

THE CONFIRMATION AND DISCONFIRMATION OF MEMORIES OF ABUSE IN DID PATIENTS: A NATURALISTIC CLINICAL STUDY

Richard P. Kluft, M.D.

Richard P. Kluft, M.D., a psychiatrist and psychoanalyst, is Director of the Dissociative Disorders Program at The Institute of Pennsylvania Hospital, Clinical Professor of Psychiatry at Temple University School of Medicine, both in Philadelphia, Pennsylvania, and Lecturer on Psychiatry at Harvard Medical School, in Boston, Massachusetts.

For reprints, write Richard P. Kluft, M.D., The Institute of Pennsylvania Hospital, 111 North 49th Street, Philadelphia, PA 19139.

ABSTRACT

The charts of 34 dissociative identity disorder (DID) patients in treatment with the author were reviewed for instances of the confirmation or disconfirmation of recalled episodes of abuse occurring naturalistically in the course of their psychotherapies. Nineteen, or 56%, had instances of the confirmation of recalled abuses. Ten of the 19, or 53%, had always recalled the abuses that were confirmed. However, 13 of the 19, or 68%, obtained documentation of events that were recovered in the course of therapy, usually with the use of hypnosis. Three patients, or 9%, had instances in which the inaccuracy of their recollection could be demonstrated. The forgetting of traumatic experiences, their reasonably accurate recovery in treatment, and the formation of pseudomemories in clinical populations were all documented in this study. This suggests that stances that are either extremely credulous of retrieved recollections or extremely skeptical of retrieved recollections are inconsistent with clinical data, and therefore are not constructive influences on the contemporary scientific study of trauma and memory.

In recent years the mental health professions have been rocked by strident, vituperative, politicized, and highly divisive debates over the reality of accounts of abuse reported by patients in psychotherapy. The veracity of reports based on recollections made after years without conscious memory of the events in question has come under particular scrutiny (Loftus, 1993), and has been subjected to especially vigorous attacks (e.g., Loftus & Ketcham, 1994; Ofshe & Watters, 1994). Skeptical authorities have derided the reality of dissociative identity disorder (DID) or multiple personality disorder (MPD) as a mental disorder (Fahey, 1988; McHugh, 1993; Merskey, 1992; Piper, 1994; Simpson, 1995). Allegations made by dissociative identity disorder (DID)

patients, most of whose memories of traumatization emerge in the course of treatment, have been challenged as largely unconfirmed and/or iatrogenic (Frankel, 1992; Piper, 1994; Simpson, 1995).

Interestingly, the skeptical literature has taken little account of reports that confirm that DID patients indeed have been abused. Bliss (1984) found collateral evidence for nine DID patients, confirming or confirmatory of abuse in eight cases, and evidence that allegations by the ninth could not be confirmed. This suggested to him that "actual events [were] hidden by a self-hypnotic amnesia" (p. 141). In the same year Fagan and McMahon (1984) documented the traumatic background of their young cases of "incipient MPD," and Kluft (1984) noted confirmation of the abuse or other types of traumata in his childhood MPD cases. Bowman, Blix, and Coons (1985) provided exemplary documentation in their case study of an adolescent with MPD. In 1986 Coons and Milstein documented abuse in the backgrounds of 85% of 20 MPD patients. More recently, Hornstein and Putnam (1992) indicated it was possible to document abuse backgrounds in 95% of their child and adolescent DID and dissociative disorder not otherwise specified (DDNOS) patients, and Coons (1994) found documentation of abuse in 95% of his series of dissociative children and adolescents.

Despite the importance of these studies, which indeed demonstrate that DID/DDNOS patients generally have suffered true abuse and/or genuinely overwhelming experiences, they do not directly address the linkage between what the patient reports in treatment and what can be documented from other sources. It is quite possible that a genuinely traumatized patient will report in therapy memories that are not consistent with the documented trauma, and/or may refer to incidents that either cannot be assessed for accuracy, or may actually be disproven. The current study was designed to address the question of whether the confirmation or disconfirmation of always available and retrieved memories of mistreatment by DID patients can be studied from naturalistic clinical material without unduly intrusive or invasive interventions that would alter the process of the therapy. It was also designed to demonstrate whether amnesia for traumata and the recovery of accurate memories are naturalistically-occurring clinical phenomena.

METHOD

The records of a series of DID patients in therapy with the author during a 30-day period between mid-August and mid-September, 1995, were reviewed for instances of the confirmation and disconfirmation of allegations of abuse.

