experiences and identities were more likely to view depersonalization as the manifestation of one aspect of a person's self, and feel comfortable with these clients.

Additionally, clinicians emphasized the importance of consistent awareness of their the implicit communication that occur in their work with DP/DR clients, as they reflected the great potential for exacerbating their clients' DP/DR and contributing to enactments within the therapeutic relationship. These might be a replaying of the client's numerous experiences of being misunderstood, or perhaps their sense that they cannot, and should not, be known by others. Participants consistently reiterated the need to *counter* the transference of depersonalized clients with responses that are *counter* to their clients' history of disconnection and deadness. The clinician's own experience of tolerating the client's state in the room, and giving shape to it through their own living in/with the client, can become a holding environment. Over time, as a patient feels that the most unreal part of them has been tolerated, they may feel more capable of the risk of exploring the other aspects of their self and story.

Critiques of the Field. Akin to frustrations with diagnosis and the medical model, several participants discussed the difficulties about the changing landscape of mental health care. The fact that this discontent frequently manifested as critiques of other clinicians in the field warrants continued discussion. Did participants really think their peers are less knowledgeable and more susceptible to ethical or treatment missteps in treating DP/DR? This could have been a displacement of participants' conscious or unconscious fears in the work, or perhaps indicative of an unconscious desire to display proficiency in the context of the research study. However, it is just as likely that this reflects a general perception that the field in which they have themselves is now less dedicated to meet the needs of clients with complex symptoms such as depersonalization/derealization. In some ways, participants framed therapy with DP/DR clients as a constant, methodical uphill battle – both for their clients, and within themselves. Perhaps it is also true that clinicians are part of a parallel process within the larger mental health

community as they are increasingly being asked to fight a similar battle: to be seen and validated that their clients' suffering is real, and that the work they are doing to ameliorate it is real, too.

Implications for Social Work Practice

This study and its findings serve as a call to both social work and other mental health related graduate programs to cease dissociating dissociative conditions, particularly DP/DR, from basic curriculum on major mental illness. According to this study, psychodynamic theory, as well as relational and intersubjective theories, can offer clinicians a basic foundation with which to conceptualize DP/DR and pursue therapeutic intervention. Additionally, the findings of this study overwhelmingly showed that personal therapy and thorough self-reflection is paramount to being capable of working with intense affective states such as those underlying depersonalization and derealization. Being able to navigate the depth of one's own sense of aliveness and selfhood, and that which threatens it, seems salient to becoming a competent practitioner for all clients, but particularly those with depersonalization/derealization.

Limitations of the Current Study

It is important to elaborate on the limitations of this study, of which there are many. Despite efforts to recruit for diverse identities in terms of race, practice setting and theoretical orientation, the sample pool was relatively homogenous in these areas. The majority of participants identified as white (n=10), and it is very likely that additional findings and themes would have emerged if the sample had reflected a level of racial and ethnic diversity. The age range of the participants may have also impacted the findings on some level, in addition to the relatively small size of the sample. In addition, because all of the participants worked solely with clients in a private practice setting, they may have reflected a bias towards long-term treatment,

given the assumption that they personally prefer this way of working. Furthermore, this type of outpatient setting provided the participants thorough opportunity to build an alliance infused with trust, safety, and an in-depth understanding of their clients over time. This potentially impacted the percentage of participants (n=10, 83%) that maintained DP/DR is treatable through therapy.

All of the participants' reflected that psychodynamic and/or psychoanalytic theory informed their work, which limits the variance of insight produced in the study. Because these lenses are oriented around looking at clients' symptoms as more deeply communicating information about the clients' inner world, this clearly impacted the findings in terms of conceptual understanding of depersonalization/derealization. This also reflects the personal biases inherent in the research, as during the time of study, the researcher was in a psychodynamic-informed social work program. Efforts have been taken to avoid bias in analyzing the findings, and maintain neutrality in the conclusions drawn here in this discussion.

Methodological biases may have also influenced the study's findings. It is probable that recruiting individuals whom identify as having specific knowledge of trauma and dissociation contributed to the general consensus that DP/DR is a defensive response to traumatic events. It is possible that potential participants may have self-selected out of the study who had experience with individuals who experience DP/DR, but did not identify with such a specialization. In addition, the nature of the overall research questions required an ability and willingness to recall specific moments in the therapeutic process, as well as a considerable level of selfawareness and openness on the part of study participants. The study is limited as a result of these conditions, as insufficient trust or comfort with the researcher could have impacted any of the participants' responses. Presumably, with additional time, the researcher could have ameliorated some of these limitations through enhanced recruitment efforts.

Future Research

This study represents a nascent attempt at understanding how clinicians respond to their clients' depersonalization and derealization symptoms, and how this impacts their perceptions of treatment. Further empirical studies are needed to further explore the efficacy and impact of long-term psychotherapy on chronic depersonalization/dereaiization symptoms. In addition, further studies measuring the impact of body-based interventions on DP/DR would add significantly to the literature that remains skeptical regarding treatment methods for those with DPD. Ideally, further qualitative research about effective treatment should also begin to include, if not prioritize, the voices and perspectives of those consumers that pursue DP/DR treatment in order to more clearly determine the impact of therapeutic efforts on these symptoms.

