CLOVEN CONSCIOUSNESS:
DISSOCIATION IN HISTORY, THEORY, AND CULTURE

by
Karen E. Jackson
B.A., Simon Fraser University, 1998

Thesis Submitted in Partial Fulfilment
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Approval

Name: Karen Eileen Jackson

Degree: Master of Arts

Title of Thesis/Project: Cloven Consciousness: Dissociation In History, Theory And Culture

Examining Committee:

Chair: Lucy LeMare

______________________________
Jeff Sugarman, Assistant Professor
Senior Supervisor

______________________________
Janny Thompson, Associate Professor
Member

______________________________
Robert Ley, Associate Professor, Psychology
Member

______________________________
Dr. Susan James, Assistant Professor, Faculty of Education
University of British Columbia
Examiner

Date Approved: March 29th, 2004
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ABSTRACT

This thesis examines the concept of dissociation, tracing its historical development, considering the related concepts of unity and multiplicity in consciousness, and exploring manifestations of dissociation in both North American and non-Western cultures. The evolution of the diagnosis of hysteria is outlined, and its relationship to Dissociative Identity Disorder (DID) is discussed with reference to the work of Morton Prince and other prominent late 19th and early 20th century clinicians. An examination of cross-cultural aspects of dissociation is undertaken, with attention to the culture-bound syndromes, amok, ataque de nervios, latah, and kitsune-tsuki. It is argued that DID is manifested as a culture-bound syndrome. In view of this, the social and cultural influences on the expression of dissociative symptoms are identified, and some of the differences between collectivist and individualist cultures are reviewed. Aspects of the clinical phenomenology of DID are detailed, and the dissociative continuum is explicated as it is viewed by contemporary researchers. Additionally, the influence of the media on the shaping of dissociative symptomatology and the prevalence of DID is discussed. Contributions to the wealth of literature on dissociation have been made by physicians, sociologists, psychologists, and theoreticians from a number of other disciplines. Some of these writings are examined with respect to their implications for future research in the field.
DEDICATION

This thesis is dedicated to my twin sister, Gail.
Your courage inspires me daily.
Is multiple personality a real disorder as opposed to a product of social circumstances, a culturally permissible way to express distress or unhappiness? That question makes a presupposition that we should reject. It implies that there is an important contrast between being a real disorder and being a product of social circumstances. The fact that a certain type of mental illness appears only in specific historical or geographical contexts does not imply that it is manufactured, artificial, or in any other way not real. . .[We] must allow a place for historically constituted illness.

Ian Hacking

*Rewriting the Soul: Multiple Personality and the Sciences of Memory*
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PREFACE

This thesis is an attempt to understand Dissociative Identity Disorder (DID) as a product of the historical and socio-cultural context in which it is embedded and has its origins. Although the disorder was first recognized as a diagnostic entity in 1980 with the publication of the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 3rd ed., 1980)*, our conceptions of this illness have emerged over the course of several centuries. It remains largely a North American phenomenon. It is a gendered disorder, and a politicized one. Its symptomatology has been coloured, chameleon-like, by social forces, such as religious beliefs and sexual mores, and the impact of events such as the Vietnam War. Further, the nature of DID, indeed its very structure, may only be understood in terms of the evolution of ideas about identity and consciousness. This thesis is concerned with the meaning of dissociative symptoms, the forms they take in other cultures, and the historical, political, and social factors that have moulded their presentation in North American and other cultural contexts.

While a decontextualized approach to the understanding of dissociation may be possible, such an undertaking would paint a specious portrait. Examining as spectacularly complex a disorder as DID in “cross-section” might yield information about the structure of the disorder, but is likely to yield little or nothing about how and why that structure has evolved. It may yield information about its clinical phenomenology, but would do so in the absence of any grasp of the meaning of the clinical aspects of its presentation. It may yield information about the impact of dissociation on family members and friends of the individual, but little regarding the reciprocal interaction
between the dissociative individual and the wider social sphere, the social significance of symptoms, or their political utility. Therefore, the focus of this investigation is to examine the evolution of DID in historical and cultural contexts to permit its apprehension as a product of forces that have converged to sustain the very existence of the disorder itself and our ideas about its nature as it currently is perceived.

In the spirit of Cushman (1995) and Madison (1988), explicating DID as a social artefact will require a hermeneutic approach. Some authors begin their exposition of philosophical hermeneutics from the age in which Hermes, messenger of the Gods, fulfilled his obligation as deliverer of "announcements, warnings, prophecies" (Ferraris, 1996, p. 1). Although the hermeneutic approach was originally used to interpret biblical writings, Richardson, Fowers, and Guignon (1999) have articulated two phases of the evolution of early theological hermeneutics to its present conception. The first phase involved a transition from a belief in hermeneutics as bound to a specific type of text (i.e., literary or theological) to a belief that it may be applied to "all forms of human communication" (Richardson et al., p. 200). The second phase mirrored a belief that methodology is incompatible with hermeneutics. According to Richardson et al., this phase:

reflected the growing awareness that devising rules for interpreting humans is impossible and that the whole fascination with method is a by-product of the very scientism being called in question. The result was a shift from seeing hermeneutics as primarily epistemological or methodological, where the aim is to develop an art or technique of interpretation, to today's ontological hermeneutics, which aims to clarify the being of the entities that interpret and understand, namely, ourselves. (p. 200)

Indeed, some hermeneuticists skirt the issue of methodology, while others reject it altogether (Gadamer, 1992). I contend, however, that some adherence to method is necessary to deal with the immediate problem, which arises out of the work of
interpretation, which is that at some point some disagreement about meaning may ensue. In Madison's (1988) view, "methodological criteria are needed in order to arbitrate what Ricouer would call 'the conflict of interpretations'" (p. 27). Madison delineates two views of method, one formal, the other, normative. The former involves the application of method with the aim of discovering objective truths, making possible "exact knowledge" (p. 28). The scientific method is the quintessential manifestation of this approach. The latter view, however, invites interpretation with the aim of supplying reasons for the judgements that one makes. In the former approach, one tests interpretations: In the latter, "one evaluates them" (Madison, p. 29).

Madison (1988) outlines a number of criteria for the interpretation of a text which may be appropriate to a hermeneutic investigation of DID. Madison maintains, first, that the interpretation must be coherent; that is, it must present a cohesive picture of the author's work. Second, it must be comprehensive, presenting the perspective of the author as a whole and attending to all of those ideas that may have relevance to the issue being discussed. Third, it must be penetrating, extracting the central or foundational intentions of the author. Fourth, it must be thorough, reflective of an effort to deal with the questions "which the text poses to one's understanding" (p. 29). Fifth, the interpretation must be appropriate. It is not the questions that the interpreter brings to the inquiry that are the focus of hermeneutic investigation, but rather those questions that emerge from the very core of the text. Sixth, an interpretation must be historically and culturally contextual, and must be suggestive in terms of inciting yet further inquiry. Finally, an interpretation must have potential with respect to being "capable of being extended" (p. 30). While the criterion of historical and cultural contextuality is of particular significance in view of the subject matter of this thesis, the others also have
relevance. These criteria – whether they constitute “rules,” as Madison (p. 29) would have it, or method, against which Gadamer (1992) might recoil – will guide my investigation of dissociation. Method provides a systematized approach to the examination of a body of literature, which aids in ensuring that conclusions do not merely reflect subjective whim on the part of the investigator.

In a later section of this thesis, I have referred to hysteria as a “text.” Although the term “text” is used in a literal sense in the work of early hermeneuticists, it has a metaphorical gloss as well, which might be understood by relating the concept to that of a script. One of the definitions of “text” given in *Merriam-Webster’s Collegiate Dictionary* (1993) is “something written or spoken considered as an object to be examined, explicated, or deconstructed” (p. 1219). In the same source, a “script” is defined as “the written text of a stage play, screenplay, or broadcast; *specific*: the one used in production or performance” (p. 1050). What do we do with a script? We study it; we say what it tells us to say; we behave as it directs us to behave. We raise or lower our voice as it implores us; we gesticulate as it prescribes; we *perform* it. In Palmer’s (1995) terms, “there is basically a performative element in the hermeneutical process. One brings a text to life in the same way a conductor or pianist brings a score to life” (p. 11). As a performance, DID is scripted. There are certain expectations we have of those who have the disorder, certain prescribed ways in which the dissociative individual behaves. As will be discussed in the second chapter of this thesis, the script associated with hysteria also has prescribed components. Further, with respect to DID, the people with whom the dissociative individual comes into contact also play roles. They are, in essence, part of the same script, part of the same play. DID is a performance, and the individual with the disorder is part of the cast. Significantly, however, she is not the only one on stage, as
the disorder is both engendered and perpetuated in the context of reciprocal social interactions. Audience members, as I will discuss at length in the second chapter of this thesis, play a crucial role in sustaining hysterical symptomatology. If hysteria, and subsequently DID, are to be understood as text, then part of the fabric of that text is comprised of scripts which are enacted not only by the dissociative individual but also by those in the wider social context.

It is a short step from this assumption to assert that DID is socially constructed, an artefact of our highly individualistic culture and complex society. If a wide variety of personal experience, including that of dissociation, is primarily determined by cultural belief and social influence, then the very meanings of the concepts of “health” and “illness” may be considered to be derived “within practice, language, relationships, and roles” (Ussher, 2000, p. 216). Further, dissociative disruptions in what some authors view as the normally integrative processes of “thought, emotions, conation, memory, and identity” (Spiegel & Cardeña, 1991, p. 367) may also be considered to be culturally contextual. Social constructionist perspectives on DID stress the differences between the configuration of the self in collectivist and individualist cultures with particular attention to the boundaries of the self. It may be that the culture-bound valuation of uniqueness and separateness of the individual has an impact on the shaping of DID. In Madison’s (1988) terms, a coherent, comprehensive, penetrating, and thorough interpretation of the text constituting DID demands an examination of those aspects of individualist culture which play a part in the production of this intriguing disorder.
CHAPTER OVERVIEWS

Chapter 1: Dissociation in History

The term “dissociation,” first employed in medical usage by Benjamin Rush in 1816, was derived from the doctrine of associationism. In this chapter of the thesis, I will trace the development of the concept from its early roots in Aristotelian thinking to the present day. I will examine the contributions of the major associationists from which our present understanding of dissociation has emerged. DID is conceived as a disorder of identity (Ross, 1989; Steinberg, 1995). In view of this, I will outline some of the ideas of John Locke, William James, and others on the continuity of consciousness, which is fundamentally impaired in the dissociative. Further, I will discuss the evolution of the psychotherapeutic use of hypnosis, elaborating upon the use of the technique in early cases of DID with reference to the work of Morton Prince (1914) and other late 19th-century and early 20th-century clinicians.

Many factors contributed to the decline of interest in dissociation in the early decades of the 20th century, including the introduction of Bleuler’s diagnostic criteria for schizophrenia, Freud’s renunciation of hypnosis, and the rise of behaviourism. I will examine the impact of these events in addition to exploring some of the social and political factors which precipitated the resurgence of interest in DID and other posttraumatic disorders of the late 1900s. This chapter offers a historical review of the concept of dissociation and its early theoretical formulations, and an examination of the
contributions of major theorists with respect to the light they shed on our current understanding of DID.

Chapter 2: A History of Hysteria

The history of hysteria spans many centuries. In this chapter of the thesis, I will trace the history of the disorder from its roots in ancient Egypt to the present day, examining the beliefs that under-gird the progression of etiological theories about hysteria, and discussing the evolution of treatment procedures. Additionally, I will explicate the relationship between hysteria and DID with reference to the work of Janet, Freud, Breuer, and other clinicians. In Micale’s (1990) view, hysteria entails “an intriguing admixture of misogyny, sensationalism and pseudo-therapeutic abuse with astute clinical observation, pioneering neuropathological research and brilliant psychological theorizing” (p. 63). Accordingly, this chapter of my thesis will address not only the theoretical advances made in the field from the 17th century to the present, but also those aspects of the social and cultural milieu of each era which have shaped the disorder and contributed to its perpetuation.

This undertaking will involve an examination of the prevailing stereotypes of the female in each historical period, an exploration of the degree to which social expectancy may have generated hysterical symptoms, and a discussion of the role played by religious belief in both the production and interpretation of the primary stigmata of the disorder. For example, most of the women who were burned at the stake as witches during the 16th and 17th centuries are considered by contemporary researchers to have been hysterics (Fink, 1996). Further, I will discuss how approaches to treatment were consistent with beliefs about women.
In line with other culture-bound syndromes, hysteria and its contemporary counterpart, DID, are clearly pathologies of powerlessness, employed by those driven to express themselves through the non-verbal means of psychogenic symptoms in the absence of access to other modes of self-expression. A number of authors (Micale, 1990; Ng, 1999; Shirali & Bharti, 1993) have articulated hysteria as a form of social protest. This finds affinity with the views of other researchers with respect to culture-bound syndromes, such as latah and ataque de nervios (Bartholomew, 1997; Guarnaccia, Rivera, Franco, & Neighbours, 1996). In this chapter, I will also explore the relationship between doctor and patient, examining ways in which hysterical symptoms may have confirmed the mastery of the physician, and addressing the relationship between the overcrowding of the medical profession in the 19th century and the over-diagnosis of hysteria (Peterson, 1978).

**Chapter 3: Dissociation in Culture**

Culture comprises a set of beliefs, attitudes, and behavioural norms, which are transmitted from one generation to the next for purposes of adaptation and individual/societal growth. Culture-bound syndromes, or CBSs, are contextual patterns of aberrant behaviour, which occur only rarely beyond the geographical boundaries of the host culture. I contend that DID is a culture-bound syndrome that is both engendered and sustained by forces similar to those that contribute to the development and perpetuation of CBSs outside the North American cultural context, such as latah, amok, ataque de nervios, and kitsune-tsuki. I will examine the literature on these CBSs to identify similarities and differences between these conditions and DID. Additionally, I will review the literature on trance and possession syndromes, which are subsumed in the
DSM-IV (4th ed., 1994) under the rubric “Dissociative Disorder Not Otherwise Specified” (DDNOS; p. 390). In fact, latah, amok, and ataque de nervios are identified in DSM-IV (1994) as examples of possession trance. It may be, however, that trance and possession in other cultures cannot be assimilated into a Western psychiatric nosology, but must be evaluated on their own terms. Caution must be exerted when viewing these syndromes through Western eyes, as we may run the risk of pathologizing where pathology may not exist. Latah, for example, is not considered an illness by Malaysians.

There are several threads that run through the literature on the CBSs with respect to their social function. Some of these syndromes serve to reconfigure the individual's social world by mobilizing social support. In other instances they provide a mechanism by which social status is elevated (Crook, 1998; Eguchi, 1991; Guarnaccia et al., 1996). Further, as with hysteria, they may constitute a form of social protest, functioning to empower individuals or groups who may have no other socially-sanctioned form of self-assertion available to them (Bartholomew, 1994). DID may serve all three functions. In terms of elevation of social status, DID is seen by Van der Hart (1990) as a "high-status disorder" (p. 66), and by Lynn and Pintar (1997) as a “trendy diagnosis” (p. 5). During the 19th century, hysteria was considered a token of social distinction (Veith, 1965); a view that persists in the writings of contemporary authors who consider DID a diagnosis bestowed upon individuals who are highly intelligent and creative (Richards, 1990). There is no question that DID functions to garner social support, not only from family and friends of the afflicted individual, but also from members of the DID “subculture,” other patients to whom the individual has access through therapy and via the internet.
Finally, as with hysteria and the culture-bound syndromes, DID may provide individuals with a means of expression unavailable to them in other forms. Like hysteria and DID, the CBSs require the participation of a group. Like hysteria and DID, they precipitate a predictable set of responses from others. And, like hysteria and DID, the culture-bound syndromes are highly scripted, their elaborate choreography engaging others in the individual's social world in a kind of dance, a performance of shared meanings. In this chapter, I will explore the nature of these meanings for both the individual and other members of his or her cultural group.

Chapter 4: Dissociation in Theory

Since the 1800s there has been a renewed interest in medical circles in investigating organic bases for mental illness. The "medical model" (Gleitman, 1981, p. 662) in psychiatry epitomizes the view of psychopathology as biological in origin. This perspective has influenced much – or most – of late 20th century thinking about dissociation, and is reflected in scientistic formulations of the etiology of DID, its clinical phenomenology, and approaches to treatment. In this chapter I will outline the development of the medical model and the evolution of the professional discourse that surrounds it. I will argue that the discourse in which DID is embedded functions to reinforce the power differential between patient and physician, in much the same way that 19th century theatrical stagings of hysterical attacks affirmed the mastery of the physicians who choreographed them.

In a later section of the chapter, I will review the literature on the core symptoms of DID to provide the reader with a sense of the subjective experience of dissociation. The two etiological theories most commonly referred to in the literature will be
explicated, and a number of models of consciousness will be examined in light of the
evidence they provide for a view of the human psyche as non-unitary in normal
individuals. The literature review undertaken in this chapter will underscore for the
reader the tenacity with which many contemporary clinicians cling to reductionistic views
of DID and the factors implicated in its genesis and perpetuation.

**Chapter 5: The Social Construction of DID**

A number of forces have converged in recent decades to create a socio-political
atmosphere in which DID has taken on the status of a social movement. The rise of
feminism and the Vietnam War, in particular, raised public and professional awareness
of the effects of trauma on the long-term psychological wellbeing of its victims. They
generated a deluge of research into post-traumatic syndromes, such as Post-Traumatic
Stress Disorder (PTSD) and DID. In this chapter, I will outline some feminist
contributions to the advancement of knowledge about the effects of trauma and review
some of the pivotal early research on combat neuroses and other "stress response
syndromes" (Horowitz, 1976, p. 81). Public and professional acknowledgment of the
reality of child maltreatment, along with its politicization, have created a climate in which
individuals may wear their diagnosis of DID, if not with pride, most certainly with the
assurance that it is socially validated. As Hartocollis (1998) notes:

> In light of the politicized contemporary view of child abuse as a widespread
social ill perpetrated on hapless victims it becomes clear why unlike other
historically defined 'women's disorders' such as hysteria and borderline
personality disorder, multiple personality disorder has taken on a certain
heroic, dignified quality. (p. 163)

There is frequent reference in the literature to issues of iatrogenesis and faking of
DID, and the field is divided with respect to considerations of the degree to which
suggestion is implicated in the genesis of the disorder and the frequency with which it is faked for secondary gain. I will explore some of the differences between genuine and malingered DID as discussed in the literature, and will examine some of the ways in which the faking of overt symptoms differs from the disorder as an enduring syndrome. Further, I will discuss the role of the therapist in the creation and perpetuation of dissociative pathology.

