Dissociative Processes, Multiple Personality, and Dream Functions

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From ancient times on, our dream processes were thought to be the uncovering of unknown connections. It may be that there is some basis to this belief, and that dreams truly represent a mirror of our unconscious and not only random processes moving along according to some brain "computation." These ideas are supported by some findings that involve connections among dissociative processes, hypnosis, and multiple personality disorder (MPD). From this point of view, MPD represents a very interesting theoretical problem, which may be understood as an extreme example of the dissociative nature of the human psyche. This in turn leads to an understanding of the complex structure of the human psyche and corresponds perfectly to our experience, which says that the pathological often sheds new light on the normal and physiological.

Pierre Janet, in his work about psychological automatisms (1), defines dissociation as being a defect of the associated system that creates the secondary consciousness, which he called the subconscious fixed idea. Similarly, Sigmund Freud and Joseph Breuer consider double consciousness in *Studies in Hysteria* (2) to be a pathological phenomenon. By contrast, Carl Gustav Jung considered the dissociation of personality not only a pathological phenomenon (3), but saw the dissociation of the psyche as a fundamental psychological process that makes differentiation and specialization of psychic processes possible. An example of this is the focusing of will or concentration on a single target, which often is a prerequisite for the development of the personality (4). During these processes, psychic entities are created and associated with certain contents of memory, patterns of behavior, and emotional charges. Jung called these entities psychic complexes, the most often dominant one being the ego-complex. Identified in his experiments in Burghölzl, Jung described these

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contents in his studies of word associations (5). When a defect occurs in free associations it is caused by a complex (5, 6). These complexes are, according to Jung, created out of inborn and inherent dispositions and their ethological manifestation is the resulting pattern of behavior. These dispositions act as ordering factors that organize psychic contents, perceptions, and fantasies into complex psychic structures. In the outer world, they are projected by neural firing patterns that affect muscular activity and glands that are involved in the ethological manifestation (pattern of behavior).

The existence of these ordering factors were recognized by Jung in his study of psychic regression in schizophrenic patients as well as their parallels in mythology and dream production (7). He called these emerging complex psychic structures "archetypes." A complex always has its own autonomy and behaves as a split part of the psyche. When a complex is evoked into the consciousness, its physiological or pathological influence depends on a degree of its autonomy or, contrary to that, compatibility with other complexes respective to the ego-complex. In the case of pathological influence the complex leads to a lowered mental level (abaissement du niveau mental), as Janet suggested (1, 8). The fundamental causes of the etiology of pathological complexes are mainly traumatic events, which produce traumatic memories. Complexes thus generate alternate fields of the psyche, and it is possible, by means of these complexes, to explain extreme cases which occur in multiple personality disorder (MPD).

CONTINUUM OF DISSOCIATION AND INHIBITORY MECHANISMS

Connectionist models, rooted in cognitive science, are very important for deeper understanding of dissociative processes and they make possible the theoretical view of dissociative continuum. According to Yates and Nasby these models of memory based on neural networks were elaborated during 1980s and are known as connectionist models or parallel distributed processing (9). Dissociation became unnecessary for further explanation of memory phenomena and for development of memory models in normal and also pathological memory processes. Increased clinical interest in dissociation led to development of models of dissociation based on associative neural networks. According to these findings emotions and inhibitory mechanisms as participants in organization of memory (9) play a key role in dissociative processes.

Affect plays a crucial role in modulation of memory processes, which, in extreme cases, lead to dissociative defects. Another important factor is

neural inhibition resulting from fundamental excitatory or inhibitory synaptic processes that are crucial for brain functions. Inhibition of very intensive and negatively modulated states enables us to describe memory phenomena, such as amnesia, fugues, MPD, and other manifestations of dissociation in normal or pathological states. Closely related to these findings is the notion of schizophrenia as a loss of dissociative inhibitory connections within the memory leading to serious defects in associative connections as, for example, the so-called "word salad (paraphrasia)" (9).

In other words, dissociated fragments, i.e., complexes, are pathologically disintegrated due to abnormal intensive affect compensated by neural inhibition. Failure of this inhibition manifests itself as a continuum of pathological dissociation from mild forms, such as repression, to serious forms, such as splitting or word salad.

From the point of view emphasized in associative models of memory, pathological dissociative processes may be conceptualized as a failure of inhibition and normal dissociative functions leading to unresolved intrapsychic conflict with serious consequences for the course and organization of psychic functions, for example reactive creation of splitting or repression.

