

## EDITORIAL:

# BUILDING UPON OUR FOUNDATIONS

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It is easy to become demoralized in the face of repeated assaults on the credibility and legitimacy of our patients, our patients' given histories and allegations of mistreatment, and the very conditions that they suffer. As clinicians and scientific investigators working with trauma victims and dissociative disorder patients, we have found it difficult to withstand withering and venomous attacks upon our professions, our motivations, and ourselves as individuals. Although there have been some notable exceptions, the last several months have been remarkable for the video and print media's love affair with those who protest the veracity of allegations of childhood mistreatment, and their willingness to promulgate polarized negative representations of those who allege childhood mistreatment and those who treat them. Since the New Year, I have been interviewed by a large number of reporters and journalists. Only two diverged from a rather stereotyped and weary script in which the legitimacy of the perspective of the False Memory Syndrome Foundation was assumed, and this assumption colored the majority of the dialog that transpired. I strongly suspect that matters will get worse before they improve.

Organized medical and mental health groups are rushing to formulate responses and commentaries. It can be expected that many of their statements will be extremely cautious and conservative with regard to the credibility of the accounts of those who allege childhood mistreatment, especially when these allegations are made on the basis of materials recovered in treatment settings. The editorial page is not the appropriate forum for a lengthy discussion of this complex and controversial topic.

Suffice it to say that there is strong evidence that a variety of social and interpersonal influences, including psychotherapy, may inadvertently play a role in the generation of inaccurate recollections, and whatever precautions can be applied to minimize the likelihood of such unfortunate outcomes should be taken, unless such steps would render treatment impossible. However, there is also strong evidence that documentable traumata can become unavailable to memory, and that there is no reason to assume *a priori* that recovered materials will prove erroneous or artifactual in whole or in part as a result of what a therapist has done in the way of interventions. This last observation is qualified, of course, by the fact that no memory can be assumed to be perfect, so that whenever anyone asks another to share an experience, it is possible that what is retrieved and recounted may diverge from historical accuracy because of basic problems with the registration, retention, and retrieval phases of mem-

ory unrelated to the specific actions of the person making the inquiry.

There is reason to be concerned that some clinicians with less than optimal competence and/or sensitivity to appropriate cautions and potential risks may have led patients to believe that events that did not occur actually have transpired. There is reason to suspect that at times clinicians with exemplary competence and exquisite sensitivity to the risks of misadventure, clinicians who make assiduous efforts to avoid leading questions and take care to anticipate and minimize the possibility of subtle demand characteristics pressing the patient toward generating misinformation or withholding information, nonetheless may encounter individuals who enter the interview either (1) primed to find certain types of memories, or (2) with expectations of finding certain types of memories, or (3) predisposed to make unanticipated idiosyncratic responses to what normally are neutral therapist activities and verbalizations, and leave a scrupulously-conducted consultation or treatment session with an inaccurate conception of what has befallen him or her in the past; e.g., he or she may leave with a believed-in pseudomemory or confabulation of abuse that never occurred.

There is equal reason to be concerned that some clinicians with less than optimal competence and/or sensitivity to appropriate cautions and potential risks may have led patients to believe that events that did occur actually have not transpired. Furthermore, there is reason to suspect that at times clinicians with exemplary competence and exquisite sensitivity to the risks of misadventure, clinicians who make assiduous efforts to avoid leading questions and take care to anticipate and minimize the possibility of subtle demand characteristics pressing the patient toward the generation of misinformation or the withholding of information, nonetheless may encounter individuals who enter the interview either (1) primed to disregard certain types of memories, or (2) with wishes not to find certain types of memories, or (3) predisposed to make unanticipated idiosyncratic responses to what normally are neutral therapist activities and verbalizations, and leave a scrupulously-conducted consultation or treatment session with an inaccurate conception of what has befallen him or her in the past; e.g., he or she may leave with a believed-in pseudomemory or confabulation that actual abuse never occurred.

I mention this because today genuine skepticism of the benign sort that looks evenly in all directions and encourages the advancement of knowledge seems vanishingly rare. Instead, we find a prevalence of pseudo-skepticism consist-

ing of harsh and invidious skepticism toward one's opponents' points of view and observations, and egregious self-congratulatory confirmatory bias toward one's own stances and findings misrepresented as the earnest and dispassionate pursuit of clinical, scholarly, and scientific truth.