In the past 2 decades, biographical and autobiographical accounts of DID have proliferated, along with made-for-television and home videos about the disorder. The book *The Three Faces of Eve* (Thigpen & Cleckley, 1957) marked the first appearance in the popular press of what was later to be termed “Multiple Personality Disorder” in *DSM-III* (1980). The publication of *Sybil* (Schreiber, 1973) stirred public interest in DID and was followed, according to North, Ryall, Ricci, and Wetzel (1993) by an epidemic of copy-cat productions of the disorder by individuals who had seen the film and, accordingly, presented themselves at physician’s offices with symptoms of “multiplicity.” The ready availability of books and, more recently, videos, in combination with public exposure to the disorder in the form of television talk shows about the subject and computer websites for dissociatives, means that the lay public have probably formulated some idea about what it means to be “multiple.” In this chapter, I will examine some of the popular media depictions of DID in terms of how they provide scripts for dissociative behaviour.

I contend that the recent resurgence of interest in dissociation has been paralleled by a concurrent fascination with recovery from the emotional “wounding” which, according to some authors (Bradshaw, 1990; Whitfield, 1989), is the result of stress and conflict affecting the majority of North American families. This, in turn, has
produced a rash of publications pertaining to such self-styled recovery movement "diagnoses" as "co-dependency" (Beattie, 1987, p. 17) and, in particular, to the healing of the "inner child" (Whitfield, p. 9). The inner child is quite clearly a simplistic metaphor for multiplicity, and the enormous popularity of books featuring this motif has likely contributed to the over-diagnosis of DID by practitioners, and self-diagnosis of the disorder by susceptible individuals. In this chapter, I will review some of the literature on the inner child from a critical perspective with the aim of clarifying the manner in which it portrays the purportedly inherent multiplicity in all of us.
CHAPTER 1: DISSOCIATION IN HISTORY

Introduction

In this chapter, I will trace the history of the concept of dissociation from its roots in Aristotelian thinking to the present day, with emphasis on the doctrine of associationism. I will examine the function of association as it is represented in early theory, and explore its relation to views of the nature of identity and consciousness in the work of William James (1890) and others, to explicate the relationship between the process of association, the concept of unity of self, and psychopathology as it was viewed in early theory. I contend that the North American conception of self as a discrete, bounded entity has evolved from the work of Locke and succeeding theorists. A view of the individual with DID as one who is split into many selves is predicated on the assumption of a pre-existing, unified self. Something – or someone – with the capacity to dissociate must first have been associated. The work of the theorists reviewed in this chapter reflects a belief in an inherent integrity of the human psyche. This belief advances a view of disunity of consciousness, epitomized by DID, as pathological, and encourages the interiorization of mental illness in the absence of any consideration of the social and cultural factors which may shape its presentation.

The Associationists

John Locke, in 1690, first used the phrase “association of ideas” (1690/1988, p. 394), to underscore the importance of the principle of association as a critical operation
of the human mind. He noted that the confusion by persons of “two different Ideas, which a customary connexion of them in their Minds hath to them made in effect but one, fills their Heads with false Views, and their Reasonings with false Consequences” (p. 401). Thus, according to associationists, if the emergence of memories into conscious awareness is a function of the process of association, then memories that are unavailable to consciousness must be considered dissociated (Wright, 1997). The concept of dissociation has more recently commanded the attention of clinicians from a number of fields, including psychology, medicine, and sociology, resulting in the increasing prevalence of the diagnosis of dissociative disorders – particularly DID and its variants – in the general population.

Dissociation is defined by Tinnin (1990) as “an obligatory self-deception supporting the conscious sense of mental unity in the presence of a competing source of identity and volition” (p. 157) and by Spiegel and Cardeña (1991) as “a structured separation of mental processes . . . [such as] . . . thoughts, emotions, conation, memory, and identity that are ordinarily integrated” (p. 367). Dissociation is experienced as being outside conscious control, and dissociated memory is experienced as inaccessible. As a resurgent topic of interest to contemporary researchers, the dissociative disorders raise many questions. What were the reasons for the decline in interest in dissociation in the early- to mid-20th century? What were the socio-cultural factors that contributed to the wave of renewed interest in dissociation during the late 1900s? What is the evidence for viewing DID as a culture-bound syndrome? What are the cultural influences that produce and sustain the disorder? How is dissociation viewed in other cultures? Are there forms of dissociative experience that are pan-cultural? Are there cultures in which dissociation is viewed as normal or even desirable? Can the symptoms of culture-bound syndromes
other than DID be construed within a dissociative paradigm? At what point should
dissociation be considered pathological? Should it be considered pathological simply
because it is outside the range of typical human experience? Should it be viewed as
maladaptive when it can also be seen as the highly adaptive response of an individual to
an otherwise intolerable situation? Should the popular, and perhaps culture-bound,
concept of an integral, unitary "I" be re-evaluated? These questions have implications for
the treatment of dissociative individuals and for how they are perceived by others. They
raise a number of issues, some of which were addressed by early theorists, whose work
provided the foundation for later research in the field, and through an examination of
whose writings the concept of dissociation may be better understood.

**Aristotle**

Themes of association and dissociation permeate Western philosophical and
scientific inquiry. Aristotle, in the 4th century BC, described a mind dichotomized, the
structure of the passive mind being sculpted by the forms acquired by way of imagery
and sensation, the active mind being separable from matter and functioning to potentiate
that which the passive mind has received (Mujeeb-ur-Rahman, 1990).

In discussing the functions of the active and passive mind, Aristotle makes a
distinction between potentiality and actuality. Potentiality rests with the passive mind,
which contains abstract universals, ideas or images of the essence of an object.
Knowledge of these universals is actualized – made manifest – by means of the
operations of the active mind, which is immortal, transcending death (Leahey, 1992).

In Aristotle's view, it is the active mind, which enables us to think and to pursue
knowledge. The mind is the rational aspect of the soul. The process of recall is an
operation of the active mind, involving what Aristotle termed "deliberation," the search for related ideas (Carlson, 1986, p. 14). He identified three associative laws that play critical roles in imposing order on ideas: similarity, contrast, and contiguity. These function to facilitate memory such that the thought of a particular object awakens recollection of an object that is similar to, distinct from, or contiguous with it. Additionally, he maintained that recall was more accurate if there existed a strong emotional connection with the original object. Memory, in Aristotelian thinking, constitutes more than simple retention, for retention is passive, while recollection is active, a voluntary process by which one idea embodies the stimulus for a whole sequence of other ideas (Brett, 1965). Thus, memory is a process involving the association of ideas. To have memory, there must be both a temporal sense, that is, an awareness of the passage of time, and the awareness of a particular perception. Recall involves an active search the aim of which is to recover past perceptions.

In the De Memoria, Aristotle (1906) states:

The occurrence of an act of recollection is due to the natural tendency of one particular change to follow another. If the sequence is necessary, it is clear that, on the former change occurring, the second will be summoned into activity; when, however, the connection is not necessary but due to custom, the occurrence of the second process will take place only in most cases. It so happens that some people receive a greater bent from a single experience than others in whom the sequence has frequently taken place, and hence, in some instances, after seeing the things once, we remember them better than others who have seen them frequently. Thus, when we recollect, one of our previous psychic changes is so stimulated which leads to the stimulation of that one, after which the experience to be to be recollected is wont to occur. Consequently, we hunt for the next in the series, starting our train of thought from what is now present or from something else, and from something similar or contrary or contiguous to it. (p. 109)
Recollection is thus an act of volition, the capacity for which Aristotle believed to be unique to human beings. He considered recollection to be a process superior to memory because “it involves a voluntary act of inference” (Spicer, 1934, p. 93).

In Aristotle’s view, memory is a repository of images that represent past experience. For him, a unitary sense of identity was comprised of innumerable memories, which combined to afford the individual a continuity of experience. He viewed identity as the capacity to locate oneself in the present moment while simultaneously maintaining an awareness of historicity and a sense of the future, and asserted that this constitutes one’s ordinary daily consciousness (Brett, 1965). This ability to locate oneself along a continuum of sequential time is fundamentally impaired in the dissociative individual, and an examination of the nature of this impairment has been a focus of attention by Frances, Sacks, and Aronoff (1977), Fink (1988), Tinnin (1990), Shoda (1993), and other researchers some 2,300 years after Aristotle.

**Descartes**

In the early 1600s, Descartes postulated that the universe was composed of two substances, consciousness and matter, and that human acts thus fell into one of two categories: the mechanical, consisting of causal associations between stimuli and neuromuscular reactions; and the rational, consisting of volitional acts made possible by faculties of judgement and choice (Murphy, 1930). Like Aristotle’s active mind, the Cartesian mind is a thinking entity, independent of physical processes. Modes of thought include sensations, perceptions, judgements, and intuitions, all of which constitute consciousness, the existence of which is, for Descartes, self-evident.
Descartes presumed the sense of self to be innate (Brett, 1965). Such innate, or inborn, ideas are contrasted in Cartesian thought with derived ideas, which arise from experience. The objective world comes to be known "through rational self-contemplation" (Hill, 1995, p. 265). In developing his epistemological dualism, which held that the body was a material, or extended substance, while the mind was of a spiritual, unextended nature, he devised an explanation for the interaction between the two. Descartes posited the pineal gland, situated deep within the brain, as "the seat of the soul" (Murphy, 1930, p. 10). The soul thinks, remembers, and wills independently of the body, yet, in Descartes' view, its union with the body makes possible the functions of imagination and instinct (Brett, 1965). The body, in Cartesian thought, is a machine, its functions and movements facilitated by animal spirits. Produced in the brain and enabled by heat from the heart, these animal spirits travelled along tubular neural pathways and blood vessels, producing bodily movements (Brett, 1965; Misiak, 1966). Further, they play a crucial role in the Cartesian conception of the process of recollection. As Hothersall (1984) notes:

Descartes believed that a particular experience produces alterations of the nervous system and that these alterations, or neural traces, have effects upon the mind when it recalls experiences. His analogy for the way in which memories are formed is characteristically original. Descartes imagined that the passage of animal spirits through certain pores in the brain forces open those pores and produces a lasting representation of their path. He compared the pores to the holes made in linen cloth by punching it with needles. When the needles are withdrawn the holes stay partially or completely open. The "memory" of the needles lingers on. When the mind seeks to recall something this volition causes the pineal gland to change its inclination from one side to the other, thus causing animal spirits to flow through the enlarged pores. (p. 30)

Further, Descartes affirms the existence of a thinking self in terms of the unity of consciousness. Self is a thing whose essence is comprised of the capacity to reason, to
apprehend, to reflect. It is this capacity which, in Descartes' (1641/1968) view, constitutes being:

I am — I exist: this is certain; but how often? As often as I think; for perhaps it would even happen, if I should wholly cease to think, that I should at the same time altogether cease to be. I now admit nothing which is not necessarily true: I am therefore, precisely speaking, only a thinking thing, that is, a mind (mens sive animus), understanding, or reason, — terms whose signification was before unknown to me. I am, however, a real thing, and really existent, but what thing? The answer was, a thinking thing. (p. 33)

Following Aristotle, Descartes postulated an association between feelings and ideas, contending that recall of a given event involves the merging of thoughts of that event and the feelings connected with it (Brett, 1965). Further, he held that events experienced by the individual as traumatic had impact on his or her behaviour long after they had been forgotten (Van der Kolk & Van der Hart, 1989).

**Thomas Hobbes**

Significant though Descartes' contribution may have been, it was the work of his contemporary, Thomas Hobbes, and succeeding empiricists that provided the foundation for the psychology of the 19th century and, with it, a surge of interest in dissociation. For Hobbes, all knowledge is derived from the senses (Roback, 1961). Thus, all behaviour is fully determined by material causes. He avoided Descartes' interactionism, proposing that human nature is entirely mechanical. Further, all mental activity, according to Hobbes, is contingent upon motions within the brain that are governed by external stimuli. Descartes had postulated that the soul, via the pineal gland, effected the passage of impulse along neural pathways, but Hobbes did not hold to the concept of the soul as a mediating influence, maintaining instead that it was solely movement within the brain itself which produced sensation (Murphy, 1930). For Hobbes, there is no
distinction between the will to undertake a given action and its execution. He addresses the issue of the association of ideas holding that: “In the imagining of anything, there is no certainty what we shall imagine next; Only this is certain, that it shall be something that succeeded the same before, at one time or another” (Hobbes, 1651/1968, p. 94).

In line with Aristotle, Hobbes (1651/1968) asserts the importance of the associative principle of contiguity, or, in his terminology, “Cohaerance” (p. 95) as fundamental to mnemonic processes, and articulates an elaborate example whereby the thought of war is succeeded by the thought of the value of a Roman penny by virtue of an intervening sequence of tangentially-related ideas. Further, he writes of imagination and memory as synonymous, maintaining that imagination constitutes a “decaying sense” (1651/1968, p. 88), and that memory comprises the expression of that decay, such “that the Sense is fading, old, and past” (p. 89). The process of recall, or “Remembrance” (p. 96) as Hobbes terms it, is nothing more or less than a process of seeking what has been lost. Hobbes describes the manner in which the individual derives both ideas and memory through principles of mechanical association. He posits that human action is generated by antecedent processes: Fear and desire are internal motions that produce action, and sensation is the product of motions that act upon organs of sensory reception. Additionally, Hobbes makes a distinction between directed purposive thought and spontaneous uncontrolled association, holding that the latter is “Unguided, without designe and inconstant . . . “ while the former “. . . is more constant; as being regulated by some desire, and designe” (p. 95).
It was John Locke (1690/1988), however, who first linked dissociated ideas to psychopathology, stating that:

This Wrong Connexion in our Minds of Ideas in themselves, loose and independent of one another, has such an influence, and is of so great force as to set us awry in our actions, as well Moral as Natural, Passions, Reasonings, and Notions themselves, that, perhaps, there is not any one thing that deserves more to be looked after. (p. 397)

In addition to the association of ideas, Locke also describes dissociative behaviour in his example of a musician who finds, once he has begun to audiate a tune, not only that the ensuing portion of the melody follows in orderly progression, but also that he is able to perform it while allowing his thoughts to roam elsewhere.

Refuting the concept of innate ideas as they had been represented in Cartesian theory, Locke posits the mind “as a blank state (tabula rasa)” (Leahey, 1992, p. 101), inscribed by experience. The source of all ideas is sensation and reflection, reflection being “that notice which the Mind takes of its own Operations, and the manner of them, by reason whereof, there come to be Ideas of these Operations in the Understanding” (Locke, 1690/1988, p. 105). He divides ideas into the simple and the complex, the latter comprised of combinations of the former. A complex idea is developed through a process of combining and abstracting the elementary aspects of experience contained in a simple idea. As Locke (1690/1988) asserts:

First, Our Senses, conversant about particular sensible Objects, do convey into the mind, several distinct Perceptions of things, according to those various way, wherein these Objects do affect them: And thus we come by those Ideas, we have of Yellow, White, Heat, Cold, Soft, Hard, Bitter, Sweet, and all those which call sensible qualities, which when I say the senses convey into the mind, I mean, they from external Objects convey into the mind what produces there those Perceptions. This great Source, of most of
the *Ideas* we have, depending wholly upon our Senses, and derived by them to the Understanding, I call *SENSATION*. (p. 105)

Thus simple ideas are irreducible. The existence of complex ideas, however, underscores the importance of the principle of association in Lockean thought. As with the process of recall in Aristotle's theory, Locke posits a volitional component in the construction of complex ideas; they are the "voluntary creations of the mind" (Alexander, 1908, p. 36). Regarding complex ideas, Locke (1690/1988) maintains that "we may observe, how the Mind, by degrees, improves in these [simple ideas], and advances to the Exercise of those other Faculties of *Enlarging, Compounding, and Abstracting* its *Ideas*, and of reasoning about them, and reflecting upon all of these" (p. 117). Examples of complex ideas provided by Locke include beauty, gratitude, and the universe.

Locke's greatest contribution with respect to our current understanding of dissociation, however, was in his explorations of the nature of consciousness and identity. He finds affinity with Aristotle in his view of the continuity of consciousness as a fundamental quality of human existence, considering it to be predicated upon the uniquely human capacity to reason and to reflect, and holding that it is memory which permits individuals to locate themselves in time and place. Consciousness reaches back in time to past action and thought, and forward to anticipate future thought and action. In Locke's (1690/1988) view:

> the same consciousness [unites] those distant Actions into the same *Person* . . . For it is by the consciousness it has of its present Thought, and Actions, that it is *self* to it *self* now and so will be the same *self* as far as the same consciousness can extend to Actions past or to come. (p. 336)

For Locke, personal identity is determined by consciousness. One cannot be the same individual without the same consciousness. Thus, in Locke's view, the dissociative individual has more than one identity. In addressing the issue of what would be termed
“double consciousness” by 19th century theoreticians (Gravitz & Gerton, 1984, p. 108), Locke provided a foundation for later research into the relationship between memory and identity. If the essence of personhood is continuity of consciousness, and if unity of personality is a function of memory, then an interruption to consciousness, in the form of a lapse of memory (a “fugue” state) will result in a disturbance in the sense of self.

If the essential quality of personal identity is continuity of consciousness, then without consciousness there is no identity; indeed, there is no person (Locke, 1690/1988). Thus, when the same consciousness is preserved, the same identity is preserved. The individual who is conscious of actions past and present is the same individual to whom those actions, and the responsibility retained for them, belong. Is it possible, queries Locke, that the same material substance, the same body, can house different persons? He notes the forensic implications of such a hypothesis:

If the same Socrates working and sleeping do not partake of the same consciousness, Socrates waking and sleeping is not the same Person. And to punish Socrates waking, for what Socrates thought, and waking Socrates was never conscious of, would be no more of Right, than to punish one Twin for what his Brother-Twin did, whereof he knew nothing, because their outsides were so like, that they could not be distinguished; for such Twins have been seen. (p. 342)

Further, Locke (1690/1988) makes reference to what contemporary clinicians term the “amnestic barriers” of the dissociative, in postulating that “two distinct incommunicable consciousnesses” (p. 344) may occupy the same body in an individual who has experienced periods of amnesia over an extended period of time.

David Hartley

David Hartley, in the mid-1700s, used principles of association to describe the manner in which the subjective experience of sensation is the result of a stimulus acting
upon the organism and producing “vibrations,” disturbances of the nerves (Brett, 1965, p. 437). These vibrations travel, unobstructed, along the nerves to the brain, whence they proceed to the muscles in an unbroken causal chain. Hartley had a background in medicine, and as a result his orientation is grounded in principles of physiology to a greater degree than that of other associationists (Hothersall, 1984). In articulating his theory of vibrations, he ascribes great importance to the medulla oblongata, that part of the brain now known to house nerve centres for both sensory and motor neurons. Far from subscribing to the Cartesian doctrine of animal spirits, Hartley asserts that the nerves are not tubular entities through which such fluids may pass, but rather are solid, facilitating the transmission of vibrations (Brett, 1965, p. 438). In Hartley’s (1749/1976) terms:

Sensibility, and the Power of Motion, seem to be conveyed to all the Parts, in their natural state, from the Brain and spinal Marrow, along the nerves. These arise from the Medullary, not the Cortical part, every-where, and are themselves of a white medullary Substance. (p. 7)

Further, in Hartley’s (1749/1976) view, alterations in the medullary matter engender corresponding changes in our ideas, for “The white medullary Substance of the Brain is also the immediate Instrument, by which Ideas are presented to the Mind” (p. 8). Adhering to the Lockean conception of the complex idea, Hartley maintains that simple ideas derived from sensation, such as warmth, taste, or smell, form the foundation for complex, or “intellectual” (1749/1976, p. ii) ones.

