

ON GIVING CONSULTATIONS TO THERAPISTS TREATING MPD:

Fifteen Years' Experience—
Part I
(Diagnosis and
Treatment)

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ABSTRACT

This paper reviews the author's experience in serving as a consultant to several hundred colleagues working with patients suffering multiple personality disorder (MPD) over the 15 year period 1973-1988. It discusses general trends in the types of patients with regard to whom consultations were sought and in the types of issues raised, and notes recurrent issues that appear to trouble large numbers of consultees. It also reviews the patient-generated consultation request, which reflects both increased consumerism and the avidity with which MPD patients seek information about their condition. Part I offers a general orientation, outlines the methods of the study, and describes consultations regarding diagnostic and treatment issues. Part II explores consultations regarding the "surround" of treatment, forensic matters, the use of hypnosis, and consultations initiated by patients; it concludes with a brief discussion. In general, the author's experience indicated that the publication of DSM-III in 1980 and the publication of four special journal issues in 1984 were watershed events, and marked notable shifts in the nature of many of the consultation requests that he received.

Multiple personality disorder (MPD), considered extinct as a psychiatric condition recently as four decades ago (Stengel, 1943), is increasingly identified and treated by contemporary clinicians. It is no longer uncommon in modern differential diagnostic thinking, and DSM-III-R has discontinued the venerable tradition of describing it as rare (American Psychiatric Association, 1987; Kluff, Steinberg, & Spitzer, 1988).

However, this rapid growth in awareness is of recent vintage. Many of those now involved in work with MPD patients are treating their first or second cases. The number of clinicians highly experienced with MPD is growing rapidly, but remains small. The often apt if grimly humorous medical school axiom of "See one, do one, teach one"

describes the state of the art in many geographical areas, where so few therapists have knowledge about MPD that persons of limited experience and expertise find themselves designated as experts, often to their surprise and chagrin, and are asked to offer advice and consultation to others. I recall such an unwelcome and embarrassing incident in the early 1970's, when I, painfully aware that I was barely out of my residency, and with only the most rudimentary idea of what to do with such patients, was introduced as "an expert on multiple personalities — he's seen THREE cases!"

It is not uncommon for the therapist confronted by his or her first MPD patient, or an individual whom he or she suspects might be one, to experience considerable anxiety and misgiving, and seek out consultation. A number promptly attempt to obtain advice from identified experts in the field. Most therapists who feel reasonably secure with those to whom they usually turn for help with difficult cases consult their customary sources as a first step. Many find that their preferred consultants have had little or no experience with MPD, and on occasion may hold strong opinions and offer advices that clash with what the therapist has observed and/or found useful in the actual clinical setting. They usually try the consultant's advice, but become discouraged if the advice, however consistent with their preferred frame of reference, is not congruent with the clinical realities with which they must contend. Those who are not accustomed to seeking consultation on a fairly routine basis often are apprehensive about approaching a respected colleague about such a potentially controversial condition, about which many otherwise mild and circumspect clinicians hold quite strong and polarized views. As Hicks (1985) remarked, "I know of no other illness that stimulates such strong denial of the possibility of its existence, and an absence of interest in many very capable clinicians who have very intense spontaneous curiosity about other clinical phenomena" (p. 244). Both Hicks (1985) and Dell (1986) commented on the "derisive criticism or ridicule" not infrequently encountered by those who make the diagnosis of MPD.

These scenarios, the immediate or prompt direct request, the request subsequent to unsuccessful efforts to use one's traditional sources of consultation, and the request motivated by apprehension about the personal and professional consequences of seeking help from those generally acknowledged as wise and experienced in most mental health matters, combine to generate a vigorous stream of requests for consultation and assistance from those individuals who become designated as experts on MPD. It is not widely

known that those persons receive considerable numbers of consultation requests, and have the opportunity to study materials relating to large numbers of MPD patients that are never reported in the literature. For example, since the early 1980's I have received between 2 and 26 telephone and mail requests per week, averaging 1 or 2 per work day and between 200 and 300 per year, from clinicians seeking help with regard to identified or suspected MPD patients. My conversations with colleagues in the field assure me that several of them receive many more such requests than I do.

