EDUCATIONAL DOMAINS AND ANDRAGOGICAL APPROACHES IN TEACHING PSYCHOTHERAPISTS ABOUT MPD

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ABSTRACT

Didactic efforts in educating students and colleagues about multiple personality disorder (MPD) often begin with rather traditional attempts to convey a body of didactic knowledge, and assume that they prepare the student learner to begin his or her clinical work. In fact, although such approaches are traditional and reasonably effective, they are perforce limited. Educators divide the goals of education into three domains: cognitive, attitudinal, and instrumental. Also, adult learners tend to absorb material best when it is oriented toward problem-solving rather than the communication of information and abstract concepts. Therefore, teaching professional students and graduate therapists ideally should address the several domains and include a large portion of material presented with the several principles of adult learning born in mind. This presentation will begin with a review of approaches used to educate therapists about MPD, and then focus on techniques to bring about learning with regard to the condition and its treatment within an andragogical frame of reference.

INTRODUCTION

Multiple personality disorder (MPD) is a relatively new arrival among the mainstream concerns of the mental health professions. As a consequence, the vast majority of the individuals within those disciplines who encounter MPD patients have received little or no systematic instruction in their diagnosis and treatment prior to that event. Unceremoniously, they arrive at a moment in time at which such skills become painfully necessary, and their absence, previously a matter of indifference, becomes intensely disconcerting. The resulting circumstances may prove anxiety-provoking, demoralizing, and overwhelming. The therapist may feel deskilled.

Suddenly the ongoing flow of a career that was otherwise progressing in a more or less satisfactory manner is disturbed with the intrusion of unwanted turbulence. New areas of competence must be established. There are novel materials to be mastered and unfamiliar skills to be acquired. There is consolation, soothing, and balm to be applied to narcissistic wounds, to feelings that are rubbed raw, and to emotions that seem to be unleashed in the therapist by work with MPD. These (1) occur in response to the patient's plight and materials; (2) are triggered in connection with the therapist's own unique dynamics and concerns; (3) are stimulated in reaction to the unpleasant professional ambiance that often surrounds such treatments (Dell, 1988); and (4) emerge in connection with the sheer difficulty of conducting the therapy.

Not only must the therapist stretch to assimilate the novel, the novel must reach some accommodation with the person and the professional that the therapist is, and the person and the professional that the therapist is striving to become. Failing this, work with MPD has the potential to exert a deleterious impact upon the trajectory of the therapist's private life, personhood, and career aspirations. An integration must be sought that will not compromise the therapist's basic values, talents, ideals, and goals.

It is hoped that the encounter between the therapist and MPD will result in the therapist's gaining new areas of competence in a relatively smooth and atraumatic manner, and encourage the therapist toward continued growth by self-directed educational efforts and by participation in ongoing collaborative learning ventures. This hope is not always realized.

EDUCATION ABOUT MPD

Available Formats

Although I have not accumulated systematic data with regard to the observations that follow, they represent a perspective drawn from twenty years of work with MPD patients, and seventeen years of consultation to others.

Probably the most frequent vehicle of education is the simple single lecture. It is brief, requires a minimum of commitment from both the sponsor and the attendee, and therefore is generally palatable. However, its ability to convey more than an overview is questionable, and post-lecture audience questions almost invariably indicate that many have found the material difficult to absorb and hard to reconcile with the bulk of what they know. Lectures rarely can speak to the needs of particular individuals. Their main impact may be to increase recognition of or openness toward the subject, and to stimulate an urge to learn more. For some

attendees, who are already grappling with MPD, the most important outcome may be the resolution of a particular confusing issue or the garnering of a crucial clinical pearl.

