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Dissociative Identity Disorder and the Sociocognitive Model: Recalling the Lessons of the Past

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In a recent article in this journal, D. H. Gleaves (1996) criticized the sociocognitive model (SCM; N. P. Spanos, 1994) of dissociative identity disorder (DID) and argued in favor of a posttraumatic model (PTM) in which DID is conceptualized as a consequence of childhood abuse and other traumatic events. The present authors demonstrate that (a) many of Gleaves's arguments were predicated on misunderstandings of the SCM, (b) scrutiny of the evidence regarding the psychopathology and assessment of DID raises questions concerning the PTM's conceptual and empirical underpinnings, (c) the treatment literature suggests that iatrogenic factors play an important role in the etiology of DID, and (d) the evidence linking child abuse to DID is more problematic than implied by Gleaves. The present authors conclude that Gleaves's analysis underemphasized the cultural manifestations of multiple role enactments and that the history of DID imparts a valuable lesson to contemporary psychotherapists.

The etiology and nosological status of dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), are among the most controversial issues in contemporary clinical psychology (L. Cohen, Berzoff, & Elin, 1995; Cormier & Thelen, 1998; Pope, Oliva, Hudson, Bodkin, & Gruber, 1999). Over the past decade, two competing views concerning the genesis and nature of DID have emerged. One perspective, referred to by Gleaves (1996) as the posttraumatic model (PTM; called the "disease model" by Spanos, 1994), maintains that DID is an etiologically distinct condition that is best conceptualized as a defensive response to childhood trauma, particularly severe sexual and physical abuse. Proponents of this view hold that DID is most typically a form or variant of posttraumatic stress disorder (PTSD) and that the features of most cases of DID can be conceptualized as coping responses to early trauma. Specifically, advocates of the PTM contend that following severe abuse or other traumatic events, individuals dissociate or "compartmentalize" their subjective experience into alternate personalities ("alters") as a means of coping with the emotional pain of the trauma. As Ross (1997), a proponent of the PTM, argued, "MPD is a little girl imagining that the abuse is happening to someone else" (p. 59).

An alternative perspective on DID is afforded by the sociocognitive model (SCM; Spanos, 1994, 1996; for related views, see Aldridge-Morris, 1989; Ganaway, 1995; Merskey, 1992; Sarbin, 1995; and Simpson, 1989). The SCM conceptualizes DID as a syndrome that consists of rule-governed and goal-directed experiences and displays of multiple role enactments that have been created, legitimized, and maintained by social reinforcement. Patients with DID synthesize these role enactments by drawing on a wide variety of sources of information, including the print and

Editor's Note. Gleaves (1996), discussed in this article, was deemed a commentary on Spanos (1994). Nicholas Spanos died in 1994, and the present article was written as a reply to Gleaves (1996) in Spanos's stead. Because Gleaves (1996) was considered a commentary and the present article was considered a reply to that commentary, no additional commentaries or replies were solicited.—NE

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This article was inspired by the work of Nicholas Spanos, whose tragic death in 1994 was a great loss to the field of psychology in general and to the fields of hypnosis and dissociative identity disorder in particular. In addition, we thank Eric Vanman, Richard McNally, and several others for their extremely helpful comments on drafts of this article.

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broadcast media, cues provided by therapists, personal experiences, and observations of individuals who have enacted multiple identities.

By *role enactment,* proponents of the SCM (see Sarbin & Coe, 1972; Spanos, 1996) mean that DID patients adopt and enact social roles geared to their aspirations and the demand characteristics of varied social contexts. According to this view, the metaphor or concept of *role* does not imply that role-related behaviors are the products of conscious deception. Instead, role enactments tend to flow spontaneously and are carried out with little or no conscious awareness and with a high degree of "organismic involvement" (Sarbin & Coe, 1972) such that the role and "self" (or "multiple selves" as the case may be) coalesce so as to become essentially indistinguishable.

According to the SCM, iatrogenic and sociocultural factors play a substantial etiological role in DID and account largely for the recent and dramatic upsurge in reports of this condition (Aldridge-Morris, 1989). Some authors (e.g., Boor, 1982) have argued that the term *epidemic* best describes this secular increase, because the number of reported cases of DID in the world literature increased from 79 as of 1970 to approximately 6,000 by 1986 (Elzinga, van Dyck, & Spinhoven, 1998). The number of reported cases at the close of the 20th century is difficult to estimate but appears to be in the tens of thousands (Acocella, 1998). The SCM further posits that DID is one variant of a broader constellation of multiple identity enactments, including demonic possession, mass hysteria, transvestism, and glossolalia, that traverse cultural and historical boundaries. Although the protean manifestations of these enactments have been shaped by cultural and historical expectations, their underlying commonalities are suggestive of shared origins.

In a recent article in this journal, Gleaves (1996) criticized a review by Spanos (1994) that presented a large body of scientific and historical evidence in support of the SCM. Gleaves further argued that the PTM provides a superior account of the etiology of DID. Because Nicholas Spanos was tragically killed in a plane crash in 1994, Gleaves's criticisms of the SCM have gone unanswered. We believe that careful scrutiny of Gleaves's assertions is warranted for two reasons. First, the arguments raised by Gleaves, although not new, have gained acceptance among a large segment of the therapeutic community (e.g., Bloch, 1991; Ross, 1997) and general public (e.g., Steinem, 1992; see Acocella, 1998, and Showalter, 1997, for discussions) and have exerted a substantial influence on the conceptualization and treatment of DID. Moreover, they have been referred to frequently by proponents of the PTM (e.g., Kluft, 1993; Ross, 1997). Second, Gleaves's article has already been heralded by some authors as providing a convincing, if not definitive, refutation of the SCM. Scheflin (1997), for example, described Gleaves's critique as "a masterful article articulating, and then refuting, the premises of the iatrogenic position" (p. 253).

Although some of the presuppositions of the PTM and SCM may not be mutually exclusive or logically inconsistent, these models differ substantially in emphasis and engender quite different expectations concerning the etiology and correlates of DID. These two models diverge most sharply in their explanations for the emergence of alters. Specifically, whereas the PTM posits that alters are a naturally occurring result of severe child abuse and other traumatic events, the SCM posits that alters arise as a consequence of therapist influences, media portrayals, and sociocultural expectations. Although the SCM is not inconsistent with the possibility that childhood trauma might produce a predisposition toward certain psychological traits (e.g., fantasy proneness; Lynn, Rhue, & Green, 1988) that in turn increase individuals' receptivity to therapist cues, this model does not posit that the creation of alters is a defensive reaction to trauma. In addition, the two models differ markedly in their views of the relative importance of iatrogenic and other sociocultural influences in the etiology of DID. Whereas proponents of the PTM have typically maintained that such influences are of relatively minor importance in the genesis of DID (or that they account for a relatively small minority of DID cases; see Ross, 1997), proponents of the SCM have typically maintained that such influences play a substantial role in DID's etiology (Spanos, 1994).

Finding evidence that would unambiguously falsify either or both models is difficult, largely because (a) direct experimental manipulation of the crucial etiological agents posited by each model (i.e., childhood trauma in the case of the PTM, iatrogenic and sociocultural expectations regarding multiple identity enactments in the case of the SCM) is impossible for obvious ethical and practical reasons (although, as we discuss later, analogue studies of the etiological agents posited by the SCM have been conducted); (b) many of the putative etiological agents posited by the PTM, particularly child sexual and physical abuse, are sometimes difficult to operationalize in a standardized fashion across investigations (Rind, Tromovitch, & Bauserman, 1998); (c) many of the putative etiological agents posited by the SCM (e.g., sociocultural expectations) are difficult to assess objectively; and (d) prospective, rather than retrospective, data would ideally be required to test the central hypothesis of the PTM, namely, that severe childhood trauma is a necessary precursor of most cases of DID.

Nevertheless, the SCM would be falsified or at least strongly called into question by data demonstrating that a large proportion of clear-cut DID cases emerged in childhood prior to therapy and prior to exposure to widely available knowledge concerning the expected features of DID. The PTM, in turn, would be falsified by data demonstrating that the majority of cases of DID were not preceded by severe child abuse or other trauma. Alternatively, the PTM would be called into question by data indicating that most individuals ultimately diagnosed with DID begin therapy with few or no detectable features of this condition, particularly multiple identity enactments, and develop these features only after therapeutic intervention.

Although we do not believe that the extant data on DID are sufficient to permit a definitive refutation of either model, we contend that adequate data are now available to accept many of the major premises of the SCM and to raise important questions concerning a number of the central tenets of the PTM. In the remainder of this article, we argue that (a) Gleaves's (1996) article contained serious misinterpretations of the SCM and dismissed this model on the basis of inadequate data, (b) the research support for the PTM presented by Gleaves was problematic and in many cases flawed, and (c) Gleaves's analysis neglected or underemphasized the historical and cultural manifestations of multiple role enactments. In addition, we aim to update important developments in the DID literature since the reviews of Spanos (1994) and Gleaves, sharpen several conceptual distinctions that have sometimes been blurred in debates concerning DID, offer a number of suggestions for methodological improvements in this area, and attempt to foster a more constructive dialogue among proponents

of both the SCM and the PTM. We organize our review around three broad issues: (a) the psychopathology and assessment of DID, (b) the treatment of DID, and (c) the etiology of DID. Before addressing these issues, however, it is first necessary to examine Gleaves's exegesis of the SCM.

Assumptions of the SCM

Early on in his article, Gleaves (1996) called into question a number of the assumptions of the SCM. Several of the assumptions criticized by Gleaves, however, appear to be misrepresentations or misunderstandings of the SCM.