Clearly, the giving and receiving of advice about MPD patients is a growing phenomenon. Much of the clinical wisdom already acquired in the field remains to be published and is difficult for the neophyte to acquire outside of conference or supervision settings. MPD patients often prove very challenging and problematic, and evoke such profound countertransference responses that many therapists find their usually adequate treatment approaches depotentiated, leaving them without a sense of mastery as they approach their professional endeavors. Furthermore, experts tend to advise consultation and participation in study groups as a preventive against becoming overwhelmed by the draining and demanding aspects of this work.

In view of the prevalence of such consultations, in one sense it is surprising that the literature is relatively silent about them. There have been four conference presentations on the subject. Kluft spoke on "Multiple Personality Consultations" in 1982 and 1988a, Marmer reported on "The Side Effects of Consultation" in 1985, and Feldman described "Supervision Issues in Treatment of Multiple Personality Disorder" in 1986, but no publication has addressed these subjects specifically. Greaves (1988), however, has described several consultation situations. In another sense, however, it is quite understandable. Often the most useful illustrations might deal with rather gross and evident problems, and might be read as reflecting poorly upon a colleague with whom the potential author continues to relate, a colleague who could recognize himself or herself in the article and experience considerable distress, and whose confidentiality might be breached to a significant number of individuals who might infer the therapist's identity. Furthermore, MPD patients are avid consumers of MPD literature. These considerations have constituted powerful constraints during the early stages of the growth of this field.

In this article I will attempt to share an overview of my experiences in consulting to other therapists with regard to diagnosed and/or suspected MPD patients. I will draw upon my recollections of well over a thousand telephone conversations and well over a thousand informal conversations in clinical settings (hallway or "curbside consultations") and brief consultations in conference settings, and my records of well over 200 in-person consultations with therapists who scheduled appointments for this purpose, and of over 250 situations in which I evaluated an MPD patient and later reported my findings to the referring therapist.

METHODS

This report is based on extensive unrecorded experience

and the review of over 450 records of varying degrees and completeness. Clearly, in its sharing of a massive amount of useful but anecdotal experience, it contributes more to the history of our field than to hard science, to the sharing of observations and ideas rather than the establishment of fact. To facilitate exposition, an effort was made to establish several categories of consultation. These were not mutually exclusive; in fact, many consultations covered several or all of the categories.

FINDINGS

One of the most noteworthy findings was that although certain themes were recurrent throughout the fifteen years covered by this report, others were not, and seemed to change markedly over time. A review of these changes indicated that 1980 and 1984 proved to be transition years, in the course of which the nature of some of the problems raised in and by consultations changed. Although it may be a series of coincidences, I am inclined to attribute these changes to certain landmark contributions that entered the literature during those years, and rapidly made significant impacts upon the field.

In 1980 DSM-III (American Psychiatric Association) reclassified MPD as a freestanding entity, established reasonable phenomenologic diagnostic criteria, and placed it in the new "Dissociative Disorders" category, severing its long historical association with hysteria. MPD entered the official nomenclature, and the DSM-III text became the "state of the art" description of MPD. Greaves' classic article, "Multiple Personality: 165 Years after Mary Reynolds," excited tremendous interest in MPD, and generated thousands of reprint requests. In the aftermath of this upsurge of attention to MPD, Dr. Greaves founded the organizational ancestor of today's International Society for the Study of Multiple Personality & Dissociation. Also, Eugene Bliss published his pioneering study of the phenomenology of MPD in 14 contemporary cases and advanced the first version of his theories on the importance of autohypnosis for the origins of MPD. Furthermore, Milton Rosenbaum described an historical perspective on why the diagnosis of MPD had declined from usage, and Philip Coons published the first contemporary account of how to make the diagnosis of MPD. In addition, Bennett Braun shared the first version of his now-familiar outline of the steps of the treatment of MPD, and Stephen Marmer attempted to explore MPD within a psychoanalytic perspective. Suddenly there was a new, exciting, and credible literature on this condition, appearing largely in mainstream psychiatric publications.

