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Between Enlightenment and Madness:

The Culture of Sensory Disruptions

A dissertation submitted in partial satisfaction of the

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in Sociology

by

Eduardo Duran

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ABSTRACT OF THE DISSERTATION

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This dissertation explores the experiences of people affected by symptoms associated with depersonalization/derealization disorder. This condition entails sensorial alterations resulting in a defamiliarization with the world and their bodies. The American Psychiatric Association, however, admits that depersonalization/derealization may be a part of meditative practices and should not, in certain cultural contexts, be diagnosed as a psychological disorder. Through a comparison of two distinct sensory cultures—communities of Vipassana meditation practitioners and patient-led communities—I explore the sense-making work that people perform to render destabilizing somatic sensations congruent with either medical or spiritual cultural worldviews. Drawing from personal narratives, online data, and psychiatric case studies, I argue

that a sociocultural cosmic order, in which people ongoingly appraise sensory experiences in terms of their potential to foster "self-actualization," largely determines whether social actors interpret these dissociative destabilizations as either pathological or aspirational—a process I term "sensory instrumentalization." This comparative study adds to our understanding of how macro-level sociocultural arrangements may profoundly impact the subjective dimensions of experience. I contend that further exploring episodes of defamiliarization, which encompass instances in which social actors come to sense that the familiar world and their bodies are imbued with strangeness, may contribute to social scientists' empirical and theoretical understanding of a tacit, sensory dimension of social experience.

The dissertation of Eduardo Duran is approved.

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Introduction

Albert, a thirty-eight-year-old physicist, excused himself to adjust the lights of the kitchen in which he sat. The lighting surrounding Albert, whom I was video interviewing and could observe through my computer screen, became dimmer and red. He explained that the red lighting calms him when he is anxious. With a thick Eastern European accent, he stated, "I am just listening to this voice that's coming out of my mouth, and it's automatic," further adding, "…what I see here and what is around me, it's like a dream, and I'm dreaming all these… things around me, and I need to wake up because this is not reality." Albert stood up to measure his heart rate; he wanted to make sure he was not panicking. I asked if he wanted to stop the interview, but he insisted that we continued. I asked Albert why he described the world as a dream. He responded:

> *When you start to fall asleep, you start not to feel the bed at some point… you forget that you are in a bed… you normally fall asleep after that… the problem is that in that state I can wake up and my body doesn't wake up… The output is still working so you can send signals to your muscles… but only the input got messed up.*

One may compare Albert's description of the world and his own body, which he describes as *unreal*, as something that he often *cannot* feel, with Michael's experience. Michael, a recent college graduate, states:

...I would feel as if I didn't have a body, and if I pinched myself on my arm I would feel a lot less pain than usual... like I was disappearing into nothingness… without a self...

These quotes are taken from interviews of people confronting sensory-perceptual alterations associated with two dissociative conditions, which the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) now combines into one category: *depersonalization/derealization disorder*. According to the DSM-5, depersonalization/derealization entail "experiences of unreality, detachment, or being an outside observer" of one's body or surroundings (p. 302). These instances are indicative of a rupture in which people *sense,* in a literal manner, that they have lost the once habitual familiarity with a previously unquestioned world. People undergoing such episodes describe a destabilization of the sensible field housing the colors, contours, softness or roughness of the phenomena they once felt with their bodies as objects of common sense -- the bedroom's window, the sensation of the hand, the reflection of a face in a mirror.

The American Psychiatric Association (APA), while categorizing depersonalization/derealization as a disorder, however, acknowledges that interpretations about these conditions may be *culturally contextualized.* As stated in the DSM-5, depersonalization/derealization may encompass "volitionally induced experiences," which can "be a part of meditative practices that are prevalent in many religions and cultures and should not be diagnosed as a disorder" (p. 304). Depersonalization/derealization, consequently, may involve states that people *aspire to*, but such sensible experiences may also be interpreted as pathological disturbances. In fact, Albert has come to perceive his dissociative experiences as a mental illness,

but Michael understands these sensory-perceptual alterations as components of the pathway to enlightenment.

In this thesis, I set out to examine the phenomenological qualities of these dissociative experiences and, further, the cultural processes through which these disruptive episodes acquire different interpretations. I explore the sense-making work that people perform to render destabilizing sensations congruent with distinct cultural orders – specifically medical or spiritual cultural perspectives. I focus on two cases: a) communities of Vipassana meditation practitioners in which individuals interpret dissociative disruptions as pathways to *spiritual beautification*, and b) patient-led communities in which people employ the language of medicine to render similar dissociative states *pathological*.

Drawing from a triangulation of personal narratives, the analysis of online discussions, and psychiatric case studies, I make three contributions: First, building on the sociology of the senses, I show that the differentiation of dissociative experiences as pathological or spiritually enlightening is inseparable from hermeneutic interpretive activities. Both meditators and people diagnosed with depersonalization/derealization initially find their sensory alterations *unintelligible*. I demonstrate how social actors -- via collective meaning-making processes, or *somatic work* (Waskul and Vannini 2008) -- not only categorize such sensory destabilizations distinctly, but structure what is significant or insignificant about dissociative sensory episodes, worthy of attending to or ignoring. I, thus, engage the complex relation between the senses and cultural worldviews.

Second, I move beyond the question of *whether* culture matters to *how* culture matters. I elucidate specific sociocultural factors that influence why similar sensory dislocations may be appraised as destructive, negative, morbid, while they may also be seen as the pathways to a

'higher' human potential. I argue that the senses are made 'sensible' (or insensible) through what I call *sensory instrumentalization*. Whether social actors interpret these sensory destabilizations as pathological or aspirational is largely influenced by the presence of a practical culture in which self-possession and self-actualization become cultural imperatives (Adams et al. 2019; Boli 1995; Pulfrey and Butera 2013; Teo 2018). Meditative induced dissociation, despite often experienced as frightful, is rendered aspirational because it is capable of being absorbed into a logic of *instrumental action*.

When the senses undergo destabilizations, social actors are *compelled* to attend to the *interpretive demands* of a sensible dimension that would otherwise be overlooked (Winchester and Pagis 2021; Vannini et al. 2012). Of direct relevance to cultural sociology, the sociology of the body, and the growing sociology of the senses, this comparative study contributes thus to our empirical and theoretical understanding of *how* culture may profoundly impact the dimension of the senses.

Third, exploring the hermeneutic sense-making processes through which people render dissociative episodes legible allows to elucidate implications for clinical research. Complementing psychiatric studies, my research indicates that cultural perspectives may shape the qualitative dimension of sensory-perceptual disruptions (Kennedy 1976; Luhrmann 2006). Spiritual orientations, which espouse a logic of acceptance that encourages people to come to terms with their symptoms, may allow those who suffer from depersonalization/derealization to engage in a process of "symbolic healing," thus attenuating the disruptive quality of dissociative symptoms (Kennedy 1976; Castillo 1990). This study, consequently, advances our knowledge about the relation between subjective dimensions of experience and macro-level sociocultural arrangements (Cerulo 2018; Desjarlas 1997).

Depersonalization/Derealization: Reality and Commonsense

Studies have surveyed how variable types of illnesses engender subjective disruptions that lead to erosions of identity and taken-for-granted understandings about the world. Depersonalization/derealization, however, differs from most conditions; the state produced by dissociative instances of depersonalization/derealization, as a psychiatrist who has studied these experiences at length points out, "is one of the very few, if not the only state, that discloses the basic, elementary fabric of being, the feeling of this fabric, the experience of this fabric" (Abugel and Simeon 2006, p. 134). Unlike chronic physical illnesses, people experiencing depersonalization/derealization are not strictly confronting an incapacitation that has ruptured a routine way of operating in the world, which forces people to reorient themselves to the word as they learn to *functionally* readapt. Depersonalization and derealization are also different from psychological illnesses such as psychosis; those affected by depersonalization and derealization remain fully aware of their cognitive alteration and do not embark on Quixotean adventures. "They are, if anything, suddenly overly aware of reality and existence and of the ways in which their own experience is a distortion of a 'normal' sense of real self" (Abugel and Simeon 2006, p. 13). And at variance with those afflicted by better-known dissociative conditions, for instance, dissociative personality disorder, symptoms such as amnesia, fugue, and identity alternations are not present in cases of depersonalization and derealization.

What characterizes the phenomenology of experiences associated with depersonalization/derealization is, first and foremost, an unremitting shift in the sensorial experience of the world, marked by an altered visual perception, an altered body experience, and a loss of agency of feelings – it is an alteration of the immediate embodied experience that serves

as the basis for all propositions and propositional attitudes. People facing depersonalization and derealization confront the violence of a ceaseless unfamiliarity, both with the world and with themselves. Those who undergo states of depersonalization/derealization come to speak not strictly of a destabilization of habitual embodied functional *routines* and a previously 'functional' self, but, primarily, of a *detachment from a sense of 'reality' that transcends them.* States associated with depersonalization and derealization, thus, fundamentally involve experiential ruptures in which people describe that their relation to their sense of self and others, as well as the world, has undergone a *defamiliarization* – that is, people become detached from what they once understood as *commonsensical.* Their bodies and surrounding objects, previous experienced as both habitual and reflexively comprehensible, may now come to appear as strange phenomena. Depersonalization/derealization, thus, entails:

> *... A pervasive and distressing feeling of estrangement… [this condition] may be defined as an affective disorder in which feelings of unreality and a loss of conviction of one's own identity and of a sense of identification with and control over one's own body are the principal symptoms. The unreality symptoms are of two kinds: a feeling of changed personality and a feeling that the outside world is unreal. The patient feels that he is no longer himself, but he does not feel that he has become someone else… (Abugel and Simeon 2006, pp. 11-12).*

Given that a primary theme in social theory concerns how people constitute the world, as well as themselves, as objects of *common sense* (Schutz 1972; Berger and Luckmann 1966; Kleinman 1992; Honer and Hitzer 2015), the comparative study of

depersonalization/derealization and meditative induced dissociation helps elucidate how people's commonsensical relation to the world may be destabilized and reorganized. Social theorists have generally posited that people employ culturally elaborated "stocks of knowledge" to structure identities and orientations towards the world. Intersubjective, culturally sedimented schemes provide the background expectancies for the programs of everyday awakened life -- a domain that, according to Garfinkel (1967), makes it possible to sustain "the world known in common and taken for granted" (p. 36).

Anthropologists and sociologists have traditionally argued that symbolic meanings serve to "synthesize a people's ethos – the tone, character, and quality of their life, its moral and aesthetic style and mood" (Geertz 1973, p. 89). "Cultural frameworks," writes Geertz (1973), make it possible for people to structure their collective worldview, it serves as the basis for the formulation of the picture a people "have of the things in sheer actuality are, their most comprehensive ideas of order" (p. 89). These symbolic schemes, which constitute the ready-at-hand frameworks people use to make "sense" of the world, enable the possibility to create a collectively shared, commonsensical actuality.

The process of constituting the collective world, one's horizon of collectively shared perception, as a taken for granted entity is always an intersubjective undertaking. One is always born into a "local world" that engenders a specific "flow of interconnected attention, feeling, and social cognition" (Kleinman 1992, p. 129). One acquires particular "language structures and perceptual schemes," one engages in specific relationships, one participates in particular social institutions – all of which serve to produce the processes through which people orient their relation to the world. "Even emotions," writes Kleinman (1992), "are mediated by such interpersonal processes such as folk meanings, linguistic forms, and shared ways of expressing

and coping with feelings" (p. 128). Social actors are thus caught in a network of interpersonal fibers:

> *What precedes, constitutes, expresses, and follows from our actions in interpersonal flows of experience are particular local patterns of recreating what is most at stake for us, what we most fear, what we most aspire to, what we are most threatened by, what we most desire to cross over to for safety, and what we jointly take to be the purpose, or the ultimate meaning, of our living and dying* (Kleinman 1992, p. 129).

Sociologists and anthropologists have, consequently, largely posited that social actors, through intersubjectively *cognitive* means, "construct" a common "reality" – relying on typifications, institutionalizations, language structures, folk meanings, functionalizations, and legitimations (Honer and Hitzler 2015).

Reality and Sensation

While sociological work concerning the "social cosntruction of reality" elucidates how taken-for-granted frameworks serve to sustain the natural orientation, this tradition has come under criticism for granting too much attention to cognition. Ostrow (1990) writes that such theoretical approaches fail "to see that it is only by virtue of our corporeal inherence within a world having sense and significance that its meanings can cohere for knowledge" (p. 29). Building on Merleau-Ponty, Ostrow criticizes sociological work for reducing the "habitual foundations" of the social world to "a stock of knowledge," which undermines the "structure of the sensibility and significance 'which we carry about inseparably with us'" (p. 35).

Building on this literature, social scientists contend that sensation may be conceived as a social practice, adding that the sensible dimension is central to the constitution of people's collective sense of community and self (Friedman 2016; Howes 2003; Low 2012; Vannini et al. 2012; Winchester and Pagis 2021). Scholarship demonstrates that people employ culturally elaborated perceptual filtrations to attend or disattend to sensory stimuli in order to activate social meanings (Friedman 2016). Perceiving gendered bodies, for example, presupposes learning to collectively attune sensory attention to sexed features while ignoring similarities amongst bodies (Friedman 2016). Sensibility – the visibility, tactility, etc. that opens up through one's bodies, and to which the body simultaneously belongs -- is susceptible to culturally elaborated patterns, habituations, and interpretations. As Howes (2003) posits, "different cultures accentuate different characteristics of each sensory field… just as they elevate and elaborate or suppress the different senses themselves" (p. xx).

Sensory episodes, therefore, may take on culturally specific arrangements (Low 2012). Waskul and Vannini (2008) coin the term *somatic work* to elucidate "how people hermeneutically make sense of perceptions" through meanings mediated by "social, cultural, or moral orders" (p. 55). Social groups often share "common ways of using their senses and making sense of sensations," thus forming *sensory communities* or *cultures* (Vanninni et al. 2011, p. 7). The facts of sense cannot be reduced to the dimension of physiological processes; as Howes (2013) writes, they are "always a product of *con-sensus* – that is, of sensing along with others" (p. 9).

Cultural processes may influence variable domains of sensory life, ranging from what people find appropriate to *touch* across different stages of civilization (Elias 2010[1939]); the

ways in which people collectively express *taste* sensations and preferences (Vannini et al. 2010); or how *scents* may be associated with intended cultural messages (Cerulo 2019).

Con-sensus and Sensory Destabilizations

While sensuous scholarship largely documents the influence of sociocultural processes on daily sensory orders, fewer studies have addressed the case of *sensory disruptions* (Becker 1953; Winchester and Pagis 2021; Gearin and Saez 2021). As Low (2012) notes, the senses "simultaneously engender… interruptions in day-to-day socialites," and it is only by considering "both sensory orders and disorders that we may more comprehensively analyze the sensorial contours of everyday life which both organize and disarray social life and subjectivity" (p. 275).

On this point, Winchester and Pagis (2021) highlight the significance of exploring *somatic inversions* -- episodes in which people undergo sensory-perceptual alterations, which foreground sensations that typically remain "tacit." Such phenomenological alterations may rupture people's habitual "sense-making routines, social roles, and identities" (Winchester and Pagis 2021, p. 14). Sensory destabilizations may be evoked via various practices such as meditation (Pagis 2019), fasting (Winchester 2008), drug consumption (Becker 1953; Gearin and Saez 2021), among other forms of sensory defamiliarization. The somatic qualities of sensory alterations engender *interpretive demands* (Winchester and Pagis 2021). Attending to the processes by which people render sensory disruptions intelligible may heighten our understanding of the dialectical relation between culture and sensory perception, given that destabilizing sensory episodes *compel* people to consider and decipher, through cultural significations, sensory phenomena that typically remains taken-for-granted (Vannini et al. 2012).

Becker (1953) elaborates this point in his seminal study, "Becoming a Marihuana User," when he convincingly demonstrates that social actors, particularly novices to marijuana

consumption, may initially find the drug's effects unintelligible. That is, such experiences may rupture people's habitual relation to a sense of "order." Only through reflexive practices do marijuana consumers progressively learn to render vague sensations *meaningful*. The development of a perspectival understanding concerning what constitutes "being high," as Becker shows, presupposes hermeneutic social processes through which people cultivate the ability to interpret unfamiliar sensations.

Similarly, Matza (1969) considers the theoretical implications of people who undergo sensory shifts – pointing out that sensory dislocations produce instances in which the sight and tacticity of familiar objects can no longer be subsumed under habitual symbolic orders. Matza (1969) writes that sensible phenomenological alterations increase a "sensibility to banality made possible by the perception of relativity, suspension of belief, and the consequent display of meaning – all directed to what happens to be around the mind of the subject" (p. 139). In other words, sensible dislocations may set the conditions that make it possible to "bracket" the culturally elaborated meanings that social actors use to construe the intuited world of extended bodies as ordinary. "Belief suspended," writes Matza (1969), "an aesthetic of the ordinary may reappear. The unappreciable may be appreciated" (p. 139). This makes instances of sensory destabilizations ideal for exploring the intertwinement, and in particular the *tension,* between cultural meanings and the dimension of felt, sensory experience.

Further, exploring these experiences allows to elucidate the processes through which people learn to attribute such instances as meaningful, particularly in relation to their sociocultural and political contexts. Learning how to conceptualize strange sensations, as Matza posits, enables social actors to reorient themselves to the world – to return to the world of

'common sense'. Exploring instances of defamiliarization, thus, further allows to study processes of *refamiliarization*.

This comparative study provides valuable insights into the relation between "sociocultural scripts and norms" and sensible phenomena (Low 2012, p. 275). As Howes (2003,) writes, the senses may be "structured and invested with meaning in many different ways" (p. xii). By exploring the specific 'con-sensual' meanings that people employ to distinctly organize sensory disruptions, I elucidate the influence that the cultural worldviews through which people render their lives meaningful -- what people conjointly consider appropriate or inappropriate, fearful or aspirational, problematic or meritorious – have over the subjective dimension of felt, sensory experience (Howes 2003). This comparative study, therefore, contributes to our understanding of the interconnection between macro and micro dimensions of experience.

Although classical sociological literature has long recognized that disruptive experiences may be interpreted via distinct discourses (Foucault 1961; Hacking 2002) – such as, and of primary relevance to this study, the language of psychiatry or the language of spirituality (Keifenheim 1999; Luhrmann et al. 2006; Scott 1999) -- few studies have documented *how* social actors *themselves* attend to the interpretive demands of sensory destabilizations through divergent perspectives. Drawing from a comparative case of two distinct *sensory communities* – practitioners of Vipassana meditation and patient-led groups of people diagnosed with depersonalization/derealization – I explore how social actors, through cultural hermeneutic processes, attend to the interpretive demands of similar phenomenological sensory destabilizations. I show not only that social actors may *categorize* similar dissociative disruptions distinctly, but that divergent cultural interpretations influence how people

collectively evaluate what is relevant or irrelevant about their experiences. This focus allows for a nuanced exploration of the senses as interpersonal and contextual social practices. The comparison further allows to observe the multidimensional *sense-making work* that subjects directly employ to render vague experiences intelligible. This study then elucidates how *specific* sociocultural elements influence why people interpret similar sensory episodes distinctly, as well as the effects that such interpretations have on people's sensible experiences.

Methods

While substantial literature recognizes the theoretical importance of embodiment, scholars raise concerns about the methodological implications involving the "turn to bodies." As Frank (1995) writes, "No satisfactory solution has been found to avoid reducing the body to a thing that is described" (p. 27). Certain embodied experiences may be difficult to articulate or too intangible to otherwise access (Harrison 2002). Methodological questions therefore emerge: is it possible to explore people's somatic experiences via their cognitive articulations?

Pink (2009) suggests that, insofar as "the researcher self-consciously and reflexively attend[s] to the senses throughout the research process… during the planning, reviewing… analysis…" it is conceivable to explore social actors' "sensory perception" (p. 7). Scholars further recognize that reflexive descriptions may be useful for accessing the sensible dimension (Harris and Guillemin 2012; Mason and Davies 2009). In their study on the social significance of family resemblance, Mason and Davies (2009) conclude:

> *Our study highlight[s] the value of talking about the sensory. It can be easy to overlook the creative potential of the qualitative interview and, particularly given the recent enthusiasm for visual methods, tempting to assume that in order to 'do'*

sensory methods it is necessary literally to see, hear, touch or smell the phenomena being studied. Similarly, it can be assumed that a sensory research encounter ought to produce some sort of sensory product such as a photograph, video or drawing. We found that when it comes to resemblance, people are generally very good at expressing their sensory affinities verbally... it is possible to make an argument that in some cases asking interviewees to verbally recount the sensory can be preferable to the researcher attempting to "sense" things first hand… Experiences and instances of fleeting sensory experiences that have vanished before one has been quite able to put a finger on them often have to be narrated. (595-597).

In parallel to these claims, Harris and Guillemin (2012) write that "we experience the world through hearing, touching, imagining, smelling, and exploring," and argue that "it seems only appropriate to draw these sensory experiences into our interview research techniques" (689). Harris and Guillemin (2012) contend that "what is required is an expanded repertoire of interview research elicitation strategies using the senses as access points," which may "serve as a portal to a complex, embodied form of memory and perceptual experience" (691). Some of these strategies may encompass utilizing sensory questions (Sandelowski, 2002; Harris and Guillemin, 2012).

Although these scholars do not propose that one could fully reproduce the sensorial dimension of participants, they nevertheless describe the "interview as a process through which we might learn (in multiple ways) about participants' representations of experience by attending to their treatment of the senses" (Harris and Guillemin 2012, 692). This procedure does not entirely move beyond the body as "a thing that is described," to borrow Frank's terminology, but it instead recognizes these descriptions as valuable access points for learning about local

sensoria. Social scientists, therefore, stress the importance of "finding ways of listening to and analysing the bodies and fleshy articulations… present in our qualitative 'data'" (Chadwick 2017, 71).

Social scientists, consequently, recognize that carefully crafted methodological approaches – ranging from methodologies in which researchers to use all their senses as tools of data-collection to in-depth interviews that encompass sensory questions -- may help elucidate the dimensions of sense-making (Waskul and Vannini 2008). The present study, which principally attends to the somatic work that social actors perform to account for disruptive experiences, draws from the methodological tools of sensuous scholarship, primarily sensory interview techniques, to explore the complex relation between the phenomenological qualities of sensory destabilizations and symbolic orders.

Data Collection

Patient led-communities	**Active meditators**
• 31 semi-structured, in-depth interviews • Ages of 19-53; 12 identified as women, 19 as men	• 23 semi-structured, in-depth interviews • Ages of 21-43; 8 identified as women, 15 as men
• Online data: approximately 100 online posts in DPSelfHelp's online forum	• Online data: approximately 200 online posts in VipassanaForum's online forum

The Institutional Review Board approved this research. In this research, I draw from in-depth interviews, online data, and psychiatric case studies (Kennedy 1976). I conducted semi-structured, in-depth interviews with 31 people diagnosed with depersonalization/derealization disorder. I recruited participants from an online depersonalization/derealization disorder support group entitled DPSelfHelp, which began as a website in 2002 and operates strictly as a patient-

run, public online forum with over 30,000 members. The mission of the website is to provide a resource for people affected by dissociation. 12 interviews took place via Skype, while the other 19 were conducted on the telephone. Participants, all located in the US and European countries, ranged from the ages of 19-53.

Similarly, I conducted 23 interviews with meditation practitioners. I recruited patients from an online forum called Vipassana Forum, advertised as "a home to a community of meditation practitioners" that began in 2007. I specifically contacted people whose online posts addressed themes about meditative-induced dissociation. Participants, also all located in the US and European countries, ranged from the ages of 21-43. 9 interviews took place on the phone, 8 via skype, and 6 online. In both cases, interviews lasted, on average, 45 minutes–1 hour.

The interview guide, in the case of both meditators and patient-led groups, covered an array of topics -- I asked respondents to give an account of the scenario, as well as the thoughts they had, when they first experienced dissociative states; their ongoing concerns and aspirations; who they have consulted; how they understand their experiences; the procedures they have adopted to cope with their symptoms; and how depersonalization/derealization influences their everyday deeds. Further, to access the sensorial dimension, I employed Harris and Guillemin's (2012) methodological recommendation to devote a section of the interviewing process to "sensory questions:" I asked respondents to carefully describe how external phenomena and their bodies feel, look, sound, etc. during dissociative states.

I complemented the interview data by additionally analyzing online discussions in DPSelfHelp's and Vipassana Forum's online discussion boards. These online forums, both highly active with dozens of new daily posts, provide a virtual space in which people may discuss a broad range of topics relevant to either meditation or depersonalization/derealization

disorder – ranging from personal experiences to careful advise about how to manage disruptive episodes.

In both forums, I screened posts by searching for terms such as "felt," "sensed," "experienced," "dissociation," etc. and further perused hundreds of threads in order to find online discussions in which people collectively talked about dissociative episodes. I analyzed approximately 100 posts in DPSelfHelp's online forum. In the case of meditators, I analyzed approximately 200 online posts in VipassanaForum's message board. The number of threads I analyzed, in both instances, was determined after no new thematic patterns ensued in the data analysis.

Lastly, in this study, I draw from two clinical case studies, in which Kennedy (1976), a psychiatrist, explores how patients may interpret long-lasting instances of depersonalization/derealization as either pathological or spiritually significant, further addressing clinical implications. To my knowledge, this is the only clinical study about depersonalization/derealization that has explored this comparative theme.

To analyze the data, I followed the procedures of abductive analysis (Tavory and Timmermans 2014), analyzing the data for surprising observations in light of existing scholarship (reviewed above). I coded the data through the program, ATLAS.ti, employing a combination of open and focused coding to uncover recurrent patterns across the dataset in both interviews and online discussions. Following the phenomenological literature this research draws from, I paid primary attention to respondents' descriptions about their felt symptoms and somatic accounts in which they imbued such symptoms with meaning. I coded various themes, such as the valuations respondents attached to recurrent, disruptive symptoms (e.g., 'must be cured', 'must be accepted', 'meaningless', 'pathway to happiness'). Through this process, I became

sensitized to the different ways in which disturbing symptoms were rendered legible in the two communities; the notion of sensory instrumentalization thus emerged. The triangulation of direct accounts concerning dissociative states, accessed through in-depth interviews and online discussions, as well clinical psychiatric studies, makes it possible to analyze people's destabilizing sensory episodes as a social process.

Comparing the Two Cases

As Becker (2010) noted, in any comparison between two or more cases, researchers must always consider whether the cases are *appropriate* for comparison, whether one has considered the right *dimensions* of comparison, as well as how one may "connect a variety of general phenomena fruitfully during the comparison of cases" (p. 9). In this research, the comparison between derealization/depersonalization and meditative induced dissociation follows from the APA's explicit recognition that depersonalization/derealization may be volitionally evoked via meditative practices in other cultures, and hence *not* labeled as a pathology. Therefore, questions concerning the processes through which such felt experiences come to possess divergent valuations become relevant for comparison.

Depersonalization/derealization and meditative induced dissociation are qualitatively distinct considering such states have different *starting points* –a person volitionally meditates to achieve altered states, while, in the case of individuals who belong to patient-led communities, people often constitutionally confront these episodes without choice. I posit that these cases, despite their distinct points of origin, merit comparison for two reasons: first, in both instances, people report phenomenological disruptive experiences that *lack* immediate comprehension. Even if a person, initially, *aims* to achieve an altered state, it does not correspond that a person is

prepared to undergo vague, disruptive sensations. In fact, in the case of those diagnosed with depersonalization/derealization, symptoms may *also* be instigated, similar to meditators, after people *intentionally* attempt to achieve altered states – as it happens in cases of drug consumption in which people subsequently experience depersonalization/derealization.