Next to be considered are workshops, which are offered at an increasing number of professional conferences. Usually one, but occasionally two days in duration, they take the student through a series of topics. Beginning workshops may differ in focus, but in general they orient the student to the phenomena, etiology, diagnosis, and treatment of MPD. The student learner who comes eagerly wanting "everything" from such and experience is likely to come away with a sense of having been overloaded with more material than one can absorb with comfort. For the most part, the workshop is an excellent vehicle for conveying what can be learned and what can be done in the abstract, but often leaves the student learner uncertain as to what aspects of that which has been conveyed have immediate applicability to his or her circumstances, and somewhat uncertain as to how to integrate the new materials and skills into the ongoing flow of daily practice. This is especially true for first-time attendees who may have begun work with their first MPD patients in a manner that they infer having heard "experts" speak is suboptimal or undesirable.

An increasing number of study groups are now available across the United States and Canada; many of them are affiliated with the International Society for the Study of Multiple Personality & Dissociation (ISSMP&D). What a study group can provide depends upon its composition and maturity. Most study groups, at their inception, consist of a nucleus of a few interested individuals concerned about their clinical work with MPD patients. Often they serve as a support group and a forum for informal peer supervision. The members struggle with basic issues together, and often are quite egalitarian. Over time, however, study groups may follow a number of different pathways. Some retain their peer support and peer supervision focus, while others become formalized or move on to advanced concerns. While study groups are of exceptional value, and should be a part of one's ongoing education if they are available, it is impossible to generalize about their place in the growth of a particular therapist's expertise. Certainly they counteract the loneliness one can feel in working with MPD, and are a valuable starting point for networking.

Some examples may illustrate the diversity and the process of change that study groups may undergo. Study group A invariably discusses clinical issues in the caseloads of the participants. Study group B has assigned readings and presentations, and resembles a graduate course in psychology. Study group C frequently invites speakers from outside of their membership. Clearly each provides a different educational ambience. The Philadelphia Study Group began in 1982 with shared clinical problem-solving, including the bringing in of patients for consultations and demonstrations. It moved to a format of presentations on problems of general concern, followed by discussion. It then moved back toward general clinical problem-solving. As its members grew in sophistication it became as well a nurturing environment for ISSMP&D presentations and publications — more than twenty current and former members have made presentations and/or published in the field and/or taught on national faculties. Currently the group is a mixture of clinicians, the very experienced and the newly interested, struggling to find its focus. In the same evening's discussion group sophisticated discussions of the integration of highly complex MPD patients alternate with earnest inquiries as to whether one indeed should talk to the personalities.

Therefore, despite their unquestionable value, the study groups of today constitute too diverse a range of organizations with too varied a range of agendas to recommend them as complete educational resources for any clinician.

Ongoing consultation or supervision is a format of incomparable value. A well-matched supervisor and supervisee/consultant and consultee can cover an incredible amount of material rapidly and in a custom-tailored manner. However, the availability of consultation or supervision may be problematic in terms of logistics or expense, and many desirable consultants or supervisors do not have sufficient time to undertake additional work. Group supervision/consultation is an increasingly popular alternative. Peer supervision may be productive. My own style is to request those in group consultation/supervision to meet between their sessions with me in peer supervision, to help them internalize critical thinking and to emphasize the autonomy and ongoing mutual support system-building that I value. One disadvantage of a complete emphasis on consultation or supervision for learning is that there are no checks upon the supervisor or consultant, nor is there assurance that alternative points of view will be offered to the supervisee or consultee.

As the literature has expanded, an increasing number of clinicians are learning about MPD from self-directed reading. This is an economical and flexible format, but often leaves the student learner at the risk of acquiring knowledge out of context. It is remarkable how frequently the individual who has learned about MPD from reading alone arrives at unrealistic and unfortunate conclusions. One egregious example I frequently encounter concerns colleagues's interpretation of two articles of my own (1984, 1986) on the treatment of MPD. In these studies a major objective was to demonstrate that MPD patients could achieve stable integration. Naturally, the emphasis was on patients who achieved integration; most of the statistics reported were descriptive of this subgroup. For this cohort the average duration of treatment from diagnosis to integration was under two years. Many therapists assumed, on the basis of these publications, that it was reasonable to expect to integrate the average MPD patient in under two years. Unfortunately, a figure based only on highly successful treatments is most atypical. In fact, several of the MPD patients described as less than successful in the 1984 article are still in treatment with me and remain unintegrated! Many therapists have misread the thrust of those articles and have been either demoralized by or skeptical of those results. The colleague who reads in isolation has no way to correct his or her misperceptions.

