IATROGENIC FACTORS IN THE PERPETUATION OF SPLITTING AND MULTIPLICITY

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ABSTRACT

The purpose of this paper is to increase the awareness of clinicians who treat multiple personality disorder patients to the possibility that misuse of treatment techniques may perpetuate splitting and multiplicity, and thus contribute to chronicity in MPD patients. Many MPD patients tend to have rapidly dissociative switching from one ego-state to another. These trance-like states make the patients highly suggestible to outside influences which include the therapists' verbal and non-verbal communication. Some therapists may have an over-investment in or or more alter personalities, and thus ignore the needs of the whole person. Treating an adult patient who is in an age regressed ego-state, or alter personality, presents a particular challenge as to the patient's boundaries since violating those boundaries may too perpetuate splitting and multiplicity. The paper reviews and discusses such issues as therapeutic limit setting, the issue of trust, and counter-transference elements as they may contribute to the perpetuation of splitting and multiplicity in MPD patients. Case vignettes are used to illustrate the above points, and suggest ways to avoid potential pitfalls so that therapy will promote progress towards integration and improved functioning of the whole person.

"The ability to be self-critical is the life blood of practice and investigation . . . the term Iatrogenic becomes a mark of good conscience rather than one of disapprobation." —A. Soffer (1970)

INTRODUCTION

Primum Non Nocere, — First of all be sure you do no harm. This old Hipocratic dictum has guided physicians through centuries, and has been fundamental to the sound practice of the healing arts. The failure to regard this principle has inspired many reforms in the field of physical and mental health. In our times of modernized medical care, when new diagnostic and therapeutic procedures are being introduced at an increasing rate, this admonition applies more than ever before. The term "Iatrogenic" originates from the Greek word "Iatros" meaning physician, and "Genesis" meaning origin. In other words, Iatrogenic stands for a condition that originates with the physician and his interventions.

In this paper, I use the term Iatrogenic more broadly, meaning a condition that develops in the patient, and originates from the therapist through his/her actions, behaviors, and statements, in the relationship with the patient. Most of the literature on iatrogenic conditions deals with the possible harmful effects of diagnostic and therapeutic procedures (Audy, 1970; Illich, 1976). Relatively little has been written on the negative side effects of a poor therapist-patient relationship (Twemlow & Gabbard, 1981; Torem & Torem, 1983; Torem & Allen, 1987), or about the unhelpful, biased attitudes on the part of physicians and therapists towards patients and their conditions (Cavenan & Cavenan, 1980; Margetts, 1987; Robertiello & Schoenewolf, 1987). Naturally, such biased and unhelpful attitudes may lead to mis-diagnosis and from there to the wrong treatment. Once the diagnosis of MPD is made, it is likely that certain attitudes, behaviors, and interventions made by the therapist may perpetuate the illness, postpone integration, and, at times, promote further splitting, further dissociation, greater anxiety, panic, depression, and thus increase patient's morbidity and reduce their ability to master the tasks of adaptive functioning in the activities of daily living (Greaves, 1988; Chu, 1986).

As therapists, we must be ready to examine the outcome of our own interventions. Whatever interventions we use in our psychotherapeutic efforts, it is not enough that they make sense; that they fit a certain theoretical model. Such interventions can only stand the test of time if they truly affect the outcome in a positive way leading to healing, integration and an improvement in the patient's mental state translated into more adaptive daily functioning. If a certain therapeutic technique has the power to heal, it certainly may also have the power to harm if misused by an untrained and inexperienced therapist.

The issue of negative effects of psychotherapy has been well known. Hans H. Strupp and his colleagues (1977) focused on this issue in their book Psychotherapy for Better or Worse. In their introduction they wrote:

Today we witness a coalescence of seemingly desperate

forces within the field of psychotherapy. There is a heightened awareness of the possibility of negative effects, while in the public domain the proliferation of malpractice suits, aimed thus far primarily at medical practitioners, but is showing signs of extending to psychotherapists, is symptomatic of a serious problem. From both perspectives, there is considerable urgency for a systematic analysis of the problem. Negative effects cannot be ignored, nor can they remain shrouded in secrecy. For the good of the profession, as well as that of the public, psychotherapists, as well as researchers, must face the issues squarely. The study of negative effects is both significant and timely.