The Iatrogenesis of DID

One of Gleaves's (1996) initial arguments was that "the all-or-nothing assumption of the iatrogenic model is false because no disorder can be entirely iatrogenic or entirely noniatrogenic" (p. 42). The SCM does not, however, posit that the etiology of DID is completely iatrogenic. Instead, as already noted, this model proposes that the features of DID can be constructed from a variety of sources in addition to unintentional prompting from therapists, including memories of one's past behavior, observations of other individuals, and media portrayals of DID (Spanos, 1994). Thus, it is relevant that the current dramatic increase in the prevalence of DID cases (Boor, 1982) began shortly after the release of the popular book and television film *Sybil* (book: Schreiber, 1973; film: Petrie, 1976). Furthermore, the SCM posits that multiple identity enactments transcend societal and historical boundaries and can be found even among cultures in which the involvement of mental health professionals is minimal.

Nor does the SCM imply that social influences are the only causal variables relevant to DID, because this model suggests that individual differences in personality or psychopathology, in conjunction with iatrogenic and sociocultural influences, can predispose certain individuals to DID (see the section below entitled The Psychopathology and Assessment of DID). Thus, the SCM is consistent with the possibility that certain traits, such as absorption (Tellegen & Atkinson, 1974) and fantasy proneness (Lynn et al., 1988), play an etiological role in at least some cases of DID (Spanos, 1996; see Bowers, 1991, for a related view). Fantasy proneness, for example, correlates moderately with indexes of dissociation (Rauschenberger & Lynn, 1995) and may place individuals at heightened risk for enacting imaginary identities in response to therapeutic and sociocultural cues (Lynn et al., 1988). Moreover, Spanos (1996) argued that DID overlaps substantially with several psychopathological conditions, including borderline personality disorder (BPD) and somatization disorder. Thus, the SCM does not deny that much of the psychopathological raw material from which DID is sculpted exists prior to professional intervention.

The Simulation of DID

Gleaves (1996) asserted that a key assumption of the SCM is "that there is something unique about DID that would make it rewarding to simulate the disorder" (p. 43). This statement represents a widespread misunderstanding of the SCM, which is careful to distinguish role enactment from simulation. This distinction is not semantic. As noted earlier, role enactment, unlike simulation, typically occurs in a seemingly spontaneous fashion, with little or no conscious effort or planning. Spanos and other proponents of the SCM do not maintain that most individuals with DID are consciously dissimulating, although in rare cases (see, e.g., Orne, Dinges, & Orne, 1984) certain individuals may feign DID to avoid culpability for criminal actions or to obtain attention.

The Pseudoissue of DID's "Existence"

Contrary to Gleaves's (1996) claims (see pp. 43–44), the SCM does not take issue with findings that (a) certain individuals consistently present with the clinical features of DID and (b) the characteristics of DID can be reliably differentiated from those of other diagnoses. Gleaves committed a similar error later in the article when he confused the question of DID's existence with the question of its etiology. For example, he contended that studies demonstrating that many of the features of DID can be readily induced in normal participants provided with instructions to role-play multiple identities (see, e.g., Spanos, Weekes, & Bertrand, 1985) do not call into question the existence of DID. He cited Carson and Butcher's (1992) opinion that

> such role playing demonstrations do not answer, let alone convincingly address, the question of the reality of MPD. That college students might be able to give a convincing portrayal of a person with a broken leg would not establish the nonexistence of broken legs. (p. 209)

But the SCM does not maintain that DID is "not real" or does "not exist" (see Arrigo & Pezdek, 1998; Dunn, Paolo, Ryan, & van Fleet, 1994; and Elzinga et al., 1998, for similar errors).[1] The crucial question concerns not DID's existence—the fact that certain individuals exhibit the features of DID is not in dispute—but rather its origins and maintenance (McHugh, 1993). Is DID best conceptualized as a naturally occurring response to early trauma or as a socially influenced product that unfolds largely in response to the shaping influences of therapeutic practices, culturally based scripts, and societal expectations?

Multiple Identity Enactments and DID

Gleaves criticized Spanos's (1994) purported contention that "multiple identity enactment and DID are equivalent phenomenon [sic]" (Gleaves, 1996, p. 43) and took issue with Spanos for equating one diagnostic feature (i.e., multiple identity enactment) with one disorder (i.e., DID). Yet Spanos (1994) never equated multiple identity enactment with DID. Instead, he emphasized multiple identity enactment as the principal feature of DID (American Psychiatric Association [APA], 1994) and argued that DID is one prominent contemporary manifestation of multiple identity enactment.

The notion of multiple identity enactment as the essential characteristic of DID did not originate with Spanos. Both the PTM and the current *Diagnostic and Statistical Manual of Mental Disorders* (fourth ed., DSM–IV; APA, 1994) conceptualize multiple identity enactment as the essential feature of DID. For example, Ross (1997) asserted that all of the features of DID "follow logically

[1] We acknowledge, however, that some skeptics of the DID diagnosis have in fact framed the DID debate in terms of this condition's existence (see, e.g., Mai, 1995, p. 157).

from the existence of alter personalities that take control of the body" (p. 136) and contended that multiple role enactments, in addition to amnesia, are the essential characteristics of DID. According to Ross, the other symptoms of DID, including blank spells and flashbacks, are "secondary features" that "are evidence of the existence, activity, and influence of the alters" (p. 136). DSM–IV noted that the "essential feature of DID is the presence of two or more distinct identities or personality states . . . that recurrently take control of behavior" (p. 484). Thus, Gleaves (1996) was at odds with other proponents of the PTM and with DSM–IV in arguing that "the core psychopathology of DID" (p. 43) includes such symptoms as identity disturbance, depersonalization, and Schneiderian symptoms (e.g., voices arguing with one another) and that multiple identity enactment is merely one symptom among many of those exhibited by DID patients.

Gleaves (1996) further maintained that these dissociative features are rarely observed in other conditions, then used this finding to call the SCM into question (p. 43). In fact, this finding is consistent with the SCM, which represents an attempt to address the question of why individuals exhibit precisely this constellation of characteristics. Specifically, this model posits that many or most of the features of DID can be explained by the fact that these features derive from culturally based scripts and expectations regarding the typical manifestations of multiple role enactments in Western culture. Because the features of DID have become widely disseminated throughout the culture via the media and other sources, it is not surprising that individuals who exhibit multiple identities often display such features.

That being said, however, some of the purportedly distinctive clinical features of DID cited by Gleaves are questionable. For example, "lack of autobiographical memory for childhood" (Gleaves, 1996, p. 43) may not be specific to DID or other dissociative disorders. Read (1997) found that 20% of a community sample of adults reported significant gaps in memory after age 3, and we are unaware of any controlled studies demonstrating that individuals with DID exhibit poorer recall of childhood memories than do other psychiatric patients or individuals without psychopathology. In addition, individuals who obtained high scores on the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), a commonly used self-report measure of dissociative tendencies, reported the same ages for their earliest memories as did individuals who obtained low scores (Lynn, Malinoski, Aronoff, & Zelikovsky, 1998), although the relation between DES scores and early memory gaps has not been examined empirically. Moreover, case studies have yielded conflicting findings regarding whether DID patients date their earliest memory later than do individuals without psychopathology (Bryant, 1995; Schacter, Kihlstrom, Kihlstrom, & Berren, 1989). Finally, the findings, cited by Gleaves, of Coons, Bowman, and Milstein (1988), which revealed that virtually all DID patients reported a history of amnesia in early childhood, are open to alternative explanations. Many therapists may either presume or attempt to elicit a history of DID based on the absence of certain memories and thereby use amnesia as a scaffolding on which to construct a DID diagnosis. Because a large proportion of adults report memory gaps for childhood (Read, 1997), Coon et al.'s failure to (a) include either a psychiatric or normal comparison group and (b) specify how amnesia was operationalized (e.g., isolated memory gaps vs. long periods of missing time) renders their findings difficult to interpret.

The Psychopathology and Assessment of DID

The Overlap of DID With Other Conditions

In his evaluation of the literature concerning the psychopathology of individuals with DID, Gleaves (1996) made the same error he accused Spanos of having made in the case of multiple identity enactments and DID: equating one diagnostic feature with one disorder. Specifically, Gleaves equated attention seeking with histrionic personality disorder (HPD) and argued that because the SCM posits that gaining attention is an important motivation for DID patients, this model predicts that these patients should exhibit higher rates of HPD than other patients (see also Dell, 1998). Gleaves's review of the literature indicated, however, that DID patients do not exhibit markedly elevated rates of HPD.

Nevertheless, attention seeking is only one characteristic of HPD and is found in a number of conditions other than HPD. Moreover, Spanos (1994) never used the terms *histrionic personality disorder* or *hysteria* in his review, and his description of the modal DID patient as exhibiting "mood swings, shameful or unrepresentative behaviors, ambivalent feelings, hostile fantasies, forgetfulness, guilt-inducing sexual fantasies, and bad habits" (p. 155) does not appear prototypal of patients with HPD. As a consequence, it is not clear that the data presented by Gleaves (1996, pp. 44–45) regarding the relatively low rates of HPD among DID patients are directly relevant to the SCM or to Spanos's (1994) exposition of it.[2]

Although Gleaves (1996) reviewed evidence from studies by Ellason, Ross, and Fuchs (1996) and Lauer, Black, and Keen (1993) indicating that many DID patients meet criteria for avoidant personality disorder (APD) and are thus presumably unlikely to be strongly motivated by a need for attention, the findings of these two studies are difficult to interpret. The study by Ellason et al. did not include either a psychiatric or normal comparison group, and the study by Lauer et al. reported no significant differences in the rates of APD between small samples of DID patients ($N = 14$) and BPD patients ($N = 13$).[3] Moreover, the finding that DID covaries with APD, if demonstrated in studies with appropriate comparison groups, does not contradict the SCM. DSM–IV (APA, 1994) noted that individuals with APD "desire affection and acceptance and may fantasize about idealized relationships with others" (p. 663) and are characterized by "a need for reassurance" (p. 664). In addition, individuals with APD tend to be overly dependent on others for approval (Trull, Widiger, & Frances, 1987). Thus, APD is associated with several traits that would be expected to increase the seeking of approval from authority figures and perhaps foster receptivity to therapist suggestions.