Hartley also gave attention to the association of ideas contending that: “The influence of association over our Ideas, Opinions, and Affections, is so great and obvious, as scarce to have escaped the Notice of any Writer who has treated of these” (Hartley, 1749/1976, p. 65). In writing of association, Hartley distinguishes two
fundamental types of associative process (Leahey, 1992). Successive associations are
developed when sequences of ideas occur, one following another, and so become
associated. Simultaneous associations are the result of ideas that occur frequently and
synchronously. These two types of association form the foundation for Hartley's view of
memory. Like Descartes' needles in linen cloth, or Hobbe's "decaying sense" (Hobbes,
1651/1968, p. 89), the faint trace of subsiding sensory vibrations "are the sources of
memory and imagination" (Watson & Evans, 1991, p. 208). When occurring either
simultaneously or successively, two sensations become connected in such a way that
"when one is evoked again, at a later time, the vibrations extend to the other" (Watson &
Evans, 1991, p. 209): The more intense the vibration, the stronger the association
between them. Finding affinity with Aristotle, Hartley (1749/1976) views the process of
recollection as a volitional act, maintaining that:

When a Person desires to recollect a thing that has escaped him, suppose
the Name of a Person, or visible Object, he recalls the visible Idea, or some
other Associate, again and again by a voluntary power, the Desire generally
magnifying all the Ideas and Associations; and thus bringing in the
Association and Idea wanted, at last. (p. 381)

David Hume

Toward the latter part of the 18th century, David Hume developed Aristotle's
notion of association in terms of three principles (Anderson, 1966). Resemblance
between ideas means that one idea engenders another similar one. In his discussion of
imagination, Hume expounds upon the principle of contiguity. Hume's belief is that
objects of imagination change as a function of contiguity; that we conceive ideas which,
at the very least, are tangentially related one to the other. Cause and effect occupy a
more prominent place in Hume's theory. Both are predicated on the principles of
resemblance and contiguity. The concept of causation arises from the repeated association of two elements. Through the consistent conjunction of similar objects, one becomes expectant, upon seeing one object, of seeing the other. Diverging from Hartley, Hume (1748/1965) reverts to the Cartesian conception of animal spirits, maintaining that when we have an idea, these spirits flow through the brain, running into its "contiguous traces" (p. 60), and reviving any ideas that are related to it. Finding further affinity with Descartes' view of animal spirits flowing in accordance with the varied inclination of the pineal gland, Hume holds that the motion of these spirits is seldom direct, and that it is this imprecision which accounts for the manner in which an idea other than that which was originally sought may present itself.

Hume, like Aristotle and Locke, proposes a theory of identity (Robinson, 1982). Unlike his predecessors, however, he limits the notion of self to little more than a set of causally related perceptions connected by means of the associative principles that form the foundation of his thesis. Hume states that the ascription of identity is erroneous if considered to consist of anything more than successive perceptions, and that the nature of the identity that we confer upon plants and animals is no different qualitatively than that which we ascribe to human beings. In Hume's terms, "The identity, which we ascribe to the mind of man, is only a fictitious one, and of a like kind with that which we ascribe to vegetables and animal bodies" (Hume, 1748/1965, p. 259). Hume gives little credence to the concept of consciousness, but does address the issue of continuity of awareness. Following Locke, he highlights the importance of memory, asserting that its function is to acquaint us with "the continuance and extent of this succession of perceptions" (Hume, 1748/1965, p. 261), and that, without it, we have no knowledge of the chain of cause and effect of which our identity is comprised.
Johann Herbart

In the early 19th century, Johann Friedrich Herbart constructed a system of principles to explain how fragments of experience come to be connected through the influence of certain mental forces which act by combining them into wholes to form complex ideas (Murphy, 1930). Herbart's system of psychology was derived from metaphysics (Watson & Evans, 1991). He conceived of the universe as comprised of independent elements, which he termed "reals" (Pillsbury, 1929, p. 140). These reals embody forces that interact with each other. The human soul itself is a real. In line with Locke, Herbart (1996) concedes the existence of simple, or elementary, ideas, contending that mental life consists of the "action and interaction" (cited in Benjafied, p. 49) of concepts or sensations such as taste and colour.

In Herbart's view, elementary ideas may interact in one of two ways. They may form into wholes in a manner similar to that by which Locke's simple ideas form complex ones, or, if incompatible, they may "come into relation with each other through conflict or struggle" (Murphy, 1930, p. 47). Herbart held, moreover, that fragments that are not compatible do not combine but rather remain in conflict with each other. Those ideas that are in opposition to others may be repressed from consciousness to resurface later. He felt that some ideas tend more than others to be brought into conscious awareness, and that there are a number of psychic forces at play in the human mind, any one of which may contribute to recall of repressed ideas.

Herbart's formulation constitutes a theory, if somewhat primitive and mechanistic, of the unconscious, with contents of conscious and unconscious minds clearly delineated. Forgotten ideas lie below the threshold of consciousness when stronger
ideas oppose them. Ideas that are associated draw each other toward conscious awareness, while dissonant ones remain unconscious. Anticipating the Freudian model of conscious, preconscious, and unconscious, Herbart proposed that there are three ways in which fragments of experience may be related to consciousness (Murphy, 1930). They may reside in the conscious mind, they may hover at the level of the boundary between conscious and unconscious, or they may remain unconscious. In Herbart's view, however, no idea is ever lost. An unconscious idea may surface if the ideas that oppose it should weaken, or if it becomes conjoined to another idea by means of an associative process.

James Mill

James Mill, a contemporary of Herbart’s, propounded the thesis that ideas and sensations represent different states of consciousness (Flugel, 1964). Mill’s theory represents the extreme of associationist thinking in that he believed the process of association to be entirely responsible for the structure of the mind. All other processes of association, including similarity, are reducible to the single principle of contiguity. Memory is merely one’s mental representation of an object and the idea of one’s past experience of it. To have an experience is to be conscious of it. Consciousness is a repository of ideas and feelings, comprising nothing more than the awareness of ideas of one’s own previous states, whether cognitive or affective. There is no “I” beyond this awareness. Thus, for Mill, considerations of the nature of identity are superfluous.

Locke’s influence on Mill’s thinking can be read clearly in Mill’s theory. Finding affinity with Locke (1690/1988), his successor viewed the mind as a passive, empty slate, receptive to simple sensations which form the units from which complex ideas are
constructed. Sensations lead to ideas, from which arise trains of associated thoughts. Indeed, ideas are copies of sensations. In line with Hobbe's concept of "Cohaerance" (1651/1968, p. 95), Mill (1829/1967a) maintains that:

Thought succeeds thought; idea follows idea, incessantly. If our senses are awake, we are continually receiving sensations, of the eye, the ear, the touch, and so forth; but not sensations alone. After sensations, ideas are perpetually excited of sensations formerly received; after those ideas, other ideas: and during the whole of our lives, a series of those two states of consciousness, called sensations and ideas, is constantly going on. I see a horse: that is a sensation. Immediately I think of his master: that is an idea. (p. 70)

Mill gave attention, as had Aristotle and Locke, to the function of the continuity of memory and its relationship to identity. In his thinking, the notion of self is a consequence of memory. Further, and again in line with Locke, he holds that "Identity and Sameness are equivalent terms" (1829/1967b, p. 165). The idea of self connects the fleeting feeling of the moment with the memory of previous feelings. Yet this is a mechanistic conception, for Mill's theory leaves no room for agency; the exercise of will is merely an illusion. His treatment of the concept of self is embedded in his discussion of the relationship between consciousness and sensation:

Those psychologists who think that being conscious of a feeling is something different from merely having the feeling, generally give the name Consciousness to the mental act by which we refer the feeling to ourself; or, in other words, regard it in its relation to the series of many feelings, which constitutes our sentient life. Many philosophers have thought that this reference is necessarily involved in the fact of sensation: we cannot, they think, have a feeling without having the knowledge awakened in us in the same moment, of a Self who feels it. But of this as a primordial fact of our nature, it is impossible to have direct evidence. (p. 229)

Another of Herbart's contemporaries, Scottish philosopher Thomas Brown, proposed a number of "secondary laws of association" (Flugel, 1964, p. 22) that were to provide a springboard for later research on memory. Brown's laws consider that, among
other factors, the recency with which events have occurred, the fluctuations in an individual’s mood, and the frequency of a given association between two elements have significant effects upon the strength of that association and the individual’s capacity for recall.

Much of the associationist theory focuses on the function of memory in the service of the development of a cohesive sense of self, and Cartesian and Aristotelian formulations of memory give prominence to the concept of volition. The dissociative disorders are conceived of as disorders of identity, in which the unifying element of a continuous historical memory is impaired, and the sense of agency may be absent. Further, early theory implies the existence of a unified self, and the concept of dissociation is predicated on just such a thesis. Something, or someone, capable of being divisible – in the instance of DID, into different sub-selves – must originally have been unified. The early clinical literature draws attention to the lapses of consciousness that constitute dissociative fugue states, and focuses attention on the relationship between dissociated thoughts and ideas and their role in the production of psychopathology. The work of Rush, Janet, and others, to be discussed in the next section of this chapter, reflects the 19th century trend toward an examination of the process by which ideas become dissociated, culminating in the theoretical formulation of the syndrome associated with hysteria which was proposed by Janet.

**The Reynolds Case**

While Mill, Brown, Herbart, and other theorists recapitulated and reformulated the associative principles that were to become the guiding force in psychology by the late 19th century, one medical practitioner of the early 1800s turned his attention to the
consideration of factors which precipitate the association of perceptions or ideas that are unrelated. In his treatise *Medical Inquiries and Observations Upon the Diseases of the Mind*, Benjamin Rush (1812/1962) referred to dissociation as a condition in which "ideas, collected together without order" (p. 259) cause the individual to manifest what contemporary clinicians would term "state changes" and, thus, to become "good-tempered and quarrelsome, malicious and kind, generous and miserly, all in the course of the same day" (p. 260). Rush describes how the diseased brain produces unrelated thoughts and ideas, maintaining that in the individual thus afflicted, consciousness is destroyed, with the result that such an individual may be "ignorant of the place he occupies, and of his rank and condition in society, of the lapse in time, and even of his own personal identity" (p. 150).

The particulars of the earliest recorded case of a dissociative disorder were detailed in a letter by a colleague of Rush's and published in the *Medical Repository of New York* in 1816. The author, one Dr. Mitchill, refers to the patient, Mary Reynolds, as "a very extraordinary case of double consciousness" (Mitchill, 1816, p. 85). Mitchill describes the manner in which, after a period of prolonged sleep, she awoke having "lost every trait of acquired knowledge" (p. 85) and found herself in the position of having to relearn spelling, arithmetic, and other educational fundamentals in addition to having to be introduced, as if for the first time, to individuals with whom she had been well-acquainted in her previous state. Of particular note is the fact that Reynolds was amnesic, in the new state, for the original one, her primary state of consciousness. In Mitchill's (1816) terms:

In her old state she possesses all her original knowledge; in her new state, only what she has acquired since. If a gentleman or lady be introduced to her in the *old* state, she will not know that person in the *new* state, and *vice
versa; and so of all other matters. To know them satisfactorily, she must
learn them in both states. (p. 86)

The presence of such amnestic barriers in instances of double consciousness
had been noted by Locke in 1690, and is one of the characteristics of DID listed in *DSM-IV* (1994).

**The Advent of Hypnosis**

During the same period of time Mitchill was chronicling the case of Mary
Reynolds, James Braid, a Scottish physician, had become an advocate of the
therapeutic use of hypnosis\(^1\) after witnessing a demonstration by the Swiss magnetizer
Charles La Fontaine (Gravitz & Gerton, 1984). Braid used the term “double
consciousness” (later employed by a number of authors including Rush, Prince, and
Janet) in reference to the somnambulistic state, and identified a number of different
levels of hypnosis. The deepest was “hypnotic coma,” a state produced in subjects by
optical fixation, an inductive technique first employed centuries earlier (Gravitz & Gerton,
1984, p. 108). Braid advised that the term “hypnosis” should be used in reference only to
those individuals who displayed post-trance amnesia but had, nonetheless, full and
accurate recall, upon being hypnotized again, of events which had occurred under
hypnosis.

It was discovered that a degree of anaesthesia could be induced via hypnotic
suggestion, and by the mid-1800s, prior to the advent of ether anaesthesia, hypnosis
was being used to inhibit pain during surgery (Carlson, 1986). Eugène Azam, the

\(^1\) Derived from the Greek *neuron*, or nerve, and *hypnos*, or sleep, the term “neurohypnotism” was later
shortened to “hypnosis” for the sake of brevity.
surgeon who pioneered this movement, was referred a dissociative patient named Félida in 1858. Azam employed hypnosis to treat her multiple personalities, reporting her case in a series of articles that were published, in 1876, in which he used such terms as "double consciousness," "periodic amnesia," and "splitting of the personality" (Carlson, 1986, p. 27). Following Rush, another physician, Jean Etienne Dominique Esquirol, in his 1845 work, *Mental Maladies: A Treatise on Insanity*, describes the manner in which "Sensations, ideas, and images present themselves... without order or connection... [in the mind of the individual who]... associates ideas the most unlike; forms images the most whimsical; holds conversations the most strange" (Esquirol, 1845/1965, p. 385). Like Rush, Esquirol argued that such associations occur only in the diseased brain.

**The Contributions of Pierre Janet**

It was Pierre Janet, however, whose work with hysterics fuelled the late 19th century surge of interest in dissociation. Although the chapter in Rush's 1812 publication probably signifies the earliest known medical use of the term, it was popularized by Janet who, in 1889, derived its usage from the doctrine of associationism (Hilgard, 1986). Janet was a student of Jean Charcot, a medical practitioner who employed hypnosis to explore underlying emotional conflicts in hysterics, conflicts that the patients were unable to confront when fully conscious (Brennan, 1986). Janet's writings contain frequent allusions to dissociated, or "subconscious fixed" ideas, which, upon isolation from the primary consciousness, became aggregated, forming a consciousness of their own which co-existed within the primary consciousness (Flora, 1988). Referring to these split-off states as "secondary" or "sub-conscious" selves (Klein, 1977, p. 85), Janet held
that dissociation of this nature was possible only in those who were hysterically predisposed, and describes the process in his 1920 publication *The Major Symptoms of Hyste-ria*:

Things happen as if an idea, a partial system of thoughts, emancipated itself, became independent and developed itself on its own account. The result is, on one hand, that it develops far too much, and, on the other hand, that consciousness appears no longer to control it. (p. 42)

Janet laid the foundation for later research into the relationship between dissociation and hypnotisability by proposing that it was the hypnotic process itself to which hysterics were susceptible.

Even prior to the completion of his medical degree, Janet made a study of several hysterical patients. His continuing research after he became a qualified psychiatrist led to the theoretical formulation of the syndrome associated with hysteria (Van der Kolk & Van der Hart, 1989). According to his theory, the primary adaptive mechanism in hysteria is the dissociation of affect and memory regarding experiences of a traumatic nature. Further, the state of psychological automatism displayed by the hysteric may be total, as in catalepsy° and artificial somnambulism;° or partial, as in the instance of what Janet termed “successive existences” (Ellenberger, 1970, p. 116), autonomous dissociated fragments of personality. He also proposed two sub-types of successive existences or “alternating personality” (Murphy, 1930, p. 283). In the first, each alter is unaware of the existence of the other. In contemporary parlance, there are amnestic barriers between personalities. The second subtype accounts for the knowledge, by one personality, of the existence of the other, who in turn is unaware of

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° A trance-like state.

°° A hypnotic state for which there is amnesia upon awakening, recall of the waking state while in hypnosis, and recall of past hypnotic states while in trance.
the first as the result of a one-way amnestic barrier. Janet contended that the
dissociated ideas that lie at the core of hysterical pathology are most effectively
reintegrated into the primary consciousness through hypnosis. He viewed this as the
chief goal of therapy (Ellenberger, 1970). Yet the retrieval of traumatic memory was, for
Janet, only one aspect of the therapeutic process. He was aware that "the tendency to
1538). In anticipation of later clinicians who would stress cognitive restructuring, mastery
of tasks and roles associated with daily living, and the importance of the therapeutic
alliance in the course of treatment of the dissociative individual (Erskine, 1993; Fine,
1988; Fitke, 1990; Torem, 1989). Janet used a directive approach to assist his patients
in developing adaptive ways of dealing with new situations in the context of a supportive
and nurturing relationship with the therapist (Van der Kolk & Van der Hart, 1989).

Janet (1920) posits a conception of mental health whereby, in normal individuals,
thoughts, ideas, and memories of events form a unified system. This system has a
unique path of development, and Janet articulates its evolution in the direction of
psychopathology:

The essential phenomenon that, in my opinion, is at the basis of these
double existences is a kind of oscillation of mental activity, which falls and
rises suddenly. These sudden changes, without sufficient transition, bring
about two different states of activity: the one higher, with a particular
exercise of all the senses and functions; the other lower, with a great
reduction of all the cerebral functions. These two states separate from each
other; they cease to be connected together, as with normal individuals,
through gradations and remembrances. They become isolated from each
other, and form these two separate existences. Here again, there is a mental
dissociation more complicated than the preceding ones. There is
dissociation, not only of a feeling, but of one mental state of activity. (p. 92)

Janet's reference to self as unified by memory is noteworthy in light of his
predecessors' emphasis on the continuity of consciousness. He too considered memory
to be a crucial element in the healthy functioning of personality, and believed consciousness to be nothing more than the synthesis of memories of psychological elements associated with a given experience, including affect, cognition, sensation, and action. Janet's work formed the underpinning for yet another focus of 20th century researchers in addressing the relationship between dissociation and state-dependent learning. He believed information to be most effectively retrieved in a state similar to that in which memory was initially encoded (Van der Kolk & Van der Hart, 1989). This aspect of his theory was to provide a foundation for Braun's (1988) BASK model of dissociation, to be discussed in a later chapter.