H. Strupp and his colleagues then ask: "What constitutes a negative effect in psychotherapy?" Their answer is divided into the following categories:

1. **An exacerbation of the presenting symptoms:**
   If the patient presented with depression, severe anxiety, sudden mood swings, panic attacks, headaches, insomnia, amnesia, etc., and during therapy there is a worsening of these presenting symptoms in terms of their intensity or frequency, that fits under this category.
2. **Appearance of new symptoms:**
   These may include a number of new symptoms such as an erosion of solid interpersonal relationships, and a decreased ability to experience pleasure, or severe psychosomatic symptoms, withdrawal, regression and rage, acting out, drug and alcohol abuse, etc.
3. **Misused or abused therapy:**
   This is different from the exacerbation of presenting symptoms, or the development of new ones. It may take a number of forms. H. Strupp described it as "the substitution of intellectualized insights for other obsessional thoughts in patients, as in a patient who appears to benefit from therapy in the sense of achieving and internalizing therapeutic insights, but who may be merely substituting these insights for early obsessional thoughts." Others have described it as utilization of a psychotherapeutic experience to rationalize feelings of smugness, superiority over others or utilizing "insights" to aggressively comment on other people's behavior. For the patient with MPD, learning the jargon of dissociation may be misused as forms of secondary gains and rationalizations for not taking responsibility for one's own behavior. Many authors writing about psychotherapy in general, have pointed out that for some patients, therapy may become an end in itself. MPD patients may (as a result of poor therapy) spend more time in dissociated altered states of consciousness, writing in their journals, or dissociated internal dialogues, painting their pictures, and neglecting to assume responsibility for the important tasks in adaptive daily living.
4. **Undertaking unrealistic tasks or goals:**
   As a result of some aspect of psychotherapeutic interventions, the patients feel constrained to undertake or pursue goals for which they are really ill-equipped and which place great strain on their psychological resources. Such situations, according to Ann Appelbaum, (1977) may arise from the patient's intense need to please the therapist, which may be related to obsessive dependency on the therapist. Some therapists feel that patients with MPD are blessed with great creative powers and should write books about their experiences, or will turn into artists in the form of painters, poets, and the like. Not only are such goals unrealistic for the majority of MPD patients, but even the patient who achieves such goals may still be dysfunctional in other major arenas of life.
5. **Loss of trust in therapy and the therapist:**
   As a result of the previously mentioned situations, the patient may lose trust in the therapy, or in the therapist. This may create a hardening towards future help in general. Moreover, a loss of confidence in the therapist may be generalized to a disillusionment to any form of human relationship. The therapist must be very careful not to raise the patient's initial hope to the point of creating an illusion of that which cannot be accomplished.

SOURCES OF MISDIAGNOSIS

Certainly, it is well known today that the under-diagnosis of MPD is much more common than the over-diagnosis of this condition (Braun, 1983; Coons, 1984; Kluft, 1987; Wilbur, 1984).

(A) UNDER-DIAGNOSIS

The following are some common reasons for the under-diagnosis of MPD:

1. **Ignorance:**
   The lack of awareness, and the lack of knowledge of what MPD is all about; what the presenting symptoms are, what the differential diagnosis is, and how to make it, are probably the most common reasons for the fact that clinicians misdiagnose patients with MPD (Rosenbaum, 1981; Kluft, 1987).
2. **The lingering myth that MPD is a rare condition:**
   This is still written in most textbooks of psychiatry and psychology, and is probably a major reason why clinicians, even when confronted with this condition, think they must have made a mistake. Since MPD is such a rare diagnosis, the patient must have some other, more common illness (Thigpen & Cleckley, 1984).
3. **MPD symptoms overlap the symptoms of most other psychiatric disorders:**
   Today, we know that MPD may present itself clinically with such great variability that it may masquerade as almost any other psychiatric condition. In order to diagnose MPD the clinician must be very experienced, astute, and familiar with the specific psychodynamics, psychopathology and life history of MPD (Kluft, 1987; Coons, 1984; Spiegel, 1984).
4. **Denial-countertransference:**
   The material any clinician hears from patients with MPD is filled with so many horror stories of abuse that the clinician finds it hard to believe that this could have possibly happened. It is sometimes easier for clinicians to believe that the patients have made up these stories, or that they are merely the fantasies of a sick mind. It is

easier to declare the patient psychotic than to believe that such horror stories of abuse and incest could have possibly happened (Watkins & Watkins, 1984; Altschuler, 1989).