Although it would be naïve to hold out hope that the current turmoil will subside or be replaced by an atmosphere in which a disinterested pursuit of the truth prevails, and foolhardy to deny that at times vigorous rhetoric must be met with equally vigorous rhetoric, it would be tragic and wrong-headed were we to become so preoccupied with the tumult and rancor of polarized argument that the field becomes focused upon and preoccupied with self-defense and counterattack, in effect abandoning the type of study and research that will ultimately establish the dissociative disorders field even in the face of ongoing contention and hostility. The papers in this issue, each in its own way, advances the credibility of the field by building upon established conceptual, clinical, and research foundations, and contributing further advances.

In his paper, Dr. Coons advances our appreciation of false positive dissociative disorder diagnoses. It is a tribute to Dr. Coons that his recent and upcoming publications deal evenhandedly with information that both emphasizes and underlines the legitimacy of the dissociative disorders while acknowledging that all patients who present with apparent dissociative disorder symptoms are not what they first appear to be. Dr. Phillips' paper offers a useful but admittedly preliminary approach to the use of the Rorschach test in the diagnosis of the dissociative disorders, broadening the still small and narrow beachhead of psychological testing in the dissociative disorders field. Rorschach testers may be helped to become more familiar with the dissociative disorders by their use of his proposed diagnostic scale.

Dr. Irwin's exploration of the role of childhood object loss in patients' subsequent dissociative diatheses widens our appreciation of etiological considerations in the development of the dissociative disorders. His approach adds much to the observations and hypotheses advanced by Barach and Liotti in their earlier publications. By establishing the convergent validity of two forms of Bernstein/Carlson and Putnam's DES, the most widely used screening instrument for the study of dissociative phenomenology, Ellason, Ross, Mayran, and Sainton make it possible for both clinicians and researchers to choose whichever version best fits their needs without undue uncertainty.

Benjamin and Benjamin continue to share their pioneering findings in running groups for the partners and parents of the dissociative disorder patient, making it possible for more and more clinicians to offer useful support for these often stressed, overwhelmed, and neglected individuals. Hall and Steinberg offer an impressive argument for the use of objective diagnostic measures under a number of challenging circumstances. They demonstrate the depth and flexibility of the SCID-D instrument on the clinical firing line. This is an especially important contribution for busy and often overworked clinicians, who have an often-unappreciated legitimate right to insist upon seeing how they and their

patients can profit from the use of a complex and time-consuming protocol before being persuaded it is worthwhile to invest sufficient time and effort to master it. Steinberg and Steinberg further this line of reasoning by providing a fascinating case report illustrating the use of the SCID-D instrument in the assessment of a blind adolescent.

Finally, Young describes his experience in treating isolated symptoms in dissociative disorder patients with the new EMDR (Eye Movement Desensitization Reprocessing) methodology. It is well-known anecdotally in the dissociative disorders field that many colleagues are using EMDR, but it has also become clear that dissociative disorder patients not infrequently have very strong and unproductive responses to the indiscriminate application of EMDR techniques. Advanced training in EMDR and special technical modifications in its use are recommended for the EMDR treatment of dissociative disorder patients. Young's report describes a pioneering effort. Replication by others in a more systematic manner will be necessary before EMDR can claim a prominent role in the treatment of the dissociative disorders. However, should such reports be forthcoming, it will be very helpful to have at our disposal a technique that can address discrete symptoms without necessarily entering into the depths of the dissociative disorder patient's misery. All too often a dissociative disorder patient is severely distressed by a symptom or symptoms that cannot be addressed easily or effectively because such an endeavor would require dealing with material the patient is not yet ready to face in the often strenuous ways that have been demonstrated to be successful in symptom-resolution.

Let us continue to learn and develop a credibility for our field that is based on an increasingly solid foundation of basic and clinical research, and a time-tested body of clinical wisdom. Detractors, like death and taxes, will always be with us. In trying times, it is important not to miss the woods for the trees. We have foundations on which to build. We should not be so preoccupied with the politics of science that the pursuit of science itself is neglected. The strong structures that we erect will ultimately be our best allies. The history of science strongly suggests that we may never change the minds of those who have already identified themselves with an adversarial point of view. However, if we succeed in demonstrating the soundness of our perspectives, over time the outcome will be favorable to us. If we fail to do so, the reverse will be the case.

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