Book Forum

MOOD DISORDERS

A Mood Apart: Depression, Mania, and Other Afflictions of the Self, *by Peter C. Whybrow, M.D. New York, Basic Books, 1997, 340 pp., $24.00; $13.00 (paper).*

One cannot help joining a chorus of praise—William Styron, Kay Jamison, Peter Kramer, and Maggie Scarf among the members—for this splendid book. The title, which is taken from a Robert Frost poem, sets the stage for a humanistic as well as scientific journey through our most comprehensive understanding of mood. Peter Whybrow, Director of the Neuropsychiatric Institute at the University of California, Los Angeles, is a well-appointed guide. He offers the perspective of a distinguished researcher, never far from that of a classically educated Englishman whose curiosity flows from the nineteenth-century naturalist tradition at its best. Whybrow identifies his approach as "that of the physiologist" (p. xvii). His thoughtfulness and sensitivity as a clinician are also readily apparent.

The text is structured as an essay woven around clinical portraits of five individuals with severe mood disorders (four patients and one former classmate and friend). We are drawn to feel close to Whybrow's subjects and their families as they speak for themselves and interact with their physician, who also shares brief autobiographical reflections. That these characters are in fact "composites," although their stories are "real," is no impediment to the author's purpose in this context (p. xix). Historical, scientific, medical, and literary elaborations punctuate and frame the clinical images. Nearly a quarter of the book is devoted to an appendix and notes, which frees the body of the text from academic and technical detail while offering readers the option of further reference and more scholarly pursuit. The writing is lucid and vivid throughout. In moments, however, it strains a bit unsuccessfully toward the prose of a novelist.

Although written for a popular audience, *A Mood Apart* contains a great deal for all mental health professionals, particularly psychiatrists, to contemplate. Functioning under shifting paradigms, we often find ourselves split into mind and brain camps or giving lip service to biopsychosocial integration. Indeed, I cannot be alone in feeling that in attending to a transference subtlety and prescribing an antidepressant in the same hour, I've changed hats, or, regarding a patient's persistent, vehement complaints, in suddenly wondering if a trial of a mood stabilizer is warranted. How disheartening it is to have a patient repeat the now familiar refrain, "I have a chemical imbalance," when, in fact, he or she seems to be experiencing an unwelcome emotion. It is equally disheartening to have a patient refuse to consider medication, saying, "This is how I am." Yes, there is integration, but it's hardly seamless.

Employing the central evolutionary biological concepts of homeostasis, adaptation, and attachment, Whybrow presents a logical and rather down-to-earth conception of mind-brain integration. This is extremely helpful in thinking about the amalgam of elements that we call character and self. Although his focus is on severe, diagnostically unequivocal disorders of mood, Whybrow makes it clear that there is a continuum of emotional experience to which his perspective may be applied. He repeatedly emphasizes that nature and nurture are inexorably linked and that both uniquely determine what constitutes stress for a particular individual. Although he recommends concurrent pharmacological and psychotherapeutic treatment, I wish he had said more about the dynamics and resolution of individual conflict in the therapeutic process, especially for patients whose symptoms are less than severe. Such pursuit might inevitably necessitate "reinvention" of psychoanalysis in the twenty-first century.

In summary, *A Mood Apart* is a superb work, an orienting compendium for colleagues, and perhaps the best overview of mood disorders that psychiatry has to offer a general audience.

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Cognitive-Behavioral Therapy for Bipolar Disorder, *by Monica Ramirez Basco and A. John Rush. New York, Guilford Publications, 1996, 291 pp., $35.00.*

In 1949, Frieda Fromm-Reichman wrote a brief paper attempting to explain why her colleagues were reluctant to do therapeutic work with individuals who had manic-depressive illness and why there had been so little research on dynamic psychotherapy with this disorder (1). Her experiences did not paint a pretty picture. Patients with manic depression, she wrote, were insecure, manipulative, and superficial. They suffered from a lack of close interpersonal relatedness and attempted to compensate by clinging dependently on the therapist. They experienced intense feelings of hatred and were more interested in and clever about finding vulnerable spots in the therapist than were other psychotic patients. She thought psychotherapy with patients with schizophrenia was an easier and more rewarding activity and recommended that patients with manic depression not be seen more than two or three times a week in treatment. It is interesting to speculate what she would think of *Cognitive-Behavioral Therapy for Bipolar Disorder.*

