IATRONGENIC CREATION OF NEW ALTER PERSONALITIES

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ABSTRACT

The initial assessment of a patient suffering multiple personality disorder (MPD) rarely discloses the full complexity of that patient's system of personalities. Like most other mental disorders, MPD reveals its inner structure gradually, in the course of the uncovering process of therapy. This common sense observation, however, is often disregarded due to the widespread concern that the very procedures designed to alleviate and integrate MPD may augment rather than reduce its complexity. This paper will review factors inherent in the treatment, the patient, and the therapist that may contribute to an actual increment in the patient's complexity or to the appearance that this has occurred. Most apparent creations of new alter personalities reflect the use of personality formation to cushion the traumatic impact of the treatment, which is inherently painful, or to protect against intercurrent traumata. Others (the majority) represent in fact the discovery of preexisting but previously unrecognized alters. Some alters emerge in response to therapists' errors in technique or inappropriate behaviors.

BACKGROUND

I write this paper with a heavy heart and a great deal of misgiving. When what is now entitled the *David Caul Memorial Symposium* was first organized, this paper was to have been given by David M. Caul, M.D., himself. The very act of writing it brings home a deep sense of loss, and a weighty burden of responsibility. I knew and treasured David for ten years. The loss remains keen. David had given a great deal of thought to this subject, and accorded it a paramount importance. I would like to do justice to David's ideas about the iatrogenic creation of new alter personalities, but this was not a subject that we discussed at length. In many crucial areas I was not privy to his thinking. Therefore, the ideas in this article are drawn from my own notes and experience. I can only hope that I have contributed some observations that are consistent with those that David felt were so very important to share.

INTRODUCTION

Often subjected to skepticism with regard to their efforts and findings, ranging from the polite expression of professional disagreement and misgiving to scathing criticisms and vituperative ad hominem attacks from colleagues and peers (Dell, 1988), many clinicians and scientific investigators treating and studying multiple personality disorder (MPD) have taken great pains to emphasize that MPD is a naturally occurring mental disorder that cannot be induced by iatrogenesis or clever experimental manipulations. Indeed, the accusation of iatrogenesis has been one of the most frequent charges leveled against those working with MPD patients.

Perhaps because this issue has been made a battleground so consistently, it has remained an area of polarized opinion, and received relatively little objective study. It is clear that those whose primary field of expertise is in the realm of hypnosis research, a field with a strong tradition of attention to the identification of confounding variables, suggestion, expectancy, confabulation, and the unwitting impact of the demand characteristics of experimental and clinical situations, approach the phenomena of MPD as if they were able to be created in connection with the impact of these and allied influences. In my conversations with many of those who hold such opinions, it has become clear that their familiarity with clinical MPD is minimal, and they have felt comfortable in drawing analogies from their experimental and theoretical work, and applying them to phenomena that they have not studied in depth and breadth.

Conversely, many clinicians with extensive familiarity with MPD have remained rather naive about the concerns raised by the more experimentally inclined. Although the majority of the contributors to the clinical literature on MPD are firmly convinced that the condition cannot be created, the nature of clinical data is such that it rarely suffices to satisfy the doubts of the skeptic.

The extant literature on the subject is not very helpful. In sum, a critical review of the articles that purport to relate to iatrogenesis demonstrates that many of the phenomena associated with MPD can be induced quite readily, the condition itself has never been created in this manner. To prove the iatrogenesis of MPD, it would be necessary to

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begin with a normal individual and demonstrate that as a result of specified interventions, that individual demonstrated the phenomena of MPD on an ongoing basis, with the phenomena manifesting themselves spontaneously and repetitively in a classical manner over time. This has not been done; furthermore, a strong case could be made that it would be ethically reprehensible to do so.

Among the first to raise concerns about iatrogenesis were Janet (1889) and Prince (1890/1975), both of whom worried whether the misuse of hypnosis might encourage the further complication of the condition. Clearly, their concern was not merely academic. The misapplication of any modality may be detrimental to a patient's clinical course. Their concerns also heralded a tradition of concern as to whether the use of hypnosis per se was inappropriate in MPD. Modern reviews (Braun, 1984; Kluft, 1982) have noted that modern hypnotherapy is a very different modality from the authoritarian hypnosis of the era of Janet and Prince, that some of their concerns were overstated, and that some of the clinical examples that were cited as examples of the creation of MPD could be interpreted as demonstrating the preexistence of dissociative disorders rather than their iatrogenesis. Two modern surveys (Putnam, Guroff, Silberman, Barban & Post, 1986; Ross, Horton, & Fraser, 1989) have shown that hypnosis does not appear to alter the phenomena of MPD, that patients diagnosed and/or treated with hypnosis do not differ substantially from those who were never hypnotized.

