

DISSOCIATIVE
DISORDERS IN
IMPAIRED PSYCHIATRY
RESIDENTS AND
GRADUATE STUDENTS
IN PSYCHOLOGY

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ABSTRACT

Although the dissociative disorders remain controversial entities within American psychiatry, they are being recognized and treated with increasing frequency. In recent years the recognition of such conditions in very high functioning individuals, including physicians and psychologists, has been reported. The current communication describes the occurrence of dissociative disorders in distressed psychiatry residents and graduate students in psychology. Illustrative vignettes are offered, and the manner in which these individuals may demonstrate suggestive signs of such conditions is discussed. The optimistic prognosis for high-functioning dissociative disorder patients and the likelihood of prolonged difficulties if such conditions are not recognized makes it useful to have a high index of suspicion for such conditions in the troubled resident or graduate student.

The dissociative disorders, especially multiple personality disorder (MPD) and those forms of dissociative disorder not otherwise specified (DDNOS) that share its structure and phenomenology, remain controversial entities within psychiatry and psychology (Dell, 1988; Bliss, 1988; Hilgard, 1988; Spiegel, 1988). Nonetheless, they are diagnosed and treated with increasing frequency. The recognition of these conditions in high functioning individuals, including medical and mental health professionals, has been described (Kluff, 1986b). The current report calls attention to the occurrence of dissociative disorders in distressed and impaired psychiatry residents and graduate students in psychology, attempting to alert those involved in the selection and training of residents and graduate students to the possibility of encountering such conditions among their trainees.

This communication was first stimulated by my being referred four psychiatry residents and two graduate students in psychology within a three month period for the evaluation of their dissociative disorders. My interest was heightened when I found, by making an informal survey of the scientific investigators in the dissociative disorders field who were serving as workshop faculty at the Fifth International Conference on Multiple Personality/Dissociative States, that several of these colleagues had themselves seen one or more

psychiatry residents or graduate students in psychology with a dissociative disorder. This indicated that my experience was neither unique nor isolated. Prior to 1988 I had seen eight other resident physicians (four in psychiatry and four in various medical specialties) and four graduate students in psychology with dissociative disorders either for therapy or in consultation. In reviewing my files I found that most had been sent with a dissociative disorder diagnosis already either confirmed or suspected. In several instances my involvement was to provide psychopharmacological interventions in support of the efforts of psychologist colleagues who were the primary therapists. In two cases a resident was referred for evaluation by a colleague who considered the resident's psychotherapy stalemated, and the diagnosis emerged in the course of the assessment. One resident and one graduate student in psychology, both of whom correctly suspected that they suffered MPD, requested treatment from me after having read some of my articles.

This body of anecdotal experiences offers no data that allow an objective statement about the incidence or prevalence of these conditions among psychiatry and psychology trainees. However, it does suggest that such situations, which have not been reported previously, may occur with sufficient frequency to merit attention. As a growing numbers of women enter the mental health professions, it is inevitable that their ranks will include many sexually traumatized individuals. As many as 38% of American women have experienced at least one inappropriate sexual advance before age 18, and 16% have experienced some form of incest or incestuous approach (Russell, 1986). Dissociative disorders are commonly encountered as sequela of childhood sexual abuse (Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989). Eighty-three percent of MPD patients report histories of sexual abuse, and 68% report histories of incest (Putnam et al., 1986) and most series indicate that approximately 90% of identified MPD patients are women. Therefore, it seems reasonable to speculate that a greater presence of women within the health professions will be accompanied by more instances of dissociative disorders among mental health trainees. Although it is possible to argue to the contrary, that women with such conditions will be differentially unlikely to be able to enter these professions due to the impairments associated with their condition, the facts that MPD usually becomes overt only in the mid-twenties or later (Kluff, 1985), by which time those who suffer it might be well along in their graduate studies, and that a number of such instances already have

been reported (Kluft, 1986b), make this alternative unlikely.

