Beginning with this issue, you will notice a new look for the book review section. Each edition will attempt to gather a collection of well-considered works that address a single topic area of scholarly and scientific interest, as well as of practical clinical value, for our readers.

The current publication offers a series of books which address various subjects related to the study and treatment of trauma and dissociation. The first two reviews were solicited by Dr. Etzel Cardeña, the Journal’s previous Book Review Editor. Dr. Richard Kluft reviews *Treating Dissociative Identity Disorder*, which explains the author’s Collective Heart Model, a treatment approach directed to the inner core of the DID patient. Dr. Steven Gold’s review follows, on Dalenberg’s *Countertransference and the Treatment of Trauma*.

The next two reviews examine works more theoretical in nature. Kathy Steele critiques Nijenhuis’ *Somatoform Dissociation*, which adds new empirical and theoretical data to the study of the complexities inherent in the dissociative response to trauma, while John Watkins investigates the issue of combat trauma presented in Shephard’s *A War of Nerves*. The final review, by Marlene Hunter, features *Healing the Divided Self*, a book which explores various applications of ego-state therapy and hypnosis in the treatment of post-traumatic and dissociative disorders.

In future issues, we are interested in reviewing a wide variety of books on hypnosis and all of its allied sciences, including mind-body medicine, consciousness studies, psychology and psychotherapy, education, history, and cultural studies. Members of the American Society of Clinical Hypnosis are encouraged to submit their own books for review. Our intent is to review books promptly; timeliness will be constrained primarily by the use of thematic organization. Feedback about the shaping of this section, and suggestions for future books and their possible reviewers, is much appreciated. Topics planned for the next two issues include applications of hypnosis in mind-body healing and behavioral medicine, and Ericksonian approaches to hypnosis and psychotherapy. To submit ideas and recommendations, please contact: mphillips@lmi.net. I offer my thanks to Dr. Cardeña for his worthy contributions to this section, and for his cooperation during this transition period.


**Reviewed by:** Richard P. Kluft, M.D., Ph.D. Bala Cynwyd, PA

In *Treating Dissociative Identity Disorder: The Power of the Collective Heart*, Sarah Y. Krakauer proposes a new model for the treatment of dissociative identity disorder (DID). She believes that “we are standing at the threshold of a new era in the
treatment of dissociative and posttraumatic disorders (p. xii),” an era that “will be characterized by more potent intervention strategies and by equal attention to avoiding countertherapeutic suggestions and ensuring therapeutic suggestions” (p. xii). Her Collective Heart treatment model, she believes, incorporates the cautions that have been advised in the context of the controversies that have surrounded hypnosis and once-unavailable memories of traumatic memories, and offers new intervention strategies designed to promote the recovery of personal authority.

There are three fundamental assumptions in the Collective Heart model. First, every individual, even those most fragmented at the level of personality, has an intact inner core that can guide him/her to a state of harmonious function. This inner core, or collective heart, “can be understood as an internal compass which each of us possesses. It directs us toward optimal psychological and behavioral functioning, that is, toward both what we ought to do and what we profoundly want to do” (p. xiv). Second, severely damaged individuals need assistance to mobilize this inner core, or collective heart, and this assistance can be provided with therapeutic techniques in the context of a therapeutic relationship. Third, highly dissociative clients have easy access to the guidance of the intact inner core. She thinks that these patients, including those with DID, can “quickly learn to enter a meditative state in order to experience inner guidance in a vivid sensory manner” (p. xii).

Her book reviews the nature and early history of hypnosis and dissociation and the development of the trauma field before reaching its main focus, the description of both the philosophy of and the techniques associated with her model of treatment. She uses a number of cases studies to illustrate the applications of her methods and their impact on particular cases. She concludes by offering observations on the characteristics of her clinical series, and a preliminary evaluation of the results of her model. She also offers a defense of her assertions that her model is new and effective.

A major strength of this book is its detailed depiction of Krakauer’s clinical work. Her techniques are given in sufficient detail for the reader to use. A main feature of her work is the use of a variety of forms of inner conferences and future oriented imaginings, rather than eliciting alters for individual work.