Fromm-Reichman's pessimistic formulation appears to have had a lasting effect, because this work by Basco and Rush is the first modern attempt to produce a psychotherapeutic treatment manual focused on patients with bipolar illness. The overall structure of the proposed therapy is similar to that promulgated for the treatment of unipolar disorder, with a somewhat greater emphasis on the role of medication, treatment adherence, and the importance of symptom monitoring. The authors caution that because their overall program has not been formally evaluated in randomized controlled clinical trials, questions remain as to whether it is effective and, if so, for whom. Nevertheless, the reader will be impressed with the face validity of many of the recommendations and with the practical and immediate benefits of

increasing patients' knowledge of their illness as well as the benefits of family education and involvement.

The book's target audience appears to be nonmedical mental health workers with limited clinical experience. It identifies many common psychotherapeutic issues in depressive and manic episodes and in times of remission and articulates specific interventions for the therapist, to the point of suggesting the actual language to be used and the questions to be asked. Consistent with the overall cognitive framework, interpersonal problems are defined principally as errors in communication based on incorrect assumptions and misattributions. To help patients improve their communication, therapists are encouraged to play "the communication game," which is defined as assuming the role of coach and teaching "the players the basic rules," having them demonstrate the behavior and practice between sessions, watching them play, and providing feedback on ways in which they could improve their skills. Such strategies are undoubtedly helpful for certain types of psychosocial stresses, as illustrated by the clinical vignettes provided, reflecting common experiences in the course of treatment.

What the limitations are of such interventions and what to do when they seem to fail is a relative weakness of the book and, perhaps, of the overall approach. Denial, someone once said, is not simply a river in Egypt. In these pages the discussion of denial occupies approximately three paragraphs; denial is seen as a conscious process emerging from the holding of false negative beliefs about the disorder or its treatments. Unconscious impediments to the benefits of rational intervention or correct information are not addressed, and neither countertransference nor unconscious processes are listed in the index. From an ideological point of view, this is not surprising, but it raises the question as to why a treatment manual that so successfully incorporates the benefits of pharmacotherapy into its schema of optimal clinical utility could not have similarly absorbed key psychodynamic contributions to clinical care as well. This may be an unfair expectation, given the absence of such integration in practice patterns in the field at large.

This manual deserves high praise for its simple existence, as a sensible and practical treatment guide specifically addressing the needs of patients with bipolar disorder. Dr. Fromm-Reichman might disagree with some of its content, but she could not disagree with the need.

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SCHIZOPHRENIA SPECTRUM

Imagining Robert: My Brother, Madness, and Survival, a Memoir, *by Jay Neugeboren. New York, William Morrow, 1997, 305 pp., $24.00; $14.95 (paperback published by Henry Holt & Co.).*

"Why did God create sick people? Tell me, Jay. Tell me." The question haunts Jay Neugeboren and permeates the book he has written about his brother, Robert, who has schizophrenia or schizoaffective disorder. *Imagining Robert* is a book with great strengths and great weaknesses, and the latter ultimately predominate.

Jay Neugeboren is a novelist and teacher at Amherst, and the book accurately reflects his considerable writing talents. His affection for, and devotion to, his sick brother are exemplary, a shining model for all who have a loved one who is disabled. It is the same devotion that keeps pushing the author to his Job-like task of asking, "Why?"

Jay Neugeboren ultimately blames his mother and the psychiatrists for his brother's illness. His mother had apparently favored Robert in childhood and, according to Jay, denigrated himself. He says, "Although it would be hard, scientifically, to prove that any human being literally drives any other human being mad, common sense indicates that if you keep hitting a child in the same sensitive place, over and over again—consistently or inconsistently—your blows will have effect." But wait a minute: by this theory, shouldn't it have been Jay who developed schizophrenia rather than Robert? And Neugeboren ignores the fact that there is not a scintilla of evidence that the quality of mothering differs in individuals who later develop schizophrenia, diabetes, multiple sclerosis, or none of the above.