Janet's work held particular fascination for William James, who made frequent reference in his 1890 treatise *The Principles of Psychology* to this prominent 19th century psychiatrist. James himself had worked with hypnosis (Klein, 1977) and, like later theoreticians (Counts, 1990; Steingard & Frankel, 1985), made a distinction between the induced dissociation of hypnosis and the spontaneous, split-off consciousness of the hysteric. He wrote of the function of thought in personal consciousness, viewing it as a process, continuous within that consciousness (James, 1890). He characterized this process as analogous to a stream, and discussed the laws of association by which it is governed. James also explored the issue of double consciousness, referring to a number of cases treated by Janet, and described the secondary selves of the dissociative individual as constituting a split from the main stream of consciousness which is experienced by the patient as a lapse in memory.

Identity, for James (1890), is a "consciousness of personal sameness" (p. 331) derived from an awareness of self, both past and present. He posits that such an awareness of one's temporal continuity is predicated upon memory, lapses of which
result in a loss of the sense of “me.” When we are unable to appropriate our memories such that continuity is no longer felt, “the sense of personal identity goes too” (James, p. 335). A century after James, such lapses in the continuity of consciousness in the dissociative individual would be noted by Putnam (1989), Ross (1989), Tinnin (1990), Steinberg (1995), and other researchers in the form of extensive amnestic episodes. Such episodes are prominent in the experience of those with DID.

James was not the only turn-of-the-century clinician to be influenced by Janet. In 1905, physician Morton Prince (1914) published an account of his patient Christine Beauchamp, to whom he ascribed four personalities. Describing Beauchamp as a *dissociated group of conscious states* (p. 153), Prince, as had Locke (1690) and Rush (1812) before him, noted the amnesia characteristic of such dissociated states. In another publication, Prince, like Janet, made a distinction between induced hypnosis and the instances of auto-hypnosis displayed by the dissociative individual. Referring to hypnosis as an “artificially dissociated state” (p. 62), Prince held that the auto-hypnotic states which contrive the dissociative defence are spontaneous, and he maintained, like Janet, that dissociated memory is most effectively reintegrated into the primary consciousness through hypnosis. These early explorations into the realm of the relationship between hypnotisability and dissociation have implications for a later discussion of trance-states and other dissociative phenomena as they present themselves in other cultures, to be undertaken in Chapter 3 of this thesis. Further, in 1906, Prince articulated the relationship between hysteria, which will be discussed at length in Chapter 2, and instances of alternating personality:

Turning now to so-called dissociated or multiple personality, we shall find that the same symptom-complex which passes under the name of hysteria may now make up one or more of the phases of the multiple individual,
where it can be recognized as the manifestation of disintegrated personality. Multiple personality, of course, is the same thing as dissociated or what is also termed disintegrated personality, where the normal individual alternately becomes disintegrated and healthy, changing back and forth from disease to health; or, from the point of view of this study, becomes alternately a hysteric and healthy. Where there are more than two personalities, we may have two hysteric states successively changing with each other, and, it may be, with the completely healthy person, that multiple (disintegrated) personality is a type of hysteria is well-recognized, but it is not recognized that the converse is true, viz., that the hysteric is a disintegrated personality, and, therefore, as contrasted with the previous normal condition, is pathologically a phase of multiple personality, and, potentially at least, always liable to exhibit the phenomenon of alteration. (p. 172)

Dissociation continued to command the attention of clinicians until well into the first decade of the 20th century. Psychotherapy relied more and more heavily on hypnotic suggestion, with special emphasis on the relationship between patient and hypnotherapist (Ellenberger, 1970). A new model of the human mind had evolved, the main component of which was the concept of mental energy. It gave prominence to both conscious and unconscious elements, and dominated theories of the pathogenesis of nervous disease. Near the turn of the century, a new adaptation of hypnotherapy was employed. The cathartic method involved the identification of the unconscious source of symptoms and dissolving them through the expression of powerful emotions. The patient, once hypnotized, would be age-regressed to the point at which the trauma responsible for symptomatology had occurred. These symptoms were relieved through abreaction of the affect associated with the traumatic event (Kelly, 1991). Prince (1914) described the production of positive and negative hallucinations under hypnosis, in addition to a number of post-hypnotic phenomena, and conducted experiments in support of his hypothesis that there “are very definite states of co-consciousness – a coexisting dissociated consciousness or co-consciousness of which the personal consciousness is not aware” (p. 249).
In 1895, Sigmund Freud and Josef Breuer published their *Studies in Hysteria*, the first chapter of which was devoted to a discussion of the traumatic origin of hysteria and the psychotherapeutic method based on the concept of catharsis. Employing the term "hypnoid states" (p. 159) in reference to altered states of consciousness, these prominent clinicians maintained, in line with Janet, that the event experienced by an individual during a hypnoid state was split off from the primary consciousness, cleaving the mind into disaggregate states separated by amnestic barriers (Tinnin, 1990). Further, Freud and Breuer averred that it is not the content of dissociated memories that renders them unavailable to consciousness, but rather the psychological state of the individual at the time the trauma occurred.

**The Decline of Dissociation**

Shortly after the turn of the century, however, Freud, with his formulation of the theory of repression, began to re-evaluate the concept of dissociation, which he would eventually renounce. His adoption of the cathartic method and development of the psychotherapeutic technique of free association found him relying less on hypnosis as a therapeutic tool (Counts, 1990). In 1909, he pronounced hypnosis "a failure and a method of doubtful ethical value" (cited in Rosenbaum, 1980, p. 1383). Other clinicians also identified serious drawbacks to hypnosis. Not every therapist was equally skilled at induction, and not all patients were equally suggestible. Some feigned hypnosis, while others were deemed highly susceptible to the unconscious wishes of the therapist (Decker, 1986). This disenchantment with a technique that had held clinicians in thrall for the latter half of the 19th century signalled the start of a waning of interest in multiple personality.
Yet another, perhaps more serious, blow was dealt to the concept of dissociation upon the introduction, in 1911, of the diagnostic criteria for schizophrenia (Rosenbaum, 1980). The term “schizophrenia,” which originated with physician Eugen Bleuler, replaced “dementia praecox” as a diagnostic label designating a variety of mental disturbances – including psychoses, paranoid states, and hallucinations – as manifestations of a single underlying disturbance characterized by a splitting of the personality. According to Bleuler (1924/1976):

It is not alone in hysteria that one finds an arrangement of different personalities one succeeding the other. Through similar mechanisms schizophrenia produces different personalities existing side by side. As a matter of fact there is no need of delving into those rare though most demonstrable hysterical cases; we can produce the very same phenomena, experimentally, through hypnotic suggestion. (p. 138)

In making such a statement, Bleuler could not have known that he anticipated the controversy that would come to surround the issue of iatrogenic creation of alternate identities through hypnosis. This heated debate not only engaged the interest of researchers in later decades (Fahy, 1988; Merskey, 1992; Torem, 1989) but also found its way into the popular press. In his treatise, “Dementia Praecox or the Group of Schizophrenias,” Bleuler (1911/1950) refers to “twilight states . . . [which] . . . obscure the schizophrenic character of the clinical picture” (p. 217). These twilight states include tendencies toward visions and trance-states, both common elements of dissociative experience. Further, Bleuler asserts that: “when a supposed hysterical becomes psychotic . . . he is . . . not a hysteric at all, but a schizophrenic” (p. 289).

Bleuler was not the only highly esteemed early 20th century clinician to influence opinion about matters concerning dissociation. In 1915, Freud dismissed the possibility of the existence of a secondary consciousness maintaining that: “We shall be right in
rejecting the term ‘subconscious’ as incorrect and misleading. The well-known cases of
‘double conscience’ (splitting of consciousness) prove nothing against our view” (Freud,
1915/1964, p. 170). By the late 1920s, the diagnosis of schizophrenia had become more
popular, resulting in a dramatic increase in the number of cases of schizophrenia
reported in the literature and a sharp decline in reports of multiple personality
(Rosenbaum, 1980).

In 1939, Kurt Schneider described a cluster of symptoms that he believed to be
pathognomonic of schizophrenia. Schneider held that these symptoms included:

Audible thoughts; voices heard arguing; voices heard commenting on one’s
actions; the experience of influences playing on one’s body (somatic
passivity experiences); thought-withdrawal and other interferences with
thought; diffusion of thought; delusional perceptions and all feelings,
impulses (drives) and volitional acts that are experienced by the patient as
the work or influence of others. When any of these modes of experience is
undiably present and no basic somatic illness can be found, we may make
the decisive clinical diagnosis of schizophrenia. (p. 133)

The 11 first-rank symptoms proposed by Schneider represented a step in the
direction of “an organic theory and treatment of schizophrenia” (Ross, 1989, p. 40), but
also subsumed many of the symptoms experienced by the dissociative individual.

Schneider failed, however, to consider the differences between the etiology of
schizophrenia and that of chronic post-traumatic syndromes, such as the dissociative
disorders, which may present similarly. Finally, from 1920 to 1950, behaviourism, with its
emphasis on observed behaviours rather than the manifestations of the unconscious
mind, further contributed to the decline of interest in dissociation. From 1927 to 1966,
“Psychological Abstracts” contains a mere 33 abstracts on the subject (Ross, 1989).

From 1966 until 1980, virtually no work was done in the area.
The Revival

The year 1980 marked the beginning of a renaissance in the study of dissociation. Multiple Personality Disorder (MPD) was given official diagnostic status in *DSM-III* (1980). One review article tabulated 50 published cases of MPD during the 9-year period from 1971 to 1980, a stark contrast to the 33 reported during the previous 39-year period (Ross, 1989). Wright (1997) enumerates other factors that contributed to the burgeoning interest in dissociation on the part of clinicians and researchers during the latter half of the 20th century. There was an increase in medical interest in post-traumatic symptoms in the wake of the Vietnam War. The women’s movement had fostered a climate in which survivors of childhood sexual abuse felt comfortable revealing their experiences of incest and other sexual traumata. Public interest in DID was revived by a stream of publications about multiplicity in the popular press, including *The Three Faces of Eve* (Thigpen & Cleckley, 1957) and *Sybil* (Schreiber, 1973), with film versions of both books accessible via television and home video.

The dissemination of medical literature, in the form of journals and books, made information about dissociation readily available to medical practitioners and therapists. Further, the evolution of behaviourism and subsequent flowering of cognitive psychology was accompanied by a re-evaluation of Freud’s work, and a rising scepticism regarding his view of incest and other forms of sexual trauma as “imagined and fantasized events” (Wright, 1997, p. 50) which lurked at the root of psychopathology. Coons (1980) implicated trauma in the etiology of MPD, providing a foundation for the ensuing empirical study of the relationship between childhood abuse and chronic post-traumatic disorders, and familial environments rife with conflict and ambivalence were later
implicated in the etiology of the dissociative disorders by other researchers (Braun, 1987; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Paley, 1988).

From 1983 to 1984, five leading psychiatric journals – *American Journal of Clinical Hypnosis, Psychiatric Annals, Psychiatric Clinics of North America, International Journal of Clinical and Experimental Hypnosis, and Investigations* – published special issues on the subject of MPD (North et al., 1993). The year 1984 saw the organization of the First Annual Conference on Multiple Personality/Dissociative States and the birth of the International Society for the Study of Multiple Personality and Dissociation. This organization was renamed the “International Society for the Study of Dissociation” (ISSD) with the publication of *DSM-IV* (1994), in which the diagnostic category “Multiple Personality Disorder” was replaced with “Dissociative Identity Disorder.” A wealth of articles and books on the subject of dissociation have been published since.

**Summary**

The dissociative disorders have been conceptualized historically as disorders of identity. The link between continuity of consciousness and a sense of personal sameness was emphasized by a number of early theorists. The loss of this continuity, in the form of periods of amnesia, was and is considered to be a defining feature of DID. The study of the principles of association provided a foundation for subsequent research into the process by which certain ideas become dissociated, and promoted a view of dissociation as pathological. Janet, in postulating different sub-types of alternating personality, set the stage for contemporary clinicians who classify DID in accordance with the number of alternate identities. The work of these early theorists is reflected in present-day efforts to explicate a continuum of dissociation and to account for
dissociative symptoms, and provides a context from within which to apprehend the nature of dissociative experience, to be explored in subsequent chapters.
CHAPTER 2: A HISTORY OF HYSTERIA

Introduction

In his thoughtful and sweeping historiography, Micale (1995) has noted of hysteria that:

Throughout its long career, the disorder has been viewed as a manifestation of everything from divine poetic inspiration and satanic possession to female unreason, racial degeneration and unconscious psychosexual conflict. It has inspired gynecological, humoral, neurological, psychological and sociological formulations, and it has been situated in the womb, the abdomen, the nerves, the ovaries, the mind, the brain, the psyche and the soul. It has been construed as a physical disease, a mental disorder, a spiritual malady, a behavioural maladjustment, a sociological communication, and as no illness at all. (p. 285)

This chapter presents a historical overview of hysteria and a discussion of the evolution of etiological theories about the disease. Both hysteria and its contemporary counterpart, DID, are clearly pathologies of powerlessness, employed by those driven to express themselves through the non-verbal means of psychogenic symptoms in the absence of access to other modes of self-expression. This view finds affinity with those of other researchers with respect to a number of culture-bound syndromes. In this chapter, hysteria is likened to a text, and its symptoms will be articulated as a grammar by means of which we may apprehend the experience of its narrator.

Hysteria in Classical Thought

The term “hysteria” is derived from the Greek “hystera,” meaning “uterus” (Wesley, 1979). Early descriptions of the course taken by the disease were found in
medical manuscripts dating to 1900 BC. For centuries it was believed to be solely an
affliction of women. Its etiology was considered specifically attributable to the
locomotions of the womb, a "wandering uterus." Classical practitioners believed that the
organ migrated to various regions of the body, including feet, chest, and throat,
producing a myriad of symptoms in its wake. These included globus hystericus, a
choking sensation; loss of voice; random pains, seizure-like twitches and convulsions;
conversion symptoms such as paralysis, deafness, and blindness; and fits of fainting
(Showalter, 1997). Writing of the uterus in the 4th century BC, Plato maintained that:

Wherefore the nature of the generative part in man is disobedient and
headstrong, like a creature that will not listen to reason, and endeavors to
have all at its will because of its frantic passions; and again for the same
reason what is called the matrix and womb in women, which is in them a
living nature appetant of childbearing, when it is a long time fruitless beyond
the due season, is distressed and sorely disturbed, and straying about in the
body and cutting off the passages of the breath it impedes respiration and
brings the sufferer into the extremist anguish and provokes all manner of
diseases besides; until the passion and love of both unite them, and, as it
were plucking fruit from a tree, sow in the womb, as if in a field, living things
invisible for smallness and unformed, and again separating them nourish
them within till they grow large, and finally bringing them to light complete the
birth of a living creature. Such is the nature of women and all that is female.
(Archer-Hind, 1973, p. 341)

Thus, the uterus is conceived by Plato as an animal with a mind of its own and
the capacity for emotion. However, Adair (1997) proposes a re-reading of Plato such that
it is not the womb that wanders, but the sexual appetite, which arises from the womb
and peregrinates throughout the female body, wreaking havoc in its path. When
anatomists of later centuries proved that the uterus, in fact, did not migrate, but rather
maintained a static position in the female body, physicians settled on an alternative
explanation for hysterical symptoms. Their source was considered to be the nervous
system, engendering a view of women as a “nervous sex” (Showalter, 1997, p. 15), prone to “vapours” and attacks of the spleen.

In the Hippocratic tradition of the 5th century BC, treatment of hysteria involved the inhaling of malodorous concoctions to drive the uterus back to its proper place and the fumigation of the genitals with sweet-smelling substances to lure it downward (Wesley, 1979). Virgins and widows were believed to be particularly susceptible to the ravages of the wandering womb (Veith, 1965) and marriage was touted as the speediest route to a cure. Hippocrates reasoned that: “the abstemious uterus dried up, lost weight, and consequently was able to migrate in search of moisture” (Beizer, 1993, p. 4).

During the 1st century AD, Soranus of Ephesus, a physician highly revered by his colleagues, rejected the Platonic notion of the uterus as an animal, characterizing hysteria as a “disease of stricture” (Veith, 1965, p. 19), which was the result of an inflamed womb. In his 1st century AD work, Gynecology, Soranus holds that “the uterus does not issue forth like a wild animal from the lair, delighted by fragrant odors and fleeing bad odors; rather it is drawn together because of the stricture caused by the inflammation” (Veith, 1965, p. 153). Eschewing the established therapeutic practices of genital fumigation and inhalation of noxious substances, his recommendations for treatment included the application of sweet olive oil to the pubic and surrounding areas with the objective of relaxing the stricture; the ingestion of natural waters; the application of mustard plasters; “vigorous local massage” (p. 152); suppositories; and “various passive exercises and promenades, reading aloud, vocal exercise, anointing, gymnastics, baths, and varied food” (1965, p. 152).

The writings of Greek physician Arataeus of Cappadocia early in the 2nd century AD include a work entitled, Cure of the Hysterical Convulsion (circa 2nd century
AD/1972). In it, the author holds forth regarding the taming of the capricious and recalcitrant uterus, and adds some anatomical information to his musings. Further, he finds affinity with Soranus with respect to the role played by inflammation in the genesis of hysterical symptoms:

The uterus in women has membranes extended on both sides of the flanks, and is also subject to the affections of an animal in smelling; for it follows after fragrant things as if for pleasure, and flows from fetid and disagreeable things as if for dislike. If, therefore, anything annoy it from above, it protrudes even beyond the genital organs. But if any of these things be applied to the [uterus], it retreats backwards and upwards. Sometimes it will go to this side or that, – to the spleen and liver, while the membranes yield to the distension and contraction like the sails of a ship. It suffers in this way also from inflammation; and it protrudes more than usual in this affliction and in the swelling of its neck; for inflammation of the fungus inclines upwards; but if downwards to the feet, it protrudes extremely, a troublesome, painful and unseemly complaint, rendering it difficult to walk, to be on the side or on the back, unless the woman suffers from inflammation of the feet. But if it mount upwards, it very speedily suffocates the woman, and stops the respiration as if with a cord, before she feels pain, or can call upon the spectators, for in many cases the respiration is first stopped, and in others the speech. (Arataeus the Cappadocian, circa 2nd century AD/1972, p. 449)

By the latter half of the 2nd century AD, the hypothesis of the wandering womb was rejected, although the idea of uterine pathology still held sway, and enforced sexual abstinence was viewed as the chief cause of hysterical symptoms. The physician Galen proposed that a condition similar to hysteria occurred in men, the cause being “retention of sperm” (Ng, 1999, p. 288). Further, he implicated retention of the menses in the onset of the hysterical seizure. Putrefied menruruum and sexual continence produced vapours, which were toxic to the organs of the body, corrupting the blood and irritating the nerves, and leading to “hysterical symptoms such as respiratory distress, palpitations and mental status changes” (Williams, 1990, p. 384). Galen described three clinical categories into which hysterical symptoms fell. Patients in the first group evidenced a loss of consciousness and hysterical paralysis, in addition to a thready pulse. Those in the
second group retained consciousness and the ability to move, but “tended to collapse from weakness and respiratory difficulties” (Veith, 1965, p. 37). Patients in the third group manifested limb contractures, a symptom which would later be noted by prominent 19th century neurologist Jean Charcot. This taxonomy of the vast array of symptoms by which the disorder was characterized foreshadows the challenges posed to succeeding clinicians in terms of differential diagnosis.