Second, I focus on cases in which people confront dissociative episodes that are *long lasting* and *recurrent* – something that neither meditators nor those diagnosed with depersonalization/derealization initially *predict*, for such instances are uncommon. In both cases, people must learn how to *make sense* of sensory destabilizations that are not only initially incomprehensible, but also periodically recurring and with no end in sight. The phenomenological similarity between both cases is evinced by the fact that while people may initially interpret their recurrent symptoms as pathological, they may later reconceptualize these episodes through a spiritual lens (Kennedy 1976; Castillo 1990).

The dimensions of comparison, in this case study, may thus be narrowed down to two components: a) the *experiential* foundation of depersonalization/derealization and meditation-induced dissociation. To what extent do both cases involve similar phenomenological, felt characteristics? And b) the *reflexive activities,* or somatic work, through which social actors account for their sensations. What do the processes by which such sensible experiences come to possess opposite valuations reveal about the cultural elements that compel such interpretations?

In answering these questions, this study suggests that while meditative induced dissociation and depersonalization/derealization encompass similar phenomenological states, the way such elusive experiential disruptions become 'sensible' is a social practice characterized by interpersonal interpretive negotiations and situational meanings. Under such circumstances,

therefore, sensations cease being strictly a physiological entity; the world of sensations, mediated by cultural meanings and habituations, becomes a social learning process.

Outline

In the first chapter of this thesis, entitled, "Opposing Worlds: Disruptions as Expressions of Cultural Perspectives," I begin by exploring literature that has documented the manner in which disruptive states may become expressions of distinct cultural orders (Sacks 1996; Segal 1996; Spiro 1965). Focusing on the renowned case of Suzanne Segal, a woman who, affected by sensory-perceptual disruptions that psychiatrists diagnosed as depersonalization/derealization, instead came to interpret such episodes as spiritual occurrences with the help of her spiritual community, I explore how felt, sensible experiences may be mediated by sociocultural orders. Further, I trace the historical trajectory through which the concept of depersonalization/derealization, first prevalent in philosophy and spiritual literature, came to be constituted as a *clinical* category. Building on Hacking (2002), I contend that distinct interpretations for similar sensory-perceptual disruptions are not merely interpretive, but also *constitutive* of specific cultural and moral worlds, producing the possibility for distinct types of *subjectivities* to emerge.

In the second chapter, "Patient-led Communities: Confronting the Neglected Mental Illness," I focus on the case of what I term 'patient-led communities.' Drawing from personal narratives and online data, I explore how people employ the language of medicine to make sense of dissociative states that are initially unintelligible. In the process, I describe the diagnostic odyssey that people affected by symptoms associated with depersonalization/derealization experience as they consult the purveyors of diagnostic knowledge – that is, clinicians. I show how patients, seeking an explanation for incomprehensible dissociative experiences, may

become actively engaged in their own diagnosis. I highlight a multifaceted process, consisting of a dialectical relation between the democratization of health information and the growth of engaged patienthood, that may shorten diagnostic delays for people affected by atypical disorders and undermine physicians' authority to diagnose. Unlike most documented cases about medical uncertainty and active patienthood, this case study adds to our understanding about the *generational effects* of the democratization of health information on the experiences of people subject to prolonged medical uncertainty in the case of *established* medical conditions.

In the third chapter, "Spiritual Cosmologies: A Contrast to the Diagnostic Route," I build on the APA's acknowledgement that interpretations about depersonalization/derealization may be culturally contextualized. I show how practitioners of Vipassana meditation may employ spiritual discourses, as opposed to the language of diagnosis, to make sense of episodes medically known as depersonalization/derealization. Drawing from personal narratives, online data, and psychiatric case studies, I argue that a sociocultural cosmic order, in which people ongoingly appraise sensory experiences in terms of their potential to foster "self-actualization," largely determines whether social actors interpret these dissociative destabilizations as either pathological or aspirational—a process I term "sensory instrumentalization." This chapter, therefore, elucidates the multidimensional sensemaking work that people may employ to make sense of similar sensory disruptions.

In the fourth chapter, "Familiarity, Defamiliarization, Refamiliarization: Towards A General Theory of Vague Sensory-Perceptual States," I situate the comparative analysis of patient-led communities and communities of meditation practitioners in current discussions concerning the relation between sensibility and cultural structures. I explore recent literature concerning the relation between culture and cognition, in which social scientists make a common

distinction between declarative and nondeclarative cultural processes to describe how social actors render the world commonsensical (Lizardo 2017; Cerulo 2018; Pagis and Summers Effler 2021). I suggest, building on recent scholarship (Pagis and Summers Effler 2021), that this dual processing model cannot fully account for certain instances of sensory-perceptual experiences. I demonstrate how instances of sensory-perceptual disruptions, therefore, fall outside of the declarative and nondeclarative model. Elaborating on the concept of *defamiliarization*, I explore how this concept may be generalizable across a broad range of social circumstances.

Lastly, I conclude this dissertation by describing the outcomes that this research has for medical sociology, cultural sociology, and the nascent field of the sociology of the senses. This study primarily suggests that people's 'natural attitude' – social actor's conception of a commonsensical organization of past, present, and future -- presupposes a continual *sensorial* familiarity with the world. This familiarity, as a broad range of literature suggests (Berger and Luckmann 1966; Desjerlais 1997; Pagis and Summers Effler 2021) is reucrrently susceptible to precarious, pheomenolcal disruptions; the dimension of sensibility may undergo ongoing destabilizations that disintegrate both habitual embodied routines and reflexive, symbolic typifications. Observing such instances of destabilization makes it possible to explore the sense-making procedures that social actors employ to reorient themselves to the world, allowing to elucidate the complex relation between the world of sensible phenomena and cultural structures. During such instances of ambiguity, it becomes possible to analyze embodied, sensory-percepual states as a social process.

Chapter 1

Opposing Worlds: Disruptions as Expressions of Cultural Perspectives

Oliver Sacks (1996) recounts the story of Greg, a teenager who, like many Westerners during the 1970s, became interested in spiritual exploration. Seeking the attainment of a "higher consciousness," Greg took residence in a Buddhist temple in Brooklyn. Dressed in saffron robes, obedient and pious, Greg daily seemed to become increasingly distant and less responsive – signs, according to the monks, indicative of spiritual beatitude. On the other hand, shock overtook Greg's parents when they visited Greg and witnessed his state, which they judged to be one of disorientation. Brain imaging later indicated that Greg suffered from a large midline tumor that had nearly destroyed his frontal lobes. To his parents and clinicians, Greg was blind and mentally disabled. To the monks, who continued to pay Greg visits in the hospital, he had reached enlightenment. A particular state may be perceived as destructive, negative, pathological, but it may simultaneously be perceived as the attainment of a 'higher' human potential.

Whether Greg was, in actuality, spiritually enlightened or in an inherent state of pathology is a question that escapes the scope of this thesis. I do not set out, throughout this study, to pick a side between two renowned antheses: *absolutism* versus *relativism*. That is, I do not seek to conclusively explore whether specific sensory-perceptual states may be said, in absolute certainty, to constitute either an *inherent* pathology or *genuine* spiritual enlightenment. Similarly, I do not argue that all phenomena are the byproduct of relativism, that everything is "constructed," negating any acknowledgement of criteria that may suggest the existence of a panhuman reality. What Greg's case suggests, as well as many other countless examples

addressed in sociological and anthropological literature, is that similar disruptive states – disruptive according to physiological criteria that, indeed, possess their own intrinsic pre-predicative qualities –may become *expressions* of distinct, culturally situated worldviews.

While certain felt experiences may possess pre-predicative qualities, *judgements* about felt experiences are, nevertheless, relative to cultural contexts **(**Howes 2003; Keifenheim 1999; Luhrmann and Marrow 2006; Spiro 1965). As Spiro (1965) documented, "'Paranoid' behavior is 'normal' if found among the Kwakiutl, or 'hysteria' -- normal in the case of St Theresa – may be abnormal in a contemporary middle-class woman" (p. 103). This is not to deny that what is termed paranoia possesses "real," felt characteristics -- in the same way that fire may, if it comes into contact with the human body, be said to pre-propositionally burn (Dewy 1958). The world of felt phenomena, as Dewey (1958) largely stressed, has its own meaningful structures; all phenomena have their own inherent qualities. However, sensible and felt phenomena may be subject to distinct cultural interpretations, habituations, and mediations (Friedman 2016; Howes 2003; Low 2012; Vannini et al. 2012; Winchester and Pagis 2021). In the case of certain psychological and embodied states, while specified criteria for the functioning of organisms may be said to exist, judgments based on such criteria are, nevertheless, necessarily relative to sociocultural orders.

It is unsurprising, thus, that what may be termed pathological in one cultural context, despite the "intrinsic" felt qualities of the experience, may be perceived differently – in many cases as something perfectly acceptable -- in another cultural environment (Keifenheim 1999; Luhrmann and Marrow 2006; Spiro 1965). Spiro (1965), in his study of monks who practice Theravada Buddhism in Burma, documents how monastic meditation practitioners tend to withdraw from the physical and social world, even from themselves. "This withdrawal," writes

Spiro (1965), "is similar to what in this society [the West] would be called schizoid, if not schizophrenic" (p. 105). Visibly, the behavior between the monks and those deemed schizophrenics in the West shares vast similarities; functionally, however, "they are importantly dissimilar (the criteria of pathology is attributable to the schizophrenic, not the monk)" (p. 106).

Spiro (1965), in fact, offers a typology of specific "pathological" features amongst the monks: 1. A high degree of defensiveness, 2. regressed expression of aggressive and oral drives, 3. cautious avoidance of emotionally laden situations as a means of obviating the necessity of handing affect, 4. hypochondriacal self-preoccupation and self-cathexis, amongst many other features.

The monks' behavior, indicative of schizophrenic features in the West, is "consistent with cultural norms within the larger society" in Burma – a context that possesses its own expectancies and modal features (Spiro 1965, p. 109). While similar behaviors could be deemed disruptive, dramatic distortions of "reality," the "world view of the monk, on the other hand, is part of the integral cultural heritage of his society… psychotics do not sustain social relations; the monk, while isolated, are still part of the 'community'" (p. 109). The monks' behavior consequently provides the "motivational basis for the persistence of the most highly valued institutions" (p. 109). Instead of obstacles to the social order, such states are cultural expressions of instances that are beneficial to social and cultural functioning.

The Case of Dissociative States

Akin to the conclusions that Spiro (1965) and Sacks (1996) draw from their case studies, indicating that particular disruptive states may be subject to opposite cultural explanations, the American Psychiatric Association (2013) today acknowledges that interpretations about

experiences that may be classified as depersonalization/derealization *disorder* could be mediated by distinct cultural worldviews. This is exemplified in the renowned case of Suzanne Segal, which gained international notoriety in the 1990s.

Segal, the daughter of two Polish immigrants, one of them a Holocaust survivor, showed an interest in questions concerning her sense of selfhood and identity during the early stages of her life. At the age of seven, Segal would sit cross-legged in her in parents' living room, close her yes, and repeat her own name. In her memoir, Segal (1996) writes, "The name would reverberate in my mind with each repetition, starting off solid and strong… then fainter… until a threshold was crossed on the identity as that name broke… then fear would arise…" (p. 34). Despite such fear, the compulsion to repeat the exercise once again would always return.

Drawn to metaphysical questions concerning her sense of self and existential relation to the world, Segal began to cultivate an interest in spirituality. At the age of eighteen, just having commenced her first year of college, her older brother introduced her to Transcendental Meditation. She began to practice meditative techniques; Segal documents that she became acquainted with different sensory-perceptual states. During 1982, however, something distinct occurred. Segal, while boarding a bus in Paris, confronted an abrupt shift that altered her sensory-perceptual relation to the world for the rest of her life:

> *I lifted my right foot to step up into the bus and collided head-on with an invisible force that entered my awareness like a silently exploding stick of dynamite, blowing the door of my usual consciousness open and off its hinges, splitting me in two. In the gaping space that appeared, what I had previously called 'me' was forcefully pushed out of its usual location inside me into a new*

> *location that was approximately a foot behind and to the left of my head. 'I' was now behind my body looking out at the world without using the body's eyes* (Segal 1996, p. 49).

Having abruptly undergone this alteration, confronting a sensory-perceptual state that seemed completely alien, Segal did not immediately know how to make sense of this novel experiential state -- in particular, she was confounded by the sense of detachment she *felt* from her previously taken-for-granted embodied self. Segal pondered:

> *Is this insanity? Psychosis? Schizophrenia? Is this what people call a nervous breakdown? Depression? What happened? And would it ever stop? ... The mind was in agony as it tried valiantly to make sense of something it could never comprehend, and the body responded to the anguish of the mind by locking itself into survival mode, adrenaline pumping, senses fine-tuned, finding and responding to the threat of annihilation in every moment… The thought did arise that perhaps this experience of witnessing was the state of Cosmic Consciousness Maharishi* (Indian Guru) *had described long before as the first stage of awakened awareness…* (Segal 1996, p. 49).

Segal continued to have repeated episodes of these frightful destabilizations. While she internally knew that her once commonsensical relation to the world and her sense of self had undergone a radical alteration, she continued to 'operate' in the world. She would eventually complete her PhD in clinical psychology in 1991. Seeking an explanation for these disruptive

experiences, which became increasingly prevalent over her lifetime, Segal sought advice from a variety of people. On one hand, given her background in meditation, she consulted California's Buddhist Community; people in this community attempted to help Segal interpret her experience under a positive light. A man called Ganaji, a renowned spiritual leader at the time, wrote to Segal, "I am very, very happy that you have directly discovered yourself to be no individual 'I.' This realization of the inherent emptiness—which is pure consciousness—of all phenomena is true fulfillment… much fear can be initially felt. Ultimately, the fear is also revealed to be only that same empty consciousness" (Segal 1996, p. 144). Considering, however, that Segal also possessed a background in psychiatry, she simultaneously consulted clinicians. The majority of clinicians she turned to could not provide a clear explanation, but two clinicians suggested that she may be suffering from one particular condition: *depersonalization*/*derealization*.

Segal's dissociative experiences, indeed, aligned perfectly with the diagnostic characteristics of depersonalization/derealization. Her experiential state encompassed having "no self at all… the infinite emptiness I knew myself to be was now apparent as the infinite substance of everything I saw" (Segal 1996, p. 49). According to the DSM-V, one of the primary symptoms of depersonalization/derealization disorder involves the experience of an "unreal or absent self" (APA 2013, p. 304).

In 1996, Segal published a book entitled, *Collision with the Infinite: A Life Beyond the Personal Self,* in which she documented her dissociative experiences. It became evident in this book that Segal opted for a spiritual interpretation to account for her sensory-perceptual alterations. Segal wrote: "There is a way that the Vastness Itself can perceive Itself so directly, without any fogging or shadowing or taking anything else to be who you are. I guess you could call it a waking up, but what seems most important to convey is that this is who everyone is all

the time whether the direct awareness of it is there or not" (p. 146). In the introduction to her book, Segal stated: "It is essential that this story be read with a spacious awareness that eschews reductionist categorization or the psychological tendency to pathologize" (p. 11).

Segal's story received vast publicity from spiritual circles. In a book review about *Collisions* that was published in *Yoga Journal*, the California Yoga Teachers Association (1997) stated, "This frank and engaging account is a fascinating view of the unfolding of a realization without a spiritual practice or intention" (p. 115). Segal would ultimately become a renowned figure in the spiritual community. A chapter was devoted to her story in a book entitled, *The Awakening West.*

In the subsequent months following the publication of *Collisions*, Segal's health began to deteriorate. The dissociative episodes became increasingly severe. Segal died in 1998. Similar to Greg, she was diagnosed with a brain tumor. Members of the spiritual and psychological community continue to debate the legitimacy of her experiences. In an edition of *Collisions*, published in 1998, her spiritual teacher, Stephen Bodian, wrote: "Those of us who were close to Suzanne never doubted the depth or the authenticity of her realization" (p. 14).

Interpreting Experiences: Constructing Selves

A disruptive experiential state, therefore, may come to possess distinct, even opposite, interpretations and evaluations. To suggest that similar phenomena – in this case experiences associated with depersonalization/derealization -- may become expressions of distinct cultural realities is not simply to indicate that similar disruptive sensory-perceptual states may be merely categorized distinctly. Rather, it is to acknowledge that distinct interpretations of particular

experiential states represent, and are simultaneously *constitutive* of, specific cultural and moral worlds, producing the possibility for distinct types of *subjectivities* to emerge.

As Hacking (2002) notes, specific historically-rooted epistemologies make it possible for "phenomena of cosmic significance" to "come into being," – amongst countless examples of such historically constituted phenomena one may find the concept of psychic trauma, the notion of child development, as well as various forms of mental illness, some which have stayed and some which have been transient (p. 16). Culturally elaborated phenomena that come into existence thus include not only "material" objects, but more often than not, also classes and *kinds of people*. Rowdiness in children has always existed, but once a plethora of professionals with the cultural legitimacy to diagnose deem such behaviors as Attention Deficit Disorder, a new *type* of human being surfaces. This new type of person, the ADHD child, becomes subject to specific social injunctions and expectancies – in this case, children must be *treated* if they are to be adequate, optimal human beings. It is in such potential to establish a given organized form of reality and personhood, perhaps, where the creative potency of *culture* lies. Depersonalization/derealization disorder is one of the many conditions that possesses such *historicity*.

When specific phenomena come into *existence*, especially those involving *types* of people, three ontological axes are typically present: knowledge, power, and ethics (Hacking 2002). The case of psychic trauma, for example, may be displayed through these three axes. First, there is the subject who must be understood, studied, and treated. "Today," writes Hacking (2002), "there is a vast body of 'knowledge' in the burgeoning field of traumatology" (p. 19). Second, concerning the field of power, there emerges a congeries of possibilities: "self-empowerment; power of victims over abusers; the power of the courts and the legislatures… the

anonymous power of the very concept of trauma that works in our lives" (p. 19). And lastly, traumatic memories produce a new moral and ethical being. "Trauma… produces a new sense of self, of who one is and why one is as one is. It takes us into the very heart of what, in traditional philosophy, has been called the theory of responsibility and duty" (p. 20). The historical emergence of a multiplicity of mental illness, such as depersonalization/derealization, is inseparable from these ontological axes.

It is in this manner, as Foucault (1997) once wrote, that we thus "constitute ourselves as objects of knowledge" (p. 316). Such domains of phenomena that come into being – whether classifications, ideas, types of people -- often become incorporated into the "natural order of things" over time, which one comes to speak about with epistemological validity, forgetting their socio-historically contextual genesis. Cultural meanings often determine how particular experiences are constituted, influencing how people come to understand and administer their experiences, their passions, their fears, and their aspirations.

Looping Effects

To suggest that specific types of people may come into being is not to imply that a new category is merely imputed on a type of person that has been passively waiting to be "discovered," instead, particular cultural classifications engender the very *ontological creation* of specific types of human beings. As Hacking (2004) points out through his concept of *dynamic nominalism,* culturally elaborated categories and the types of people that come into being have an inherently mutual association, they emerge "hand-in-hand":

> *Dynamic nominalism is a nominalism in action, directed at new or changing classifications of people. In some cases it suggests that there was not a*

kind of person who increasingly came to be recognized, and to which a new name was given. Rather a kind of person came into being at the same time that the name became current. In some cases our classifications and the classified emerge hand-in-hand, each egging the other on… (p. 279).

The processes through which types of human beings come to be constituted encompasses a "dynamics and dialectics in action" (Hacking 2004, p. 280). This implies that "the historical dynamics of naming and the subsequent use of name" do not remain static (Hacking 2002, p. 26). Rather, classifications and the 'kinds of people' who are classified "recursively change one another over time" (Navon and Eyal 2016, p. 1418). People who are given a label, on one hand, come to see themselves through the lens in which they are classified; however, they are simultaneously aware of their classification, potentially engendering alterations to their own behavior and, further, even to the classifications over time. The practices of naming, therefore, dynamically interact with the people who are named, resulting in a cycle of changes. This is what Hacking calls *looping effects*. As Hacking (2004) articulates in his example of inner-city crime:

…Young men, trapped… learn that experts hold there is a genetic tendency to crime. 'So I am a born criminal! No point in even trying to stay away from all those things my mom told me not to do' – and the tendency to crime, if ever there was one, is radically enforced. The alleged correlations between crime and genetic markers would thereby become 'over-confirmed'. If such an effect came to pass, it would be a classic looping effect. First, we have people of an alleged type, having a tendency to violence and crime. Then there is some proposed knowledge, that this tendency is associated with inherited biological

> *traits. The knowledge becomes generally known. The objects of this knowledge, the young men, learn about it and become more uncontrollable than before. Then, whatever was the case to start with, we really would get new strong correlations, not caused by anything genetic, but caused by the classification itself* (p. 298).

The process of 'looping' implies a circular process that stems as types of people come into being by practices of classification. Through the process of looping, two effects tend to occur: a) nominalist categories "change the way people with an existing classification understand themselves and are understood and treated by others" (Navon and Eyal 2016, pp. 1420-1421). And b) as people become invested in their categories, this may induce reactions amongst the classified, engendering new international modalities of being and behavior, which "in turn can modify expert understandings… and thereby the self-understandings of the people picked out by the classification" (Navon and Eyal 2016, p. 1421). The looping effect has been explored in a variety of circumstances such as the instance of autism (Navon and Eyal 2016), national trauma (Amarami 2018), or criminal behavior (Hacking 2004).

Building on Hacking's notion of dynamic nominalism, it is possible to explore the case of depersonalization/derealization as a historical process that produces particular classes of people. What today has come to be understood as depersonalization/derealization *disorder,* like many other types of current and transient mental illnesses that have come into existence, has a historical genesis – that is, derealization/depersonalization, as a *medical* category, is something that had to come into *being*. In the process, therefore, particular classes of people simultaneously came into existence, specifically those categorized as depersonalized/derealized; this presupposes the constitution of specific types of subjects and, thus, subjectivities.

At the same time, however, the medicalization of dissociative episodes subsumed under the category depersonalization/derealization, as in happens in the case of culturally elaborated phenomena, encompasses an epistemological viewpoint that is not *absolute*. That is, such dissociative experiences may also be rendered legible through *distinct interpretations*, in particular *spiritual discourses*. Depersonalization/derealization is one of the few conditions, if not the only officially recognized psychological disorder, in which the *APA itself* acknowledges the presence of *cultural contextualization*. Unlike the majority of sociological studies that have explored processes of dynamic nominalism, the case of depersonalization/derealization is unique; it allows to compare two modalities in which similar experiential states may be rendered comprehensible. This allows to compare two distinct pathways in which particular types of people, undergoing similar phenomenological states, may come to *emerge* – on one hand, those categorized as depersonalized/derealized and, on the other, those classified as subjects on the pathway to spiritual enlightenment.

The comparative case of depersonalization/derealization and meditation-induced dissociation, therefore, allows to observe the constitution of people in two distinct contexts. This makes it possible to raise questions of a comparative nature: how does the act of categorizing particular dissociative experiences as either a medical pathology or as a spiritual state *affect* the way people understand themselves and the way they are understood and treated by others – in other words, what subjectivities are produced when certain dissociative states are interpreted either as a *disorder* or, in this case, as a pathway to spiritual beautification? How do these opposite interpretations and categorization for particular types of people come to *shape* the qualitative dimensions of people's experiences as they manage their dissociative, felt

predicaments? What looping effects may be observable as people, belonging to either culture, become invested in the cultural perspectives that render such categories possible?

Depersonalization/derealization: Pre-Diagnostic Category

Prior to the genesis of depersonalization/derealization as a *medical disorder,* and thus to the origin of depersonalized/derealized people, allusions to the estrangement of self and the external world were copious in literature, philosophy, art, and religious writings. In the aforementioned case of Suzanne Segal, the community of active meditators opted for a spiritual interpretation to render her dissociative state legible; such interpretation was not born in a vacuum. The language of spirituality, for centuries, has provided a logic through which dissociative states may be rendered comprehensible, and, potentially even *aspirational*. This is exemplified in a letter from an obscure Jesuit priest, Jean Pierre de Caussade, written in 1731, addressed to Sister Mary-Antoinnette de Mauhet. In this letter, Pierre de Caussede describes his experience of a sense of detachment from his own self and the external world. Alluding to a state of 'emptiness' highly reminiscent to what may be called depersonalization/derealization, Pierre de Caussede (1751) wrote:

> *It often happens that God even places certain souls in this state, which is called the emptiness of the spirit and of the understanding… the state of nothingness. This annihilation of one's own spirit… prepares the soul for the reception of that of Jesus Christ. This is the mystical death to the workings of one's own activity, and renders the soul capable of undergoing the divine operation. This… emptiness of the spirit frequently produces another void even*

> *more painful–that of the will; so that one has seemingly, no feeling, either for the things of this world, or even for God, being equally callous to all… One must not, then, try to get rid of this state, since it is a preparation for the reception of God's most precious operations… intended to precede a happy resurrection to a new life… It is a double annihilation very difficult for pride and self-love to endure, and must be borne with the holy joy of an interior spirit* (p. 43).

Pierre de Caussede perceived such felt state of emptiness, in which one loses attachment to the oneself and the "things of this world," as a necessary precondition for *spiritual awakening*. Positive interpretations of dissociative emptiness, conceived as *aspirational,* have been prevalent in a copious amount of spiritual works. In particular, allusions to the sensible detachment from one's self may be found in the writings associated not with Christianity, but with the tradition of Theravada Buddhism. Developed from a sect known as Vibhajjavada located in Shri Lanka in the third century BCE, the school of Theravada Buddhism has long espoused one primary tenet: *anattā*, generally translated as "not-self" or "no-self." The principle states the following:

> *From a Buddhist perspective, the entity we tend to call "I" is made up of five impermanent aggregates: the body, sensations, perceptions, reactions, and consciousness… We can call these five aggregates "I," but the true nature of the aggregates is that they are impersonal and ephemeral. However, since we do not understand the impermanent and essence-less nature of these aggregates, we tend to attach ourselves to and identify with all of them, or one of them. Such identification leads to clinging and attachment, as we refuse to part with one or*

> *more of these elements we think of as "I." The path of dhamma leads to a realization that there is no essence or stability behind these aggregates and that "they are not the same for two consecutive moments"* (Pagis 2010, p. 475).

The Buddhist tradition, consequently, has historically targeted the notion of an ontological self – the "feeling that there is an inherent… core at the center of one's experience that is separate, substantial, enduring self-identical -- the *atta"* (Engler 2003, p. 52). According to Buddhist philosophy, this "self" and the "world" one is attached to are mere *representations*, *illusions* which "cannot be found in the constituents of experience*"* (p. 52). The purpose of Buddhist meditation, for centuries, has been to engage in the proper methods that may allow one to sensibly *detach* from worldly illusory representations (Engler 2003).

While the conceptual elements of this Buddhist tenet are clear, a discursive orientation that finds its legitimacy in being categorized as "wisdom," it is thus through *embodied practices* that Buddhist practitioners have aimed to go about attaining such a state of no-self. Embodied operations, via meditation, enable the conceptual dimension of Buddhist knowledge to undergo a transubstantiation – from the realm of symbolic knowledge to that of *felt, sensorial* experience. Without the embodied re-attunements, Buddhist discourse cannot attain validity, it cannot enter a practitioner's phenomenological reality (Engler 2003; Pagis 2018).

