

MULTIPLE PERSONALITY DISORDER AND THE FAMILY PHYSICIAN

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ABSTRACT

Although a wealth of knowledge is being accumulated about the whole field of dissociative disorders, very little attention is being paid to relating this information with the role of the family physician. This is unfortunate. Because of his or her unique relationship with the patient, such physicians are in the best position to pick up the warning signals that herald the emergence of dissociative phenomena, and may thus play a significant role in helping the patient to enter appropriate therapy. Symptomatology and phenomenology indicative of a possible dissociative disorder are discussed with reference to complicating health issues and other concerns that may, from time to time, have to be addressed.

MPD AND THE FAMILY PHYSICIAN

In the past decade, there has burgeoned a wealth of information and literature about what was once considered to be a flamboyant and rare mental disturbance—Multiple Personality Disorder (MPD).

We now know more about Dissociative States than many of us would have thought it possible to know. Indeed, the research in this field has spilled over, in the most positive and unexpected way, to add to our general knowledge about normal and abnormal brain function, neurophysiology and the biochemistry of the central nervous system.

Because what has been conspicuously lacking in this cornucopia of learning is some small attention paid to that first-line bastion of medical DEW (Distant Early Warning) lines, the Family Physician, the topic for this paper is the Multiple Personality patient in General Practice.

I am a family physician, with Certification and Fellowship in the College of Family Physicians of Canada. I encountered my first MPD patient in my family practice in 1978, and subsequently realized that I had at least two other patients, one a seventeen-year-old girl and one a young mother of three small children, who displayed the same spectrum of symptomatology as did that first-recognized patient. If my practice was representative, that indicated an incidence of 3:2500 in a general FP/GP population. This ratio was simi-

lar to that reported by Lloyd (1987), who had found a ratio of 3:3000 in his practice in eastern Canada.

Anderson (1991) studied a population of patients attending two general practice outpatient clinics. He concluded that there may be a higher incidence of dissociative experiences and pathology seen in family medicine outpatients than one would find in the general population. Many authors have referred to the variety of somatic complaints which dissociative patients exhibit (e.g., Putnam, Guroff, Silberman, Barban, & Post, 1986; Coons, 1988; Ross, Heber, Norton, & Anderson, 1989). As these symptoms fall within the purview of the family physician, who is often the first contact with the patient, it is vital that family physicians be aware of these correlations.

Role of the General Practitioner/Family Physician

There are three possible roles which the GP/FP might find himself or herself filling in the care of an MPD patient: that of personal physician; that of primary therapist in treating the dissociative disorder; and/or the sentinel physician who both can and should include MPD in his/her differential diagnosis of patients who appear to meet certain criteria. These roles may overlap, coincide, or meet head-on. I realize that I, as both a family physician and a primary therapist for dissociative patients, have a different experience and expectations than do most of my GP/FP colleagues. Nevertheless the other two roles are of prime importance and the development of good communication between the doctor and the therapist is vital.

Manifestations of Probable MPD Noted in Routine Medical Practice By the Personal Physician

The family physician is in an admirable position to first question the possibility of MPD/D.

- 1) Dissociative disorder patients frequently tend to somatize (Ross et al., 1989). There is often a plethora of physical complaints. One problem just gets resolved when two more pop up to take its place and yet the patient appears to be relatively healthy and many symptoms elude an organic explanation. Psychophysiologic manifestations of the disorder were described by Braun & Braun (1978) in an early paper, and later (Braun, 1983). Putnam et al. (1986) reported the more common of these, reported in decreasing order of frequency: headache, unexplained pain, unresponsive periods, gastrointesti-

nal disturbances, nausea and vomiting, palpitations, paraesthesias and analgesias, weight loss, visual disturbances, involuntary movements, seizure-like episodes, and paralysis. Despite these frequent somatic complaints, the patient often holds down a steady job, goes to school or university, and/or cares for a family.

- 2) There is a confusing response to medication (Coons, 1988; Barkin, Braun, & Kluft, 1986; Hunter, 1985). Indeed, one may hear, via a telephone conversation, that some new drug is "Fantastic, wonderful — why didn't you give me that before?" then later in the day have the patient appear in the office, saying that the new drug was not worth the paper in the prescription pad. One of the most frequent complaints, that of headache, seems to be particularly recalcitrant. There may have been occasions where huge doses of analgesics are reported to have been taken, with no relief at all.