Furthermore, many of the clinical features Gleaves (1996) described may be associated with BPD, which Gleaves largely ignored in his review. BPD, like HPD, is characterized by attention

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[2] Gleaves (1996) asserted that among individuals with DID, "the prevalence of histrionic personality disorder appears to be no higher and, in actuality, *lower than* in other general or specific clinical and *nonclinical samples*" (p. 44; emphasis added). Inspection of Gleaves's Table 1 (p. 45), however, clearly reveals that HPD is more prevalent among DID patients than among patients in nonclinical samples.

[3] Although not calculated by Ellason et al. (1996), the 95% confidence interval surrounding the proportion of patients with DID who met criteria for APD (50%) ranges from 24% to 76%.

seeking (APA, 1994, p. 657). In addition, BPD has been found to co-occur extensively with DID. Across a number of studies (Boon & Draijer, 1993; Dell, 1998; Ellason et al., 1996; Horevitz & Braun, 1984; Lauer et al., 1993; Ross et al., 1990; Scroppo, Drob, Weinberger, & Eagle, 1998; Tutkun et al., 1998; Yargic, Sar, Tutkun, & Alyanak, 1998), the proportion of DID patients fulfilling diagnostic criteria for BPD has ranged from 35% to 71%. Although several of these studies lacked comparison groups (and the study by Lauer et al., 1993, included only a comparison group of BPD patients), the study by Scroppo et al. (1998) found statistically significant and large (Cohen's $d = 1.52$) differences in the rates of BPD between DID patients and nondissociative psychiatric patients. In addition, Yargic et al. (1998) reported significantly higher rates of BPD among a group of DID patients than among three groups of patients with schizophrenia, panic disorder, and partial complex seizure disorder, respectively, and Dell (1998) reported significantly higher rates of BPD among DID patients than among patients with a diagnosis of dissociative disorder not otherwise specified.

Gleaves (1996) sidestepped the issue of the extensive overlap between DID and BPD by stating that "to thoroughly discuss the connection between borderline personality disorder and DID would be beyond the scope of this article" (p. 44) and noting that the overlap between these two conditions is not surprising given their association with child abuse and PTSD. Nevertheless, Gleaves did not address the possibility that both the history of abuse and PTSD symptoms may be seized upon as evidence of potential DID by therapists who seek to explain many of the puzzling features of BPD, such as identity disturbance, dramatic changes in mood, and marked instability in interpersonal relationships, in terms of DID (Ganaway, 1995; see Piper, 1997, for a discussion of the potential "elasticity" of the DID diagnostic criteria in the hands of some clinicians). Because a number of the signs and symptoms of BPD resemble those of DID, the possibility that these two conditions are readily confused with one another merits systematic examination in studies of diagnosticians' judgments.

The Assessment and Diagnosis of DID

Gleaves (1996) reviewed a large body of evidence indicating that the diagnosis of DID can be made reliably and validly using self-report and structured interview measures. It is unclear, however, how this literature is relevant to the validity of the SCM. As noted earlier, this model does not take issue with the claim that individuals with DID display relatively distinctive features that are rarely found in other conditions. As useful as the measures of DID and dissociation reviewed by Gleaves might be for diagnostic purposes, they are not designed to differentiate conditions that are largely iatrogenic (or otherwise influenced by social expectancies) from other conditions.

Gleaves's (1996) conclusions concerning the convergent and discriminant relations of the DES with various psychopathological conditions are similarly open to alternative explanations. Many DES items (e.g., "Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people") refer explicitly to common signs and symptoms of DID (Spanos, 1996). As a consequence, the finding that the DES consistently distinguishes DID from other conditions is neither surprising nor informative and might instead by attributed to the largely tautological overlap between the content of DES items and the symptoms of DID. Although this problem of content overlap is not unique to the literature on DID and probably accounts partly for a number of commonly reported correlations among measures of psychopathology (see Nicholls, Licht, & Pearl, 1982, for a general discussion of this problem in the self-report assessment of personality and psychopathology), it is important to note that Gleaves invoked the correlation between the DES and DID as evidence against the claim that the features of DID are largely iatrogenic (p. 46).[4] However, this correlation is equally consistent with both an iatrogenic and noniatrogenic hypothesis, because it can more parsimoniously be explained by content overlap.

The Treatment of DID

The Clinical Presentation of DID Before and After Treatment

Although proponents of the PTM have sometimes been hard-pressed to address the question of why the DID diagnosis was rarely made prior to 1970 (Piper, 1997), they have typically responded by contending that the signs and symptoms of DID are subtle, covert, and easily missed. Moreover, they have contended that individuals with DID often hide or minimize their symptoms (Ross, 1997). As a consequence, these authors have suggested, the diagnosis of DID was frequently overlooked by clinicians of previous generations, because these clinicians (a) were often unaware of the features of DID or (b) neglected to probe sufficiently for these features.

Gleaves's arguments are similar. He asserted that Spanos's (1994) description of many DID patients, namely, "that of someone who openly calls herself or himself by different names and behaves like different people on different occasions" (Gleaves, 1996, p. 44), is at variance with what is reported in the DID literature. He further argued that DID often goes unrecognized for many years and that "a florid, obvious presentation of the disorder is atypical" (p. 45).

It is unclear, however, how these findings are best interpreted. On the one hand, they may help to explain why DID was presumably underdiagnosed for many decades (Ross, 1997). On the other hand, if a florid and obvious presentation is atypical prior to therapy and becomes typical only during therapy, these findings raise the possibility that iatrogenic factors play an important role in DID. Kluft (1991) estimated that only 20% of DID patients exhibit clear-cut indications of this condition at the beginning of therapy and that the remaining 80% exhibit only specific "windows of diagnosability," namely, transient periods during which the classic features of DID are evident. Although there is disagreement concerning the exact percentages, virtually all authors in this literature have concurred that a large proportion—perhaps a majority—of DID patients in their samples exhibit few or no unambiguous signs of this condition prior to therapy (Kluft, 1984; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, 1997).

[4] Gleaves (1996) cited studies on the relation between the DES and DID in a section entitled Creating Multiplicity (p. 46) and concluded this section by asserting that "the data do not support the hypothesis that assessment or treatment procedures are responsible for the creation of DID" (p. 49).

Moreover, although systematic data are lacking, numerous advocates of the PTM (e.g., Kluft, 1984; Ross, 1997; Schafer, 1986) have contended that DID patients themselves are frequently unaware of their alters prior to therapy. This is a point that Gleaves (1996) did not clearly acknowledge and that is consistent with an iatrogenic explanation. Putnam (1989) estimated that 80% of DID patients possess no knowledge of their multiplicity before beginning treatment, and Dell and Eisenhower (1990) reported that all 11 of their adolescent patients with DID professed no awareness of their alters at the time of diagnosis. Lewis, Yeager, Swica, Pincus, and Lewis (1997) similarly reported that none of the 12 murderers with DID in their sample reported any awareness of the existence of their multiple personalities. Although Gleaves maintained that DID patients "appear to have experienced their symptoms most of their lives, well before they were ever in treatment for a dissociative disorder" (p. 49), the only published evidence he offered for this assertion was the reports of Coons et al. (1988) and Fahy, Abas, and Brown (1989), both of which are uncontrolled studies that did not provide either (a) evidence of alters prior to treatment or (b) external corroboration for the patient's pretreatment DID symptoms. Moreover, the pretreatment symptoms reported by the patient in Fahy et al., which included "blackouts," seizures of apparent psychogenic origin, depersonalization, memory gaps, auditory hallucinations, depression, and anxiety, were nonspecific and consistent with a number of diagnoses other than DID, including somatization disorder (which is sometimes characterized by both unexplained physical symptoms and amnestic periods; APA, 1994, p. 449) and BPD.

Although proponents of the PTM (e.g., Ross, 1997) have often maintained that the essential features of DID are frequently "latent" and therefore difficult to detect prior to therapy (see Piper, 1997, for a discussion), this proposition raises important concerns regarding the falsifiability of the PTM. When confronted with evidence that DID patients often exhibit few clear indications of multiple identity enactments prior to therapy, advocates of the PTM could argue that these features were present but had not yet been elicited. Without independent evidence of the existence of these features, however, this assertion is difficult to refute.

Several authors have also reported that the number of alters tends to increase over the course of treatment (see, e.g., Kluft, 1988; Ross, Norton, & Wozney, 1989). In addition, although the number of alters per DID case at the time of initial diagnosis has apparently remained constant over time (Ross, Norton, & Wozney, 1989), the number of alters per DID case in treatment has increased (North, Ryall, Ricci, & Wetzel, 1993). Although these findings are consistent with Gleaves's hypothesis that DID patients tend to hide their dissociative symptoms prior to treatment, they are also consistent with an iatrogenic hypothesis. Moreover, proponents of the PTM will again need to make explicit what data could potentially falsify the former hypothesis.