Nonetheless, there is no reason to discard their concerns or to consider them without merit. Kluft (1982) described the plight of an MPD patient who, subjected to inappropriate hypnotic interventions, developed a plethora of alters in response to these misadventures. It would appear that although there is no evidence that MPD can be caused by the judicious and circumspect use of hypnosis, there is every reason to fear it can be worsened by its inept employment.

In the 1940s Harriman (1942, 1943) and Leavitt (1947) demonstrated the creation of phenomena of MPD with hypnosis. Harriman (1942) analogized automatic writing to MPD and argued that the hypnotic encouragement of the former might suggest a similar origin for the latter. In his second study (1943) he suggested away his subjects' personalities and inferred that their subsequent behaviors would enact a fantasy. In one case he cited, the subject had and enacted detailed fantasied roles, but, he noted, "Very infrequently are these 'secondary selves' anything more than poorly acted, ineffectual, compliant personalities" (p. 640). He concluded that perhaps he had done no more than to suggest a role for his subjects.

Leavitt (1947) suggested the creation of a secondary personality to facilitate treatment of a young marine, but it impeded therapy. He therefore suggested the creation of another to balance matters. "The 'personalities' appeared to be exact and elaborate responses to suggestions to undertake specific roles and/or activate and dramatize specific ego states" (Kluft, 1982). They appeared only in therapeutic hypnosis, and were quite limited. It appears that rather than having created MPD, Leavitt was an unwitting ancestor of the

ego-state therapy devised more formally by Watkins and Watkins (1979).

Kampman (1976) suggests that MPD can be created by hypnosis, but in fact his data show something different. The most hypnotizable 7 percent of his adolescent subjects were instructed, in trance, to go back before their birth and be "someone else, somewhere else." Forty-one percent (of the 7%) did so. That approximately 3 percent of subjects can enact an ego-syntonic past life fantasy is slender evidence upon which to argue that MPD can be caused by hypnosis.

Most recently Spanos, Weekes, and Bertrand (1985) and Spanos, Weekes, Menary, and Bertrand (1987) have undertaken some ingenious experiments to suggest that MPD is a social psychological construct. It is unfortunate that these workers' lack of familiarity with the clinical entity about which they draw conclusions compromises their interpretation of their results.

In a most welcome recent development, Ross, Norton, and Fraser (1989) have begun to explore the issue of iatrogenesis by assessing the phenomenology of MPD patients diagnosed by those identified as having an interest in MPD and those who are not so identified. They found minimal differences in the data on these two cohorts, suggesting no firm role for iatrogenesis in determining the overall phenomenology of MPD.

The clinical literature is virtually unanimous that full MPD cannot be created iatrogenically. There is no evidence that such a case has been demonstrated; clinicians of widely different orientations have studied the available information and arrived at similar conclusions (e.g., Braun, 1984; Gruenewald, 1984; Kernberg, in press; Kluft, 1982; Putnam, 1989). Nonetheless, most of these observers have noted that many of the phenomena of MPD can be created quite readily, and that phenomena with striking superficial resemblance to MPD can be generated with relatively little effort. In fact, I noted in passing (Kluft, 1986a) that I had replicated the interventions of Harriman (1942, 1943), Leavitt (1947), and Kampman (1976), and found the resultant phenomena clearly distinguishable from clinical MPD.

Faced with evidence that there is no proof that MPD can be created de novo, but that many of its phenomena can be elicited, several investigators have offered relevant comments. Braun (1984) is confident that full MPD cannot be created iatrogenically, but leaves open the possibility that a fragment, an entity less developed than a full personality, might be. Gruenewald (1984) writes: "Although injudicious use of hypnosis may have a variety of untoward effects, causation de novo of multiple personality does not seem to be one of them" (p. 175); and "While it is highly unlikely that current situational variables — including the use of hypnosis — are involved in creating the multiple personality syndrome, it is conceivable that they may be instrumental in concretizing and possibly encouraging a pre-existing tendency" (p. 185).

Kluft (1982) remarks, "Phenomena analogous to and bearing dramatic but superficial resemblance to clinical multiple personality can be elicited experimentally or in a clinical situation if one tries to do so or makes technical errors....Furthermore the phenomena described in Hilgard's

hidden observer work . . . and the Watkins' ego state articles can be elicited by hypnosis and overinterpreted as multiple personality. . . . However, the evidence that skillful therapeutic hypnosis creates or worsens multiple personality remains to be presented" (p. 232). Kluft (1988a) has also pointed out that ego-syntonic phenomena with similarities to MPD such as mediumistic trance (and its more "new age" variant, trance-channelling) can be easily suggested or self-suggested, a circumstance demonstrated compellingly by D. Spiegel (1987).