To further the confusion, there may have been reports from the patient of some bizarre "allergic reaction" to some antibiotic which had been given without incident in the past. Such a reaction may disappear just as quickly again, apparently resolved. The front of the chart may become crowded with such "allergies."

- 3) Lab reports and investigative procedures are frequently erratic. Reports of variant EEGs are quite common (Miller & Triggiano, 1992). In many patients on one occasion there may seem to be epileptiform activity, particularly in the temporal lobe, yet when the EEG is repeated, there is no such indications. Thyroid studies are often confusing, leading one to suspect lab error (Hunter, 1986; Nair & Mapps, 1992; Gillette & Garbutt, 1987).
- 4) The patient is one who may be described as a "Thick Chart Patient." The doctor may find him/herself groaning at the sight of the name on the day sheet. Yet there is often a somewhat endearing quality to the patient, leading the doctor to a state of exasperated fondness.
- 5) From time to time, a situation may arise when the doctor finds him/herself thinking "So-and-So seemed like a different person today." It may be difficult to pinpoint the difference, or it might be blatant — an entirely new hairstyle or type of apparel or make-up. Some years after recognizing a patient in my family practice as MPD, I was re-reading her earlier chart entries and found, to my amazement, my written comment, "Hardly even recognized her — looked different, talked different." This young woman had, at that time, recently married and was then in early pregnancy. An alter that I had not previously met had made the appointment to talk about

nutrition in pregnancy. At the time I did not know she had MPD but was struck with her "new, more mature personality"!!

One or two of the above observations may not have much significance, but when a physician finds the patterns recurring, consistent over time, warning lights should start going off. This may be a time for reviewing the early history of such a patient, perhaps asking a few more questions about the family of origin and what was it like growing up. If the patient (laughingly or otherwise) remarks that she does not remember much of her childhood, that is one more factor to put into what I call The Probability Equation for MPD and MPD-like states.

Hospitalization Issues of Concern to the General Practitioner/ Family Physician

- 1) *Surgery.* There are several issues which must be recognized if the MPD patient requires surgery. One of the most important is to contract that "whoever" (i.e., which alter) goes under anaesthetic, comes out of anaesthetic. In the medical community where I practice, and indeed in many medical communities in Canada, the family physician will also be the first assistant in surgical procedures. In outlying areas, the primary care physician often is the surgeon. I have had the slightly unnerving experience of having a woman patient, who had been in my practice for many years, look up at me through drooping eyelids in the post-anaesthesia room (PAR) and, in a young male voice, roughly demand "who the hell are you?" It was not nearly as unnerving for me, however, as it was for the PAR nurses. If the family physician is not so directly involved, he or she can consult with the primary therapist about arranging such contracts.

Contracts are also useful with regard to "who" is going to be taking medication and/or "who" is responsible to see that all necessary medication is taken; for example, such arrangements are essential for a diabetic patient. Contracting is not only a helpful but, some believe, central part of MPD treatment, adaptable to many situations (Ross & Gahan, 1988; Ross, 1989).

Attention must be paid to the way in which this patient's personality system manages pain, and the recognition that *post-operative pain is different than other kinds of pain which have been suffered in the past*, and therefore requires different management. Otherwise there is the risk that the alter whose job it has always been to experience the pain will believe him- or herself to be again victimized. The importance of post-operative pain as an indicator of possible complication (e.g., infection) must be explained, lest all sensation of pain be abated auto-hypnotically and symptoms about which it is necessary to inform the doctor to assure good medical care be blocked out. Some pointed work is required to prevent a fur-

ther split. Teaching the patient some simple hypnotic pain relief techniques, with specific explanations of how they are to be used, is useful. Furthermore, the doctor needs to impress upon the patient the "unwiseness" of allowing an alter who does not perceive pain to get up prematurely or otherwise engage in contraindicated activities.

