

Common Errors in the Treatment of Multiple Personality Disorder

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ABSTRACT

Psychotherapists report widely different experiences in their attempts at treating multiple personality disorder (MPD) patients. Some have deepened their interests and developed full-time specialized practices with this clinical population. Others have declined to have any further contact with them at all, referring possible MPD patients to colleagues when they first suspect that this disorder may be present. Still others have decided against treating more than one or two MPD patients. These diverse decisions are examined with a focus upon the effects of therapists' uneven attention to the formal properties of the dyadic psychotherapeutic experiences as a possible influence upon their future work with MPD. Problems concerning the framework of psychotherapy and the countertransference conflicts which often move the therapist unconsciously and irrationally to alter the canons of psychotherapy in mutually detrimental ways appear to be crucial determinants.

Beginning in 1980 a dispute of some proportion arose as to whether multiple personality disorder (MPD) could be assumed to be as rare as ever, or whether it simply had been misdiagnosed and mistreated for generations, and in fact was more common than generally appreciated (e.g., Boor, 1982; Braun, 1984; Greaves, 1980; Thigpen & Cleckley, 1984). Recent arguments against the existence of MPD as a major psychiatric illness have been obviated by a number of factors: a) the publication of a large number of scientific papers in major journals documenting MPD phenomena and patients in detail; b) a paucity of negative scholarly critiques on the subject (and those few that have been published are proffered by authors who have admittedly seen few, if any, MPD patients); c) the completion of four well-attended international meetings on the subject of MPD, held annually in Chicago since 1984 and sponsored by Rush-Presbyterian-St. Luke's Medical Center and Rush Medical College; d) the commitment of millions of dollars by major hospitals in Chicago, Atlanta and elsewhere, dedicated to the construction, renovation and staffing of special units and programs specifically designed for the treatment of MPD patients on a 24-hour basis; e) the inclusion of the Dissociative Disorders as illnesses in their own right in DSM-III (1980) and DSM-III-R (1987).

Although scientists and scholars will debate the incidence and prevalence of MPD for the foreseeable future, it is indisputable that increasing numbers of therapists are treating increasing numbers of MPD patients. This paper offers a series of explorations of the types of problems that frequently emerge as therapists struggle to learn to treat this challenging patient population.

THE THERAPY FRAME

Psychotherapy takes place within a highly complex emotional environment involving many factors. Some therapists, depending on their training, character structure, and personal proclivities, assign great weight to the interpersonal psychodynamics, in a formal sense, that occur in the psychotherapeutic process. Others seem to pay little heed to the formal process of psychotherapy at all, regardless of their schooling.

In early consultations it became obvious to the author that those therapists involved in the most egregious misadventures in their relationships with MPD patients, misadventures that ranged from the haphazard to the heinous, were either oblivious to the bipersonal dynamics of psychotherapy (Langs, 1976)—the minority, or had opted with no sound clinical reason to abandon the major precepts of the psychotherapeutic framework—the majority.

In these early consultations it also was impossible to escape noticing that the consultees who were best informed in psychoanalytically-oriented psychotherapy and who tried to follow the formal demands of psychotherapy had the least problematic cases. They grasped misalliance issues most quickly, moved rapidly to address them, and reported the best outcomes. On follow-up, these therapists most often stressed changes in their own behavior first, observing both how anxiety-provoking and difficult it had been to carry out the clinical suggestions made during brief consultations, and how greatly their patients had benefited as a result. In contrast, therapists inattentive to issues surrounding the therapy frame and bipersonal field required seemingly endless, unscheduled, "emergency" consultations

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and seemed to repeat the same mistakes over and over; i.e., "The patient did this to me, then she did that, then yesterday she did that, and in today's session — you won't believe it — she even did this. . ."

Consultant: "Did you try what we discussed?"

Consultee: "Well...I thought about it...but I really couldn't."