We are hard-pressed to identify another DSM–IV disorder whose essential feature (viz., multiple identity enactment) (a) is often or usually unobservable prior to treatment and (b) tends to emerge and become considerably more florid during treatment. These two observations probably help explain why iatrogenesis has long been a serious concern in the DID literature (e.g., Aldridge-Morris, 1989). Although Gleaves (1996) acknowledged that "additional alters can be iatrogenically created" (p. 54) once the disorder has begun, he denied that iatrogenic influences play a role in DID's onset. Although it is difficult to refute this hypothesis given the absence of relevant data, Gleaves's argument hinges on the critical assumption that iatrogenic factors can lead patients with one or more alters to develop additional alters but cannot lead patients without alters to develop one or more alters. Although the theoretical basis underlying this assumption was not articulated by Gleaves, a clear explication of the grounds for this assumption appears necessary for evaluating the assertions of the PTM's proponents.

Hypnosis and the Creation of Multiplicity

Gleaves (1996) took issue with the claim that hypnosis plays a causal role in a number of cases of DID. He cited studies (Coons et al., 1988; Ross, Norton, & Wozney, 1989) indicating that most DID patients have never been hypnotized, as well as studies that reported no differences in the diagnostic features of DID patients (e.g., number of alters, number of diagnostic criteria) who had and had not been hypnotized (see, e.g., Putnam et al., 1986; Ross & Norton, 1989). According to Gleaves, these results refute predictions derived from the SCM. Nevertheless, the SCM does not maintain that hypnosis is necessary for the creation of DID, because hypnotic procedures do not possess any inherent or unique features that are necessary to facilitate responsivity to suggestion (Barber, Spanos, & Chaves, 1974; Spanos & Chaves, 1989). Other methods, such as leading interviews and suggestive questions, may be equally likely to induce clients' adoption of multiple roles (Barber, 1979; Spanos, 1996). Moreover, many of the features of DID may derive from widely available societal scripts concerning the characteristics of this condition. Thus, the SCM would not necessarily predict differences between hypnotized and nonhypnotized individuals in their rates of DID or DID symptoms, particularly if both groups were subjected to suggestive therapeutic procedures.

It might nonetheless be argued that (a) hypnosis is one technique among many that can facilitate responsivity to suggestion, (b) therapists who use hypnosis may be especially likely to utilize potentially suggestive techniques (e.g., guided imagery) in general, and (c) because hypnosis is widely viewed as a technique that can penetrate defensive barriers, the use of this technique may help to legitimize the emergence of alters (Stafford & Lynn, 1998). If so, the findings of Putnam et al. (1986) and Ross and Norton (1989) may warrant closer examination.

Nevertheless, for two reasons, these two studies do not, as argued by Gleaves, provide evidence against iatrogenesis. First, because all patients in these studies had DID, the finding that hypnotized and nonhypnotized patients did not differ in the number of diagnostic criteria for DID is difficult to interpret in light of ceiling effects (see also Powell & Gee, in press). For example, all of Ross and Norton's (1989) patients met the criteria for DID given in the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1987), and the percentages of these patients who met the three additional DID criteria from the third edition (DSM–III; APA, 1980) and the National Institute of Mental Health criterion sets ranged from 94.4% to 95.7% (Putnam et al., 1986, did not report descriptive statistics for the number of DID criteria met in their sample). A more relevant question, which has yet to be examined, is whether patients who initially present without symptoms of DID and are then hypnotized subsequently exhibit more symptoms of DID than do comparable patients who are not hypnotized.

Second, contrary to Gleaves's claims, the results of Ross and Norton (1989) did reveal differences between hypnotized and nonhypnotized patients with DID. In a reanalysis of Ross and Norton's data, Powell and Gee (in press) found that hypnotized patients exhibited greater variance in the number of alters at the time of diagnosis and in subsequent treatment. Although the meaning of this finding is not entirely clear, the authors conjectured that this finding might reflect bimodal attitudes regarding iatrogenesis among practitioners who use hypnosis, with some practitioners (i.e., those who believe that hypnosis is potentially iatrogenic) using hypnosis with caution and others (i.e., those who believe that hypnosis is not iatrogenic) using hypnosis relatively indiscriminately and producing a large number of alters. In addition, Powell and Gee reported that practitioners who used hypnosis reported a significantly higher number of DID patients in their caseloads than did practitioners who did not use hypnosis. Although this finding is correlational and open to multiple interpretations (e.g., specialists in DID may be more likely to use hypnosis), it is potentially consistent with iatrogenesis. Thus, Ross and Norton's (1989) data do not argue against an iatrogenic hypothesis and may in fact provide suggestive evidence for this hypothesis.

Current Treatment Methods for DID

Gleaves criticized Spanos's (1994) characterizations of the DID treatment literature as "at best, lacking in support" (Gleaves, 1996, p. 47). He contended that Spanos's assertions that "therapists routinely encourage patients to construe themselves as having multiple identities, provide them with information about how to convincingly enact the role of 'multiple personality patient,' and provide official legitimization for the different identities that patients enact" (Spanos, 1994, p. 144) are not borne out by an examination of the DID treatment literature. Instead, Gleaves claimed, this literature discourages therapists from treating DID patients as though they possessed genuine personalities and encourages them to treat patients' alters as self-generated. He contended that "skeptics of the reality of DID seem to assume that therapists who treat people with DID conceptualize alters as different people or entities or conceptualize patients with DID as having more than one personality" (Gleaves, 1996, p. 48; see also Ross, 1990).

Nevertheless, an examination of the widely available treatment literature on DID reveals that much, and arguably most, of this literature is oriented around such techniques as mapping the system of alter personalities and establishing direct contact with alters (e.g., see Ross, 1997, pp. 305–315). These "reifying" techniques appear to be especially common in the early phases of therapy, although the later phases of therapy often focus on unreifying alters and achieving integration among them (Ross, 1997). Moreover, many prominent authors do in fact appear to treat DID patients as harboring multiple discrete personality-like entities, if not fully developed personalities (Piper, 1997). A sampling of quotations from five of the most influential and widely cited proponents of mainstream treatment methods for DID illustrates this point.

Kluft (1993) argued that "when information suggestive of MPD is available, but an alter has not emerged spontaneously, asking to meet an alter directly is an increasingly accepted intervention" (p. 29). Kluft further acknowledged that his most frequent hypnotic instruction to DID patients was "Everybody listen" (see Ganaway, 1995). Braun (1980) wrote that "after inducing hypnosis, the therapist asks the patient 'if there is another thought process, part of the mind, part, person or force that exists in the body'" (p. 213). Bliss (1980) noted that in the treatment of DID, "alter egos are summoned, and usually asked to speak freely. . . . When they appear, the subject is asked to listen. [The subject] is then introduced to some of the personalities" (p. 1393). Putnam (1989) advocated the use of a technique known as the "bulletin board," which permits DID patients to have a "place where personalities can 'post' messages to each other. . . . I suggest that the patient buy a small notebook in which personalities may write messages to each other" (p. 154). Finally, Ross (1997; see also Putnam, 1989), recommended giving names to alters and stated that "giving an alter a name may 'crystallize' it and make it more distinct" (Ross, 1997, p. 311). According to Ross, this technique is used primarily among patients with possible DID as a means of clarifying the individual's personality system. In addition, Ross advocated the use of "inner board meetings" as a "good way to map the system, resolve issues, and recover memories" (p. 350). He described this method as follows:

> The patient relaxes with a brief hypnotic induction, and the host personality walks into the boardroom. The patient is instructed that there will be one chair for every personality in the system. . . . Often there are empty chairs because some alters are not ready to enter therapy. The empty chairs provide useful information, and those present can be asked what they know about the missing people. (p. 351)

An inspection of the mainstream DID treatment literature reveals that these quotations are representative of those of many other authors (see Piper, 1997, pp. 61–68, for similar examples). These quotations appear to contradict Gleaves's (1996) assertions that "alters are explained and conceptualized as part of a whole person, not as separate people or entities" and that the "general recommendation is that one speaks with alters to understand all parts of the person in therapy but not as if they were different people" (p. 48). As is evident from the preceding quotations, many or most influential authors in the DID treatment literature treat alters as independent entities or even personalities, at least in the early phases of treatment, although systematic data are needed to ascertain the prevalence of these practices among therapists in the community. Moreover, although Gleaves (1996) described the therapeutic practices of most DID clinicians as a relatively passive process of "acknowledging [that] a patient with DID [has the] *genuine experience* of alters or real people or entities" (p. 48; emphasis in original), many of these practices (e.g., summoning alters that have not yet appeared, naming alters) appear to be quite active or potentially suggestive, particularly if, as noted earlier, many DID patients have no conscious awareness of multiple identity enactments prior to therapy. From a behavioral or social learning perspective, this reification of alters may adventitiously reinforce DID patients' displays of multiplicity.[5]

[5] We should note that the process of mapping and communicating with alters differs substantially from the process of mapping and communicating with the voices of a psychotic patient (cf. Ross, 1997). Although clinicians often inquire about auditory hallucinations in order to better understand their patients' phenomenology or establish a diagnosis, they rarely encourage patients to elaborate in great detail on the content of these voices, summon these voices repeatedly over the course of treatment, refer to these voices by name, or attempt to elicit reports of new voices for which the patient has no recollection.

