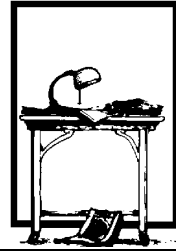

EDITORIAL



A President's Perspective: The Human Face of the Diagnostic Controversy

I sit with 17-year-old Alan in my office and we chat about his college plans, his new girl friend, and his desire to take up a career in medical technology. Five and a half years ago I had diagnosed Alan with DID (dissociative identity disorder) after he was brought to me by his birth mother and step father with whom he began to live at age 10. After ten years of neglect and abuse in the home of his birth father in another state, he moved to his new caring family in Maryland. When he arrived at his new home, Alan's parents noticed that he talked to himself in different voices, went into catatonic, unresponsive states when corrected for minor infractions, and had no memory for destructive episodes. When angry, Alan destroyed furniture, killed a household pet, and set a fire in a trash can in his school's cafeteria.

Four years ago, Alan became a student at the day school at Sheppard Pratt Hospital where he received grade level education in small classes, several times a week therapy, family therapy, and benefitted from a

structured school program with clear consequences and rewards. His individual treatment course followed from a theory about his behavior that was implicit in his diagnosis. His behavioral and psychiatric problems were seen as adaptive responses to a disturbed and traumatic environment in which the development of integrative emotional functioning was precluded by inconsistent and abusive caregiving. His internal voices were seen as his mind's coping mechanism with the binds, confusions and traumatic circumstances of his early years, symbolically personified in an internal microcosm of the external chaos and conflict. His therapy emphasized listening to the internal voices that held in tense feelings about his abandonment, neglect and abuse and helping him express these feelings and conflicts directly. Alan's betrayal by the circumstances of his early life were contained in a voice he called "Silent Rage." "Silent Rage" was not silenced further by psychotropic medicine, but given a voice in his treatment so that the betrayal of his early years was shared and acknowledged with his treatment team. He was taught that his brain was adaptive and creative and he could learn now, as he had in the past, to adapt to the new circumstances of his life. Currently, Alan has full memory for his behavior, no longer hears voices commanding him to do destructive things, and has developed attachments to his new family. There have been no destructive episodes for over two years, and Alan is eagerly embracing a productive future.

In an office two doors away, a therapist is meeting with 17-year-old Suzie, who attends the same school, with access to the same plethora of special services. She receives twice a week psychotherapy, family therapy, speech and language services, and has the same small classes and environment of structured consequences. Suzie was sexually abused between the ages of 3 and 5 by a friend of her father, and began to display self-destructive behavior at age 11, including self-cutting, which resulted in three hospitalizations before the age of 16. Suzie hears voices, a male voice commanding her to harm her self, and other voices which argue about her. Occasionally, even at school, she enters catatonic unresponsive states and hides in a corner sucking her thumb. Suzie has been diagnosed with major depression with psychotic features. Suzie's treatment course follows from the theoretical model implicit in her diagnosis, just as Alan's has. While her traumatic background is acknowledged, the problem is viewed as primarily a disorder in Suzie's brain. Her brain simply will not be have it self, and her treatment team must help her control it. The rage and storm within her from the betrayal of her early years has been reinterpreted to Suzie as Suzie's problem, a problem to be taken care of with chemical interventions and external

control. Most recently, Suzie was given her second ECT treatment to help her with her intractable depression, and she takes an antidepressant, antipsychotic and mood stabilizer. However, the voices have not stopped.

During her most recent hospitalization, the attending doctor suggested that maybe the long term consequences of her traumatic background had been overlooked, and after a consult with the trauma disorder program, a provisional diagnosis of Dissociative Disorder, Not Otherwise Specified was suggested. Now that Suzie has a new provisional diagnosis, it is possible that she too will find a way to give voice to her "Silent Rage" so that it is no longer directed against the self. Perhaps she can learn to reinterpret her angry voices as a protective strategy, and to break away from her close identification with the perpetrator, signified by the condemning, persecutory voice that she hears. Like most abuse victims, Suzie blames her self for her suffering, and perhaps the new psychiatric response will no longer provide subtle collusion with her own self-directed anger, but teach her to transcend her self-blaming posture.

Alan and Suzie are prototypical of hundreds of cases I have seen over the last ten years, which illustrate that the questions raised in this important issue are not simply a pedantic exercise. The way we resolve the controversies about diagnosis have profound implications for the lives of thousands of people who are entrusted to the care of mental health professionals. It is the patient to whom we owe our allegiance and it is for the patients that this diagnostic controversy has any relevance. Stories like Alan's and Suzie's convince me that diagnosis profoundly affects the way these youths are treated in our psychiatric settings and, in turn, the way these youngsters see themselves and their future potential.