> *It is only through the practice of meditation that the [Buddhist] tenets are experienced on the bodily level and thereby are "realized" as truth… participation in… meditation… facilitates the production of specific subjective*

experiences that infuse the knowledge of Buddhist tenets with embodied meaning (Pagis 2010, p. 469).

Meditators and monks, throughout history, have aimed to engage in practices through which they may become *detached observers* of themselves and the world. By undergoing such practices, Buddhist meditation aims to produce a rupture concerning one's full engagement with the commonsensical reality of the world of every day. It is by becoming distanced observers of their own bodies and the world through such corporal practices, by underdoing *sensorial re-attunements* leading to *deviations* from the commonsensical and habitual reality of everyday life, that meditators have historically been expected to merely observe "how everything changes" – one's moods, emotions, and sensations (Pagis 2018), thus suspending, and consequently deviating from, the symbolic and habitual structures that had previously made a commonsensical world possible. Engler (2003), in his discussion of the concept of *anatta*, describes such sensible destabilization as an experience highly reminiscent of what is often called depersonalization/derealization:

> *In this process, the singular, continuous self, is discovered to be an illusion, a construction only, a byproduct of nothing being able to perceive the more microscopic level of events… there is a profound awareness of the radical impermanence that I have taken to be "me"… things disappear -- what is apparent is only events in the order of milliseconds… discovering that there is no core to consciousness or self that is independent and enduring and no stable objects, just the basic qualities of experience out of which our… feelings,*

*percepts, and representations are being constructed moment by moment, like virtual particles bubbling up in a quantum vacuum and immediately vanishing away, with no "I" or thing enduring across the gap between disappearance of one construction and arising to the next – this is a profound shock (*p. *76).*

Instances akin to what is termed depersonalization/derealization, consequently, have been documented in various cultures without any connotation to *medical pathology*. In fact, the term depersonalization first appears *not* in the clinical office, but in the diary of a philosopher and poet – Henri-Frederic Amiel, who coined the term "depersonalization" as he reflected on the experience of his own perceptual metamorphosis (Simeon and Abugel 2006):

I can find no words for what I feel. My consciousness is withdrawn into itself; I hear my heart beating, and my life passing. It seems to me that I have become a statue on the banks of the river of time, that I am the spectator of some mystery… I am, a spectator, so to speak, of the molecular whirlwind which men call individual life; I am conscious of an incessant metamorphosis; an irresistible movement of existence, which is going on within me – and this phenomenology of myself serves as a window opened upon the mystery of the world… since the age of 16 onwards I have been able to look at things with the eyes of a blind man recently operated upon. That is to say, I have been able to suppress in myself the results of the long education of sight, and to abolish distances; and now I find myself regarding existence as though from beyond the tomb, from another world; all is strange to me; I am, as it were, outside my own body and individuality; I am depersonalized, detached, cut adrift. Is this madness? No. Madness means the

> *impossibility of recovering one's normal balance after the mind has thus played truant among alien forms of being, and followed Dante to invisible worlds. Madness means the incapacity of self-judgment and self-control. Where it seems to me that my mental transformations are but philosophical experiences* (Amiel 1882/1906, p. 304).

Amiel conceived of depersonalization as a philosophical encounterter – a confrontation with the seeming irreducibility of the intuited world that is always already there as the ground for all possible experiences, not as a pathologhy. For decades, instances that today may be categorized as depersonalization/derealiztion were, thus, *outside* the scope of the medical domain.

Clinical Psychiatry: The Birth of Depersonalization/Derealization Disorder

> *"When a doctor thinks he is diagnosing madness as a phenomenon of nature, it is the existence of this threshold that enables him to make such a judgment... But there is nothing to compel a diagnosis of "mental" illness… neither psychology nor therapeutics can become those absolute viewpoints from which the psychology of mental illness can be reduced or suppressed"* (Foucault et al. 1993, p. 79).

Until the middle of the nineteenth century, the term *illness* referred, strictly, to a "bodily disorder whose typical manifestation was an alteration of bodily structure" (Szasz 1961, p. 36). Illness was, consequently, tied to that which was corporeally manifested – "a visible deformity… or lesion, such as a misshapen extremity, ulcerated skin, or a fracture or wound" (Szasz 1961, p. 36). The field of psychiatry emerged through a *reinterpretation* of the essence of disease. As

Szasz (1961) writes, "to the established criterion of detectable alteration of bodily structure was now added a fresh criterion… the former was detected by observing the patient's body, the latter was detected by observing his behavior" (p. 37):

> *It would be difficult to overemphasize the importance of this shift in the criteria of what constitutes illness. Under its impact, persons who complained of pains and paralyses but were apparently physically intact in their bodies—that is, were healthy, by the old standards—were now declared to be suffering from a "functional illness." Thus was hysteria invented. And thus were all the other mental illnesses invented—each identified by the various complaints or functional-behavioral alterations of the persons affected by them* (p. 37).

To consolidate itself as a proper medical specialty, psychiatry not only needed to reinterpret the traditional dimension of pathology – the body – but it also required the constitution of categorical depictions that mapped out a new class of diseases in the *mental* dimension that it laid claim to. As Jutel (2019) points out, medicine justifies its existence via the constitution of *diagnoses,* which grant medical experts epistemic legitimacy. Whereas in the pre-existing forms of medicine "new diseases were discovered, in modern psychiatry they were invented. Paresis was proved to be a disease; hysteria was declared to be one" (Szasz 1961, p. 37).

The early stages of psychiatry were swarmed with "physicians who tried to bring order into the variety of manifestations of mental illness" (Stengel 1959, p. 602). Zilboorg (1941) quotes Nasse, a psychiatrist, as having observed, in 1818, that in his day "practically every

worker dealing with mental diseases felt he had to offer a classification of his own" (p. 42). Stengel (1959) writes that "in the latter part of the nineteenth century, to produce a well-ordered classification seemed to have become the unspoken ambition of almost every psychiatrist of industry and promise" (p. 602).

The initial impetus to categorize mental illnesses was chiefly found in the industry of "institutional psychiatry in which a small number of doctors were dealing with large numbers of patients" (Stengel 1959, p. 603). Mental institutions provided a ground in which nosological classificatory systems flourished, particularly those which concerned *psychoses*. A growing number of doctors, however, began to enter psychiatry not through the mental hospital, but via the "out-patient clinic and consulting room, where psychoses were comparatively rare" (p. 603). It is in this setting that the systematic study of new conditions began, specifically "neuroses and personality disorders" which, from the beginning, "were the most controversial areas of classification" (p. 603). Like the initial psychiatrists who found their home in mental institutions, clinical psychiatrists carried on the legacy of creating, categorizing, and systemizing a multiplicity of new mental illnesses.

It is in this soil, in which psychiatry enters the clinical office, that depersonalization/derealization *disorder* first came into existence. Similar to various mental illnesses, those currently legitimized by modern medicine or the broad array of illnesses that have transiently passed through nosological diagnostic manuals, depersonalization/derealization emerges in a period in which a myriad of psychiatrists, working in the clinic for the first time, began to engage in efforts to develop a "vocabulary, a syntax, [and] assumptions about the nature of behaviour" (Berrios 1996, p. 1). During the mid-1800s, a few psychiatrists commenced documenting instances in which their patients reported a "dreamy state"; patients described that

their own bodies seemed "to come from far away" (Berrios 1996, p. 274). These behaviors "elicited great interest in France and, by the turn of the century, important literature began to accumulate" (Berrios 1996, p. 274). Debates ensued amongst psychiatrists who did not know not how to typify these experiences. The concept of depersonalization, as explored in the following, would eventually be coined by a French psychiatrist, Ludovic Dougas, as he attempted to classify these experiences. The conceptualization of depersonalization is indicative that "the notion of person and self," during the late 1800s, "was beginning to take shape in French psychology (it was a very old one in metaphysics and theology)," which made it possible for clinicians to discuss clinical phenomena as "disorders of the self" (Berrios 1996, p. 274).

Entering the Clinic

Beginning in the middle of the 19th century, the first descriptions of experiences redolent of depersonalization/derealization can be found in medical literature. In 1845, Griesinger -- founder of a medical-psychological society in Berlin -- quoted a letter written by a patient to Esquirol, the prominent French psychiatrist who developed a classification system of mental illnesses in the early 1800s that remains influential today. The patient's letter read:

> *I continue to suffer constantly; I don't have a moment of comfort, nor experience human sensations… My existence is incomplete. The functions and acts of ordinary life, it is true, still remain to me; but in every one of them there is something lacking. That is, the sensation which is proper to them … Each of my senses, each part of my proper self is as if it were separated from me and can no longer afford me any sensation. This impossibility seems to depend upon a void*

> *which I feel in the front of my head and to be due to a diminished sensibility over my whole body, for it seems to me that I never actually reach the objects that I touch. I no longer experience the internal feeling of the air when I breath … My eyes see and my spirit perceives, but the sensation of what I see is completely absent* (Sierra and Berrios 1997, p. 214).

Despite being aware that such symptoms may be similar to the characteristics of melancholia, Griesinger believed that such sensory states were unique in their own right: "'This very remarkable state, which the patients themselves have much difficulty in describing, and which we also have ourselves observed in several cases as the predominant and most lasting symptom …'" (Sierra and Berrios 1997, p. 214). Around the same period, in France, Esquirol (1845) described similar experiences in patients: "An abyss, they say, separates them from the external world, I hear, I see, I touch, say many lypemaniacs, but I am not as I formerly was. Objects do not come to me, they do not identify themselves with my being; a thick cloud, a veil changes the hue and aspect of objects" (p. 414). In 1847, nother prominent French psychiatrist, Billod, depicted a patient who complained of similar experiences: "'she claimed to feel as if… objects [in her environment] looked as if surrounded by a cloud; people seemed to move like shadows, and words seemed to come from a far away world'" (Sierra and Berrios 1997, p. 215).

It was not until 1894, however, that the aforementioned French psychologist, Ludovic Dugas, building on this literature, introduced the word "depersonalization" into medical lexicon. Dugas, appropriating the term after coming across Amiel's journal, first used it as a *clinical diagnosis*. Dugas, in fact, believed that Amiel suffered from "depersonalization" – for the first time subsumed under the confines of a medical viewpoint (Abugel and Simeon 2006, p. 43).

Dugas first employed the term as a diagnosis for a patient who claimed that his own voice sounded alien to himself. Dugas wrote: "'In 1894, when dealing [with patients] with false memories, I had not yet knowledge of depersonalization. Not realising its novelty, I missed [the phenomenon] when I first met it'" (Sierra and Berrios 1997, p. 215). Shortly after, however, Dugas published a series of medical papers on the subject (1898, 1912, 1915, 1936) and wrote a monograph entitled *La Dépersonnalisation*, which he co-authored with the French neurologist Maurice Moutier (Dugas and Moutier 1911). Dugas and Moutier (1911) defined the condition as "a state in which there is the feeling or sensation that thoughts and acts elude the self…and become strange… there is an alienation of personality; in other words a depersonalization" (Dugas and Moutier 1911, p. 13).

Speaking about his patient, Dugas stated, "'Although he knows that it is his voice, it does not give him the impression of being his own... Every time the subjects moves he cannot believe that [he] is doing it himself… The state in which the self feels that its acts are strange and beyond its control will be called here alienation of personality or depersonalization'" (Abugel and Simeon 2006, p. 51). Dugas added that "'depersonalization behaviors not only seem automatic; to an important degree, they are… by automatic I mean any behavior to which the self feels indifferent and foreign, and which it produces without thinking or wanting, as might happen in states of total distraction or absent mindedness'" (Abugel and Simeon 2006, pp. 51-52).

A few decades following Dugas' interpretation of these experiential states, the first *technical* definition of depersonalization appeared in a medical textbook entitled *Modern Clinical Psychiatry* in the 1930s. Here, the following is written:

> *Depersonalization, a pervasive and distressing feeling of estrangement, known sometimes as the depersonalization syndrome, may be defined as an*

> *affective disorder in which feelings of unreality and a loss of conviction of one's own identity and of a sense of identification with and control over one's own body are the principle symptoms. The unreality symptoms are of two kinds: a feeling of changed personality and a feeling that the outside world is unreal. The patient feels that he is no longer himself, but he does not feel that he has become someone else. The condition is, therefore, not one of so called transformation of personality. Experience loses emotional meaning and may be colored by a frightening sense of strangeness of unreality. The onset may be acute, following a severe emotional shock, or it may be gradual onset following prolonged physical or emotional stress. It is more frequent in personalities of an intelligent, sensitive, affectionate, introverted, and imaginative type. The patient may say that his feelings are 'frozen', that his thoughts are strange; his thoughts and acts seem to be carried away mechanically as if he were a machine or an automaton. People and objects appear as unreal, far away, and sometimes lacking color or vividness. The patient may say he feels as if he were going about a trance in a dream* (Noyes and Kolb 1939, p. 84).

The term depersonalization was used to account for feelings of "unreality" concerning the "outside world" – such as objects and other people. *Derealization* was not yet classified as a standalone condition. The description of depersonalization in this textbook officially identifies a specific demographic of potential sufferers – the sensitive, introspective kind. More importantly, this description is the first to offer an account of the *etiological* factors that may potentially cause the condition – severe emotional shock or stress. In the current version of the DSM, the APA

now employs the term "peritraumatic dissociation" to account for conditions encompassing traumatic emotional shock.

In the late 1930s, psychiatrist Wilheim Mayer-Gross contended that existing theories concerning depersonalization were inadequate given that too many aspects of the condition that remained unclear. Mayor-Gross (1935) argued that depersonalization was an "expression of a 'preformed functional response' of the brain, analogous to delirium, catatonia, or seizures" (p. 117). In Mayer-Gross' viewpoint, "depersonalization is a characteristic form of reaction of the central organ, which can be set going by different causes. The difficulty of description by means of normal speech, the defiance of comparison, the persistence of the syndrome in the face of complete insight into its paradoxical nature - all these point to something more than purely psychic connections" (p. 118).

Mayor-Gross was the first to make a distinction between *depersonalization and derealization*. The psychiatrist coined the term "derealization" in reference to "the feeling of alienation of the surroundings," as opposed to the feeling of becoming estranged from one's self (Mayer-Gross 1935, p. 114). Mayer-Gross (1935) is also the first to shed light on the etiological ambiguity of these conditions -- "Depersonalization and derealization often appear suddenly, without any warning," wrote Mayer-Gross, "a patient sitting quietly reading by the fireside is overwhelmed by it in a full blast together with an acute anxiety attack. In some cases it disappears for a short period, only to reappear and finally persist" (p. 119).

Around the same time, the prominent psychologist, Pierre Janet, categorized depersonalization "'as a manifestation of 'psychasthenia'" (Sierra 2009, p. 16). According to Janet, "'complaints of depersonalized patients included reference to 'incompleteness' affecting perception, motor activity, emotions, and feelings of self: The fundamental feeling conveyed by

these expressions is therefore the same as we already dealt with when talking about action, intelligence and emotions, that is, an infinite feeling of incompleteness'" (p. 16). Sierra (2009) writes that Janet used the term depersonalization "to refer (in a narrower sense) to 'feelings of incompleteness' as applied to personality." In the words of Janet, "'What characterizes the feeling of depersonalization, just as the other feelings we have seen, is that the patient perceives himself as an incomplete, unachieved person'" (p. 16).

Beginning in the 1950s, psychoanalytic writers gave additional explanations for these conditions by linking depersonalization to the Freudian concept of the ego. The psychoanalytic framework posits that depersonalization "may be linked to a poorly integrated ego or sense of self, resulting from the presence and activation of conflictual and inadequately integrated parts of the self" (Abugel and Simeon 2006, p. 58). Paul Federn contended that "depersonalization and derealization [are] diseases of the ego caused by a lack of libidinal investment affecting the ego structural core and the ego boundaries, respectively" (Sierra 2009, p. 17). Federn additionally related depersonalization to schizophrenia, arguing that they "shared (to a different degree) the same psychodynamic mechanism" (Sierra and Berrios 1997, p. 223). Depersonalization, argued Federn, might be an initial sign of schizophrenia. Paradoxically, Oberndorf proposed the opposite and argued that "'an increased libidinal investment in thought processes was central to depersonalization'" (Sierra 2009, p. 18). Bulding on Oberndorf, Fenichel explained that "'the experiences of estrangement and depersonalization are due to a special type of defense, namely to a counter-cathexis against one's own feelings which had been altered and intensified by a preceding increase in narcissism. The results of this increase are perceived as unpleasant by the ego which therefore undertakes defensive measures against them'" (Sierra 2009, p. 19).

Psychoanalyst Jacob Arlow made a similar argument; he contended that depersonalization "represents the outcome of intrapsychic conflict, 'in which the ego utilizes, in more or less successful ways, various defenses against anxiety'" (Abugel and Simeon 2006, p. 60). As quoted by Abugel and Simeon (2006), Arlow added that "'the split in the ego results in the disassociation between the *experiencing self* and the *observing* self takes place in the interest of defense'" (p. 60). In this sense, depersonalization is regarded as a response that serves to protect the ego in perilous circumstances. The participating self experiences the peril, and the observing self undergoes a separation to avoid a direct confrontation with the perilous circumstances.

Simeon and Abugel (2006) point out that, although most psychodynamic authors lack a coherent theory, the majority perceive depersonalization and derealization as defenses "against a variety of negative feelings, conflicts, or experiences, when the individual's more adaptive mechanisms fail" (p. 58). Yet, it is difficult to disagree with Simeon and Abugel when they contend that "defense mechanism" is a problematic term that may not adequately account for the variable characteristics of these conditions. "Most contemporary theorists would probably agree that dissociation is more than a defense mechanism," write Simeon and Abugel (2006), "instead, it is a subjectively experienced self-state or state of being" (p. 60).

Through the work of a myriad of psychiatrists who, working from the clinic, began to report cases of people affected by symptoms associated with depersonalization/derealization, depersonalization and derealization thus became medical categories that attained clinical legitimacy. Initial descriptions of depersonalization/derealization, born in the psychiatric office in a period of nosological expansion, elicited interest that eventually fostered debates and calls for additional research, a reality that continues to this day. Depersonalization/derealization, since

its emergence as a recognized diagnostic category, thus became ripe to be included in the renowned diagnostic manuals, such as the DSM, that would appear decades later.

Entering the DSM

In the mid-1900s, psychiatrists, following the tradition of their predecessors who had been involved in great efforts to develop a categorical systems for various classes of mental conditions, began to discuss the importance of developing a *unitary* nosological system. Many psychiatrists believed that the failure to develop such a widely accepted nosological system would throw psychiatry in a state of crisis:

> *Everybody who has followed the literature and listened to discussions concerning mental illness soon discovers that psychiatrists, even those apparently sharing the same basic orientation, often do not speak the same language. They either use different terms for the same concepts, or the same term for different concepts… The lack of a common classification of mental disorders has defeated attempts at comparing psychiatric observations and the results of treatments undertaken in various countries or even in various centers of the same country* (Stengel 1959, p. 601).

This was amongst one of the reasons why the World Health Organization, which had already published 5 editions of the ICD, collected information about psychiatric classifications used in a number of countries; the aim was to develop a single classificatory system. The *ICD-6*, published in 1949, was the first edition to include a comprehensive list of psychiatric conditions. The term "depersonalization" already appears in this initial classificatory system, listed as a psychoneurotic disorder under code 318.1.

The first attempts to formally classify psychopathology in the United States were undertaken shortly after the publication of the ICD-6 – the first edition of the DSM was published only three years after the ICD-6. In the 22 diagnostic categories included in the first volume of the DSM, depersonalization was listed under code 000-x02. Influenced by the ICD-6, the APA listed depersonalization as a dissociative *psychoneurotic* disorder; the phrase "depersonalization" only appears once. Published in 1968, The DSM-II, under code 300.6, included the category "depersonalization neurosis" and categorized the condition as a "syndrome" – it also provided a description closely aligned with the ICD-8, which reflected "a collaborative effort between the WHO and American psychiatrists sent to Europe prior to the publication of both the *ICD* and *DSM* manuals that same year" (Kawa and Giordana 2012, p. 5). Depersonalization was defined as:

> *This syndrome is dominated by a feeling of unreality and of estrangement from the self, body, or surroundings. This diagnosis should not be used if the condition is part of some other mental disorder, such as an acute situational reaction. A brief experience of depersonalization is not necessarily a symptom of illness* (APA 1968, p. 41).

Advances in psychometric instruments such as rating scales and checklists for anxiety and depression, progress in therapeutics and psychopharmacology, and a growing number of criticisms against psychiatry produced a series of responses from clinicians: 1) first, in 1965, a conference addressing psychiatric classification that was sponsored by the Psychopharmacology Research Branch of the NIMH took place, 2) the formulation of the Washington University criteria for operational diagnosis emerged in the early 1970s, and 3) the Research Diagnostic Criteria (RDC) by the NIMH Psychobiology of Depression Collaborative Study was developed

in 1978, . Thus, a multitude of factors created a propitious climate for change that culminated in the publication of the third edition of the *DSM, which occurred* in 1980.

Modifications incorporated into the *DSM-III "*constituted a veritable paradigm shift" – one of the most telling features of this shift was the official removal of the psychodynamic term "neurosis," a category under which depersonalization was listed for decades (Kawa and Giordana 2012, p. 6). This version encompassed an amplification in the *specificity* of diagnosis, the expansion of broad categories into several individual "subtypes," as well as "defined operational criteria for inclusion and exclusion… for each disorder" (Kawa and Giordana 2012, p. 5). It is in this version that the term "depersonalization disorder" first appears, distinguished from "derealization," the former indicating a "a sensation of self-estrangement" and the latter "a strange alteration in the perception of one's surroundings so that a sense of the reality of the external world is lost" (APA 1980, p. 259). The definitions for depersonalization/derealization have remained similar in the subsequent publications of the DSM. The DSM-V, in the most recent change, now combines these two conditions under a single category: *depersonalization/derealization disorder.*

Opposing Definitions

For decades, therefore, psychiatry has recognized depersonalization/derealization as a *legitimate* mental illness. Depersonalization/derealization disorder came into being as an object of scientific inquiry due to two primary factors: first, the genesis and a concept such as depersonalization/derealization was made possible by the labor of individual agents working, for the first time, in the clinic. The clinic provided a setting that made it possible for psychiatrists to explore, analyze, and codify an array of experiential states previously ignored; some of these

states encompassed “disorders of the self.” Second, a climate, in which an *impetus to categorize* a plethora of human experiences previously outside the scope of medicine, was born within the nascent field of psychology and psychiatry; the survival of these disciplines, in fact, *incentivized* such *compulsion to typify* and generate a systematic, nosological categorical system for a multiplicity of experiential states. Various mental illnesses that have either persisted or momentarily passed through the lexicon of psychiatry, such as avoidance personality disorder, agoraphobia, or Cotard's syndrome, were born in the midst of this time period.

Considering that clinicians have historically recognized depersonalization/derealization as a medical category, and given that clinical experts have historically given much consideration to the etiological and diagnostic components of such states, it is unsurprising that many people susceptible to experiences associated with depersonalization/derealization will seek the language of medical diagnosis to account for their dissociative disruptions. Today, medicine provides, arguably, the dominant cultural lens through which people in the West interpret disruptive experiences (Jutel 2019). Social actors may find that the diagnostic language provides the tools to render such experiences meaningful, for it offers culturally elaborated schemes to structure these disruptive experiences, formulate post-illness identities, and reorient themselves to the world (Kleinman 1992).

Yet, for centuries, dissociative experiences, which may today be subsumed under the language of diagnosis, were rendered legible by distinct epistemological perspectives -- in particular, as historical evidence suggests, by the language of spirituality. Such spiritual epistemologies have not disappeared. Suzanne Segal’s legacy, if anything, serves as a reminder that spiritual discourses today remain largely relevant. Today, multitudes of people will visit meditation retreats and engage in meditative practices that were once only common in remote

corners of the world. Thousands of meditative participants now expose themselves to multi-level processes that transform their orientation towards the world "not only in the symbolic, abstract level but at the level of embodied semiotics" (Pagis 2019, p. vi). Like Segal, a multiplicity of Westerners, familiar with spiritual discourses, may come to confront instances of meditative-induced dissociation.

Meditative practices that may engender dissociative states, thus, now form part of a growing market renowned for its pragmatic and instrumental promises to provide people with tools to achieve self-actualization (Purser 2018). "Psychiatrists should be aware," writes Kennedy (1976), a psychiatrist who has largely studied depersonalization/derealization, that the number of "organizations in the 'consciousness movement' is increasing," adding that "psychiatrists should ask people manifesting depersonalization about any involvement in activities leading to altered states of consciousness" (p. 1326).

What we have, therefore, are two prevalent cultures of sensory dissociation – one is primarily composed of people who, upon confronting dissociative states, will seek the language of diagnosis. This is what I call, in the subsequent parts of this study, a patient-led community. The second community is predominately composed of people who, like Segal, seek spiritual beautification – that is, the attainment of *anatta*. Through meditative techniques, people participating in these cultures volitionally induce instances of prolonged meditative dissociation in order to experience a detachment from their commonsensical sense of self (Pagis 2019). How does one reconcile that similar sensory destabilizations may possess opposite valuations – one in which such instances are pathologized and another in which similar phenomenological states are rendered acceptable? Building on the APA's acknowledgement that depersonalization/derealization may be volitionally evoked via meditative practices in other

cultures, and hence not labeled as a pathology, I explore (1) the experiential foundation of depersonalization/derealization and meditation-induced dissociation. To what extent do both cases involve similar phenomenological, felt characteristics? And (2) the reflexive activities, or somatic work, through which social actors account for their sensations. What do the processes by which such sensible experiences come to possess opposite valuations reveal about the cultural elements that compel such interpretations?

In the following chapter, I focus, firstly, on the case of *patient-led communities.* These are communities in which people adopt the language of medicine as the primary discursive system to account for dissociative experiences. I pay specific attention to the processes through which social actors come across a diagnosis, documenting their interactions with clinical experts – that is, the purveyors of diagnostic expertise. I discuss how patients, invested in their own categories, may come to appropriate diagnostic criteria to render their dissociative states comprehensible, delegitimizing clinicians as the experts of medical knowledge. In the processes, social actors ongoingly produce and reproduce specific types of subjectivities – in particular the depersonalized/derealized person.

Chapter 2

Patient-led Communities: Confronting the Neglected Mental Illness

The constitution of depersonalization/derealization as a *disorder*, a process which begins in the late 1800s, aligns with the expansion of clinical psychiatry, a discipline that promulgated the impetus to typify and codify a multiplicity of new psychological conditions. Psychiatry targeted an array of human *behaviors* that had never been previously subsumed under the medical gaze. A salient feature of the variable psychopathologies described and classified by the emergent specialists, as Kaplan (1964) writes, was that they were opposed to a state of "normality… intimately related to the value orientations of western society" (p. xi). The psychiatric field dictated that any potential deviation from a *standard*, unidimensional psychic reality could, potentially, *merit* being classified as a psychopathology.