Krakauer’s book is unfortunately dismissive of hypnosis in the treatment of DID patients. To her credit, she is aware of the inevitability of the intrusion of trance phenomena, and acknowledges the possible overlap of hypnosis with the meditative techniques she employs. She does not appear, however, to understand that hypnotizability, which is known to be high in DID patients, may exert more of an influence on the possible distortion of memory than the formal induction of hypnosis per se. Thus, she ends up dismissing a hypnotic literature replete with techniques that could be used without formal hypnosis to augment her model. Krakauer has a relative lack of familiarity with hypnosis, which she does not use because she accepts warnings about the possibility of memory contamination associated with its use. Thus, she is unaware of the wide number of others who have developed similar techniques and images, and communicated them in the hypnotic literature, Ericksonian approaches, and dissociative disorder fields, or taught them in workshop settings. Her efforts to distinguish her techniques from interventions taught by others are not well-informed, and consequently are not convincing.

A major asset of the book is Krakauer’s unusual candor in reflecting on alternative understandings of her findings and ideas, and on the possible limitations
on the utility of her methods because of her sample of DID patients, who had very small personality systems and whose lives were very stable. Of her twelve patients, nine had seven or fewer alters (four had three alters), two had more than two dozen, and the system of one patient was not assessed prior to her leaving treatment. Krakauer herself wonders whether her approach would be amenable to more complex cases. Motivated simple DID cases dominate Krakauer’s caseload, but this is not typical of the experience of most others who work with DID. In any case, simple high functioning DID cases tend to get well rapidly as long as the DID is specifically addressed (Kluft, 1984, 1999), so that a method’s success with this group leaves unanswered whether its use should be generalized. It is this reviewer’s opinion that the Collective Heart model as explicated in this book would not be adequate to address the needs of a more demanding DID caseload.

Krakauer’s discovery and use of the Collective Heart follow in the footsteps of many who have asserted that there are special types of alters or mental functions that can serve as sources of inner wisdom. She maintains that the Collective Heart, which can speak and interact, is not an alter, but something else, something unified and whole despite the fragmentation of the personality of the DID patient. This reader is skeptical of the concept, but has less trouble with the technique of using “it.” In an earlier paper (1989), I reflected that certain types of alters or structures which many believed to be universal were found in DID patients in proportion to the belief of clinicians that such alters would be found in their patients. It is well known that patients with DID may create alters in response to the therapeutic setting, either spontaneously or in response to planned or inadvertent suggestions. I observed that it was not always problematic to elicit, inadvertently or by design, an alter whose presence might be constructive and raise the self-esteem of the patient, but that it could be detrimental if one suggested that a possibly destructive type of alter would be inevitably found. In my opinion, Dr. Krakauer’s Collective Heart is a close relative of Ericksonian hypnosis’ unconscious wisdom, Allison’s Inner Self Helper, helper alters, and various forms of Guides, all dissociated parallel processings, often with a sense of self, elicited under the aegis of demand characteristics that help the patient feel that there is something powerful and good within, a strong force promoting recovery, no matter what other difficulties and problems may prevail. Since they inculcate hope and may enhance the therapeutic alliance at times, they may be more helpful than problematic. In my practice, if such an entity is encountered, I will engage it in the therapy, but if one is not, I will not endeavor to suggest or construct one. The differences between Krakauer’s Collective Heart and other allied phenomena are not compelling.

For readers who have followed the development of the treatment of DID from the early 1980s to the present, reading Treating Dissociative Identity Disorder may have some jarring moments. Not infrequently, observations made by pioneers in the field and/or published in seminal articles are attributed to secondary sources or to verbal communications with individuals who were familiar with the work and expressions of some of the earlier contributors. This appears to be a generational phenomenon, but for some readers (and some pioneers!), it may be disconcerting.

Dr. Krakauer has written a book that is stronger for its clinical contributions than for its theoretical concepts. Many of her ideas and approaches are thought-provoking and deserve further study, but it is difficult to endorse her model as a new clinical paradigm or her techniques as “more potent intervention strategies” (p. xii).
This book is very well written. It reads more smoothly and clearly than most texts of its type. It will be of marginal interest to a hypnosis-oriented readership, and it is not suitable as a basic text for the treatment of DID. However, Dr. Krakauer is a clever and skilled clinician, and those interested in the treatment of DID who are already experienced and well-grounded in the literature of that field will find it worthwhile to acquaint themselves with her contributions.

References


In several important respects, Constance Dalenberg’s book, *Countertransference and the Treatment of Trauma,* is unique. This will come as no surprise to those familiar with her work. Dalenberg is both an original thinker and an original “doer.” Few are as successful at bridging the realms of research and practice as she. Dalenberg has the creativity to formulate intriguing questions of interest and relevance to clinical practitioners, and to design and execute studies that effectively address these questions. As a result, her research is simultaneously methodologically sound and directly applicable to real-world clinical practice.