A final format for learning is one that I will term extrapolation. Many individuals assume that the best way to understand and treat MPD is to build an understanding of MPD based on theories and approaches which are accepted within

their primary area of expertise. At best these efforts are fascinating; at worst they approach questionable practice. For example, a number of individuals who are basically skeptical about MPD continue to advance treatment strategies that take the form, "if you don't reinforce it it will go away." Periodically one of their patients comes my way after failing in treatment with them, and does well, to which they rejoin, "she went to someone who would gratify her fantasies." The basic datum of the failure of their preferred paradigm and the success of an alternate is not registered, and they continue to approach MPD patients with a set of ideas and techniques that they find congenial.

Summary Re: Formats

When all is said and done, one has to ask of these formats, What do they generate? Do those who employ them emerge knowing the field? Can they work with MPD? Can they handle MPD?

I know many therapists who are excellent individuals, have attended study groups for years, have read every major article, and have attended all manner of workshops, yet still are unable to access alters. They simply do not know how. Many therapists who have attended every International Conference still struggle when they must deal with hostile alters. They have not mastered how to contend with these phenomena. They are receiving teaching without acquiring the relevant learning. This is worthy of reflection.

Certainly there are some therapists who are not cut out for this sort of work, but this side-steps a much larger issue. It remains an unpleasant possibility that those individuals involved in training others about MPD are better clinicians and researchers than teachers. I recall that when I began to teach in the early 1970s I was, I thought, a very good teacher. If my students did not "get it," the fault had to be theirs. Any professional educator would cringe at these words, but I was not a trained educator. Over a period of time, however, and despite generally good ratings as a teacher, the negative feedback I received gradually made an impression. I began to study education. One of the first discoveries I made is that what must be learned and what must be taught do not constitute a whole— they consist of a series of educational objectives that can be understood as constituting a series of domains.

EDUCATIONAL DOMAINS

Although several authorities have divided the domains of learning somewhat differently (Bloom, 1956; Gagne, 1972; Tolman [in Hilgard & Bower, 1966]), a simple condensation would maintain that learning has cognitive, affective or attitudinal, and instrumental or psychomotor domains.

Following primarily the model of Bloom (1952), the cognitive domain has to do with the recall and recognition of knowledge and the development of intellectual abilities and skills. The affective/attitudinal domain pertains to changes in interests, attitudes, and values, and the development of appreciation and adequate adjustment. The instrumental or psychomotor domain involves skill mastery and a "how to do it" perspective.

The importance of this discourse to our topic is that work with MPD involves learning in all of these domains; and learning involves change, the act or process by which behavioral change, knowledge, skills, and attitudes are acquired (Boyd, Apps, & Associates, 1980). Most of our focus has been on education, which emphasizes the agent of change. Not only has the MPD field neglected these domains in its teaching— it also neglects them in its evaluation process. I have reviewed my evaluations from several dozen workshops that I have taught. I have been criticized many times because student X could not read my slides or felt that I spoke too rapidly— however, I have never been criticized because student X left one of my workshops unchanged by the experience.

HOW DO ADULTS LEARN?

It becomes crucial to reflect for a moment upon what sort of person becomes a student learner with regard to MPD. Absint the presence of some child prodigy in our midst, and the occasional interested undergraduate or relatively young graduate student, the modal consumer of information about MPD is an adult learner. To summarize a wealth of information eloquently reviewed and synthesized by Knowles (1984), the adult learner is a very different individual from the youngster in school. For the latter, the principles of pedagogy apply; for the adult learner, whom Knowles referred to as a "neglected species," the ideas of andragogy are far more relevant.