5. **Clinicians tend to diagnose conditions they know how to treat:**

Patients with MPD will make the inexperienced and untrained clinician feel helpless and incompetent. It is not enough to make the diagnosis of MPD. It is also very important that any clinician who makes a certain diagnosis also be aware of his/her own feelings for the need to feel competent and helpful. If a therapist uses mostly biological modes of treatment, he must be aware of his own tendency to make more diagnoses of conditions that are treated by the use of biological modalities, such as medications. If one does not know how to treat a patient with MPD, but knows well how to treat a patient with schizophrenia or manic depressive illness, it is clear how biased one may become toward making one diagnosis or another (Buckley, 1970; Illich, 1987).

(B) OVER-DIAGNOSIS

Although this is rather rare compared to the under-diagnosis of MPD, there have been some cases described where this may happen (Torem & Toth, 1985; Braun, Kluft & Torem, 1988). Here the sources of misdiagnosis may be the following:

1. **Clinician's bias in favor of MPD:**

Certain patients with borderline personality disorder maypresent with extreme ego fragmentation and dissociative features. These patients are very different than those with a true multiple personality disorder (Kemp, Gilbertson & Torem, 1988). A similar phenomenon may happen to a patient with schizophrenia that may present with ego-fragmentation. When this patient is seen by a therapist who believes that patients with MPD have a better chance to heal, recover, and get well than do patients with schizophrenia, and if such a clinician is newly familiar with multiple personality disorder, he/she may become overly optimistic, and want to assign this diagnostic label to many patients, even when the data may point otherwise. Another sitation that we must be aware of is that clinicians who do not use biological treatments have greater faith in the power of psychotherapy and therefore will be un comfortable in making diagnoses of conditions that must be treated with medication. These reasons of wanting to feel helpful and competent may contribute to the over-diagnosis, as well as to the under-diagnosis of MPD (Torem & Toth, 1985).

2. **Over-diagnosis due to a fad:**

We must be aware that many patients are quite educated, and may find out that there are certain diagnostic entities that interest certain clinicians, and that it is more fashionable to have MPD than to have schizophrenia or borderline personality disorder. Some patients may come in and declare themselves as having MPD so that they can get more attention, more time and energy from an expert MPD therapist than if they just merely had schizophrenia or a border line personality disorder. This condition tends to occur more on in-patient units where patients with MPD are treated in a milieu including psychiatric patients with other diagnostic entities (Spanos, 1985; Fahey, 1988; Margetts, 1987; Torem & Toth, 1985).

IATROGENESIS IN TREATMENT

The basic goal of treating patients with MPD is an improvement in their level of function regarding adaptive daily living, and full integration of the personalities. However, in their zealousness to help patients work through their abreactions, flashbacks, and traumatic memories, some clinicians get so involved in the details that they may forget the whole picture. In this global goal it is the improvement in the patient's daily functioning, and movement towards integration that must be a priority. The following are some specific issues that must be addressed:

1. **Therapists' over-investment in one or more alters:**

Therapists, because of their own needs, may be come overly-invested in child alters, and spend a great deal of time in play therapy, forgetting that they are dealing with an adult individual who needs to leave the therapy session and be responsible to take care of his/her own needs as an adult. Such over-investment may also take place with alters that are pleasant and nice to the therapist, while the therapist avoids the hostile alters that carry with them a great deal of anger, sadness, and painful memories.

Case Illustration: This patient, Lynn is a 33-year-old woman who has been in therapy due to MPD for over three years. She is seen two to three times a week. The patient had a number of personalities referred to by the therapist as "the little ones." In a typical session, the patient regresses into a younger state, calling herself "Katie," stating she is 5 years of age. She refers to the therapist as "good mommy," and sits down on the floor to play with her teddy bears and crayons. The therapist responds by sitting on the floor and spending the session talking to this patient at her age-regressed level. This goes on for weeks while, at the same time, the patient acts out by alcohol abuse and sexually promiscuous behavior in an altered ego-state in which she calls herself "William," declaring she is gay, and hates women. The therapist has avoided addressing these behaviors with the reasoning that "the little ones" have been neglected for many years, and they are weak — therefore their needs must be addressed first. The therapist went on stating that she would be manipulated by "William," who is a bully.

2. **Suggestibility:**

Patients with MPD suffer from a condition which is underlined by dissociation, and a high degree of hypnotizability and suggestibility. Therefore, any clinician must be very careful in the use of hypnosis and hypnotic suggestions with these patients. Some alters, due to their need to please the therapist, may create by dissociation

new ego-states as a response to the therapist'squestioning and to imbedded suggestion in his questions about the existence of more personalities (Braun, 1984).