THE MULTIPLE PERSONALITY AS A MODEL OF THE DISSOCIATED CHARACTER OF THE HUMAN PSYCHE

In the 1980 DSM-III (*Diagnostic and Statistical Manual of Mental Disorders*) classification (10), the criteria of the multiple personality were introduced for the first time. The revised definition for multiple personality (i.e., dissociative identity disorder) according to DSM IV criteria are as follows (11):

1. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
2. At least two of these identities or personality states recurrently take control of the person's behavior.
3. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
4. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures).

Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

As a consequence of splitting, the personality becomes alternating and dissociated. Several personalities are distinguishable in one person. The birth personality develops in the individual from birth, while the personality that controls the body for most of the time, analogical to the ego-complex, is called the host personality. Birth and host personalities are called primary, while other personalities are called secondary. The presenting personality is the one actually present at a given moment. As a consequence of therapy or hypnotic suggestion, the personalities may integrate or fuse. Occasionally, they may integrate spontaneously.

In the past, MPD as a subject of study was grouped with dissociative disorders, such as hysterical neurosis. In ICD 10 (12), the multiple personality belongs to the group of dissociative disorders (F 44). Extending the concept of schizophrenia was also considered by Bleuler among others. He also felt that MPD was a rare phenomenon of great theoretical value (13, 14). Bleuler also defined schizophrenia ('splitting') as a disorder of integrity. In his textbook of psychiatry he wrote (14):

> It is not alone in hysteria that one finds an arrangement of different personalities one succeeding the other. Through similar mechanism schizophrenia produces different personalities existing side by side. (p. 138)

Bleuler's introduction of the group of schizophrenias in 1911 replaced Kraepelin's term dementia praecox. A review of the Index Medicus from 1903 to the revival of interest in multiple personality in 1978 shows a dramatic decline in the number of reports of multiple personality, which indicates that many patients with multiple personality had been diagnosed and treated as schizophrenics (15). It corresponds to findings that a substantial number of patients with multiple dissociative identity disorder (DID) have previous diagnoses of schizophrenia (16, 17). It is mainly due to the presence of positive symptoms of schizophrenia in patients with dissociative identity disorder that report more positive symptoms of schizophrenia than schizophrenics. It is important to note that schizophrenics report more negative symptoms. A primary emphasis on positive symptoms may result in false-positive diagnoses of schizophrenia and false-negative diagnoses of dissociative identity disorder (18). Similar findings confirm other studies that examine dissociation in schizophrenic patients (19–22).

The creation of personalities, according to Bleuler (14, 16, 17), is the same as the process of splitting in schizophrenia. Among its characteristic symptoms belong the emergence of alter personalities and typical amnesia. Etiology is thus traditionally explained along the lines of Pierre Janet (1, 8,

13, 23) as being a consequence of dissociative reaction, analogous to somnambulism, fugue states, hypnosis or psychogenic amnesia, most often as a consequence of abuse or traumatic experiences mainly occurring between the ages of four to eight. It is a splitting of psychic connections similar to hysteria, but in an extreme version. Psychotic decompensation of some personality may occur and has corresponding symptoms, such as hallucinations.

Because of a spontaneous course or therapy, elucidating information among secondary personalities, is possible. Nevertheless the host personality often does not have this knowledge. An Internal Self-helper (a term coined by psychiatrist R. B. Allison) repeatedly appears (23, 24) that has knowledge of other personalities and their organization and relationships. It often becomes the center of the treatment for the integration of the personality.

In hypnosis with healthy individuals a similar entity, called the "hidden observer," (25) is often found. The hidden observer or internal Self-helper thus empirically corresponds to Jung's the Self (das Selbst).

According to Jung (7, 26, 27), associated connections of dissociated fragments of the personality represent a certain psychic entity which he called the Self. According to him, compensating integration processes in cases of pathological dissociation lead to the generation of symbols of the Self that stand for the psychic wholeness. These symbols represent psychic contents that penetrate separated psychic structures. In the case of a multiple personality, it leads to the manifestation of the Internal Self-helper that has knowledge of other parts of the psyche and has the ability to integrate other alter personalities. The Self thus represents the wholeness of psychic processes manifested by way of dreams, fantasies or projections in the form of gods, people, animals, vegetables or objects. Dissociation is thus compensated by factors that create connections, relationships, and knowledge among these dissociated psychic structures.