**The Virtues of Abstinence**

The writings of Augustine during the late 4th century AD embody the transition from classical to medieval thought. Augustine’s education followed the standard Roman practice of the study of philosophical texts (O’Daly, 1999). He held a post as a public orator in Milan at the age of 29. Three years later, he underwent a conversion experience and was subsequently baptized. These events led to his adoption of a life of celibacy. As Veith (1965) has noted, with Augustine and other early ecclesiastical writers, “Questions of lust, sensuality, carnal pleasure, sin and guilt began to pervade all thinking about sex and differentiations were introduced between physical union for procreation and the evil of erotic pleasure” (p. 43). In a moral climate such as this, there existed no sanction of marriage for therapeutic purposes as had been advised by physicians of earlier eras in the treatment of hysteria.

In Augustine’s view, the only justifications for intercourse, even within the confines of the conjugal bond, were the need for procreation and for precaution against the adultery of a spouse (O’Meara, 1992). He considered sexuality to be infused with lust, and even marital sex “should be untainted by any vestiges of sensual pleasure” (Veith, 1965, p. 43). For Augustine, carnal pleasure was the domain of the unholy; he
associated it with demonology and witchcraft. Further, it is, by and large, the province of women:

And then there is all that talk about those gods in the wilds and the woods commonly called *incubi*, who have been so frequently importunate and successful in seeking to satisfy their lust with women. We have the accounts of a great many victims, or of trustworthy reporters who talked with the victims, of these assaults. There are also the demons whom the Celts called *deuces*. There are so many tales of their attempted or completed impurities that it would be verging on rudeness to deny them all. However, I would not dare to decide on evidence like this, whether or not certain spirits, embodied in the kind of aerial substance, whose force we can feel when it is fanned against our bodies, are subject to the passion of lust and can awake a responsive passion in women. (cited in Veith, 1965, p. 51)

Although Augustine did not address hysteria directly in his writings, he held the belief that illness arose from witchery and hence from the mind. Demonic possession was held to be expressed, not in the form of somatic ailments, but rather in “behavioural disorders” (Veith, 1965, p. 49). Under Christian influence, the popular image of the hysteric as a woman plagued by organic illness was transformed into that of a woman “plagued by demons and at the mercy of supernatural forces” (Dixon, 1995, p. 22). In concert with an intellectual atmosphere dominated by spiritual themes, beliefs about female susceptibility to possession by demons, and a view of mental illness as a token of bewitchment, Augustine’s work fertilized the soil in which the seeds of the witch-hunt craze of the Middle Ages would take root.

**The Malleus Maleficarum**

Micale (1995) has noted that:

In contrast to the classical centuries, the history of ideas about hysteria during the Christian Middle Ages has received comparatively little attention from scholars. The relative absence of occidental texts during the medieval millennium reflects of course the change in conceptualization of hysteria from a morbid natural phenomenon to a supernatural visitation. . . .
Discussion of the subject was submerged in clerical commentary on religious ecstasy, demonic possession, and exorcism. (p. 46)

The most notorious publication to emerge from the post-Augustinian tradition of demonology was written in 1486 by two Dominican monks, Heinrich Kraemer and Johann Sprenger (Roback, 1961). The *Malleus Maleficarum*, or *Witche's Hammer*, as it was popularly known, became an instrument of mass murder. Spectacularly misogynist, the document is organized in three sections. The first is devoted to defining the necessary constituents of witchcraft, the second deals with the "modus operandi" (Veith, 1965, p. 61) of witches, and the third describes the court proceedings pertaining to those accused of dealings with devils. Between 1487 and 1669, 30 editions of the book appeared. The first section of the *Malleus* reflects its authors' conviction that belief in witchcraft is an underpinning of the Catholic faith, and that denial of the existence of witches is heretical. Therein, Kraemer and Sprenger (1486/1951) also delineate their view of the inherent traits of the female: "What else is woman but a foe to friendship, an unescapable punishment, a necessary evil, a natural temptation, a desirable calamity, a domestic danger, a delectable detriment, an evil of nature, painted with fair colors" (p. 43).

In the distorted perception of the authors of the *Malleus*, any sexual activity that evoked pleasure was considered to be the work of the devil, and females, being "naturally more impressionable" (Kraemer & Sprenger, 1486/1951, p. 44) and weaker than men, were considered more susceptible to copulation with demons. Kraemer and Sprenger maintain that: "all witchcraft comes from carnal lust, which is in women insatiable" (p. 47). The two monks endow women with an astonishing array of supernatural abilities, including the capacity to change men into animals; to offer children
up to devils; to cause lightning to strike; to induce abortion in another woman by a mere touch of the hand; and to cast spells on men such that their penises are caused to disappear. Styling themselves “dogs of the Lord” (Roback, 1961, p. 217), Kraemer and Sprenger pronounced women “hot to satisfy their filthy lusts,” (p. 47), shamelessly fornicating with devils, or “incubi,” and perpetrating all manner of otherworldly crimes. As Veith (1965) has noted:

By tortuous reasoning based on the works of Augustine, the ability to experience sexual pleasure derived from involvement with the devil. A woman’s pleasures could have come only from satanic copulation; the man in turn derived his gratification from the unholy wiles of his devil-inspired partner. Thus, if either party was guilty of lust, the blame inevitably fell on the female. (p. 62)

In the second part of the Malleus, its authors recount in detail the manner in which pacts are made with the devil. Included are a description of how the carnal act is performed, an extensive discussion of the ways in which witches “deprive man of his virile member” (Kraemer & Sprenger, 1486/1951, p. 118), and a series of lurid musings regarding the question of “Whether the Relations of an Incubus Devil with a witch are always accompanied by the Injection of Semen” (p. 112). The third part of the Malleus is given over to a discussion of the process of inquisition and a description of the legal proceedings against those suspected of witchcraft. In addition to interrogation, assessment of the culpability of the accused involved humiliation and torture, the latter to be applied by progressive degrees until a “confession” was elicited. As Veith (1965) has noted, “Interrogation was supplemented by actual testing. Pricking the skin for areas of anaesthesia was a frequent test; regions of insensitivity were considered satanic stigmata, confirmatory of bewitchment” (p. 65). This loss of cutaneous sensation in parts of the body was one of the symptoms Edward Jorden (1603/1971) would later identify as
pathognomonic of hysteria. Indeed, Fink (1996) adheres to a belief that most of the women burned at stake during the 16th and 17th centuries were hysterics. As Evans (1991) notes with regard to 19th century clinicians' efforts at the differential diagnosis of hysteria, this practice was not restricted to the Inquisition:

The search for stigmata cannot help but recall the pricking technique used by the witch hunters in the sixteenth and seventeenth centuries. Then, the suspected witch was stripped and pricked all over her body in an attempt to find the "devil's mark," the place where he had marked her to seal their bargain and which was reputedly insensitive to ordinary touch. Much the same thing was done with the nineteenth century hysterics; sometimes they were subjected to treatment that seems brutal to us. Bourneville and Rénard (1879-80) report that to test skin sensitivity, they would sometimes scratch words in the patient's skin with pins, or again, to test the reality of the anaesthesia, they might stick a large needle through the entire hand. Thus, the doctors of the new scientific age unwittingly repeated actions they had described as barbarous in their religious predecessors. (p. 26)

The 17th Century

The 1603 treatise by Edward Jorden, *A Disease called the Suffocation of the Mother*, is held by Micale (1995) to have introduced the concept of hysteria into English medical discourse. Jorden's interest in the malady was elicited in 1602 by a highly controversial court case involving the 14-year-old daughter of a prominent London politician. The young woman, whose name was Mary Glover, had been beset by a myriad of symptoms, including intermittent episodes of mutism and blindness, swelling of the neck and throat, and anaesthesia of the left side of her body. Bradwell (1603/1991), in his commentary entitled *Mary Glover's Late Woeful Case*, describes the girl's behaviour when in the throes of a hysterical attack:

In so much as now, she was turned rounde as a whoop, with her head backward to her hippes; and in that position rolled and tumbled, with such violence, and swiftness, as that their paynes in keeping her from receaving hurt again the bedsted, and postes, caused two or three women to sweat;
she being all over cold and stiffe as a frozen thing. After she had been thus
tossed and tumbled in this circled roundnes backward, her body was
suddenly turned round the contrary way, that is, her head forward between
her leggs, and then also rowled and tumbled as before. (Fol. 3r)

Mary was thought to have been bewitched by a neighbour with whom she had
recently had a violent argument. The woman, one Elizabeth Jackson, was known in the
community as “eccentric and ill-tempered” (Micale, p. 48). Jackson was indicted, but not
before having a number of courtroom confrontations with her alleged victim during
which, according to Micale, “Glover flew into hysterical fits and spoke in a bizarre nasal
voice” (p. 48). Jorden was one of several physicians requested to examine the afflicted
girl, and made a diagnoses of hysteria. Nonetheless, the Lord Chief Justice Anderson
held Jackson to have been responsible, and she was summarily sentenced to the pillory
and subsequently imprisoned.

The full title of Jorden’s (1603/1971) treatise is A brief discourse of a disease
called the suffocation of the Mother. Written upon occasion which hath beene of late
taken hereby to suspect possession of an evill spirit, or some such like supernaturall
power. Wherein is declared that divers strange actions and passions of the body of man,
which in the common opinion, are imputed to the Divell, have their true naturall causes,
and do accompanie this disease. In this compact tract, Jorden describes the
symptomatology of the disorder, proposing, in the Galenic tradition, that symptoms fell
into three categories, each of which subsumed some principal faculty, and which, taken
together, governed the entire body. Symptoms associated with the “vitall” (Jorden,
1603/1971, p. 9) faculty include those pertaining to cardiac function, such as weak pulse,
palpitations, and dilation of the arteries with resultant fatigue such that the afflicted
individual may lie “like a dead corpse three or four hours together, and sometimes two or
three whole dayes without sense, motion, breath, heate, or any signe of life at all" (Jorden, 1603/1971, p. 9). Symptoms associated with the “naturall” (p. 18) faculty include abdominal pain, vomiting, the voiding of copious quantities of urine, swelling in the throat, a pallid complexion, and “rumbling and noise in the belly” (Jorden, 1603/1971, p. 18) along with “extraordinarie hunger” (p. 18).

Symptoms associated with the “animall” (Jorden, 1603/1971, p. 12) faculty affect memory, judgement, and the capacity to understand. Jorden distinguishes this faculty from the vital and natural faculties in terms of the fact that its functions are under control of the will. Manifestations of hysterical disturbances of this faculty include forgetfulness, indiscreet actions, and sleepwalking. Further, in Jorden’s view, those afflicted by hysterical disturbances of the animal faculty may evidence deafness, blindness, and anaesthesia, one of the symptoms by which witches were identified by their Inquisitors. Yet other symptoms are enumerated by Jorden, including muscle contractures, involuntary gestures of the arms and legs, and convulsions, in concert with shortness of breath and difficulty swallowing. Jorden holds that:

This disease is called by diverse names amongst our authors. Passio Hysterica, Suffocatie, Prafoacatie, and Strangulatus vteri, Caducus matricis, &c. In English the Mother, or the Suffocation of the Mother, because most commonly it takes them with choking in the throat: and it is an affect of the Mother or wombe wherein the principle parts of the bodie by consent do suffer diversely according to the diversity of the causes and diseases wherewith the matrix is offended. (p. 5)

Jorden refutes the symptoms of the disorder as indicative of devilry, maintaining that they are manifestations of disease. As such, his treatise constitutes, in Micale’s (1995) view, “a clear defense of the naturalness of hysterical phenomena in the midst of the witchcraft craze” (p. 48).
Jorden's (1603/1971) work represents a turning point in both theory of etiology and approach to treatment. In line with Platonic thinking, he adhered to a view of the soul as tripartite, and held the brain to be the seat of the animal faculty and the heart the seat of the vital faculty, while the natural faculty was seated in the liver (Veith, 1965). As the animal faculty governed the senses of vision and hearing, in addition to controlling movement, he considered the brain the source of the principal symptoms of hysteria. This conception of the etiology of hysteria stands in stark contrast to that of Jorden's predecessors, who had either held to the uterine theory of etiology or viewed hysteria as a token of bewitchment. Jorden's recommendations for treatment included the avoidance of inhalation of sweet-smelling substances lest this lure the uterus upward and the avoidance of "sweet savors, pleasant meats and drinks" (p. 24) to the same end. This finds affinity with the therapeutic practices of earlier clinicians. However, Jorden also notes that:

If the perturbations of the mind be any occasion hereof, let them have their proper remedies, as anger and jealousie are to be appeased by good counsel and persuasions: hatred and malice by religious instructions, fear by encouragements, love by inducing hatred, or by permitting them to enjoy their desires, & c. (p. 24).

Thus, treatment must involve something more than mere relief of the physical symptoms of hysteria. To this end, Jorden was the first physician to suggest a kind of psychotherapy aimed at the assuaging of the emotional distress that was believed by him to contribute to hysterical symptomatology.

Another British physician, John Sadler, finds affinity with Jorden in his description in 1636 of the physiological bases of hysteria, noting that the cause of the disorder is "a Symptomatical motion . . . a convulsive drawing upward of the wombe" (1636/1977, p. 66). In line with Galenic thinking, Sadler holds the retention of menstrual blood to affect
the position of the uterus, and thus to be one precipitant of the hysterical fit. Like others before him, he outlines a kaleidoscopic array of symptoms, which serves to underscore the elusive and mercurial nature of the illness. In Sadler's view, the objective of treatment was 2-fold: the expulsion of "malignant vapours" (p. 66), which was accomplished by the application of herbal and pharmaceutical preparations; and the administration of "proper medicines" (p. 71) in the form of pills and suppositories to reorient the uterus to its accustomed position.

In his 1636 publication, *The Sicke Womans Private Looking-Glass*, Sadler describes an inventive list of other therapeutic interventions, including the application of cupping-glasses to the hips and navel; rubbing "the extreame parts" (p. 71) with mustard and salt vinegar; forcing the patient to sneeze by having her inhale pepper with the aim of driving the uterus downward from the pressure so incurred; and burning partridge feathers, leather and other malodorous substances under the nose in the hope that the uterus would travel downward, away from the repugnant smell. Unlike Jorden (1603/1971), Sadler (1636/1977) makes no reference to psychosocial or emotional factors which might bear upon the genesis or the perpetuation of the disorder.

By the mid-17th century, the uterine theory of etiology was supplanted by a view of hysteria as a disorder of the brain. Hysteria was at this time considered to be a disease of the middle and upper classes, an affliction of women of leisure, and further, in the Hippocratic tradition, one of young widows and spinsters. It is interesting that hysteria found its way into public discourse at this time via cookbooks (Micale, 1990). Such tomes were compilations of women's favourite recipes that included remedies for common medical ailments, amongst which hysterical symptoms figured prominently. The
recipe titles reflect the tenacity of the uterine theory of pathology. As Williams (1990) notes:

Eleven different recipes for curing hysteria can be found in a hand-written calf-bound book by an unknown author. Titles such as 'To bring the mother in her place wheresoever' and 'To make the mother sinke', reveal acceptance of the Hippocratic theory of the wandering womb, while others reflect the putrefaction hypothesis. (p. 390)

Thus, it seems that hysteria was a disorder well recognized not only by physicians, but also by members of the non-medical community.

During the mid-17th century, Thomas Willis (n.d./1980), a neuroanatomist and physiologist, advanced the hypothesis that hysterical fits were the result of explosions of the animal spirits that inhabited the brain. Willis, like Galen, maintained that an analogous malady could strike men, but that due to their more fragile constitutions and weaker nerves, women were far more prone to developing the disease (Slavney, 1990). Additionally, Willis asserted, as had Galen and Sadler before him, that there was a link between hysteria and retention of menses. He carries this further than either of his predecessors, however, in maintaining that the blood of the female contained particles which, if not expelled in the menstrual flow, were deposited in the brain, causing the characteristic twitches and convulsions of the hysterical fit. In Willis' (n.d./1980) terms:

The blood of females is richer in fermentative particles than that of males, and if this kind of matter is not completely expelled with the menses (as rarely happens), it is regurgitated into the blood and deposited with the nervous liquor in the brain. Then on account of its being in disproportion to the animal spirits, it is gradually separated out and accumulates in the brain, until by its turgescence it becomes deposited sometimes in the higher part of the brain, sometimes in the lower, toward the origins of the nerves, and so by provoking diverse motions of that matter various spasms occur. (p. 80)

Willis also notes that women are more vulnerable to hysterical attacks by virtue of a weaker constitution, such that they are prone to suffer the effects of "events and
passions" (n.d./1980, p. 89) and are more easily driven to states of melancholy. Like many of his predecessors, Willis held widows and virgins to be at particular risk for developing the disorder.

The most renowned 17th century theorist of hysteria, however, was physician Thomas Sydenham. Highly respected for his astute powers of clinical observation, Sydenham formulated what was essentially a neuropsychological model of the disorder. According to Micale (1995), Sydenham “believed that the condition was produced by an imbalance in the distribution of animal spirits in the brain” (p. 22). He further hypothesized that this imbalance was precipitated by the passions of the mind. The external causes of hysteria are “over-ordinate actions of the body; and still oftener over-ordinate commotions of the mind, arising from sudden bursts of anger, pain, fear or other similar emotions” (Sydenham, 1681/1848, p. 90). This finds affinity with Jorden’s view of hysteria as related to emotional factors. Sydenham’s theorizing reinforced the movement away from the uterine theory of hysteria, placing the disorder “firmly in the domains of neurology and psychiatry” (Williams, 1990, p. 385).