- 2) *Childbirth.* All of the above are applicable to the event of childbirth, with a few extra items. Specifically, "who" is going to have this baby? Is there already a birthing alter from previous confinements, and/or an inside mother alter? Are there arrangements for those alters for whom birthing would be disturbing to an extreme degree (children, males) to go to a safe place for the duration of the event? Simple hypnotic procedures can be used to accomplish this if "the System" (by which I mean the personality organization of this patient) needs a little help.

There may also be the complication of the patient denying pregnancy, and/or some of the alters being unaware of the woman's pregnant state (van der Hart, Faure, Van Gerven, & Goodwin, 1991). It may take considerable time and patience on the part of the family physician, helped perhaps by his or her nurse, to gently but realistically convince all parts of that patient as to the very real situation. If the birth attendant is other than the family physician, e.g., the midwife or obstetrician, that person must obviously be informed of the situation.

Hospitalizations may offer good opportunity for some useful blending of alter personalities for a specific purpose. This can be an excellent ego-strengthening experience and may be the first time "they" have had the chance to work together.

This brings up another point, applicable to all non-psychiatric hospital admissions for the dissociative patient. Those hospital and medical personnel who are going to be dealing with the patient must be made aware of MPD. This is no small problem, given the present state of medical awareness and teaching in this field. In my experience, surgeons are only slightly less resistant to the theory of MPD than are most psychiatrists. They will respond with disbelief which may border on the hysterical. Nevertheless this education process must be zealously pursued, for the benefit of all. Other doctors (the surgeon, the obstetrician/gynecologist, the anaesthesiologist, other physicians on call for you), nurses, the pharmacist ("Do you realize that these doses are *very* unusual, doctor?"), physiotherapists—all must be advised. It is important also that the patient be aware of this education process—he or she can help, especially if it is sympathetically explained. Such a patient will not appreciate being discussed as if he or she were a freak.

- 3) *Trauma, the Emergency Room.* The patient may already

have had some very unpleasant experiences in the Emergency Room of the local hospital. Generally the MPD patient is taken there in a state of extreme agitation, only to meet yet again with hospital personnel who have no understanding of the dissociative state. Time must first be taken with the patient—soothing and reassuring him or her that this is a different situation—they have been injured in some sort of accident; they have *not* done something "bad." After that comforting is achieved, all of the comments in the previous paragraph apply.

- 4) *Psychiatric Hospitalizations.* For the family physician, this is usually a hospitalization over which he or she can exert little control. Hopefully, the psychiatrist has been one of the family physician's choice, and is knowledgeable and appropriately sympathetic. These may also be the hospitalizations during which patients most need the support of their friendly "family doc." Just the usual brief professional visit, to let the patients know that they are still valued, is vitally important. The psychiatric ward experience is too often one of alienation, polarization of all medical and non-medical staff, and further feelings of abandonment.

Further Issues

- 1) *Insurance Companies.* Involvement with various types of insurance agencies can be a complicating factor which may surface in several situations.

Firstly, I will address the issue of reimbursement, especially for time spent by the family physician. In Canada, with our Health Care System, office visits to the general practitioner/family physician are, of course, covered—but only two of the ten provinces have a fee schedule item for what has been termed "G.P. Psychotherapy," and usually only a limited number of "Counseling" sessions are billable per year per patient. In my province, the Medical Plan fee schedule for an office visit covers about eight minutes' worth—the time it would take, for example, to look at a sore throat, feel for swollen glands, perhaps take a swab for culture, make up one's mind whether probably viral/bacterial/monial, and maybe write out a prescription. Eight minutes will very seldom cover the usual MPD patient visit, even in a strictly general practice situation.

Most of us simply accept the fact, and write off the lost income under the 'just one of those things' heading. For those of us who also serve as primary therapists for the dissociative disorder, it is a particularly difficult dilemma. As the situation stands, it is not satisfactory, and in the long run must be addressed, but few of us have the time or energy to involve ourselves in the diligent and exhausting lobbying efforts that it will take to change things.

Secondly, there is the case of third-party insurance for any one of several scenarios—e.g., a motor

vehicle accident.