The psychiatrists come in for an equal share of the blame because they cannot get Robert well. The author is ambivalent about medications, recognizing that they sometimes help his brother to live outside the hospital but that they also have side effects and do not cure him. Jay wanted Robert to be given "individual psychotherapy once or twice a week…for say, two or three years" in addition to medication. Jay himself has apparently undergone extensive psychoanalytic psychotherapy and believes it helped him. So why shouldn't it also help his brother? The book cover has an endorsement by Joanne Greenberg, author of *I Never Promised You a Rose Garden* (1), the mythical tale in which talk therapy cured an individual who had some form of unspecified mental disorder.

For those of us who have a sibling with schizophrenia or other severe psychiatric disorder, it is a delight to see books being published that discuss our concerns. Margaret Moorman's *My Sister's Keeper* (2), Clea Simon's *Mad House* (3), Victoria Secunda's *When Madness Comes Home* (4), and Diane Marsh and Rex Dickens' *Troubled Journey* (5) are all excellent. *Imagining Robert* climbs partway to these heights but is ultimately dragged down by the recurring voice of the author's psychoanalyst.

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Towards a Comprehensive Therapy for Schizophrenia, *edited by Hans Dieter Brenner, Wolfgang Boker, and Ruth Genner. Bern, Switzerland, Hogrefe & Huber, 1997, 251 pp., $49.00.*

Schizophrenia is a severe mental illness that profoundly affects an individual's functioning in numerous domains, including interpersonal (i.e., social skills), intrapersonal (i.e., sense of self), occupational, and cognitive (e.g., conceptual skills). Since the advent of neuroleptics in the 1950s, major inroads have been made in ameliorating deficits in these areas. However, traditional neuroleptics, such as chlorpromazine, while alleviating many florid "positive symptoms" of schizophrenia (i.e., hallucinations and delusions), did not "restore" or "remediate" social or occupational skills. Furthermore, many neuroleptics were beset by untoward side effects (e.g., akathisia), and they were fairly ineffective in reducing the "negative symptoms" of the disorder (e.g., flat affect, anhedonia), which are often associated with negative outcome. Thus, from the 1970s to the present, many psychosocial and pharmacological interventions emerged to address treatment gaps in the literature. From the pioneering work on token economies to family treatment of expressed emotion, the unfolded picture was one of multimodal intervention. Thus, this book is written within the spirit of psychosocial and pharmacological integrated therapies.

This text comprises papers from the fourth international symposium on schizophrenia held in Bern, Switzerland, in 1993. Consistent with most published versions of symposia, many chapters summarize the presenter's previous work and describe recently completed and ongoing projects. An advantage of published proceedings is that the reader is privy to the contributor's unique perspective on a given topic, particularly in works in progress that may be "cutting edge." Chapters on "Emotional Management Training" by Hodel and Brenner and "Coping-Oriented Therapy" by Schaub and colleagues, in particular, present preliminary findings of promise. Because the edited volume is limited to symposium presenters, a weakness is that viewpoints of important scientists may not be equally represented. This situation is particularly true in view of the limited coverage of some topics (and techniques) relevant to the treatment of schizophrenia, such as token economies, cognitive therapy for positive symptoms (as conducted primarily in the United Kingdom), issues in dual diagnoses (e.g., substance abuse and mental retardation), psychoeducational and behavioral family treatment, and structured skill modules. The restricted breadth of the coverage notwithstanding, this book effectively strikes a balance between theoretical perspectives on psychopathology and specific clinical interventions by addressing the psychosocial and neurochemical anomalies associated with schizophrenia.