Participants

I generated a list of all patients seen by me over the study period. From this list I eliminated all patients who had not fulfilled *DSM-IV* (American Psychiatric Association, 1994) criteria for the DID diagnosis at some point while under my observation. I further eliminated all *DSM-IV* DID patients who were primarily under the care of another therapist and were seen by me only for medication management, hospital care, forensic assessment, or consultation. With these exclusions, 34 DID patients, 32 (94%) female and two (6%) male, remained. One female was African-American, and one was Oriental. The average age was 44.4 (range: 19-70) years for 32 of the patients. One female would not give her age, and one female insisted her official date of birth was inaccurate. These patients had been in treatment with me for an average of 5.5 years (range: three months - 19 years). Six were integrated patients being seen for follow-up or continuing therapy. Four were nearly integrated. Four had ceased to show overt DID behavior, but their DID adaptation, however well-contained to external appearances, was still vigorous. The remaining 20 patients had classic overt DID by *DSM-IV* criteria at the time of the study. Many had additional diagnoses not relevant to the purposes of this study. While this study included several DID patients seen only for follow-up or infrequent supportive sessions, the majority were seen between one to four sessions per week. During the period of the study, one patient was continuously hospitalized, one was discharged after a long hospital stay and died of a cardiac event during the study period, and another had a three-day hospital stay for the treatment of a toxic response to a new medication.

Hence, the average patient in the study was an outpatient in her mid-40s seen slightly less than twice a week on the average, and a "treatment veteran."

Procedure

No efforts were made to obtain additional information for this study. For many years I routinely have flagged events in which memories were either confirmed or disconfirmed. The 34 charts were reviewed for such events. Confirmation or disconfirmation required either the witnessing of an episode of abuse or the confession of abuse by the alleged perpetrator, either communicated verbally or documented by some legal authority or investigative agency. I accepted my patients' accounts of such confirmations and confessions, choosing to remain within the frame of therapy, but on occasion I was witness to a confession, or given a confession by

an alleged perpetrator. In some instances I received telephone calls or letters from witnesses. I did not accept as confirmation the information that a sibling or other relative had experienced or had recalled similar experiences. However suggestive such accounts may be, I decided to eliminate "confirmation by inference" in this study. Likewise, I did not include as confirmations instances in which two or more sources disagreed as to whether an event had occurred. I did not want to mix clear confirmations with conflicted and uncertain ones, however likely they appeared to be valid on clinical grounds. The same considerations applied to disconfirmations.

Findings

The results of this study demonstrate that more than half of the DID patients had instances of confirmed abuse, and that both always recalled and newly-retrieved memories were among those abuses confirmed. Nineteen of 34 DID patients, 56%, had instances of confirmed abuse. Ten of the 19 (53%) had always recalled the abuses that were confirmed. However, 13 of the 19 (68%) obtained documentation of events that had not been available in memory at the beginning of treatment, but had been retrieved in the course of therapy. As the figures indicate, several patients were able to confirm both always recalled and recently retrieved memories. Interestingly, 11 of the 13 (85%) with one or more confirmed recovered memories had recovered the confirmed memory with the help of hypnosis. One patient recovered a later confirmed memory during free association in psychodynamic psychotherapy, and the last retrieved the memory during eye movement desensitization and reprocessing (EMDR) treatment (Shapiro, 1995) of a theme at least superficially unrelated to abuse.

The sources of the confirmations of mistreatment are presented in Table 1.

Table 1 indicates that several patients had multiple sources of confirmation. Furthermore, a single entry of sibling verification may actually represent many confirmations from within the sibship. For example, one patient had eight siblings, all of whom confirmed instances of the patient's abuse, and three of whom, in addition to the patient's mother, made their confirmations directly to me in a family meeting. Also, an allegation of extrafamilial abuse was confirmed by police and medical reports.