Case Illustration: The patient, Sharon, is a 38-year-old, married, mother of two children. She has been in therapy for over 18 months in twice per week sessions. The therapist has identified 12 personalities. In one session, the patient's facial expression conveys sadness and tearfulness. The therapist, observing this behavior, responds by saying, "Who are you?" "You look so sad. . . . What is your name? . . . I don't think I've talked to you before." These questions have imbedded suggestions to the patient. The therapist may, in fact, be suggesting to the patient that she is supposed to be someone else with a different name. The patient responds by saying that her name is "Sadie," and she is only six years old, and carries all of the sadness. The therapist must be aware of the suggestibility inherent in spontaneous trance states, and devise questions to be neutral, non-leading, and avoid imbedded suggestions of multiplicity. Such investigating questions may be phrased as, "How old are you feeling right now?" or "How would you like me to call you right now?" These questions suggest to the patient the recognition of being one person, although, at times, when in an altered ego-state, he may feel as if he were a different person.

3. Boundaries:

In some ways MPD can be viewed as an illness created in a chaotic childhood where boundaries were blurred and violated. These patients frequently have unrealistic expectations of relationships with other people. Often, what they experienced in childhood tends to be replicated in the relationship the patient develops with the therapist. This issue was pointed out by Dr. James Chu (1986) who said,

> *Although each therapist must choose where the boundaries are to be according to his or her style and comfort, boundaries are essential to helping the multiple maintain control and perspective. The self-perceived neediness on the part of the multiple is endless, and the wise therapist recognizes that it is stabilizing in the long run to be clear as to what is realistically possible or not. Furthermore, therapists need to feel comfortable with boundaries that protect their own privacy.*

One has to wonder as to the wisdom of therapists touching patients without asking asking for permission, and even if such permission is given, what effect will it have on hidden alter personalities. Tarachow (1962) wrote, "The task of setting aside the other as a real object I regard as the central problem in the theory of the treatment process," (p. 377). He spoke of the therapeutic barrier, and the importance of observing it in order to make real progress in the patient's treatment.

Case Illustration: The patient, Nancy, is a 26-year-old single, college student. She has been in therapy for MPD for over two years. One day, the patient came upon the therapist in a shopping mall, and they entered into a conversation. The therapist introduced the patient to her husband, and went on to show her the new clothes she bought on sale for her children. During the following session, the patient regressed into a child-like ego-state and cried, asking to be held while she was alone in the dark closet, afraid of the monsters. The therapist responded empathically, holding the patient, who suddenly switched into an altered ego-state, accusing the therapist of being cheap and uncaring about little kids. She continued to lash out in anger at the therapist. The therapist reported later on how devastated she felt, and responded by withdrawing from the patient, who was described as "ungrateful," since the therapist had always been so good to her.

4. Limit Setting:

Experienced clinicians know that part of the effective treatment of patients with MPD is the containment of dysfunctional behaviors. Endless gratification of patients with MPD becomes not only a problem for the therapist, who eventually develops a sense of anger and hostility, but also because it clearly does not produce a positive outcome for patients with MPD. This is not only damaging to the therapist's own private life, but also promises to patients with MPD that any of their excessive needs can be met, and they should notbe concerned with facing the limitations of reality. Therapists who start neglecting their personal lives in promising patients to meet needs that cannot be fulfilled must seriously examine such behavior, and determine to what extent they provide a masochistic role model for patients to identify with.

Case Illustration: The patient, Lillian, is a 28-year-old college student who has had a long history of many psychiatric hospitalizations in which she was misdiagnosed as having schizophrenia, and was treated with antipsychotic medications. The therapist, who correctly made the diagnosis of MPD, is highly invested in the treatment of this patient, and has vowed to protect her from further hospitalization. In one session, the therapist learns of an incident in which the patient's friend took the patient to a nearby hospital emergency room following the patient's attempt to cut her wrists. The therapist responds, "You should have called me. . . . I will always be there for you. . . . you can call me anytime, day or night." This was followed by numerous incidents of acting out by the patient. The therapist was called at home, at times, after working long hours. The therapist became resentful, and accused the patient of testing her sincerity. She became more depressed, and made a serious suicidal attempt, followed by an admission to the intensive care unit of a general hospital.