The concept of the therapy frame is empirically-derived. Robert Langs (1979) explores and explains what is necessary to support the psychotherapy process in such detail that it defies a short precis. Despite this difficulty, the author will offer an abbreviation and paraphrasing of Langs' intent and his usage of this concept.

The therapy frame consists of:

- (a) definitions of who and what the therapist is, as therapist;
- (b) clarifications of what the patient wants, needs and expects of the therapist (emotionally, spiritually, intellectually, etc.);
- (c) explanations of what the therapist can reasonably provide in response to the patient's stated needs;
- (d) a detailed discussion of the therapist's fees and acceptable method of payment;
- (e) a mutual understanding of where, when, how and in what form the psychotherapy is to be applied and
- (f) an agreement about the stated reason for the psychotherapy.

The purpose of setting the therapy frame is to provide a safe, predictable "holding environment" for the patient (Winnicott, 1958) during therapy, through establishing clear guidelines for the conduct of the treatment. The frame is also designed to protect the therapist; such as, for example, from inappropriate and unwarranted intrusions into his or her personal life and time. When the guidelines of the frame are adhered to the therapy hour becomes intensely focused and task-oriented. When they are not, psychotherapy becomes diffused by a wide variety of extraneous matters that become martialled by the patient against the work of the therapy and become manifest as resistance phenomena. In other words, the purpose of the therapy frame is to facilitate the treatment.

Among the several hundred psychotherapists known to have undertaken the treatment of MPD patients in recent years, a consensus exists that such patients are extremely difficult, even hazardous (Kluft, 1983; Watkins & Watkins, 1984) to work with. On the other side, patients finding their way to care in the hands of highly-skilled specialists may expect an excellent prognosis and outcome (Kluft, 1984).

This paper is written from the perspective of the author's notes and remembrances of a large number of clinical consultations requested over the last several years from others involved with these difficult patients, mainly other psychotherapists. Many were far more experienced in the field than the author.

Colleagues are afforded the same disguise of identity and circumstances as would be required in publishing or lecturing on contemporary patient case histories. No compromise of the clinical integrity of case material presented below is knowingly made; it is quite impossible to identify any particular patient or therapist by any means. It is the author's purpose that these candid examples will help experienced and inexperienced therapists alike to successfully negotiate and transcend some of the errors most commonly made in the treatment of MPD.

INABILITY TO TOLERATE PATIENT PRODUCTIONS

When a therapist finds the utterances of the MPD patient unbearable, and this, by whatever means, is communicated to the patient, he or she abdicates a key position of the therapist's role: that of exploring, reflecting, interpreting, and assisting in the integration of the contents of the patient's consciousness and the experiences stimulated by the therapeutic field. Jean Goodwin (1985) has explored this phenomenon primarily from the perspective of therapists' countertransference struggles with the credibility of the content of MPD patients' productions. More commonly encountered in consultation are therapists who not only believe in patients' productions but become "frozen" by them. The result is that the therapist, once deeply disturbing material is uncovered, avoids the meticulous verbal processing and abreaction of the feelings or events described that ultimately result in the mastery of the once overwhelming material. Langs characterizes this situation as a mutual collusion between therapist and patients to avoid therapy (1982). A variant of this phenomenon results when a therapist chooses to avoid engaging angry, sadistic, hostile alter personalities, selecting only gratifying alters with which to interact whenever possible. The results of such approaches, which are undertaken by therapists needing to rely on defensive self-protection on a routine basis, always seem to be unsatisfactory.