The mental health trainee who suffers a dissociative disorder may encounter more problems in being identified and in seeking help than the trainee who suffers a more familiar type of difficulty. The dissociative disorders are almost invariably associated with findings that suggest the presence of more commonplace conditions (Bliss, 1980; Putnam et al., 1986; Ross et al., 1989; Coons, Bowman, & Milstein, 1988; Coons & Milstein, 1986; Kluft, 1985) which may either co-occur with them or be expressions of a superordinate dissociative disorder diagnosis (Putnam, Loewenstein, Silberman, & Post, 1984). The natural history of MPD and MPD-like forms of DDNOS, although recently described (Kluft, 1985), remains unfamiliar to most clinicians, who continue to think of these conditions in terms of their less frequently observed but more familiar florid manifestations. It would not be unfair to state that many psychiatrists and psychologists have yet to develop a body of experience with such patients, a situation that might be expected to impact upon their ability to recognize these conditions. Furthermore, it is common for those who suffer these conditions both to deny their difficulties and to dissimulate quite skillfully (Kluft, 1985, 1986b, 1987c). Conversely, those who present for treatment having made an accurate self-diagnosis are frequently disbelieved. The result of these factors is that the patient with this type of condition is likely, on the average, to remain undiagnosed for over half a dozen years within the mental health care delivery system (Putnam et al., 1986; Ross et al., 1989; Coons et al., 1988).

Unhappily, the controversy that surrounds these conditions may obscure diagnostic objectivity. Should a resident be in training in a program in which the condition that he or she suffers is the object of skepticism or derision, it is not unlikely that the halo effects of such attitudes will influence both the resident's freedom to express his or her circumstances (to the extent that he or she is aware of them) and the ability of potential therapists affiliated with that program (who may share those attitudes) to hear what is being said in an unbiased manner. Furthermore, the likelihood that the faculty members of such a program would feel it necessary to keep abreast of the relevant literature of a disregarded field is remote.

The vignettes below are drawn from cases encountered over a dozen years. Although highly abbreviated and somewhat modified in the interests of space and confidentiality, they may prove useful in alerting those involved in the training and supervision of psychiatric residents and graduate students in psychology. Further, in the interests of confidentiality, all illustrations are written as if the individuals in question had been residents in psychiatry.

Case Illustrations

1. A highly-regarded female psychiatric resident attempted suicide shortly after her father died. Initially she appeared to be having a major depressive episode, but her psychiatrist soon appreciated that she had few classic indicators of depression and failed to fulfill diagnostic criteria for this condition. Looking further, he noted that her moods fluctuated widely and rapidly, sometimes within minutes.

She also showed subtle signs of switching (Putnam, 1988; Franklin, 1988), and many other suggestive signs of MPD (Franklin, 1988; Kluft, 1987a), including amnesic episodes. Suspecting MPD, he involved a consultant, who observed that the patient's signs of switching were often related to questions about her father. In a series of interviews, the consultant simply focused attention upon her relationship with her father, and the spontaneous emergence of another personality occurred in the course of discussing conflictual material. The diagnosis confirmed, she continued therapy with her psychiatrist and shortly thereafter recovered memories of father-daughter incest. After a brief leave of absence, during which she handled the recovery of many painful memories in a series of long sessions, she was able to resume and complete her training. Her case proved rather simple; within a year she had integrated. She went on to obtain a full-time academic position and to perform well.

2. Shortly before returning to her home state for residency training, a woman began to have flashbacks of severe sexual and physical abuse within her family of origin. She attempted suicide by injecting what she anticipated would be a lethal air embolus. Her experience of the act was without a sense of ownership. She had not willed it. She recalled "seeing it [from a vantage point outside of her body] as if someone else were doing it" Furthermore, when she saw herself injecting the embolus she thought she did not look like herself. She felt that she was watching some other person who somewhat resembled her and was vaguely familiar.

She had entered treatment a year prior to this episode. Her history was remarkable for a virtually global amnesia prior to age 12. When she began to explore her flashbacks she began to hear voices inside her head. Some were command hallucinations, urging self-mutilation or suicide. She was first considered schizophrenic, but the voices did not respond to an adequate trial of neuroleptics. Her therapist became aware of an article (Kluft, 1987b) indicating the overlap of apparent schizophrenic phenomenology with MPD.

Two consultants confirmed the presence of DDNOS with features suggestive of MPD, and doubted the patient's capacity to proceed with training. She deferred relocating and remained in treatment with her therapists, who soon documented the full phenomenology of classic MPD. Ultimately she was able to complete a residency and enter practice, supported throughout by intensive psychotherapy.