Three patients (9%) had instances in which allegations could be conclusively disproven. I did not count as disproven an allegation that might be deemed unlikely or implausible, but had not actually been disproven. Nor did I consider recanting a disconfirmation, because a recanting has no more or less credibility than an initial allegation. Neither has standing without external corroboration. Almost every instance of recanting encountered in this series occurred under circumstances of profound interpersonal persuasive influence, and was contaminated for that reason. Furthermore, every

TABLE 1
Sources of Confirmation of Abuse Allegations for 19 DID Patients

(C = Always Recalled; R = Recovered in Therapy)	Total	C	R
Confirmation by a Sibling Who Witnessed Abuse*	10	4	8
Confirmation by One Parent of Abuse by the Other Parent	5	3	2
Confession by Abusive Parent (Deathbed or Serious Illness)	4	1	3
Confession by Abusive Parent (Other Circumstances)	3	1	2
Confirmation by Police/Court Records	3	2	1
Confirmation to Author by Abusive Therapist	2	1	1
Confirmation by a Childhood Neighbor of Witnessed Abuse	1		1
Confession by Abusive Sibling (During Terminal Illness)	1		1
Confession of Abusive Sibling (Other Circumstances)	1		1
Confirmation by Relative (Neither Parent Nor Sib)	1		1
Confirmation by Friend Who Witnessed and Interrupted Abuse Attempt	1		1
Totals	32	12	22

*For three patients sibs confirmed both C and R material; one report is unclassified because the dissociative handling of the incident involved depersonalization and derealization, but not frank amnesia.

episode of recanting was followed by at least one cycle of renewed insistence on the allegation's veracity. Cycles of allegation and recanting were not uncommon, and I hypothesize that this phenomenon is related to the cycles of intrusive and restrictive phenomena so familiar in the study of post-traumatic states (American Psychiatric Association, 1994), as well as interpersonal persuasive influences.

DISCUSSION

This study demonstrates that it is possible to confirm that many DID patients in treatment have been abused. It shows that while often confirmable traumata are retained in available memory, amnesia for genuine trauma is a genuine clinical phenomenon. It further demonstrates that in some instances such amnesia can be lifted in treatment without undue distortion occurring in the process. It disconfirms the often-voiced caution that information retrieved with the help of hypnosis is invariably contaminated and/or unreliable, but does not in any way suggest that pseudomemories will not be encountered.

These findings confute both the extreme credulous and the extreme skeptical positions on the recovery of memory of traumata. There are no grounds on which to discount a

priori the anecdotal and systematic findings of clinicians who maintain that repressed/dissociated memories of trauma and their recovery and confirmation in clinical settings are commonplace events; nor are there grounds on which to dispute the relevance of laboratory studies on the potential distortion of memory for clinical practice. The reader is referred to the work of those scholars who have tried from the first to acknowledge the complexity of this situation and refuse to be stampeded into a premature disambiguation of this most complex and important area of study (e.g., Alpert, 1995a; Brown, 1995a & b; Hammond et al., 1995; Kluft, 1984, 1995; Nash, 1994; Schooler, 1994; Spiegel & Schefflin, 1994; van der Kolk, 1995; van der Kolk & Fisler, 1995).

One of the most important implicit findings of this work is that the vast majority of memories of alleged abuse, whether always in memory or newly recovered, are neither confirmed nor disconfirmed in the course of the psychotherapy of DID. The number and percentage of proven and disproven events is very small, and unfortunately cannot be calculated because verbatim transcripts, which might make such an enumeration and calculation possible, were not available. That one memory is confirmed does not allow the inference that all other memories produced by the patient in question are accurate. Nor does the fact that one allegation is disproven allow

the inference that the remainder of the patient's allegations may be summarily dismissed. It is of interest that one of the patients who identified an abuser to the police, and whose abuser was tried, convicted, and jailed, years later made an allegation that was disproven in the course of this study. Another, whose memory of a Satanic experience could be disproven, had three sibling witnesses to her always-recalled memories of incestuous misuse by her father, had further confirmation from her mother, and received a confession and apology from her father. Furthermore, she retrieved memories of a rape by an older brother under hypnosis, and three years later, the brother, dying of cancer, spontaneously confessed to her and apologized.

It was interesting to note that in many instances siblings who initially had denied that the patient could have been abused later admitted they had lied, usually to protect family unity. Not infrequently, it was the death or incapacitation of an abusive parent that made the sibling willing to speak up more forthrightly. Virtually all sibling confirmations occurred in patients who had been in treatment for quite a while, during which the health and circumstances of their alleged abusers changed substantially. Some siblings came forward when they appreciated their sibs were improving in connection with dealing with the past, while they, in their disavowal of what they knew, were becoming increasingly symptomatic.

That one parent confirmed another's abusiveness might be understood as possibly emerging from situations of domestic discord, where false accusations are an increasingly common weapon. This situation was not represented in this series. All five such confirmations were buttressed, by the confession of the alleged perpetrator in four cases, and by sibling confirmation in the fifth. Four were made by wives about their deceased or dying husbands, the fifth was made by the husband of an abusive wife, only after the wife had admitted her abuse of their daughter in a family therapy session with myself and a social worker.