In 1984, four major journals published special issues on MPD: the *AMERICAN JOURNAL OF CLINICAL HYPNOSIS*, (26: [2], dated October, 1983 but not distributed until mid-1984), *PSYCHIATRIC ANNALS* (14:[1]), *PSYCHIATRIC CLINICS OF NORTH AMERICA* (7:[1]), and the *INTERNATIONAL JOURNAL OF CLINICAL AND EXPERIMENTAL HYPNOSIS* (32:[2]). This was followed by a special issue of *INVESTIGATIONS* (1:[3-4]) in 1985. A profusion of new data became available; a number of these issues' articles are of enduring significance. Still further numbers of mental

health professionals were exposed to modern thinking about MPD; many of these contributions addressed treatment concerns.

Viewed from this perspective, the clinician seeking consultation prior to 1980 was frequently an isolated individual attempting to work "by the seat of his/her pants" with what he or she believed was an MPD patient, but with little guidance from the literature. The clinician seeking consultation thereafter had some recent sources available, but these spoke more to concerns of diagnosis than treatment. By 1984 a useful and pragmatic literature on treatment had begun. These historical factors influenced the nature and types of the consultation requests that were made. Therefore, in each classification of consultations, the findings will be subdivided: 1973-1980, 1981-1984, and 1985-1988.

CONSULTATIONS REGARDING DIAGNOSIS

Making the diagnosis of MPD can be difficult, especially if a clinician has had no prior familiarity with the disorder. Florid presentations are the exception rather than the rule; many MPD patients try to deny and dissimulate their condition (Kluft, 1985). Not unexpectedly, many mental health professionals are reluctant to take the consequences of making a potentially controversial diagnosis. Furthermore, as clinicians' indices of suspicion are raised, they become aware of increasingly subtle manifestations of possible dissociative disorders, and want second opinions on covert and/or marginal cases. Therefore, a consultation request to confirm or disconfirm an initial impression or a clinical hunch based on soft or elusive findings is not uncommon. Discussion of the diagnostic assessments made over the period of this study is complicated by the fact that it spans three diagnostic systems, DSM-II (American Psychiatric Association, 1968), DSM-III (American Psychiatric Association, 1980), and DSM-III-R (American Psychiatric Association, 1987). Under the first scheme, legitimate questions could be raised over what the boundaries of the syndrome were meant to be. Under the second, diagnostic criteria were clearly stated, but vulnerable to obsessional worrying over their quantitative dimensions. Furthermore, some descriptors and criteria proved inconsistent with clinical realities (Kluft, Steinberg, & Spitzer, 1988). It is too early to assess the strengths and weaknesses of DSM-III-R.

1973-1980. MPD was mysterious and ill-defined. Many therapists who had been dealing with certain puzzling patients for years now considered the MPD diagnosis a possible explanation, and referred the patients for assessment. Only a small number proved to have MPD, and those who did had rather classic and florid cases that simply had gone unrecognized until their therapist's index of suspicion had been raised, often by reading *SYBIL* (Schreiber, 1973). While most patients had more common conditions, in several cases therapists had overinterpreted phenomena and mistaken elicited ego-states (Watkins & Watkins, 1979) or hidden observers (Hilgard, 1977) for clinical MPD. Malingers were encountered. Not uncommonly a patient's expression of the experience of the acute introjection of a lost loved one (Freud, 1917/1957) was mistaken for MPD. Several dozen

patients were seen who were highly dissociation-prone and had been socialized to therapeutic interventions that reified and enacted separate aspects of self, such as transactional analysis, gestalt, and psychodrama. These were easily distinguished from clinical MPD. Patients with ego-syntonic religious and mediumistic practices that evoked dissociative phenomena were encountered fairly frequently. I had to give considerable moral support to the therapists who had made an erroneous false positive diagnosis. Many of the therapists with true MPD patients quickly passed through a stage of fascination, became overwhelmed, and requested their transfer.