3. A female resident had experienced repeated difficulties throughout the first two years of training. She followed recommendations to seek treatment, but felt that her complaints were not understood. Three attempts to enter therapy proved unsuccessful on this basis. Initially she felt understood by her fourth psychotherapist, but he approached her sexually. She fled this man's office, and began to have nightmares she could not recall, and vague impressions that she had been abused as a child. She found a female therapist by whom she felt understood. This therapist recognized that many of her symptoms were dissociative in nature. The therapist wanted to be able to sustain the resident through the course of training, and feared that an uncovering treatment would leave the resident, already very shaky and

beleaguered, completely overwhelmed. Consequently, the therapist requested consultation. The consultant concurred with the therapist's diagnosis of DDNOS and agreed that supportive measures were in order. A year later the patient had become much stronger, but was beginning to get vivid flashbacks of memories of abuse; her functioning began to deteriorate. The consultant was asked to do a series of hypnotic interventions to preempt the emergence of distressing material during the resident's professional activities. This strategy proved effective – the material was accessed and abreacted in a manner that preserved the resident's function. She was able to complete her training and obtained a full-time position within an academic setting.

4. A female resident performed adequately but unevenly. Some supervisors considered her to have excellent potential; others found her confusing and enigmatic. She had frequent absences, missed many conferences and supervisory sessions, and often had to labor to explain her failures to deal with paperwork in a timely fashion. She had difficulty taking adequate histories, and often "spaced out" when patients shared upsetting material, especially about sexual abuse. She sought treatment, but was unable to relate to six successive psychiatrists. After a year of floundering, she sought treatment with a former supervisor, who had confronted her over several dissociative phenomena he had witnessed during his perception of her. Two years after incestuous material had been retrieved in therapy her father confessed his sexual misuse of her and her mother admitted that she had been aware of the incest. In retrospect it could be appreciated that this resident's absenteeism had occurred when certain personalities had assumed executive control. She had succeeded in disguising her condition from her colleagues and all but one of her educators. She graduated and is doing well in practice.

DISCUSSION

Many obstacles obstruct the recognition of the distressed or impaired health professional. The majority of the literature on this subject concerns physicians. Denial, both by the physician, concerned others, and colleagues is commonplace (Scheiber, 1983). The problems of the psychiatric resident, and less so those of the graduate student in psychology, may be rationalized as due to the burdens of a heavy workload and new responsibilities upon an immature and inexperienced young person who has yet to master his or her new profession. This may occur even in programs that encourage their trainees to pursue personal therapy or psychoanalysis – such treatment is often seen as being in the service of professional growth rather than for the treatment of a diagnosable mental disorder.

Individuals with dissociative disorders are unlikely to be identified during the routine process of interviewing candidates for psychiatry residencies or graduate schools in psychology. Most, however florid their difficulties, are able to "get their act together" for brief periods of time and/or to dissimulate (Kluft, 1985, 1986b, 1987c). A colleague recalls interviewing such an individual and rating her highly, only to learn many years later that she had suffered classic MPD, and

had taken her interviews in one highly functioning personality.

Perhaps the most suggestive sign that one is dealing with a dissociative disorder is the failure of a patient to enjoy a full and lasting recovery as a result of conscientious and competent treatment of adequate duration for a treatable condition that the patient is assumed to be suffering. Such circumstances are rarely evident in trainees, who may be just beginning a first therapy experience and/or may not have shared the fact of their being in treatment with their program. Nonetheless, a history of a trainee's failure to connect with a series of competent therapists may offer suggestive hints. Also, since specific indications of a dissociative disorder may be difficult to infer absent a series of diagnostic interviews, and may never be noted or elicited by a clinician who is not familiar with these disorders, it is important to begin to consider the possibility of such a condition when a resident is showing a general "failure to thrive" in either the program, therapy, or both.

The latter advice is not meant to indicate that all such residents are likely to have dissociative disorders. It merely stands as a reminder that the presence of such a disorder might well be suspected on this basis, and kept in one's differential diagnosis. This is especially true in the case of the female resident. The more chronic dissociative disorders are post-traumatic conditions, often related to child abuse (Putnam et al., 1986; Coons & Milstein, 1986; Putnam, 1985; Spiegel, 1984; Schultz, Braun, & Kluft, 1989). Typically the adult sequela of child abuse are disguised, have dissociative features, are mistaken for any number of conditions, and fail to respond to the treatments usually effective for those conditions (Gelinas, 1983). This line of reasoning is not based on studies that demonstrate that a given percentage of incest victims, for example, develop dissociative disorders. Instead it stems from the overall thrust of an extensive literature, summarized elsewhere (Kluft, 1990), that indicates that since many females are abused, and many abused females develop dissociative symptoms that are usually misinterpreted and misdiagnosed, the possibility that a distressed female is a survivor of sexual abuse with dissociative aspects to her psychopathology should be considered.