Confessions by abusers were usually made by males of the Roman Catholic faith who literally feared going to hell unless they made confession and amends. One abusive mother made her confession on her deathbed; three mothers confessed physical abuse, two with me present; and one to her daughter as the mother "worked" a 12-step program. Two abusive therapists made confessions to me directly. In one unique case, a friend of a patient returned with the patient to her parents' home for an errand. The patient entered the house first, and, apparently not expecting another visitor, her father insisted on immediate sexual gratification. The patient "spaced out." When her friend walked through the door a minute or two later, she found the patient on her knees before her partially disrobed father, who was trying to induce her to perform a sexual act. The patient was amnesic for this event for several weeks. Increasing distress without apparent cause had led me to use exploratory hypnosis

to uncover its etiology. The patient's friend, who initially had told me only that "something bad" had happened, later described to me in detail the event I had retrieved from the patient, who, in her mid-40s, was still using dissociation to handle difficult events, and experiencing considerable revictimization (Kluft, 1990).

Although most memories could neither be confirmed nor denied with available data, it is of note that there were certain classes of reports that would be classified *a priori* as likely to be inaccurate by many scholars. For example, 13, or 38%, at one time alleged themselves to have been the victims of Satanic ritual abuse. One such allegation was disproven, because certain unique factors in the report had particular referents that were amenable to rechecking with the patient's school records. In this series there were no alien abductions, prior life reports, or similar phenomena that skeptics often link with DID populations.

While this study makes several observations that are relevant to hotly debated issues and controversies, it has potential weaknesses, and fails to address some issues of concern. Although many confirmations were made to me, or were in official documentation of some form, many were made to the patient and the patient's account of the confirmation was accepted at face value. Lest this be discounted dismissively, however, I note in every instance of sibling confirmation I was given permission to talk to the sibling, but I chose not to violate the therapy frame to do so. At times siblings called or wrote me at their own or the patient's insistence, which I permitted with the patient's consent and release, or they spoke in a family therapy session. Furthermore, it would have been preferable to have done this study in collaboration with colleagues, who could have made independent assessments of the confirmations, but pragmatically this is not possible in the context of private practice with a patient population that tolerates non-therapeutic interventions poorly. I did not want my patients to be "on trial" as to their veracity, nor did I wish to distort their treatments for the sake of this research. It is my hope that this type of work will be replicated in a more controlled fashion. In the interim, although I hope any pressures in me toward confirmatory bias (Baron, Beattie, & Hershey, 1988) will be compensated for somewhat by my lack of motivated skepticism (Ditto & Lopez, 1992). I had not set out to prove or disprove either polarized position in the debate over recovered memory.

Another weakness of this study is its failure to address the nature of traumatic memory. Van der Kolk (1995) and van der Kolk and Fisler (1995) have argued persuasively that much traumatic memory is initially fragmentary, with affective and somatic/sensory elements. However, in the absence of verbatim transcripts I could only refer to my records, which were not made with this study in mind, and rarely documented the process of a traumatic memory's emergence. I am unable to offer any systematic commentary on whether

my patients recalled vague bits, which were augmented as the process continued, and elaborated with some aspects that are clearly reconstructive, as therapy brought once dissociated implicit memory to the level of explicit memory. I am considering undertaking a project that could allow me to document this process. In the interim, I am unwilling to trust my memory of the process of sessions often years in the past in order to offer further observations/speculations in this context. What I can state from my small sample of verbatim notes is that I have encountered instances in which memories emerged in a fragmentary, piecemeal way and were reassembled over time, and instances in which they emerged in full narrative form from the first. Instances of both types of recall were found among the confirmed recovered memories. Elsewhere (Kluft, in press) I have attempted to explain why I think both types of memory can be recovered in clinical populations.

It is important to indicate that had I used looser criteria for confirmation of allegations this study would have suggested a far higher degree of corroboration. For example, had I not excluded instances in which one sibling confirmed the allegations and another insisted they were not so, the percentages for both confirmation in general, and the confirmation of retrieved memories would have been higher. There were several situations in which I was sure that the sibling in denial had ulterior motives, or was so different in age from the patient that his or her observations were simply irrelevant. There is a degree of systematic underreportage inherent in my restricting myself to charted materials, because at times I yielded to patients' request that I not record certain informations, the existence of which they considered too humiliating to allow to be documented. Nonetheless, I let such circumstances dictate a finding of non-confirmation. Had I used internal indices of confirmation, which are quite suitable for clinical use (e.g., Alpert, 1995b), confirmation would have been virtually universal. I chose the most conservative standards and accepted the exclusions as noted because I judged that such a course was essential when addressing a controversial topic.