Example: Several successive patients referred by consultation by a therapist from another state, all of whom had reached impasses in treatment, volunteered similar complaints. Whenever they would begin to voice their suicidal feelings to their therapist, he would become sullen, withholding, unsupportive and withdrawn. "I feel like I'm paying my therapist to take care of him," was the most succinct of their statements. In discussing this issue with the therapist, he readily admitted that he was extremely uncomfortable with such discussions. He was fearful of the impact of any lawsuits that might follow an accomplished suicide on his reputation and income. This generally effective therapist was much more comfortable treating the celebrated members of his community than trying to work with the more distributed individuals among his "carriage trade" patients' own problematic clientele,

whom they had begun to refer to him from their law firms, medical practices, political offices, et cetera. In a series of discussions, the therapist's candor was commendable. Realizing that he was both temperamentally unsuited to working with most MPD patients and unwilling to seek specific psychotherapy and ongoing consultation (which would better prepare him to undertake such treatment), he opted to discontinue treating dissociative disorder patients, a process that required nearly two years of disengagement and many subsequent consultations.

Example: Six months into the treatment of a flagrantly-presenting MPD patient, a highly-trained and well-read therapist sought consultation because his patient's symptoms were growing steadily worse. Although the patient purportedly had more than 25 personality states, the therapist had worked predominantly with only three during this period: "The three most cooperative ones." When asked to explore why he was choosing not to work with the whole patient, he rationalized that the "nasty" personalities rarely ever appeared during sessions, and when they did it was "hell to get them back under control." Realizing what he was saying, that this severely traumatized and tormented woman had no right to bother him with her unresolved rage, he readily accepted the suggestion that he invite the angry elements to hold audience with him. The patient's response was immediate. She stabilized rapidly. Potentially hazardous acting out was resolved within a month.

ABDICATING THE CONDUCT OF TREATMENT TO THE PATIENT

One of the remarkable qualities of many MPD patients is that various alter personalities sometimes have cogent suggestions both as to specific goals that need to be achieved in treatment and as to particular methods for accomplishing them. This has been described as the co-therapist capacity of the MPD patient; i.e., the ability to take on a high degree of responsibility for the therapy, even to work assiduously on treatment material outside the session. The therapist is warned, however, against carrying this model too far. He or she must a) never agree to procedures which he/she would consider to be unsound; and b) always make clear to the patient that procedures proposed by the patient are undertaken only because the therapist approves of them as good ideas. In the common version of this error, the therapist, lost in the trees, simply tends to overrely on the patient's ability to know how next to proceed and comes to be "led around" by her/him. In the extreme version of this error, the therapist comes to adopt a belief system that the split-off higher ego functions and observing ego functions, formed into alter personality states, actually represent entities with transcendent and mystical power: that they are somehow incapable of errors in judgment. This recapitulates a prevalent 19th century belief that such patients had clairvoyant powers

(van der Hart & van der Velden, 1987).

Example: The chief of psychiatry at a large midwest hospital had reached an impasse with his MPD patient in regard to her system-wide sexual phobias and dysfunction, the cause of much distress to the patient and her husband. Rather than seek expert consultation with this problem, the therapist deferred to the patient for guidance who suggested that the therapist romance a particular alter personality who was the seat of the problem and to use the power of their mutual trust and his tenderness to repair the wrong. When the therapist acceded to this request (which was totally out of character for him), the patient sued for malpractice, presumably under the influence of an outraged alter. Quite aside from suspending cognizance of his own extremely deviant behavior, the therapist was oblivious to the sadistic, contemptuous side of the transference dynamics of the patient, and blinded by her strongly positive transference projections. When this episode came to light, the therapist was summarily fired, lost privileges to practice at all major hospitals in his community, and suffered a grievous loss of the status and privileges he had built carefully over many years.

Example: A therapist complained that her MPD patient was requiring more and more time than she had available to treat her and was, in fact, becoming quite an expense and nuisance to treat because of the many trips and excursions that she took with the patient. The therapist soon volunteered that she had made contact with two Inner Self Helpers (ISHes) (Allison, 1974) who were incredibly wise and who were directing her to take the severely suffering woman to various religious and natural shrines where she would receive solace and relief from the savage storms raging within her. She had further been told by the ISHes that if this were not done with regularity the patient would die, as these pilgrimages were all that were keeping her alive. In consultation, the therapist was advised that while the ISHes were likely being sincere in reporting their beliefs, they were not psychologists and were not in the best position to judge what was best for the patient. The therapist was advised to imagine how best to examine the conduct of such a case if she could return to zero in the treatment and to discuss these ideas openly with the ISHes. The therapist followed this advice with some reluctance and was surprised to find that the ISHes listened to her with interest and curiosity and capitulated to her suggestions, as they were aware matters were getting out of hand. In articulating her treatment plan the therapist had established a formal treatment frame for the first time. The situation improved.