Case Example: One of my patients, a young married woman with three young children, was driving when her car was rear-ended. There was no question of the accident being her fault—she was stopped at a red light, the other driver came up too quickly and hit her, pushing her car into the car ahead. She suffered the typical whiplash injury which was incredibly complicated by her MPD because several of her alters who were not involved with pain perception would take over when there was work to be done, especially caring for the children. The insurance company sent out agents to literally spy on her from cars parked across the street from her home. They reported seeing her going about her chores and of course the conclusion was that she was 'just a malingerer.' The several alters who were suffering extreme pain were thus caused to suffer even more distress due to the allegations of an deliberate attempt to defraud the insurance agency.

- 2) *Other Anomalies.* As previously mentioned, there are anomalies in the medical presentations of MPD patients which may confuse the clinical picture considerably, especially to a doctor unfamiliar with the syndrome. Many of these aspects have been investigated or there is ongoing research. An excellent review article by Miller and Triggiano (1992) addresses many of them.

Some alters appear to be allergic to a given substance, while others do not (Braun, 1983a). Some appear to have infections and others *simultaneously* do not (Hunter, unpublished data). The patient may arrive in the office or the ER with strange, unexplained wounds—or evidence of wounding is discovered at some later date. Self-inflicted injury is very common in MPD (Ross, 1989; Gilliland & Hicks, 1987). This is one of the areas where there is considerable overlap with borderline behavior. It often arouses intense antagonism in, e.g., emergency room staff who interpret it as attention-seeking behavior without realizing the emotional pain behind it. Healing may occur unusually quickly, often without benefit of suturing, especially (it seems) for such mysterious wounds. Conversely, at times healing is inexplicably delayed and the patient is accused of factitious intervention, an accusation which is vigorously denied and which has a tendency to erode the fragile trust with which the patient regards the doctor. There is always the possibility of a sabotaging alter causing the delayed healing, so that there has been factitious intervention completely blocked from the host by an amnesia barrier.

- 3) *Trust.* Issues of trust are constantly surfacing when working with MPD patients in any environment (Ross, 1989; Braun, 1985a). As has been stated many times but can never be overstated, these patients learned very early in their lives that trusting is dangerous, that trusting grown-ups is particularly dangerous and that trusting grown-ups who say they care for you is the most dangerous of all, because those are the people that hurt you.

Enter the Family Doctor, who fills all of those roles—a grown-up (with some authority) who says he or she can help you and who may even hurt you in the name of treatment. As doctors, we *expect* our patients to trust us; indeed, the doctor-patient relationship is based, essentially, on such trust. If we suddenly find out (usually in a crisis situation) that this trust which we so naively expected, is completely absent, we ourselves have a very difficult time to come to terms with that fact.

We must simply remember that this lack of trust has nothing personally to do with us, but has everything to do with the vicious conditioning which this patient experienced so early in his or her life. *We can still show trust in them.*

Family Constellation Issues

- 1) *Immediate or Nuclear Family.* One of the major issues in this area is that of support to the other family members. It is one of the ironies of treatment that the patient will in all probability become less stable, harder to live with, and more confused and confusing as therapy progresses.

First and foremost, the spouse or adult partner of the patient must be included in the disclosure of the diagnosis and be updated at all major therapeutic events along this terrible and difficult journey. Whether or not the family doctor is going to be the therapist, there is a major role for him or her in this situation—to support and reassure, explain and interpret. Most of the time the diagnosis will be received with relief. "I was ready to leave, but now that I know what it's all about I'll stay," said the husband of one of my newly-identified MPD patients. His reaction was, I have learned, typical. Unfortunately, he had no idea how difficult a journey it was going to be and there were many agonizing times along the way when he was again ready to leave.

It is also unfortunately often the case that a spouse or partner is him- or herself dysfunctional in various ways. Perhaps the spouse or partner is insecure, or also the survivor of an abusive childhood. These past events may never have been discussed between the couple, or may have become triggers for misunderstandings, quarrels, guilt/blame trips, or further abuse.

There are very few places where the other family members can go for help, but their family doc-

tor's office is one of them. The husband of the MPD patient may just need to sit and ventilate for a while. Where else can he relax and do that? If friends of this couple do not know what the true situation is, he can hardly go to a friend's for relief; even if they do know, he is still limited as to the amount of their time he can co-opt. He will feel more and more isolated and alienated himself.