Although it is not appropriate for a residency or graduate school's directors or supervisors to initiate the diagnostic assessment of such a resident, such individuals' thinking might be facilitated by a review of some of the suggestive signs of the most studied dissociative disorder, MPD, and a consideration of how they might present themselves in the context of a training program. The diagnosis and differential diagnosis of such disorders is a complex area beyond the scope of this communication; the interested reader is referred to a growing literature on this subject (Coons, 1980; Coons, 1984; Franklin, 1988; Kluft, 1985; Kluft, 1987d).

The signs below are modified from a list in a recent review (Kluft, 1987a). They constitute an attempt to share how the trainees seen by the author showed suggestive signs of dissociative disorders within the context of their programs.

1. The trainee has a history of treatment failure as manifested by having failed to stabilize or make gains in the hands of a competent colleague, having an extensive therapy

career at a relatively young age, having seen a number of therapists, having sought out fringe practitioners, and/or having been unable to connect with a therapist despite his or her own perception that therapy is advisable. Trainees will often be quite candid about their therapy careers unless their program devalues their seeking psychotherapy.

2. Trainees may, from direct knowledge of which diagnoses they were given or by describing their having been exposed to very different therapy approaches, indicate that they were given many different diagnoses. Many dissociative disorder patients are given several other diagnoses before their dissociative disorder is recognized (Bliss, 1980; Putnam et al., 1986; Ross, 1989; Coons et al., 1988; Coons & Milstein, 1986; Kluft, 1985; Putnam et al., 1984).

3. The presence of concurrent psychiatric and somatic symptoms is characteristic of such individuals (Bliss, 1980; Putnam et al., 1986; Ross, 1989; Coons et al., 1988; Coons & Milstein, 1986; Kluft, 1985; Putnam et al., 1984). The troubled trainee with psychosomatic complaints is suspect.

4. Patients with MPD and MPD-like conditions are characterized by fluctuating symptoms and an inconsistent level of function (see case 4 above). This results from the switching of the personalities and their differential levels of function and behavioral styles. This may be expressed in discrepant evaluations of the trainee by different supervisors and/or on different rotations; sometimes supervisors' evaluations make it clear that they were confused by the resident. Supervisors often note that the trainee does a very different quality of work with different patients or types of patients. This is because some patients and conditions raise anxieties that prompt switching and the use of dissociative defenses, while others do not. One generally outstanding resident whose abusive father had been intermittently psychotic became depersonalized in her work with psychotic men; another was superb in dealing with the affective disorders, but had panic attacks while working with patients who had been sexually traumatized.

5. Severe pain syndromes, especially headaches that are rather refractory, are typical of these patients. Headaches are by no means specific for dissociative phenomena, but are found in the majority of MPD patients (Bliss, 1980; Putnam et al., 1986; Ross, 1989; Coons et al., 1988; Coons & Milstein, 1986). They often are indicators of either severe conflict among the personalities or the incipient emergence of painful material. Other pain syndromes may reflect the somatic aspects of a painful experience (Kluft, in press; Braun, 1988a, 1988b). One resident's chronic abdominal pain was relieved after the abreaction of a deeply repressed incest-rape.

6. The presence of some form of amnesia may be an indicator. Many of the trainees whom I saw were conspicuous for their forgetting to attend scheduled activities or for arriving late. Although forgetfulness is very characteristic, it must be emphasized that this is a finding without diagnostic specificity in trainees, and is more commonly associated with preoccupation with their work-load or with passive-aggressive traits than with dissociative disorders.

7. Although most individuals with dissociative disorders who are capable of entering a residency or graduate school

in psychology and escaping detection in a demanding professional environment are excellent dissimulators, a minority (four) of the twelve residents and two of the graduate students in psychology had been told by others of behaviors that they themselves had forgotten, and/or of observable changes in their face, voice, and behavioral style. Such incidents were often rationalized, with noteworthy ingenuity. One trainee, after several such embarrassing confrontations, consciously adopted the strategy of coming in with dramatically different make-up, hair-style, and clothing every day, so that colleagues and supervisors became accustomed to seeing her in many drastically different ways. She ingenuously maintained that she was "into clothes and things."

8. Auditory hallucinations are characteristic of MPD (Putnam et al., 1986; Ross et al., 1989; Kluft, 1985; Kluft, 1987b). Two of the twelve residents and one graduate student had approached a trusted supervisor or teacher in a state of terror, and confided that they were hearing voices and feared that they were going psychotic. Unfortunately, they were assumed to be having genuine psychotic episodes, and became involved in treatments that failed to address their difficulties. Eight of the others had heard voices, but had withheld this at first, fearing that to acknowledge it would mean the end of their careers. It is useful to bear in mind that most MPD patients suffer auditory hallucinations (of traumatic flashbacks or the voices of other alters), but that in 80% of the cases they are heard as emanating from within the head (Kluft, 1987a, 1987b).