Gleaves (1996) also committed a logical error by confusing the absence of appropriate treatment ("benign neglect") with the behavioral technique of extinction. The potential utility of extinction techniques in the treatment of DID was illustrated by Kohlenberg (1973) using a single-subject design. Kohlenberg found that systematically ignoring and attending to a DID patient's behavioral expressions of multiplicity reduced and increased, respectively, the frequency with which this patient presented with an alter personality. To argue against the efficacy of extinction, Gleaves cited reports (e.g., Ross, Norton, & Wozney, 1989) indicating that many patients with DID whose condition went unrecognized (and whose DID was presumably not addressed in treatment) for many years exhibited little improvement. He then used this evidence to contend that the approach advocated by proponents of the SCM—not attending to or otherwise reinforcing the patient's displays of multiplicity—is countertherapeutic. Gleaves (1996) asserted that "of these hundreds of patients with DID, not addressing and treating the dissociative condition did not lead to clinical improvement" (p. 49).

For three reasons, however, these data do not provide evidence against the SCM. First, the evidence cited by Gleaves derives exclusively from uncontrolled studies and anecdotal reports by DID patients (see, e.g., B. M. Cohen, Giller, & W., 1991) and therefore does not provide a stringent test of the SCM. Second, these data are subject to a potentially serious selection bias, because those patients who remained in non-DID-oriented treatment for many years are presumably those who failed to benefit from this treatment. It remains possible that the majority of DID patients benefited from such treatment. Third and most important, the absence of appropriate such treatment is not synonymous with the use of extinction techniques advocated by behaviorists (e.g., Kohlenberg, 1973). To the contrary, the behaviors of untreated patients with DID may have been intermittently reinforced by others, including mental health staff, relatives, and friends, in the absence of explicit treatment for DID. Gleaves in effect equated a systematic psychological treatment (viz., extinction) with the absence of psychological treatment and then erroneously extrapolated from the literature on the latter to evaluate the effectiveness of the former. As an analogy, Patterson (1982) would not equate the absence of adequate treatment for a child with conduct disorder (CD) with extinction. Instead, he would almost certainly contend that the antisocial behaviors of an untreated child with CD were being intermittently reinforced by parental attention and submission to the child's actions and that extinction of such behaviors by eliminating this pattern of reinforcement was necessary for behavior change.

As Gleaves noted (1996, p. 54), there exist no controlled studies on the treatment of DID. Ellason and Ross (1997) reported that a sample of hospitalized patients with DID showed improvement after a 2-year period following discharge, but this study did not include either a randomized or a matched group of DID patients who received either no treatment or an alternative treatment. Nor was the nature of the treatment received by DID patients made explicit. Further complicating the interpretation of Ellason and Ross's findings is the fact that their original sample comprised 135 patients, of whom only 54 (40%) were located and reassessed at follow-up (see Powell & Howell, 1998a, 1998b, for additional methodological criticisms of Ellason and Ross's design). Controlled treatment studies of DID will be necessary to better evaluate the relative merits of competing therapeutic approaches (e.g., extinction, traditional treatment methods emphasizing integration among alters).

The Distribution of DID Diagnoses Across Clinicians

To address the SCM's assertion that iatrogenesis is an important factor in the etiology of DID, Gleaves (1996) disputed Spanos's (1994) claim that a disproportionate number of DID diagnoses are made by a small number of therapists. Gleaves cited data indicating that the DID cases described by three investigative teams were referred by a large number of different clinicians. Careful inspection of these studies, however, reveals serious selection biases. Putnam et al. (1986) distributed 400 questionnaires to "clinicians . . . who had previously indicated an interest in multiple personality disorder" (p. 291) and received responses from 92 individuals. Schultz, Braun, and Kluft (1989) mailed questionnaires "to 676 clinicians who had indicated an interest in MPD" (p. 47) and received 355 responses. The mean number of DID patients seen by each of the responding clinicians ranged from 1 to over 100. Ross, Norton, and Wozney (1989) mailed questionnaires to 515 members of the International Society for the Study of Multiple Personality and Dissociation (ISSMD) and to 1729 members of the Canadian Psychiatric Association (CPA). The 236 cases of DID examined by Ross, Norton, and Wozney were referred by 154 members of ISSMD and 49 members of CPA. Thus, members of ISSMD were between 10 and 11 times more likely to report having seen a case of DID than were members of CPA.

Thus, the results of these studies do not refute Spanos's (1994) contention that a disproportionate number of DID diagnoses are made by a small number of therapists, because (a) in all three studies, many or all or the questionnaires were mailed to clinicians with specialized interests in DID, who make up a small proportion of all therapists, and (b) therapists with interests in DID are much more likely than other therapists to report cases of DID. Along similar lines, Mai (1995) found evidence for considerable variability in the number of DID diagnoses across psychiatrists and concluded that diagnoses of DID derive mostly from a relatively small number of psychiatrists. These findings dovetail with those of Qin, Goodman, Bottoms, and Shaver (1998), who found that reports of satanic ritual abuse (which are closely associated with DID; Mulhern, 1991) derive primarily from a small number of therapists.

Contrary to Gleaves's (1996) claims, the results of these studies are thus consistent with the possibility that iatrogenesis is a key factor in the genesis of DID. Moreover, they provide one important test of the SCM, because if DID diagnoses were not made disproportionately by a subset of therapists—namely, those who are ardent proponents of the DID diagnosis—the iatrogenic hypothesis would be called into question. Nevertheless, these findings are causally indeterminate and do not prove iatrogenesis, because they are also consistent with the hypothesis that specialists in DID receive referrals for a disproportionate number of DID cases. Longitudinal studies examining whether patients tend to experience the symptoms of DID, particularly multiple identity enactments, before or after referrals to specialists would help to determine whether these data speak primarily to iatrogenesis or to differential referral patterns.

The Epidemiology of DID in Adulthood and Childhood: Implications for Iatrogenesis

One set of findings that is sometimes invoked as evidence against the SCM is the literature on the prevalence of DID in community and clinical samples (see, e.g., Ross, 1997). If it could be shown that a large number of individuals in the general population, for example, met criteria for DID prior to treatment and to extensive exposure to information concerning the signs and symptoms of DID, this finding would provide evidence against iatrogenesis and the SCM more generally. The study by Ross (1991) represents the only published study on the epidemiology of DID in the general population (see Gleaves, 1996, p. 50). Ross (1991) used a structured interview, the Dissociative Disorders Interview Schedule (DDIS; Ross, Heber, et al., 1989), to establish diagnoses of DID and conducted interviews with 454 community residents in Winnipeg, Canada. These residents formed a subset of an initial sample of 1,055 respondents identified by a stratified cluster sampling method. Ross (1991) reported that 14 individuals (3.1%) met criteria for DID according to the DDIS, 6 of whom reported histories of child abuse.

Nevertheless, these findings are difficult to interpret for several reasons. First, the DDIS has not been validated for use in nonclinical (e.g., community) samples (Ross, 1991), and its false-positive rate in such samples is unknown. This issue is of particular concern because diagnostic measures developed for use in clinical samples often yield high false-positive rates when applied to samples with low base rates of the diagnosis (Finn & Kamphuis, 1995). This concern is heightened by the finding (Ross, 1991) that 13 out of the 14 respondents who met DDIS criteria for DID scored in the average range (10 to 20) on the DES. Because Ross (1991) did not follow up positive DDIS diagnoses of DID with blind diagnostic interviews by an independent assessor, the issue of false positives is difficult to evaluate.

Second, because there is no information on whether the 14 individuals who met criteria for DID had received psychotherapy, the possibility of iatrogenesis cannot be excluded. Perhaps more important, Ross did not report data on the extent of respondents' exposure to explicit information concerning the features of DID (e.g., media coverage of DID). Such data would be helpful in evaluating the extent to which the SCM could account for these cases of DID. Similar problems apply to studies of the prevalence of DID in clinical samples (e.g., Ross, Anderson, Fleisher, & Norton, 1991), which do not provide data on the exposure of DID patients either to potentially suggestive treatment practices (e.g., repeated probing regarding the existence of potential alters) or to explicit information regarding the expected features of DID.

A second source of data potentially relevant to evaluating the SCM is findings on the prevalence of DID in children. As noted earlier, data indicating that unambiguous cases of DID emerge in childhood prior to either treatment or extensive exposure to information regarding the features of DID would call the SCM into question. Although cases of DID have been reported in children (Putnam, 1997), there are no large-scale systematic studies of the prevalence of childhood DID in the general population (Ross, 1996). In addition, studies of the prevalence of childhood DID in psychiatric samples (e.g., Waterbury, 1991) have not provided data on the exposure of participants to either (a) potentially suggestive diagnostic and treatment practices or (b) information regarding the expected features of DID. The former issue is of particular importance given research demonstrating the heightened suggestibility of children compared with adults (Ceci & Bruck, 1993), although this literature focuses primarily on children's episodic memory rather than on their willingness to endorse the presence of latent personality structures (e.g., alters). Moreover, it is not known whether cases of DID in children tend to persist into adulthood. Such information would be helpful in evaluating whether such cases represent stable syndromes that are etiologically related to adult DID or instead represent transient conditions that differ qualitatively from adult DID. More detailed information concerning both the antecedents and the course of childhood DID should prove useful in testing the predictions of both the SCM and the PTM.

The Etiology of DID

Analogue Studies

Gleaves (1996) was correct that role-playing studies (e.g., Spanos et al., 1985; Spanos, Weekes, Menary, & Bertrand, 1986) do not by themselves demonstrate that DID is produced iatrogenically. Nevertheless, his assertion that "to conclude that these studies prove that DID is simply a form of role-playing is unwarranted" (Gleaves, 1996, p. 47) represented a misreading of these studies' purpose. These studies were designed not to reproduce the full range or subjective experience of DID symptoms, including multiple identity enactments, but rather to demonstrate the ease with which cues and prompts can trigger participants without DID to display the overt characteristics of this condition.