Using the perspective of the complex theory, it is very interesting that in hypnosis components of the personality very similar to subpersonalities of the multiple personality were found also in normal individuals (28–34). For example, Bowers and Brecher (29) reported interesting material involved in the emergence of multiple-personality structure under hypnosis. The authors conclude that this structure was not produced by the hypnosis, but preceded the beginning of the hypnotic work. The patient in the case under discussion had not shown in the multiple structure in clinical and psychological examinations prior to the hypnosis. In his conscious state the patient was not aware of his three underlying personalities, each of which reported distinctive dream material and Rorschach responses.

Conversely, Barret (34) describes similarities between the states of dreaming and MPD, including amnesia and other alterations of memory. This suggests the dream character as a hallucinated projection of aspects of the self that can be seen as a prototype for the alter personalities. It corresponds to findings that the physiological mechanism for amnesia and the manufacture of alter identities, and the cognitive and personality processes that operate outside conscious awareness occur during dreaming. Extreme early trauma may mutate or overdevelop these dissociated parts, inducing them to function in the external world, and thus leading to development of MPD. According to these data the dream model parallels the observed phenomena of multiple personality more directly than do explanations relying on waking fantasy processes.

Dissociation and Dream Functions

Immediate connections between dreams and the dissociated structure of the personality represent alter personalities that occur on parallel levels—on the one hand, in dreams and, on the other, in hypnosis. These connections are exhibited in a case study by Salley (35).

> Salley described the case of Frank, a 37-year-old white man with multiple personality. His biological father was imprisoned at the time of his birth. Frank lived with his maternal grandparents soon after his birth. The multiple organization began when he was six and began living with his biological mother. His mother had remarried an alcoholic who abused Frank physically and emotionally. Frank's medical history from his late teens included blackouts, amnesia for certain actions, fugues, abrupt personality changes, and hysterical conversions. His past diagnoses included chronic undifferentiated schizophrenia, organic brain syndrome, inadequate personality, and seizure disorder. He had a long history of appearing on hospital grounds in a state of seizure with amnesia. The memories would typically come back within a few days for all but a brief period of time. It takes from a few days to month just preceding the seizure. His life from early childhood was an almost constant pattern of hospitalizations and fugues that have taken him all over the country.
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> In the following therapy Salley described these events: "Hypnotherapy was used to attempt to uncover lost memory. An ISH (Internal Self Helper) was discovered through hypnosis who identified himself as Self, a protector of Frank. Self in somnambulistic trance, explained that the seizures resulted from a struggle between Frank and Self at those times when Frank would resist regaining consciousness after a blackout and Self would to attempt to force him to be conscious. Self stated that his only line of communication with Frank was through dreams and that he would create a dream that would explain to Frank the functions of the seizures. Out of trance, Frank as was typical, had no memory of what had occurred in hypnosis. That night Frank dreamt that

> he was standing on a pedestal and two voices were shouting at him; one voice shouting "Yes!" and the other "No!" The vibrations from the shouting were so intense that the pedestal began to shake and split open, whereupon he fell to the ground shaking. Free association to the elements of the dream led Frank to relate the shaking to his seizures and the screaming to internal conflict and his resistance to regaining consciousness after a blackout. In the two years since he had this dream, he has experienced no recurrence of the hysterical seizures." According to Salley, in this dream sequence, a dissociated aspect of personality organization predicted and apparently created a dream to communicate with another aspect of the personality. (35)

Frank had 13 personalities, two of which claimed a dream-production function. These personalities were able to organize and create dreams for the communication with the host personality.

Further literature also shows the clinical evidence that "dream work" of the ego is operative in both the representation of a separate self in dreams and in alter personalities (36–38). For example, a striking relationship of dreams and dissociative states was demonstrated in a patient with MPD, who, in her usual state of consciousness reported a very distressing dream: she was watching a young girl being sexually abused by an unknown man while an unknown woman was holding her down. A number of days later, a young-girl alter spontaneously emerged in a session, who described an eerily first-hand experience. This alter had no awareness that the dream had been reported and the patient had amnesia for the time when her alter was "out" giving her report of the trauma (36).

Similarly, Barrett (39, 40) reported cases of multiple personality with alters appearing as dream characters, or alters who could orchestrate dream content, and even cases of integration occurring within a dream. He discussed the strong potential of these dream characteristics to facilitate the therapy of dissociative disorders.

However, in contrast to Salley's case, Epstein (41) reported cases when recurrent dreams occurred episodically during sleep or waking, and also as a seizure content in temporal-lobe epileptics. As is known, such recurrent dreams occur also in individuals who are clinically nonepileptics and may arise after a traumatic event.

