Dr. Spiegel Replies

TO THE EDITOR: What's in a name? Dr. Nakdimen concurs that dissociative identity disorder is underdiagnosed, but criticizes the current DSM-IV-TR nosology for removing multiplicity of identity from the name and for not including hiddenness among the diagnostic criteria, which is more like the DSM-III criteria. Undoubtedly, there are multiple ways of naming and describing the identity disturbance of such individuals, some emphasizing fragmentation, others the proliferation of partial competing identities. The diagnostic criteria themselves make it clear that the problem is the presence of "more than one identity or personality state." The current title emphasizes the failure of integration rather than multiplicity of identities, which has the advantage of indicating that the "personalities" are not really personalities but rather fragments of identity indicative of a damaged personality. It is true that hiddenness is not explicitly mentioned in the diagnostic criteria, but that is also characteristic of many psychiatric symptoms, such as delusions in schizophrenia, which are sometimes jealously guarded and only mentioned in response to specific inquiry. Clearly, the exact title of the disorder will again be explored, and hopefully more attention will be paid to the diagnosis and treatment of dissociative disorders. They have been with us for a long time. A rose is a rose is a rose.

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Pierre Janet and the Concept of Dissociation

TO THE EDITOR: In his important plea for a greater recognition and appreciation of traumatic dissociation, David Spiegel, M.D., refers to Pierre Janet's dissociationist model of psychopathology, stating that "Janet used the term *desaggregation mentale*, which is poorly translated by the word 'dissociation'." Apart from mentioning that the French concept is *désagrégation*, it should be pointed out that, here, Dr. Spiegel repeated a common misunderstanding among North American students of dissociation (e.g., 1).

It is true that in *L'automatisme psychologique* (2), Janet spoke of *désagrégation*, actually *désagrégation psychologique*. As far as we have been able to ascertain, it was only the second (1893 edition) that he also used the expression *désagrégation mentale*. However, both before and after this monumental publication (3), he regularly used the term dissociation (e.g., 4, 5), thereby following a tradition that may have started with Moreau de Tours (6, 7). Consequently, Janet's use of the term dissociation in his Harvard lectures (published in 1907) (8), for example, was not the simple result of translation. Rather, his use of the word dissociation reflected prior usage of the term by himself and others in French publications. Thus the term dissociation as evidenced in the literature today was present in the French literature prior to Janet and does not owe its psychiatric existence to being the closest English translation for the French term *désagrégation*.

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Dr. Spiegel Replies

TO THE EDITOR: My point in referring to Pierre Janet's use of the term *desagregation mentale* was not to misattribute the English term dissociation to a poor translation of Janet's language, but rather to highlight his superior understanding of the phenomenon, which involves not a mere separation of elements of identity, memory, and consciousness but rather a failure of the normal processes of integration of these elements that would normally aggregate. While Janet may have used the more common term dissociation as well, it is clear that he thought of the problem as a failure of integration rather than a mere separation. At a time when modern neuroscience is uncovering specific brain regions (perirhinal cortex and hippocampus) involved in binding previously disparate aspects of perception (1), it behooves us to recognize early thinkers who identified problems in integration of various aspects of perception, identity, memory, and consciousness, rather than merely describing their dissociation or disintegration.

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Using a Medical Model With Psychotic Patients

TO THE EDITOR: In the March 2006 issue of the *Journal*, Douglas Turkington, M.D., and colleagues (1) provided a useful review of the state of the field regarding cognitive behavior therapy in treating schizophrenia. While we eagerly await further study and greater availability of this treatment modality for patients with schizophrenia, we were dismayed by the authors' characterization of a medical approach.

The authors presume a "biomedical" medical model in which one is "more likely to ignore" (p. 367) aspects of the patient's experience, "forbids any exploration of a personal meaning (formulation) of psychotic experiences" (p. 370), and goes about in an effort to "persuade or force the patient to agree that he or she has symptoms of a mental illness" (p.