Sydenham further referred to the protean nature of the malady, and noted that its signs and symptoms bore resemblance to a myriad of other clinical entities. This anticipates the work of 20th century theorists whose research would centre around the differential diagnosis of DID (Benner & Joscelyne, 1984; Buck, 1983; Clary, Burstin, & Carpenter, 1984; Steinberg, 1995). Like Galen and Willis before him, Sydenham held that males were susceptible to a parallel illness whose origins lay in the hypochondria, but conjectured the ratio of female hysterics to male hypochondriacs to be 20:1 (Libbrecht & Quackelbeen, 1995). Further, he maintained that men who entered the ranks of the hypochondriacal were of a mentally or morally feminine constitution.
In his *Epistolary Dissertation to Dr. Cole*, Sydenham (1681/1848) divides pathology into two nosological categories: Acute illnesses include such afflictions as smallpox, which Sydenham treats at length in his *Dissertation*; hysteria and hypochondria, however, are categorized as chronic illnesses. Both have their origin in the brain, and both result from the turbulence of animal spirits (Trillat, 1995). Sydenham held that the female was constitutionally predisposed to hysteria due to a “fragile nervous apparatus” (Micale, 1995, p. 22). In Sydenham’s view, the female was “endowed by Nature with a more fine and delicate habit of body, as being destined to a life of more refinement and care” (1681/1848, p. 91). Men, whose lot it was to labour in the fields, hunt animals for sustenance, and otherwise toil, had stronger constitutions and were therefore less susceptible to the illness. Sydenham, like preceding clinicians, outlines the symptoms of hysteria, but with a degree of detail and specificity in keeping with his reputation as a keen observer of clinical phenomena.

In his *Dissertation*, Sydenham notes the mimetic capacity of the illness, holding that “Few of the maladies of miserable mortality are not imitated by it” (1681/1848, p. 85). He asserts that hysteria may mimic an apoplectic fit; that it may create “terrible spasms like epilepsy” (p. 86); that it may produce vomiting and engender palpitations of the heart; that it may give rise to a persistent cough; and that it may also affect the kidneys, the bowels, the muscles of the extremities, and even the teeth. Sydenham further holds that “hysterical women break out into immoderate fits, sometimes of laughing, sometimes of crying, and that without any manifest cause” (p. 88). For Sydenham, however, the sign that is pathognomonic of both hysteria and hypochondria is the voiding of “a great quantity of limpid urine, clear as the water from the rock” (p. 88). Hysteria, for Sydenham, is further accompanied by profound feelings of depression,
located in the region of the chest. However, women who lived “a hard and hardy life” (p. 85) were less susceptible to the disorder. Physician Ambrose Paré, a contemporary of Sydenham’s, adhered to a belief in the association between enforced sexual abstinence and hysteria, as had Sydenham’s predecessors and, like Sydenham, proposed a link between hysteria and a life of gentility and refinement stating, “Maids that live in the countrie are not so troubled with these diseases, because there is no such lying in wait for their maidenheads, and also they live sparingly and hardingly, and spend their time in continual labor” (cited in Veith, 1965, p. 117).

**Hysteria in Art**

As hysteria had surfaced in 17th century recipe books, so it found its way into the public vision by way of artists’ representations of the ailing hysterical female. In a penetrating account of the depictions of hysteria in art from the 13th to the 19th centuries, Dixon (1995) traces the history of the disorder in terms of its treatment and beliefs about etiology. In a 13th century painting, we see a woman beneath whose nose a feather is being burned, in the tradition of Hippocrates. She assumes a position, which is suggestive of the presence of muscle contractures, and is administered to by four attendants. Other paintings of the same era depict women recumbent in the death-like pose that would be noted in later centuries by Jorden and other clinicians as typical of hysterics. As Dixon notes, “The Christian concept of supernatural intervention in cases of *furor uterinus* remained strong in the popular imagination throughout the fifteenth and sixteenth centuries” (p. 38), and this too was reflected in artistic depictions of women, who, having been overcome by the symptoms of hysteria, are prayed over assiduously by family members.
Most fascinating of all, however, are artists’ renditions of hysterical women in the 17th century. The photographs of paintings from this period in Dixon’s (1995) book suggest the sexualization of a disorder, which during the 19th century would become virtually synonymous with nymphomania. The paintings centre on themes of female passivity and the dominance of male medical practitioners. Further, they contain the suggestion of the debilitated female as wanton even in the throes of her infirmity. Women are portrayed reclining in chairs, heads supported by pillows, legs wide apart under floor-length skirts, attended by male physicians who earnestly examine flasks of urine in an effort to determine the degree of clarity à la Thomas Sydenham. Presumably this is done in the hope of confirming a diagnosis of hysteria. In other paintings, the ailing female patient proffers a flaccid wrist while her pulse is taken. Dixon notes that:

The act of taking the pulse, like the pose of the urine examiner, was an attitude associated with the earliest physicians. As an essential part of medical caregiving the act of grasping the wrist of another person – usually a male authority figure gently taking hold of a woman’s wrist – became absorbed into the 17th century language of gesture. (p. 85)

In yet other canvases of this period, the sickly female is portrayed not only with knees opened but also with breasts exposed, bodice having been unlaced, one imagines, for purposes of medical ministration. These portrayals serve a dual purpose: to reinforce cultural stereotypes of women as tractable, passive, and effete; and to sexualize, however subtly, the ailment from which they suffer.

**The 18th Century**

The 18th century saw the ascription of a rise in the diagnosis of hysteria to the increasing complexity of modern civilization. Contemporary writers also have contended that higher levels of social complexity are reflected in more complex dissociative
disorders. For example, reports of cases of alternating personality in the 19th century specified instances of dual identity. However, a late 20th century publication (Ross, Norton, & Wozney, 1989) states the mean number of alternate identities as 15, with another author (Kluft, 1988) claiming to have treated a patient having 4,500 clearly defined alters. Further, in a reversal of classical thinking, the writings of 18th century clinicians linked hysterical symptomatology with sexual overindulgence and a life of refinement and moral laxity.

One physician of the early 1700s who adhered to a view of a life of affluence and luxury as deleterious was George Cheyne (1733/1976). Cheyne produced a volume on the causes and treatment of nervous "distempers" (p. 127) including hysteria and hypochondria. Claiming to suffer from the latter disorder himself, Cheyne notes that "especially among the fair Sex" (p. 34) excessive consumption of "Coffee, Tea, Chocolate and Snuff" (p. 34) leads to all manner of states characterized by a morbid heaviness of spirit and accompanied by a range of other symptoms including epileptic convulsions, hemiplegia and numbness of body parts (the hysterical anaesthesia, which has appeared for centuries in the writings about hysteria), fainting, muscle spasms, and a death-like immobility. Cheyne’s major work, entitled The English Malady: or, a Treatise of Nervous Diseases of all Kinds, as Spleen, Vapours, Lowness of Spirits, Hypochondriacal, and Hysterical Distempers, & c, attained widespread popularity, garnering fame for its author and rendering information about such afflictions accessible to the general public (Veith, 1965). This publication exhorts individuals to guard against indulging in the culinary excesses and sensual pleasures, which its author believed to predispose one to nervous disorders, and contains prescriptions for treatment which include a diet of milk, seeds, and vegetables, in addition to a regimen of exercise. The
latter is prescribed with the objective of regaining “Firmness, Strength and Activity” (Cheyne, p. 121).

Implicating socio-cultural factors in the genesis of hysteria and other nervous illnesses, like Sydenham and Paré, Cheyne maintains that “When Mankind was simple, plain, honest and frugal, there were few or no Diseases” (1733/1976, p. 121). Indeed, Cheyne proselytizes at length regarding the dangers inherent in the lifestyle of the bourgeoisie:

When I behold, with Pity, Compassion, and Sorrow, such Scenes of Misery and Woe, and see them happen only to the Rich, the Lazy, the Luxurious, and the Unactive, those who fare daintily and live voluptuously, those who are furnished with the rarest Delicacies, the richest Foods, and the most generous Wines, such as can provoke the Appetites, Senses and Passions in the most exquisite and voluptuous Manner: to those who leave no Desire or degree of Appetite unsatisfied, and not to the Poor, the Low, the meager Sort, those destitute of the Necessaries, Conveniences and Pleasures of Life, to the Frugal, Industrious, the Temperate, the Laborious and the Active: to those inhabiting barren, and uncultivated Countries, Deserts, Forests, under the Poles or the Line, or to those who are rude and destitute of the Arts of Ingenuity and Invention. (p. 20)

This tirade against sloth and the excesses of the middle class reflects a growing concern of 18th century medical practitioners, who exalted the benefits of a plain and simple existence over that of the “good life” (Dixon, 1995, p. 128). Cheyne's work is notable for the fact that he believed the over-indulgences he associated with hysteria to be more common in densely populated cosmopolitan areas, such as London, where nervous disorders, including hysteria, were commonly diagnosed and their symptoms highly dramatic (Veith, 1965). This is in line with a view of hysteria as related to social complexity. If not regarded as pioneering from a theoretical standpoint, Cheyne’s book nonetheless constitutes a kind of self-help manual for those afflicted with nervous disorders. It is quaint and highly readable.
Further developments during the 1700s included the treatment of hysterical symptoms with animal magnetism, an early form of hypnosis pioneered by Anton Mesmer (Winter, 1998), and Robert Whytt's affirmation of Sydenham's thesis of the relationship between emotion and hysteria (Veith, 1965). Whytt, a physician and neurophysiologist, regarded "hysteric" and "hypochondriasis" as two different names for a single disorder. Nonetheless, he extended the view that women were far more susceptible than men to the ravages of hysteria due to a greater delicacy of the nerves and, consequently, a more fragile constitution. Maintaining that physiological symptoms could be produced by emotional stimuli, Whytt believed such symptoms to be "mediated by the nervous system" (Slavney, 1990, p. 23). Given the presumed delicacy of the female's nerves and her weaker constitution, a portrait of women as victims of their own affect emerges from Whytt's theorizing:

It is to be observed that strong nervous symptoms are seldom occasioned by fear, terror, grief, the force of imagination, or any sudden impression on the organs of sense, in persons whose nerves are firm and less sensible; but, when the contrary is the case, the causes above mentioned will often produce the most sudden and violent hysteric fits or convulsive disorders (cited in Slavney, 1990, p. 23).

Such a perspective promotes a view of the female as emotionally friable and a psychoneurological conception of hysteria as the product of passions of the mind impressing themselves on the brain. Further, Whytt wrote of the episodic nature of hysteria, later to be noted as a characteristic of DID. Patients with DID alternate between periods during which they are highly symptomatic and those of quiescence (Kluft, 1985). Whytt's list of the symptoms typical of the hysterical fit echo those of his predecessors, and his recommendations for treatment are reminiscent of Cheyne's, including a healthful diet and moderate exercise (Veith, 1965). At the turn of the century, physician
Benjamin Rush maintained that alternating personality, one of the manifestations of hysteria, was the result of a disconnection between the two hemispheres of the brain (Putnam, 1999). Rush, whose account of a young woman with DID was discussed in the first chapter of this thesis, further held that hysteria had become a token of social distinction, affecting, as it seemed, primarily women of the middle and upper classes.

**The 19th Century**

The major themes of the 19th century were the confirmation of hysteria as a functional, rather than an organic, disorder; the positing of a traumatic etiology for the malady; the explication of the relationship between hysteria and dissociation; and a preoccupation with a sexual component, which supported the cultural stereotypes of the time. Hysteria was linked to nymphomania and treacherous sexual behaviour on the part of women, and many clinicians used photographs and descriptive prose to record, according to Micale (cited in Bronfen, 1998), “the erotic misbehaviour of their female patients in loving and lurid detail” (p. 185). Given the contention of early theorists that the disease was associated with an absence of sex and the frequent prescription of marriage as a treatment, this development can be seen as a chauvinistic sexualization of a disorder presumed by male clinicians throughout the centuries to be largely the province of women.

Symptoms of hysteria have changed from era to era much as beliefs about etiology have evolved, conditioned by social expectancy, by religious belief, and also perhaps by public knowledge about medicine. As the concept of hysteria became part of public discourse, more information about the disorder became accessible to the average individual. It may be conjectured that the more detailed the medical knowledge
possessed by the patient, the wider the range of symptoms she experienced (Veith, 1965). This is evident if one compares the complexity of modern-day DID with early instances of dual personality. Additionally, symptoms have been modified by the prevailing concept of the feminine ideal. From classical times forward, the female was presumed to have a more delicate constitution than the male, and her brain was considered to be of a weaker texture, rendering her more liable to violent passions (Merskey, 1979). In yet a more pejorative vein, hysterics of the 19th century were considered deceitful, often charged with malingering, and their condition was presumed to be confirmatory of the moral inferiority of women (Evans, 1991). An examination of the contributions of some key 19th century theorists, an exploration of the social and cultural restraints on women during this period, and a discussion of factors pertaining to the practice of medicine in the 1800s will shed light on our understanding of hysterical symptoms as they were experienced, and performed, during this period.

The Contributions of Robert Carter

Robert Brudenell Carter was born in 1828. Educated in private schools, he apprenticed, as a young man, to a general practitioner and later entered the London Hospital as a medical student (Veith, 1965). A well-known and well-respected medical author, Carter relates hysteria to emotional factors and, as noted by Veith (1965), “He implicated three main factors in the etiology of hysteria: the temperament of the individual, the event or situation which triggers the initial attack, and the degree to which the affected person is compelled to conceal or ‘repress’ the exciting causes” (p. 201). The emotion associated with the triggering event may be fear, or, more likely in Carter’s view, “sexual passion” (Veith, 1965, p. 201). Carter did not consider the disorder to be
the result of uterine disease, for, like others before him, he contended that a parallel illness may affect men (Merskey, 1979). As with his predecessors, however, Carter claimed that women demonstrated a higher level of emotional sensitivity than men, which rendered them far more vulnerable to hysteria. Of particular note in Carter's work is his exclusion of organic disease or dysfunction in the genesis of hysterical symptoms. Rather, Carter's emphasis on emotional factors represents a step in the direction of the positing of a psychogenic origin for hysteria and a rudimentary conception of repression prior to Freud.

Jean Charcot

The later half of the 19th century was dominated by the work of Jean Charcot at the Salpêtrière Hospital in Paris. Charcot was engaged in 1862 as physician to some 5,000 hospital inmates, and during the ensuing decade established himself professionally as both neurologist and teacher (Bronfen, 1998). His reputation as a pedagogue was widespread. Known for his charisma, he brought a sense of the dramatic to the study of hysterical patients while retaining an outwardly aloof and dispassionate demeanour. Approximately 1,000 of the patients housed in the Salpêtrière were hysterics, admitted at the rate of one per day, and to these individuals Charcot devoted most of his time and clinical focus, studying hysterical stigmata, defining the phases of the hysterical attack, and devising therapeutic devices such as the ovarian compressor. By 1885, when Freud came to Paris, Charcot was regarded as “the master of hysteria in the Western world” (Evans, 1991, p. 9).

Charcot proposed a hereditary predisposition to hysteria, and maintained that hysterical attacks were triggered by psychic shock. While conceding that the condition
was not restricted to women, and while positing a psychical trigger for both genders, he formulated a separate set of secondary causal factors that were consonant with the prevailing notions of the masculine and feminine: Women developed the disorder because of their vulnerable emotional natures and inability to control their feelings, and “men got sick from working, drinking and fornicating too much” (Bronfen, 1998, p. 188). In his *Clinical Lectures on Diseases of the Nervous System*, Charcot (n.d./1991) addresses the issue of male hysteria at length, underscoring the robust masculinity of the patients, anchoring his case study commentary in descriptions of their brawny physiques, and expressing wonder that the triggers for hysterical symptoms in a man could parallel those of a woman:

> One can conceive that it may be possible for a young effeminate man, after excesses, disappointments, profound emotions, to present hysterical phenomena, but that a vigorous artisan, well built, not enervated by high culture, the stoker of an engine for example, not previously emotional, at least to all appearance, should after an accident of the train, by a collision or running off the rails, become hysterical for the same reason as a woman, is what surpasses our imagination. (p. xxiii)

Thus, Charcot expects that the female, with her proclivity toward emotional excess and preponderance of inner turmoil, will evidence hysterical symptomatology, but marvels at its presence in the stalwart male. Charcot’s view of hysteria in males was that it was an unnatural condition, whereas in women it was a natural extension of feminine unrestraint. Indeed, he is cited by Evans (1991) as having stated that: “In boys, hysteria doesn’t generally take hold. One might say that the disease has been transported into a soil that doesn’t suit it. . . . [In males] it is a fire easy to put out. It’s as simple as pie” (p. 28). Thus, male hysterics suffer from excesses of a masculine nature, while females suffered from those of a feminine ilk. Given to verbal incontinence and dramatic displays of emotion, one moment laughing, the next weeping uncontrollably, hysterical women
were essentially parodies of femininity exploited by Charcot in his pursuit of professional recognition.

In formulating his theory of the pathogenesis of hysteria, Charcot asserted that the disorder was the result of a "dynamic lesion" (Evans, 1991, p. 28) in the brain. This defect, in concert with some sort of physical or emotional shock, produced hysterical fits. Although Charcot's search, via autopsy, for this elusive lesion was not rewarded, his work nonetheless fostered the view that hysteria was an expression of an aberration of the brain and that it thus fell within the domain of neurology. Hysteria was essentially "a dysfunction of the central nervous system, akin to epilepsy, syphilis, and other neurological diseases" (Micale, 1995, p. 25). The role accorded by Charcot to physical accident or psychic shock in producing hysterical symptoms is delineated by Havens (1995):

He highlighted the specific role of trauma; the traumatic shock determined the hysterical picture by eliciting hysterical mechanisms. This means that, according to Charcot, the (often minor) physical injury was not the determining element, but the emotion, e.g. the fear experienced at the time of the accident. The so-called traumatic suggestion, i.e. an idea, subsequently produced the hysterical symptom. For instance, the idea of being paralyzed produced a paralysis. This conception of an idea determining a hysterical phenomenon was the truly novel element Charcot introduced in explaining traumatic hysteria, and was rendered possible through Charcot's hypnotic experiments with hysterical patients. (p. 372)

Charcot was the first physician to identify a systematic pattern in the manifestations of a disorder that hitherto had been regarded as "the epitome of unruliness" (Evans, 1991, p. 24). From a seemingly random assortment of symptoms, the grand master of hysteria identified stigmata that were considered by him to be pathognomonic of the affliction, including a restricted field of vision and the local anaesthesias that had characterized the hysterics of the middle ages. Further, Charcot
delineated four phases of the hysterical attack. He maintained that each attack followed an orderly and predictable pattern, comprised of four distinct phases each of which was characterized by sub-phases. In the articulation of these phases lies Charcot's true originality as a nosologist. Scrupulous observation being a hallmark of the positivist creed to which he adhered, Charcot went so far as to record through photographs the contortions of his prize hysterical patients. As Evans (1991) notes:

Charcot's division of hysterical attack into phases - prodromes, clonic phase, "clown" phase, period of grandes attitudes, and resolution - brought him admiration and praise, and enabled him and his colleagues to systematize and control intellectually a phenomenon that had hitherto eluded them. His labels gave doctors a scientific vocabulary to use in talking about these attacks which freed them from the phenomenological language grounded in hysteria's past history of demonology and sexual license. So while the patients who suffered from hysterical attacks and lay people who observed them experienced them as a chaotic, violent, uncontrollable, and inexplicable display of unknown origin, Charcot and his colleagues could now regard them as the predictable and orderly evolution of a symptom of an identified disease. (p. 24)

The prodromal phase that preceded a hysterical attack was signalled by epileptic-like spasms, the globus hystericus, pain in the ovarian region, generalized abdominal pain, pain and pressure at the temples, and visual impairment. The first phase of the attack, known as hystéro-épilepsie for its similarity to epileptic convulsions, was comprised of a period of agitation that was characterized by facial pallor, vocalizations, and an ensuing loss of consciousness, followed by muscular rigidity. After this, the hysterical patient would perform tonic convulsions of the body, circling into a ball in the manner of Mary Glover, and completing this sub-phase in what Charcot termed "tetanus paralysis" (Bronfen, 1998, p. 180), a total musculature rigidity followed by "clonic spastic convulsions" (p. 180). During the second stage of an attack, which Charcot termed the "clown phase" (Faber, 1997, p. 283), the hysteric engaged in
sweeping movements of the arms and grotesque bodily contortions, all such bizarre motions being characterized by an enormous expenditure of muscle power and epitomized by the "arc en cercle" (Faber, 1997, p. 283). In this most theatrical of hysterical poses, the patient would arch her back in a circular motion such that only her feet and the top of her head rested on the floor. The acrobatic movements that typified this phase were often accompanied by screams and hissing noises, unintelligible vocalizations of an almost animalistic nature. Charcot regarded the symptoms of this phase as mimetic of some powerful emotion such as fear or anger.