Dream as Reflection of Dissociative Processes

Alter personalities with dreaming functions thus support the view of the dream as a reflection of the self-monitoring dissociated system in the study of Gabel (42), who shows important connections and similarities between hypnotic states and dreams. From these connections among complex theory and dream production in multiple personality we may support the

view that the dreams of a healthy person also represent a reflection of interactions and an arrangement of dissociated components of the personality. The relationship of hypnotic and dream processes, in the case of alters, with dream functions shows a closer connection between hypnosis and dreams. Conversely, in their manifestations, the consequences of posthypnotic suggestion are very similar to some psychopathological phenomena (43) that are induced by the mechanism of repression and lead to a dissociated state by lowering the corresponding psychic contents under the limit of consciousness. Probably both repression and posthypnotic suggestion are connected to subliminal perception and information processing. According to Stross and Shevrin (44–46), alterations of the thought contents under hypnosis can be observed during investigations of "freely evoked images" after the subliminal presentation. Their major conclusion was that hypnosis leads to heightened access to subliminal stimuli. As a result, Stross and Shevrin concluded that thought organization during hypnosis shares some common elements with thought organization during dreaming. Other studies (47–49) supporting their conclusion, showed that subliminally presented images were found in dreams.

All the same, Salley's findings (35) and other documented dream works with patients suffering (23, 50–52), where dreams can play an important role in uncovering buried trauma or identifying secretive alters, represent important data for research and the resolution of the problem concerning the relationship between dreams and hypnosis. It suggests that individual alter personalities may shape or create dreams separately from other alters. In addition, these data support Gabel's hypothesis that dream material in healthy persons, being similar to that of multiple personalities or to the phenomenon observed in patients with traumatic neurosis (53, 54), demonstrates the personality system of dissociated and disowned experiences.

A comparable paradigm for dreams establishes connection of recurrent dreams and nightmares after trauma (55). A traumatized person may dream first about the actual trauma, but not always. Later, the dreams appear to deal with dominant emotion and about original sensory input from the actual trauma. The dreams contextualize, i.e., they find a picture context for the emotional concern represented by a dominant emotion. This contextualization can be seen in stressful situations, in pregnancy, or in patients whose lives are dominated by one emotion. This pattern may be paradigmatic for all dreams but often it is difficult to detect it in ordinary dreams, because there may be a number of other relatively smaller emotional concerns that interact with dominant one (55). The contextualization found in traumatized patients corresponds to transformation of

unconscious contents into the dream symbols according to Jung (6, 7), or Silberer who called it a "functional phenomenon" that transforms thoughts into images and changes the unconscious thoughts into the dream contents (56, 57).

Similarly, there are findings that show empirical foundation for a self psychology of dreaming (58). Laboratory evidence demonstrated that dreaming serves three primary functions: 1. the maintenance of self-cohesiveness, 2. the restoration of a crumbling or fragmenting self, and 3. the development of new psychic structures. This supports Kohut's view of the dream as perfect (metaphorical) description of the entire patient's "self" the so-called "self state dream."

Also many further studies support the view that dreams provide access to underlying personality structure, as well as its defensive and adaptive structures (59).

In the neural-network models dreaming represents the hyperconnective process in the autoassociative net with rapid information processing corresponding to neurobiological findings that during REM sleep are intensively new synaptic connections are being created (55).

The above leads us to propose the hypothesis for future research that the dreams of healthy persons also represent a reflection of interactions and order of dissociated components of the personality.

CONCLUSION

A characteristic feature of many trends in depth psychology is the attempt to make some sense of the dream scenery. If we explain dreams as dissociative processes that reflect an actual state, then we are open during the therapy to any prospective messages that can help in the integration of the personality. It has great importance for diagnostics and therapy because dreams can help in recovering and solving an unconscious conflict. Many of those who have worked in dream analysis have had similar experiences. Nevertheless, it is hardly possible to believe in any universal theory of dreams or analysis of symbols because dreams are unique phenomena and their "messages" are recovered from the intentions of the dreaming personality. Conversely, it is probable that some "invariants" exist in the human psyche that represent universal meanings and motifs that repeatedly occur in mythology, fairy tales, and dreams.

REFERENCES

1. Janet, P. (1890). *L'Automatisme Psychologique.* Paris: Felix Alcon.
2. Breuer, J., & Freud, S. (1895). *Studies in hysteria.* New York: Basic Books.