1981-1984. Many therapists asked for confirmation of their diagnosis in straight-forward cases, often in the face of collegial disbelief or the skepticism of supervisors. However, an ever increasing number of consultations were from therapists who had seen the phenomena of MPD, but found that the patient denied all signs of the disorder, or who, conversely had a patient recount all the phenomena and suggestive signs of MPD (Greaves, 1980), but who had not seen signs of separateness within session. I also began to hear from therapists who had become familiar with classic MPD, had learned its subtle manifestations, and then saw those subtle manifestations in patients in whom they had not previously considered the diagnosis of MPD. As a rule, almost all of the referring clinicians' suspicions were confirmed, with the exception of a small group of psychoanalytically-oriented individuals who could not grasp that dissociation and splitting were not the same process, and sent individuals with severe pregenital psychopathologies, primarily borderline and narcissistic. Overall, false positives were few. I began to get a number of requests for consultation in which a prior consultant, who rarely had seen or treated a patient with MPD, had offered the opinion that a particular patient could not have MPD because "a true MPD would do X, and the patient does not do X." Generally consultations surrounding these criteria or tests, which I describe as "capricious rules consultations," were tense and difficult. As an example, a prestigious professor said that a patient could not have MPD because in true MPD the personalities are unaware of one another. He insisted the patient should not be treated for MPD. This erroneous stance is an overgeneralization of one amnesic pattern in dual personality described by Ellenberger (1970); in fact, in most cases there are many different types of amnesic barriers and lacks of barriers among the personalities (American Psychiatric Association, 1980). The consultee was a low-ranking individual whose career was dependent upon the professor who was in error; his clinical work was overseen by this professor as well. A gracious solution proved possible. "Capricious rules" tests are very common in the approach to MPD taken by individuals eager to press for diagnostic certainty, and who are basically either skeptical toward or unfamiliar with MPD (Kluft, 1988b). They are also common in forensic settings, where experts strive to develop tests to unmask malingers (Kluft, 1987b; Orne, Dinges, & Orne, 1984b). In the zeal to eliminate the false positive, there is an inevitable risk of the false negative. Not surprisingly, many, who believe MPD is very rare, conclude that the latter possi-

bility is minimal, and may be risked with impunity, while the former type of error might free a dangerous malefactor. Such opinions are widespread, if erroneous, and are thought to be quite objective by many investigators who discount the recent literature.

1985-1988. The former types of consultations continued to be seen, but more and more requests were received from clinicians who noted increasingly more covert and dissimulated cases of MPD, who wanted help in assessing the dissociative component of the pathology of a patient who they doubted had MPD, or who wanted help in understanding how to assess and treat patients with atypical dissociative psychopathologies. Many patients of extreme complexity and fragmentation were assessed — they had such extreme dissociative dividedness and switched so chaotically that their MPD had proven hard to appreciate. As more clinicians diagnosed more carefully hidden cases, I began to see patients who had not wanted to be diagnosed and, once they knew their conditions were suspected, took pains to conceal them, prompting the request for a second opinion. Often I concluded that the patient had MPD, relieving the initial diagnostician, but that the patient was not motivated for treatment, relieving the patient, who now no longer had to carry out a charade in an unwelcome therapy. Generally I advised a permissive regimen of occasional contact with such patients, and most eventually sought definitive treatment with the referring therapist. I also have begun to see occasional patients in which the diagnosis is not in doubt, except to the patient. Either the patient agreed to get a second opinion hoping I would prove the referring therapist was in error, and/or I was represented as an authority, who, it was hoped, would get the point across to the patient. Like all other short-cuts to slow uncovering and interpretive work, sometimes such interventions have been effective, but sometimes they have been without impact, or even heightened the resistance.

CONSULTATIONS REGARDING TREATMENT

The treatment of MPD remains an area of controversy and ferment. Putnam recently reviewed the state of the art (1986), and noted that the effective treatment of MPD has been demonstrated, but that no controlled or definitive studies are available to compare and contrast different approaches. Many therapists who are undisputedly competent in their application of a form of therapy to a wide variety of patients encounter difficulty employing their preferred methods to MPD. Many therapists of established expertise are nonetheless unaccustomed to dealing with the abuse backgrounds so common in MPD patients. Struggling with the need to move beyond their preferred modalities, the impact of working with upsetting material, and the complexity of the experience of work with MPD, a good number are perplexed, uncertain, or overwhelmed. The advices of the experts may prove difficult to apply, and the experience gap between many of these experts and those whom they advise and teach may appear monumental, even insurmountable. It is not unusual for a therapist to find himself or herself breaking the boundaries of the therapy situation, extending