That which was deemed pathological, therefore, was opposed to valuations concerning that which clinicians judged as an *optimal* behavioral state. In the process, clinical psychiatry negated distinct cultural perspectives. Relevant to the case of depersonalization/derealization, psychiatry dictated that the dissociative effects produced by meditative and yogic states, socially accepted in the East throughout generations, were to be "regarded as pathological, and their practitioners were regarded as neurotic or psychotic in the West" (Walsh 1993, p. 740). This perspective is reflected in the Group of the Advancement of Psychiatry's discourse, whose representatives wrote that "the obvious similarities between schizophrenic regressions and the practices of yoga and Zen merely indicate that the general trend in oriental cultures is to withdraw into the self from an overbearingly difficult physical and social reality" (Alexander and Selesnick 1966, p. 457).

Psychiatry, today, has become possibly the dominant institution that dictates how alterations of the sensory-perceptual field should be classified, diagnosed, and treated. The DSM, along with the International Classification of Diseases manual (ICD), constitute some of the primary tools utilized for the classification and diagnosis of experiences judged as 'deviations' from an acceptable sensory-perceptual state. Sociological literature has largely documented how the historical diffusion of psychiatric discourses has had a *causal* power – that is, it has largely entered the most individual and tenuous forms of subjectivity, influencing how social actors attribute meaning to their most intimate experiences and monitor their behaviors (Foucault 2006; Hacking 2002).

Considering the broad dissemination of psychiatric knowledge, which is to acknowledge its *hegemonic* force in Western cultures, it is unsurprising that many social actors susceptible to sensory-perceptual deviations associated with depersonalization/derealization in Western societies will, first and foremost, *resort to clinical explanations* in order to account for their experiences (Jutel 2009). This is something that I continuously observed in this research. Respondents belonging to patient-led communities, who typically employ phrases such as "feeling unreal" or "feeling dreamlike" to describe their symptoms, commonly describe their dissociative states as psychopathological deviations from an acceptable state of *normality*. As Pierre points out:

> *Once you lose that normal state of what these senses should be like and what things should look like and what things should sound like or what things should feel like… it immediately puts you in this kind of horror.*

Miguel articulates a similar point:

The biggest thing… is the feeling of… not being authentic... It's just not the same as a normal reality that a normal person would experience…

Judging that they have transgressed a state which a normal person *ought* to continually experience, those who belong to patient-led communities will seek explanations from those who have cultural legitimacy over the codification of sensory-perceptual experiences deemed experientially disruptive – clinicians. As Molly states, following her initial experience with symptoms associated with derealization/depersonalization, which she attributes to stressful circumstances in her life, the reasonable option was to visit a clinician:

I went to see a psychologist… she was just real honest with me… that she doesn't really know how to treat that condition, so I was referred…

Albert, similarly, describes the logical course of action after his initial confrontation with symptoms associated with depersonalization/derealization:

At the time [when his symptoms began] *I had no idea what it was… How do you feel out what you have if you don't… know about this thing… for quite a while, I didn't… know what this thing was... I remember I was in my mother's room, and told her… 'I don't know what's going on.' She told me to go to the doctor.*

The clinician, for people belonging to patient-led communities, becomes not simply the most logical figure to consult as they seek a rationale to account for their symptoms, but, often,

respondents perceive the clinical visit as the *only* intelligible option. For those belonging to patient-led communities, such dissociative states represent inherent *psychopathological occurrences*. As Pierre states, "I really feel that this is a neurological brain problem at its very heart. This is without question a neurological, medical phenomenon, and I really feel like if we're gonna make strides in addressing this issue, we have to target the neuroscientist."

Literature indicates that interpretations for instances associated with depersonalization/derealization may be subject to cultural contextualization; in certain social groups, people may employ religious interpretations to account for phenomenological states otherwise known as depersonalization/derealization (Castillo 1990). Yet, in the case of patient-led communities, the only sensible lens through which such experiences may be framed, according to respondents, encompasses the logic of medicine.

A Neglected Illness

While depersonalization and derealization have been *legitimate* medical categories within psychiatric nomenclature for decades, however, psychologists and psychiatrists have been slow to diagnose these dissociative experiences (Abugel 2010). Those belonging to patient-led groups often come to realize that the purveyors of diagnoses, and the medical system itself, is ridden with *uncertainty.* Patients and a handful of psychiatrists, primarily clinicians who have experienced depersonalization/derealization themselves, have labeled the depersonalization/derealization, "*the neglected mental illness"* (Sierra 2009).

As an uncommon disorder, depersonalization/derealization has eluded contemporary clinicians' attention due to the belief that depersonalization/derealization constitutes secondary symptoms of other mental illnesses such as depression, the nature of its subjective and elusive

symptoms, and the lack of clinical research concerning depersonalization/derealization in comparison to more prominent mental illnesses (Abugel 2010). Diagnostic approaches, namely self-report measures, have been common screening tools for evaluating dissociative symptoms, but the complexity and intangible character of dissociation means that it may "take an average of seven years or more" for dissociative conditions, in general, "to be accurately diagnosed" (Mychailyszyn et al. 2021, p. 20).

Similar to those who suffer from medically unexplained symptoms that lack a clear etiology and objective diagnostic indices, those affected by depersonalization/derealization have traditionally embarked on a diagnostic odyssey searching for an appropriate diagnosis; their symptoms have repeatedly been misdiagnosed as byproducts of more common illnesses such as anxiety disorder, depression, or schizophrenia. Although symptoms of depersonalization/derealization may, in certain cases, be an aspect of broader schizoaffective disorders or depression, those susceptible to these experiences often describe depersonalized/derealized symptoms without the presence of depression or schizoaffective states (Abugel 2010). Misdiagnosi*s*, in the eyes of depersonalization/derealization sufferers, specifially concerns clinicians' failure to diagnose depersonalization/derealization as a *standalone* disorder.

For people affected by depersonalization/derealization, living with misdiagnosis or non-diagnosis has historically meant perpetually wondering if they are "mad," causing alienation of friendships and relationships, experiencing trouble to perform school or work tasks, and, in certain cases, contemplating or attempting suicide (Simeon and Abugel 2003). What is at stake for sufferers largely concerns the potential to legitimize an array of disruptive symptoms, find ways to manage the severity of dissociative episodes, and learn to live with a condition with no explicit end in sight. Affected by the disruptive symptoms of dissociative episodes, people

belonging to patient-led communities perceive states of depersonalization/derealization as circumstances that need to be medically acknowledged, and, ultimately, cured.

It is for this reason that people affected by symptoms associated with depersonalization/derealization, unhappy with clinicians, have managed to appropriate medicine's own language to accomplish their own diagnosis. The widespread dissemination of health data has not only allowed people affected by such dissociative symptoms to self-reliantly find a diagnosis, it has made it possible for patients to subordinate clinicians' diagnostic interpretations to their own lay diagnostic discoveries – resulting in a delegitimization of clinicians' status as diagnosticians. The case of patient-led communities makes it possible to highlight the emergent pathways that people subject to long diagnostic odysseys increasingly embark on in order to confront medical uncertainty, particularly during the case of atypical illnesses which may elude clinicians' awareness. At the same time, the case of patient-led communities allows to explore the processes through which the logic of clinical psychiatry may ongoingly disseminates itself, even *without* the traditional authority of clinical experts.

Confronting Depersonalization/Derealization: The Initial Shock

Those affected by symptoms associated with depersonalization/derealization describe recurrent sensible disruptions, which engender an unfamiliarity with the world. Dana, a thirty-one-year-old who has experienced symptoms for six years and, as a consequence, has quit multiple jobs and avoided romantic relationships, states, "Things around me will look and feel really strange… it'll feel like I'm in a video game…"

Thrown into a defamiliarizing state, those susceptible to these episodes characterize the onset of the disorder as a "shock." These episodes are experienced as 'shocking' for two reasons: these are disruptive states that people have never experienced in their lifetime, and people

initially lack an explanation to meaningfully organize such perceptual ruptures. During the early illness phase, people desperately rely on the cultural schemes they carry "at-hand" to interpret their sensible alteration. Seth, a twenty-year-old who recently experienced initial symptoms after an abrupt panic attack, states:

> *I have been in an OCD-like state… I'm so… scared of severe mental illness like schizophrenia… I'm… beginning to think I'm… psychotic…*

Many respondents use terms such as "madness" and "psychosis" when their symptoms appear. Robert, whose sensory destabilization began during the 1980s, reports that "at the outset…it all started with a panic attack… followed by a severe fear of going mad… I stayed awake for almost two to three days because I was very afraid."

People affected by these experiences not only sense that they have transgressed a "normal" experiential domain, but the experiential transgression conjures a multiplicity of socially contextual meanings -- the imagine of the straightjacket, the "madman." Consequently, such destabilizations are, from their inception, invested with folk significations. Such significations are, even during the early stages, largely influenced by psychiatric interpretations (e.g. the concept of 'madness'). The DSM-V, in fact, acknowledges that these are 'typical' responses to depersonalization/derealization:

> *Individuals with depersonalization/derealization disorder may have difficulty describing their symptoms and may think they are "crazy" or "going crazy"…* (p. 304).

Seeking a Diagnosis: The Generational Gap

Respondents affected by phenomenological alterations associated with depersonalization/derealization, sensing that they are suffering from a *psychopathology* – for this is the immediate comprehensible explanation that comes to mind -- report the importance of finding an "official" *diagnosis,* which is to say, a *formal medical diagnosis* to account for their symptoms. Here, however, one may note a *generational gap* between "traditional" patients and those who may be categorized as "engaged skeptics." The experience of people who first presented manifestations of depersonalization/derealization over two decades ago differs from the accounts of people who have recently become affected by such symptoms.

This distinction, which is noted by respondents themselves, encompasses both material and cultural factors. First, while older patients had no other viable option but to visit clinicians or remain undiagnosed, modern skeptics have access to novel diagnostic routes and sources of information. Second, skeptics are born into a world in which a depersonalization/derealization culture has come into existence, whereas, for decades, the terms depersonalization/derealization remained in obscurity (Sierra 2009). This culture fosters transposable expressive tools to make 'sense' of an embodied sensory experiences that would otherwise remain elusive, enabling people to situate themselves in social space and develop an illness identity.

<u>Diagnosing the traditional patient</u>

Older patients' only viable course of diagnosis, unlike modern sufferers, involved consulting medical experts. This is exemplified in Albert's aforementioned response, whose symptoms commenced over two decades ago:

> *At the time* [when his symptoms began] *I had no idea what it was… How do you feel out what you have if you don't… know about this thing. You… search the Internet for some stuff that you are feeling, and then you… find… people talking about these kind of things. But when I was 20… there was no possibility to search the Internet… for quite a while, I didn't… know what this thing was... I remember I was in my mother's room, and told her… 'I don't know what's going on.' She told me to go to the doctor.*

The private doctor-patient relation, consequently, was the primary route for traditional patients to find a diagnosis, but this often ensued in disillusionment. Robert, a Danish man in his 50s whose diagnostic quest with depersonalization/derealization began during the 1980s, illustrates the ups and downs of the odyssey.

Robert recalls the severity of his initial dissociative symptoms, which caused him to temporarily drop out of school. Similar to Albert's case, clinicians were the only feasible authorities, in the eyes if Robert, to *logically* consult at the time. "I started a long course with psychiatrists, they also sent me to neurologists because I had perception disorder," states Robert, *"*but my reality testing was intact… so they sent me to other neurologists. And to a new psychiatrist and so on and so on." When I asked Robert to describe what clinicians diagnosed, he explains:

> *Some didn't have any idea… some thought it was depression… I ended up in 2000 in a mental hospital… because many psychiatrists couldn't find out what was wrong... first they thought I was suffering from hypochondriasis… and then they dropped that, and they said, 'well it must be a schizotypal disorder.'*

Robert recounts that a renowned clinician "supported the schizophrenia diagnosis… because of his authority nobody questioned his remarks." Under the influence of Zyprexa, a medicine used to treat schizophrenia, he recalls convincing himself that "perhaps the numbing was a negative symptom of schizophrenia… then they put me on the highest doze and I gained 10 kilos of weight and also developed severe anxiety… so I stopped that." Robert subsequently visited various psychiatrists, who also "couldn't find… what was wrong."

> *Then I thought to myself, everything is subjective, they have no idea what is wrong with me… I will try to look in English for my symptoms to see if I can come up with something… I came across the term depersonalization online, and that lead me to the depersonalization research unit in King's College. I wrote a letter to them about my story… in 2006 I found out that it was depersonalization. It was more than 20 years… I was angry…*

While Robert believes that his case was a peculiar experience confined to the Danish medical system, literature suggests that such uncertainty is widespread. Hunter et al. (2003) write that, in the US, "DPD sufferers have been found to have an average time of 7–10 years before being given their correct diagnosis of DPD… or around 12 years in a UK and are likely to have had conflicting information about their problems during this time" (p. 1460). Damien, at the tail end of the "traditional generation," was similarly misdiagnosed in the early-2000s.

> *Damien: I consulted… a neuropsychiatrist, a psychopharmocologist… in one of the psychiatric centers of downstate New York.*
>
> *Interviewer: What did he tell you?*

Speaker 1: He said I was schizophrenic...

Like Robert, Damien initially took his diagnosis at face value, listing the various medications he had to ingest -- "I had a stint with Olanzapine... Risperdal… finally, with Clotiapine…" Damien progressively became disillusioned with the efficacy and side-effects of the medications, doubting whether his condition was, in fact, schizophrenia. Similar to Robert, he sought advice online when it became an option:

> *I initially was on website called Hallucinogen Persistent Perceptions Disorder Online… I went to DPSelfHelp as a result of people giving me advice to go there… it was immediately obvious that they understood what was happening… you have to figure out who you can trust.*

Damien suggests trust is earned by those who comprehend the phenomenological experience of such embodied disruptions. Dissatisfied with clinical assessments that they consider inappropriate after years of uncertainty, many "traditional" respondents articulate opting for a *self-reliant approach* – an orientation in which they independently seek an explanation for their experiences.

Many patients who first experienced symptoms associated with derealization/depersonalization disorder prior to the mid-2000s confronted a state of perplexity. Not only did patients undergo a sensory-perceptual disruption, but upon seeking a clinical diagnosis, they confronted medical uncertainty. Patients found themselves lost in social space, for they did not belong to any illness community, nor did they know how to frame their experience to foster a comprehensive illness identity.

The traditional medical approach, in which clinicians treated the characteristics of depersonalization/derealization as secondary symptoms of conventional mental illnesses, resulted in the perpetuation of misdiagnosis and inadequate treatment. Hunter et al. (2003) write that the misinterpretation of depersonalization/derealization "as indicative of severe mental illness" results in "a vicious cycle of increasing anxiety…" (p. 1451).

Patients' eventual *self-reliant* approach and growing skepticism against clinicians was initially *reactive*; a response to years of sensing that contradictory medical interpretations did not align with lived experience. A typical series of steps summarizes the trajectory of traditional patients' diagnostic odyssey: 1) the initial confrontation with dissociative symptoms, 2) a visit to the clinician, 3) the unearthing of a diagnosis under the jurisdiction of clinicians (often a misdiagnosis), 4) the intake of medications prescribed by doctors, 5) the cultivation of a self-reliant approach after years or decades of medical uncertainty.

The modern skeptic

The interviews reveal a stark contrast between "traditional" patients and "modern" subjects affected by depersonalization/derealization; the primary difference involves an attitudinal shift. This is exemplified by Andrew, who first experienced symptoms approximately five years ago, and who diagnosed himself with depersonalization/derealization eight months after his symptoms began:

Andrew: *I've been to a psychologist a couple of times. I just started a new one because I want to try some meds…*

Interviewer: *What has been your experience with the psychologists...?*

Andrew: *They're… clueless… They're curious and ask me all sort of things because they try to put the diagnosis on me… [they] don't want to touch depersonalization… because they don't really know it… they don't… trust me because I'm self-diagnosed…*

Interviewer: *How did you come to diagnose yourself with depersonalization?*

Andrew: *Just Googling… saw it on Wikipedia. It… says you feel disconnected from the world and yourself. I was like yeah, that's me… [after some months] I found the DPSelfHelp. Then I finally found all these people who actually had the same symptoms as me, which was huge, to know I'm not alone with all this weird shit.*

Compared to the traditional patient experience, one notes a *reversal* in the physician-patient role. The lived experience is initially the same for modern skeptics and traditional patients – a confrontation with a state of unreality. However, prior to his medical visit, Andrew already possesses a diagnosis that he has independently, and in a much shorter time-period than traditional patients, discovered. This knowledge is made possible by the availability of new diagnostic routes (in this case the virtual information that may be accessed online). This precludes the development of an extensive diagnostic odyssey. On average, the time it took for traditional patients in this case study to attain a diagnosis was over a decade; for modern skeptics, however, it was a matter of weeks to months.

One may note, consequently, that the course of action for the modern skeptic is the following: 1) an initial confrontation with dissociative symptoms, 2) a self-reliant approach that results in self-diagnosis after perusing readily available public health information, 3) an inclination to try medication, 4) a visit to the purveyors of this medication, who are treated as

mere "suppliers" of the desired medication, 5) a rejection of clinicians' judgement, including the diagnosis that they try to "put on." While self-reliance, for the traditional patient, had to be cultivated throughout decades of trial and error, it is for the modern skeptic a self-evident truth.

Clinicians' secondary role

For the modern skeptic, as demonstrated in Andrew's case, the natural attitude is one of initial mistrust towards psychiatrists; clinicians are screened, and those deemed out-of-touch are not conferred control over the epistemic aspects of disease. Jake's response, who diagnosed himself with depersonalization/derealization around three months after experiencing symptoms by accessing health data online, also captures this "modern" attitude:

> *Doctors will tell you different things… because DP/DR is not a well understood or well defined condition in medical literature… It is possible to work it out yourself. There are various tests available online to see if you have the symptoms…*

Unlike the traditional experience, today's skeptics have access to a depersonalization/derealization *illness culture*, which is largely infused by a collective mistrust of psychiatrists and a spirit of independence, relegating clinicians to a *secondary diagnostic role*. Sandra's portrayal of her first psychiatric visit typifies this reality:

> *It was the first time I met him* [the psychiatrist] *and I told him about my DP and the reason why I came to see him… he said I have a "severe personality disorder" and gave me a number to call… I didn't call… or went in again… I didn't feel very compatible with the doctor.*

Sandra rejects the doctor's evaluation, mentioning to the support group that she finds the term "personality disorder" inadequate. Addressing Sandra, an older patient encourages her perspective:

> *I wouldn't accept a diagnosis from a psychiatrist… I saw several psychiatrists over a period of 40 years… none of them ever game me an accurate diagnosis. I diagnosed myself after finding a case history in a neurological journal…*

Those affected by depersonalization/derealization, consequently, collectively treat psychiatrists' evaluations as marginal and often encourage self-diagnosis. According to Abugel (2010), patients' growing skepticism is foreseeable. After decades, "most accurate assessments come from… a handful of professionals who have experienced the disorder" (p. 107). Patients who believe to suffer from depersonalization/derealization are typically met with "a condescending nod and a prescription for a new anti-depressant, even though [they] have emphasized that [they] are not depressed at all" (p. 108).

Distrustful of clinicians, many modern skeptics opt for collectively sharing information, such as ready-at-hand frameworks that render their experiences sensible. In one typical scenario, a person affected by dissociative episodes asks the support group – "what convinced you it was DP?" He describes his symptoms and his fear of becoming psychotic. Another respondent, with the reputation of a diagnostician, articulates, "The fact that you're contemplating these thoughts… is what makes you fall under the latter category [depersonalization]. Someone with psychosis believes the delusions wholeheartedly and isn't able to question their beliefs" – he continues to list resources that may facilitate the diagnostic revelation of the initial inquirer. As

Sierra (2009) acknowledges, the growing circulation of health information and these virtual interactions have made it possible for lay people to frame their experiences:

> *In my experience, chronic depersonalization sufferers usually present their symptoms by means of highly rehearsed description, often plagued with technical or 'textbook' terms. This is not surprising, given the currently available access to relevant websites and discussion forums. One long-standing depersonalization disorder sufferer acknowledged this: "it has taken me years to learn how to describe what I feel"* (p. 56).

Respondents who lived through the Internet transition consequently believe that the democratization of information and the emergence of new diagnostic routes – particularly virtual support -- symbolizes a shift in which those susceptible to such disruptions come to make sense of their phenomenological states. The virtual dimension grants not only the possibility to address the intersubjective qualities of experience, find additional support, and facilitate self-reliance; it compensates, first and foremost, for what many respondents see as psychiatrists' recurrent uncertainty and failure to offer frameworks that render their symptoms discernible.

Via self-reliant efforts, "modern skeptics" often come to relegate clinicians to a "secondary role" – this implies, first, that subjects reject the diagnosis that clinicians suggest and opt for self-diagnostic endeavors, mistrustful of clinicians' interpretations. The online community compensates for what is perceived as clinical uncertainty, allowing people to legitimize their sensible destabilizations without the input of medical experts.

Second, since depersonalization/derealization has no clear evidence-based cure – yet another reason why people affected by these conditions become dissatisfied by psychiatrists --

people come to perceive treatment as a *collective experiment.* Those affected discuss experimental "cocktail" cures with those who share similar symptoms, which typically range from specific diets, supplements such as L-Theanine, medications (typically Zoloft or Lamotrogine). If skeptics belonging to patient-led groups visit clinicians for medication, they often do so with hopes of trying a medication that they have in mind, which they have already discussed with members from the community. Clinicians represent mere medication provisioners, not experts whose input will lead to a cure. Such patient-led treatment experimentation has been documented in other cases of self-diagnosable disorders for which medicine has not offered much respite, such as treatment for cluster headaches (Kemper and Bailey 2018).

Diagnostic Slippage

The potential to diagnose reinforces clinicians' epistemic posture and claim to authority (Jutel 2019). Yet, the case of depersonalization/derealization indicates that doctors' epistemic credibility may disintegrate. A diagnosis, once textually sedimented in the DSM, may possess cultural legitimacy in the eyes of observers (Schnittker 2017), becoming an independent, symbolic criterion. Psychiatric knowledge, therefore, propagates through a broad range of avenyes. Diagnoses may, under certain circumstances, slip away from clinicians and become susceptible to lay appropriation. One of these circumstances, as the responses in this study indicate, may occur when, having access to health information, patients collectively determine that clinicians remain *uncertain* about diagnosis.

The ability for social actors to disregard clinicians as primary diagnosticians is not indicative of medicine's authoritve demise. On the contrary, the diffusion of diagnostic criteria,

increasingly available to a lay public, is suggestive of a growing *dissemination* of medical discourses that social actors perceive, often, as the only legitimate explanations for a broad range of symptoms. Diagnostic categories may, therefore, fall into a diagnostic vacuum – a domain in which the traditional process of diagnostic revelation ruptures. A multiplicity of diagnostic routes, from online forums to books written by patients, emerge and to a large extent may displace the private doctor-patient relationship, providing new avenues and points of reference that guide the constitution of illness identity – enabling the expansion of a medical gaze. A primary diagnostic route for many people affected by symptoms associated with depersonalization/derealization today has become the Internet. As Robert posits:

> *I think internet has been an important tool for patients to isolate and find out quickly what is wrong with them… it is easier to find the correct diagnosis now than it was 10 years ago or 20 years ago.*

These new reference points not only provide a support structure, they may simultaneously foster a new modality of patient-led, diagnostic entrepreneurship. A new technique to publicly diagnose depersonalization/derealization, for example, involves online videos in which what may be called "patient influencers" – patients with multiple online followers -- identify and classify the symptomology of dissociative episodes to help their viewers find an immediate prognostication.

In one such video, Justin, an ex-patient, becomes the expert diagnostician. With a camera pointed towards his face, Justin promises to *"help [people] decide if [they] might have depersonalization."* "How do you know if you are depersonalized? What are the telltale signs?" asks Justin. The video contains a link to an online course lead by Justin which, for a payment of

$97, promises to "naturally and permanently" help patients "recover from depersonalization and derealization."

This constitutes an orientation concerning illness prognostication and treatment in which patients do not undergo a "narrative surrender" by relinquishing all elements of illness interpretation to the jurisdiction of clinicians. If, as Jutel (2009) writes, ownership concerns the assignment of authorship over illness, the case of depersonalization/derealization illustrates ways in which modern patients affected by rare disorders may increasingly claim possession over their narratives upon sensing that traditional medical routes are plagued with uncertainty, consciously questioning clinicians' capacity to diagnose.

Changing the Traditional Diagnostic Route

Social scientists have long distinguished illness from disease, with the former standing "for what the patient has when he (sic) goes to the doctor," and "disease" for what the patient "has on the way home from the doctor's office" (Cassell 1976, p. 28). This study elucidates emergent and categorical factors that may lead to the destabilization of this traditional diagnostic revelation process, resulting in what I have called "diagnostic slippage." The factors that have facilitated the disruption of the traditional patient-doctor relation encompass a cultural shift towards active patienthood, facilitated by the democratization of health information on the Internet (Lupton 1997, 2013; Timmermans 2020). Data from the 2019 US Health Information National Trends survey confirms that while 42.4% of US adults consult clinicians first for medical information, 44% use the Internet as their initial resource (HINTS 5). This has resulted in the growth of self-diagnosis (Semigran et al. 2015). Consequently, "Access to formal medical information is no longer confined within or controlled by medical institutions" (Jutel 2010, para. 4).

The expanded access to health data foregrounds that diagnoses are referential signs discoverable outside clinicians' offices. The growing transferability of classification systems means that patients may employ medical dictionaries, books, the Internet, or past personal experiences to diagnose themselves. While the Internet contains much misinformation leading to erroneous self-diagnosis, it may also help diagnosing rare and neglected conditions (Rodriguez and Rashid 2001; Bowman et al. 2010).

A "slippage" of medical classificatory systems may occur when social actors come to collectively perceive their self-diagnostic efforts as legitimate practices that *supersede* clinicians' traditional diagnostic role. Yet, role shifts in the power to diagnose do not in themselves automatically result in diagnostic slippage. A person who self-diagnoses him or herself with dyspepsia or the common cold has not henceforth questioned the capacity or legitimacy of clinicians to diagnose these conditions. In the case of certain contested illnesses, self-diagnostic practices may simply be steps in the search for official medical recognition (Barker 2005; Copelton and Valle 2009).

Diagnostic slippage involves an intersubjective component; it is rooted in peoples' *collectively elaborated attitudes,* who come to develop, after years of variable or contradictory diagnoses from clinical experts, an attitudinal reorientation in which they doubt clinicians' ability to provide a proper diagnosis. Diagnostic slippage alludes to a *negation*, not of medical knowledge, which it serves to *reinforce*, but of medical experts' claim to diagnostic expertise. One finds traces of the attitude central to diagnostic slippage in the case of conditions marked by medically unexplained symptoms. Stockl (2007), in her study of Systemic Lupus Erythematosus, notes that patients affected by SLE opt for a self-reliant attitude after years of diagnostic uncertainty. Stockl (2007) states:

> *People with SLE… doubt… the knowledge of… doctors. [They feel] that [they have] better experiential knowledge than [their] doctors* (p. 1556).

Self-diagnosis not only gives patients a diagnosis but also gives these medically neglected conditions an increased presence, denying clinicians' cultural command to define what constitutes a "true" disease while simultaneously bolstering the diffusion medical discourses.

The relevance for rare disorders

While clinicians generally mock people who, relying on Dr. Google, mistake a common cold for lung cancer, the case of depersonalization/derealization indicates that the democratization of health information is significant during instances of diagnostic complexity for rare conditions that already possess diagnostic legitimacy. People susceptible to prolonged diagnostic uncertainty may sense that everything is subjective. It is the access to additional sources, however, that validates patients' skepticism.