The SCM asserts that (a) the experiences and behaviors of DID patients are substantially culturally influenced and (b) data demonstrating that simulators accurately reproduce some of the critical features of DID indicate that the culture contains sufficient cues for individuals to learn what kinds of experiences and behaviors are typical of this disorder. As a consequence, the findings of role-playing studies provide a sufficiency proof that many of the overt features of DID can be reproduced following interviewer prompting. For example, Spanos et al. (1985) reported that most participants provided with suggestions for DID (e.g., "I think perhaps there might be another part of [you] that I haven't talked to") spontaneously reported amnesia for their alters following hypnosis, whereas no control participants did so. In addition, Spanos et al. found that many role-playing participants spontaneously adopted a different name, referred to their primary personality in the third person, and exhibited striking differences between their primary and alter "personalities" on self-report measures. All of these characteristics are commonly exhibited by DID patients (Ross, 1997). When situational demands are conducive, normal participants can readily role-play a number of characteristics of DID, including reports of physical, sexual, and satanic ritual abuse (Stafford & Lynn, 1998).

These findings demonstrate that the behaviors and reported experiences of DID patients are familiar to many members of the general population. Were this not the case, the SCM would not be able to account for a number of the features of DID. Analogue studies thus provide corroboration for one important and potentially falsifiable precondition of the SCM, although they do not provide dispositive evidence for this model.

Motivations for Developing DID

Gleaves (1996) asserted that an assumption of the SCM is that patients with DID enjoy having this disorder. According to

Gleaves, this assumption stems from the SCM's proposition that DID is largely maintained and in some cases partly caused by social reinforcement, such as attention from others. Nowhere, however, have Spanos (1994) or other proponents of the SCM posited that patients with DID "find having DID enjoyable or rewarding" (Gleaves, 1996, p. 45). To the contrary, proponents of the SCM emphasize that patients with DID often experience profound suffering. Spanos (1996), for example, described patients with DID as "chronically disturbed, unhappy, polysymptomatic . . . people who are emotionally needy" (p. 259).

Gleaves (1996) further maintained that the intense suffering experienced by many or most individuals with DID implies that reinforcement processes are largely irrelevant to the etiology and maintenance of this condition. Both behavioral and social learning theorists, however, have long recognized that individuals often engage in pathological and psychologically painful behaviors as a consequence of reinforcement (e.g., see Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, and Mowrer's [1948] classic discussion of the "neurotic paradox"). For example, many theorists have argued that a variety of forms of psychopathology can be conceptualized as resulting from short-term reinforcement at the expense of long-term suffering (see, e.g., Ullman & Krasner, 1975). To contend that reinforcement plays little or no role in the genesis of DID because the symptoms of DID are deeply distressing is no more logically defensible than to contend that the etiology of obsessive–compulsive disorder (OCD) is independent of reinforcement because OCD is intensely painful to its sufferers. In fact, there is compelling evidence that OCD is maintained and perhaps partly caused by reinforcement processes (Rachman & Hodgson, 1980).

Gleaves (1996) also did not discuss the hypothesis that much of the suffering of DID patients is iatrogenically induced. Indeed, a number of individuals who retracted reports of child abuse have reported that their condition deteriorated as they became increasingly dependent on their therapists and alienated from friends and relatives (de Rivera, 1997; Lief & Fetkowitz, 1995). Gleaves's analysis overlooked the possibility that maladaptive and even subjectively distressing behaviors that might not appear to be reinforcing from the perspective of outside observers (e.g., displays of multiplicity) might nonetheless be reinforcing to clients with weak social support systems who have become intensely dependent on their therapists. Indeed, there is evidence that socially deprived individuals tend to find negative social attention more reinforcing than no attention at all (see, e.g., Gallimore, Tharp, & Kemp, 1969).

Child Abuse and DID

In his analysis of the literature linking child abuse to DID, Gleaves (1996) again cited Carson and Butcher's (1992) opinion: "while it is somewhat amazing that this connection [between DID and child abuse] was not generally recognized until 1984, there is now no reasonable doubt about the reality of this association" (p. 208). Scrutiny of the literature reviewed by Gleaves, however, calls this conclusion into question.

Before we examine the child abuse–DID link, it is important to note that recent quantitative reviews raise questions concerning the magnitude of the association between child sexual abuse and later psychopathology. Specifically, the meta-analysis of Rind et al. (1998) suggests that the association between child sexual abuse and psychopathology may be (a) considerably weaker than previously believed (see also Tillman, Nash, & Lerner, 1994) and (b) at least partly mediated by dysfunctional family environment. Moreover, Rind et al. reported a low effect size (.09) for the association between child sexual abuse and self-reported dissociative symptoms across eight studies (N = 1,324). The interpretation of Rind et al.'s findings and conclusions is potentially complicated, however, by the fact that their analyses were based on college samples, which were found by Jumper (1995) to yield smaller effect sizes for the relation between child abuse and psychopathology than did either community or clinical samples. In contrast, a separate meta-analysis by Rind and Tromovitch (1997) found comparably low effect sizes for this association in college and community samples.

Despite the findings of Rind et al. (1998), we believe for at least two reasons that the issue of whether child abuse predisposes to DID remains an open question that merits further investigation. First, it is conceivable that the relation between child abuse and psychopathology is pronounced in magnitude only among individuals who have experienced abuse that is severe, repeated, or both, although Rind et al. found that the frequency, duration, and force of sexual abuse did not moderate the association between early abuse and later psychopathology. Second, there is some evidence that self-reports of physical and sexual abuse may underestimate actual abuse rates (Widom & Morris, 1997; Widom & Shepard, 1996). A nontrivial rate of false negatives for child abuse might have attenuated the reported relations between child abuse and psychopathology in a number of studies. Nevertheless, the formidable methodological difficulties involved in operationalizing and assessing child abuse when it is mild or moderate in severity (see Rind et al., 1998), in corroborating abuse reports (e.g., see Schooler, Bendiksen, & Ambadar, 1997, for an illustration of some of the methodological complexities involved in corroborating child abuse reports), and in determining whether child abuse–psychopathology correlations imply causation (DiLalla & Gottesman, 1991) demand a circumspect analysis of the evidence regarding the association between child abuse and DID. In the following section, we separate our evaluation of the literature concerning the child abuse–DID link into two major issues: (a) the corroboration of child abuse reports among DID patients and (b) the interpretation of the child abuse–DID association.

The corroboration of child abuse reports among DID patients. Although Gleaves reviewed a number of studies suggesting a high prevalence of child abuse among DID patients (see Gleaves, 1996, Table 3, p. 53), in none of these studies was the abuse corroborated by independent sources. In Coons et al. (1988), Ross et al. (1990), Boon and Draijer (1993), and Ellason et al. (1996), the abuse reports were based exclusively on patient interviews, and in Putnam et al. (1986), Ross, Norton, and Wozney (1989), and Schultz et al. (1989), the abuse reports were based exclusively on clinician questionnaires. The absence of corroboration for reported abuse in these studies (see also Scroppo et al., 1998) is problematic in view of recent findings indicating that memory is considerably more malleable, reconstructive, and vulnerable to suggestion than previously believed (Loftus, 1993, 1997a; Malinoski & Lynn, 1995).[6]

[6] Gleaves (1996) dismissed this problem by citing the review by Brewin, Andrews, and Gotlib (1993), who concluded that the evidence regarding the validity of retrospective reports did not support an extreme reconstructive model of memory. Nevertheless, the data reviewed by Brewin et al. dealt with the retrospective assessment of events by means of standardized questionnaires, interviews, and other methods of assessment in which (a)

Moreover, recent evidence suggests that memories of traumatic events (e.g., combat experiences) may not be immune to this problem (Southwick, Morgan, Nicolaou, & Charney, 1997).

Although the research of Pezdek, Finger, and Hodge (1997) indicated that memory implantation may be likely to occur only when the event being implanted is plausible and accords with script-relevant knowledge existing in memory, the relevance of their findings to early abuse reports requires clarification. Pezdek et al.'s findings might suggest that unintentional implantation of child abuse memories in DID patients can occur only when these patients possess implicit causal theories regarding the association between early abuse and DID, although this possibility has not been examined. In addition, abuse memories recovered in therapy may be less likely to be veridical than abuse memories recalled continuously since childhood (Loftus, 1993), although there is little empirical evidence directly relevant to this assertion. Because none of the studies cited by Gleaves (1996, p. 53) provided information on whether the reported abuse was recalled continuously or recovered in treatment, this potentially important distinction cannot presently be addressed.

In addition, the phenomenon of "effort after meaning," whereby individuals interpret potentially ambiguous events (e.g., hitting, fondling) in accord with their implicit theories regarding the causes of their disorders, further renders some reports of relatively mild or moderate physical and sexual child abuse difficult to interpret without independent corroboration (Rind et al., 1998). Finally, it is difficult to exclude the possibility that the same unintentional cues emitted by therapists that may promote the creation of alters might also promote the creation of false memories of abuse (Spanos, 1994), although little is known about the prevalence of suggestive practices among DID practitioners. As a consequence, it is not known whether the reported association between child abuse and DID might be at least partly spurious and contaminated by therapists' methods of ascertaining information.