What if Suzie's therapist had found in a diagnostic and statistical manual a way to describe Suzie's self-injury, catatonic states, regressions, and voices, in the section on dissociation, under a major dissociative disorder diagnosis, as suggested by Dell (this is sue), or under pervasive dissociative disorder, as suggested by Coons (this is sue). What if, this hypothetical DSM facilitated a way to see Suzie the way Alan had been seen, as having developed an adaptive process that led to fragmentation of the self? Might Suzie's treatment have taken a totally different course as Alan's has? Of course, one can never know for sure, but as a consultant to cases like Suzie's, I have seen important therapeutic changes made after the treatment changed direction to frame the problem as a posttraumatic adaptation. For at its best, a diagnosis provides a mutual

language of therapeutic dialogue. This therapeutic dialogue provides the frame work for the pa tient to see him self/her self in new ways that can fa cil i tate power ful changes.

Di ag no sis can be seen as a mu tu ally agreed on nar ra tive, an ab bre vi ated “story” that dis tills the es sence of a prob lem. This prob lem and its resolu tion can then be ex am ined within a con text where the ther a pist and pa tient share mu tual as sump tions. While Dell ac know led ges that the clas si fi ca tion of even mam mals is “fuzzy” at best, how much more “fuzzy” are clas si fi ca tion schemes for hu man be hav iors! But an ad di tional irony sep a rates psy chi a tric clas si fi ca tion from its cous ins in the nat u ral sci ences. Un like clas si fi ca tions of mam mals, the ul ti mate goal of our clas si fi ca tion is to fa cil i tate changes that re sult in the cat e gory no longer hav ing any rel e vance. In other words, as ther a pists, we seek to name the thing in a way that the name soon out lives its use ful ness. Thus, there is an in her ent ten sion be tween sci en tific clas si fi ca tion, which best re mains static in or der to ver i fy and val i date one’s clas si fi ca tions, and ther a peu tic clas si fi ca tion, which im plies an evolving and tem porary state in which po ten tial change is al ways pos si ble. The chal lenge for us is that our nam ing and clas si fi ca tion does not be come the end in it self, and the “sto ries” that we tell about our pa tients with our “nam ing” of their dis or ders are heal ing sto ries that po ten ti ate growth and re cov ery. Within this per spec tive, the most ac cu rate di ag no sis is the one that tells the story in a way that po ten ti ates the great est change.

What “story” does the cur rent DID di ag no sis as de scribed in DSM-IV (Amer i can Psy chi a tric As so ci a tion, 1994) tell us about the po ten tial for change? Surely the words “pres ence of two or more dis tinct iden ti ties” (APA, 1994, p. 487) con veys the sense of an im mu ta ble con di tion. For Alan, I did not show him these cri te ria, or even com mu ni cate them to his fam ily, as the way this di ag no sis is de scribed in DSM-IV would not as sist Alan with a story about him self that would move him to a new un der stand ing. In my ed u ca tion to Alan about the na ture of his di ag no sis, I relied on my clin i cal and the oretical un der stand ing of trauma and its con se quences, gleaned from read ing both sci en tific and clin i cal lit e ra ture, and from my clin i cal ex pe ri ence. I cer tainly did not em pha size that his dis or der was a prob lem of “dis tinct per son al ity states” (“each with its own unique way of per ceiv ing, re lat ing to and think ing about the en vi ronment and sel f” [APA, 1994, p. 487]) as the DSM-IV def i ni tion would ad vise me. This would be coun ter ther a peu tic to the mes sages I am try ing to teach him, about his own ca pac ity for change and the im por tance of in te gra tion of his dis pa rate self-views. In fact, I wor ried that the DSM-IV con cep tu al iza tion of DID was so po ten tially mis lead ing in its

em pha sis that I never told his di ag no sis to his teach ers in the school who work with him daily, for fear they would start to ei ther look for “al ters” or rid i cule him or my self for our mu tual un der stand ing of this dis or der. Had the di ag no sis been “ma jor dissociative dis or der” as sug gested by Dell, might I have felt more com fort able com mu ni cat ing this? Per haps.

The ultimate agreed-upon iteration of the diagnostic criteria of the dissociative dis or ders, is not yet clear, but Paul Dell has moved our field for ward in urg ing a re con sid er a tion of the im pli ca tions of our cur rent diagnostic criteria. As Putnam (this issue) and Steinberg (this issue) suggest our cri te ria must rely heavily on the re search that has al ready been done, as well as venturing out in new di rec tions. As Coons sug gests, these criteria must emphasize the polysymptomatic nature of dissociative dis or ders, and as Spiegel sug gests the cri te ria must em pha size a care ful de scrip tion of the phe nom en ol ogy as well as in ten sity of the symp toms.

This is sue has taken a bold step for ward in help ing us de fine what that ul ti mate it er a tion might look like. We must not for get that our pa tients are the ul ti mate ben e fi cia r ies of our di ag nos tic clar i fi ca tions. It is they who will use these con cep tu al iza tions to de fine them selves and the na ture of their strug gles to wards health. The di ag nos tic con tro versy de bated in this is sue pro vides an im por tant stim u lus to spur the de vel op ment of an in creas ingly re fined shared lan guage. That shared lan guage will likely en cour age the evo lu tion of in creas ingly more com pas sion ate and com pe tent treat ments. I am grate ful to all of the con tri bu tors to this is sue for mov ing us along this im por tant path.

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REFERENCE

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)*. Wash ington, DC: Au thor