Patients subject to diagnostic odysseys may find that information found online, in medical dictionaries, or in support groups provides a better description of their embodied disruption than the doctor consultation. As Bowman et al. (2010) demonstrate, parents of children suffering from lysosomal storage disease often make a correct diagnosis by using the Internet after a long "doctor's delay" (p. 641). The possibility for patients to self-reliantly curtail their diagnostic odyssey, as exemplified in this study, may consolidate the process of diagnostic slippage.

In the case of depersonalization/derealization disorder, medical legitimacy has been established *ex ante*. The discernability of people's symptoms may be buried due to variable circumstances such as misinformation or lack of clinical research. If, relying on secondary

sources, patients come across a diagnosis that they deem appropriate, they do not question the authenticity of their symptoms. Instead, they question the competence and legitimacy of professional diagnosticians unable to provide answers. Under such circumstances, practices such as self-diagnosis cease having a neutral orientation towards clinicians' authority to diagnose; engaged skeptics, on the contrary, come to perceive their self-reliant enterprises as superior and may therefore claim ownership over their diagnosis. With the growing possibility for patients susceptible to diagnostic odysseys to seek alternative information, one may expect diagnostic slippage to increase in cases of rare or neglected illnesses.

The analytical crux of diagnostic slippage, therefore, is that it allows us to distinguish circumstances in which self-diagnosis ceases being either an endeavor that is impartial towards clinicians' claim to diagnostic expertise or a step in the search for official medical acceptance; a diagnostic slippage ensues, namely, when lay skeptics come to perceive clinicians' diagnostic authority as subsidiary to their self-diagnostic efforts. For this to occur, a diagnosis, as the case of depersonalization/derealization demonstrates, must possess predetermined legitimacy in social actors' eyes. It is for this reason that distinguishing whether patients self-diagnose in the instance of established medical conditions subject to medical uncertainty, as opposed to the case of contested illnesses, is of particular significance, for such differential circumstances may influence whether patients' self-diagnostic efforts ultimately result in a delegitimization of clinicians' status as diagnosticians.

Nevertheless, while such self-diagnostic endeavors undermine the traditional diagnostic role of clinicians in the case of depersonalization/derealization, it is ultimately the lingering power of psychiatry that persists in the diffusion of clinical nomenclature and the construction of patients narratives in terms of medical discourses. The experience of those belonging to

depersonalization/derealization patient-led communities, therefore, follows other instances in which the role of medicine may simultaneously expand and contract (Eyal et al. 2010). The case of depersonalization/derealization points to the *conceptual* propagation of psychiatric discourses, through which social actors come to account for experiences that they deem experientially deviant, while also indicating a delegitimization in the dimension of *traditional institutionalized practices*.

Conclusion

People belonging to patient-led communities, thus, embark on a journey to find an explanation for what they consider to be a deviation from a legitimate state of 'reality'. For those belonging to patient-led communities, the field of medicine is the only imaginable domain in which they may find a potential solution to their dissociative plague. The instance of patient-led communities elucidates how patients may appropriate clinical uncertainty for a diagnostic process that allows them to claim ownership over their own diagnostic criteria. The case of depersonalization/derealization indicates that such processes may emerge in response to years of misdiagnosis or failure to diagnose, which may lead to a culture of skepticism towards clinicians and traditional diagnostic procedures.

That said, it is premature to see the development of lay diagnostic expertise, as well as the capacity for patients to claim ownership over their diagnosis, as an irrevocable turning point in clinician's monopoly over diagnoses. The medical profession has long been able to appropriate and neutralize challenges of lay social movement to its jurisdiction (Starr 1982). Instances of diagnostic uncertainty, rather than weakening professional power, may reinforce the need for more professionally validated knowledge and nosological discrimination (Timmermans and Buchbinder 2010). One may hypothetically imagine how a diagnostic slippage, in the case of

depersonalization/derealization, may in the long run potentially result in psychiatrists being reminded that there is more expertise to catch-up with.

The case of patient-led communities, nevertheless, points to the emergent pathways which influence how people affected by rare or neglected disorders may now come to collectively cope with their diagnostic odyssey. As engaged skeptics with recourse to medical information, people affected by rare or conditions occupying a low status in the hierarchy of disease awareness, once at the mercy of medical experts, now theoretically have the option, even if unintentionally, to point clinicians to the "right direction" -- something that traditional patients affected by such conditions formerly found impossible.

Clinical interpretations, for those affected by symptoms associated with depersonalization/derealization, thus provide the explanatory tools that, in their eyes, solely account for dissociative states. People belonging to patient-led communities perceive their dissociative plight as a violation of the experiential dimension that a 'normal' human being must inhabit. Finding a community of people who share the same experiences, especially after years of medical uncertainty, allows sufferers to reorient themselves to the world and construct an illness identity. The construction of an illness identity entails, as Hacking contends (2002), the constitution of specific types of human beings. In this case, though self-reliant efforts, those affected by symptoms of depersonalization/derealization ongoingly produce and reproduce a specific type of human being: the depersonalized/derealized subject.

It follows that the subjects who, undergoing dissociative experiences, come to be labeled or who label themselves as depersonalized/derealized, produce and reproduce the normative standards that characterize such cultures they inhabit. Such sociocultural worlds, in this case Western culture, are characterized by their own modal qualities and expectancies, which become

embedded in the dimension of people's subjectivities. Let us note that the prefix "de-" indicates a "privation, a removal." The term de-personalization comprises a discourse in which people are said to be *deprived* of personhood, a breach of the conditions deemed necessary to meet a qualified standard. Similarly, "de-realization" is indicative of a *loss* of reality. One needs to only look at other cultures to observe that to be "deprived" of "reality" presupposes a cultural belief in the rational structure of a uniform world (Keifenheim 1999).

As I explore in the next chapter, instances of depersonalization/derealization, in contrast to the logic of those belonging to patient-led communities, need not be self-evident psychopathological disruptions. The human language offers the possibility to cultivate an array of interpretations for the broad range of felt experiences. The logic of medicine, despite its seeming self-evidence, has its contenders.

Chapter 3

Spiritual Cosmologies: A Contrast to the Diagnostic Route

Sociological and anthropological scholarship has long recognized that disruptive experiences may be interpreted via distinct cultural lenses (Foucault 2006; Hacking 2002). Certain studies, which are of primary relevance to the present dissertation, have specifically compared how the language of spirituality, in specific cultural contexts, may supersede the language of psychiatry to account for sensory-perceptual disruptions (Keifenheim 1999; Luhrmann et al. 2006; Scott 1999).

Hallucinatory episodes, typically perceived as pathological disruptions of a singular reality in the West, may represent superior states of reality in other traditions, such as the Cashinahua of Peru (Keifenheim 1999). Also exemplary, the embodied and sensory convulsions of Christian saints were, historically, collectively perceived as spiritual states; such episodes would now be subject to the language of medical diagnosis, respectively the category of epileptic seizures (Carrazana and Cheng 2011). Further, as demonstrated by the case of Suzanne Segal, dissociative experiences may come to be framed via the language of spirituality, as opposed to the language of pathology (Segal 1996).

Such juxtaposition between religious experiences and mental illnesses are, thus, *central* to the case of depersonalization/derealization. For those who employ the language of diagnosis, coming across medical interpretations of depersonalization/derealization symptoms constitutes a watershed moment in their confrontation with dissociative episodes – it marks, after a long diagnostic odyssey, the point in which people first find the interpretative tools to account for elusive, sensory-perceptual states. This research, however, suggests that medical discourses are

not the only interpretive frameworks that may account for dissociative episodes of depersonalization/derealization.

The APA (2013), in fact, recognizes that such experiences may be subject to distinct *evaluations* and *interpretations.* As stated in the DSM-5, depersonalization/derealization may "be a part of meditative practices that are prevalent in many religions and cultures and should not be diagnosed as a disorder" (p. 304). Instances of depersonalization/derealization, thus, may constitute either a *psychopathology* or instances *of spiritual beautification*. In certain cultures, in stark contrast to the experience of those who belong to patient-led communities, social actors may seek to *affirm* instances of depersonalization/derealization. I explore one of these cultures: the case of Vipassana meditation practitioners.

The Case of Meditators

The 19th century has seen the mass diffusion and popularization of meditative practices in the Western world. Meditation centers, once confined to remote corners and limited to small monastic Buddhist groups, are now prominent in most major cities worldwide. In the last century, various meditation movements emerging from the Buddhist tradition have risen in popularity. Amongst the meditation traditions that have gained popularity is the school of Vipassana mediation, a particularly demanding form of Buddhist meditation primarily characterized for its exacting meditative techniques, in which practitioners may often be expected to practice meditative techniques for up to eleven hours a day – aiming to induce altered sensory-perceptual states.

Today, thousands of Vipassana practitioners seek to experience alterations of their sensory-perceptual field by subjecting their bodies to contemplative practices. People, even those

"who… do not call themselves Buddhists," often "go to silent meditation retreats where they practice renunciation and embodied introspection, entering a process meant to lead to the de-stabilization of the experience of a permanent, stable self" (Pagis 2019, p. vi). Participants expose themselves to multi-level processes that transform their orientation towards the world "not only in the symbolic, abstract level but at the level of embodied semiotics" (Pagis 2019, p. vi). Through embodied processes, people attempt to "detach from external contexts that stabilize self and experience" (Pagis 2019, p. vii, emphasis added).

Central to the sensory destabilizations found in Buddhist meditation, as mentioned in the first chapter, is the concept of anattā, translated as "no-self" (Engler 2003). The doctrine of *anattā* can be understood as Buddhism's central premise of the self's impermanence. As Rahula explains:

> *What we call 'I', or 'being', is only a combination of physical and mental aggregates, which are working together interdependently in a flux of momentary change within the law of cause and effect, and that there is nothing permanent, everlasting, unchanging and eternal in the whole of existence (Rahula, 1967, p. 66).*

In the canonical *Milinda Panha*, a monk, known as Nagasena, conveys the concept of anatta as he ruminates on his name: "this designation, this conceptual term, a current appellation and a mere name," adding that "In ultimate reality, however, the person cannot be apprehended' (Conze 1959, p.149). Similarly, in the Visuddhimagga, Buddhagosa writes: "For there is ill but

none to feel it; For there is action but no doer; And there is peace, but no-one to enjoy it; A way there is, but no-one goes it" (Pérez-Remón 1980, p. 11).

Buddhist beliefs target the notion of an ontological self, positing that the self is an illusion, which "cannot be found in the constituents of experience" (Engler 2003, p. 53). The aim of this tradition is to escape one's attachment to a chimerical self and world; only then may one achieve happiness. Through meditative practices, Buddhist tenets may be "experienced on the bodily level and thereby…'realized' as truth" (Pagis 2010, p. 469; see also Engler 2003). Today, thousands of people worldwide seek 'transcendence' via meditation-induced sensory alterations, aspiring to experience a felt dissociation. "Meditation," according to psychiatric literature, may thus "cause depersonalization and derealization" (Castillo 1990, p. 158).

Instrumentalizing Dissociation

Considering that people who practice Vipassana meditation may confront sensory perceptual states akin to depersonalization/derealization, the opportunity to explore how people may interpret similar dissociative states distinctly becomes possible. In the process of this comparison, I move beyond the question of *whether* culture matters to *how* culture matters. I elucidate specific sociocultural factors that influence why similar sensory dislocations may be appraised as destructive, negative, morbid, while they may also be seen as the pathways to a 'higher' human potential. I argue that the senses are made 'sensible' (or insensible) through what I call *sensory instrumentalization*. Whether social actors interpret these sensory destabilizations as pathological or aspirational is largely influenced by the presence of a practical culture in which self-possession and self-actualization become cultural imperatives (Adams et al. 2019; Boli 1995; Pulfrey and Butera 2013; Teo 2018). Meditative induced dissociation, despite often

experienced as frightful, is rendered aspirational because it is capable of being absorbed into a logic of *instrumental action*.

Building on Weber's renowned historical analysis of rationality, social scientists and psychologists posit that the realm of rationalized action, in the West, has become a growing "dominant institutional sphere… a dominant moral order" (Boli 1995, p. 101; see also Adams et al. 2019; Pulfrey and Butera 2013; Teo 2018). The expansion of rationalized behavior, rooted in the economy, may traverse into daily life, influencing a variability of people's subjective orientations and behaviors, often resulting in an "entrepreneurial understanding of self as an ongoing development project" guided by an imperative for "personal growth and fulfillment" (Adams et al. 2019, p. 189).

The sphere of rationalized action has, in fact, come to influence the 'con-sensual' meanings that people attach to sensory perception (Le Devedec 2020; Moore 2018). Westerners, according to growing literature, increasingly appraise and pattern the sensory dimension in terms of its "functionality," "practicality," and potential to foster pragmatic "self-actualization" (Le Devedec 2020; Moore 2018; Pustovrh et al. 2018).

The treatment of the sensory dimension as instrumental has led to the emergence of various self-enhancement procedures and industries such as "sophisticated prosthetic applications that may provide specialized sensory input or mechanical output" (Coenen et al. 2009, p. 6), psychostimulants to enhance concentration in the workplace (Pustovrh et al. 2018), "sensory algorithmic devices" that intend to improve "subjective productivity and wellbeing" (Moore 2018, p. 39), or even architectural structures that increase efficiency via designs that "appeal" to the senses (Golzar and Nia 2016).

Trends concerning the instrumentalization of embodied sensibility influenced how Eastern spiritual practices have become incorporated in Western culture (Karjalainen et al. 2019; Purser 2018). Programs related to embodied practices of contemplation and spirituality, which may produce sensory-perceptual disruptions, used to be categorized as inherently *pathological*. This perspective is reflected in the Group of the Advancement of Psychiatry's discourse, whose representatives wrote in the 1960s that "the obvious similarities between schizophrenic regressions and the practices of yoga and Zen merely indicate that the general trend in oriental cultures is to withdraw into the self from an overbearingly difficult physical and social reality" (Alexander and Selesnick 1966, p. 457).

Such meditative practices, however, have become not only increasingly tolerated in Western society, but they now form part of a growing market renowned for its pragmatic and instrumental promises to provide people with tools for "achieving happiness, well-being, and career success" (Purser 2018). Meditative practices and its related effects, as Karjalainen et al. (2019, p. 3) write, now constitute a "model of corporate intervention emerged amid preoccupations of self-enhancement and individual achievement characteristic of neoliberal… transformations." Such trends have further been documented in cases such as "Western neoshamanism;" Ayahuasca consumption has become increasing popular in the West as people aim to undergo "a spiritual quest for 'personal growth' that appears to reproduce classic Western notions of material possession" (Gearin and Saez 2021, p. 148).

I show that the growing treatment of meditative-induced dissociation as an experiential product that may foster personal growth has made it possible for social actors to instrumentalize *disruptive* sensory states that, according to the APA, may otherwise be classified as depersonalization/derealization. Unlike those medically diagnosed with

depersonalization/derealization, meditators have recourse to collectively elaborated meanings that allow them to 'con-sensually' rationalize destabilizing sensory episodes as components of the path to 'self-actualization'; I call this process *sensory instrumentalization.* I argue that the presence of practical culture, therefore, is a demarcating index that influences whether states of dissociation, once intrinsically relegated to the realm of pathology in the West, have come to be perceived as acceptable.

This comparative study provides valuable insights into the relation between "sociocultural scripts and norms" and sensible phenomena (Low 2012, p. 275). As Howes (2003, p. xii) writes, the senses may be "structured and invested with meaning in many different ways." By exploring the specific 'con-sensual' meanings that people employ to distinctly organize sensory disruptions, I elucidate the influence that the cultural worldviews through which people render their lives meaningful -- what people conjointly consider appropriate or inappropriate, fearful or aspirational, problematic or meritorious – have over the subjective dimension of felt, sensory experience (Howes 2003). The comparison of patient-led communities to active meditators, therefore, contributes to our understanding of the interconnection between macro and micro dimensions of experience.

Confronting Depersonalization/Derealization and Meditative Dissociation

> *In Vipassana... the goal is... open concentration. Scan your body, and feel everything there… Do not react… If you encounter urges… just… observe...*

Johnny, a twenty-six-year-old who participated in a meditation retreat, explains the premise of the Vipassana tradition; it encompasses an action of embodied awareness. Such prolonged focus on the tacit dimension of the body may bring forth an embodied, experiential

detachment from the felt world. Diego, who is twenty-eight and began practicing Vipassana meditation two years ago, describes an episode he underwent while meditating:

> *I had an experience as if there was a video camera… between my eyes and I was watching everything through it… it felt as if my own body was doing things on its own... I just watched it move... it scared me. This experience lasted for… days...*

One may contrast Diego's description with Albert's experience, who is diagnosed diagnosed with depersonalization/derealization:

> *At least a few times… My voice doesn't sound like my own voice and things like that... this is maybe like level one… When it goes to ten on the scale… basically I don't feel myself at all. It's some kind of… synesthesia… of the senses…*

These two excerpts elucidate dissociative phenomenological states that, based on the DSM-5's guidelines, may be categorized as episodes of depersonalization/derealization. These felt experiences entail anxiety-inducing sensory disruptions, which may last from days to months and recur for years, that cause people to feel defamiliarized from their own bodies and a previously taken-for-granted state of 'reality'. Despite the dissociative similarities, however, Albert understands his dissociative episodes as a mental illness. Diego, on the other hand, perceives these destabilizing occurrences as spiritual enhancement.

How does one reconcile that similar sensory destabilizations may possess opposite valuations? In the following, I explore these themes via a series of steps: 1) I first elucidate how the somatic qualities of depersonalization/derealization and meditative-induced dissociation,

which encompass *vague* sensible disruptions, engender *interpretive demands*; 2) I subsequently explore how meditators, through the process of *sensory instrumentalization,* employ the language of spirituality to render such destabilizations intelligible. The presence of a practical culture, I contend, leads meditators to evaluate dissociative episodes as instrumental to 'self-growth'; 3) lastly, I contrast how people diagnosed by depersonalization/derealization employ the language of psychiatry to 'con-sensually' frame similar sensory dislocations, exploring, in the process, the distinctions between the cosmological orders of psychiatry and spirituality.

Responding to Interpretive Demands

The data suggests that both meditators and people diagnosed with depersonalization/derealization describe their initial confrontation with dissociative episodes, *despite their distinct starting points*, as disruptive *shocks* that *escape immediate explanation*. These shocks, for both medical patients and those who initially evoke such episodes volitionally, produce what Schutz (1972) conceptualizes as disturbances of the world of commonsense and, thus, *compel* cultural interpretations. Take, for example, Michael's description:

> *A few months ago I attended a 10-day Vipassana retreat in the tradition of Goenka… on the 4th day the actual Vipassana was taught… I started to experience strange sensations. I would feel as if I didn't have a body... for the next week I felt like I was disappearing into nothingness…without a self... I thought I may be going insane or that I did something wrong… I talked to many different people since who told me that I… experienced the beginning of an ego dissolution and that I fought it, while I should have let myself go… it sounds like a pretty normal scenario in Buddhist teachings…*

Michael, a recent college graduate who began meditating to deal with his depression, experiences his meditative-induced dissociation as a frightful predicament that lacks immediate intelligibility. In fact, Michael initially resorts to a *psychiatric* interpretation. With the subsequent aid of other meditators, however, Michael's embodied destabilization gains a sensible organization; he comes to frame his experience as the beginning of *anattā*, as opposed to madness, which he fails to achieve because he has resisted 'letting go' of the ego-driven desire to remain in control. In this manner, such disruptive state acquires a comprehensive *meaning*; it begins to sound, as Michael states, "like a pretty normal scenario."

The data reveals a parallel in the case of depersonalization/derealization, in which respondents, akin to meditators, describe their initial dissociative episodes as disruptions that escape immediate comprehension. Albert, who began experiencing recurrent dissociation after experimenting with psychedelic drugs, states:

> *At the time [when his symptoms began] I had no idea what it was… How do you feel out what you have if you don't… know about this thing… I remember I was in my mother's room, and told her… 'I don't know what's going on.' She told me to go to the doctor.*

Dissociative destabilizations, for both meditators and people diagnosed with depersonalization/derealization, do not contain an immediate 'sense' – the data shows that in both cases, people must *learn* to attend to the *interpretive demands* engendered by such dissociative episodes. Via publicly elaborated processes, people come to learn that they are either depersonalized/derealized or on the path to enlightenment. This reality is manifested by the fact that people may *switch* interpretations, as documented in psychiatric literature (Castillo 1990;

Kenney 1976). Castillo (1990), in his analysis of psychiatric case studies, discusses an instance concerning a patient affected by depersonalization/derealization that is of particular relevance:

> *The patient (a 37-year-old businessman) developed the feeling of being outside his body and looking down on himself after experimenting with a series of meditative exercises… depersonalization and derealization experiences began to occur spontaneously· and uncontrollably. The patient sought admission at a local hospital and was treated with tranquilizers and released… the tranquilizers…seemed to exacerbate his feelings of unreality... On the advice of a friend he sought help from a Yoga instructor. The patient stayed with the Yoga instructor for several days, learning about his experiences from the perspective of Yoga psychology. He was then able to return to work, even though the episodes continued to occur, because he felt he had gained enough insight into the occurrences so that he was no longer bothered by them…* (p. 161).

People affected by these dissociative disruptions, whether induced through meditation or experienced spontaneously, thus rely on cultural significations to organize an array of pre-predicative feelings, only through such meaning-making processes do they situate elusive sensations under the umbrella of a comprehensible order, whether this order entails the language of diagnosis or spiritual frameworks. What are the parallels and contrasts between both sensory cultures?

Instrumental Rationalization: The Case of Meditators

While both, those diagnosed with depersonalization/derealization and those who experience meditative-induced dissociation must learn to make their sensory re-attunements

intelligible, the data shows a major distinction between the two cases: meditators who confront prolonged states of dissociation, through spiritual interpretations, may learn to affirm such episodes as *acceptable* and, often, as *instrumental* states.

Such instances of affirmation are primarily pertinent in cases when meditators undergo *repeated* or *prolonged* disruptive somatic destabilizations. Most casual meditators do not confront dissociative experiences; if they do, they *make immediate amends to escape*. As Pagis (2019) reports in her study on Vipassana meditation:

> *I encountered a meditator that experienced an experience of flow... as she put it, her body completely disappeared… instead of this feeling leading to a realization of the Buddhist ultimate truth, she panicked. In an effort to regain her hold on reality, she moved. Moving… brings the world back as attention shifts to the outer lining of experience. She got her "ordinary self" back* (p. 142).

There are instances, however, in which meditators do *not* immediately 'dial back', resulting in recurrent or long-lasting states of meditative-induced dissociation. Under these circumstances, through the process of *sensory instrumentalization,* meditators collectively learn to rationalize disruptive sensory shocks as components in the path to self-actualization.

The "Quest" to Self-Actualization

The case of Anne, who, in a phone interview described that she began meditating to "find a more meaningful life," elucidates the instance of instrumental rationalization. Anne, whose search for *anattā* continues, explains that she has, with the help of other meditative practitioners, come to learn that the journey to *anattā* is "a slow process." In the excerpt below, Anne asks meditators online to help her make sense of her recurrent dissociative episodes:

Anne: *Recently when I have been meditating I have been experiencing what seems like I see my eyelids behind my eyes… I have had a couple times where… my mind is off and… there is no me there… there's just what I am staring at, which is way too overwhelming… Am I doing something wrong?... I have felt like I could go insane.*

Another mediator, playing the role of the expert diagnostician, advises:

The experience you are describing is shaking the fundaments of the self. It is a part of the way, though…

The data reveals multiple scenarios in which meditators, by collectively employing spiritual explanatory tools, recurrently frame sensory destabilizations as rational enterprises conducive to spiritual 'self-growth'. Sebastian, who has been confronting on-and-off effects of meditative-induced dissociation for *months*, has an interaction that parallels Anne's case:

Sebastian posts online*: I have been struggling for 3.5 months now… fear came up in March and instead of accepting it, I resisted it… I cannot feel my body very much… I have been… stuck for months now… Is there some sort of thing I can do?…*

Sebastian's inquiry leads to a discussion in which various meditators, while encouraging Sebastian to proceed carefully, attempt to help him understand that sensory disruptions are comprehensible occurrences in the torturous path to spiritual self-actualization, highlighting the logic of *acceptance*. The following response is particularly illuminating:

Notice what your experience is like, it's… a bundle of thoughts, feelings, physical sensations, memories or associations... You can believe its content and let fear or despair run free, or you can detach from the thought and choose to look at the process… Equanimity doesn't mean absence of unpleasant experiences, it just means you're able to stay with these experiences... Being at peace with… fear. Mindfulness, acceptance... it is a process and it will take time!... until you (your body-mind) learns how to handle these unpleasant internal and external events in a skillful way… I'm sorry you're suffering, but wishing to find a fix… is just prolong [sp] *your suffering…It is hard, but you can do this work… we're all doing it... exploring, learning our way out of the suffering. You're not alone in this, but only you can do this work…*

Relying on Buddhist discourses, meditators engage in collective meaning-making processes to attend to the interpretive demands of their sensible disruptions, 'con-sensually' appraising sensory detachments as episodes that may not only be common in the *quest* towards the no-self, but even *necessary.* By *learning to cease fearing* these episodes, according to this tradition, suffering will eventually disappear in the path to self-actualization. The strange terrains of this dissociative odyssey, in fact, are *meant* to be frightful. As Engler (2003), a psychologist who has embarked on the path to *anattā*, writes about his 'journey':

It is one thing to… acknowledge emptiness of self and… to actually experience emptiness of self moment to moment… when I take myself to be that separate, ongoing "entity residing within"… any realization of this self's inherent emptiness as a… moment-to-moment construction can only be profoundly disturbing. That accounts for its pervasiveness and its resistance to meditative

inquiry and insight… this… makes the confrontation with selflessness or "emptiness" in the higher stages of meditative practices so terrifying (p. 78).

In this manner, meditators who confront long-lasting or repeated disruptive sensory states situate sensory destabilizations as part of the 'grand scheme'. One must, paradoxically, experientially lose the self – via shocking and disruptive sensible experiences with ensuing effects that may last days, weeks, months – in order to *actualize the self* by incrementally attaining *mastery* over one's soteriological destiny. As Manuel, a 41-year-old linguist seeking *anattā*, further advises Sebastian online:

> *Don't resist the fear... learn to sit with it. If you begin to shake, let yourself shake and lie down… do nothing… when the terrible feelings come. The Holy Buddha promised that all things shall pass, even our darkest moments. Happiness is waiting, if we "just be." Even our darkest moments are just thoughts generated by the mind…*

In a subsequent interview, Manuel added:

> *When you feel strange [dissociation]… there is fear and panic… because we're ignorant about ultimate reality… This still happens, but I'm learning it's just a delusion… Buddhism is about learning to... be in the here and now… ending suffering and becoming… friends with yourself.*

Through multiple venues – such as collective discussions, exposure to meditative literature, or even the guidance of spiritual leaders -- meditators inhabit a context in which they have access to frameworks that *rationalize* dissociative occurrences. Meditators rely on

spiritual discourses to develop an *unresisting attitude* toward such states, situating their experiences within a narrative of self-actualization. Psychiatric literature indicates that these spiritual interpretations, in fact, may facilitate people's ability to *cope* with and *endure* disruptive sensations (Castillo 1990; Kennedy 1976). Chriss' description concerning how he handles the anxiety that ensues during recurrent dissociative states is exemplary:

> *When my anxiety is super high, I get feelings that everything is closing in on me… it's terribly frightening and I think I am going crazy… I'm learning to be fine with it, I tell myself; 'I accept it'… Buddhism requires us to accept all feelings and sensations… we cling to the rejection of the terrible feelings and sensations.*

The process of sensory instrumentalization is, in essence, teleological; it presupposes a *destiny* for which dissociative episodes are merely logical functions in a linear path that will – if one learns to accept – culminate in spiritual self-fulfillment. Through these processes, meditators learn to conceive disruptive states of dissociation as *legitimate*. As opposed to medical interpretations, meditation practitioners do not automatically perceive their dissociative episodes as signs of a *disorder*. This is a significant contrast, as evinced in the following description about depersonalization/derealization to the experience of those who employ a diagnostic language.