Many theories of pedagogy are essentially behavioral, and regard the student as the recipient of skillfully contrived stimuli. This so-called mechanistic view regards the learner as essentially passive, reactive, and empty. In contrast, and more relevant to adult learning, is an organismic view, which focuses on the learner as a developing organism whose essence is activity. Theories that stem from the mechanistic model are educator-centered in the main, and largely behavioral. Theories that stem from the organismic model are often of the artistic/humanistic variety, and focus upon the motivation and self-actualization of the student learner.

Eduard C. Lindeman (1926) was the pioneer in exploring how adults learn. He found that adults are unlikely to be stimulated either by abstractions, uncompromising requirements, or authoritarian models. For adults to be stimulated, the route of education is that of situations rather than of subjects. The highest resource is the adult learner's experience. Adult learning "represents a process by which the adult learns to become aware of and to evaluate his experience. To do this he cannot begin by studying 'subjects' in the hope that some day this information will be useful. On the contrary, he begins by giving attention to the situations in which he finds himself, to the problems that present obstacles to his self-fulfillment. Facts and information from the differentiated spheres of knowledge are used, not for the purpose of accumulation, but because of need in solving problems" (Lindeman, 1926, p. 160).

The educator moves from authority and oracle to facilitator. "None but the humble become good teachers of adults" (Lindeman, 1926, p. 160). Summarizing Lindeman's

work, Knowles observed: "1. Adults are motivated to learn as they experience needs and interests that learning will satisfy; therefore, these are the appropriate starting points for organizing adult learning activities. 2. Adults' learning is life-centered; therefore, the appropriate units for organizing adult learning are life situations. 3. Experience is the richest resource for adults' learning; therefore, the core methodology of adult education is the analysis of experience. 4. Adults have a deep need to be self-directing; therefore, the role of the teacher is to engage in a process of mutual inquiry with them rather than to transmit his or her knowledge to them and evaluate their conformity to it. 5. Individual differences among people increase with age; therefore, adult education must make optimal provision for differences in style, time, place, and pace of learning" (1984, p. 31).

The teaching style that facilitates adult learning best involves warmth, indirectness, cognitive organization, and enthusiasm (Gage, 1972).

How does one design an andragogical climate and format? Knowles (1984, p. 116) has offered some comparisons between pedagogy and andragogy that are valuable and instructive. While pedagogy assumes the dependency of the student and creates a climate that is authority-oriented, formal, and competitive, andragogy assumes the increasing self-directedness of the student and creates an atmosphere that is characterized by mutuality, respect, collaborativeness, and informality.

While pedagogy assumes that the student's experience is of little worth, and planning must come from the teacher, andragogy assumes that the learner is a rich resource for his or her learning, and effects a mechanism for mutual planning.

Pedagogy assumes readiness for learning is a matter of biological development and social pressure, so that learning needs are to be diagnosed by the teacher. Conversely, andragogy assumes that readiness stems from the developmental tasks of social roles, and that learning needs must be diagnosed mutually.

What is learned in pedagogy is for postponed application; objectives are formulated by the teacher. Andragogy is focused upon immediacy of application, and the objectives are to be formulated by mutual negotiation.

Learning in pedagogy is subject-centered, so that the course is designed into content units determined by the logic of the subject matter. In contrast, andragogy is problem-centered, and designed into problem units that are sequences in terms of the adult learner's readiness.

Naturally, the activities of pedagogy emphasize transmittal techniques, or how to get the knowledge into the student. Conversely, andragogy emphasizes experiential techniques that focus on inquiry.

The evaluation of pedagogy is, of course, the province of the teacher alone. In andragogy, evaluation occurs by the mutual re-diagnosis of educational needs and the mutual measurement of the program.

What follows from the above is the candid realization that the majority of educational endeavors that are mounted or self-constructed with regard to MPD do not create an atmosphere that is consistent with the needs of the adult learner. The early histories of many of the study groups have involved periods in which these conditions were met, but many of those groups changed as they come to contain members whose needs were so diverse that the needs of all participants were unlikely to be fulfilled on an ongoing basis.