I had not anticipated that 85% of the confirmed retrieved memories would have been accessed with hypnosis, but I am not surprised that this proved to be the case. Hypnosis has been receiving a good deal of unwarranted "bad press." Because confabulation is possible with hypnosis, it is appropriate that its use in legal settings be scrutinized carefully. However, this has been conflated in the media and skeptical literature so that what is possible has been considered likely, even inevitable. In fact, this is a most complicated area of study. Most laboratory studies of memory distortion, with or without hypnosis, lack general ecological validity in the clinical situation (Kluft, in press), but may, in certain instances, illuminate the mechanism of a variety of clinical mishaps and therefore be relevant to bear in mind (Brown, 1995 a & b). Most critics of hypnosis have not appreciated

that hypnosis is a facilitator of therapy, not a treatment in and of itself (Frischholz & Spiegel, 1983). McConkey's (1992) analysis of the literature of hypnosis and memory distortion demonstrated that given the hypnotizability of the subject and the demand characteristics of the situation, inducing formal hypnosis does not add to the likelihood of memory distortion. The problematic factors are the nature of the interpersonal influence that is being applied and the vulnerability of the subject. The crucial considerations, to the thoughtful student of the problem, are what the hypnosis is being used to facilitate and with whom it is being used. Generic condemnations of the use of hypnosis with trauma victims represent overgeneralization to the point of irrationality.

My use of hypnosis is in the service of an approach to therapy that is psychoanalytically-informed, and sensitive on a ongoing basis to the risk of undue suggestion. My use of hypnosis to recover memory is fairly infrequent. Given these considerations, I am not surprised that in my daily practice much of what is retrieved with the use of hypnosis proves valuable.

In conclusion, the findings of this study indicate that it is essential to move beyond the polemics that have clouded the study of memory in the traumatized. Both clinicians and researchers are in the possession of data and approaches to understanding that can enrich one another. The clinician should not dare to condescend to the researcher, nor should the researcher treat the clinician with contempt. The disregard of data and/or ideas is unscientific in the extreme. Those who entitle themselves to dismiss relevant ideas and data to which they are not sympathetic will be remembered by history as fanatics and fools. ■

REFERENCES

- Alpert, J.L. (Ed.). (1995a). *Sexual abuse recalled: Treating trauma in the era of the recovered memory debate*. Northvale, NJ: Aronson.
- Alpert, J.L. (1995b). Criteria; Signposts toward the sexual abuse hypothesis. In J.L. Alpert (Ed.), *Sexual abuse recalled: Treating trauma in the era of the recovered memory debate* (pp. 363-396). Northvale, NJ: Aronson.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders - 4th edition*. Washington, DC: Author.
- Baron, J., Beattie, J., & Hershey, J.D. (1988). Heuristics and biases in diagnostic reasoning: Congruence, information, and certainty. *Organizational Behavior and Human Decision Processes*, 42, 88-110.
- Bliss, E.L. (1984). Spontaneous self-hypnosis in multiple personality disorder. *Psychiatric Clinics of North America*, 7, 135-148.
- Bowman, E.S., Blix, S., & Coons, P.M. (1985). Multiple personality in adolescence: Relationship to incestual experience. *Journal of the American Academy of Child Psychiatry*, 24, 109-114.