Five broad sections of two to five chapters each are presented. The first section, Unfolding of the Area, is devoted to the application of systems and chaos theory to the treatment and psychopathology of schizophrenia, respectively. These chapters, particularly the two on chaos theory, will probably appeal to the reader who is more interested in basic research than practical applications. The second section, Focus on Biological Vulnerability, comprises two chapters devoted to the efficacy of atypical neuroleptics. The chapter by Moller and colleagues describes research on whether negative symptoms can be influenced by neuroleptics, long a vexing issue in the pharmacological treatment of schizophrenia. The third section, Focus on Influencing Cognitive Vulnerability, consists of four chapters on different aspects of cognitive dysfunction in schizophrenia. Especially recommended is the chapter by Green and colleagues, which summarizes a program of studies devoted to remediation of executive and visual processing skills.

The fourth section, Focus on Weakening Stressors and/or Strengthening Protectors and Promoting Social Network and Social Support, will likely be the section of most interest to practitioners and clinical researchers. Three chapters are of particular note. These are Bellack's review of social skills assessment and training, Test and colleagues' overview of their program of assertive community treatment, and Goldstein and colleagues' work on the interactive behavior between the identified patient and the patients' relatives that may precipitate displays of high expressed emotion. The final section comprises five chapters listed under the rubric Focus on the Concept of Illness and on Coping Aimed at Episode Prevention. Gaebel's chapter on pharmacological strategies for relapse prevention (i.e., low doses and intermittent strategies) not only reviews the research in this area but identifies significant weaknesses in the premises underlying these approaches (i.e., the low association between prodromal symptoms and subsequent relapse rate). Finally, the chapters by Strauss and by Sarwer-Foner, which focus on the individual's experience of schizophrenia and sense of self, will be a pleasant respite for readers who feel that the field tends to overemphasize biological and neurochemical aspects at the expense of personal aspects of schizophrenia.

In summary, *Towards a Comprehensive Therapy for Schizophrenia* will likely appeal to clinical researchers and graduate students in the field who are looking for a brief reference source on the treatment of schizophrenia. Its limited scope and lack of attention to the details of specific clinical interventions (a goal to which the book does not aspire), make it less relevant reading for the practitioner. These issues, of course, are typical of books based on symposia and should be evaluated accordingly.

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The Psychiatric Team and the Social Definition of Schizophrenia: An Anthropological Study of Person and Illness, *by Robert J. Barrett. New York, Cambridge University Press, 1996, 332 pp., $69.95.*

Psychiatrists have long been willing, and indeed anxious, to see their profession reflected through the eyes of sociologists and anthropologists. Occasionally, these observations catalyzed large shifts in psychiatric thinking and practice. Goffman's account of the potentially harmful effect of the "total institution" (1) pointed to community-based care as an alternative. Similarly, Estroff's description of the sometimes oppressive experience of being a patient in a community-based program (2) heightened awareness of the importance of peer support and patient participation in self-defining treatment goals.

Robert Barrett is a self-described organizational stereotype, the "skeptical insider—who has been stalking around since the very inception of the asylum." A graduate student in anthropology (and a physician), he describes a "Schizophrenia Team" in an Australian public hospital where he works as a staff psychiatrist. The Team's approach is modern (circa 1980s), compassionate, and scientifically informed by a "biopsychosocial" model of etiology and treatment. Barrett's aim is interpretive: to uncover a core set of culturally

defined constructs that, invisible and taken for granted, shape our ideas about illness and its treatment. His data are the everyday operations of "Ridgehaven Hospital"—its architectural and organizational structure, the formal and informal discourse of its staff, and the way patient interview data are translated into medical records and case formulations.

The idea of Ridgehaven as progressive is central to the institution's self-identity and public image. With a charge to reduce beds, progress implies the movement from hospital to community, from old to modern, and from ignorance to knowledge. Pressure to discharge patients links movement and progress to clinical thinking; treatment is conceived as keeping patients moving along an expected trajectory. Value and worth are also aligned with these notions. The hospital's acute units treat patients whom the staff value most (those expected to follow a progressive trajectory) in a modern and well-staffed building adjacent to the positively valued community. Patients deemed unlikely to progress are housed in old and isolated buildings adjacent to a prison and institution for mental retardation.