Though the majority of participants did not reflect a sense that there may be commonalities in the sociocultural identities of their clients with DP/DR, social work practitioners, in particular, are well positioned to explore the relationship between DP/DR and oppression. Discussions about the psychological implications of oppression and marginalization perpetuated on micro, mezzo and macro levels are often a part of current graduate training. Further research that explicitly explores how dominant culture and systems of power and privilege impact the intrapsychic lives of marginalized individuals warrants our attention as mental health providers and human beings.

Conclusion

This study explored the implicit and explicit ways in which 12 mental health providers have conceptualized depersonalization and derealization through their experience with clients, as

well as the ways these symptoms' have personally impacted them and their resulting treatment interventions. The most profound findings of this study illuminate the possibilities inherent in therapeutic relationships as a medium to more broadly understand depersonalization/derealization. Further education and training of social work and other mental health professionals is imperative to improving upon the assessment and care of those who suffer from such profound feelings of estrangement from themselves and others. Intrapsychic, interpsychic and systemic oppression have made the act of identifying and representing one's inner self such a common unconscious and conscious struggle that depersonalization and derealization can no longer be dissociated from our conversations about mental health and wellness. Whether these symptoms occur as unremitting or as episodic, we must begin to respond more broadly to our clients' feelings of being unreal as unique manifestations of individual challenges with the construction, maintenance and reproduction of their sense of self in everyday life.

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APPENDIX A

HSR Approval



School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

December 19, 2013

Meghan Doherty

Dear Meghan,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Stefanie Speanburg, Research Advisor

APPENDIX B

Informed Consent

**CONSENT TO PARTICIPATE IN A RESEARCH STUDY
Smith College School for Social Work • Northampton, MA**

**Title of Study: Clinicians' Experiences Treating Clients Affected by Chronic
Depersonalization/Derealization**

Investigator(s): Meghan Doherty, MSW Candidate, (xxx) xxx-xxxx

.....

Introduction

- You are being asked to be in a research study of clinicians' experiences with clients that suffer from chronic depersonalization and derealization.
- You are eligible to participate in this study if you are a licensed mental health clinician that identifies having worked with a client that has experienced chronic depersonalization/derealization.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore your perspectives and personal insight on the understanding and treatment of chronic depersonalization/derealization symptoms. The population under investigation will be any individual defined as having chronic experiences with depersonalization/derealization, as stated in the DSM 5 diagnosis. I am interested in what has helped and not helped, what has been a struggle, and what has been successful in therapeutic work with these clients.
- This study is being conducted as a research requirement for *my masters of social work degree at Smith College School for Social Work*.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things:
 - Provide demographic/personal information about yourself, including: gender, race, a brief description of your agency/setting in which you work (e.g. agency, medical center, private practice) and number of years practicing. I ask these questions so that I will be able to describe my participants accurately, but they are optional.
 - Participate in a face-to-face interview that will be conducted either in a public area (i.e. coffee shop, or library), your personal office space, or over Skype, that will take approximately 45 minutes to 1.5 hours, depending on your answers. The interview will be audio recorded with your permission. I will ask a number of open-ended questions about your experiences with treating your client with depersonalization/derealization, and how working with this client impacted you. At your request, I can provide you the interview guide in advance.

Risks/Discomforts of Being in this Study

There are risks in that asking you to reflect upon your past experiences, and talk about previous or current cases, may cause you to feel emotional distress or discomfort. Please tell me if you feel that way

so that I can stop the interview and ask if you wish to take a break, skip the question or stop the interview. Please do not give names or identifying information for any clients you mention.

Benefits of Being in the Study

- The benefit of participating in this interview is that you will have an opportunity to share your clinical experience with others in the field. Your experiences will be included with those of other clinicians being interviewed and may inform theory and practice regarding approaches in working with depersonalization and derealization symptoms. This study will be one of the first to examine clinicians' experiences working with those that present with these symptoms. You will not receive monetary compensation for your participation in this study.
- Your participation could provide assistance and insight regarding how clinicians can approach therapeutic work with those experiencing chronic depersonalization/derealization. Your insight could also assist clinicians, individuals and agencies that work with this population in developing and implementing improved resources and approaches to therapeutic work with those presenting such symptoms.

Confidentiality

- The recordings and transcripts from the interviews will be kept strictly confidential. All information will be kept in a locked file and all electronic information will be coded and secured using a password protected file. I will be the only one with access to the audio taped data. I will not include any information in any report I may publish that would make it possible to identify you. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed.

Right to Refuse or Withdraw

- The decision to participate in this study is up to you. You are free to refuse to answer any questions and/or withdraw from the study at any time prior to April 30th, 2014, without affecting your relationship with the researchers of this study or Smith College. If you decide to withdraw, I will immediately remove and destroy all data you provided and not use your information in the study. You must notify me of your decision to withdraw by email or phone by April 30th, 2014. After that date, your information will be part of the thesis. If you agree to participate, all of your information, as required by Federal Guidelines, will be kept securely locked in a file for three years after I complete my thesis. After that time, provided I do not need access to the information, all data and audio recordings will be destroyed. I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me by email or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

1. I agree to be [audio or video] taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

APPENDIX C

Recruitment Email

Hello!

