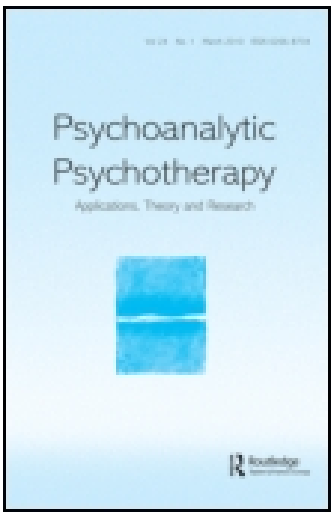

Psychoanalytic Psychotherapy
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rpps20

Understanding and treating dissociative identity disorder: a relational approach

Joanne Stubley[a]
[a] Consultant Psychiatrist in Psychotherapy, Lead Tavistock Trauma Service for Adults, London, UK
Published online: 02 May 2014.

To cite this article: Joanne Stubley (2014) Understanding and treating dissociative identity disorder: a relational approach, Psychoanalytic Psychotherapy, 28:2, 235-239, DOI: 10.1080/02668734.2014.908518

To link to this article: http://dx.doi.org/10.1080/02668734.2014.908518

Psychoanalytic Psychotherapy, 2014
Vol. 28, No. 2, 235–239, http://dx.doi.org/10.1080/02668734.2014.908518

BOOK REVIEW

Understanding and treating dissociative identity disorder: a relational approach, by Elizabeth Howell, Hove, Routledge, 2011, 330 pp., £80.00 (hardback), ISBN 978-0-415-99496-5

Although erudite, highly informed and cohesive in structure, Howell's book on *Dissociative Identity Disorder* (DID) presented me with a particular problem that took some time and thought for me to understand. If this book were not about DID and much of the same theoretical material had been brought together with a title of say Dissociative States or even Trauma, I would feel less uneasy and less uncomfortable in recommending it. This would perhaps have allowed me not to directly address the conflicting views within psychoanalytic societies about the diagnosis of DID. Some of the case material also contributed to my unease as I tried to conceptualise how I personally understand the psychiatric diagnosis of DID (or in European terms *Multiple Personality Disorder*). Perhaps, it is impossible to read these kinds of cases without recognising some link to the Hollywood versions of 'The Three faces of Eve' or 'Sybil' with the mixture of disbelief and fascination that is inevitably engendered.

I was reminded of a similar personal experience when I first came to live in the UK and took up my psychiatric studies here, having begun them in Australia where a considerable American influence was present. In the early 1990s, the Americans were breaking new ground both theoretically and psychoanalytically in working with the group of patients whom they called 'borderline'. However, my use of this concept when I first arrived in the UK was to meet with some scepticism and disquiet at the diagnosis. This seems difficult to believe now when Borderline Personality Disorder is such a well-recognised diagnostic entity and I find myself wondering whether DID may also have a similar fate over time. If this might be true then Elizabeth F. Howell's book is likely to play a role in bringing the British on board.

Elizabeth Howell, described on the back cover as a psychoanalyst and traumatologist, provides a detailed, thoughtful and coherent account of a wide range of theoretical issues that deserve to be addressed in this diagnostic setting. She divides her book into two parts, linked to her title, by first understanding and then treating DID. The first part covers trauma theory, attachment theory and research, psychoanalytic theory including an historical overview of dissociation and neurobiological explanations of trauma. It is this first part that I was particularly impressed by. There is something deeply satisfactory in the carefully considered and straightforward way in which Howell links together the diverse fields of neuroscience with attachment and relational psychoanalysis to elucidate

trauma theory. This is an area that, as someone who works in the trauma field, I feel presents such interesting and creative ways of understanding our patients.