My study of the literature of adult learning inclines me toward increasing respect for the concept of learning contracts in andragogy. A classic reference in the field is Knowles' *Using Learning Contracts* (1986). In essence, a learning contract is "an alternative way of structuring a learning experience: It replaces a content plan with a process plan. Instead of specifying how a body of content will be transmitted (content plan), it specifies how a body of content will be acquired by the learner (process plan)" (Knowles, 1986, pp. 39-40). The contract may be between the student and himself or herself, with a group, or with a mentor, etc. Knowles notes that it involves a series of steps.

Step 1 is *the diagnosis of your learning needs.* A learning need is the gap between where the student is and where the student wants to be with respect to a particular set of competencies. What does the student need to acquire? The learner, after reviewing his or her own thoughts, can get help from other resources to complete this process.

Step 2 is *specifying your learning objectives.* What are you to learn? Here the educational domains are a good guide, because they will help you toward the next step.

Step 3 is *specifying learning resources and strategies.* The adult learner is ill-served by simply accepting what is offered. It may have little relevance to his or her own needs.

Step 4 is *specifying evidence of accomplishment.* What will demonstrate the presence of the competency in question?

Step 5 is *specifying how the evidence will be validated.* By what criteria will the evidence noted above be judged? How and by whom will those criteria be applied?

Step 6 is *reviewing your contract with consultants* for the purpose of assuring that you have assembled a contract that relates to your needs in an optimal manner.

Step 7 is *carrying out your contract.* You need not hesitate to revise it in midstream.

Step 8 is *the evaluation of your learning,* getting some assurance that you have, indeed, learned what you set out to learn. The simplest way is to return to your consultants and ask them for their assessment.

The student learner who undertakes to monitor his or her education in such a manner becomes a more discriminating user of educational resources, better able to focus upon acquiring the competencies that he or she actually needs, and better able to focus his or her attention toward his or her own needs in the process of general educational endeavors and consultations.

What then of the lectures and workshops? How are we best to understand their function? I submit that they are most easily understood as somewhat pedagogic predidactic mobilization experiences. They teach the vocabulary and the culture of the field so that the process of adult learning has a substrate upon which to build. For example, it is simply not cost-effective to hire a consultant to teach one the basics about MPD. One can acquire that knowledge more readily from workshops, lectures, and reading. Apart from the need to address urgent crises, the time to turn to a consultant is

either after the diagnosis of one's learning needs and the establishment objectives, or if one is stymied in his or her efforts to achieve the aforementioned basics. At this point what one will glean from the consultation or supervisory experience will be infinitely richer.

STUDENT THERAPISTS VS. GRADUATE THERAPISTS

Within the community of psychotherapists, certain differences exist between the needs of those who are still officially students within their disciplines and those who have graduated. In my experience a substantial percentage of student therapists remain cognitively geared to expect an authoritative pedagogy model of explanation and instruction. I have found that a more andragogic approach may leave such students with either a sense of insecurity (the "truth" has not been revealed/one has not been told what to do and continues to have anxieties as one searches for guidelines and rules) or the conviction that the teacher does not have credible intellectual rigor. I have also found it most useful to convey to such students an appreciation of the best that is known, but to then attempt to facilitate their examination of these materials in the light of their growing experience. Often the anxieties that are engendered in the neophyte who is not given a pedagogical mix sufficient to allay apprehensions and establish a certain baseline of knowledge are sufficiently intense to incapacitate the individual from moving toward greater autonomy.

It is extremely helpful to avoid the infliction of narcissistic injury with all student learners, but with the neophyte it may not be immediately apparent just where the areas of narcissistic vulnerability and the residues of adolescent narcissistic concerns may impinge on the educational process. In contrast, with the more experienced practitioner it is easier to ascertain the narcissistic investments in various ideas and practices, and to assess character issues with relative facility. I am particularly concerned with the provision of a safe learning environment for neophytes, lest an overwhelming experience with MPD blight their young careers or dampen their enthusiasm for their chosen vocation.

One of the most difficult dilemmas that I have encountered, and admit that I have not resolved to my satisfaction, is the thorny issue of teaching the student therapist how to deal with MPD when that therapist still is lacking in general knowledge about psychopathology and psychotherapy. Often I have found no alternative to proceeding in a very didactic manner.