My name is Meghan Doherty, and I'm currently a masters' student at Smith College School for Social Work. I am writing with the hopes that you might be interested in participating in a research study. The topic is clinicians' experiences treating clients affected by chronic depersonalization and/or derealization symptoms. For the purposes of this study, I am defining depersonalization and/or derealization through the criteria listed in the DSM 5 for depersonalization/derealization disorder, which is briefly described below:

1. **Depersonalization:** Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).
2. **Derealization:** Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).
3. During the depersonalization or derealization experiences, reality testing remains intact.

If you are 1) a licensed mental health clinician (Speed, LCSW, MA, MS, MFT, PhD) that is currently practicing; 2) have a self-identified specialization in trauma and/or dissociation, and 3) can identify having worked with client(s) that meet the above criteria, I would love to interview you! If you believe you have never worked with a client that has experienced these symptoms, you unfortunately would not be eligible for the study.

The open-ended questions will take approximately 45 minutes to 1 hour to answer, and the data collected will be used for my Masters' in Social Work thesis. I will ask demographic/personal information about you (gender, race, a brief description of the setting in which you work, and number of years practicing). The bulk of the interview will consist of open-ended questions about your experience with clients that describe depersonalization/ derealization, and your perspective on how therapeutic treatment addressed or did not address your clients' primary concerns. At your request, I can provide you the interview guide in advance. The interview can either be face-to-face (if you live in the Greater Boston area) or over the phone at a time and place that is convenient for you, and private. Informed Consent materials will be sent to you beforehand. There is no compensation for participation, but yummy snacks will be provided.

I would greatly appreciate learning from experienced clinicians, such as yourself! Please contact me at the email address below if you have any questions or an interest in participating. You can also help me by forwarding this email to your friends, colleagues, and peers who are clinical social workers that may be interested and qualify for the study.

Thank you so much for your time!

Sincerely,
Meghan Doherty
MSW Candidate

APPENDIX D

Demographic Questionnaire

Thank you for your willingness to participate in my study. As you know, I am interested in talking with you today about your experiences working with clients that have experienced chronic depersonalization and derealization. I want you to feel comfortable raising things that come to mind during our dialogue together – even if it seems off topic or not quite what my questions are asking. I really want to learn from your experiences, and there may be things that occur to you that I didn't think to ask about.

Before we get started, I am collecting the demographic information to get to know who my participants are.

1. Please provide the following information. What is your:
 - a. number of years in clinical practice
 - b. setting you normally practice in (ER, clinic, private practice, etc)
 - c. client population (e.g. children, adults, sociocultural variables)
 - c. age
 - d. gender
 - e. race
 - f. theoretical orientation (if any) (e.g. psychodynamic, relational, existential, etc)
2. What contributes to this self-defined specialization in trauma/dissociation? (e.g. trainings, coursework, client exposure?)
3. What led to your pursuit of this specialization?
4. Do you have knowledge of dissociation measurement scales (such as The Structural Clinical Interview for DSM-IV Dissociative Disorders; Trauma Symptom Inventory; Cambridge Depersonalization Scale; Multidimensional Inventory of Dissociation)?
5. Have you ever used these scales with clients in your work?

APPENDIX E

Interview Guide

Just as a reminder as we begin, please read the following DSM 5 diagnostic criteria for depersonalization/derealization disorder, which I provided you prior to the interview.

1. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:
 - **Depersonalization:** Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).
 - **Derealization:** Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).
 2. During the depersonalization or derealization experiences, reality testing remains intact.
 3. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 4. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).
 5. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative disorder.
- What are your initial thoughts of this diagnosis? Has it ever been something you have assigned, officially or unofficially, to a client? Why or why not?
 - How would you define depersonalization and derealization?
 - During your career, how many people would you say you have worked with clinically that met these criteria?
 - When you expressed an interest in participating in this study, you indicated that you had experience working with a client that was affected by these symptoms. Initially, how did the client describe their symptoms to you?
 - What strategies, if any, did you utilize to address these symptoms with your client? How did it turn out?
 - What do you believe was most helpful for your client in your clinical relationship?
 - What do you think is the best way to approach treating clients that experience chronic depersonalization/derealization symptoms? How did you form this opinion, or what has been your experience?
 - How did you contextualize and understand the client's symptoms in the context of their psychosocial history and experience? What contributed to these symptoms for the client?
 - In comparison to other clients' struggles and symptoms of distress that have been described to you before, how did working with this client affect you?

- What were some of the prominent feelings and thoughts you had about and around their symptoms of depersonalization/derealization?
- How do you feel these thoughts and feelings impacted you? How did they impact your treatment?
- Are you able to imagine or envision what experiencing these symptoms is like?
- If you could, what would you have done differently with this client? Why?
- Do you believe there might be commonalities in the population that experiences these symptoms chronically? If so, what might they be?
- Is there anything that came up for you during this interview that is pertinent to depersonalization and derealization symptoms that you would like to share before we end?