It would not occur to many contemporary researchers to empirically investigate countertransference. Nevertheless, sound empirical examination of the role of countertransference in the treatment of trauma is precisely what Dalenberg has accomplished. However, this book is written in a way that will be readily comprehensible and accessible to those without an extensive science background.

The material comprising this volume is based on clinical case studies and one half-dozen empirical studies conducted by Dalenberg and her research team at the Trauma Research Institute (TRI) in La Jolla, California. Detailed explanation of the methodology of the most directly relevant of these six research studies, the “Trauma Countertransference Study,” is provided in an appendix. This structure prevents discussion of the technical aspects of the research from derailing the flow of the narrative in the main text.

Interestingly, Dalenberg cites research indicating that therapists generally believe that while they can accurately detect and interpret their clients’ transference reactions, clients remain unaware of their therapists’ countertransference reactions. Her data challenge the latter supposition; clients report that they are well aware of their therapists’ emotional responses to them and find it disturbing that therapists often try to deny and mask their reactions. Therefore, unlike the majority of existing clinical and research investigations of countertransference, which rely almost exclusively on therapists’ reports, a major component of Dalenberg’s research consists of clients’ observations about their therapists’ reactions to them.
The catastrophic and extraordinary nature of traumatic events and their impact evoke particularly intense responses from therapists, raising exceptionally imposing challenges to the maintenance of an effective therapeutic relationship and the attainment of positive treatment outcomes. Dalenberg persuasively argues that the trauma survivor’s disrupted sense of safety leads therapy itself to feel unsafe. She explains that this is caused “in large measure [by] the potential triggering of the therapist’s countertransference behaviors—disapproval, disgust, dominance, rejection—client’s behavior and history” (p. 26).

The nature of countertransference and its special relevance to the treatment of trauma survivors is discussed in the first two chapters of the book. In chapter 3, Dalenberg turns her attention to the failure of language to capture adequately the enormity of trauma. Faced with the insufficiency of words, both therapist and client can easily lapse into silent despair. Dalenberg considers how the therapist can align with the client to simultaneously acknowledge and transcend this potential obstacle.

Another issue that can arise in the treatment of trauma survivors is the questionable nature of their accounts and the countertransferential responses this evokes from clinicians. Chapter 4 explores the impact of disbelief on the therapeutic relationship. Dalenberg’s research shows that therapist disbelief is related to a decrease in expressions of compassion toward the client. Her discussion of this issue, therefore, emphasizes the need for therapist and client to maintain sufficiently “clear communication” to achieve “success in finding a way through doubt without losing connection” (p. 103).

Chapter 5 addresses the topic of shame. One of Dalenberg’s findings that most surprised her was that almost half of the clients she studied expressed the conviction that their therapists were ashamed of them. Dalenberg argues that while in some instances clients were projecting their own feelings of shame onto the therapist, in others these perceptions of therapist shame were accurate. However, she contends that in many of the latter cases therapists were ashamed not of their clients but of themselves. Awed by the scope of what their traumatized clients have endured, it is not unusual for therapists to feel humiliation and inadequately equipped to be helpful.

One of the greatest countertransferential challenges in treating traumatized clients is tolerating and productively responding to patterns of recurring victimization. Commonly referred to as “repetition compulsion,” this phenomenon is the focus of chapter 6, where Dalenberg stresses two crucial points. One is that repetition of experiences of victimization can be explained in ways that do not assume that the client is motivated to seek out these assaults. The other is that often these recurring patterns are unwittingly fueled by therapists’ countertransferential reactions.

Chapters 7 and 8 tackle two realms of countertransferential experience that therapists rarely acknowledge and for which they even less frequently accept responsibility—anger and sexual arousal. Dalenberg does a masterful job of thoroughly exploring these potentially explosive topics in a way that practitioners will find invaluable. As she does elsewhere in this volume, she weaves together her empirical findings with clinical illustrations. She clearly conveys how these experiences manifest in the therapeutic relationship and how they can be managed so that they enhance rather than impede the treatment process.

 Appropriately, the ninth and final chapter centers on termination. The intensity of trauma treatment can foster a correspondingly powerful interpersonal bond between
therapist and client. Dalenberg observes that, “a disturbing number of the accounts of termination that I have read in the client autobiographical literature... present termination as poorly handled or not discussed at all” (p. 252). In this final chapter she discusses how the resolution of trauma, the treatment process, and the therapeutic relationship are interrelated and must be handled accordingly.