Several investigators have, however, attempted to corroborate the retrospective abuse reports of DID patients. Gleaves (1996) cited the findings of Coons and Milstein (1986) and Coons (1994), who claimed to provide objective documentation for the abuse reports of a number of DID patients, as offering especially compelling support for the child abuse–DID link. Close inspection of these studies, however, reveals various methodological shortcomings. In neither study were diagnoses of DID made blindly of previous abuse reports. This methodological shortcoming is problematic because certain therapists might be especially likely to attempt to elicit features of DID among patients with a history of severe abuse. In the Coons (1994) study, DID diagnoses were made only after medical histories and psychiatric records (many of which may have contained information regarding abuse histories) had been reviewed. Moreover, because standardized interviews were not administered in Coons and Milstein (1986) and were administered only to an unknown number of participants in Coons (1994), the possibility of diagnostic bias is heightened. Finally, the patients in Coons (1994) "were diagnosed personally by the first author over an 11 year period" (p. 106). Because there is no evidence concerning whether these patients had DID prior to treatment, the possibility of iatrogenic influence is difficult to exclude.[7]

Gleaves (1996) neglected or underemphasized several pieces of data that appear to call into question the veracity of some reports of child abuse in studies of DID and that underscore the importance of corroborating these reports. In the study by Ross et al. (1991), 26% of DID patients reported being abused prior to age 3, and 10.6% reported being abused prior to age 1. Similarly, Dell and Eisenhower (1990) noted that 4 of 11 adolescent patients with DID reported that their first alter emerged at age 2 or earlier, and 2 of these patients reported that their first alter emerged between the ages 1 of 2. Memories reported prior to age 3 are of extremely questionable validity, and it is almost universally accepted that adults and adolescents are unable to remember events that occurred prior to age 1 (Fivush & Hudson, 1990). It is possible that the memories reported in these studies were accurate but that they were dated incorrectly. Nonetheless, the nontrivial percentages of individuals in Ross et al. (1991) and Dell and Eisenhower (1990) who reported abuse and the emergence of alters at very young ages raise concerns regarding the accuracy of these memories.

In this context, it is worth noting that Ross and Norton (1989) found that DID patients who had been hypnotized reported significantly higher rates of sexual and physical abuse than DID patients who had not been hypnotized. Because there is little evidence that hypnosis enhances memory (Lynn, Lock, Myers, & Payne, 1997), this finding is consistent with the possibility that hypnosis produces an increased rate of false abuse reports. Nevertheless, this conclusion must remain tentative in view of the absence of independent corroboration of the abuse reports and the correlational nature of Ross and Norton's data.[8]

the opportunity for unintentional prompting was minimal and (b) events were typically assessed on only one occasion. In the therapeutic context, in which clinicians have ample and repeated opportunities to cue the emergence of abuse histories, the possibility of false memories is considerably more problematic.

[7] Lewis et al. (1997) recently reported findings from a study of 12 murderers with DID that, in the authors' words, "establishes, once and for all, the linkage between early severe child abuse and dissociative identity disorder" (p. 1703). Nevertheless, close inspection of their results reveals six problems: (a) Because violent individuals tend to have high rates of abuse in childhood (Widom, 1988), Lewis et al.'s findings are potentially attributable to the confounding of DID with violence; (b) the objective documentation of abuse provided by Lewis et al. was often quite vague (in several cases, there were indications only that the "mother [was] charged as unfit" or that "emergency room records report[ed] severe headaches"); (c) the objective documentation of childhood DID symptoms was similarly vague in many cases and was often based on the presence of imaginary playmates and other features (e.g., marked mood changes) that are extremely common in childhood; (d) diagnoses of DID were not performed blindly with respect to knowledge of reported abuse history; (e) the murderers' handwriting samples, which differed over time and were used by Lewis et al. to buttress the claim that these individuals had DID, were not systematically evaluated by graphoanalysts or compared with the handwriting samples of normals over time; and (f) the possibility of malingering (which may be a particular problem among criminals) was not systematically evaluated with psychometric indexes.

[8] Another reason for emphasizing the importance of corroborating the child abuse reports of DID patients is recent findings that high DES scorers (a) exhibited a response bias toward endorsing a large number of autobiographical memories on life events questionnaires, including memories of both negative and neutral life events (Merckelbach, Muris, Horselenberg, & Stougie, in press), and (b) were especially likely to accept misleading statements, including those dealing with autobiographical events (Öst,

Gleaves (1996) contended that "there have been no cases in the scientific literature where the alleged abuse in a patient with DID was found to be totally fabricated" (p. 54). To maintain this position, Gleaves would be forced to argue that most or all of the memories of satanic ritual abuse that have been recovered by a large proportion of DID patients (estimated by Mulhern, 1991, to be 25% as of the mid-1980s) are veridical. Nevertheless, federal law enforcement officials have been unable to detect the existence of satanic cults (whose purported crimes involve multiple murders, cannibalism, and bizarre human sacrifices) despite years of intensive investigation (Bottoms, Shaver, & Goodman, 1996; Hicks, 1991; Lanning, 1989). Although it is conceivable that a subset of satanic ritual abuse reports represent the memory overlay of actual abuse incidents (Loftus, 1997b), the burden of proof would appear to rest on Gleaves and others, rather than on critics of the PTM, to provide documentation of such incidents.

Interpretation of the child abuse–DID association. Even if the child abuse reports of most DID patients could be corroborated, several important questions arise concerning the interpretation of these reports. In particular, it remains to be determined whether a history of child abuse is (a) more common among DID patients than among psychiatric patients in general and (b) causally associated with risk for subsequent DID.

With respect to the first issue, base rates and referral biases pose potential difficulties for Gleaves's interpretation of the abuse data. Because the prevalence of reported child abuse among psychiatric patients in general tends to be high (see, e.g., Pope & Hudson, 1992), these data are difficult to interpret without a psychiatric comparison group. Moreover, the co-occurrence between reported abuse and DID could be a consequence of several selection artifacts that increase the probability that individuals with multiple problems seek treatment. Berksonian bias (Berkson, 1946) is a mathematical effect that results from the fact that an individual with two problems can seek treatment for either problem. Clinical selection bias (see du Fort, Newman, & Bland, 1993) reflects the increased likelihood that patients with one problem will seek treatment if they subsequently develop another problem. Either or both of these artifacts could lead to the apparent relation between child abuse and DID discussed by Gleaves. Indeed, Ross (1991) found that nonclinical participants with DID reported substantially lower rates of child abuse than did patients with DID recruited from a clinical population. This finding is consistent with the hypothesis that selection biases account at least partly for the high levels of co-occurrence between reported child abuse and DID. Moreover, Ross, Norton, and Fraser (1989) reported that American psychiatrists reported a substantially higher prevalence of child abuse among DID patients (81.2%) than did Canadian psychiatrists (45.5%). This finding suggests the possibility of biases in the assessment or elicitation of child abuse reports and raises questions concerning the claim that child abuse is necessary for most cases of DID (Spanos, 1994).

Gleaves (1996) dismissed[3] Spanos's (1994) argument that the relation between child abuse and DID, even if shown to be genuine, is correlational in nature and could be a product of unidentified third variables, such as adverse family environment. Gleaves likened the literature concerning the relation of child abuse and DID to the literature concerning the relation of trauma to PTSD: "the empirical support for the relationship between PTSD and trauma is also correlational. However, such a state of affairs would not seem to be a convincing argument that PTSD is not a posttraumatic condition" (Gleaves, 1996, p. 53). But this analogy is questionable. Many studies have revealed dramatically increased rates of PTSD shortly after objectively documented events, such as Hurricane Andrew (Garrison, Bryant, Addy, & Spurrier, 1995) and the 1988 Armenian earthquake (Goenjian et al., 1994). Thus, although the relation between trauma and PTSD is correlational, the (a) objective nature of the traumatic event, (b) immediacy of many individuals' reaction to this event, and (c) clear-cut link between the nature of the stressor and individuals' intrusive imagery provide compelling support for the assertion that this relation is causal in at least some cases. The relation between child abuse and DID is markedly different: the traumatic event is often neither clear-cut nor readily corroborated by objective evidence. Nor are there data demonstrating that this event is unambiguously followed almost immediately by the signs and symptoms of DID. Moreover, Gleaves's assertion (1996, p. 55) that most patients with DID meet criteria for PTSD borders on being tautological and begs the very question that is at issue: Is the child abuse genuine? If not, the diagnostic criteria for PTSD would not be satisfied, as this diagnosis requires exposure to a life-threatening or otherwise extremely dangerous event (APA, 1994).

Summary of the DID Literature: The SCM Reappraised

Gleaves (1996) concluded by recommending that "the sociocognitive model be abandoned as an etiological explanation of DID" (p. 54). Careful scrutiny of his central arguments, however, reveals that this conclusion is premature and unwarranted. Although Gleaves arrived at strong conclusions regarding the psychopathology of DID, the motivations of DID patients, and the efficacy of extinction treatments for DID, these conclusions appear to be based largely on uncontrolled and, in some cases, anecdotal evidence.

Moreover, several of the central premises of the PTM, such as the assumption that the prevalence of child abuse is substantially elevated among DID patients compared with other psychiatric patients, require more compelling data before they can be accepted. In particular, Gleaves's (1996) conclusion that "there does not appear to be any convincing reason to doubt the association between DID and childhood trauma" (p. 54) is not borne out by a careful examination of the evidence. Although a causal link between early abuse and DID cannot be excluded, studies that provide corroborated abuse reports, distinctions between continually recalled and recovered memories of abuse, and psychiatric comparison groups are needed to bring clarity to this methodologically complex area. In addition, causal modeling studies may help to rule out competing hypotheses for the high levels of co-occurrence between reports of early trauma and later DID and thereby provide more compelling support for the claims of the proponents of the PTM. If such abuse can be corroborated and shown to be correlated with risk for subsequent DID, such studies will be especially informative if they incorporate potential third variables that might account for this correlation, such as adverse early home environment.