Upon close examination, there is little real contradiction among the factual findings and the opinions of those with extensive experience with MPD. However, in the hurly-burly of clinical practice, where decisions may have to be made on the basis of limited data and where the imprecise nature of the definition of the terms "personality" and "personality state" can become confusing, distinctions can become difficult to draw, and have the potential to reactivate unproductive polarized thinking. For a discussion of the problems of defining "personality" the reader is referred to Kluft (1988b), and to Braun (1986) for a glossary of terms that attempts to resolve this dilemma by quantifying the term "personality."

Consider the following example: a young woman with no previous history suggestive of MPD is undergoing hypnosis, and is asked if another part of the mind exists that could comment upon the problem under exploration from a different perspective. Another part emerges, and indeed does so. When asked how long it has been separate, it promptly launches into a long history of its impact upon the hapless patient, and of its assuming executive control on numerous occasions. This intervention has been observed from behind a one-way mirror by three very different individuals. The first, a seasoned hypnosis researcher, concludes that he has witnessed the iatrogenic creation of an alter by suggestion and the elaboration of a confabulated pseudohistory (for an excellent discussion of the dynamics of such processes, see Gruenewald, 1984). The second, an experienced clinician, familiar with the myriad manners in which cases of MPD become identified, concludes that he has witnessed the serendipitous diagnosis of a hitherto unsuspected and highly disguised case of MPD. The third, who is to deliver a lecture on the iatrogenic creation of new alter personalities at the David Caul Memorial Symposium, utters a deep and painful groan, and tries to persuade observers one and two that, in the words of Sherlock Holmes, "It is a capital offense, Watson, to hypothesize in advance of the facts," (Conan Doyle, no date given).

Given the current state of the art, there are many occasions in which the nature of the proofs demanded by one side or another in these interminable debates can never be fulfilled, and one's experience and clinical judgement remains one's surest compass in a vast and stormy sea of uncertainty. The remainder of this discussion will address the issue of the iatrogenic creation of new alter personalities with attention to the contributions of the clinical process, aspects of the therapy itself, factors primarily within the patient, and factors primarily within the therapist.

THE PROCESS OF PSYCHOTHERAPY AND ITS IMPACT UPON THE APPARENT CREATION OF NEW ALTER PERSONALITIES

It is rather infrequent that a patient is completely understood and comprehended at the time of his or her initial assessment. For a patient to be open in all respects to the inquiries and observations of the interviewer would require the absence of the normative defensive operations of the mental apparatus, the ablation of the functions of the shame and guilt families of affect, and the suspension of normal caution, anxiety, and the maintenance of self-control and self esteem. Such a patient would be in rather tenuous mental balance, if not overtly psychotic and/or masochistic. To cite a more typical scenario, a mental health professional who consulted me in the mid-1970s initially withheld her history of child abuse, and only shared it a few sessions later when she decided that I was trustworthy. However, she did not confide that she was a lesbian until she felt still more relaxed and safe with me. I did not learn the details of her painful experiences until therapy was well under way, and there was little abreactive work for many months. Still later, a mass of deeply repressed material was recovered, and some aspects of her professional and personal life of which she was deeply ashamed were confessed much later still.

It is useful to apply this not uncommon scenario, by analogy, to MPD. If the various affects and experiences alluded to above had been sequestered in alter personalities, it is most unlikely that I would have been exposed to the full roster of alters within the first interview, or even within the first few months of the treatment. Instead they would be most likely to emerge slowly, some entering therapy spontaneously, and some, the existence of whom I had learned from other alters, might have to be invited into the therapy of elicited in some manner. The alters the existence of whom was unknown to the alters with whom I was working would enter treatment only as the work with others drew them into the process, serendipitously unearthed them, or as I either inferred their presence or continued to explore for the possible presence of other layers of alters.

In short, the gradual nature of the uncovering process and the phenomenon of layering (Kluft, 1984a) would dictate that the full number of personalities in most MPD patients will not be known until treatment is quite advanced. It is not unusual for no more than half a dozen alters to have an active and ongoing overt role in an MPD patient's life at any given point of time (Kluft, 1985), despite the fact that the average number of alters in contemporary cases is over 13 (Kluft, 1984a, 1986; Putnam et al., 1986). The very natures both of therapy and of MPD dictate that more and more alters should be expected to emerge, a phenomenon that distresses those who insist that active treatment rather than benign neglect worsens rather than helps such patients, and that the apparent proliferation of alters is an artifact of such interventions. Actually, it would be most unusual if new personalities were not encountered in the course of the treatment of all but the most simple of cases.