Many practitioners have experienced the misery of failing their clients and feeling overwhelmed because they were not adequately prepared to effectively manage the emotional intensity of trauma treatment. As a field, we are just beginning to recognize and confront the complexities of this territory. Dalenberg’s book has the potential to serve as a map that can spare many therapists and their clients some of this anguish.


Reviewed by: Kathy Steele, M.N., C.S. Atlanta, GA

Dissociation is a term that has been reified and ridiculed, altered and misunderstood over the course of the past century. It has become the subject of intensive theoretical and empirical study that seeks to refine related concepts and add greater understanding to this confusing phenomenon. Over the past three decades, clinical strides have been made in the treatment of dissociative disorders, yet without a clear theoretical frame for treating the myriad of symptoms that are labeled as dissociative. In this book, Dr. Nijenhuis offers some startling perspectives on dissociation that have their foundation in late 19th and early 20th century psychiatry. He has added new theoretical and empirical data to some overlooked older notions to create a clear view of dissociation for modern psychology and psychiatry.

The particular focus of the book is on a little understood subset of dissociative symptoms, somatoform manifestations, i.e., symptoms that manifest in the body rather than in the mind. These include many of the old hysterical symptoms found in patients at the Salpêtriére Hospital in Paris, for instance, who were treated by Pierre Janet and others such as Briquet and Charcot. Janet (1907) proposed that dissociation of “systems of ideas and functions of the personality” was a major component of hysteria (p. 332), and he attributed hysteria primarily to traumas, which produced “disintegrating effects in proportion to their intensity, duration and repetition” (1909, p. 1556). An in-depth contemporary case study is included to describe these dissociative symptoms.

Nijenhuis notes that manifestations of dissociation in the body include paralysis, contractures, tics, spasms, pain, anesthesia, and analgesia, among others. Most contemporary views of dissociative symptoms only recognize psychoform dissociation, i.e., dissociation of mental functions pertaining to memory, consciousness, and identity (as found in DSM-IV). The fact that dissociative symptoms also pertain to functions of movement, sensation, and perception, i.e., somatoform dissociation, has been largely overlooked. This oversight is remarkable, since somatoform dissociative symptoms were regarded as major symptoms of hysteria (e.g., Janet, 1907), and later, of shell shock in World War I (cf., Van der Hart, Van Son, Van Dijke, & Steele, 2000). Typically, however, these symptoms have been labeled conversion disorders, although there have been a number of proposals to change the name of conversion symptoms and disorders to somatoform dissociative symptoms and disorders, as this has been increasingly shown by empirical evidence.
Somatoform Dissociation provides studies that link primary somatoform dissociative symptoms to animal behavior that is part of an evolutionarily prepared system of defense. This places dissociative symptoms related to trauma within a psychobiological frame, which is imperative for understanding the phenomenon from a more scientific perspective. For example, at a general level, Nijenhuis and his colleagues draw a parallel between the defensive and recuperative systems of animals and characteristic somatoform dissociative responses of trauma-reporting patients diagnosed with dissociative disorders (Nijenhuis et al., 1998a). The authors’ review of empirical data and clinical observations suggested that there are similarities between animal and human disturbances of normal eating patterns and other normal behavioral patterns in the face of diffuse threat: freezing and stilling during serious threat, analgesia and anesthesia when threat to the body is about to occur, and acute pain when threat has subsided and recuperation is occurring.

Based on this theory that threat to bodily integrity evokes animal defense actions with somatic components (Nijenhuis et al., 1998b), Nijenhuis and his colleagues developed a questionnaire that distinguishes somatoform dissociation. The Somatoform Dissociation Questionnaire (SDQ). The SDQ consists of 20 items (SDQ-20), and a subscale of 5 items (SDQ-5) that discriminates for dissociative disorders. The SDQ has excellent reliability and validity, and has been tested across a number of populations. It is easy to administer and score, and avoids the criticism of iatrogenic questioning, since the items relate to physical symptoms, not the typical dissociative symptoms of amnesia and depersonalization, which patients may be aware are connected to dissociation. The book includes an appendix with the SDQ-20.

What is missing from the book is a stronger element of clinical application. Although one case example is indeed extensive, perhaps more could have been given to make the empirical research more readily applicable in a clinical setting. In addition, more information could have been included about psychoform dissociation, thus contributing a more complete definition of dissociation. However, Nijenhuis and his colleagues continue work in these areas, and other publications are forthcoming, so the reader will not be ultimately disappointed in these minor aspects.