OBSERVATIONS ON TEACHING

One of the most important realizations to achieve in the education of therapists with regard to MPD takes us back to the domains. The cognitive domain's content can be mastered from well-organized presentations and reading, and its strategies from exercises in which challenges to thinking are presented. The latter is sorely underemphasized in education about MPD, and is one of the main reasons that so many student learners can acquire considerable knowledge, but make the same errors of thought over and over again. We need to develop exercises that allow our student learners more opportunities to test their critical thinking with regard to the problems that they perceive as relevant.

In connection with affective and attitudinal domain, modelling and vicarious reinforcement seem to be critical methodologies. Should we not move toward educational formats that include more demonstrations? Should we not require more active participation from student learners, and place them in exercises that offer them the opportunity to "try on" what they need to acquire?

With regard to the instrumental and psychomotor domain, practice is the essential component of learning. Yet there is little in our educational packages to allow for that sort of skill-building. Supervised role-playing might be a valuable adjunct to current workshop formats. Clearly many student learners leave the workshops of today cognitively engorged, but not "knowing how to do it."

At this time, I am advising those who want to learn about MPD to participate in workshops and study groups, but to devise their own learning contracts and monitor themselves quite carefully. I am suggesting that they obtain consultation when there is a wish or need to do so, but I am increasingly advising that they form a buddy system with another interested colleague so that they can discuss cases on a mutual "as needed basis," learn together, and always have a partner with whom they can role-play difficult situations and get feedback about their acquisition of skills. I am also advising learners who want to learn particular skills to contract with more experienced hands to do so by either bringing their patients along to the consultant or by spending a day with an experienced person, observing them work. I have been impressed with the incredible richness of these learning formats for making "breakthroughs" in the learning process.

ILLUSTRATIONS

1. A Brief Contract

An experienced MPD therapist had spent years in the field without encountering allegations of ritualistic abuse. Upon first exposure to this material, the therapist felt deskilled. The learning needs proved to be largely in the affective and attitudinal realm, and secondarily cognitive. In the absence of a concise summary of this area to which the therapist could be referred, an initial consultation, largely didactic, was held. The needs in the affective and attitudinal domain, which are best addressed by modelling, were attended to by freewheeling discussions about the learner's and the consultant's experiences. The learner calmed rapidly, felt competent in clinical work with the patient in question, and on follow-up demonstrated a clear capacity to continue the patient's therapy.

2. An Intermediate Contract.

A skilled therapist sought consultation about the MPD patients in the therapist's caseload. After some preliminary discussion, the therapist was encouraged to do an educational self-diagnosis. To the therapist's astonishment, what had appeared to be a bewildering variety of problems could be reduced to the therapist's lack of certain very specific skills

and a particular recurrent countertransference difficulty. The therapist and the consultant agreed to discuss and practice in role-play the skills in question. The therapist rapidly mastered the necessary skills and carried them over into his own practice. Simultaneously, the therapist returned to his old therapist to explore the countertransference problems in question. After three months of biweekly consultations, the educational objectives seemed firmly acquired. On follow-up a year later, the therapist is more confident in working with MPD and has produced some significant research in the field.

3. A Sequential Rediagnosis Contract

An individual with an intense involvement with the MPD field is attempting to build further upon an already impressive mastery. This individual has undertaken an ongoing process of rediagnosing his/her unique educational needs, and evolving novel approaches to acquire new competencies. At each rediagnostic step, this individual involves a consultant. The consultant may or may not be involved in the acquisition of the new competency, but always is presented relevant clinical material thereafter to assist in determining whether the competence has been acquired.

DISCUSSION

The previous sections have addressed major topics concerning the importance of educational domains and andragogical approaches in teaching psychotherapists about MPD. I would like to build upon these themes to reflect on the importance of these realizations for the MPD field in two areas, chosen from among many possible examples.