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THERAPY'S CONTRIBUTIONS TO THE CREATION OF NEW ALTER PERSONALITIES

It is indeed unfortunate that "iatrogenic" has become a negatively-valenced descriptor, with the connotation that some wrongful action has occurred. The transference neurosis of classic psychoanalysis is iatrogenic, yet its development is considered essential to the treatment, and is encouraged. Many of the events that occur in the course of treatment of MPD may be considered as iatrogenic, in that they emerge from the impact of the clinician's interventions, yet they are not necessarily an indication that something is amiss.

The MPD patient has developed the capacity to respond to intolerable pain by either the sequestering of what is unmanageable into alter personalities and/or the switching of those alters. The MPD patient's life is characterized by repetitive and severe abuse, and/or by other overwhelming incidents in response to which these patterns of adaptation and defense occurred. The treatment of such a patient involves the reviewing, reliving, abreacting, and working through of these incidents, these traumata, and the way in which the patient responded to them. The treatment of MPD can be exquisitely painful and arduous for the patient (Kluft, 1984b), who may reexperience painful events with the same degree of intensity with which they were suffered initially. To the extent that therapy is intense and involving, it is, inevitably, a trauma, and may be responded to with the same armamentarium of defenses that the patient has already acquired to manage traumata. It stands to reason that the MPD patient may employ once again the mechanisms by which these events were once put at a same distance; i.e., he or she may form new alters to encapsulate or repress them. In fact, the formation of transient entities under such circumstances is quite common. The sudden derepression of unsettling material may well lead to the formation of another alter that will hold the knowledge or, conversely, is amnestic for it and untouched by it.

The patient's need to run from the pain of the therapy and the past may generate a flight into health, which may take the form of the creation of either an ostensibly healthy personality, or one to hold the overwhelming knowledge and/or affect associated with what has been learned in therapy. An extreme form of this new alter that is a clone of the host, but that has repressed all traumata, and steadfastly denies that he or she has or ever had MPD.

The impact of medication, other treatment modalities, or hospitalization may generate new alters. It is quite common to find that an MPD patient experiences certain medications as disorganizing, and creates new alters to cope with the perceived sense of dyscontrol. Likewise, few clinicians with extensive experience with MPD have not had a highly symptomatic MPD patient enter the hospital, experience its milieu and regulations as a retraumatization, and shortly thereafter request discharge, representing himself or herself as in good control or, in fact, as well. The most clever variation of this that I have encountered was undertaken many years apart by two separate patients. Each created a psychiatrist alter that called me over the weekend and represented itself as a consultant called in by the family, who had examined the patient and concluded: 1) that the patient did not have MPD, 2) that the patient would be worsened by prolonging the hospital stay, and 3) should be discharged forthwith. When I reexamined the patient, indeed I found an alter who professed to be well, and to be amused by my efforts to convince her that she had MPD. I was told that we could discuss the matter further in court. Since in each case I had ascertained that the patient was using a telephone on the unit at the time the "psychiatrist" called me, these situations were not difficult to resolve. However, the host personality was amnestic for the entire sequence of events for some time.

The intensification of the transference may reactivate the pressures to divide object representations in the same manner as the patient had segregated positive and negative representations of the important figures of his or her early life. In fact, this reenactment within the transference often is a most informative source of information about how the patient managed the vicissitudes of the years of childhood. Sometimes the clinician has the opportunity to watch such an alter attain increasing organization and structure over a few days, and observe the reshufflings and reconfigurations that occur as the patient tries to cope with juggling several representations of the therapist in several alters. The psychoanalytically-oriented therapist will treasure this chance to watch the epigenesis of transference phenomena in what appears to be not unlike what one observes in time-lapse photography, in which the budding and unfolding of a flower is condensed into a few moments.

For example, one patient and I began our work together in the glow of a positive mutual regard, a good therapeutic alliance, and a globally positive transference. As the events of her childhood were uncovered, the object relationships of that time and place were projected upon me and attempts were made to reenact them. She began to perceive me as evil and rapacious, with fiendish sexual designs upon her. She also began to fear that unless she pleased me, I would beat her mercilessly. She could not tolerate what she experienced as the loss of me as a safe object, and of the therapy as a safe haven from a dangerous external world. Not too long thereafter, she arrived at the office with the initial positive transference reestablished, but frequently switching to alters that were hostile to me, seductive to me, and cringing in fear of me. Exploration revealed that these alters, although analogous to preexisting ones, had been created anew within the therapy. They proved transient.