Howell offers helpful definitions of dissociation, linking these to different theoretical constructs as well as contrasting dissociation with repression. At the simplest level, she describes dissociation as 'the separation of realms of experience that would normally be connected.' She then elaborates on the multiple and at times confusing uses of the term to describe a variety of structures, defences, taxonomies and so forth. Helpfully this is then clarified into two main areas – dissociative structures of the mind and dissociative processes. Dissociative structure of mind is perhaps best understood through Bromberg's (1998, 2006) descriptions of dissociated self-states. Bromberg suggests that the hallmark of dissociation is the ability of the mind to adaptationally limit its self-reflective capacity and that this is both normal and pathological. It is his belief that a unitary, integrated self is an illusion; rather the structure of the mind is one of fluid, multiple self-states. This description of dissociative structure includes Bucci's (1997, 2002, 2003) cognitive–psychoanalytic model of dissociation that involves the lack of sufficient referential process to link symbolic and subsymbolic aspects of experience. It may also include Stern's (1997) description of unformulated experience. Dissociative process is seen as activities such as going into a trance, depersonalisation, derealisation and selective inattention, all of which may contribute to dissociative structure of mind.

Having given these definitions, Howell then takes us through the history of the concept of dissociation, focusing on the way in which the concept has had moments of popular interest with clinicians such as Charcott, Janet, and Freud and Breuer's work with hysterical patients and the links that were made with trauma. Thus, one sees Janet's description of fixed ideas as precursors to Jung's 'complex' and Bleuler's definition of schizophrenia. Fairbairn's and Ferenczi's clinical descriptions of dissociation as a defence against trauma are also noted. With the rise of both psychoanalysis with its focus on repression of incestuous wishes, and behaviourism which eschewed anything unconscious, dissociation was displaced as a focus of clinical attention in the early twentieth century. Howell then describes a resurgence in interest in the dissociative mind today, led by relational psychoanalysis in America with writers such as Bromberg, Chefetz, Frankel, Howell, Mitchell, Schwartz and Stern. Bromberg in particular has written prolifically on the universality of the dissociative mind. Linked to this notion is the proposition that DID is a much more common clinical condition than has previously been recognised (a prevalence rate of 1.1–3% in the general population – ISST_D Guidelines, in press).

This is one of the moments in reviewing the book that I find somewhat disconcerting. If one turns to ICD 10 as the European psychiatric diagnostic manual, then Multiple Personality Disorder (or DID) is described as 'rare, and controversy exists about the extent to which it is iatrogenic or culture specific'. To me, this suggests the considerable divide across the Atlantic and is indicative of the suspicion that meets the diagnosis here in the UK. Howell attempts to

answer some of these concerns when she describes the considerable misdiagnosis and comorbidity often seen with DID. Yet to me, the historical overview she provides fails to fully address the question of why such a split has developed between the USA and the UK. I found myself wondering whether one answer lay within the very nature of Howell's title of 'Psychoanalyst and traumatologist'. This book, and other American papers on trauma written by psychoanalysts, will often present a synthesis of the analytic viewpoint within the broader trauma field, thus including neuro-scientific theory, attachment theory and cognitive evidence to complete their conceptual understanding. This is not something that is often seen in British analytic papers focusing on trauma and I wonder whether this has in part been due to the competitive split that has been reflected in NICE guidelines in the NHS between cognitive trauma treatments and psychoanalytic therapy. Perhaps, this is partly why I found this book so thought-provoking as it is an attempt to bring together so much of what is known about trauma from different fields and bodies of knowledge.

This may be better illustrated through one example. Howell comments on Schore's description of projective identification as a process that may be understood as a sub-symbolic channel of communication that neuro-biologically represents Right Hemisphere to Right Hemisphere communication. This might also be understood as a description of procedural memory where communication occurs through the relational experience, at an unconscious level. In contrast, Howell suggests that projective identification is one person's dissociated experience in communication with another person's dissociated experience. Each description brings a different perspective, deepening the understanding of what occurs between therapist and patient.

Schore's work on understanding the development of pathological dissociative states is a particular example of the synthesis of different models and paradigms being brought together in the trauma field. He describes in detail the impact on the developing brain in a child who suffers abuse, severe neglect or massive misattunement. He states:

> The symptomatology of dissociation reflects a structural impairment of a right brain regulatory system and its accompanying deficiencies of affect regulation.