LITERAL REPARENTING ATTEMPTS

Though Kluft (1985) points out that there are no reports in the literature demonstrating the efficacy of reparenting in the treatment of MPD, a surprising number of therapists adopt and persist in this approach, which may include literal sucking of the therapist's breast, diapering, potty training, bathing together,

opening up one's home to the patient, making oneself available 24 hours a day, encouraging the child alters to refer to one as "mommy," and so on. Concerns must be raised about the possible adverse consequences of such an approach on the developmental dynamics of the separation-individuation state, usually the focus of such treatment, and on the likelihood that such an approach will lead to inappropriate narcissistic gratification and fixation at this state. While Stone (in Langs & Stone, 1980) points to the crucial role of the evolving capacity of verbal communication in resolving the rapprochement crisis, one wonders if largely relieving regressed patients of the emphasis on verbal mastery through frequent direct physical gratification does not further stifle the resolution of issues from the separation-individuation phase. One is certainly impressed with the heroics put forth by reparenting-orienting therapists on behalf of their patients, the enormous numbers of hours put in with comparatively little recompense, the intense symbiotic bonding between patient and therapist, and the very long course of many of these treatments, often spanning a decade or more. Quite apart from whether such an approach is really psychotherapy at all, as distinguished from attempting to love a patient into health, one wonders whether such an approach is necessary. Actual children work through separation-individuation issues in comparatively short shrift, as well as most of the subsequent early childhood stages which follow. To select reparenting as a model of MPD treatment, in light of the existing literature, seems to be a questionable choice.

Example: A therapist from the West Coast phoned to see if a letter could be supplied to her patient's insurance company, which had begun to withhold payments until the therapist could justify her treatment. Payments were now \$8,000 behind and she had already billed another \$4,000. The adverse impact on her income was coming to be a difficult issue between her and her patient. She was seeing the patient between 10 and 14 hours per week, though she had been billing the insurance company for only eight sessions, fearing that to "go higher" could cause problems. This situation had evolved over a period of 9 1/2 years, graduating from an initial three visits per week to five, then eight, and now averaged about 12 hours per week, many of which sessions were held in her home.

The question of multiplicity as a diagnosis was not an issue in the case at all. She had simply stuck with a nexus of child alters for several years and had been gamely attempting to work through their perceived needs for nurture. It was pointed out to the therapist (who, incidentally, was a reputedly good therapist) that in her failure to maintain expert consultation over the long haul, in her failure to distinguish herself through publishing or presenting in the field, in her failure to be able to report special training or expertise in MPD treatment, she had no leverage with the insurance company's peer review system. An eleventh-hour tele-

phone consultation would simply not get the job done.

A few months later the therapist called again. Having had to decrease the intensity of the treatment for financial reasons, a major crisis had ensued. The patient entered a major depression and there was considerable suicidal acting out. She was advised again to seek weekly consultation from an area specialist to see what, if anything, could be done to stabilize the now chaotic events. She rationalized by explaining that she could not afford this because the insurance company had retroactively set the maximum number of sessions at two per week, and she now was busy rebuilding her practice. What happens in reparenting when the fantasy-collusion is suddenly exposed? In this case, irreconcilable chaos.

DUAL RELATIONSHIPS

The forming of dual relationships between therapist and patient is clearly the most common category of errors in the treatment of MPD. These can run the gamut from the insidious to the flagrant. The following examples speak for themselves.