Contrast to Diagnostic Rationalization

One observes a stark similarity and, simultaneously, a distinction in the narratives of those affected by depersonalization/derealization. Those suffering from these dissociative conditions, like meditators who do not instantly dial back, describe sensible disruptions that induce a feeling of detachment from their bodies, sense of self, and 'reality'. As Albert mentions:

...It kind of feels like you are in some kind of jelly… when you start to fall asleep, you start… not to feel the bed at some point… then you normally go to sleep… the problem is that… in that state I can wake up and my body doesn't wake up…

Like meditators, people affected by depersonalization/derealization remain conscious and reflective about their predicament. This is why they, too, long for an *explanation* that renders such sensory destabilizations comprehensible. In search for an explication, which immediate friends and family generally are unable to offer, those affected by depersonalization/derealization, as discussed in the previous chapter, tend to undergo two trajectories: A) For some, consulting medical professionals becomes the immediate logical step. B) Increasingly, people take advantage of the democratization of health information, searching for their symptoms on the Internet or in medical textbooks; in the process, they self-diagnose themselves with depersonalization/derealization.

The categorization of these experiences through medical categories, regardless of how people come across these frameworks, serves a comparable function as Buddhist discourses: the language of psychiatry structures people's disturbing sensory-perceptual episodes by locating them in an interpersonal, sociocultural dimension. Respondents generally describe coming across relevant medical information, or communities of people sharing similar symptoms, as a *relief,* for it grants social actors the possibility to 'map out' their sensible alterations under the umbrella of a comprehensive order. A medical diagnosis, therefore, can be the beginning for patients to regain control over their psychological destiny. As Albert said:

I would feel pretty alone if I wouldn't have found this community... you can categorize things… it makes you feel somehow safe… the feeling that at least you can put a label on this thing because you see that other people are having exactly that… same thing.

The Quest to Nowhere

Yet, while the language of medicine provides the cultural tools for people to 'con-sensually' map out their experiences, a significant contrast remains between meditative practitioners and those diagnosed with depersonalization/derealization: respondents affected by depersonalization/derealization, while finding solace in a diagnosis, describe enduring these sensible destabilizations without 'good reason', a sentiment exacerbated by the fact that medical practice has not offered an official cure for such episodes. Unlike Vipassana orientations, the language of medicine is primarily preoccupied with etiological and prognostic concerns; it does not employ an arsenal of metaphysical speculations through which such episodes may come to be rendered either *acceptable* or *teleologically aspirational*.

Those diagnosed with depersonalization/derealization, when dissociative symptoms surface, confront the felt dissolution into a *no-self* without the assurance of a forthcoming spiritual serenity. Instead, respondents appraise such episodes as *illegitimate* deviations from the 'normal', singular world. As Miguel posits, "The biggest thing… is the feeling of… not being authentic... It's just not the same as a normal reality that a normal person would experience…"

"Reality" and "self," in this instance, do not denote philosophical speculations about the ontological elements of existence, as in meditators' descriptions. These terms allude, purely, to an experiential state that had hitherto existed as a habitual sensorial world for respondents, which they recognize as the world that 'normal' people *ought to* inhabit. It is in this manner that

respondents perceive their sensory destabilization as a *transgression* from the world 'known in common', and consequently as a *disorder*. As Castillo (1990) posits:

> *The response of the individual to depersonalization and derealization seems to be quite variable and subject to shaping by social and cultural factors. The 'mythic world' of some individuals, lacking any other alternative for depersonalization/derealization, may be pathologizing what could be viewed as a normal experience, transforming it into an episode of mental illness* (p. 167).

The contrast between the meanings, or mythic worlds, that meditative practitioners and those diagnosed with depersonalization/derealization employ to make such experiences legible becomes evident when people who rely on the language of diagnosis discuss themes that are central in spiritual discourses. One observes this in the case of Max, who posts in the depersonalization/derealization online forum:

> *I… feel like I don't… exist anymore… I feel like I am just experiencing everything consciously, emotionally, and somatically, but there is no "me" that is experiencing it… It's terrifying… a loss of self is… threatening to me… Just wondering if anyone can relate to feeling like there is no actual person inside…*

One may imagine how meditators, for whom losing the self is conceived as an *achievement*, would prospectively respond to this inquiry, or at least the themes that Vipassana meditative practitioners would pick up on. Yet, in this instance, the community of people who employ the language of diagnosis do not raise any discussions about the significance of the "no-self," "acceptance," "purification, "the quest." Instead, ensuing responses address, strictly,

themes concerning diagnosis, prognosis, or potential cocktail cures to mitigate symptoms. A person responds to Max's inquiry: "A classic and usual symptom of DP." Another asks, "Are you taking therapy? Assuming you haven't that would certainly assist you..." A third person, in stark contrast to meditators' espousal of acceptance, suggests practical techniques that may help Max "grab [depersonalization/derealization] by the throat."

What one observes, in other words, are two distinct 'con-sensual' positions. The language of spirituality and the language of diagnosis encompass not only different ways of categorizing such dissociative experiences, but distinct *cosmic orders* – that is, different comprehensive cultural orientations, expectancies, and modes of evaluating what is significant or insignificant about such dissociative sensory episodes, aspirational or problematic, worthy or unworthy of even being brought up to discussion to begin with. Such distinctions have been documented in the case of other mental, physical, or emotional states that members of a society find disruptive (Obeyesekere 1985). Spiritual discourses, for example, often define the constellation of symptoms that psychiatry terms *depression* as existential vicissitudes that must be accepted, not in terms of illness that requires treatment (Obeyesekere 1985).

The data here reveals that those who inhabit a meditative culture, through spiritual discourses, situate sensations of 'unreality' as elements in a path to 'transcendence'; those diagnosed with depersonalization/derealization, on the other hand, describe dissociative states of 'unreality' as *pointless* – inexcusable detachments from a 'normal' world. This sensation of pointlessness may exacerbate people's anxiety. Jonathan's description captures this reality:

> *You lose that sense of comfort… You… start wondering, "Maybe this is all meaningless..." I think that's probably what makes me panic…*

Lacking cultural recourse to interpret the loss of self and the detachment from reality as a desirable *destiny*, those diagnosed with depersonalization/derealization tend to interpret experiencing the 'no-self' and 'unreality' in one way – as a *depletion*. Or, metaphorically speaking, as a "quest to nowhere." As Alex, who has been confronting on-and-off dissociative episodes for seven months and has been diagnosed with depersonalization/derealization, states:

> *If you're in a dream… it… depletes the value in life. I wouldn't want to have my experiences erased just because none of it was real…*

Between Enlightenment and Madness

Drawing from the comparative analysis of respondents' narratives – who inhabit two distinct sensory cultures -- it becomes possible to discuss the factors that influence whether social actors interpret dissociative episodes as acceptable or pathological, as well as the consequences of these interpretations. According to the APA (2013), the experiential predicaments associated with depersonalization/derealization become a *disorder* when those "who initially induce these states intentionally... over time lose control over them and may develop a fear and aversion for related practices" (p. 304). My research offers two critical qualifications of the APA's assumptions: a) the concept of 'control' needs qualification, for its meaning is not obvious, and b) as this comparative study demonstrates, the APA's definition overlooks the collective processes through which social actors, even in the face of fear and aversion, may continue to render their experiences meaningful as spiritual occurrences.

Beginning with the qualification of control -- one can think of various ways in which control over one's sensible body may be destabilized or rescinded through external pressures, such cases may involve the sensory agony of the homeless (Desjerlais 1997), or the sensible

experiences of undocumented immigrants undergoing persecution (Willen 2019). Hedva (2016), an artist affected by depersonalization/derealization, who now advocates for empowering "de-persons," similarly points out:

> *I have been diagnosed with depersonalization/derealization disorder… at various times, my body, self, environment, and the world itself do not feel real… I'd like to ask the APA… what about derealization when the state has detached your environment from you, dispossessed you of your land, or turned your surroundings into something unbearable, something that cannot possibly be real?* (para. 1-16).

What the APA implies by control, therefore, is not *control in-itself*, but an institutionally defined standard for *self-possession*. This type of medical definition is influenced by a cultural and political dimension in which sustaining dominion over one's embodied comportment is an index for appraising people's *worth* (Russell 2011). The sociocultural context of the APA's definition is further evidenced by instances in which what is classified as an obvious loss of control in the West has been con-sensually interpreted otherwise cross-culturally. For instance, while hallucinatory episodes are perceived as disruptions of sensory control by Western standards, they may represent legitimate states of reality in other cultural traditions (Keifenheim 1999). Or, embodied ecstatic seizures rather than being indicative of epileptic disruptions, may be collectively appraised as spiritual raptures (Carrazana and Cheng 2011).

To contextualize the issue of control is not to deny its qualitative significance in the phenomenological experiences of people affected by depersonalization/derealization, nor to question the utility of psychiatry. Rather, I argue that control over sensory experience, defined in the DSM-5 as *the index* through which dissociative episodes may be defined as pathological, is

inseparable from sociocultural con-sensual standards, or, in other words, “prevailing normative social prescriptions” (Kaplan 1964, p. xi).

Secondly, as demonstrated in the case of Vipassana meditative practitioners, social actors, despite experiencing fear and aversion, may nevertheless continue to define their dissociative experiences as spiritual occurrences. The meanings that people attach to destabilizing experiences may, in fact, *mitigate* disruptive symptoms (Castillo 1990; Kennedy 1976; Luhrmann 2006). Luhrmann’s (2006) cross-cultural study about schizophrenia demonstrates, for example, that cultural perspectives influence whether people experience hallucinations in a “positive” or “negative” light. Concerning depersonalization/derealization, Kennedy (1976) similarly concluded:

> *The presence or absence of panic/anxiety in association with depersonalization can be a function of the nature of the ideational construction of the experience in the mind of the individual… if the individual holds catastrophic interpretations of this state, such as, "I am going crazy"… then a panic/anxiety response may result. However, if in the same situation the individual interprets the episode with the thought, "I am having a sacred experience:’ then an entirely different bodily response may develop*… (p. 1327).

Respondents’ narratives and psychiatric case studies suggest that the presence of cultural ideations that *rationalize* instances of sensory dissociation as steps to spiritual beautification allows social actors to manage and cope with their symptoms. A more benign interpretation of such symptoms offers a pathway towards “symbolic healing” (Dow 1986), leading observers to

suggest that "perhaps what we need to do with patients who exhibit primarily a depersonalization syndrome is to teach them…to accept their depersonalization" (Kennedy 1976, p. 1327).

At the same time, religious worldviews do not always lead to the instrumentalization of disruptive experiences. Distinct spiritual languages may offer room for interpreting disruptive states as spiritual descent without serenity (James 1902). Further, the languages of spirituality and medicine are not necessarily *mutually exclusive*; meditators confronting prolonged dissociation may also incorporate psychiatric terminology or practices, such as therapy, in conjunction with spiritual meanings. Some Vipassana practitioners additionally reject the rationalization of dissociative states, warning against specific meditative techniques that could induce recurrent embodied destabilizations; therefore, intracultural variation exists.

In general, however, this study shows that social actors may organize similar disruptive sensations through distinct symbolic valuations. In the case of meditators, the logic of self-actualization provides a pathway to affirm sensory disruptions, thus allowing social actors to construe such episodes as *instrumental*. The arsenal of Eastern spiritual practices that have become incorporated into the West have become renowned for their *practical* logic (Karjalainen et al. 2019); this may help explain why disruptive meditation-induced sensory destabilizations, previously considered intrinsically pathological by the Group of the Advancement of Psychiatry, have grown increasingly popular.

Practicality versus Impracticality

Building on Weber, social scientists recognize that a growing "dominant moral order" in the Western world encompasses the pursuit of purpose and meaning via *rationalized action* (Adams et al. 2019; Boli 1995; Pulfrey and Butera 2013; Teo 2018). This leads people to "establish a parallelism between" their "individual lives and ultimate reality… translating

abstract Meaning and Purpose and Order into the meaning and purpose and order of… existence" (Boli 1995, p. 107). Subject to the rationality of the economic world, it becomes common to treat oneself as a rational project that ought to be ongoingly "enhanced" or "realized" (Adams et al. 2019; Teo 2018), leading to the growth of "experiential products" and "personal enhancement industries," such as education and therapy (Boli 1995, p. 108). Self-enhancement industries have targeted people's relation to their senses, such as sensory tracking technologies intended to foster subjective well-being and productivity (Moore 2018), medical or nonmedical drugs that alter sensory-perception to increase generative capacity (Pustovrh et al. 2018), or "self-care" techniques (Rubin 2001). These divergent enhancement processes share their treatment of embodied sensibility as a locus in which rationalized action may be meaningfully and instrumentally enacted.

The growing popularity of Vipassana meditative practices can be situated in these larger cultural developments (Karjalainen et al. 2019; Purser 2018; Rubin 2001). Casual meditators tend to go to meditative retreats to 'recalibrate' by focusing on their interiority, aiming to attain pragmatic goals such as the reduction of stress and anxiety (Rubin 2001). Devoted practitioners pursue a soteriological goal; via disruptive dissociative states, they seek the attainment of a spiritual beautification that promises to eradicate "the root of all self-generated suffering" (Engler 2003, p. 88). Practitioners may then hermeneutically render sensory alterations as *pragmatic* events to improve one's latent potentialities through a process of *sensory instrumentalization*.

In contrast, those diagnosed with depersonalization/derealization, while confronting similar sensory destabilizations, do not speak of these practical orientations, but generally of an estrangement of self in which the possibilities to transform such sensory episodes into logical

pathways to rational self-enhancement are lacking. Despite similarities with the phenomenological loss of self that meditators experience, depersonalization/derealization is not, in respondents' eyes, amenable to the quest to spiritual self-actualization.

To suffer from depersonalization/derealization *disorder*, therefore, is not merely to undergo a detachment from an interpersonal sensibility through felt destabilizations, but to experience such deviation as a privation of a *rational* organization of self. Within the logic of a cultural classificatory system that lionizes practical 'self-growth,' this destitution of pragmatic control gains its pathological connotation due to its eminent *pointlessness*; it becomes a disruption without 'higher purpose.' In contrast, meditative induced dissociation has become increasingly accepted because it is capable of being absorbed into the logic of *rationalized action*. As this study indicates, meditators largely justify sensory disruptions insofar as they offer a pathway to 'self-actualization.'

To suggest that cultural preconditions influence whether dissociative disruptions are acceptable or not is not to undermine the suffering of those who experience dissociative instances, nor is my aim to critique psychiatric or spiritual viewpoints. As respondents articulated, both sensory cultures may help people reorient themselves to the world. Rather, the differentiation of dissociative conditions as either aspirational or pathological is largely mediated by cultural mythic worldviews that pattern what such sensible destabilizations, which are not immediately self-evident, *represent*. Such differentiation, being inseparable from culturally situated 'con-sensual' perspectives, is, therefore, a social learning process.

Conclusion

This research suggests that people's relation to the world's sensible qualities cannot be conceptualized exclusively in biological or neurological terms. The case of dissociative

disruptions and their interpretative demands makes it possible to observe how social actors – influenced by contextual semiotic orders and interpersonal relations – engage in somatic work to render vague experiences *sensible*. Via these processes, sensation ceases being a self-evident, organoleptic entity; it constitutes a multidimensional *social practice*.

In this study, I identify the presence of a practical culture that affects how social actors interpret their sensory experiences. This has led to the popularization of various industries and practices, which treat the sensible dimension as a locus through which rationalized action may be materialized. In the instance of dissociative experiences associated with depersonalization/derealization, these criteria influence what social actors render pathological or spiritually aspirational. Respondents' narratives demonstrate that social actors may rationalize disruptive experiences as components of the quest to self-actualization, a process I have called *sensory instrumentalization*. Social scientists have principally explored the rationalization of the senses in professional settings. This study suggests that these matters may be relevant across a broader spectrum of social circumstances.

Extending beyond cases of depersonalization/derealization and meditative-induced dissociation, this study also suggests the sociological promise of exploring what additional sensory destabilizations – such as experiential modifications induced by drugs, multiple other kinds of mental illnesses, sensory enhancement procedures, or the experiences of populations susceptible to sensory distress -- may reveal about social, political, and cultural environments that structure predominant, 'con-sensual' sensory orders. Is that which is deemed experientially pathological or spiritually enlightening (or any alternative interpretation, as offered by the rich vocabulary of human experience) – or, additionally, that which is worthy of being legal or illegal, meritorious or demonized, legitimate or illegitimate -- grounded solely on self-evident

qualitative dimensions of experience? Or, to what extent may the complex variety of such valuations be influenced by cultural perspectives that pattern how 'competent' embodied subjects ought to commonsensically perceive in the context of specific sociocultural and political environments, in which social actors are always situated via their sentient bodies?

As Desjarlas (1997) wrote, the social sciences are "in dire need of theoretical frames that link the phenomenal and the political … especially [studies] that convincingly link modalities of sensation, perception and subjectivity to pervasive political arrangements" (p. 25). Further research concerning these issues may advance sociological knowledge that addresses the links between "individual, micro-level meaning-making and macro-level cultural dynamics" (Cerulo 2018, p. 384).

Chapter 4

Familiarity, Defamiliarization, Refamiliarization: Towards A General Theory of Vague Sensory-Perceptual States

The comparative case of depersonalization/derealization and meditation induced dissociation, as explored in the previous chapters, makes it possible to observe circumstances in which social actors undergo vague, experiential felt states that are neither habitual nor, initially, reflexively comprehensible. People must learn to cultivate a perspectival understanding that renders such states, which initially lack intelligibility, legible. These episodes, therefore, encompass situations in which social actors' *commonsensical* relation to the world disintegrates; subsequent efforts to furnish such dissociative instances with meaning, by situating them under the umbrella of comprehensible cultural order, are thus attempts to reinstate the security afforded by commonsense. In this chapter, I ask: to what extent is it possible to generalize such processes of defamiliarization and refamiliarization to broader dimensions of social life – in particular those experiences which constitute people's embodied, sensory-perceptual relation to the world?

For decades, social scientists have set out to explain how social actors may activate culture in order to transform the world into a commonsensical actuality. Sociologists and anthropologists have typically conceptualized the processing through which social actors experience the world as taken-for-granted as a dichotomy between two modes of cultural processing: 1) cultural processing which may be reflexive, strictly cognitive, and evaluative; and 2) cultural processing which may be said to be automatic, habitual, and effortless. This has often resulted in distinctions such as symbolic/embodied culture, explicit/implicit, declarative/nondeclarative (Lizardo 2017, Cerulo 2018, Pagis and Summers□Effler 2021).

Bourdieu (1990), for example, largely explored the modalities of culture which may be said to be automatic – grounded in the dimension of durable, embodied habitual dispositions through which social actors, without awareness, produce and reproduce regular and regulated social structures. It is through these habitual processes that the world comes to possess its "doxic," which is to say taken-for-granted, character. On the other hand, social scientists have explored the series of steps through which people may internalize discursive commitments in order to make reflexive judgements, evaluations, and articulations about the world (Alexander 2003; Foucault 2006; Geertz 1973; Schutz 1972) -- a mode of culture that, instead of habitually enacted, presupposes controlled cognitive processing. Through reflexive evaluations, social actors produce the stories, narratives, and moral commitments through which the world comes to acquire a comprehensive order (Cerulo 2018).

While this dichotomy of dual cultural processing provides an elegant framework to think about the manner in which culture is activated to make the world commonsensical, this dual model has come under critique for failing to capture the complex dimensions of people's experiences, in particular those which may not fit neatly into these boundary oppositions (Winchester 2018, Cerulo 2018, Pagis and Summers□Effler 2021). As Pagis and Summers□ Effler (2021) write, the "dual processing model cannot account for some types of experiences central to the embodied aspects of culture" (p. 1371). There are instances, in other words, in which particular experiential states lack both reflexive clarity and dispositional habituality. Such experiences encompass a shift of attention, opening up a zone "that temporarily inhibits type 1 [reflexive] and type 2 [habitual] thinking while sustaining uncertainty" (Pagis and Summers□ Effler 2021, p. 1371).

One finds cases across a broad range of sensory-perceptual states that lack reflexive lucidity and, further, in which the durable dispositions concerning modalities of perception, action, and appreciation are suspended. Examples of these experiences entail instances of aesthetic engagement (Pagis and Summers□Effler 2021), the effects of meditative practices (Engler 2003), sensory-perceptual re-attunements produced via religious rituals (Winchester 2018), experiences ensuing after drug consumption (Becker 1953; Matza 1969; Gearin and Saez 2021), or, as Berger and Luckmann (1966) once wrote, the very "sinister ecstasies" that ongoingly threaten to display daily life as an alien occurrence, constructed in the face of chaos.

The case of dissociative experiences associated with depersonalization/derealization falls under the domain of experiences that cannot be precisely subsumed under the duality of habitual dispositions or reflexive clarity. Depersonalization/derealization, encompassing an alteration of the sensory-perceptual relation to the world, instigates particular episodes that, as explored in the previous chapter, a) are initially hermeneutically incomprehensible and b) disrupt people's habitual embodied relation to the world.

Focusing on instances that deviate from commonsensical flows of experience, what may sometimes be called *fringe* experiences (James 1982), makes it possible to explore the contours that both organize and disorganize people's daily lives and subjectivities. By granting serious empirical and theoretical attention to situations that do not clearly align with current sociological theories concerning experience, social scientists may develop a more comprehensive "theory of experience based on particular types of *engagement with the world* that are neither nondeclarative nor declarative" (Pagis and Summers□Effler 2021, p. 1371). Only then, thus, may one fully grant attention to the complex dimensions of life and, in particular, social actors' lived experiences. As Throop (2009) writes while building on James, "Anything we call

meaningful in our lives is as much defined by moments of focused clarity as it is by ever fluctuating undercurrents of vagueness and ambiguity" (p. 377).

Building on literature that has aimed to grant attention to ambivalent experiential episodes, the case of depersonalization/derealization further demonstrates the complex dimensions of social life. By focusing on the estrangement that people affected by symptoms associated with depersonalization/derealization confront -- particularly that which concerns their sense of self and the multiplicity of phenomena inhabiting the surrounding world – it is possible to explore what I identify as instances of *defamiliarization*. The concept of defamiliarization, initially conceptualized as an artistic *technique*, literally means "making strange" (Miall and Kuiken 1994). States of defamiliarization encompass circumstances in which the habitually commonsensical phenomena one encounters in the world of daily life, such as familiar objects or events, become imbued with felt strangeness. This lack of familiarity may accentuate the perceptive process, induce uncertainty, and allow fresh modalities of experience. Such states, thus, destabilize the habitual automatic structures through which people orient themselves to the world. Simultaneously, such states often lack reflexive clarity, suspending, therefore, both nondeclarative and declarative forms of cultural cognitive processing.

Conceptualizations of what I identify as defamiliarization, I argue, have been implicit in the social sciences, particularly in the renowned work of Berger and Luckmann (1966), but such instances have nevertheless been largely taken-for-granted. For Berger and Luckmann (1966), the social world is constructed in a sensory-perceptual dimension that always threatens to become *unfamiliar*. According to Berger and Luckmann, the social order perpetually floats in a sea of chaos, in which one's own reflection in the mirror – generally a commonsensical experience – may become experientially foreign. Extending beyond the case of

depersonalization/derealization, thus, I argue that instances of defamiliarization may exist, at varying degrees of severity, across a broad range of circumstances in daily life, making the concept of defamiliarization *generalizable*.

Experiences of defamiliarization, further, often follow a pattern. Defamiliarization is typically anxiety-inducing, for it forces social actors to realize that the comfortably *familiar* is, in fact, highly volatile. This may evoke efforts towards *refamiliarization* (Miall and Kuiken 1994). It is under these circumstances, as explored in the previous chapter, in which it is possible to observe how social actors engage in *multi-dimensional* interpretive activities in order to reorient themselves to the world. Instances of felt ambiguity allow to elucidate how social actors embark in the processes of *sensemaking* in order to collectively render vague felt experiences comprehensible. This allows to properly explore not only the phenomenological states that fall outside the spectrum of habitual experiences, but also the manner in which social actors, always situated in particular social and political contexts, render such instances meaningful in an effort to reach a state of refamiliarization.

In this chapter, I draw from sociological and anthropological literature that have explored the multiplicity of experiential circumstances that deviate from type 1 and type 2 forms of cultural processing. I situate the concept of defamiliarization amongst these broader ranges of experiences characterized by an embodied, sensible vagueness. Echoing recent sociological literature (Winchester 2008; Cerulo 2018; Pagis and Summers□Effler 2021), I argue that social scientists may benefit from exploring instances of sensible, vague states, for only by paying attention to flowing dynamics of both, the definite and the ambiguous, is it possible to explore social actors' embodied experiences as a flowing process shifting between familiarity (commonsense), defamiliarization, and refamiliarization. Extending beyond the case of

depersonalization/derealization, therefore, in this chapter I accentuate a general theory of defamiliarization.

Familiarity and Culture: Contemporary Theories of Cultural Processing

In Kafka's (1971) renowned novel, *The Metamorphosis,* Gregor Samsa awakens one morning and, through a paranormal transmutation, finds himself transformed into the body of an insect. "What about sleeping a little longer and forgetting all this nonsense," Samsa tells himself as he awakens (p. 81). He attempts to return to sleep, seemingly unaffected by the abrupt metamorphosis. Sleep does not come easily, however, for Samsa is unaccustomed to the sensations of this new, foreign body. Awake, Samsa proceeds to lay in bed as he contemplates his career – "What an exhausting job I've picked on! Traveling day in, day out…" (p. 81).

Here, one finds an absurd scenario in a double-sense: first, the explicit ridiculousness of Samsa's embodied transmogrification. Second, however, there is an implicit absurdity inherent in Samsa's reaction – or rather, *nonreaction*. Awakening in a body that has become illogically foreign, arguably, is a cause of concern and, in particular, a shocking destabilization of the world of commonsense and the experiential components that sustain one's subjective sense of a familiar, embodied self. But Samsa, unphased, overlooks the unreasonableness of these circumstances. He merely proceeds to ponder about seemingly "mundane" activities. It is here that perhaps one find's Kafka's implied lesson: people awaken, on a daily basis, in bodies that are inherently foreign. The body of an insect is no stranger than the physiological components that constitute the human body. But every day, without any sense of alarm, social actors proceed to navigate daily life without apparent consideration of the strange peculiarity inherent in their

embodied fates. This lack of startlement at the sight of the irrecusable, enigmatic components of the world is reflective of what may be termed the "natural attitude" (Schutz 1972).