Somatoform Dissociation is well worth the read. The style of the book is clear, concise, and the flow is logical. Nijenhuis has managed to integrate history, theory, psychobiology, clinical practice, and empirical data into a useful and thoughtful work that distinguishes somatoform dissociation from psychoform dissociation, suggesting how dissociation is correlated with degree of trauma, and demonstrating its basis in psychobiological processes that are evolutionary prepared.

References

reactions to predatory imminence and injury. *Journal of Abnormal Psychology, 107*, 63-73


Reviewed by: John G. Watkins, Ph.D. Missoula, MT

Every major war created numerous psychiatric casualties, called “Shell Shock” in World War I, “Combat or War Neuroses” in World War II, and more recently, “Post-traumatic Stress Disorders (PTSD).”

Shephard’s book deals with this topic historically and includes an encyclopedic survey of the literature. It is a scholarly, well-written tome that details clinical descriptions of war trauma and theoretical controversies replete with case studies, relating these to the various schools of psychotherapy. This material provides the most significant and thorough exposition available to date. Covering numerous research sources, this book will be authoritative for many years to come.

Shephard centers his focus around the conflict between the army’s view that the goal of military psychiatry is to return men to duty, vs. the medical ethics of healing, and reviews this issue and its consequences through various wars, examining as well the traumas of prisoners, the Holocaust and the treatment of civilian PTSD in current practice.

Although originally considered as physically due to the physiological shock of explosions, by 1916 shell shock was universally recognized as a misnomer for a psychogenic disorder. Treatment was complicated by much professional controversy over diagnostic criteria and appropriate treatment. Were the significant factors in causation combat stress or individual predisposition? Was shell shock an illness or due simply to weak motivation and cowardice?

Controversies often centered over treatment strategies. A modified psychoanalytic approach, which included hypnotic abreactions and was drawn from the work of Freud, Ferenczi, Janet and others, was found to be of great value in eliminating symptoms when administered immediately after a soldier’s breakdown. This frequently resulted in returning the soldier to service, and his resumption of relationship with his “buddies.” However, further combat stress often aborted that return.

William Rivers, one of the therapists (then called “neurologists”), argued that all psychoneuroses of war were manifestations of regression to early development. He also insisted that the “personality” of the therapist was a key element in treatment—thus foreshadowing later developments of “therapeutic self” theory (Watkins, 1978) and the “therapeutic alliance,” (Phillips & Frederick, 1995, pp. 277-78).

Others, called “psychiatrists” (imbued with the pessimism of mental hospital practice, like Gordon Holmes), dismissed this therapy, claiming that psychoanalysis produced the neuroses. Military officers, seeking greater return of men to combat, vacillated in their support for one or the other approach, depending on reported results.

One of the book’s greatest values is its intensive study of the psychology and
motivational conflicts within the combat soldier. Since very few mental health clinicians had learned any hypnosis (Watkins, 1947), reliance was placed on abreactions under drug-induced narcosis, first by William Sargent with sodium amytal and later by Grinker and Spiegel (1945) using pentothal. These set the pattern for more individual psychotherapy in World War II. The military objected to the latter, claiming that pentothal treatment did not return men to combat.

Another issue of interest to current readers is that of secondary gain. Shephard claims that by offering generous treatment and pensions following World War II, the Veterans Administration turned millions of military patients into chronic PTSD sufferers, a situation that occurred less frequently after World War I, where France gave no pensions for psychoneurosis, and Germany eliminated them in 1924.

Shephard’s book is interesting, scholarly and thorough in the areas covered. The book’s extensive detailing of personal conflicts between foreign psychiatrists may not be of much interest to American readers, however, coverage of developments in the Korean War, the Vietnam War, and subsequent conflicts are unfortunately quite brief, the greatest attention being given to British casualties. Yet, Shephard’s book fills a great vacancy in the literature for World War I.

The thrust of this book suggests that we should reconsider the diagnosis of PTSD. Although combat breakdowns and chronic dissociative reactions stemming from child abuse both originate in trauma, Shephard argues that their development and relevant social situations differ. Combat neuroses are acute when discovered, but the circumstances of the trauma are usually conscious. Chronic civilian cases, originating years earlier in disturbed childhood experiences (often unconscious and repressed), on the other hand, may require different theoretical conceptions and different treatment methodologies. The reader is left with the question: Should both types of traumatic conditions be diagnosed with the same label, PTSD?

