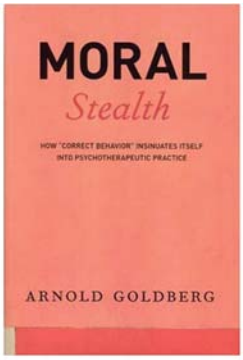

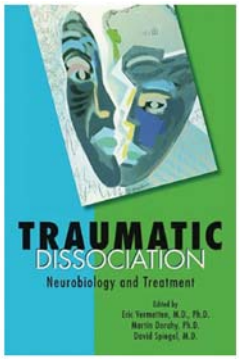

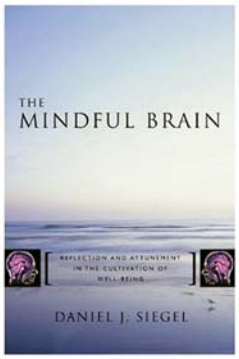

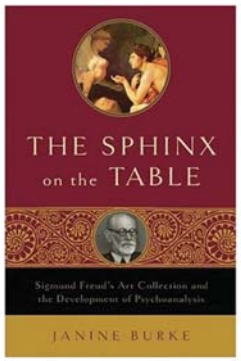

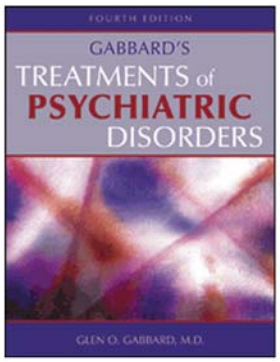

Moral Stealth: How "Correct Behavior" Insinuates Itself Into Psychotherapeutic Practice, *by Arnold Goldberg, M.D. Chicago, University of Chicago Press, 2007, 144 pp., $32.00.*

The word "stealth" in the title of Goldberg's slender book describes the author's easily verifiable observation that unspoken and unrecognized moral positions have "insinuated themselves" in the daily practice of psychiatry, constituting a proud bulwark of unexamined "correctness," which survives independently of its therapeutic effects. Early in the book appears an analyst whose patient confessed that she had just stolen a dress from a department store and asked him what he thought of her. "I immediately told her 'you are a thief.'" End of story? No! Probably sooner rather than later the patient quit treatment and perhaps even increased the quantity of her thefts to meet her financial obligations to a number of new therapists. Laws like the Tarasoff decision, fears of malpractice, and elaborate professional codes of ethics rarely suffice to guide our responses to patients' immoral or amoral, dishonest, or ugly behaviors. In the example just cited above, there were some other possible responses. First, the patient might have wanted to be helped in understanding why she needed to violate her own standards. The therapist might have waited until he understood more about the subjective state of the patient who stole and her weak inner voice questioning the theft.

But even in conceptualizing the psychological details that comprised the patient's behavior, Goldberg finds traditional analytic theory inadequate. Freud did not prepare us adequately for ethical responses with his structures of the unconscious Id, with its nonmoral imperious instincts striving for release, the often hypermoral Super-ego, a kingdom of duties and behests mysteriously bequeathed by the child's parents, and the Ego as an erratic doubting judge striving to be good. Nor does one analytic or psychotherapeutic system provide more help than any other. Through well selected treatment examples, Goldberg shows us the weakness of prevailing assumptions and their fundamental inapplicability.

The Ten Commandments of the Old Testament and the "Golden Rule," likewise, are inadequate guides. As Nietzsche taught us, "submission to morality can be slavish or vain or selfish or resigned…or an act of desperation like submission to a prince; in itself it is nothing moral" (1). In any case, "absolutes in psychoanalysis and psychotherapy are (mere) conventions that do us more harm than good" (p. 100). Neither religious behests nor moral absolutes cover a complex topic such as violation of confidentiality deemed vital to obtain collegial help with a difficult patient or needed in order to write a scientific clinical article. At the opposite pole of invariant standards, the author finds little value in "moral relativism." The principle "anything goes" is far out of step with a current American culture of corporate malfeasance, preoccupation with terrorism, and conservative religious revivalism.

So, Goldberg turns to Philosophers for help and shifts his therapeutic focus from morality to ethics. Whereas morality examines what is imperative and obligatory—the "thou should and must" requirements—ethics is more concerned with the questions "What is good"; "what is the good life?" Answers are always preliminary and swathed in an atmosphere of uncertainty with the necessity to doubt, to persistently puzzle about meaning, and to consider the uniqueness of each apparent violation of moral or ethical standards. We can be quite kind, fair, and loving, and yet our own even fully examined values, rules, and standards may not apply at all to the inner lives and actions of our patients. We are compelled to move away from the answer to the question *if* something should, ought, or must be done to the question *why* a unique individual in special circumstances with a special emotional history might chose path A or B.

Goldberg finds the "discourse ethics" of J. Habermas helpful here. "Moral questions can only be solved by participants finding concrete answers in particular cases through a sustained effort to accept the perspectives of all involved" (2, p. 24). This position requires a special kind of neutrality from the therapist, requiring a "move from an individual perspective on principles and judgments to that of a shared or communicative one based on argument and interpretation" (p. 111). Above all, our implicit assumptions about both ethics and morality need to become explicit, so they can be empirically tested, studied, compared, and debated with patients and peers alike. To be asked to be explicit about our moral standards of course does not suggest we abandon them.

The reviewer highly recommends this book as a valuable stimulus to clarify our therapeutic stance toward those many patients who so often confront us with behaviors that make us uneasy with our own lifelong therapeutic belief system distinguishing right from wrong.