As Schutz (1972) writes, social actors, through a multiplicity of typifications and "stocks of knowledge," transform the unclarified circumstances of daily life into warranted ascertainability. Stocks of knowledge provide the schematic rules for codifying and interpreting objects, interactions, social relationships, and one's own self. It is through these recipes of knowledge, according to Schutz, that people come to develop a taken-for-granted relation to the world. Such system of symbolic codifications, further, confer the possibility for social actors to create the reflexive narratives through which they construe a comprehensible notion or order. Cultural sociologists, primarily those who are often subsumed under the "cognitive" tradition, thus posit that people orient themselves to the world through symbolic "typifications, institutionalizations, functionalizations, [and] legitimations" (Honer and Hitzler 2015, p. 4).

While Schutz's work helps elucidate how taken-for-granted frameworks serve to sustain the natural orientation, his work has nevertheless come under criticism. Ostrow (1990) writes, "Schutz fails to see that it is only by virtue of our corporeal inherence within a world having sense that significance that its meanings can cohere for knowledge" (p. 29). Ostrow criticizes Schutz for reducing the "habitual foundations" of the social world to "a stock of knowledge," which undermines the "structure of the sensibility and significance which we carry about inseparably with us…" (p. 35). Ostrow, similar to Bourdieu, contends that one should locate habitual foundations at an embodied, pre-reflexive level of familiarity with the world, prior to the determination of the world through "sedimentations of meaning" (p. 36). It is through a habitual, felt familiarity with the world, according to Ostrow, that people produce and reproduce their commonsensical relation to the world. Here, thus, one finds a dichotomy between two

conceptualizations concerning modalities of cultural processing through which social actors construe the world as a familiar, taken-for-granted entity; contemporary sociological work has, in fact, continued to make similar distinctions.

Recent work concerning cultural experience divides cognitive processing into two analytically and empirically distinct forms: 1) *declarative,* which constitutes a form of cognitive processing that is accessed and deployed in an "explicit, symbolically mediated format" (Lizardo 2017, p. 91). This type of cultural processing encompasses, primarily, symbolic structures; it requires people to "access mnemonic knowledge stored… in significant semantic forms" (p. 91). When a person is asked to report world events that may be deemed significant, they may be said to be engaging in declarative processing as they intentionally reason, evaluate, judge, and articulate expressions about events, objects, persons, or experiences. Everything ranging from personal narratives to articulated motivational justifications about one's behavior – through which people work out the reasonings in order to come up with a particular conclusion – may thus be said to fall under the domain of declarative cognitive processing. Declarative culture involves explicit and controlled processes. As Cerulo (2018) writes:

> *…Our application of declarative culture is typically slow, deliberate, and reflective. It comes into play when people carefully and consciously classify people, places, objects, or events; reason through problems and potential solutions; build justifications or rationalizations for their opinions or actions; or tap established rules to evaluate information, actions, or possibilities* (p. 364).

2) On the other hand, the second type of cognitive processing may be termed *nondeclarative*, which encompasses experiences that are "opaque and not open to linguistic articulation" (Lizardo 2017, p. 89). Sharing similarities with what Bourdieu (1990) conceptualizes as the *habitus*, nondeclarative culture entails "implicit, durable… bodily comportments, and perceptual and motor skills built from repeated long-term exposure to consistent patterns of experience" (Lizardo 2017, p. 93). This type of cultural processing is not structured according to semantic, symbolic links. In fact, people typically cannot explain how they apply nondeclarative culture. Nondeclarative culture differs from declarative culture in three primary ways:

First, persons internalize nondeclarative culture "only via slow learning (habituation and enskillment) processes after a (relatively) large number of repeated encodings," while declarative culture may be acquired via "fast memory binding even after a single experience" (Lizardo 2017, p. 92). Second, nondeclarative culture may be internalized and elicited without explicit symbolic mediation, but instead "*directly* via experiential correlations or manipulation of the body" (p. 92). Declarative culture, on the other hand, presupposes a form of linguistically mediated interaction in order to be acquired. Lastly, nondeclarative culture, instead of being strictly symbolically stored, is stored in the form of a "complex multimodal and multidimensional network of associations between a large number of subsymbolic elements, each of which has a close link to experience" (p. 93). While declarative culture requires a process of *reflection*, nondeclarative culture may be accessed and deployed, via rapid, non-reflective pathways. A primary example of nondeclarative processing encompasses skill acquisition, through which certain modalities of perception, action, and appreciation become tacitly *habitual.* Instances of nondeclarative culture may involve the embodied skills required to ride a car, the ability to

rapidly distinguish humans from animals, or unconscious processes through which people classify gender (Cerulo 2018). As Lizardo (2017) writes:

> *Persons… deploy nondeclarative culture "online" and in real time, as a result of perceiving an environmental prompt or opening that requires a response… This is in contrast to declarative culture, which, due to its encoding as (relatively) context-free representations, can also be used for "offline" processes of reasoning, planning, imagining, anticipating, remembering, justifying, and narrating outside the action contexts under which it was initially acquired. Because nondeclarative culture has an underlying associationist basis, it is usually deployed online in a fast (effortless) mode; this is in contrast to declarative culture, which usually requires relatively high levels of attention, motivation, and cognitive capacity (e.g., activation and temporary retention in a short-term memory store) to be deployed* (p. 93).

Both declarative and nondeclarative culture manifest the interjection between the subjective and the public: they are situated at the intersection between the individual, which is to say *personal culture,* and that which is externalized via *public culture*. That is, the interface between personal culture (in either its declarative or nondeclarative forms) and public culture emphasizes the coupling between either nondeclarative skills or "declarative discursive commitments" and public, structural dimensions such as fields, institutions, and public cultural codes.

According to Lizardo (2017), "the mode of cultural acquisition depends on the dynamics of exposure and encoding, and modulates the process of cultural accessibility, activation, and use" (p. 88). Through both declarative and nondeclarative culture, social actors come to experience the world as a *commonsensical* actuality. Nondeclarative culture allows social actors to operate swiftly in the world through effortless schemes of perception and embodied action. Declarative culture, on the other hand, allows social actors to orient themselves to the world through symbolic accounts – it is through declarative culture, for example, that people develop narratives and storylines through which they construct a coherent identity, as well as a comprehensive conception of "the order of things."

Beyond the Dual Processing Model

The dual processing theory provides a sophisticated conceptual formulation that may help explore how social actors engage with the world as a recognizable entity, whether such recognition is instigated by a tacit habituality or reflexive accounts. Social scientists, however, have begun to highlight the importance of exploring experiential states that cannot be subsumed under the logic of the dual processing model (Winchester 2018; Cerulo 2018; Pagis and Summers□Effler 2021). People may experience, in certain cases, a shift to "the fringe of attention that opens a zone of curiosity and fascination," which suspends both declarative and nondeclarative culture (Pagis and Summers□Effler 2021). Such instances, which share similarities with what "James famously called attention to fringe or vague experiences," may encompass "experiences in which meaningful articulations of objects of experience are yet to crystallize" (Throop 2009b, p. 536). These experiential states may bring to the foreground what

Dewey called *perception* and, simultaneously, suspend processes of *recognition*. As Dewey wrote (1934[2005]):

> *"The difference between [recognition and perception] is immense. Recognition is perception arrested before it has a chance to develop freely. In recognition there is a beginning of an act of perception. But this beginning is not allowed to serve the development of a full perception of the thing recognized … In recognition we fall back, as upon a stereotype, upon some previously formed scheme … perception replaces bare recognition. There is an act of reconstructive doing, and consciousness becomes fresh and alive"* (Dewey 1934 [2005], p. 54–55).

Recognition, in this sense, encompasses both the schemes of perception and modes of habitual action through which social actors routinely organize their relation to the world and their sense of self, construing the world as a taken-for-granted whole. When recognition is suspended, people's commonsensical relation to the world may be unsettled, bringing to the foreground a world of *perception* that exceeds the confines of habitual embodied dispositions and reflexive accounts. Such experiences may be found during cases in which social actors undergo sensory-perceptual experiential states that exist at the margin of what is typically customary; these states may entail variable circumstances such as extreme pain, drug consumption, fasting and other forms of religious rituals, the sensory agony of marginalized populations, among various other circumstances.

Pagis and Summers□Effler (2021), for example, document instances that fall outside the dual processing model in what they term *aesthetic engagement*, defined as "open and purposeful

attention to the immediate context that overrides both habitual and reflective/deliberative processing" (p. 1372). Instances of aesthetic engagement may be produced by a broad range of activities such as fly-fishing (Summers-Effler, forthcoming), meditation (Pagis 2018), or even mundane activities such as cooking. Such instances "inhibit both type 1 and type 2 thinking during aesthetic engagement and enter an alternative cognitive space based on fascination and open exploration" (Pagis and Summers□Effler 2021, p. 1373).

In the case of meditation, scholars have documented how meditative activities may produce a state of de-automatization resulting in built-in uncertainty (Engler 2003). On one hand, meditation produces sensory-perceptual states that alter people's habitual, embodied relation to the world, engendering sensible experiences that may be novel or unusual. On the other hand, such states are not immediately translatable into clearly defined modalities of symbolic articulation. As Pagis and Summers□Effler (2021) write, "during these experiences, people are highly aware, yet their controlled awareness is sensual/embodied and does not have a conceptual/declarative quality. If anything, these experiences are stubbornly ineffable even when actors make efforts to articulate them" (p. 1374). These states, therefore, bring to the foreground a perceptual dimension through which people exhibit instances of wonder and ambivalence, one in which the schemes of perception and appreciation that render recognition possible are interrupted. This is manifested in the data I collected, particularly in the narratives of people who practice Vipassana meditation. As Meryl describes about one of her experiences as she was meditating:

> *...There was almost no thought or great gaps where there seemed to be none and I felt sucked into the present where suddenly I was aware of everything*

around me… What occurred afterwards however, was not so standard… a great burst of energy began to radiate through me. Mind you, I am not an energetic person at all. This intensity of energy was unreal. I felt like a new person… I believe I came close to dissolving or putting aside the false identity that is the ego… I do not know. I cannot know, the moment came and I got too scared to continue… I could be completely wrong, perhaps that is not the end. Perhaps this is no precursor to enlightenment, merely another scene on the path to see and follow.

The sensory-perceptual alterations associated with "aesthetic engagement," therefore, elucidate experiences that lie outside the dual processing model. Such states entail sensory-perceptual occurrences that destabilize recognition and, on the other, stimulate perception. As manifested in Meryl's case, people undergoing these experiences describe novel sensations that are typically difficult to articulate. In most cases, instances of aesthetic engagement may be experienced as "positive," evoking episodes of sustained wonder that may cause people to feel "exhilaration, calm, less anxiety, and less self-destructive" (Pagis and Summers□Effler 2021, p. 1377). Simultaneously, however, parallels may be drawn between instances of pleasant aesthetic engagement and disruptive states.

Disruptive States and Ambiguity

As indicated by the case of depersonalization/derealization, as well as a vast number of case studies in the social sciences (Matza 1969; Desjerlais 1997; Throop 2009b), instances of *disruptive* sensory perceptual experiences, like cases of aesthetic engagement, may also produce

suspensions of recognition. Throop (2009b) elucidates, for example, how extreme pain encompasses an embodied interference that may resist being codified through symbolic structures; during such states, which Throop calls *intermediary states*, social actors often struggle to decipher where the pain begins and where it ends.

> *In some of its manifestations, pain can be considered an intermediary experience par excellence. Pain often obdurately resists meaningful forms of objectification… I found that pain too inhabits a number of possible articulations that range from a fully discernable… to its most inchoate and intense manifestations as un-namable, unspeakable forms of suffering…* (pp. 541-542).

Pain becomes an "intermediate" experience, according to Throop, because it destabilizes any notion of an inside and an outside, the subjective and the objective. Certain experiences of pain resist being codified in the realm of declarative culture – they become "indescribable"; such instances simultaneously produce disruptions in the nondeclarative domain. Those susceptible to disruptive states of agony, found in the multiplicity of forms of human cruelty and suffering, are all too familiar with the domain of ambiguous states lying at the fringe of experience (Throop 2009b; Desjarlas 1997).

Vague, disruptive experiences have also been documented in a variety of circumstances of a different nature, such as the destabilizations ensuing in the case of drug consumption (Matza 1969; Becker 1953; Gearin and Saez 2021). Matza, building on Becker (1953), contends that marijuana consumption, as well as many other drugs, produce a phenomenological alteration of the world by increasing a "sensibility to banality made possible by the perception of relativity,

suspension of belief, and the consequent display of meaning – all directed to what happens to be around the mind of the subject" (p. 139). In other words, the marijuana experience may set the conditions that make it possible to "bracket" the cultural processes through which social actors construe the intuited world of extended bodies as ordinary. To Matza, such instances of sensory-perceptual alteration may restore "meaning" to sensibility. During such states, writes Matza (1969), "an aesthetic of the ordinary may reappear. The unappreciable may be appreciated" (p. 139). The act of restoring "sensibility to banality," in Matza's words, shares vast similarities with what Dewey (1934 [2005]) terms the suspension of *recognition* and, instead, the heightening of *perception*. Such states foreground the tacit dimension of sensory experiences that, if pushed too far, may come to be experienced as *frightful disruptions.*

Instances of destabilization, found across a broad range of circumstances, thus engender an encounter with the uncanniness of a sensory-perceptual world that is no longer familiar and which, further, simultaneously resists being immediately typified. Here, thus, one finds occurrences that are "barely graspable and yet still palpable… parts of the stream of consciousness that serve as the connective tissue between more clearly defined thoughts, ideas, images, feelings, and sensations" (Throop 2009b, p. 536). To revisit Segal's (1996) initial thoughts as she first confronted experiences associated with depersonalization/derealization:

> *Is this insanity? Psychosis? Schizophrenia? Is this what people call a nervous breakdown? Depression? What happened? ... The mind was in agony as it tried valiantly to make sense of something it could never comprehend, and the body responded to the anguish of the mind by locking itself into survival mode,*

adrenaline pumping, senses fine-tuned, finding and responding to the threat of annihilation in every moment… (p. 49).

Segal describes a state of frightening exultation, in which the *vagueness* of particular sensations causes the world to become an incomprehensive totality. One observes a reflexive rumination in which the mind rushes to make this novel, felt experience symbolically intelligible. Similar to the case of pain of aesthetic experiences, the vagueness of such experiential state *resists* reflexive clarity.

The world of experience, while typically commonsensical to social actors, is therefore susceptible to instances of experiential unfamiliarity. Fringe experiences, as Throop (2009), building on Geertz, documents, often result in anxiety due to their inherent unclarity. Such instances, for example, encompass many of the modalities of experiences that often come to be defined as "religious."

… Numerous thinkers have suggested that religious systems often arise to address both extraordinary events and humankind's recurrent confrontations with the limits of interpretability. Without the coherence provided by culturally elaborated systems of significant symbols, humans find themselves, Geertz asserts, on the brink of chaotic dissolution. Such a lack of 'interpretability' leads to forms of moodedness that are permeated by anxiety, angst, and disquiet (Geertz 1973, p. 100). The quest for meaning, in particular the quest for religious meaning, is understood in this light as a response to the forms of moodedness that arise in the

> *face of the 'opacity' of certain events, such as 'the dumb senselessness of intense or inexorable pain'...* (p. 373).

In both, declarative and nondeclarative types of cultural processing, social actors are oriented to the world in a manner in which the world is *comprehensible*. Marginal experiential states are characterized by a deviation from traditional conceptualizations of cognitive processing; during such experiences, social actors do not immediately experience commonsensical recognition. During fringe experiences, "our habitual perspective shifts so that our perspective becomes fluid (from the experience of having shifted) and fresh (because it is not habitual—instead, it is unexpected). People leave these experiences feeling wonder…" (Pagis and Summers Effler 2021, p. 1377).

Defamiliarization: The Mundane As Strange

> *"At this point of his effort man stands face to face with the irrational. He feels within him his longing for happiness and for reason. The absurd is born of this confrontation between the human need and the unreasonable silence of the world" – Camus*

States of ambiguity -- found in the destabilizations induced during drug consumption, the effects of meditation techniques, extreme pain, or the variable instances that may be characterized as aesthetic experiences -- disclose the instability of the natural attitude. Ambiguity, as Berger and Luckmann (1966) wrote, is the underlying *rule* of everyday, sensible life. The "human condition," it appears, has decreed that social actors inhabit a space in which

the typical modalities of cultural processing (habitual and reflexive) may be ongoingly suspended. The social order, embedded in the deep-rooted structures of everyday life that serve to affirm that one lives "in the most real world possible," is perpetually unstable -- a construction "in the face of chaos" that must constantly be reaffirmed through habitualized rituals (Berger and Luckmann 1966, p. 121). As Berger and Luckmann write (1966):

> *From the weather report to the help-wanted ads it assures him that he is, indeed, in the most real world possible. Concomitantly, it affirms the less-than-real status of the sinister ecstasies experienced before breakfast - the alien shape of allegedly familiar objects upon waking from a disturbing dream, the shock of non-recognition of one's own face in the bathroom mirror, the unspeakable suspicion a little later that one's wife and children are mysterious strangers... most individuals susceptible to such metaphysical terrors manage to exorcize them to a degree in the course of their rigidly performed morning rituals, so that the reality of everyday life is at least gingerly established by the time they step out of their front door. But the reality begins to be fairly reliable only in the anonymous community of the commuter train. It attains massivity as the train pulls into Grand Central Station. Ergo sum, the individual can now murmur to himself, and proceed to the office wide-awake and self-assured* (p. 169).

Berger and Luckmann (1966) imply that mundane, commonsensical sensible experiences may come to be recurrently unsettled. The *sight* of familiar objects, the faces of friends and family, one's own reflection in a mirror – all familiar episodes situated in the mundanity of

everyday sensible life – threaten to ongoingly appear as a "sinister ecstasy." Berger and Luckmann posit that the familiar, thus, situated in the nondeclarative dimension of embodied habituality, is susceptible to moments of obscurity. It is the *totality* of extended bodies that constitutes what one calls a world that, instead of being *recognized*, may thus become *perceived* as a strange terrain sustaining the most alien forms of experiential fauna. One's own home, in other words, may become a cold and foreign desert. This is precisely what I call *defamiliarization.* As Camus (1942) once wrote, "This divorce between… the actor and his setting, is properly the feeling of absurdity" (p. 6).

Defamiliarization is exemplarily found in what Matza (1969) calls "sensibility to banality," in the various instances of aesthetic engagement documented by Pagis and Summers Effler (2021), as well as in the descriptions of people affected by dissociative symptoms documented in my research. Such states entail an experiential detachment in which social actors undergo a suspension of recognition and, as if having become spectators of the world for the first time, confront a heightened state of perception that causes the previously taken-for-granted to become unfamiliar. To revisit Amiel's (1882[1906]) description about his confrontation with dissociative states:

> *…I hear my heart beating, and my life passing. It seems to me that I have become a statue on the banks of the river of time, that I am the spectator of some mystery… I am, a spectator, so to speak, of the molecular whirlwind which men call individual life; …Since the age of 16 onwards I have been able to look at things with the eyes of a blind man recently operated upon. That is to say, I have been able to suppress in myself the results of the long education of sight,*

and to abolish distances; and now I find myself regarding existence as though from beyond the tomb, from another world… (p. 304).

Defamiliarization encompasses, consequently, sensory-perceptual occurrences that destabilize people's habitual transcendent sense of self, their relation to others, and their commonsensical orientations to the world -- rendering such instances worthy of sociological inquiry. Exploring instances of defamiliarization can help elucidate various dimensions of social life that have been largely overlooked, which do not fit neatly in the domain of the dual processing model. Such instances do not need to encompass instances of drug consumption or cases of "mental illness." One can find states of defamiliarization in seemingly mundane events. The case of immigration, for instance, is exemplary.

To immigrate, in its "bare sense," encompasses the relocation of bodies across space. As sociological literature recognizes, immigration entails a process in which, via the resettlement of bodies in new localities, people come into contact with distinct, prevailing cultural patterns in a new host country – this ranges from changes in language, social values and norms, religious practices, social relations, and even social institutions (Willen 2019).

The adaptation to new cultural phenomena in the process of immigration may engender significant distress as people face the difficulties of acculturation and assimilation (Skuza 2007; Willen 2019).

Yet immigration also entails a process in which people must adapt not only to distinct languages, social values and norms, or even social institutions; immigration is also a process in which people, who carry a sensory habitual paradigm from 'home' in their bodies, come into contact with a *new sensory world.* Immigrants often undergo sensory, felt disruption as they

adjust to a new visual, auditory, olfactory, and even tactile dimension. As Low (2012) writes, "how one responds to sensory use in a different cultural context resulting from short/long-term migration is contingent upon one's situated sensory paradigm at 'home'" (p. 279). "Sensory memory" – one's habitual embodied patterning -- serves as a "pertinent resource for which the sense of self is sustained… by engaging with the transnational aspects of how social actors negotiate these sensorial interfaces," one may be "able to augment our understanding of particularity and difference in sensuous appropriation taking place vis-à-vis cross-cultural meeting points" (p. 279).

Episodes of immigration may engender instances of embodied defamiliarization in which people must learn to reassess the relation to their own bodies and selves as they adapt to a new cultural, sensorial dimension. Social actors, during such instances, may become *strangers* to themselves. Such instances of defamiliarization may be especially exacerbated during disruptive circumstances related to immigration, such as the destabilizations ensuing from entering a new sensory world while simultaneously being labeled "illegal." This is exemplified by Nicola's (2017) phenomenological account of her own immigration experience:

> *The reality of our undocumented status… would send me… into a dissociated trance… fear's stronghold continued to grip firmly throughout my adolescent years and early adulthood… My distorted, yet very real embodied experience, meant that the terror and anger I felt would continue to grow over the years…* (p. 297).

Exploring cases of defamiliarization across a broad range of circumstances -- whether in the sensory agony of marginalized groups of people, the sensory destabilizations ensuing from immigration, various instances of aesthetic engagement, or the embodied re-attunements resulting from drug consumption -- may thus provide fruitful knowledge about the various dimensions of social actors' experiences through which common sense, as well as people's own subjectivities, is ongoingly being disorganized, formulated, and reformulated. Such instances may help sociologists better elucidate the various dimensions through which social actors experience, disorient, and reorient themselves to the world.

Refamiliarization: Making Sense of the Ambiguous

One of the common responses to instances of defamiliarization, which foregrounds the volatility of the familiar, encompasses the pursuit of *refamiliarization* – that is, a process through which social actors seek to reorganize their sense of self and readjust themselves to the world. For Berger and Luckmann (1966), it is through collectively elaborated, rigidly performed rituals that social actors are capable of exorcizing the frightful ecstasies ensuing from the threat of defamiliarization. What we call "reality," as Berger and Luckmann contend, "begins to be fairly reliable only in the anonymous community" (p. 169). Through the development of specific habitual patterns of behavior and reflexive accounts that organize social life, people may in consequence undergo a process of refamiliarization. This is exemplified, as explored in the previous chapters, in the case of dissociative disruptions associated with depersonalization/derealization. Social actors embark on a journey to render vague, disruptive experiences legible as either a medical pathology and spiritual beautification, thus developing

new identities and comprehensive understandings about order, whether this encompasses the language of spirituality or medicine. People affected by depersonalization/derealization must learn to render the initially vague comprehensible. As Sierra (2010) writes, "chronic depersonalization sufferers usually present their symptoms by means of highly rehearsed description, often plagued with technical or 'textbook' terms… One long-standing depersonalization disorder sufferer acknowledged this: 'it has taken me years to learn how to describe what I feel'" (p. 56).

Akin to instances of depersonalization/derealization, parallels may be found in a broad range of experiences, such as the defamiliarization induced through drugs. Drug consumption may produce sensory-perceptual states that are initially difficult to codify. Through a social process, as Matza (1969) documents, those susceptible to such sensory-perceptual alterations often engage in a quest to render ambiguous sensations *meaningful*. For Matza, in the case of drug consumption, interpretability is reached when social actors learn to interpret sensations that are initially incomprehensible as the logical effects of a "substance." As Matza (1969) writes, social actors undergoing the experience of drug alterations may reorient themselves to the world "by connecting the display of meaning with the substance, marihuana, the process by which it is achieved itself becomes taken for granted" (p. 140). For most marijuana users, it is often the case that a "sensibility to banality becomes obtuse" (p. 140). These experiences, through socially elaborated hermeneutic interpretations and repeated exposure, may consequently become part of declarative culture (as social actors learn to symbolically frame such episodes as "being high"), and nondeclarative culture, as social actors become habitualized to the sensibility of the experience.

Through cultural processes, social actors learn to situate initial instances of defamiliarization within a logical symbolic and habitual structure. The *social world* may consequently be said to operate as a metaphysical buffer – creating patterns and externalized symbolic orders that protect social actors from the chaotic dissolution that threatens not only their sense of self and identity, but their most comprehensive ideas of order. It is in this manner, as Fligstein and McAdam (2012) point out, that the social serves as *existential* function. Fligstein and McAdam (2012) write that "the effectiveness of any collaborative existential project rests in its ability to inhibit self-consciousness by embedding the individual in a system of socially constructed meanings that substitutes the reassuring subjectivity of the 'inner view' for the alienating effects of the 'outer perspective" (p. 42). Through social processes of refamiliarization, social actors may supersede the "self-consciousness" that brings the reality of "chaos" to the foreground.

Instances of defamiliarization, which initially suspend the social world's metaphysical buffer, thus engender sensemaking demands through which people reconceptualize their commonsensical relation to their sense of self and world. This is particularly why such episodes may result in a heightened state of "self-consciousness." As Ellis, who confronts depersonalization/derealization, states:

I'll sit at an important meeting and be asked crucial questions, and somehow I come up with the answers. But I'm not really there... I look out the window 40 stories up and wonder where the sky ends. Or I see myself sitting in this meeting, discussing bottom lines and sales promotions as if they actually had meaning to me. It's more than daydreaming. It's like I'm too aware of certain larger aspects of reality. In the face of the infinite sky above me, or infinite time

before and after my short existence, how could such things as my job have any meaning at all? Doesn't anyone else ever wonder about this stuff?

Such experiential instances of defamiliarization may lead to the suspension of people's habitual roles and identities; in this manner, social actors may undergo a detachment from their natural attitude. As exemplified by Ellis, people may come to ruminate on the nature of their Being, aware, in a Heideggerian sense, of an *existential* dimension that has entered the foreground. People's habitual storylines become disorganized, opening up the possibility for those susceptible to defamiliarization to ponder the enigmatic character of their personhood, mortality, and the ontological preoccupation of being in the world. The "existential analytic" of "Dasein" becomes, in other words, increasingly heightened.

While instances in which social actors come to experience the "fringe" of experience suspend people's taken-for-granted narratives, these destabilizations simultaneously engender the possibility to create *new* storylines. Defamiliarization may induce a freshness and curiosity that pulls attention to the uncertain. When stories fail to align with lived experience, "new storylines become both possible and attractive. Thus, conditions become ripe for change" (Pagis and Summers□Effler 2021; see also Barker 2005). Defamiliarization, by disrupting people's comprehensive notions of cosmic order, opens up possibilities through which social actors may learn to reconstruct the relation to themselves, others, and the world in general.

Instances of defamiliarization, and in fact, the broader range of vague and disruptive experiences in general, therefore demonstrate that a wide range of embodied, sensory-perceptual states cannot fall systematically into the domain of declarative or nondeclarative culture. Occurrences situated at the fringe of experience destabilize renowned modalities of cultural

processing – both the reflexive and the habitual. People's search for meaning, the quest towards refamiliarization, emerges as a desire to rid oneself of the absurd uncertainty permeating the senselessness of an experiential dimension that has become a formless desert. Observing such ongoing shifts in the experiential dimension of people's sensory-perceptual states– ranging from familiarity, defamiliarization, and refamiliarization – may thus help comprehend the complex layers and contours of lived experience.