Example: A therapist, with the assent of his patient, signed a contract with a book publisher to publish an account of her nearly complete treatment. The deadline for the submission of the manuscript passed and the editor began pressing for results. The therapist and patient began working harder and faster, only to discover heretofore unanticipated work to be done. Now, under continuous pressure from the publisher, the therapist and patient colluded to take short-cuts and ignore symptoms, and the patient made a flight into health and a flight into reality through the preparation of the manuscript. Eventually the truth became apparent: treatment was actually far from finished. The patient responded with a major depressive and regressive crisis, and the treatment deteriorated. On consultation, the therapist readily admitted to his pursuit of fame, but also was motivated by a genuine desire to be helpful to other therapists and patients. He immediately grasped the irony that in striving to be helpful he had set a bad example. He was relieved to learn that several good manuscripts were already in various stages of publication and also began to explore the leadership responsibilities that attend fame — responsibilities he was not sure, upon reflection, that he really wanted. He was able to work out of his publishing contract with some minor penalties, and restored his therapeutic relationship with his patient.

Example: A highly successful and widely-known therapist, completely unfamiliar with MPD, became fascinated by what she saw as her patient's profound psychic, metaphysical, and trance capabilities. Unknowingly to her colleagues, the therapist secretly practiced a form of witchcraft and recruited her patient into her coven by night while treating her by day. In an attempt to defend against this bizarre experience, the patient's

MPD symptoms became flagrant, though ignored or overlooked by the therapist. Despite being sworn to secrecy, the MPD patient eventually sought the services of another therapist, deciding eventually to file a series of suits and complaints against her previous therapist. Ironically, the protracted litigation which followed drew the new therapist into an unavoidable dual role with the patient because she was forced to make depositions and appear at repeated court hearings. She came to be viewed by the patient as a kind of advocate-protector. This contaminated the role of therapist. The second therapist was able to avoid further broaching of the therapy frame through expert consultation and on-going peer supervision, bringing the treatment to a favorable conclusion and termination.

Example: A licensed psychologist in one of the north central states, who had acquired uncommon knowledge and experience in the treatment of MPD, agreed to treat a financially destitute MPD patient in exchange for personal services. The patient became the therapist's regular babysitter and her maid, accompanying her and her family on vacation to care for the children, and was sometimes asked to visit and/or sit with other MPD patients in their homes, during times of distress. When the therapist's patient underwent a rapid deterioration and regression some 18 months into this arrangement and required psychiatric hospitalization, the therapist insisted on attending her although psychologists were denied any privileges in the hospital. When the therapist was ordered to leave the premises by medical authorities, she phoned the patient and instructed her to refuse any neuroleptic medication. The patient complied vigorously with the therapist's recommendations. When the attending psychiatrists learned what had happened, they filed a complaint against the therapist with the state licensing board and the ethics committee of the state psychological association. They merged their investigations and hearings. During the investigation phase the nature of the relationship between the therapist and patient was revealed. Consultation in this instance consisted of reviewing the circumstances of the case and serving for two days as an expert witness, describing to the governing bodies and the therapist how matters should have been handled throughout. Acknowledging fully they had no jurisdiction over the acts of physicians, the board was impressed that the psychiatrists responsible for the patient's welfare refused, upon entreaties both by the patient and therapist, to consult a psychiatric specialist on MPD. Because of this openly-admitted fact, they dismissed the medical complaint against the psychologist, ruling that in this circumstance the therapist had followed the ethical prescription of attempting to do good for her patient. She had done this based on her professional knowledge, experience, license to practice psychology, and special training, under trying circumstances.

On the other hand, the board ruled the psycholo-

gist had been conducting the treatment improperly throughout because of her overt dual relationship with the patient, whose exacerbated condition had actually been precipitated when she had been requested to stay overnight at the home of one of the therapist's extremely regressed patients. The therapist's license was revoked for three months and one year's subsequent supervision of her clinical activities was mandated. Ironically, cleared of the charges brought in the original actions, the therapist became caught up in a net of her own making.