The third phase was that of the "attitudes passionelles" (Faber, 1997, p. 283). Charcot believed the passionate attitudes to constitute hallucinoses. It was his contention that during this phase of the attack:

The patient gives a very personal report of the stations in her psychic development, exhibiting emotionally laden, compelling gestures and articulating fragments of sentences. In other words, he understood the hysteríc to be converting her psychic trauma and its symptoms into a personal drama, within which she finds herself enclosed or rather within, and in which she believes she is playing the main part, much as Freud would later call the phantasy a mise-en-scène of desire. Whether these performed hallucinations were cast in a comic, or a tragic mode, Charcot claimed, they were oblique representations of the passionate events and emotions from the patient’s psychic reality – love scenes or fires, wars, revolutions, murderous acts, amorous supplications, ecstasy – with the hysteríc experiencing false sensory and mental images as true, with visions of animals and monsters calling forth actual fear or joy, tears, screams, or laughter. (Bronfen, 1998, p. 181)

Charcot sought to determine the nature of the trauma being recapitulated in these performed hallucinations but without concern for interpretation. His primary interest was neurological; he sought to impose order on an unruly and seemingly meaningless somatic narrative. The fourth and final phase of the hysterical fit constituted a period of delirium during which the patient, having traversed the preceding cycles of
the attack, would gradually regain consciousness (Faber, 1997) while weeping or laughing uncontrollably. The entire cycle of four phases was usually performed in approximately 15 minutes. However, this cycle might be repeated up to 200 times consecutively. This meant that over the course of a year, one patient might endure literally hundreds to thousands of attacks.

While Charcot's access to hysterical patients was virtually unlimited, his interest remained primarily centred on recording the phases of the attack for medico-scientific purposes and disseminating his knowledge of the disorder. He had little interest in therapeutic intervention, although he did identify a number of "hysterogenic" zones of the female body which included the ovarian region, and devised a contraption called the "ovarian compressor" (Evans, 1991, p. 29), a belt-like device which patients were forced to wear for hours – or days – at a time in the hope of preventing an attack. Believing hysteria to be hereditary and degenerative, treatment was limited to the relief of symptoms in the absence of any real hope of a cure. Teaching occupied much of Charcot's time, and every Tuesday night he staged lecture-demonstrations at the Salpêtrière which featured performances by a number of hysterics, during which the afflicted women would enact the four phases of the hysterical fit publicly before an attentive group of male medical practitioners. The walls of the theatre in which these demonstrations took place were decorated with images of hysterics in poses, which typified the phases of an attack. One of these was a painting by artist André Brouillet of Charcot with one of his patients. Acocella (1999) describes the painting:

In it, the great doctor addresses his all-male audience while supporting the swooning body of his star patient, Blanche Wittman, known at La Salpêtrière as la reine des hystériques, the queen of the hysterics. The bosom of this attractive young woman is bared almost to the nipples. She is having a hysterical seizure, although if you didn't know it, you might think she had just
had an orgasm. Close by stands a bed, sit of sleep, illness, sex. Hysteria, before being an illness, was a theory of women. (p. 31)

For the purposes of demonstration, a hysterical attack would be precipitated by pressure exerted on one of the hysterogenic zones or induced via hypnosis. Patients such as Wittman earned fame amongst the inmates of the Salpêtrière and widespread notoriety in the word of medicine. Viewed as deceitful, sexually insatiable, and morally bankrupt, performing hysterics raised the hysterical attack to the status of an art form. Yet, as Bronfen (1998) has noted, if the attack “was seen as a representation of sexualized manipulative power on the part of the patient, the inextricable counterpart to that equation is that it was publicly reproduced in order to confirm the mastery of the physician” (p. 184).

Pierre Janet

It was Janet’s work with hysterics which forged the link between hysteria and DID. His identification of the subconscious fixed idea, which was discussed in Chapter 1 of this thesis, formed the foundation for a structural model of dissociation which accounted for the cleaving of consciousness in such a manner that “in the dissociated state (e.g., following psychological trauma) subconscious ideas, emotions and memories are pathologically split off from the main focus of attention” (Brown, MacMillan, Meares, & Van der Hart, 1996, p. 481), or what contemporary researchers would term the “primary identity.” These secondary states became autonomous in instances of DID, co-existing with the primary identity. Janet viewed dissociation as existing only in those with psychiatric disorders, primarily hysteria. For him, a doubling of the consciousness lay at the heart of the hysterical condition (Crabtree, 1993). Further, dissociation and a
narrowing of the field of consciousness, defined as "the reduction of the number of psychological phenomena that can be simultaneously united or integrated in one and the same personal consciousness" (Van der Hart & Horst, 1989, p. 404), were described by Janet as the two essential characteristics of hysteria.

Hysteria comprised all dissociative and related disorders; the primary stigmata of the malady were anaesthesia and amnesia (Kihlstrom, 1994). These core phenomena were believed to be produced by an underlying defect in the process of psychological synthesis, and were reflected in loss of cutaneous sensation and fugue states, respectively. Janet outlined a number of personality factors that he believed characterized the hysteric, including "sexual preoccupation" (Merskey, 1979, p. 26), a preoccupation with self, and affective lability. He also believed hysterics to be highly suggestible, possessing a hypnotic sensibility, which rendered them both prone to dissociation and responsive to treatment by hypnosis.

Janet conceptualized hysteria as a post-traumatic syndrome, employing the term "hystérie traumatique" (Brown et al., 1996, p. 482), and consolidating the natural history of the disorder in a triphasic model. In the acute stage, the individual is overcome by intense affect, such that the experience of trauma cannot be assimilated or, in Janet's terms, synthesized. In the second stage, a narrowing of the field of attention occurs as memories of trauma become "dissociated as subconscious fixed ideas" (1996, p. 482). These memories are re-experienced as flashbacks, nightmares, and related dissociative symptoms. The third stage is characterized by depression and a loss of volition. In Brown et al.'s (1996) terms:

Janet thus considered the mechanism of post-traumatic hysteria to be dissociation with a progressive deficiency in the capacity for synthesis, first of traumatic images and emotions, then of traumatic memories as
subconscious fixed ideas, and ultimately of a progressively wider range of personality functions and variables. (p. 482)

Like his mentor Charcot, Janet was a fastidious clinician, and held to the belief that patients could not be adequately treated without a thorough and detailed understanding of their pre- and post-morbid histories. However, unlike Charcot, who held little hope for the hysteric's recovery because of his belief in the organic basis of the disorder, Janet held the belief that recovery was possible. His approach to treatment was to interview not only the patient, but relatives and close friends as well, to obtain as complete a picture as possible of the patient's level of function both prior to and after the onset of hysterical symptoms (Van der Kolk & Van der Hart, 1989). He made extensive use of hypnosis in an effort to gain access to the subconscious fixed ideas that lay at the core of dissociative symptomatology, and used psychotherapy to facilitate patients' exploration of traumatic memories and related subconscious (dissociated) phenomena" (1989, p. 1537).

**Sigmund Freud**

Sigmund Freud's contributions to the study of hysteria are linked to the origins of psychoanalysis itself. In 1885, Freud, then a youthful neurologist, travelled to Paris to study with Charcot at the Salpêtrière, remaining there until the following year (Libbrecht & Quackelbeen, 1995). Fascinated by what he saw at the hospital, Freud was particularly interested in Charcot's studies of male hysteria. Freud would later credit Charcot with having influenced him in the direction of psychiatry rather than neurology, in which he had been trained. In Micale's (1995) terms:
Upon his return from Paris to Vienna, he began an intellectual evolution, extending across the next fifteen years, from a neurological to a psychological construal of nervous illness. No disorder was more important for this historical development of Freud's thinking than hysteria. Psychoanalysis in essence began as a theory of hysteria. (p. 27)

The treatise *Studies in Hysteria*, published in 1895, was written by Freud and his colleague Joseph Breuer, and constitutes Freud's first papers on psychoanalysis. The introductory essay in the book presents the view that ideas or memories that are absent from the patient's conscious awareness in a normal psychical state can be revealed through hypnosis (Breuer & Freud, 1895/1937). These ideas embody psychic traumata that produce an abnormal state because of the affective charge associated with the trauma or "because of a disposition to hypnoid states" (Merskey, 1979, p. 30). Freud further hypothesized that such unresolved mental conflict produced hysterical symptoms. Symptoms such as amnesia were held by Freud to be dissociative, while somatic symptoms such as pain, anaesthesia or paralysis were termed "conversion" (Breuer & Freud, 1895/1937, p. 83) symptoms.

Freud also addressed the issue of doubling of the personality. In his view, a "condition seconde" (Breuer & Freud, 1895/1937, p. 11) resulted from a hypnoid state gaining control over the normal consciousness, or primary identity. During a hysterical attack, control of the body became entirely the province of the hypnoid consciousness. Freud conceded the possibility of a predisposition to hysteria, in much the same way that contemporary researchers (Braun, 1987; Fahy, 1988) propose the existence of a biopsychological capacity to dissociate. However, Breuer and Freud (1895/1937) believed splitting to be precipitated by severe trauma or the suppression of sexually-charged affect and held this to be possible even in individuals who are not predisposed. Breuer and Freud further hint at the existence of a continuum of dissociation, holding that "the
facility of dissociation in a particular individual and the magnitude of the affective trauma vary inversely" (p. 9).

In his early work on hysteria, Freud noted the repeated emergence in his patients' histories of themes of a sexual nature, and believed that these women had experienced a sexual trauma that "played an important role in the aetiology of the particular hysterical syndrome for which they sought treatment" (Spielman, 1995, p. 577). This observation led to the formulation of his seduction theory, where he put forth the view that the repression of memories of childhood sexual trauma led to the production of hysterical symptoms, which could be alleviated by the retrieval and re-experiencing of memories of these events (Gleaves & Hernandez, 1999). Freud deemed two conditions to be necessary for hysterical symptoms to develop: The memory of the traumatic event must be repressed from consciousness, and this memory must at some point – in Freud's view, after puberty – be triggered by a later event.

Freud's work completed the transition from uterine to demonological to neurological theories of etiology, coming to rest on a foundation of belief that the origins of hysteria were psychogenic in nature. In Micale's (1995) terms, "he reversed the previously projected direction of mind/body causality: hysteria, he claimed, was a psychological disease with quasi-physical symptoms" (p. 27). Such a model of hysteria entailed a revolution in approaches to treatment. As a product of intra-psychic factors, hysteria was seen to lend itself well to psychotherapeutic intervention. Employing hypnosis and the technique of free-association, Freud sought to rid his hysterical patients of the burden of the psychic trauma and thus to free them of the symptoms it had generated.
Social and Cultural Influences on Hysteria

The sheer number of hysterics identified in the late 19th century demands an examination of some of the social, cultural, and political factors that may have contributed to the over-diagnosis of the disorder. One reason for the excess of diagnoses may have been the overcrowding of the medical profession during the latter half of the 19th century (Loudon, 1986). In the early part of the century, with an increased emphasis on hospital-based instruction rather than the apprenticeships that had previously comprised medical education, the training of physicians became a thriving industry. Whereas no common basic medical training had existed in the 18th century, the 19th century saw the flourishing of large medical schools to which students forged strong loyalties. As Loudon notes:

The process of training and initiation into the world of medicine was the same for the future physician, surgeon, or general practitioner. All were branded deeply with the mark of their teaching hospital. Being a Guy's, Bart's, Thomas's or Middlesex man produced powerful emotional ties, gluing the profession together and sometimes even transcending subsequent differences in status, income, or position. (p. 51)

Students paid handsomely for the privilege of affiliation with these institutions, which meant that many – or most – left medical school with a passionate desire to compensate monetarily for years of financial deprivation. Constant competition amongst medical practitioners for practice wherever it could be found meant the identification of pathology in the most benign of symptoms. The struggle of the physician for professional autonomy and better pay led to the development of voluntary associations which devoted themselves to the improvement of conditions of public employment for physicians in posts such as orphan asylums and hospitals for the insane (Peterson, 1978).
Although public employment was readily available, it was not readily accepted. Asylums housed those of a lower economic stratum, and physicians sought a more affluent population whence to increase their earnings. Female hysterics provided a new, lucrative clientele, affording the practitioner both a stable income and the security of a long-term patient. As Duffin (1978) maintains:

The middle-class woman was the ideal patient: her illnesses were rarely severe; she required frequent visits and long-term treatment; the financial resources of her affluent husband were almost inexhaustible. A few dozen well-heeled ladies as patients nicely lined the pockets of the aspiring medical practitioner. (p. 33)

Given, according to popular belief, the refractory nature of hysterical symptoms, the hysterical patient fit this bill beautifully. The relationship between the hysterical patient and her medical practitioner was not totally unilateral, however. The services of a physician were considered a status symbol (Peterson, 1978). Given to vapours and uterine fits, the hysteric of the 19th century thus played a role not only in terms of providing the physician with a source of income, but also in terms of elevating his social and political status. Struggling against the legacy of its early roots in the apothecary trade, the medical profession as a whole strove to attain an elite position, both socially and professionally. Political authority was attained by legislation to exclude apothecaries from membership in ivy-league medical colleges. Further, the passage of prescription laws afforded physicians’ control over the physical welfare of the general public. In Peterson’s (1978) terms:

Through struggles for power, law, codes of ethics, and the restructuring of their professional community, medical men created a new corporate structure... [they] created a special place for themselves in which modern science justified a “traditional” structure of authority and social relations. (p. 287)
As medical practitioners gained "expert" status, the average medical consumer (including the hysterical patient) was disenfranchised, subject to the authority and expertise of the physician, and denied an active role in the quest for health. And as physicians gained professional solidarity, there was increasing social acceptance of their expertise and authority, which not only reinforced cultural assumptions about male dominance, but also underscored the power of the physician in terms of his unique ability to name, to describe, to classify, and to judge. This in turn emphasized the power differential between men and women, male physicians and their female hysterical patients. Armed with their new scientific standing and the positivist discourse instituted by Auguste Comte in the mid-19th century, physicians enjoyed a prestige accompanied by an increase in political power (Evans, 1991). The politics of the profession and those of the government were closely intertwined. Government agencies were involved in the establishment of regulations concerning the profession and the promotion of its members. Additionally, although medicine had a long history, psychiatry was at this time only beginning to establish itself as a specialty. Psychiatrists sought to claim the neuroses, of which hysteria was one, as part of their professional turf. In Evans' (1991) terms, "the promotion of hysteria as an illness worth serious study would thus have furthered the interests of psychiatrists desirous of charting the territory of their new discipline" (p. 14). Medicine was the province of men, illness the province of women.

In no arena was the newly acquired power of the male medical profession exercised more rigorously, more dramatically, or more devastatingly than in its use of clitoridectomy as a cure for hysteria, masturbation, nymphomania, and other sexually-related "disorders" of the mid-to-late 19th century. In the view of obstetrician Isaac Baker Brown, female insanity progressed through a series of eight stages, beginning with
hysteria and culminating in outright lunacy, and was preceded by episodes of autoerotic
behaviour or sexual excess (Lewis, 1984). The procedure itself involved the excision of
the hood of the clitoris, the clitoris itself and, not uncommonly, the removal of the labia.
The earliest account of this surgery dates from 1851. It was particularly favoured by
American physicians (Moscucci, 1996). The combination of an arid moral climate and
the misuse of medical power is captured by Lewis:

Like legislators, doctors set themselves up as women’s protectors and the
preoccupation with women’s reproductive systems as the source of their
illness and weakness led them to assume the role of moral guardian. Female
well-being was classically associated with passivity, a love of home, children
and domestic duties, and, in the mid- and late nineteenth century, sexual
innocence and absence of sexual feelings. Healthy development in women
was thus signified by an attachment to their prescribed sphere and by the
manifestations of moral virtue. (p. 86)

The corollary is that women’s illness and lack of mental well-being are caused by
resistance to or dissatisfaction with socially-sanctioned outlets for personal expression
and/or infractions of the prevailing moral code in terms of sexual behaviour. Nineteenth
century women who felt sexual excitement were considered on the road to
nymphomania (L’Esperance, 1977). Clitoridectomy was the quintessential form of
treatment for such a violation of the prevailing moral code; it returned women to their
“natural” benign state and ensured that they did not threaten their husbands by
expressing forbidden sexual desires or making sexual overtures that were considered
taboo even within the confines of the marital bond. As Ender (1995) notes with respect
to 19th century writings about hysteria, “it seems impossible to conceive woman’s mind
outside of a moral frame” (p. 15). Women were the ill, men the well; women were the
weak, men the strong. In Duffin’s (1978) view, “Defining women as ill began by defining
all specifically female functions as pathological” (p. 32). Menstruation, ovulation,
pregnancy, childbirth, lactation, and menopause which, together, cover most of the lifespan of the female, were pathologized not just by the medical profession, but also by and large on a societal level. Defining women as weak began by defining them in terms of what they were not: not rational, not constitutionally strong, not intelligent, not self-controlled, not male.