Closely related to this is the not uncommon finding of an alter based on the therapist, often used as a buffer against object loss, to console the patient in between sessions or over a vacation, or less commonly, for other purposes. The incidence of such phenomena appears to differ widely among therapists, so that there may be an interaction between the patient's needs and the therapist's style. Only 2 percent of my own patients have formed such alters, yet I am aware of many therapists who encounter them more frequently, and of a few who actively encourage such phenomena.

The uncovering of long dormant or latent problem areas and alters and/or less structured dissociative phenom-

ena related to them is inherent in working through the issues of an MPD patient. Originally less structured entities may have to assume greater structure on a transient basis in order to express themselves. After I first became familiar with this type of event, I learned to encourage less structured entities to express themselves by collaboration with a willing personality rather than by building themselves up in order to talk. This strategy has been almost uniformly successful in discouraging this form of elaboration.

The language of MPD may become the convention of communication within the therapy, and the patient may become socialized to express his or her concerns within that framework. It is not uncommon for patients to develop transient ad hoc alters simply to communicate with the therapist about a problem, experience, or concern.

The therapy may be inappropriately assigned the responsibility for the patient's formation of new alters in response to contemporary events that occur while the patient is in therapy. For example, a woman learned that another of her therapist's MPD patients had committed suicide. She formed several alters to deal with this event.

Finally, it is improtant to note that as trying as treatment for MPD may become, for many MPD patients their relationship to their therapist is the most powerful and/or gratifying event of their lives, and they may produce more alters in the hopes of prolonging it. This is best avoided by making efforts not to dramatize the importance of integration, and telling the patient that the therapy will continue beyond their unification. This uncouples the connection of having personalities to having access to the therapist.

FACTORS WITHIN THE MPD PATIENT CONDUCIVE TO THE FORMATION OF NEW ALTER PERSONALITIES

The factors alluded to above are inherent in the interaction of the general psychopathology of MPD with the essential ingredients of any conscientious therapy. This does not discount the fact that many patients' contributions to the dynamics above are so strong that one might quite appropriately regard them as intrinsic to that particular patient rather than to the treatment process per se.

In this section I will not review the patient's contribution to the factors noted above. Instead, I will emphasize particular patient factors themselves. It is my observation that the main patient variable here is the quality of the therapeutic alliance that the patient can form. As the patient adopts and values the culture and values of the therapy, he or she is increasingly motivated against worsening the psychopathology.

Some patients are so eager to please their therapists that they will create alters to do so with little provocation. In this respect they are like the Schmoon in the late Al Capp's "Little Abner" cartoons, a type of creature than instantly transforms itself into what it believes those in its environment wish it to be. Most MPD patients were severely exploited, and learned to assess situations and produce what they perceive to be the desired behavior with an alarming rapidity that was quite adaptive during their childhoods.

A related phenomenon is encountered in those MPD patients, often alleging a history of ritual abuse, who have had the experience of having had their dissociative structures deliberately shaped and influenced by their abusers. They enter treatment with the performed expectation in the transference that they must be infinitely malleable to the demands of those in power, in this case, to the therapist. A commonly encountered but rarely identified manifestation of this is the patient who decides to follow the therapist's model and become a therapist, and forms an alter to display this motivation. That this type of identification is often encountered but rarely interpreted may be due to therapists' professional narcissism. Few are likely to see as psychopathological the drive to emulate someone as worthy as themselves, yet the percentage of MPD patients with alters professing the urge to become therapists appears inordinately high. It is essential to consider the possibility that the alter who emerges and voices such plans may be an iatrogenic artifact.

Certain other patient characteristics auger for the formation of additional alters in the course of therapy. These include poor ego strength as manifested in little anxiety tolerance within the major alters and the relative paucity of non-dissociative alternative defensive structures and adaptive resources. A patient who is readily overwhelmed by strong affects and has a limited defensive repertoire is more likely to shed additional alters under pressure than one who has a fairly robust host with well-developed obsessional mechanisms and a spectrum of anxiety-reducing coping behaviors, and who is less likely to call upon and exhaust the roster of available alters when in a jam. Some patients simply do not know how to do anything else but become more multiple; the early and middle phases of their treatments may be characterized by the proliferation of alters and the rapid loss of any apparent fusions.