9. Many patients with MPD or allied conditions at times use the first person plural or refer to themselves in the third person. Such idiosyncrasies of expression should raise one's index of suspicion.

10. Increasing numbers of individuals are rather open about their backgrounds of child abuse, especially incest. The distressed trainee who openly avows such experiences deserves consideration for referral to someone with the expertise in the areas of abuse and dissociative disorders.

The treatment of the trainee suffering a dissociative disorder is too broad a topic for the current communication; a review (Kluft, 1987a) and two recent books (Braun 1986; Putnam, 1989) are excellent resources. The issue of therapist selection and referral for a trainee who has or who is suspected to have a dissociative disorder is a thorny matter. Many excellent therapists are unfamiliar with these conditions; in some areas no person with specific expertise is available. The outcome studies available (Coons, 1986; Kluft, 1984; Kluft, 1986a) demonstrate that the prognosis for MPD patients in the hands of those who are very experienced with MPD is much more optimistic than it is for those treated by therapists who are encountering their first case. The choice of a therapist may be a difficult one. My own experience may not be extensive enough to serve as the basis for generalizations, but it indicates that if a therapist who is experienced with dissociative disorders is not available, it is critical that the therapist be someone who is willing to learn the therapeutic approaches that have proven useful with such patients rather than attempt to fit the patient to the procrustian bed of his or her preferred models and theories. For example, it is clear that although many MPD patients recover in thera-

pies that do not involve hypnosis, hypnosis has been demonstrated to be an invaluable adjunct to the treatment of such patients (Braun, 1986; Coons, 1986; Kluft, 1985, 1986a; Putnam, 1989). Therefore it is sensible to ensure that the therapist of such a trainee either knows hypnosis or is willing to learn it. Treatments that fail to address the dissociative psychopathology are incomplete at best, and often are associated with clinical deterioration (Kluft, 1985).

The treatment of the trainee with a dissociative disorder who is able to continue in training should be treated in accord with the principles established for preserving the function of "the high functioning MPD patient" (Kluft, 1986b). Preservation of function should take priority over rapidity of results, and the therapist must be prepared to manage the occasional crisis and/or the emergence of unsettling material with additional and/or longer sessions. Because young professionals with dissociative disorders are fearful of failing their own patients and indeed have weighty responsibilities, reassurance of telephone access to the therapists is vital. I have not encountered any abuse of my accessibility by residents and psychology graduate students with dissociative disorders. For example, a resident on call was called to the emergency ward to evaluate the victim of an incest rape. Herself the victim of a similar experience, she became panicky during the interview, began to have flashbacks, and feared switching into another alter or having a fugue. She calmed rapidly as she explained her plight to me over the telephone, and completed her night on duty uneventfully.

I have made efforts to see such trainees at the beginning or end of the day, or on weekends, in order to buffer their therapy from their patient responsibilities. Also, when dealing with difficult material, I take special efforts to effect restabilization by the end of the session. I also find it helpful to discourage electives and rotations that will impose and intensify any unnecessary stress upon the trainee, whose own dissociative defenses may limit his or her ability to anticipate the degree of difficulty to which he or she may be exposed. For example, one resident who was an incest survivor was dissuaded with difficulty from electing a rotation in which she would have spent much of her time working with sex offenders. In retrospect she was able to see that such a selection would have exposed her to intolerable stressors.

Because such trainees may have times during which they function rather poorly, it is useful if they can arrange with their programs to use their sick leave and vacation time flexibly. Those trainees who know that they can take off a brief period of time when they are under extreme duress are usually very relieved by this knowledge, and rarely have had to do so. It is a far more difficult situation when a resident or graduate student who is transiently compromised knows that it is not possible to take off a day or so to restabilize without suffering adverse consequences.

This brief report documents the occurrence of dissociative disorders in psychiatric residents and graduate students in psychology. Hopefully it will serve an alerting function. When highly motivated high functioning dissociative disorder patients enter treatment with therapists who are familiar with these conditions, their prognosis is good (Kluft, 1986a,

1986b). Confidentiality precludes a detailed follow-up of the trainees discussed in this article. However, virtually all of those who entered treatment with psychotherapists already experienced with dissociative disorder patients were able to continue or complete their professional education and to make substantial gains in their function and quality of life. The prompt recognition and treatment of these conditions in mental health trainees is much to be desired. ■

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