himself or herself to the extremes that he or she can hardly believe, and, in effect, becoming the captive of an out-of-control process. Many consultations in all periods have had the focus of helping the therapist restore order, reestablish the treatment frame, or, should this fail, transfer the patient. It is normative to become fascinated by and overinvested in one's first MPD patient. It is also normative for therapists to struggle with any and all of four subsequent countertransference responses (Kluft, 1988b). They may retreat from the pain and confusion of the work into a defensive cognitive stance from which they play detective rather than therapist, and become defensive skeptics, or obsessive worriers over "what is real." They may abandon conventional neutrality and undertake to provide an actively nurturing corrective emotional experience, in effect, attempting to "love the patient back to health." They may move beyond empathy to counteridentification, and become more an advocate than a therapist. Finally, they may engage in masochistic self-endangerment and/or sacrifice on the patient's part. Helping therapists deal with countertransference issues has been a major consultation focus during all periods under discussion.

1973-1980. Many therapists' requests for consultation on matters of treatment were followed by those therapists' efforts to transfer the patient. This is not hard to understand. There was minimal recent literature to which to refer them for guidance and there was a widespread belief that the condition was rare, so that few therapists thought it was worth-while to make the effort to master new skills for work with a type of patient that they never expected to encounter again. Few had or were motivated to acquire expertise in hypnosis. Many had profound difficulties giving credence to the patients' accounts of abuse. Many were frankly eager to rid themselves of a patient that they found disruptive and disquieting. Of those who decided to work with the patients they referred for assessment or called about, the majority of their concerns focused on whether or how to relate to the personalities, how to set limits, and on pragmatic issues of how to pace the treatment, how to use prolonged sessions, etc. A smaller number wanted to discuss their own plans of how to facilitate treatment; almost all had the same idea, to use videotaped feedback to destroy denial. Of course, despite occasional dramatic successes and equally impressive fiascoes, this plan is no more than an adjunct of uneven utility (Caul, 1984). Many struggled over whether to see MPD patients at highly reduced fees and/or at a higher than customary intensity.

1981-1984. Increasingly, consultees inquired about how-to-do-it issues, and requested ongoing collaboration and/or consultation. Many inquiries related to how to achieve integration of the personalities, how to deal with helper and/or persecutor personalities, etc. The most frequent constellation of issues related to self-injurious patients who were intermittently overwhelmed by alters that hurt the body or who imposed their will on others through passive influence experiences or command hallucinations. Not infrequently these consultations began with emergency calls for help. On occasion I was called by therapists whose patients were still in the office as they called, or I received a call in the wee hours

when a therapist had just been unsuccessful in controlling a crisis in his or her patient, and wanted my advice, or for me to call the patient! A fair number of consultations were from therapists with rather unsophisticated therapeutic skills and/or minimal training, who raised issues that had more to do with the basic processes of therapy than with MPD. Another area of concern was patient violence. Many therapists were very frightened by patients' threatened or enacted aggressive behaviors, and most uncomfortable about facing hard decisions as to whether patients unwilling or unable to control themselves should be continued in outpatient treatment. This was almost invariably a problem for non-psychiatrists, and was raised predominantly by nurturing female psychologists and social workers who knew that they could not continue their patient's treatment if the patient was hospitalized. A related issue was raised by male therapists, who felt that they could control their patients' violence, but only at the cost of considerable physical activity in restraining the patient from aggression against self or others in the course of the session, activity they feared would be interpreted as sexualized. Many consultees were generally sophisticated, but were frankly not knowledgeable about hypnosis or dissociation, and had rather basic questions to ask. A good percentage of these callers followed my advice to take appropriate training in this area. I began to get a number of calls from clergymen and practitioners who added the prefix "Christian" to their profession, e.g., "Christian Psychiatrist." Such calls usually began with reference to the work of Ralph Allison (1974; Allison & Schwarz, 1980) or M. Scott Peck (1978, 1983), and inquired about issues that bore on exorcism. I learned of a massive subculture in which such practices were commonplace, and had occasion to take a number of failed exorcism patients into treatment for what appeared to me to be classic MPD. In the last year of this time period, virtually all the above consultation types persisted but with diminished frequency. With the publication of my 1984 article, "Treatment of Multiple Personality," the most frequent type of consultation request I received became the exploration of the stalemated therapy. This will be the first subject of the next period, in which it was the predominant type.