References

1. Nietzsche F: The dawn, in The Portable Nietzsche. Edited by Kaufman W. New York, Penguin Books, 1982

2. Habermas J: Justification and Application: Remarks on Discourse Ethics. Cambridge, Mass, MIT Press, 1993

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Traumatic Dissociation: Neurobiology and Treatment, *edited by Eric Vermetten, M.D., Ph.D., Martin J. Dorahy, Ph.D., and David Spiegel, M.D. Arlington, Va., American Psychiatric Publishing, 2007, 398 pp., $62.00.*

The term "dissociation" refers to the splitting apart of streams of consciousness, psychological processes, or personality structures that would normally form a cohesive whole (1). Dissociative phenomena cut across multiple axis I and II DSM-IV-TR disorders. Several conditions explicitly include dissociative symptoms, notably dissociative amnesia, dissociative fugue, dissociative identity disorder, and borderline personality disorder. In others, a relationship with dissociation has been suggested by the literature but is not explicitly mentioned by DSM. For example, peritraumatic dissociation has been shown to predict the later development of posttraumatic stress disorder (PTSD) (2). Trichotillomania has been linked to childhood trauma, and repetitive hair pulling is often undertaken in a state of dissociation (3). Therefore, our understanding of the relationship between dissociation, trauma, and psychopathology is very important clinically (4–7). In their welcome book, Eric Vermetten and co-editors bring together contributions from a variety of experts in order to chart the ascent of traumatic dissociation, beginning with Piaget and Freud, moving on to DSM, and thence the neurosciences, translational medicine, contemporary controversy, and treatment.

The book comprises three overarching sections. The first probes conceptual and historical issues surrounding dissociation, such as a potential role for disorganized attachment during childhood (e.g., frightening and abusive behavior from parents) as a vulnerability factor for dissociative psychopathology in later life. Traditionally, dissociative identity disorder (a contentious entity at the best of times) has been conceptualized in terms of cognitive avoidance, or reduced processing of traumatic stimuli per se. Neurocognitive findings in patients with dissociative identity disorder, reviewed in this section, instead suggest *increased* processing of trauma-salient stimuli. Elsewhere, there is a critique of the complex relationship between dissociation and PTSD, which contrasts the heightened noradrenergic tone and hypermnesia often characteristic of PTSD with "shut down" amnesic symptomatology typically occurring with dissociation. It is concluded that although PTSD and dissociation can both arise after trauma, they should nonetheless be regarded as distinct entities whose etiologies differ.

The second section of the book focuses on neurobiology and opens with a carefully crafted and thought-provoking translational framework for researchers. The authors outline laboratory-based induction of dissociative phenomena—for example, using ketamine. Physiological correlates of dissociation are explored, including pulse rate, the hypothalamo-pituitary-adrenal stress axis, and tonic immobility (which can be modeled in animals). This helps us to glean insights into putative vulnerability and resilience factors. There is subsequent coverage of human studies in military personnel showing that the propensity to dissociate during stress was linked to low capacity for neuropeptide Y release and a low ratio of DHEA-S:cortisol. Recruits who showed baseline dissociative experiences were more likely to fail military training. The objective measurement of dissociation and its neurobiological correlates could contribute to the selection process for occupations often involving trauma in order to minimize the risk of subsequent psychopathology. As well as physiological correlates, some research has explored brain correlates of dissociation. In a chapter comprehensively covering symptom provocation in PTSD patients, it is noted that dissociative symptoms were associated with functional changes in the prefrontal, temporal, and parietal cortices, and the anterior cingulate gyrus and amygdala. Different findings were reported for arousal and flashback responses, which supports the need for further study and careful delineation of dissociation and its relationship with other symptomatology in DSM.

It is the last section of the book that covers clinical management issues. As it stands, the book (as with medical training) involves somewhat delayed gratification. There is a well-written précis covering psychiatric approaches to dissociation (history, biology, and clinical assessment). Greater emphasis on clinical features at the start of the book, rather than here toward the end, would have been less frustrating. A subsequent chapter covers the assessment of dissociation using semistructured interviews, questionnaires, and prospective tests. Problems facing practitioners when assessing dissociation are also addressed, such as the relative lack of normative data and the broad nature of the term "dissociation" itself. Finally, there is an overview of treatments for dissociation that are supported by the available literature.

In all, this book succeeds in drawing together different historical, research, and clinical strands into a largely cohesive text. It acknowledges the considerable controversy regarding dissociation in psychiatry and takes a realistic attitude toward limitations in the current body of knowledge. *Traumatic Dissociation: Neurobiology and Treatment* will be of interest to practitioners likely to encounter patients with a history of traumatic exposure and to researchers in the field of dissociation, since it offers insights from a multitude of perspectives.

References

1. Spiegel D: Recognizing traumatic dissociation. Am J Psychiatry 2006; 163:566–568
2. Briere J, Scott C, Weathers F: Peritraumatic and persistent dissociation in the presumed etiology of PTSD. Am J Psychiatry 2005; 162:2295–2301
3. Lochner C, Seedat S, Hemmings SM, Kinnear CJ, Corfield VA, Niehaus DJ, Moolman-Smook JC, Stein DJ: Dissociative experiences in obsessive-compulsive disorder and trichotillomania: clinical and genetic findings. Compr Psychiatry 2004; 45:384–391
4. Simeon D, Greenberg J, Nelson D, Schmeidler J, Hollander E: Dissociation and posttraumatic stress 1 year after the World Trade Center disaster: follow-up of a longitudinal survey. J Clin Psychiatry 2005; 66:231–237
5. Maaranen P, Tanskanen A, Haatainen K, Honkalampi K, Koivumaa-Honkanen H, Hintikka J, Viinamaki H: The relationship between psychological and somatoform dissociation in the general population. J Nerv Ment Dis 2005; 193:690–692