As progress shapes views of the institution, disintegration and degeneration invisibly shape thinking about the illness. Although psychiatrists emphasize to the public that schizophrenia is not "split personality," in informal (unprofessional) conversation, staff often refer to patients as cracking up, falling apart, or going to pieces. An acute psychotic episode is called a break, and the design of psychiatric book covers and pharmaceutical advertisements often feature split or fractured images. Psychodynamic concepts represent this as the dissolution of ego boundaries and personality accompanied by a unmodulated emergence of primitive and incomprehensible experience. Biologists express this idea in terms of neural circuits released from inhibitory control, perhaps by an unmodulated excess of neurotransmitters. Barrett the psychiatrist competently reviews the history of these formulations, but Barrett the anthropologist is concerned not with their scientific merit but, rather, the cultural meanings they carry. He argues persuasively that different theoretical perspectives reflect common, deeply embedded conceptions expressed in different idioms. Clinicians, scientists, patients, and the public alike are influenced by these cultural images and metaphors.

The modern unit of organization that constructs the social definition of schizophrenia is the Team. Members from each professional discipline who constitute the Team merge their distinct perspectives into "the fully worked up case." One patient is viewed as a passive sufferer, another as a willful and calculating strategist. An optimal treatment trajectory implies progressive attribution of intentionality to the patient from a "schizophrenic" to a "person with schizophrenia" to a "person managing schizophrenia."

Nonmedical social scientists have sometimes mistaken the sick role for the sickness itself. Barrett does not make this mistake. He recognizes that schizophrenia and the suffering it causes are real. Unlike his predecessors, however, Barrett does not seem to have an axe to grind. I found myself wishing he did. His insights are interesting, but, given the reality of schizophrenia, description without some prescription misses the mark.

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STRESS AND DISSOCIATION

The Last Witness: The Child Survivor of the Holocaust, *by Judith S. Kestenberg and Ira Brenner. Washington, D.C., American Psychiatric Press, 1996, 272 pp., $36.50.*

This book has a mission. The authors seek to describe the effects of the Holocaust on child survivors, "not as historians but as psychoanalysts who wanted to know what happened to the human psyche." The book was written as part of a project in which 1,500 survivors were interviewed, but the summary of those interviews is deferred, and the book itself is informed by interview vignettes. Life histories can give soul and meaning to events that are hard to imagine and put them into perspective for those of us who have not endured these most extreme traumata.

There are themes considered here in an innovative way that are quite absent from other psychiatric discussions of the Holocaust. The role of the Holocaust in identity formation is particularly well considered, and there is a chapter segment on genocide and the assault on Jewish identity of children that is particularly informative. Identity distortion and fragmentation are described for the most fundamental components of identity, including gender identity and the sense of wholeness of the body and its parts, in the case of very young children.

Many children survived through being hidden; numerous components of their identities became fragmented and then reformed with greater or lesser degrees of success. The best-known example of this (not included in the present study) remains the Archbishop of Paris, a Jewish boy given over to the Catholic Church for safekeeping, who experienced a profound conversion at the age of 14 and would not return to his religion of origin afterward. The stories recounted here are more prosaic but have a more believable quality. Children of latency age found comfort in the Polish Catholic culture and religion, even as they were aware that they were the hated Jewish Christ-killers. Adolescents remained in Poland and married into abusive relationships they later left. One striking story was that of a woman born in 1928 who was able to give an interview only after psychotherapy. She had been able to ingratiate herself with numerous Polish, German, and Russian people to whom she was exposed and who were generally playing oppressive roles during these times. Doing this, she helped several members of her family to survive. Yet when her mother and sister went to the United States in 1946, she would not join them. She returned to Poland and married into an abusive relationship. When she eventually left with her children and reunited with her mother and family, she was rejected for having left her faith. Her children felt they belonged to none of the cultures from which they came. The authors describe the phenomenon of survivors who grew up feeling they could find a haven only among Gentiles as a widespread one, and it is understandable.