Although a number of therapists have distinguished themselves by their outstanding results in the treatment of MPD patients, this has not been followed by the widespread learning of their methods, techniques, and approaches. Clearly, such therapists have something to teach, but it is questionable how often they have the opportunity to do so. The very nature of content-oriented traditional pedagogy makes this unlikely. Likewise, the format of the workshop does not allow for this, nor does traditional supervision. It is only when the informed adult learner identifies the skills across the several educational domains that constitute the differential competency of the expert as deficits in terms of his or her learning needs, that this type of competence can be sought out and thereafter shared. The student learner cannot immediately leap to a higher level of competence, but unless he or she begins to identify the difference between his or her best level of performance and that of the expert, and strive to erase it, there is no way it will be taught. The failure on the part of student learners to define their needs in such a way delays the spread of expertise within the field. My best supervisees have pushed me to the limit to verbalize and/or demonstrate what I know. It is essential to acknowledge that a great deal of the accumulated wisdom of those of acknowledged expertise is never shared, and it is essential to appreciate that the expert cannot simply sit down and teach such wisdom in a didactic manner. The expert may not even realize what constitutes his or her expertise. This expertise can, however, be shared in response to a planned and inquisitive learning program.

Also, it is essential to realize that it is not impossible to help a hospital or clinical staff come to grips with MPD. Usually the individual who attempts to teach a staff about MPD has his or her hands full. That individual usually is highly invested in sharing what he or she knows about MPD, and in indicating what he or she would like the staff to know and to do. Implicitly a mechanistic and pedagogic focus is maintained. Many difficulties may ensue. If, however, that individual follows the principles of andragogy, and helps the staff to problem-solve and to learn only what the staff is ready to learn, the process is much facilitated. In the training of staff for The Institute of Pennsylvania Hospital's Dissociative Disorders Program an andragogical focus was maintained, and is continued with weekly education built around problem-solving. The result has been the development of a cadre of nurses and psychiatric technicians who are competent in many of the techniques that often are considered rather advanced, and a sense of mastery on the part of the staff, and security on the part of the patients.

In closing, let me acknowledge that we have much to learn from professional educators. Professional education in its other sense, i.e., the teaching offered to students in the professions, is often less effective than it is imagined to be, and, as we model ourselves upon our own teachers, often we perpetuate models of teaching which are mediocre or worse. In many areas of endeavor, where data bases are well-established, the ideas are well-known and familiar, and there are many authorities to whom the learner can turn, one can "get away with" not offering the highest quality of education—the student has many resources with which to repair his or her teachers's deficits and shortcomings. However, in a new and controversial field where much still remains to be established and often the best knowledge that is available is that which comes directly from the so-called experts, students are largely at the mercy of the skills of their teachers; and those who teach must be prepared to conduct themselves accordingly. ■

REFERENCES

Bloom, B.S., et al. (1956). *Taxonomy of educational objectives. Handbooks I-III.* New York: McKay.

Boyd, R.D., Apps, J.W., & Associates (1980). *Redefining the discipline of adult education.* San Francisco: Jossey-Bass.

Dell, P.F. (1988). Professional skepticism about multiple personality. *Journal of Nervous and Mental Disease,* 176, 528-531.

Gage, N.L. (1972). *Teacher effectiveness and teacher education.* Palo Alto: Pacific Books.

Gagne, R.M. (1972). Domains of learning. *Interchange,* III, 1-8.

Hilgard, E.R., & Bower, G.H. (1966). *Theories of learning.* New York: Appleton- Century-Crofts.

Kluft, R.P. (1984). Treatment of multiple personality disorder. *Psychiatric Clinics of North America,* 7, 9 - 29.

Kluft, R.P. (1986). Personality unification in multiple personality disorder: A follow-up study. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 31-60). Washington, DC: American Psychiatric Press.

Knowles, M.S. (1984). *The adult learner: A neglected species.* Third edition. Houston: Gulf.

Knowles, M.S. (1986). *Using learning contracts.* San Francisco: Jossey-Bass.

Lindeman, E.C. (1926). *The meaning of adult education.* New York: New Republic.