3. Jung, C. G. (1972). On the nature of the psyche. The structure and dynamics of the psyche. In *Collected Works of C.G. Jung 8.* Princeton: Princeton University Press.
4. Jung, C. G. (1972). Psychological factors determining human behaviour. The structure and dynamics of the psyche. In *Collected Works of C.G. Jung 8.* Princeton: Princeton University Press.
5. Jung, C. G. (1973). *Collected Works of C. G. Jung 2.* Princeton: Princeton University Press.
6. Jung, C. G. (1972). A review of the complex theory. The structure and dynamics of the psyche. In *Collected Works of C.G. Jung 8.* Princeton: Princeton University Press.
7. Jung, C. G. (1968). *Analytical Psychology: Its Theory and Practice.* London: Routledge & Kegan Paul.
8. van der Hart, O., & Friedman, B. (1989). A reader's guide to Pierre Janet on dissociation: A neglected intellectual heritage. *Dissociation, 2,* 3–16.
9. Yates, J. L., & Nasby, W. (1993). Dissociation, affect, and network models of memory: An integrative proposal. *Journal of Traumatic Stress, 6,* 305–326.
10. American Psychiatric Association, (1987). *DSM III-R, Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: American Psychiatric Association.
11. American Psychiatric Association, (1994). *DSM IV, Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington DC: American Psychiatric Association.
12. World Health Organization, (1993). *The ICD-10. Classification of Mental and Behavioural Disorders. Diagnostic Criteria for Research.* Geneva: World Health Organization.
13. Boleloucký, Z. (1986). Multiple, dissociated personality-new interest in an old problem. *Ceskoslovenska Psychiatrie, 82,* 318–327.
14. Bleuler, E. (1924). *Textbook of Psychiatry.* (A. A. Brill, Trans.). New York: Macmillan Publishing Co. Inc.
15. Rosenbaum, M. (1980). The role of the term schizophrenia in the decline of diagnoses of multiple personality. *Archives of General Psychiatry, 37,* 1383–1385.
16. Bottero, A. (2001). A history of dissociative schizophrenia. *L'Evolution Psychiatrique, 66,* 43–60.
17. Scharfetter, C. (1998). Dissociation and schizophrenia. Schizophrenias—a dissociative nosopoietic construct? *Fortschritte der Neurologie-Psychiatrie, 66,* 520–523.
18. Ellason, J. W., & Ross, C. A. (1995). Positive and negative symptoms in dissociative identity disorder and schizophrenia: a comparative analysis. *Journal of Nervous and Mental Disease, 183,* 236–241.
19. Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174,* 727–735.
20. Spitzer, C., Haug, H. J., & Freyberger, H. J. (1997). Dissociative symptoms in schizophrenic patients with positive and negative symptoms. *Psychopathology, 30,* 67–75.
21. Startup, M. (1999). Schizotypy, dissociative experiences and childhood abuse: relationships among self-report measures. *British Journal of Clinical Psychology, 38,* 333–344.
22. Read, J., Perry, B. D., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: a traumagenic neurodevelopmental model. *Psychiatry, 64,* 319–345.
23. Putnam, F. W. (1989). *Diagnosis and Treatment of Multiple Personality Disorder.* New York, London: The Guilford Press.
24. Allison, R. B. (1974). A new treatment approach for multiple personalities. *American Journal of Clinical Hypnosis, 17,* 15–32.
25. Hilgard, E. R. (1986). *Divided Consciousness. Multiple Control in Human Thought and Action.* New York: Wiley.
26. Jung, C. G. (1972). Aion. In *Collected Works of CG Jung 9.* Princeton: Princeton University Press.
27. Jung, C. G. (1972). Mysterium Coniunctionis. In *Collected Works of CG Jung 14.* Princeton: Princeton University Press.
28. Watkins, J. G., & Watkins, H.H. (1979–1980). Ego states and hidden observers. *Journal of Altered States of Consciousness, 5,* 3–18.
29. Bowers, M. K., & Brecher, S. (1955). The emergence of multiple personalities in the course of hypnotic investigation. *International Journal of Clinical and Experimental Hypnosis, 3,* 188–199.
30. Watkins, H. H. (1993). Ego-state therapy: an overview. *American Journal of Clinical Hypnosis, 35,* 232–240.
31. Lynn, S. J., Maré, C., Kvaal, S., Segal, D., & Sivec, H. (1994). The hidden observer, hypnotic dreams, and age regression: Clinical implications. *American Journal of Clinical Hypnosis, 37,* 130–142.