References


Reviewed by: Marlene Hunter, M.D. Victoria, BC

Although this book was first published several years ago, it is still very relevant for those therapists who work with traumatized patients. It is unfortunate that this work was not reviewed by this publication at the time when it represented the state of the art, because its datedness does present a few considerations.
The first is that, compared with more than half a decade ago, specific and structured hypnosis is used by many therapists much less often today than in the mid-1990’s. This has to do, in part, with new laws that are now to be found in many states regarding the legality of court testimony vis-à-vis having been hypnotized, and also with the spectre of the False Memory Syndrome Foundation which, although with considerable less impact than in the past, is still with us.

The content of the book relies heavily of the uses of hypnosis and of ego state therapy—two superlative therapeutic tools. The format is very well laid out, following a natural order. Its fifteen chapters start at the beginning, with “What is the Divided Self?” and proceed through to “Spirituality and the Generative Self”—one of my two favourite chapters for many reasons, not the least of which is that it is a topic so seldom found in this type of professional presentation: “We have found it valuable to correlate the tasks of psychological development…. (Erik Erikson) in tandem with the stages of spiritual development as outlined by…..de Chardin.” Valuable indeed, and enlightening; the authors are to be commended for its inclusion.

The other favorite chapter is “Working with the Divided Self: The Use of Ego-State Therapy”. Among many valuable statements (and one which is reiterated throughout the book) is that which identifies ego states as “personality energies”, rather than “little people inside”. This is a splendid way to describe them and makes the point about inner entities very neatly. I intend to plagiarize this definition at every opportunity.

The authors use the 4-stage SARI model of treatment (Safety and Stabilization; Accessing the trauma and related resources; Resolving traumatic experiences and Restabilization; and personality Integration and the creation of the new Identity) rather than the simpler 3-stage (safety and containment; working through the traumatic material; and resolution) which has been more common in many areas. The SARI model has stood the test of time well. They also make it clear that “...the assignment of truth and meaning of the material belongs to the patient and not to the therapist” (page 119). This follows strong advice for the therapist to be clear about his or her own role as “facilitator, witness and advocate”, rather than as investigator. One is reminded of Herman’s admonition that the therapist’s job is to “bear witness”.

The frequent inclusion of case histories works very well to exemplify the therapeutic suggestions. The authors offer valuable guidance, such as to “beware of confusion techniques and double binds”, pointing out that dissociative patients have been subjected to confusions and double binds throughout much of their lives; and there is an excellent little section on “Abreaction Do’s and Don’ts” (page 123). Chapter 10 on Transference and Countertransference Issues invites us to take a clearer look at ourselves, and how we may unwittingly jeopardize the therapeutic process. A quote from the book itself encapsulates the essence of this work, and why I think the book is so useful. The authors are referring to Magritte’s sculpture, The Therapeutist (sic):

It would seem that Magritte has captured the essence of the sense of divided-ness experienced by all therapists.... The ability of the therapist to be able to perceive self-division can be an extremely powerful force for progress in psychotherapy. If understood, it can contribute to therapeutic empathy, to the therapist’s understanding of the true nature of the patient’s problems, and to creative reexaminations of treatment
approaches. A healthy awareness of ordinary self-divisiveness by therapists can be the beginning of truer, deeper understandings of their patients (p. 237).

They also stress, as have many other authors, the absolute necessity to establish and protect the therapeutic alliance, and to recognize that, for the patient, trust is almost impossible and that we, as therapists, will be pushed into proving that we are trustworthy again and again and again.

The second of my comments regarding datedness has to do with the incredible wealth of research in the areas of neurophysiology (stress, trauma and the brain), memory (implicit and explicit), and somatoform dissociation, which has been offered to us during the past decade. Amongst other areas, this is relevant in the chapter on “Dissociative Symptoms in Disguise” with regard to ‘somatic expressions of trauma’. Ellert Nijenhuis’ work on somatoform dissociation is an excellent example of increasing clarification in the field.

The third quibble, if you will, is the book’s apparent emphasis on child sexual abuse as an underlying cause in many cases. Indeed it very frequently is one of the underlying causes, but only one; physical and, to my mind, emotional trauma take just as much responsibility—in fact, emotional trauma may be the deadliest of all, as it erodes into the very heart of the child.

Despite the equivocations, I heartily recommend Healing the Divided Self. It is full of useful information, guidance, and experience. It clarifies many murky issues in the therapeutic journey that our traumatized patients must take, and that we must take with them, and effectively separates the two.