Time needs to be scheduled in the doctor's office for clarifying what MPD is all about (and it will need to be clarified over and over again). The family is helped by knowing what stage of therapy the patient is in, and why things are more (or less) confusing now. *Safety issues MUST* be addressed—safety for the patient, and for all other family members. "Safety nets" need to be set up against both inadvertent and deliberate harm, most particularly for children in the home.

Many such families come and talk to me about "support groups," which may already be established in the community, or which are envisaged as being composed of friends, church members, etc. In my experience, few of these work very well and all too often they invite or precipitate another disastrous failure. This is not to say that all reasonable attempts to locate or arrange such a support network are useless or should be avoided — on the contrary. In my experience, which is echoed by that of many colleagues, most of those well-meaning people who volunteer have really no idea of what they are getting into, or what demands will be put upon them. When these become evident they will back away. Such proposals need to be discussed thoroughly, and there must be an informed, experienced facilitator present at every group meeting. This is not a do-it-yourself project.

Support groups, which often are lead or facilitated by peers or non-professionals, are not to be confused with group therapy for MPD patients, which certainly may have a place in the therapeutic plan (Coons & Bradley, 1985; Caul, Sachs, & Braun, 1986). The family physician must be even more than usually vigilant with families of patients who are themselves survivors of abuse. The transgenerational quality of this disorder is well known. Marital and family therapy may be of extreme importance (Sachs, Frischholtz, & Wood, 1985). There is a strong correlation between dissociation, family dysfunction, and medical care utilization (Anderson, 1991).

- 2) *When the Family of Origin is Also in the Doctor's Practice.* This is a very difficult, disruptive, and schism-making circumstance which is, given the basic premise, fairly common. The whole point of family medicine is that *families* are treated there; understanding the family dynamics and their relationship to illness and health is what family medicine is all about.

How, then, does a doctor relate to a family in

which it is becoming increasingly evident that horrible abuse was perpetrated by one or more of them, on another or others of them. It is extremely likely that the perpetrating generation will completely deny such abuse. The doctor will then be placed in a "Do you believe *me* or *them*?" no-man's-land which is both intolerable and unproductive.

Clear boundaries must be established between all parties, and the strictest professionalism observed. This area is fraught with hazards — personal, medical, and legal. It may be prudent to seek advice from senior colleagues and/or medical protective counsel. It is slightly easier if the family physician is not also the primary psychotherapist. To reiterate, referral to an experienced family and marital therapist may be a key therapeutic intervention (Sachs, 1986).

Family Physician/General Practitioner as Sentinel Physician

This is, for most FP/GP's, the key role. We are usually the first contact that the patient has with the medical/mental health care system. If we are alert we may be instrumental in helping the patient to early diagnosis and thus avoid years of further suffering. In an earlier section I listed several findings suggestive of undiagnosed MPD. Here I note additional phenomena that are highly associated with MPD. To what must we be particularly alert?

- 1) *Apparent Over-utilization.* Their tendency to somatize frequently results in many MPD patients over-utilizing the doctor's office or community clinic. There may be multiple referrals, diagnoses, or surgeries. As implied earlier, patients with a thick chart may have been trying to tell us something for a long time. It is time we heard them. At the very least, they deserve one more referral—to someone knowledgeable and experienced in dissociative disorders.
- 2) *Any Suggestion of Child and/or Sexual Abuse.* In Canada, as in most Western countries, it is required by law to report suspicions of child abuse. We all have our own inner battles about the apparent betrayal of trust that this involves—emotion battling intellect. It may be of some small solace to reflect that, by such reporting, we have saved not only the present real, ghastly physical damage to this child, but also the future, different though equally ghastly emotional and psychological trauma that will take years of intensive therapy to heal.

That dissociative disorders right across the spectrum to MPD evolve from child abuse has been so well documented that it is redundant to comment further. Our vigilance as family physicians can save years of terror, both experienced and remembered. The work of Kluft (1985), Braun and Sachs (1985), Putnam (1989), and Ross (1989), to name just a few, attests to this irrefutably.
- 3) *Eating Disorders.* "All anorexics are abuse survivors

until proven otherwise," a colleague of mine pronounced recently. Although this is too blatant a generalization, if a new patient comes into the practice with obvious anorexia or bulimia, or if a patient already in the practice develops such a state, it is a clear invitation to explore, gently but very persistently, the childhood and teenage years of that patient (Torem, 1986, 1987). "I don't really remember much of my childhood," is a reason for even more intense suspicion and query.