DISCUSSION

It is uncommon to find a static or out-of-control treatment case in which only one aspect of the treatment frame has been broached. The normal rule is that once the clinician begins to bend one guideline of treatment without sound clinical reason, rationalizations readily follow for bending or even suspending others. In extreme cases, as we have seen, treatment has been reduced to such a debacle that the dyadic relationship is beyond salvage altogether.

An equally common rule is that in most cases where the treatment of MPD patients has gone seriously awry, the therapist has acceded to unwarranted treatment variations or deviations in the first several sessions (or even initiated them to the patient's confusion and dismay), setting the stage early on for severe difficulties that may not become apparent for several months or even several years.

The issue must not be ignored that some therapists, regardless of their high level of curiosity or genuine aspiration to relieve the suffering of MPD patients, are unsuited to work with them. Indeed, some of the most telling errors that are to be seen in work with these patients have been unwittingly designed by intensely interested and caring therapists. By way of example, therapists who enter into identification dynamics with these patients, with all the symbiotic patterns such identification entails, are likely to produce no better treatment outcome than the situation in which the patient is involuntarily paired with a therapist who has a callous disregard or prejudice against any possibility of the illness and often at greater expense to the patient. In the latter instance, treatment-worn MPD patients eventually learn to reject quickly those clinicians who display not the slightest understanding of their illness, preserving their emotional and financial resources in the sometimes long search for someone who does.

The plea which most commonly enters into an MPD patient's spoken vocabulary on early interview is a poignant entreaty for understanding — to be listened to, to be heard, to be responded to in ways that affirm understanding, to be acknowledged and confirmed. Such a plea is a strong statement of a sometimes surging drive for identity: to be identified, to be defined and described by others as someone, to be known in one's

completeness. The most effective MPD therapists ally with every mainstream component, vestige, and remnant of this drive toward mature unity, rarely being dissuaded from the course of integrating what amounts to pathologically diverse psychic functions in an adult. The least effective MPD therapists become somehow lost in their own unintegrated intrapsychic diversity, immobilized by powerful, affectively-laden conflicts mirrored by their patients. It is during these moments that otherwise mature and high-functioning therapists suddenly begin regressing into part-object perceptual experiences: When they suddenly start believing that the person sitting opposite them is actually 93 different people, when they uncharacteristically start offering (or agreeing to) fame, fortune, sex, parenting, financial aid, protection, advocacy, unconditional love, friendship, social connectedness, mentorship, sponsorship, romance, a long future together, dining out, trips to the zoo, and so on—none of which has a proper place in the therapeutic environment.

In a psychodynamic sense, the concept of understanding can have at least two meanings which preserve the emotional level of understanding. Empathic understanding implies recognition, respect, caring, concern, attentiveness and compassion, all within a dyadic structure in which the therapist feels and maintains a

distinct sense of separateness, uniqueness, independence and objectivity regarding the patient. It is this combination of compassion and objectivity (including the objective application of therapeutic technique in the context of subjective relatedness) that allows the therapy to proceed, guided by the therapist. Understanding by *identification* implies direct sharing (often in intimate, albeit sexually sublimated ways), mutual regression, dyadic fusion, poorly-boundaried ego and primary process bonding, and pernicious coupling dependency. Such fusion results in a radical loss of objectivity on the part of the therapist, who truly does understand the patient in the direct sense of mutual suffering, in which case so-called psychotherapy is reduced to perpetual commiseration.

SUMMARY

An article on common MPD treatment errors naturally emphasizes negative responses and interactions on the part of both therapist and patient which can undermine and even render further treatment impossible between the two. On the other hand, MPD patients appear, as a group, to be eminently treatable in a conscientiously articulated and maintained framework of therapy, and in the care of therapists trained to the task.

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