Also, problematic superego functioning that is either infiltrated by identifications with unreliable and/or sociopathic individuals or compromised by idiosyncratic cognitions or trance logic can prove difficult. The patient with a strong, reality-oriented, but non-punitive superego is more likely to hold to a culture of therapy in which it is understood that no more alters are to be formed than is one to whom historical reality has remained fluid and malleable, and by whom agreements and promises are not understood to have a binding force.

To illustrate, let us consider the courses of three patients in treatment, all of whom have committed themselves against the formation of additional alters. They each arrive for a session after having had a difficult experience the previous day. The first is found to have generated a new alter. When confronted, she maintains, "I just couldn't take it. I felt so bad, and I didn't know what to do. If I hadn't done that I would have hurt myself. Would you have wanted me to do that?" The message, of course, is that the patient has made the best of a bad lot, and the therapist should not be angry or disappointed — in fact he will be perceived as sadistic if he is. Left unstated is the fact that there are many ways to reduce stress that do not inflict self-injury or worsen one's psychopathology.

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The second has also created another alter, and responds to confrontation with an ingenious rationalization that indicates that rather than having violated a commitment, the patient has in fact followed the instructions to the letter. The therapist's head spins as he or she tried to comprehend how black has become white with such astounding facility, and is represented as such with staunch conviction. In teaching seminars I have used the whimsical acronyms M.A.D. and M.U.D.D.L.E. to describe this fluid approach to circumstances, the former standing for Mental Alchemy Disorder and the latter denoting Multiples Unwilling to Deal Directly with Life Events. The message is that reality can be redefined as the circumstances dictate, in order to disavow potentially troublesome confrontations. Unstated and unrecognized goes the fact that such cognitive debasements guarantee future difficulty and sabotage adaptive ego functioning.

The third patient protests having to stay and "face the music" of a troublesome event, and berates the therapist for holding her to such demanding standards. She reports, "I thought of letting it all go, and I sure was tempted, but I decided that if I do, what the hell am I coming here for, and, besides, I promised. Maybe it was stupid of me to promise, but I did. So, as soon as I got away from that jerk, I realized that in the past I wouldn't have even been able to get away, and it would have been a lot worse. So I went and got my dog and headed off for a long walk. On the walk we all discussed how we got into that jam in the first place and figured out how to avoid it in the future. Sometimes I think that getting well isn't worth it — I mean, if I just let go, it would have been easier. Well, for a while it would have been easier." Clearly the first and second patients exemplify the compromises of function noted above, while the third patient is in a far more productive posture toward resolving her MPD pathology.

As a less frequent but far from rare factor in the formation of new alters is the patient's sense of loneliness and/or fear of autonomy. In those who have treasured the relationships among the alters, the grief for alters that integrate may well be assuaged by the formation of further alters.

THERAPIST FACTORS ENCOURAGING THE CREATION OF NEW ALTER PERSONALITIES

Certain factors within the therapist or certain therapist behaviors may promote the formation of new alters. Although most skeptics assume the most problematic therapist behavior is fascination and consequent reinforcement of MPD behaviors, my experiences as a consultant (1988c, 1988d) suggest that while this does occur (v.i.) the problem that stems most frequently from this error is sibling rivalry among the alters for the therapist's attention, with the consequent suppression of most of the alters by a few powerful ones eager for the therapist's regard and concern.

The most common factors in situations under my observation have related to inexperience, ineptitude, poor pacing, and a failure to behave in a consistent and evenhanded manner to all of the alters. Many therapists find themselves confronted with an MPD patient and either by circumstances or by choice do not begin to avail themselves of the literature of the field or training opportunities. Others have had little training in the practice of long term intensive psychotherapy, and lack familiarity with the vicissitudes of transference and countertransference. There is a high probability that such individuals, without realizing what is occurring and while trying their best, may impose demands upon the patient that prove overwhelming or counterproductive. One psychiatrist who had no formal training in hypnosis hypnotized an MPD patient with three known alters. After seven such sessions, the details of which defy description, the patient had 21 alters, 18 of which were the direct result of the patient's attempt to cope with the misadventures of the treatment. They were reduced back to three with a single circumspect hypnotic intervention, and never recurred.

Sophisticated and well-schooled therapists may nonetheless be relatively unacquainted with the management of abreactions. They may fail to complete abreactions, neglect to build in a sense of mastery for the patient, or overlook the importance of structuring the session to allow the patient to leave the session with some sense of control. The patient who receives the message thereby that the therapy will not speak to his or her fear of dyscontrol is being taught, implicitly, that he or she is being left to her or her own devices when the going gets rough, and his or her devices include, preeminently, the encapsulation of dysphoria in new alters.