1985-1988. All forms of consultation noted above persisted, but the majority of consultations focused on the assessment and relief of treatment stalemates, and dealing with a limited number of special topics. Requests to take patients in transfer declined sharply. Most consultees had worked with their patients for several years, and felt that they were at a standstill, or at least not moving ahead as rapidly as they might. In some cases, therapists were comparing their own results unfavorably to the statistics in my 1984 article, and in fact were doing excellent work with their first or second cases, or a case that I considered profoundly challenging. Often reassurance and support sufficed, and I learned months later that the treatment had prospered. In others, it was clear that no real therapeutic alliance was operative, and the therapists were "carrying the therapy." Most of these consultees called back and reported that they had been able to reestablish a viable therapy or reach a reluctant conclusion that treatment would have to shift to a

supportive focus or be terminated. For virtually all of the remaining consultees, the vast majority, the issue proved to be related to the presence of unsuspected additional personalities, or to personalities of which the therapist had heard, but which had not yet been encountered. Since MPD is a layered pathology, and all improvements remain friable until the last layers are encountered and treated, this finding is not surprising.

Many special issues surfaced quite frequently, but the new major areas involved accounts of satanic cult involvement, decisions re: treatment goals, and dealing with conflicting advices. A large number of callers asked if I had encountered patients who alleged satanic cult experiences, and wanted to know if such patients could be helped, and if special treatments were necessary. They also wanted reassurance as to their personal safety in dealing with these patients. They were pleased to learn that such patients can recover, but that their treatment is usually longer, more arduous, more crisis-filled, and more likely to involve episodes of serious self injury and prolonged hospitalization than those who have not experienced such brutalizing traumata.

As more scientific and clinical investigators publish their ideas about treatment and treatment goals, the clinician is increasingly likely to hear conflicting recommendations. Many called to discuss whether they should pursue integration — it seemed such a difficult objective, the patient seemed reluctant, and they had heard other experts describe it as unnecessary. In such cases, I helped each caller find his or her own way to approach the particular patient. Under this heading as well are instances in which a therapist began to work with an MPD patient and tried to fulfill an unrealistically ambitious therapeutic agenda in short order. It will be no surprise that many such callers were psychiatry residents or psychology interns who had limitless enthusiasm, but a very limited amount of time during which to work with the patient, and the remainder were salaried inpatient psychiatrists whose chance to help the patient would end with the expiration of insurance benefits.

I also began to receive calls from advice shoppers, some of whom were straight-forward, and some of whom would hear me out only to say, "But Dr. X said. . . ." It is difficult to generalize about how such calls were handled, because some callers seemed earnestly confused, and some seemed to have had their own covert agendas.

A fairly new group of requests began to come in from specialized units or programs which had discovered an MPD patient or were involved with an MPD patient with whom they were trying to work with another problem, a problem with which they had special expertise. Examples are drug and alcohol units, adult children of alcoholics groups and programs, eating disorder units, incest survivors groups, rape crisis centers and rape victims counseling services, etc. It often is quite challenging to arrive at some way of making these services available to the MPD patient, or to support the MPD patient during their participation in such programs. In all candor, feedback to date indicates that results are mixed. Often the MPD patient cannot tolerate the stress of these programs (or vice-versa), or does so at the expense of suppressing MPD manifestations, to the detriment of other

therapeutic objectives. A small but significant number of consultees asked hard questions about my treatment recommendations for children, and said that their experience was less optimistic. In each case I found that some of the conditions that I feel are necessary to treat childhood MPD (Kluft, 1986b) could not be arranged, and therefore the optimistic

results I have described could not have been achieved.

The discussion of consultation issues continues in "On Giving Consultations to Therapists Treating Multiple Personality Disorder: Fifteen Years' Experience — Part II (The "Surround" of treatment, forensics, hypnosis, patient-initiated requests)." ■

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