5. Trust:

Patients with MPD have a very difficult time establishing trust in anyone, including the most competent clinician. Since patients with MPD have backgrounds of severe abuse, neglect, and abandonment, including betrayal from their own parents, these patients have never experienced in their childhood the meaning of a stable, trustful relationship. A workable level of trust

between the therapist and patients with MPD usually takes many months to develop, and is constantly tested as to the limit of such a trusting relationship. It must be remembered that patients with MPD fully expect people who are nice to them to follow it up by betrayal of the trust. In fact, they may even provoke the therapist to act out with anger and then look for evidence of a failing of the trust.

Case Illustration: The patient, Linda, is a 31-year-old, married, mother of three. She has been in psychotherapy for over a year, during which she had two hospitalizations. In one session, the therapist announced to the patient that she was going on vacation for three weeks. The patient responded by dissociating into a child-like state, and started crying, talking in the voice of a young child, saying she was afraid the therapist would not return, and that she would be abandoned. The therapist responded by moving closer to the patient, holding her arms in a motherly hug, and saying, "I am a good mommy. I will be back. You can trust me." The patient suddenly changed, and switched into an angry ego-state. In that ego-state the patient accused the therapist of breaking promises in the past, and not being there for the patient when she was supposed to. The therapist responded by disclosing to the patient the itinerary of her vacation, and where she could be located. She also promised to write the patient a postcard once a week. The patient reacted to that by switching into another hostile, and angry ego-state, saying to the therapist, "I am undeserving of such kindness. You shouldn't bother to spoil your vacation worrying about me."

D. Spiegel (1984, 1988) described what he termed the "traumatic transference." In this situation, the patient subconsciously expects to be traumatized in a close relationship with the therapist as a reenactment of the childhood abuse. If the therapist is perceived as nice and kind, the patient sees that as a seduction to be followed by betrayal. If the therapist keeps a distance, it will be perceived as being cold and uncaring, allowing the patient to be exposed to excessive risks and dangers, without proper interventions. The therapeutic solution is the interpretation of such behaviors as a reenactment of the past.

6. Misalliances:

It is basic knowledge that a working and therapeutic alliance are a necessary cornerstone for any effective psychotherapy to take place. At times, however, a misalliance may develop in the relationship between the therapist and the patient (Langs, 1975). The misalliance may be based on any type of dynamic constellation in which the patient and the therapist unconsciously live out a compromise derived from the pathological intrapsychic and interactional needs that each of them has.

What may happen is a form of a collusion between the two that may perpetuate the patient's splitting, delusions of separateness, and the existence of alter personalities and ego states for the sake of pleasing the therapist, and so maintaining the relationship. Effective therapy with MPD patients is a most challenging task. Being aware of their own countertransferences and imperfections allow therapists to develop a mature and realistic approach that will help to diminish the iatrogenic factors in treatment.

Case Illustration: The patient (Francine) is a 24-year-old, single, college student who has been in therapy due to MPD for over one year. The therapist reports the patient to be extremely talented in drawing and painting, and brings into supervision and discussion groups the patient's drawings, emphasizing with pride her talents and skills. However, these drawings are done (according to the therapist) by an alter personality named Carla. The therapist reports having a very good relationship with Carla, and has attended art shows and visited art museums with Carla, rationalizing this by encouraging the patient's creativity, and ability to possibly make a future career of drawing. At the same time, little attention is paid to the patient's host personality, Francine, and the difficulties she has in concentration, sleep, relationships with men, and in studying for exams. The patient's alter personality Carla, has made more than one statement to the therapist on how well they get along, and how, in fact, she could be the one to handle everything, providing the therapist helps her to get rid of Francine, who is described by Carla as being chronically depressed, and incompetent. The therapist does not explore the meaning of such statements, and, in fact, ignores them to continue interacting with the Carla personality in helping her plan for a future art exhibit of her drawings. The therapist offers the patient names and phone numbers of various art galleries that might be interested in selling her artwork. Two weeks later Francine reports to the therapist suicidal ideas. The therapist responds by asking for Carla so they can discuss her recent drawings.

The foregoing case illustrates how, at times, therapists treating MPD may enter into a misalliance. This might include writing a book together. In some cases, the patient's artistic talents are used by the therapist as a narcissistic expression of the therapist's own subconscious needs. Therapists must be aware of their own needs, and ensure that these needs are to be met outside of therapeutic work. In therapy, priority should be given to the patients' needs, and moving them forward towards integration and improvement in their adaptive functions with the activities of daily living.