A common experience of the sophisticated therapist is to have difficulties with regard to issues of dosage in treating MPD. The patient often experiences therapy as a guided tour of his or her personal hell without anesthesia. When a therapist fails to pace the treatment to the tolerance of the patient, the patient may become overwhelmed over and over. A certain percentage of these genuinely retraumatized patients will have recourse once again to the formation of new alters. It is unfortunate that an emphasis on the dramatic abreactive aspects of therapy often leads to a relative neglect of the more difficult art of slowly building the ego strengths of the patient and encouraging skills of mastery.

It is difficult to avoid responding differently to different alters. Some therapists have great difficulty avoiding this pitfall, and some achieve this skill with most MPD patients, but find there are some who can often "reach" them and disarm their best efforts. Nonetheless, the general rule of complete evenhandedness toward and equal treatment of all alters is violated at peril, and should be approximated to as great a degree as possible, though not at the cost of unresponsive or wooden behavior. Failing this, the therapy builds in a differential reinforcement system that foments sibling rivalry among the alters, impedes integration, undercuts the therapeutic alliance, and covertly encourages the patient to generate a new version of a type of alter the therapist favors at difficult times in the therapy, especially when limit-setting or confrontation is in order. Such favoritism reenacts a family configuration in which behavior pleasing to the authority figure rather than behavior that is an intrinsic expression of the patient's state of mind and/or developmental needs receives preferential treatment. One of the most common expressions of these problems occurs when a therapist spends an inordinate amount of time with child alters and defers dealing with the more hostile alters.

This suggests the presence of a rather gratifying interaction between therapist and patient that both are loath to forego, begetting pressures to maintain the child alters, to rapidly resurrect integrated child alters, and/or to the proliferation of child alters.

Another type of problem may occur when a therapist regularly employs techniques that are established methods of mobilizing ego states, and then either intentionally or by being rather naive about the demand characteristics inherent in their interventions, decide that every entity that they encounter is a personality. Such behaviors are anathema to the founders of ego state therapy, John and Helen Watkins (personal communications, numerous, 1984-1989). Iatrogenically mobilized ego states may be accessed repeatedly over time (Watkins & Watkins, 1979-1980), but there is no evidence that such an entity has assumed executive control of the body outside of the realm of the therapist's interventions.

This mislabeling process is a frequent cause of the apparent creation of iatrogenic alters (Kluft, 1982), and raises serious difficulties. Indeed, entities that have never assumed executive control may indeed be legitimate alters that exert their impact from behind the scenes, via passive influence (Kluft, 1985, 1987). Often it is impossible to be sure beyond a reasonable doubt as to whether a relatively covert entity should be called an alter. In practice, this is rarely a major problem, although it may complicate, prolong, and diffuse the process of therapy. Example: a woman was referred as an extremely complex multiple. Her therapist had cataloged meticulously a mind-boggling array of alters, elicited and labelled in the manner described above. I found that few of these entities had any genuine history of their own, but could offer a plausible account given a few clues. They were not invested in separateness. A series of hypnotic interventions decimated the hordes, and, in short order, an MPD patient with eleven alters stood revealed, and did well in therapy.

The imposition of a therapist's theoretical beliefs or idiosyncratic ideas can shape the form of an MPD patient's pathology quite readily if the pressures exerted are basically ego-syntonic. Two of the most readily available demonstrations of this are the MPD field's versions of the familiar dictum: "Freudian analyst's patients have Freudian dreams, and Jungian analysts' patients have Jungian dreams." These are the prevalence of inner self helper personalities (ISHs), first described by Allison (1974), and the prevalence of so-called demonic alters.

It is a curious phenomenon that some therapists find ISHs universally, others assume their ubiquity (but concede that they may be inaccessible in certain patients), and still others find them in a minority of their patients. There are also significant geographical factors in the therapists' beliefs and reportage of ISHs. In some areas the ISH phenomenon is widely accepted and reported, and in others it is not. These observations imply that either: 1) practitioners vary widely in their awareness of and sophistication in identifying the ISH phenomenon, or 2) the ISH phenomenon (apart from a certain degree of naturalistic occurrence, which is not disputed) may be an epiphenomenon of the belief systems and

or the conduct of some therapists. Because having a wise and serene aspect of one's self is ego-syntonic and may encourage an otherwise demoralized patient to have hope and self-respect, it may be argued that even if its occurrence is iatrogenic, it is harmless. The main danger that resides in the ISH phenomenon is in the belief of the occasional therapist that the ISH represents a higher source of wisdom that should be allowed to govern the therapy, with the consequent abdication of professional responsibility.