A related identity fragmentation is described as a hidden knowledge of being Jewish. The knowledge of her Jewish identity by the current Secretary of State, Madeleine Al-

bright, has become a public issue in recent times. Although she is not a Holocaust survivor herself, her story is more understandable after reading this book. Within a family, multigenerational deception and denial about facts that very obviously determined the family's destiny can take place. Usually this is accompanied by the hope that this will be protective in some manner, but it also can result in lacunae and instability of identity and of integration in the generation thus "protected."

As worthy as their enterprise is, it is hard to say that the authors have succeeded in it. The almost exclusive use of the psychoanalytic metaphor in conveying and interpreting the material they deal with makes for heavy reading. Real lives are being described here, but by and large the descriptions lack the raw power of cases described in other volumes on psychiatric problems and treatment of Holocaust victims, and they certainly do not have the power of fictional descriptions.

Exclusive reliance on psychoanalytic interpretation also results in striking omissions of scholarship. Although the Holocaust is unique in many respects, there is an entire literature on the effects of abuse on children and adolescents and posttraumatic stress disorder that is largely ignored. There is also much that has been written on the psychiatric sequelae of exposure to the Holocaust and psychotherapy on surviving victims (a particularly compelling account is contained in Charney's *Holding On to Humanity* [1]). This literature is referred to, but in a most meager manner.

No critical discussion or consideration is offered of alternatives to the perspectives of the authors and the procedures they have followed. Toward the end of the book, there is a chapter on the "integrative" effects of the interview on the people who participated. But what about people for whom healing has failed, where the trauma cannot be integrated and engaging these memories serves only to reawaken the unhealed trauma?

For those of us treating adult victims of severe childhood abuse, including Holocaust survivors, this is a valuable book. I expect that many readers will have similar critical reactions to this volume but, like me, will find it a worthwhile addition to our knowledge of this most horrible of evils that humans have inflicted on other humans.

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Handbook of Dissociation: Theoretical, Empirical, and Clinical Perspectives, *edited by Larry K. Michelson and William J. Ray. New York, Plenum, 1996, 645 pp., $95.00.*

During my psychiatric residency some 25 years ago, we received virtually no training in dissociative disorders. Some of our patients were reading *Sybil* (1), which did little to enhance the credibility of multiple personality disorder in our minds. Like most of my colleagues, I spent the first several years of my practice assuming that multiple personality disorder was either rare, factitious, or iatrogenic. Eventually, intensive therapeutic work with several dissociative patients convinced me that these disorders are quite real and not rare, and reading the extensive literature in the field helped me shift to a new paradigm in conceptualizing the etiology, phenomenology, and treatment of these illnesses. Therefore, I was pleased to get this book for review. I advise the prospective reader who is relatively unfamiliar with the burgeoning literature in this area, however, to begin with a text by a single author to provide bearings (reference 2, for example). Then there are several multiauthored books I would recommend (references 3–6, for example) over the one under review.

But what about *Handbook of Dissociation*? It is full of peaks and valleys of quality, interest, and readability. The editors have assembled a book that includes excellent chapters by some leading authorities in the field but that also is riddled with poor organization and egregious assaults on the English language. The book is marred by poor grammar, numerous typographical errors, and stylistic abominations. (Did no one notice that the lengthy list of "therapeutic tasks" starting on page 495 is virtually a repeat of the one starting on page 454?)

Enough said about the book's faults. It also has many strengths. In addition to examining dissociative identity disorder (formerly multiple personality disorder), the book also explores many other aspects of normal and pathological dissociation, including its role in borderline personality disorder, acute stress disorder, and posttraumatic stress disorder (PTSD). I can highlight only a few of the chapters in this lengthy book. Ross notes that the prevalence of dissociative identity disorder in the general population may be as high as 1% and that dissociative identity disorder has extensive comorbidity, most frequently with depression, panic disorder, PTSD, substance abuse, and eating disorders.