- Brown, D. (1995a). Pseudomemories, the standard of science, and the standard of care in trauma treatment. *American Journal of Clinical Hypnosis*, 37, 1-24.
- Brown, D. (1995b). Sources of suggestion and their applicability to psychotherapy. In J.L. Alpert (Ed.), *Sexual abuse recalled: Treating trauma in the era of the recovered memory debate* (pp. 61-100). Northvale, NJ: Aronson.
- Coons, P.M. (1994). Confirmation of childhood abuse in childhood and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. *Journal of Nervous and Mental Disease*, 182, 461-464.
- Coons, P.M., & Milstein, V. (1986). Psychosexual disturbances in multiple personality: Characteristics, etiology, and treatment. *Journal of Clinical Psychiatry*, 47, 106-110.
- Ditto, P.H., & Lopez, D.F. (1992). Motivated skepticism: Use of differential decision criteria for preferred and non-preferred conclusions. *Journal of Personality and Social Psychology*, 63, 568-584.
- Fahey, T.A. (1988). The diagnosis of multiple personality disorder: A critical review. *British Journal of Psychiatry*, 153, 597-606.
- Fagan, J., & McMahon, P.P. (1984). Incipient multiple personality in children: Four cases. *Journal of Nervous and Mental Disease*, 172, 26-36.
- Frankel, F.H. (1992). Adult reconstruction of childhood events in the multiple personality disorder literature. *American Journal of Psychiatry*, 150, 954-958.
- Frischholz, E., & Spiegel, D. (1983). Hypnosis is not therapy. *Bulletin of the British Society of Clinical and Experimental Hypnosis*, 6, 3-8.
- Hammond, D.C., Garver, R.B., Mutter, C.B., Crasilneck, H.B., Frischholz, E., Gravitz, M.A., Hibler, N.S., Olson, J., Schefflin, A., Spiegel, H., & Wester, W. (1995). *Clinical hypnosis and memory: Guidelines for clinicians and for forensic hypnosis*. Chicago: American Society of Clinical Hypnosis Press.
- Hornstein, N.L., & Putnam, F.W. (1992). Clinical phenomenology of child and adolescent multiple personality disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 1055-1077.
- Kluft, R.P. (1984a). Multiple personality in childhood. *Psychiatric Clinics of North America*, 7, 121-134.
- Kluft, R.P. (1984b). Treatment of multiple personality disorder. *Psychiatric Clinics of North America*, 7, 9-29.
- Kluft, R.P. (1990). Dissociation and subsequent vulnerability: A preliminary study. *DISSOCIATION*, 3, 167-173.
- Kluft, R.P. (1995). Current controversies surrounding multiple personality disorder. In L. Cohen, J. Berzoff, & M. Elin (Eds.), *Dissociative identity disorder* (pp. 347-377). Northvale, NJ: Aronson.
- Kluft, R.P. (in press). The argument for the reality of the delayed recall of trauma. In P.S. Appelbaum, L. Uychara, & M. Elin (Eds.), *Trauma and memory: Clinical and legal issues*. New York: Oxford University Press.
- Loftus, E. (1993). The reality of repressed memories. *American Psychologist*, 48, 518-537.
- Loftus, E., & Ketcham, K. (1994). *The myth of repressed memory: False memories and allegations of sexual abuse*. New York: St. Martins.
- McConkey, K.M. (1992). The effects of hypnotic procedures on remembering: The experimental findings and their implications for forensic hypnosis. In E. Fromm & M.R. Nash (Eds.), *Contemporary hypnosis research* (pp. 405-426). New York: Guilford.
- McHugh, P.R. (1993). Multiple personality disorder. *The Harvard Mental Health Letter*, 10(3), 4-6.
- Merskey, H. (1992). The manufacture of personalities. *British Journal of Psychiatry*, 160, 327-340.
- Nash, M.R. (1994). Memory distortion and sexual trauma: The problem of false negatives and false positives. *International Journal of Clinical and Experimental Hypnosis*, 42, 346-362.
- Ofshe, R.J., & Watters, E. (1994). *Making monsters: False memory, psychotherapy, and sexual hysteria*. New York: Scribners.
- Piper, A., Jr. (1994). Multiple personality disorder: A critical review. *British Journal of Psychiatry*, 164, 600-612.
- Schooler, J.W. (1994). Seeking the core: The issues and evidence surrounding recovered accounts of sexual trauma. *Consciousness and Cognition*, 3, 452-469.
- Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford.
- Simpson, M.A. (1995). Gullible's travels, or the importance of being multiple. In L. Cohen, J. Berzoff, & M. Elin (Eds.), *Dissociative identity disorder* (pp. 87-134). Northvale, NJ: Aronson.
- Spiegel, D., & Schefflin, A.W. (1994). Dissociated or fabricated: Psychiatric aspects of repressed memory in criminal and civil cases. *International Journal of Clinical and Experimental Hypnosis*, 42, 411-432.
- van der Kolk, B.A. (1995). The body, memory, and the psychobiology of trauma. In J.L. Alpert (Ed.), *Sexual abuse recalled: Treating trauma in the era of the recovered memory debate* (pp. 29-60). Northvale, NJ: Aronson.
- van der Kolk, B.A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress*, 8, 505-525.