Closely related is the prevalence of demonic alters. They seem to be more common in those therapists with religious belief systems that accord a powerful role to the intercession of evil forces in human events. While there is a certain ego-syntonic element in being able to attribute one's difficulties to the efforts of evil forces rather than to one's own self or to abusers (toward whom the patient continues to have some positive feelings or wishes for love and affection), there is also the risk that the patient who believes this may feel more hopeless and determined to destroy himself or herself. The patients whom I have seen who were told by previous therapists that certain of their alters were demonic did not seem to have profited from the experience. Some had created alters to accommodate these beliefs, some had accepted their designation as demons and behaved accordingly, and some had created other alters to deal with the impact of these belief systems.

The problem of therapists' general fascination with the phenomena of MPD is seen less and less, but there remain a small number of individuals who seem unable to move beyond the neophyte's understandable curiosity to a more pervasive concern for the patient in whom they occur. Clearly, if the attention of the therapist is deemed desirable, the therapist whose attention remains fixed upon the MPD per se is conveying a powerful suggestion to the patient to emit such phenomena — implicitly, the more the better. This stance on the part of the therapist conveys a profound disrespect for the personhood of the patient.

The story of Pygmalion, the gifted sculptor and king of Cyprus who fell in love with the statue he had made, Galatea, to whom Aphrodite granted life, is not without its parallels in psychotherapy. Analogs are encountered among those who work with MPD. Occasional therapists are fond who seem inclined to craft rather than to cure the patient, attempting blendings in the spirit of the alchemist rather than that of the healer. Under the pressure of being treated as a narcissistic object as a precondition for the therapist's attention and affection, a good number of MPD patients will create an alter that responds to the ideal self-object of the therapist.

Closely related are those occasional efforts that have been made to create a new alter deliberately. This excludes the creation of new entities by the unification of previously separate entities, which is an inevitable aspect of integration. It is understandable that such attempts would be part of the pioneering explorations to determine what kinds of interventions are effective, but, to date, there has been no demonstration of the efficacy of such strategies. At this point in time, in the absence of any proven indication for this technique, its practice may reflect the therapist's difficulties

with fantasies of omnipotence.

It is important to realize that in MPD as in other conditions, there may be a brief recrudescence of the symptoms of MPD in the termination phase, including the creation of some alters. If their emergence is understood in the context of the dynamics of termination, they fade rapidly. However, if they are not recognized as such, a confusing "wild goose chase" may ensue.

A small number of therapists have gone beyond Wilbur's (1984) wise observation that the person who treats MPD must be prepared to tolerate the patient's dependency in the course of helping the patient to achieve autonomy. Instead they have encouraged a regressive dependency and provided gratifications that infantilize the patient and exert strong pressures to maintain the alters that enjoy such a situation and to develop more alters in order to maintain the concomitant benefits.

Finally, there are instances in which the creation of new alter personalities constitutes a defense against unethical behaviors on the part of a therapist. I have seen all too many MPD patients who have resurrected the capacity to form alters in a desperate attempt to preserve their relationship with a cherished individual who has behaved unethically and become their exploiter.

CONCLUSION

This necessarily selective and incomplete overview of a most complex area should not be regarded as more than a preliminary survey. It has attempted to enumerate the factors inherent in the process of therapy, certain aspects of therapy, the patient, and the therapist that may contribute to the apparent or actual iatrogenic increase in the number of alter personalities during the course of the psychotherapy of MPD.

It would appear that the weight of available evidence, although far from conclusive, suggests quite strongly that the iatrogenesis of MPD *de novo* has yet to be demonstrated. Most of what would appear to be examples of the iatrogenic creation of new alters reflects the uncovering process of psychotherapy as it reaches already extant alters that were not immediately accessible for a variety of reasons, or the ongoing use by the patient of his or her characteristic ways of coping within the context of therapy. Nonetheless, once these causes for the apparent emergence of new alters in the course of therapy are taken into account, there remain a considerable number of ways in which the suboptimal management of the treatment process can contribute to the increasing complexity of the MPD patient. This latter classification constitutes those instances of iatrogenesis in the sense of the more negative connotation of the term. Hopefully the drawing of this type of distinction will diminish the global accusations of iatrogenesis that have been characteristic of the more polarized discussions of the treatment of MPD, and allow a clearer focus on the development of techniques to diminish the incidence of the expectable varieties of the emergence or creation of new alters in the course of treatment, and to educate therapists against committing the types of errors that appear to be associated

with the encouragement of the formation of additional personalities. ■

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