7. Ownership of Unacceptable Behaviors:

Case Illustration: The patient, Theresa, is a 34-year-old, married, mother of three children who had been accused by Children's Services Board of abusing her children physically and emotionally. Children's Services Board had decided to take the children out of the patient's home, and place them in foster homes. The patient is allowed to see them once per month under supervision. The patient has amnesia to the abuse, and claims to love her children. She is feeling perplexed, and has no understanding of why she is being accused of abusing her kids.

During therapy, it is found that the patient abused her children when she was in an altered personality state, calling

herself Sylvia. Sylvia sees herself as being single, never married, and does not recognize these children as being hers. She reports pouring boiling water on the kids, stating she hates those children, and hates Theresa.

One day, the patient reports to the therapist a dream in which she sees herself to be the abuser of her kids. The patient starts crying, and accuses herself of being an unfit mother, and that she will never get custody of her kids again. She expresses guilt and remorse, saying how awful she feels remembering the episodes of the abuse. The therapist admits feeling empathic to the patient, and responds by saying, "Come on, Theresa, you know you have always been a good and loving mother to your kids. I told you we will work together to get your kids back. You know you didn't abuse your kids. You love your kids. It was Sylvia who did it. We will simply have to make sure that Sylvia doesn't do that again."

The above case illustrates how the therapist's interventions perpetuate splitting, and disowning of unacceptable behaviors, which is part and parcel of MPD.

8. Therapists' Communication and Perception of Patient:

The following case illustrates how the therapist's language, as well as the therapist's perception of MPD might contribute to the perpetuation of splitting and multiplicity during therapy.

Case Illustration: The patient, Rose, is a 27-year-old female studying for her master's degree in social work, and has been in therapy due to MPD for over six months. In consultation, the therapist reports that the patient has 20 different personalities. She refers to the patient repeatedly as "they," and discusses with great pride the fact that she has witnessed 18 different personalities "come out" to talk to her. In a discussion with the therapist it is revealed that her perception of the patient is that of a group of "people" of various ages trapped in the same body. The therapist conceptualizes her role as getting to know them all, and encouraging them to express their talents and creativity in their separate and unique ways. During one session, the patient reported (in an alter personality "Paul") feeling a fear of dying if "he" continues to get close to Rose. The therapist responds by reassuring Paul that he would not die and that the therapist will guarantee his continuing existence since he had so much to contribute to the patient's survival, and deserves special credit for it. This perpetuated the patient's confusion regarding her identity in general and her sexual identity in particular.

9. Overemphasis on Internalization:

Following is a case which illustrates how the therapist's interventions may, in fact, encourage the patient to continue to dissociate, and perhaps stay fragmented as a way of coping with daily living, while at the same time showing how overemphasis on the patient's internal world may foster a regression that could be accompanied by a loss of employment, and being placed on disability. The challenge of effective therapy with MPD patients is to continue therapeutic progress by pacing them gradually towards greater insight, awareness of behaviors, acceptance of the past, as well as behaviors in the present while maintaining adaptive functioning with the activities of daily living. This delicate balance is indeed of crucial importance to both the patient and therapist. Therapists in this field must have knowledge and awareness of the risks involved in a premature overemphasis upon the past. Too much focusing on the patient's internal world may contribute to a dysfunctional regression in the patient, and may unnecessarily perpetuate splitting and multiplicity.

Case Illustration: The patient, James, is a 35-year-old married man, and father of two. He has been in treatment for MPD for over two years. During this time the patient had lost his job and was placed on Social Security Disability. However, the therapist sees the patient three times per week, and proudly reports on the great accomplishments in therapy, and speaks of the productive therapeutic work the patient is engaged in. This includes always being on time for sessions, following all instructions of the therapist regarding writing in a journal, doing therapeutic drawings, practicing inner dialogues, and developing insights about the patients childhood, including acceptance of abuse by his parents. The patient reported to the therapist that he has been spending an average of five to six hours every day writing in his diary, and doing therapeutic drawings, as well as inner dialogues. The wife complains of the patient neglecting his family and, at times, even avoiding family dinners. When this is discussed during the consultation time, the therapist reports with pride that she asked the patient to dissociate and assigned the task of playing with his children to a child personality, "Tommy" who has been very playful with the therapist in sessions and would know best how to relate to little children.

CONCLUSION

This paper has focused on the potential for the iatrogenic worsening of MPD. Therefore, it has emphasized possible negative outcomes. These remarks must be placed in the context of the overall literature of the MPD field. The illustrations cited are not meant to be seen as typical of the behaviors of therapists working with MPD patients; instead they depict the types of situations one must make efforts to avoid. ■

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