32. Merskey, H. (1992). The manufacture of personalities. The production of multiple personality disorders. *British Journal of Psychiatry, 160,* 327–340.
33. Rickeport, M. M. (1992). The interface between multiple personality, spirit mediumship and hypnosis. *American Journal of Clinical Hypnosis, 34,* 168–177.
34. Barret, D. (1995). The dream character as prototype for the multiple personality alter. *Dissociation, 8*(1), 66–68.
35. Salley, R. D. (1988). Subpersonalities with dreaming functions in a patient with multiple personalities. *Journal of Nervous and Mental Disease, 176,* 112–115.
36. Brenner, I. (1996). The characterological basis of multiple personality. *American Journal of Psychotherapy, 52,* 154–166.
37. Brenner, I. (1999). Deconstructing DID. *American Journal of Psychotherapy, 53,* 344–360.
38. Brenner, I. (2001). *Dissociation of trauma: Theory, phenomenology and technique.* Boston: International Universities Press.
39. Barret, D. (1994). Dreams in dissociative disorders. *Dreaming, 4,* 165–175.
40. Barret, D., (Ed.) (1996). Dreams in multiple personality disorder. In *Trauma and dreams.* Harvard University Press, pp. 68–81.
41. Epstein, A. W. (1964). Recurrent dreams; their relationship to temporal lobe seizures. *Archives of General Psychiatry, 10,* 49–54.
42. Gabel, S. (1989). Dreams as a possible reflection of dissociated self-monitoring system. *Journal of Nervous and Mental Disease, 177,* 560–568.
43. Huston, P., Skehow, J., & Erickson, M. (1934). A study of hypnotically induced complexes by means of the Louria technique. *Journal of General Psychology, 11,* 65–97.
44. Stross, L., & Shevrin, H. (1962). Differences in thought organization between hypnosis and the waking state: An experimental approach. *Bulletin of the Meninger Clinic, 26,* 237–247.
45. Stross, L., & Shevrin, H. (1968). Thought organization in hypnosis and the waking state. *Journal of Nervous and Mental Disease, 147,* 272–288.
46. Stross, L., & Shevrin, H. (1969). Hypnosis as a method for investigating unconscious thought processes. *Journal of the American Psychoanalytic Association, 17,* 100–135.
47. Silverstein, S. M. (1993). Methodological and empirical considerations in assessing validity of psychoanalytic theories of hypnosis. *Genetic, social, and general psychology monographs, 119,* 5–54.
48. Fischer, C. (1954). Dreams and perception: The role of preconscious and primary modes of perception and dream formation. *Journal of the American Psychoanalytic Association, 2,* 389–445.
49. Poetzl, O. (1960). The relationship between experimentally induced dream images and indirect vision. *Psychological Issues Monograph, 2,* 46–106.
50. Jeans, R. F. (1976). The three faces of Evelyn: A case report. I. An independently validated case of multiple personalities. *Journal of Abnormal Psychology, 85,* 249–255.
51. Marmer, S. S. (1980). The dream in dissociative states. In Natterson J M (Ed.), *The Dream in Clinical Practice.* New York: Jason Aronson.
52. Marmer, S. S. (1980). Psychoanalysis of multiple personality. *International Journal of Psychoanalysis, 61,* 439–459.
53. Ferenczi, S. (1934). Gedanken über das trauma. *International Zeitschrift für Psychoanalyse, 20,* 5–12.
54. Levitan, H. (1980). The dream in traumatic states. In Natterson JM, (Ed.), *The Dream in Clinical Practice.* New York: Jason Aronson.
55. Hartmann, E. (1998). Nightmare after trauma as paradigm for all dreams: A new approach to the nature and functions of dreaming *Psychiatry, 61,* 223–238.
56. Silberer, H. (1909). Bericht über eine Methode, gewisse symbolische Halluzinations-erscheinungen hervorzurufen und zu beobachten, *Jahrbuch,* Vol. 1.
57. Silber, A. (1970). Functional phenomenon: Historical concept, contemporary defense. *Journal of the American Psychoanalytic Association, 18*(3), 519–538.
58. Fiss, H. (1986). An empirical foundation for a self psychology of dreaming. *Journal of Mind and Behavior, 7,* 161–192.
59. Guralnik, O., Levin, R., & Schmeidler, J. (1999). Dreams of personality disordered subjects. *Journal of Nervous and Mental Disease, 187,* 40–46.