- 4) *Panic Attacks.* Sudden attacks of anxiety so acute that they immobilize the patient—literally—are common in MPD (Coons, 1988; Putnam et al., 1986; Smith, 1992). These attacks may erupt, apparently out of nowhere, at any age; but, on the other hand, the patient may admit to having suffered them "all my life." The usual pattern is for patients to suddenly find themselves panic-stricken, with all the signs and symptoms of an adrenaline rush, unable to breathe and with heart pounding (the two most common and frightening symptoms), frantic to get away from where they are, sure that they are going to die. The attacks are terrifying. Anxiolytics can be helpful, but techniques such as breathing into a paper bag, physical exercise of some *specified* type, or certain "active" relaxation methods are more useful and less potentially dangerous. As therapy progresses, if indeed the patient is dissociative, it will be possible to discover the why's and how's of these attacks, which send such a clear message of distress.
- 5) *Insomnia/Nightmares/Sleepwalking.* Like the anxiety attacks, these may intrude suddenly upon the scene or have "always" been part of this patient's life. Of course, most insomniacs do not have MPD, and all those who have nightmares are not abuse survivors—but if these are relatively new phenomena or have "always been there," it is another little warning light. I try to avoid chemical hypnotics, and teach my patients gentle hypnosis approaches instead.
- 6) *Sexual Dysfunction.* A common presenting complaint, sexual dysfunction may take the form of dyspareunia, erectile dysfunction, low sexual drive (in males or females), wishes to avoid sexual contact, inordinate fear of sexually transmitted diseases, or pelvic pain. Intimacy—even the thought of intimacy—is frightening (not just unwelcomed—*frightening*). The connection to early abuse is obvious but the patient him- or herself may still have very strong amnesic barriers and be cognitively unaware of it. If there is a spouse or stable partner, such dysfunction may threaten to sever the relationship. Sexual counseling is not always helpful, and almost never so if the amnesia is profound. Any laboratory or other investigative procedures (e.g., hormone levels) will probably be normal. This is particularly con-

fusing if the patient is male; often the libido is very low but testosterone is high, nocturnal erections strong, etc.

- 7) *Depression.* Many a dissociative patient has been mislabelled as "bipolar disorder." As many MPD patients seem to have at least one depressed alter, any unusual presentation (e.g., healthy young active adult or no family history of depression) in a patient who is exhibiting other "warning lights," is worth consideration as a possible abuse survivor.
- 8) *Unexplained "Accidents" to Self or Children.* Such presenting complaints must be considered particularly carefully, looking for inconsistencies or incongruities in the history.

All of the above symptomatology may be evaluated more carefully by an alert family physician who has been properly educated about dissociative disorders. Very few patients will offer up for our appraisal the "typical" symptoms of dissociation—internal voices, amnesia, losing time, etc. Instead they come with some of the foregoing symptoms, and it is up to us to decipher the meaning and to question accordingly with gentle but persistent inquiries. We have a unique opportunity, being cognizant, informed, and in positions of relative trust.

In some of the situations which I discussed earlier in this paper, the family physician will doubtless ask for cooperation from the attending psychiatrist or psychotherapist, if the patient has been so referred. An example would be contracting with the pre-surgical patient. I believe that the family doctor must be included in arrangements related to the medical management of his or her MPD patient in order to care for him or her in a knowledgeable and optimally helpful manner.

SUMMARY

The family doctor who is aware of the existence and incidence of MPD in the general population is the most logical person to serve as "sentinel physician" in the recognition of this disorder.

It is essential, therefore, that education in this field be extended to ALL medical students, but to family practice residents (and, of course, psychiatric residents) in particular. Much subsequent damage could be prevented, earlier treatment instigated, better support systems for the patient elaborated, and—a "fringe benefit" if there ever was one—millions of dollars cost to health care and social services would be saved. ■

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