Fellows, & Bull, 1997). Nevertheless, because the relevance of this literature to child abuse and to DID per se has yet to be established, it is not reviewed further here.

Although the relative paucity of data on the role of iatrogenic factors in DID renders a definitive verdict premature, several lines of evidence converge upon the conclusion that iatrogenesis plays an important, although not exclusive, role in the etiology of DID: (a) The number of patients with diagnosed DID has increased dramatically over the past several decades (Elzinga et al., 1998); (b) the number of alters per DID case has increased over the same time period (North et al., 1993), although the number of alters at the time of initial diagnosis appears to have remained constant (Ross, Norton, & Wozney, 1989); (c) both of these increases coincide with dramatically increased therapist awareness of the diagnostic features of DID (Fahy, 1988); (d) a large proportion or majority of DID patients show few or no clear-cut signs of this condition, including multiple identity enactments, prior to therapy (Kluft, 1984); (e) mainstream treatment practices for DID patients appear to verbally reinforce patients' displays of multiplicity and often encourage patients to establish further contact with alters (Ross, 1997); (f) the number of alters per DID case tends to increase over the course of DID-oriented therapy (Piper, 1997); (g) therapists who use hypnosis appear to have more DID patients in their caseloads than do therapists who do not use hypnosis (Powell & Gee, in press); (h) the majority of DID diagnoses derive from a relatively small number of therapists (Mai, 1995); and (i) laboratory studies demonstrate that nonclinical participants provided with appropriate cues can successfully reproduce many of the overt features of DID (Spanos et al., 1985). Given the high rates of preexisting mental conditions among DID patients (Spanos, 1996), however, it seems likely that iatrogenic factors do not typically create DID *in vacuo* but instead operate in many cases on a preexisting substrate of psychopathology, such as BPD.

We believe that each of these nine sources of evidence is fallible and that several (e.g., a, b, f, g, and h) are open to multiple causal interpretations. For example, the finding that the number of alters per case tends to increase over the course of therapy is potentially consistent with the assertion (Ross, 1997) that therapy for DID is often accompanied by the progressive uncovering of previously latent alters. Moreover, as Ross (1997) noted, several of these arguments are probably applicable to psychological disorders other than DID; diagnoses of PTSD, for example, have increased dramatically over the past two decades (Zohar, 1998). Nevertheless, the consilience of evidence across these nine quite diverse sources of data appears to provide an impressive, if not compelling, circumstantial case for the role of iatrogenic factors in DID. Moreover, Gleaves (1996) acknowledged that iatrogenic factors can produce additional alters, and Ross (1997) estimated that approximately 17% of DID cases are predominantly iatrogenic (see also Coons, 1989). Thus, the principal unresolved question appears to be not whether iatrogenesis sometimes plays a role in either the etiology or maintenance of DID but rather its relative importance compared with other potential causal variables, such as media influences, widely available cultural scripts regarding the expected features of DID, individual differences in personality and psychopathology, and perhaps early trauma. Further research examining the symptomatic characteristics of DID patients before and after treatment is needed to clarify this issue. Nevertheless, because proponents of the PTM, including Gleaves, have typically contended that the multiple identity enactments of DID patients typically remain hidden prior to treatment, they need to explicate what findings could potentially falsify the assertion (Gleaves, 1996, p. 42) that DID cannot be iatrogenically created.

Discussion: Recalling the Lessons of the Past

The diagnosis of DID has a short history but a long ancestry. Historically, dissociative and somatoform disorders were grouped together as subtypes of hysteria. Beginning with DSM–III (APA, 1980), these conditions were dissociated from each other, and the overarching construct of hysteria was eliminated entirely (Hyler & Spitzer, 1978). This decision was understandable, largely because the concept of hysteria was imprecise and ill defined. Nevertheless, the SCM suggests that the dissociation of dissociative and somatoform disorders may have been an error (see also Kihlstrom, 1994). These superficially different groups of disorders may reflect phenotypically different expressions of a shared diathesis (Goodwin & Guze, 1996; Lilienfeld, 1992). The underlying nature of this diathesis (e.g., fantasy proneness, absorption), however, remains to be determined. Slater (1965) similarly noted that many conditions that would today be subsumed under the rubric of somatoform and dissociative disorders can assume a variety of superficially different manifestations across individuals.

Moreover, the behavioral expression of these conditions may be shaped substantially by cultural and historical factors.[9] For example, *latah,* a condition characterized by sudden and transient episodes of profanity, command obedience, trancelike states, and amnesia, is limited primarily to women in Malaysia and Indonesia (Bartholomew, 1994). Conversion disorders were prevalent at the end of the 19th century but are apparently much rarer now (Jones, 1980). In moving from one fin de siècle to the next, DID may have replaced conversion disorders as the disorder in vogue (see Hacking, 1995). Although further research using external validating variables (e.g., family history, course and outcome, biological variables) is necessary to corroborate the hypothesis that DID, latah, and conversion disorders are expressions of the same underlying etiology, this hypothesis has the potential to unify a large number of disparate observations.

Veith (1965) argued that the manifestations of somatoform and dissociative conditions have changed dramatically over time in accord with prevailing cultural conceptions. For example, she observed that Victorian England in the 19th century experienced a marked increase in the prevalence of dramatic and unexplained somatic symptoms (e.g., paralyses, aphasias), which were subsequently displaced by less florid episodes of fainting ("the vapors"). Veith pointed out that

> the manifestations of [these conditions] tended to change from era to era much as did the beliefs as to etiology and the methods of treatment. The symptoms, it seems, were conditioned by social expectancy, tastes, mores, and religion, and were further shaped by the state of medicine in general and the knowledge of the public about medical matters. . . . Thus we have seen departures from and returns to the generalized convulsion, the globus hystericus, the loss of consciousness, the cessation of breathing. We have watched the

[9] Gleaves (1996) cited data indicating that DID had recently been diagnosed in the Netherlands and other European countries and invoked these data to dispute Spanos's (1994) contention that DID is a culture-bound condition. Nevertheless, without additional information regarding the accessibility of information about DID to the general public in such countries, these findings are difficult to interpret. In the Netherlands, for example, the writings of several well-known researchers (e.g., van der Hart, 1993; van der Kolk, van der Hart, & Marmar, 1996) have resulted in greatly increased media and professional attention to DID.

> acting-out of demonic posession and the vast variety of delusions related to it. (p. 209)

Most proponents of the PTM have not explicitly attempted to explain the cross-cultural and cross-historical manifestations of multiple role enactments and have instead focused primarily or exclusively on the etiology of DID per se. This is especially true of Gleaves's (1996) exposition of the PTM, which dethrones multiple identity enactment as the essential feature of DID and instead largely emphasizes secondary features (e.g., Schneiderian symptoms, depersonalization) not commonly found in other conditions characterized by multiple role enactments (e.g., transvestism, glossolalia; see Spanos, 1994).

The existence of social, cross-cultural, and historical influences on the manifestations of multiple role enactments may not in principle be incompatible with the PTM (Castillo, 1994) and may in fact represent one potential area of common ground between the PTM and the SCM. Ross (1997), for example, acknowledged that social psychological factors (e.g., therapist expectations) often play a role in the etiology and maintenance of DID (e.g., p. 81) and suggested that demonic possession may be a culture-bound variant of DID. In contrast, Gleaves's (1996) categorical rejection of the SCM (p. 54) leaves little room for the incorporation of sociocultural and historical influences into the PTM. To integrate such influences into the PTM, proponents of this model need to clearly articulate how the etiological variables (e.g., iatrogenesis, media influences) postulated by the SCM could interact with childhood trauma to produce DID, as well as how cultural and historical factors might differentially shape the phenotypic expression of multiple role enactments. As Bronowski (1978) noted, a number of the most significant advances in science stem from the demonstration that phenomena previously believed to be distinct are in fact interrelated. From this perspective, the SCM represents a step forward in the effort to address the puzzling question of why certain individuals display markedly different identities at different times.

By focusing primarily or almost exclusively on the overt manifestations of DID rather than on its commonalities with other conditions, many modern DID practitioners may unwittingly be repeating many of the errors of the past. For example, in the 1880s, Charcot believed that he had identified a new disease, "hystero-epilepsy," characterized by fluctuations in consciousness, seizures, and fainting spells. Charcot frequently displayed hystero-epileptics at conferences and accorded them special attention. Nevertheless, one of Charcot's students, Joseph Babinski, convinced Charcot that hystero-epilepsy was the inadvertent product of his mentor's creation. He persuaded Charcot to isolate hystero-epileptics from each other and from epileptics (they had originally been housed with epileptics and had begun to mimic their seizures) and to withhold attention from their dramatic symptomatic displays. Babinski's prescription worked (McHugh, 1993).

By reinforcing the multiplicity of DID patients, many modern therapists may be recapitulating Charcot's error. Moreover, by underemphasizing the possibility that DID is a *forme fruste* of the same psychological disposition underlying other multiple role enactments, Gleaves and some other proponents of the PTM may have erroneously reified one variant of a broader constellation of multiple role enactments into a distinct nosological entity (Fahy, 1988).

When viewed in historical context, the current epidemic of DID cases (Boor, 1982) may be neither as inexplicable nor as surprising as it appears. This epidemic does, however, impart a valuable lesson to today's psychotherapists. The well-replicated finding that psychotherapy, although generally effective (Wampold et al., 1997), can be harmful in a select number of cases (Strupp, Hadley, & Gomes-Schwartz, 1978) serves as a needed reminder that the clinician qua diagnostician and treatment provider can be the creator as well as the discoverer of psychopathology.

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