Charting New Directions

One of the theoretical and empirical promises of exploring instances of sensory-perceptual defamiliarization is that such instances bring to the foreground the background expectancies that sustain the structures of social life and people's transcendent sense of self. Garfinkel, for example, largely explored instances in which social expectancies are breached, documenting how such disruptions may shed light on the routine grounds through which social actors produce the "natural facts of life." Such "natural facts," according to Garfinkel, are inherently moral facts given that they structure what social actors consider right or wrong, problematic or aspirational. Garfinkel may be said to be a pioneer who first gave significant attention to instances in which social actors become defamiliarized with the taken-for-granted conditions of daily life. However, Garfinkel's work was primarily, if not strictly, *situational* in character, which leaves much room for theorizing about instances of defamiliarization and refamiliarization. The social order does not merely exist in social situations, it is "tattooed," as Bourdieu (1984) once said, in people's sentient bodies – it is precisely because the social order is deeply embedded in the manner in which people *feel* with their bodies, bodies which they can never escape, that the social order is transposable. People carry the social order with them across

situations, making it possible for the social order to shape people's transcendent sense of self. How does defamiliarization, thus, affect the transcendent relation that people have to the social world and their own coherent self?

Exploring the experiences incurred by those susceptible to sensory-perceptual destabilizations may shed light on the background expectancies of everyday life that up to now have been largely taken-for-granted. Instances of sensory-perceptual familiarity, defamiliarization, and refamiliarization elucidate that people's conceptions of selfhood and social order do not simply entail conceptual expectancies dictating what is appropriate or inappropriate in certain social contexts; rather, selfhood and the sociocultural order presupposes a *sensible*, and in particular "con-sensual," field that often remains invisible. It is through their sensible experiences that people maintain a coherent sense of past, present, and future. People's transcendent sense of self and of social reality, thus, rest upon active practices that "amalgamate into the embodied self as a 'somatic accomplishment'." A promising direction for cultural sociology and the sociology of the senses is to explore instances in which people undergo felt states of *defamiliarization* – instances when the habitual modes of sensibility are breached. Only then may social scientists develop a better understanding of the "con-sensual" background processes through which social actors maintain "common sense" and, further, cultivate more nuanced theoretical formulations that explain the pathways through which the social order impinges people's subjective experiences. A promising direction for research, for example, is to explore what Low (2012) terms "sensory transnationalism." As Low (2012) writes:

> *While it is logical and necessary to study the senses by contextualizing them within the milieu in which they are employed, one also has to consider how such sensory knowledge, when taken out of context, is either subscribed to in*

> *similar or contrasting manners… it is imperative to regard such transnational registers as not only materially bounded in space and place. Instead, transnational sensescapes… implies an acknowledgement of the importance of sensory memory; how one responds to sensory use in a different cultural context* (p. 279).

How do social actors, in other words, respond to circumstances when they enter a social space in which the habitual modalities of sensory memory can no longer be sustained? As described above, exploring such instances of sensory defamiliarization may provide valuable insights that account for the tacit, collective experiences of people such as immigrants – given that immigrants, by relocating to a new sensory landscape, must relearn how to inhabit a new sensory interface. Such instances may further provide valuable insights in additional cases, such as the experience of prisoners who go in and out of distinct sensory landscapes –the enclosed prison institution and the landscape of daily life. One may also theorize about the experiences of people from different socioeconomic backgrounds who traverse distinct sensory spaces. How may the experience of first-generation college students, for example, entail adapting to the sensory landscape of the university, which they may be unfamiliar with? Exploring the processes of familiarity, defamiliarization, and refamiliarization, accordingly, may help produce knowledge about the components that structure the tacit dimension of people's experiences across a broad range of social circumstances.

Conclusion

Despite Simmel's renowned essay, "Sociology of the Senses," published in 1907, sociologists have remained slow to address the topic of sensibility, especially in contrast to their counterparts in the humanities. The sensible dimension of the world -- colors, sounds, smells, qualities of touch, etc. -- as many social scientists in the growing field of sociology of the senses point out, cannot be strictly conceptualized as a psychophysical process. The senses are themselves a field of *social experience* (Ostrow 1990; Howes 2003; Edwards, Gosden, and Phillips 2006; Vannini, Waskul, and Gottschalk 2012; Cerulo 2018). "Perception is a social activity in that it is conditioned by culture," writes Howes (2013), "and cannot be thought exclusively in terms of neural activity" (p. 12).

The comparative study of depersonalization/derealization disorder and meditation induced dissociation, in line with the findings of sensuous scholarship, supports that sensation may be conceptualized as a social process. Experiences associated with depersonalization/derealization allow us to observe how social actors, subject to experiential states that evoke ambiguous sensations, may engage in a hermeneutic processes in order to construe initially vague sensations as comprehensible phenomena. Through a cross-cultural analysis of two distinct sensory communities – patient-led communities and Vipassana meditation practitioners – this comparative study demonstrates how the senses may become expressions of distinct cultural contexts, mediated by interpersonal relations through which social actors learn to interpret their dissociative states by employing distinct mythic worldviews.

The instance of depersonalization/derealization, highlighting various cultural pathways through which sensible experiences may be invested with social meanings, thus elucidates that sensibility is susceptible to *culturally contextual* modal patterns, habituations, and

interpretations. One may discuss, in other words, different pathways through which the senses become socialized. As Hall (1966) writes, "People from different cultures not only speak different languages but, what is possibly more important, inhabit different sensory worlds" (p. 2).

This is not to imply that somatic, sensible experiences do not possess, as continental philosophers have pointed out, pre-propositional qualities and structures – that everything is always "constructed" in accordance to particular social contexts. In this study, I primarily demonstrate, as stated in chapter one, that the sensible field – despite its intrinsic structures -- is concomitantly intertwined with social indexes that regulate what the senses express in particular sensory cultures. It is in this manner that the senses are "con-sensual"; people in particular cultures collectively produce and reproduce notions of what the senses ought to constitute, perspectives that impinge people's subjectivities and, in particular, people's relation to their own sensible experiences.

This research, which elucidates how social actors "con-sensually" appraise experiences associated with depersonalization/derealization, has implications for the growing sociology of the senses, medical sociology, and the broader field of cultural sociology.

Implications for the Sociology of the Senses

Concerning the sociology of the senses, this research suggests the sociological relevance of further exploring instances of *sensory disruptions*. Up to now, the sociology of the senses has predominantly focused on instances of sensory order, highlighting, for example, how various sensible domains – smells, touch, sounds, etc. – may be mediated by social processes. Exploring

instances of sensory disruptions, as I demonstrate in this research, may allow sociologists to chart new directions for the sociology of the senses. As Low (2012) writes:

> *It is… necessary to consider, beyond the senses as ways of ordering social life, sensorial disorders as a second theoretical direction… sensuous disruptions… proposition on dealing with 'experiences of the senses [that have] gone awry' – that may be located in such contexts as sensory powerlessness and illness… sensory distress of the homeless… and the presumed sensory inferiority and racial differentiation in the context of slavery… This undertaking would thereby broaden the field of sensory studies… (p. 275).*

According to Low (2012), by focusing on instances of sensory disruptions, social scientists may develop a better understanding of the "con-sensual" processes that organize social life. As the case of depersonalization/derealization demonstrates, instances of sensory destabilizations are of particular empirical and theoretical importance given that these cases foreground how social actors engage in multidimensional forms of *somatic work* – the hermeneutic meaning-making activities through which social actors render their sensations meaningful according to social and cultural environments. This allows, as I have argued, to move beyond the broad question of *whether* culture matters to the specific question of *how* culture matters; that is, it becomes possible to explore *how* culture shapes social actors' notion of sensory order – what people find meaningful or fearful, aspirational or problematic. In the process, one may show how particular macro cultural patterns may come to shape people's relation to their subjective sensible experiences, and thus how culture may influence the *qualitative dimension* of people's sensory states.

In the case of experiences associated with depersonalization/derealization, I have described two distinct pathways through which public meanings may influence how people come to render their own subjective sensations legible. In the first case, which encompasses *patient-led communities,* I show how people learn to employ the language of medicine, interpreting their dissociative states as illegitimate deviations from a standard state of *normality*. Such diagnostic interpretations may help people regain control over their psychological destiny. At the same time, by typifying such instances through the lexicon of psychiatry, particularly as a mental illness, people's subjective disruptions come to be subsumed under a comprehensible order that produces and reproduces Western psychiatry's standards concerning what constitutes the acceptable parameters of sensibility. Such medical definitions are influenced, as sociological scholarship demonstrates, by a cultural and political dimension in which self-mastery over embodied comportment is an index for appraising the worth of human beings.

In the case of active meditators who evoke recurrent and long-lasting episodes of dissociation, I demonstrate a second pathway through which social actors render similar disruptive sensations comprehensible. I show that, through a process of *sensory instrumentalization*, which I identify as a growing cultural trend in Western culture, social actors may conceptualize disruptive sensations as *acceptable* and, in certain instances, even aspirational states. In the process, through interpretations that espouse the logic of *acceptance*, people may learn to cope with their symptoms; both, patients' personal narratives, as well as psychiatric case studies, demonstrate this reality. This shows the extent to which cultural meanings may shape people's subjective dimension of experience.

The presence or absence of a *practical culture*, thus, largely influences whether social actors interpret dissociative experiences associated with depersonalization/derealization as

pathological or aspirational. I locate this practical culture as part of a larger cultural process, which has led to the growing marketization of industries that target the sensible dimension, espousing a logic of self-actualization. Experiential states that were once rendered pathological by the Group of the Advancement of Psychiatry, although historically accepted in the East, are now marketed in the West as instrumental pathways to achieving happiness and "self-growth."

Given that cases of sensory disruptions make it possible to observe how cultural structures may shape people's interpretations of their sensible experiences, additional research should be conducted about instances when the senses go awry in order to explore how social actors render their experiences "congruent with… interpersonal and/or cultural notions of moral, aesthetic and/or logical desirability" (Waskul et al. 2009, p. 7). This may add to sociological knowledge concerning the relation between individual meaning making processes and public culture.

Further, the comparative study of depersonalization/derealization elucidates the sociological relevance of continuing to explore how instances of somatic work, through which social actors render their sensations legible, may lead to the ontological genesis of specific *types of people*. As Waskul et al. (2009) point out, "selfhood rests "upon perceived sensations and active sense-making practices" (p. 6).

Social actors, by rendering dissociative episodes associated with depersonalization/derealization legible as either pathological or pathways to spiritual enlightenment, simultaneously produce modalities of understanding themselves and their relations to others. Those who use the language of pathology come to interpret themselves, and are also interpreted by others, as subjects who inhabit a sensible dimension that is experientially *deviant*. Their dissociative states, by becoming representative of disruptions of the acceptable

parameters of a sensibility that "normal" people ought to inhabit, thus engender specific notions about the specific types of subjects who undergo such destabilizations. Those who belong to meditation communities, on the other hand, learn to understand their dissociative instances as functionally acceptable and, in the process, also perceive *themselves,* and are perceived by those in their local group, as subjects who, rather than transferring the parameters of reality, sustain the cultural heritage of their community. In the case of mediation communities, dissociative experiences accordingly comprise culturally sanctioned, rather than culturally prohibited, behavior.

As Hacking (2002) contends, it is in this sense that cultural meanings have implications for the types of people that come to be historically constituted. The comparative study of depersonalization/derealization shows that, even in the case when people experience similar sensory disruptions, distinct types of people may come into existence in relation to the meanings that social actors employ to make their sensory disruptions comprehensible. Such categories of people lead to the emergence of distinct types of *moral* beings – people with distinct aspirations, duties, and desires. In the case of patient-led communities, one finds the aspiration to undergo psychiatric treatment in one group; in the case of Vipassana meditation communities, one finds the duty to embrace experiential disruptions. It is in this manner that such categories may produce "a new sense of self, of who one is and why one is as one is" (Hacking 2002, p. 20).

Further research should explore how "con-sensual" practices may, thus, mediate the projection of selves and identities. The socialization of the senses is fundamental to people's *personhood*, given that one, through one's body, is always caught in an intercorporeal sensorial engagement with other embodied subjects. As social scientists posit, sensorial experiences provide a structure "both offering and constraining possibilities for the human subject"

(Edwards, Gosden, and Phillips 2006, p. 23), considering that the sensible dimension mediates "the relationship between self and society, mind and body, idea and object" (Bull et al. 2006, p. 5).

Sensory states, imbued with cultural meaning, may even structure the possibilities for social *exclusion* or *inclusion*; this is a reality that sociologists have remained slow to address. Employing the term *embodied citizenship,* for example, Fretwell (2011) elucidates that sensible experiences such as "taste, touch, smell, sight and sound articulate otherwise intangible feelings of national belonging," engendering a "sense" that separates insiders from outsiders (p. 1). Similarly, scholars have pointed out that social actors rely on sensible qualities such as 'sonic styles' or distinct smells to situate people across class, racial, or ethnic groups (Schwarz 2015; Cerulo 2018).

"Sensory experience," writes Walmsley (2005), "provides a visceral dimension to identity that impinges directly on our daily lives without necessarily entering into dialogue" (p. 43). In his ethnographic study about Ecuador, Walmsley (2005) shows that "taste, in particular, is an emotionally charged marker of either familiarity and belonging, or strangeness and alienation" (p. 43). Coining the term *organic race,* Walmsley contends that the sensory experiences of food in Esmeraldas, a city in Ecuador, is a "factor in the construction and reproduction of local black identities," which, by expressing pride in their cultural difference, challenges the national pressure for Black and indigenous peoples to assimilate into the image of the state-sponsored citizen (p. 46). Fretwell (2011) contends that "citizenship has a history of sensual embodiment... more than a claim to political representation, it connotes a fantasy of a common relation among strangers that is based on shared legal, cultural, and familial connections" (p. 1), pointing out that sensibility accentuates "intangible feelings of national

belonging" (p. 1). Additional research in the sociology of the senses, therefore, should explore how the relation between macro social structures and the micro dimension of sensibility may lead to the constitution of particular selves, the projection of identities, and the demarcation of ingroups and outgroups.

Implications of Medical Sociology

Given that the manner in which social actors interpret sensory disruptions engenders particular types of selves and identities, this research shows that people may become highly invested in the categories through which they frame their experiences. This becomes particularly evident in the case of depersonalization/derealization patient-led communities. People belonging to patient-led communities have become increasingly participative in the processes of diagnostic categorization, particularly by becoming active patients that engage in collective, lay diagnostic efforts upon sensing that clinicians have not kept up with their expected expertise.

In spite of detailed nosological systems that circumscribe patients' symptoms, uncertainty remains prominent in medicine. Patients, especially those affected by symptoms that are difficult to decipher, are susceptible to misdiagnosis and inappropriate treatment (Rafalovich 2005; Henry, 2006). Patients subjected to medical uncertainty historically have had relatively few ways to obtain a diagnosis in a paternalistic system that concentrated medical knowledge among clinicians (Henry 2006), but patient's engagement in their own healthcare over the last decades has increasingly allowed patients to question clinical diagnoses, seek alternative information, and in the process, deny clinicians' cultural authority to frame peoples' illness experiences (Swoboda 2008; Conrad and Barker 2010; Jutel 2010; Timmermans 2020).

Although, since the 1980s, research has documented transformations of the doctor-patient relationship, demonstrating how patients may take control over their disorders and push the

medical profession to take their conditions seriously (Epstein 1998; Cohn 1999; Brown and Zavestoski 2004; Barker 2005), this study of depersonalization/derealization contributes to our understanding of medical uncertainty in two respects: first, unlike the majority of documented cases, those affected by depersonalization/derealization do not seek medical recognition. Depersonalization/derealization *already possesses medical legitimacy as a diagnostic category*. It is the rarity and peculiarity of the condition's symptoms that causes patients to confront clinical uncertainty and express dissatisfaction with medical practitioners. By exploring the process in which patients suffering from depersonalization/derealization appropriate medicine's own language and accomplish their own diagnosis, this study elucidates that people affected by *established medical conditions* susceptible to diagnostic complexity now have recourse to options that may curtail prolonged diagnostic delays, precisely during instances of medical uncertainty.

Second, this study elucidates the generational effects of the democratization of health information on the experiences of people subject to prolonged medical uncertainty. People currently affected by depersonalization/derealization may access health data online that allows them to swiftly locate a diagnosis. In the process, they forego past efforts to find receptive and knowledgeable clinicians (Cohn 1999; Barker 2005). The widespread dissemination of health data, in the case of depersonalization/derealization, has not only allowed people affected by such dissociative symptoms to self-reliantly find a diagnosis, it has also made it possible for patients to subordinate clinicians' diagnostic interpretations to their own lay diagnostic discoveries – resulting in a delegitimization of clinicians' status as diagnosticians.

The generational shift towards active, engaged patienthood, along with the democratization of information, has ensued in the growth of self-diagnosis (Jutel 2010; Semigran

et al. 2015). Studies demonstrate that "more than a third of adults in the United States regularly use the internet to self-diagnose their ailments, using it both for non-urgent symptoms and for urgent symptoms such as chest pain" (Semigran et al. 2015, p. 1). Jutel (2010) states that the rise of self-diagnosis, while posing threats for certain ailments, may be desirable across a range of conditions such as "the common cold, acute uncomplicated urinary tract infections (UTIs), vaginal yeast infections, dyspepsia, and melasma. A number of case studies also celebrated instances where individuals … presented an unusual or rare, but correct diagnosis to their doctors such as human scrotal myiasis" (para. 14).

These ongoing diagnostic shifts may impact how patients confront instances of prolonged clinical misdiagnosis or non-diagnosis (Henry 2006; Bowman 2010). As Copelton and Valle (2009) note, the combination of "unsatisfactory medical diagnoses" and "access to medical information …" may "lead individuals to construct practical epistemologies and self-diagnose" (p. 626). This self-reliant turn, in certain cases, could open new possibilities for diagnostic discovery, curtailing prolonged diagnostic odysseys (Bowman et al., 2010). According to Bowman et al. (2010), "these cases illustrate the utility of publicly available internet search engines in diagnosing rare disorders and … illustrate the lengthy diagnostic odyssey which is common in these disorders" (p. 642).

For this reason, as the cultural trend towards more active and engaged patienthood grows in the Internet age, additional sociological research should attend to factors that may either hinder or bolster such transformative challenges to medical diagnostic authority across a broader spectrum of rare, neglected diseases characterized by medically unexplained symptoms.

Implications of Cultural Sociology

Lastly, this study also suggests that exploring sensory-perceptual destabilizations is of empirical and theoretical relevance for the broader field of cultural sociology. States of sensory-perceptual destabilization produce circumstances that the dual processing model of cultural cognition, which dominates cultural sociology today, cannot account for. As I have pointed out in chapter four, social scientists begun to explore a multiplicity of experiential states that are neither habitual nor reflexively clear; such instances may be found across a broad range of experiences such as aesthetic engagement (Pagis and Summers□Effler 2021), meditative practices (Engler 2003), sensory-perceptual destabilizations induced via religious rituals (Winchester 2018), experiences ensuing after drug consumption (Becker 1953; Matza 1969; Gearin and Saez 2021), as well as suffering and extreme pain.

Similar to these states, dissociative experiences associated with depersonalization/derealization evoke sensations that disrupt, on one hand, pre-reflexive habitual modalities of experience subsumed under the category of *nondeclarative culture*, as well as the reflexive modalities of cultural processing – typically categorized under *declarative culture*. Instances of sensory-perceptual disruptions thus allow for the development of comprehensive theories of experience that cannot be captured by the logic of the dual process model.

The case of depersonalization/derealization, in particular, brings into light experiential conditions that I have categorized as *states of defamiliarization*. Theories concerning defamiliarization, although largely taken-for-granted in the social sciences, have been implicit, as I point out in chapter four, in the work of renowned sociologists such as Berger and Luckmann, who have suggested that the familiar, sensible world is under perpetual threat of becoming unfamiliar. The topic of defamiliarization has been, further, explicitly documented in the ethnomethodological work of sociologists such as Harold Garfinkel, who largely explored how

familiar social circumstances may become abruptly unfamiliar when particular sociocultural expectancies are *breached*. Much remains to be theorized, however, about how experiential instances that defamiliarize social actors from their commonsensical relation with the world – and states which fall outside the dual processing cultural model in general -- may affect social actor's lives.

Ethnomethodological work has primarily explored defamiliarization in *situated social interactions*. How do instances of defamiliarization, however, affect the *transcendent* sense of social actors' lives? The social world does not merely exist in immediate interactions, it is embedded in people's sentient *bodies*; it is precisely because social actors are embodied subjects that the social world is transposable and trans-situational. Instances of sensory-perceptual states of defamiliarization demonstrate that, during circumstances in which people's sensory relation to the world is destabilized, people's overall commonsensical expectancies – both embodied habitual patterns and reflexive accounts, through which social actors construe a comprehensive sense of past, present, and future– undergo an inherent disruption. For this reason, it is imperative to consider a) how the social world is embedded in people's sensible relation to the world, and b) to explore how alterations to the sensible dimension may destabilize the dual cultural processes through which social actors uphold commonsense. In fact, Garfinkel himself, in the concluding remarks of his famous essay, "Studies of the Routine Grounds of Everyday Activities," wrote that social scientists should explore a "second" type of modification that may disrupt the background expectancies of daily life. This "second modification," wrote Garfinkel (1964), "consists of instrumental transformations of environments of real objects such as occur in experimentally induced psychosis, extreme fatigue, acute sensory deprivation… and the use of hallucinogenic drugs" (p. 249). By exploring such circumstances, according to Garfinkel (1964),

sociologists may develop a better understanding of the "socially managed production of their everyday affairs" (p. 250).

The case of sensory-perceptual alterations, as literature in the social sciences indicates, is thus of particular relevance given that such instances foreground a world of sensation that cannot be immediately accounted for by traditional cultural theories. Giving serious empirical and theoretical attention to such states may allow to theorize about instances that are neither declarative or nondeclarative, highlighting modalities of experience that largely shape and reshape social actor's relation to their sense of self, others, and the world of phenomena.

The concept of *defamiliarization* may help conceptualize social actors' dimension of experience across a broad range of circumstances. Such instances of defamiliarization may be found in the experiential destabilizations engendered by medical or nonmedical drugs; various forms of illness; sensory enhancement procedures; the experiences of populations susceptible to sensory distress, which includes the various forms of human suffering evoked by circumstances such as war, slavery, or even imprisonment; the sensible destabilizations that stem when social actors come to inhabit distinct "sensory interfaces," as it happens during immigration or dislocation; destabilizations evoked through various religious rituals; amongst many other conditions that may produce sensory disturbances.

Of primary relevance to current sociological literature, exploring instances of defamiliarization may provide promising theoretical and empirical insights during cases in which distinct modalities of sensory-perception come into contact; this may allow social scientists to elucidate tacit dimensions of experience that have been largely overlooked. As I describe in chapter four, I have in mind instances that sociologists may find relevant such as immigration, imprisonment, or even colonization. Sensory destabilizations, as social scientists point out, may

occur during episodes in which distinct modalities of "sensation" intersect (Low 2012; Willen 2019). In order to explore the materiality of sensory defamiliarization, concepts such as *sensorial interface* may be especially practical, where it "refers to 'the site of two or more dissimilar sociocultural contexts of sensory knowledge and use'" (Low and Kalekin-Fishman 2010, p. 198). The concept of sensory interface may be found in the works such as Iida's study (2010) on Thai massage, which elucidates the cross-cultural "haptic encounter between Thai masseuses and foreign clients," demonstrating that "tactility is experienced different amongst people in the West (Europe and US) and people in East Asia" (Low 2012, p. 279). Similarly, the concept of 'sensescapes', as proposed by Igˇsiz (2008) in her study on the 1923 Greek-Turkish compulsory population exchange, may be particularly useful to elucidate the different sensory worlds that cultural groups may inhabit – worlds that may come into contact with each other.

Building on this literature, one may raise questions that have, up to now, been overlooked: how may immigration, for example, be conceptualized not solely as a process in which social actors must learn new languages and customs, but also as a process in which people must come into embodied contact with, and adapt to, a new sensory context? How do immigrants navigate new sensible spaces that they are unaccustomed to, such as the hospital, or adapt to unfamiliar sounds, such as helicopters and highways? How do immigrants relearn to understand their own bodies, which they must sense distinctly upon entering a new sensescape? Similarly, in cases of imprisonment, one may ask: how do people who, upon entering the prison system, adapt not solely to the new expectancies and customs of the enclosed institution, but to a completely new sensory landscape in which previous habitual modalities of sensation are no longer possible? How do prisoners, in other words, learn to *resocialize* their sensible relation to the world and their own bodies? The social world is *felt*; it is lived in the intracorporeal

entanglement located in "con-sensual," sensorial landscapes. Considering that social actors carry a socialized, sensory habitual paradigm in their bodies, it is thus important to explore the sensible modes of familiarity, defamiliarization, and refamiliarization experienced by people susceptible to sensory shifts. The exploration of sensory-perceptual dislocations offer a plethora of new approaches through which social actors' experiences may be explored, making it possible to theorize about the tacit dimensions of experience that have been largely taken-for-granted in the social sciences, but which are nevertheless central to the manner in which social actors experience social life and subjectivity.

Ending Remarks

To surmise, one may find, consequently, that "the flesh of the world" offers the possibility of undergoing culturally elaborated adaptations, as well as being imbued with distinct social meanings. Accordingly, sensible indexes may influence what and how particular social actors may be expected to sense via their bodies in particular social contexts. As Panagia (2009) states, "Dynamics of the sensible suggest that our capacity to comprehend things is grounded in… the self-evident dispositions of a sensing body," further adding that "such assurances and the practices of sense making that enable them are, by definition, political" (p. 7). This political dimension emerges because such culturally elaborated regimes "determine the conditions through and by which we might sense the world and those who occupy it; in short, such regimes of perception confer what counts as common sense" (p. 7).

Instances of people confronting depersonalization and derealization suggest that the senses, saturated with cultural evaluations and stipulations, are interlinked to the classifications and identities projected on those for whom the physiognomic and tactile characteristics of the sensible have undergone an alteration. Such alterations, therefore, do not remain pre-

propositional, *felt* destabilizations independent to lone, sensing subjects. Such disruptions, which are always sensed with and in relation to others – that is, in an intersubjective social space -- become vehicles that "personify" types of human beings, demarcating the boundaries that separate the human-proper from the improper. Such boundaries, as this study suggests, cannot be divorced from cultural expectancies concerning what constitutes a "legitimate" reality and a "competent" human subject.

It is in this manner that sensible qualities may be susceptible to various forms of monitorizations and suppressions; rankings and hierarchizations; classifications and distinctions. For this reason, it is of sociological merit to continue exploring the relation between cases of sensory "orders and disorders" and social configurations. Such configurations, as anthropologists and sociologists in the nascent field of the sociology of the senses have pointed out, may imbue the sensible in variable ways; they may encompass the manner in which people's tactile relation to the world is socially patterned across different stages of civilization, as well as the identities projected on people -- structured by indexes concerning the tactile. This may demarcate, for example, the civilized from the sensuous "savages" who use touch as their primary perceptual modality (Classen 2005), or, as this study demonstrates, the pathologized from those considered to be on the pathway to enlightenment. During such instances, sensibility becomes a domain of cultural expression – a social process.

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