Thus, early abuse increases the likelihood of disorganised attachment through the impaired capacity for affect regulation and the use of pathological dissociation as a defence, which then inhibits further attachment communications and interactive regulation. This leads to the suggestion that therapy involves:

> ... the psychobiologically attuned therapist acts as an interactive affect regulator of the patient's dysregulated state. The model clearly suggests that the therapist's role is much more than interpreting to the developmentally disordered patient either distortions of the transference, or unintegrated early attachment experiences that occur in incoherent moments of the patient's narrative. Even more than the patient's late-acting rational, analytical and verbal left mind, the growth-facilitating psychotherapeutic relationship needs to directly access the deeper psychobiological

> strata of the implicit regulatory structures of both the patients' and the clinician's right mind. (Schore, 2009)

This quotation of Schore's work by Howell is important as it provides an understanding of Howell's position when it comes to the treatment of DID. This leads into the description of treatment adaptations and requirements in part two of the book, preceded by a chapter on diagnosis and assessment which highlights again the belief held by Howell and others that DID is underreported and underdiagnosed. The therapeutic approach proposed by Howell makes use of a notion much used in the treatment across modalities of trauma – phase-oriented treatment. Howell dates this back to Janet and also focuses on Judith Herman's approach with complex trauma.

One is struck by the integration of models of treatment with a combination of cognitive behavioural techniques, in the first phase including psycho-education and safety agreements, and in the second phase with the various techniques described for working with traumatic memories. These include fractionating the memories (dividing each memory up into manageable bits), muting (as though using a remote to adjust sound, brightness and so on) and using a 'calming screen' (imaging a split screen where one side is playing the memory and the other contains something calming and safe). These more active techniques are combined with a more traditional objects relational perspective, which emphasises the importance of boundaries and establishing a therapeutic alliance. Much detail is given to transference/counter-transference issues in the work. The question of aim with phase two leads Howell to propose that it is not abreaction or catharsis that is the aim in working with traumatic memories. Rather she places the aim firmly in a relational perspective by suggesting that it is the communication of emotion and memory to another person that is vital. She also emphasises, like Herman, the importance of mourning in the second phase.

I found a great deal of this description of the treatment helpful and thought-provoking in relation to my own work with complex trauma patients. In severely traumatised patients, one repeatedly finds that a more traditional psychoanalytic approach may initially be unhelpful and the need to have a period of engagement and development of the therapeutic alliance is one that in my service we often address through initially offering what we call 'intermittent treatment'. This is generally less than once a week and often has supportive, more structured, psycho-educational and attention to risk elements as part of the engagement. It may then be possible to move into phase two work whereby working through the trauma is inevitably part of the transference/counter-transference experience. Howells' detailed descriptions of counter-transference issues with these kinds of patients provide much food for thought.

However, when one gets to her detailed accounts of patients and their therapies, I return to the problem I raised at the start of this review. There is an unpublished paper written by Sarah Mandow called 'Inauthentic states of mind' where she describes the counter-transference experiences with dissociative

patients including feelings of disengagement, scepticism, uncertainty, confusion and outright disbelief. She helpfully links this with the disturbing reality of working with someone who defends against further trauma through dissociation, creating aspects of the self that are unknown to other aspects. As she describes, there is a

> ... withdrawal into a sealed off state that serves to protect other self states from the danger and allows the person to remain in a state of constant vigilance over the self.

By only having a particular self-state in the therapeutic room at any one time, inevitably there is only a kind of partial truth that is available. This contributes to the sense of disbelief or inauthenticity.

This is one important aspect of the unease I spoke of at the beginning of this paper. The counter-transference experience one may have with this kind of presentation is inevitably felt in reading the case material in this book. However I think my unease is also linked to the bigger picture of how we bring the understanding of dissociation and its impact on patients – clinically and theoretically – into object relations theory in a way that does not polarise us into either fervent believers or profound sceptics. For this reason alone, I would recommend Howell's book as a way of further opening up the topic of Dissociative Disorders into the psychoanalytic and the trauma communities on this side of the Atlantic.

References

Mandow, S. (2009). *Inauthentic states of mind*. Unpublished manuscript.

Schore, A. N. (2009). Attachment trauma and the developing right brain: Origins of pathological dissociation. In P. F Dell & J. F O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM V and beyond* (pp. 107–141). New York, NY: Routledge.

Joanne Stubley
Consultant Psychiatrist in Psychotherapy,
Lead Tavistock Trauma Service for Adults, London, UK
Email: jstubley@tavi-port.nhs.uk