Goodwin and Sachs list the several forms of memory distortion that may occur in dissociative patients, but they note that "when corroborative data have been available, time and again the therapeutic conclusion has been that the end result of these distortions had led to minimization, rather than exaggeration, of the extent of the childhood abuse" (p. 95; compare this with the work of Lewis et al.[7]). Goodwin and Sachs highlight the extreme and sadistic forms of childhood trauma that lead to dissociative disorders: "in the sexual abuse cases, these patients seem more likely to have experienced incest pregnancies, instrumentation with physical damage to genitalia, involvement of multiple sexual abusers, involvement of siblings and other children as covictims, threats of death or threats with weapons [typically, to coerce the child not to disclose the abuse], and beating or bondage associated with the sexual contact" (p. 93). Of the several types of childhood trauma, sexual abuse has received the most attention as a source of adult psychopathology, but Goodwin and Sachs remind us that other important forms of childhood trauma (which often coexist) include physical or emotional abuse, physical or emotional neglect, abandonment, and witnessing violence. They also anticipate an important aspect of our psychological response to this book and its subject matter in observing that "patients [with dissociative identity disorder] and incest victims require us to believe things about parents [and other perpetrators of childhood trauma] that we would prefer not to know" (p. 102).

Main and Morgan summarize fascinating research on attachment behavior in infants and present their speculations about possible connections between certain forms of "disorganized/disoriented" attachment status and subsequent dissociative behavior. Hornstein's chapter, "Dissociative Disorders in Children and Adolescents," made me reflect on the crucial role of mental health professionals who work with children in the primary and secondary prevention of post-

traumatic pathology by identifying and protecting abused children. Hornstein lists six categories of dissociative symptoms that may be misdiagnosed as other disorders.

Cardeña and Spiegel argue that somatization disorders should be classified as dissociative disorders, and they note the close connection between conversion and dissociative disorders. They go on to explain the changes made in the dissociative disorders section from DSM-III-R to DSM-IV, including the controversial renaming of multiple personality disorder as dissociative identify disorder (Kluft writes that the DSM-IV committee was polarized and contentious and that the criteria were influenced by "the power of skeptical authorities insistent on promoting their opinions" [p. 341]).

Loewenstein has an excellent chapter on dissociative amnesia as a disorder and especially as a symptom in the various dissociative disorders, acute stress disorder, PTSD, and somatization disorder. In fact, he writes that a DSM-IV work group recommended a new category of trauma disorders that might include all of these, along with conversion disorder. Loewenstein faults analysts for neglecting the role of extreme trauma in pathogenesis and for not integrating dissociative disorders into our theoretical system, despite the fact that patients such as Anna O probably had dissociative disorders. He conceptualizes dissociation as "a basic part of the psychobiology of the human trauma response: a protective activation of altered states of consciousness in reaction to overwhelming psychological trauma" (p. 312). He notes that psychogenic amnesia affects explicit but not implicit memory (I wish the book had devoted far more attention to the role of implicit memory in trauma and dissociation). Loewenstein reviews evidence that single, brief childhood trauma tends to be remembered verbally, whereas trauma that begins earlier in childhood and is more severe, repetitive, and physically harmful—with multiple perpetrators who are emotionally close to the child and who threaten to harm the child for disclosure—is more likely to result in amnesia. However, amnesia for severe or preverbal trauma coexists with a record of the trauma in implicit memory, which leads to "often uncannily" accurate behavioral reenactments of the trauma. Loewenstein calls the establishment of safety the most important but also the most frequently neglected aspect of treating dissociative patients. Although he values the potential usefulness of hypnosis, he reassures those of us who are not trained in its use by affirming that dissociative patients "can and have been successfully treated without the use of formal…hypnosis" (p. 325). Addressing forensic issues, Loewenstein warns that clinical recovery from abuse does not require that patients confront or prosecute their abusers and that such confrontations may result in a poor outcome for both the accuser and the accused (not to mention the clinician).

Kluft counters the stereotype of dissociative identity disorder as an exhibitionistic attempt by the patient to draw attention to the various "personalities" (this description fits only 6% of dissociative identity disorder patients). To the contrary, he calls the purest form of dissociative identity disorder "isomorphic," and he emphasizes the covertness of the disorder, which is congruent with the patient's efforts to forget and conceal the childhood traumata that shaped it. Alters characteristically "determine behavior from behind the scenes without emerging" and "commonly try to pass for one another." The patient's manifest behavior "often is the combined vector of numerous influences, functioning as a system" (p. 340). Most patients with dissociative identity disorder spend much of their lives with their illness so covert that they sometimes fulfill diagnostic criteria for dissociative disorder not otherwise specified but not criteria for dissociative identity disorder. Alters often experience their interactions with other alters as if they were interactions among separate people, based on the patient's childhood interactions with perpetrators of abuse, so that sadomasochistic experiences are internalized and repeated. So-called Schneiderian first-rank symptoms of schizophrenia may reflect the impact of one alter on another in a patient with dissociative identity disorder. For example, one study found command hallucinations in 82% of dissociative identity disorder patients. Although there is now excellent documentation of the history of childhood trauma in dissociative identity disorder, "the account that the dissociative identity disorder patient gives of his or her traumatization may include elements of inaccuracy and distortion" (p. 353). Iatrogenesis has not been shown to cause dissociative identity disorder, but the therapist's fascination or ineptitude can worsen it. Neural network and information-processing models show promise as explanatory models for dissociative identity disorder.

Despite its limitations, this book has much to offer readers who wish to expand their knowledge of dissociation and dissociative disorders.

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MEMORY

Multiple Identities and False Memories: A Sociocognitive Perspective, *by Nicholas P. Spanos. Washington, D.C., American Psychological Association, 1996, 353 pp., $29.95.*

Dr. Spanos suggests that patients with multiple identities learn to consider themselves as possessing multiple selves, learn to present themselves in terms of this construct, and then learn to reorganize and elaborate on their own biographies so as to make them congruent with their understanding of what it means to have multiple personalities. He believes that patients are actively involved in using available information to create a social impression that is congruent with social and situational demands.

I think there are two fundamental problems with this book. First, Dr. Spanos is a researcher and not a clinician, and, because of this, I think he is seriously limited in his view of the events that he is attempting to understand and explain to us. He does not mention and even seems to discount and minimize childhood histories and unconscious or psychody-

namic views of these events; as a result, he presents what I believe is a simplistic view of multiple personality. Second, Dr. Spanos essentially collapses the concept of multiple personality along with what he calls the sexual abuse survivor movement and the development and popularity of incest resolution therapies into one concept, which he then argues against. He talks about multiple personality early in his book, but the real focus and power of his argument is directed at the issue of what is essentially group hysteria in some instances of alleged pervasive sexual abuse, incest, or supposed satanic cult behavior. In these instances, certainly, a very widespread phenomenon involving alleged victims, naive and reactive therapists, lawyers, judges, and other individuals have all participated in creating what is essentially a false event. His apparent outrage is understandable, and many people would agree. The supposed sexual abuse at certain day-care facilities immediately comes to mind.

While reading Dr. Spanos' book, I was reminded many times of the nineteenth-century novel *Extraordinary Popular Delusions and the Madness of Crowds* (1). It seems to me that Dr. Spanos addresses in a more scientific manner the fascinating occurrence of madness and hysteria in group functioning. Group delusions, however, are very different from what we see in multiple personality. This is where I think that Dr. Spanos falls short in this book. If he took out his discussions of multiple personality and left the rest, I think he would have a good book. For him to discuss multiple personality and to discount the important research done by Putnam, Ross, and Kluft, among others, seems to me to be denying an important reality. Dr. Spanos suggests that even these very respected researchers and clinicians are simply participating in the social construction of reality and producing multiple personalities. This seems not only arrogant but reductionistic and simplistic. It is true, of course, that patients who may be dissociative, sexually abused, or incest victims might be unduly influenced by therapists. Of course caution should be taken in how the history is obtained and where the information leads. I think Dr. Spanos doesn't appreciate that some people become diagnosed as having multiple personality without being led to it by their therapists and that there is more going on here than the simple influence of interpersonal effects.

REFERENCE

1. Mackay C: Extraordinary Popular Delusions and the Madness of Crowds (1841). New York, Gordon Press, 1991

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