The use of clitoridectomy was reflective of the double standard of Victorian morality, made possible by widespread acceptance of the "natural" passivity and purity of woman's essential being. As L'Esperance (1977) notes, "Lack of education, of employment opportunities and of legal rights combined to help the woman accept the inevitability of her dependence on the man, and therefore the naturalness of the 'double standard'" (p. 112). Another manifestation of this was the prescribed standards for socially acceptable behaviour on the part of the female, reflected in the Victorian emphasis on the importance of home and family. In order to ensure her very eligibility for marriage, the young Victorian woman had to display a capacity for one form of obedience above all others — fidelity. A woman was trained from girlhood to submit to the authority of her father, to content herself with parlour activities, and to confine her ambitions to the domestic sphere. As Harrison (1977) maintains:

The selection of occupations considered suitable for a young lady was severely restricted. She was permitted to pass her time only with those activities likely to enhance her chance of attracting a husband. . . . Sketching, playing the piano and singing ballads were thought to be amusements in which a young lady might display herself to her best advantage. The construction of shell boxes, seaweed albums and wax flowers were considered fitting tasks for delicate fingers. Decorative needlework was thought charming in a girl; darning and mending, however, were not. Familiarity with literature, say the romantic poets, classical authors and certain lady novelists, was also thought charming, providing no dangerous avant-garde or blue-stocking tendencies obtruded. A girl was expected to love flowers and animals, but to know nothing of biology, particularly its darker side. She was expected to feel sorry for the poor, to
distribute Christmas boxes and behave decently to the servants, but politics and economics were deemed to be above her pretty head, and anyway none of her business. Needless to say, elaborate steps were taken to ensure that sex and all related matters remained a sealed book to her. In short, she was required to devote her energies to advertising the fact that her upbringing consisted only of perfecting a set of dainty aptitudes which bore no taint of practical utility. (p. 29)

Thus from an early age the limits of appropriate behaviour were inculcated in the 19th century female. There were no women, only ladies. Sexual feelings were to be expressed only within the confines of the conjugal bond, and in the Augustinian tradition, the primary purpose of marital sex was reproduction. Sex for any other reason was considered unnatural, as was the use of any means to avoid becoming pregnant (Plante, 1997). A woman’s first duty was to bear children. Thus, she was prevented from achieving success in any arena that did not centre around hearth and home. As physician Henry Maudsley noted in 1879:

The range of activities of women is so limited, and their available paths of work in life so few compared with those which men have in the present social arrangement, that they have not, like men, vicarious outlets for feelings in a variety of healthy aims and pursuits. (cited in Showalter, 1997, p. 16)

These constraints on female behaviour were reinforced by a plethora of publications devoted to the subject of etiquette. Given the popular belief that women were not only constitutionally weaker but less intelligent due to a smaller brain, such tomes were considered not only to provide valuable information that would help ladies ensure “correct” behaviour but also to provide ample intellectual stimulation. The Young Lady’s Guide to Knowledge and Virtue, Godey’s Lady’s Book, The American Woman’s Home, and other manuals extolled the rectitude of domesticity while delineating a moral code that applied to every possible situation in which the Victorian woman might find herself, whether out to dinner, shopping, or visiting friends (Plante, 1997). Further, as
cultural historian John Kasson has noted, “the entire ritual structuring of urban life, although performed in the name of honouring women, assumed and encouraged their subservience to men” (cited in Plante, 1997, p. 107).

**Hysteria as Text**

In exploring the textual aspects of hysteria, some attention must be given to the dramaturgical elements of the disorder. There is certainly a theatrical component to Freud’s thesis of hysterical symptoms as being the result of repressed sexual trauma; his patients’ psychic conflicts were quite literally acted out in conversion symptoms. As I will discuss, hysteria – particularly hysteria of the Charcotian era – was theatre in its “pure” (Goffman, 1974, p. 125) form. Micale (1990) has noted the extensive effort on the part of 19th century clinicians to record in detail the behaviour of the hysterical female, and the poses typical of hysterics were preserved in photographic records during the late 19th century. Indeed, Charcot’s collection of photographs, which he used for didactic purposes, was remarkably extensive. Countless photographs of hysterical women were collected and published in a 3-volume work entitled *Iconographie photographique de la Salpêtrière* (Showalter, 1985). The most famous of these remains the lithograph of Blanche Wittman, referred to in an earlier section of this chapter. This picture, which portrays Charcot lecturing to a group of medical students while Wittman swoons into the arms of his assistant, hung on the wall of the theatre in which the Tuesday lecture-demonstrations took place. As Showalter (1985) notes, it constituted “yet another representation that seemed to be instructing the hysterical woman in her act” (p. 149). In King’s (1995) terms, “These images may seem a particularly voyeuristic intrusion into the life of the patient, but the condition requires an audience; there are no solitary
hysterics" (p. 447). At the Salpêtrière, the audience consisted not only of the male physicians who attended Charcot's Tuesday evening lecture demonstrations, but also fellow hospital inmates who replicated each other's symptomatology and strove to out-do each other in terms of sheer dramatic virtuosity.

Yet if hysteria is in large part mimicry, one must query: "Whence do its actors learn their roles?" They were learned from the images that preserved them, from photographs of hysterics lining the walls of the lecture theatre at the Salpêtrière. Further, they were learned from the doctors whose expectations were borne out in the bodies of highly suggestible women who had opted for a kind of "flight into illness" in order to escape the burden of conventional social roles and the expressive limitations they imposed. Additionally, they were learned from fellow inmates. The mimetic nature of the illness had been noted in the 17th century, by Thomas Sydenham, who held that it imitated a myriad of clinical entities in the diagnostic repertoire. Kihlstrom (1994) makes reference to the fact that when, during a rearrangement of inmates' housing facilities at the Salpêtrière, hysterics and epileptics were roomed together, hysterical patients began to emulate the convulsive seizures of the epileptics. Charcot recognized the form taken by hysterical symptoms as being due, in part, to suggestion, and used the term "hystero-epilepsy" (Faber, 1997, p. 281) to denote the manifestations of true hysteria.

King (1995) maintains that hysteria "is women's language, the language of the body expressing what cannot be said verbally due to the conventions of the day" (p. 447). The hysterical body is thus textual, insofar that it is something that can be read, interpreted, deciphered. Hysteria can be seen as an outlet for creative self-expression and as a form of communication in the absence of access to those forms of communication available to men. Further, in light of the historical powerlessness of
women and in terms of the very hyperfemininity of the symptomatology of the disorder, it can be seen as a form of rebellion, of social protest. As Showalter (1985) suggests, women are “typically situated on the side of irrationality, silence, nature and body, while men are situated on the side of reason, discourse, culture and the mind” (p. 3). Thus, women “often act as repositories for the disavowed anxiety and irrationality of a patriarchal culture” (Hartocollis, 1968, p. 164).

Kendall (1982) asserts that the phenomenon of hysteria may be understood in light of role theory. According to Kendall, when the demands of life (such as those associated with a rigidly prescribed gender role) become burdensome, the adoption of the sick role becomes a viable option. In proof of the fact that a view of the hysteric as deceitful did not expire with the termination of the 19th century, Kendall (1982), in a sexist and pejorative vein reminiscent of earlier clinicians, holds that “manipulative behaviour is essentially a strategy for achieving power in the context of a role which does not normally provide it. This is why it is exhibited . . . by patients toward their doctors, and by women towards men, and not the other way around” (p. 33). Freidson (1975) notes four characteristics of the sick role. First, the individual’s incapacity is believed to be outside his or her control. Second, the illness frees the individual from obligations pertaining to professional or domestic spheres. Third, it provides an opportunity for the individual to “deviate legitimately” (p. 317). Fourth, the sick role carries with it the expectation that the individual will seek competent professional help for his or her affliction and will make every effort to adhere to medical practitioners’ advice. As Showalter (1985) maintains:

When the hysterical woman became sick, she no longer played the role of the self-sacrificing daughter or wife. . . . Instead, she demanded service and attention from others. The families of hysterics found themselves
reorganized around the patient, who had to be constantly nursed, indulged with special delicacies, and excused from ordinary duties. (p.133)

Thus, hysterical symptoms have a kind of political utility, serving to reconfigure familial relationships and permitting the patient to reassert personal power.

Dramaturgically, hysteria also can be seen as the embodiment of a deeply aberrant script of doctor-patient interplay: The helpless passive female exhibiting traits of stereotypically feminine behaviour according to social expectancy, the heroic male medical practitioner, all-knowing, all-powerful, and equipped with the authority of his superior status and the skill to intervene, further reinforcing his masculinity and disenfranchising the hysteric. The power of the physician is underscored by Evans (1991), who quotes one of Charcot's patients, a 14-year old anorexic, as having said, “Since I had a horror of eating, I didn't eat. But when I saw that you were the master, I was afraid, and in spite of my repugnance, I tried to eat” (p. 37). However, the refractory nature of the symptoms themselves suggests not only that the sick role was one of the few arenas in which hysterical women could exert some influence, but also that it embodied the potential to alter the power differential between the patient and her physician. Resistant to treatment, as hysteria was, the very fact of its recalcitrance underscored the inadequacy of the male medical professional as healer. Showalter (1985) maintains that “physicians perceived hysterical women as their powerful antagonists” (p.133), were concerned about aiding and abetting their patients' relinquishing of domestic responsibility and, worse, were being forced to side with them against their husbands in support of their inability to function in their accustomed role. Indeed, during the mid-19th century, Robert Brudenell Carter had expounded upon the difficulties inherent in dealing with female hysterical patients. Casting the doctor-patient
encounter as a potential battlefield, he cautioned the physician to stand firm against any challenges to his authority:

[This] first conversation with an hysterical girl, is a thing that must not be hastily or lightly undertaken, for upon the method of its performance will chiefly depend the success of after management. However much the practitioner may possess of firmness, coolness, and tact; however much knowledge of human nature generally, and of the character of the individual under his charge, he will have commenced a task in which none of these powers or acquirements will be found either redundant or superfluous. He will be called upon to place unwavering trust in his own professional opinion, and to act upon his faith; to express himself with such determination as to show the hopelessness of a contest with him (italics added). (cited in Micale, 1995, p. 147)

In explicating hysteria as text, Beizer (1994) makes reference to the "devocalized bodies" and "voicelessness" of hysters (p. 12). The hysteric, while in the throes of an attack, utters garbled, inarticulate, almost animalistic sounds. Thus there is an absence of coherent narrative. Beizer's thesis is that the hysteric's body is ventriloquized. For Beizer, ventriloquy constitutes the process by which the hysteric's speech is first suppressed and then "dubbed" (p. 9) by a narrator in the form of the male medical practitioner. Thus, Beizer seems to view the hysteric as a kind of puppet manipulated by the physician and, further, to imply an absence of volition in the hysterical individual.

According to Merriam Webster's Collegiate Dictionary (1993), to "dub" is "to provide (a motion picture film) with a new sound track and esp. dialogue in a different language" (italics added; p. 357). The language, in the dubbing of the hysteric's voice, is the language of science; it is the language of logic, the language of the positivist tradition; it is the language of men. It is the language employed by Charcot in his efforts to impose order on a seemingly meaningless assortment of symptoms; it is the language employed by Freud in his formulation of hysteria as a psychogenic illness; it is the language employed in medical treatises about the disorder. It is a language that speaks of male
dominance and female submission. It is a language that makes sense of feminine symptoms in masculine terms. Further, as Davis (1977) maintains:

The move to align the male body with scientific “logic,” as if doing so were natural and inevitable, is a strategic move to make a male seem to be the only “natural” speaking subject. The nature of this strategy helps to explain how the strength or weakness of particular manifestations of maleness may do little to change patriarchy . . . . In this way, male authority derives from a fundamentally discursive practice, from privileging males as ideal knowers and the ones who speak of and for knowledge. (p. 53)

In the opening pages of this thesis, I referred to hysteria and DID as scripted behaviours. A script is the “written text of a stage play, screenplay or broadcast, specif: the one used in production or performance” (Merriam Webster’s Collegiate Dictionary, 1993, p. 1050). It is thus something written by someone that is performed in accordance with the wishes and intentions of that person. The script associated with hysteria is cultural. It is grounded in misogyny, in the views of male medical practitioners with respect to the “inherent” weakness and infirmity of women, grounded in social constraints on female behaviour, grounded in assumptions about female moral insufficiency. The script is written by men and enacted by women. Its elements include prescriptions for appropriately female behaviours. As Ussher (2002) holds, “rather than ‘femininity’ being seen as pre-given or innate, it is seen as something that is performed or acquired” (p. 220); that is, it is dynamically constructed through social relationships.

The sphere of activity of the 19th century female was clearly circumscribed. A woman must not think too much, read too much, say too much, or extend herself in any domain beyond the domestic. She must content herself with activities pertaining to home and family; she must not indulge in intellectual or creative pursuits beyond those associated with the education of her children. Further, she was expected to be emotionally labile, to be given to displays of affective excess, and to be incapable of rational thought.
The body of the hysteric is essentially "hyperfemale, hyperexpressive," (Beizer, 1994, p. 22), hyperfluid, hypersuggestible, and verbally inarticulate. It is, in many respects, a caricature – a hyperbolic parody – of femininity. But the hysteric is not voiceless, for it is in the very expression of these symptoms that women found a voice. The enacting of hysterical symptoms was a way of saying "this is what you want me to be, this is what you will permit me to be, so I will take that to its extreme." It was simultaneously a gesture of submission and an act of defiance. But the submission is part of the script, grounded in cultural beliefs about female passivity. Thus, there is narrative in the performance of the phases of a hysterical attack. The narrative is somatic, but nonetheless narrative in a very real and intelligible sense. Whether construed as a subconscious fixed idea, as Janet would have it, or a repressed sexual trauma, as Freud would have it, whatever else might underlie the symptoms of the disorder, the shape taken by them – their very hyperfemininity, their very excess – was dictated by the men whose fantasies they embodied and whose voices spoke for them. The double standard of Victorian morality was reflective of centuries-old beliefs about women as constitutionally weak and morally bankrupt, reflective of the newfound "expert" status of the medical profession, reflective of the conflicting images of Madonna/whore in art and in medical treatises. All of these factors are part of the cultural baggage of a disorder that provided women with a much-needed opportunity for creative expression and protest against social and cultural constraint. The hysteric is enacting something bigger than the subconscious fixed idea of Janetian theory, of wider scope than the repressed sexual trauma. She is enacting what lies at the heart of these, what lies behind them, enacting centuries of marginalization, centuries of suppression, centuries of the misuse of medical power. The hysteric is far from voiceless; her body is
a metaphorical voice. Beizer's (1994) thesis leaves no room for volition, and further
disenfranchises the hysteric - she cannot speak for herself. But she can, and she does.
Beizer (1994) seems not to take into account volition. But hysterical behaviour is highly
colitional: It is an active agentic, striving to be "heard."

**Hysteria as Theatre**

A conception of hysteria as theatre is closely related to the ideas of hysteria as
text and hysterical behaviour as scripted. According to sociologist Erving Goffman
(1959), "A theatrical performance . . . requires a thorough scripting of the spoken content
of the routine" (p. 73). With respect to hysteria, the "spoken content" (p. 73) comprises
the highly expressive enactment of the phases of the hysterical attack, the scripting of
which, as previously discussed, is grounded in social and cultural processes. The
hysteric's performance constitutes the production of symptoms in accordance with
prescriptions inherent in the script. If a performance, as Goffman maintains, is
considered to constitute "all the activity of an individual which occurs during a period
marked by his continuous presence before a particular set of observers and which has
some influence on the observers" (p. 22), hysterical behaviour, particularly that of the
Charcotian era, may be considered a performance to the utmost degree.

In Goffman's (1974) terms, dramatic scriptings such as those embodied in the
hysteric's behaviour are "pure" (p. 125); that is, no performance exists in the absence of
an audience. This view is in line with King's (1995) contention that "there are no solitary
hysterics" (p. 447). Thus in conceiving hysteria as theatre, attention must be given not
only to the role of the performer, but equally to that of the audience, comprised largely of
medical practitioners, whose response both influenced and was influenced by her "on-
stage" presentation. Schechter (1995) observes that theatre is a collaborative
eendeavour. In the instance of hysteria, this collaboration occurs between the hysteric
and her audience, whose members are, in effect, co-producers of the theatrical
experience. In Bennett's (1997) terms, "Along with the artist, the audience enters the
performance arena as a participant – or ideally, the audience disappears as the
distinction between doer and viewer . . . begins to blur" (p. 9). Audience members are
active participants in the creation of a theatrical event, and are ultimately responsible for
sustaining the performance by virtue of their very presence, by virtue of the cues they
transmit to the performer, and by virtue of the fact that they are receptive to the unusual,
the unexpected, the exotic.

A performance thus constitutes a collaboration between audience and performer.
The performance of the hysteric is fed by the undivided attention of the medical
professionals before whom the phases of the attack are enacted. Its choreography is
structured to conform with audience expectations of what constitutes a typical
presentation of the overt manifestations of the disorder. Audience response to the
performance functions to perpetuate the symptomatology and increase the likelihood of
more virtuosic future performances. As Wenegrat (2001) notes:

Grand hysteria could be called an idiom of distress within the Salpêtrière. But, rather than speaking a stable, culturally transmitted idiom, grand hysterics improvised a new role of their own. Rather than passively listening to patients expressing distress, Charcot and his staff helped stage-direct the improvised new illness. They rewarded the most convincing patients, coached others, and even punished some for poor performances. Charcot apparently banished many aspiring hysterics who failed to convince him. By giving them more attention, Charcot and his fellow physicians encouraged inventive patients to add dramatic new symptoms to their repertoires. The Salpêtrists were like a company in rehearsal: New roles were being refined and practiced by promising actresses under the guidance of their stage directors. Also, in the Salpêtrière, patients and doctors alike had goals above and beyond merely communicating. Grand hysterics, for instance, were
using their illness behavior to secure their place in the hospital, to garner attention and privileges, and to raise their status in relation to that of other patients. Charcot and his colleagues were hoping to further their reputations. The more dramatic the symptoms, and the more sweeping the generalizations to which they led, the more they believed they would gain by studying grand hysterics. The hope for dramatic findings, and the resulting competition between patients, led to more dramatic illness presentations. (p. 87)

From the physician's perspective, the witnessing of lavish displays of female irrationality, unrestraint, and excessive emotionality served to underscore his self-control and to reinforce a sense of professional solidarity with fellow medical practitioners who aligned themselves with reason and with restraint. From the hysteric's perspective, these performances constituted a vocation. Patients achieved notoriety in medical circles and amongst their fellow inmates for their ability to generate attacks "on command," and spent years enacting them for Charcot and his colleagues during the infamous Tuesday evening lecture-demonstrations at the Salpêtrière. The reciprocal nature of the relationship between hysteric and doctor, in which there is a mutual investment by patient and physician, finds its analogue in the interdependence between performer and audience. As Goffman (1975) notes, "When an individual or performer plays the same part to the same audience on different occasions, a social relationship is likely to arise" (p. 76). Thus, in considering the performative aspects of hysteria, the roles of both physician and patient must be considered. Each is actor; each is audience. The hysteric is as necessary a component of the medical practitioner's drama as he is a component of hers. As there is no hysteric in the absence of an audience, so there is no physician in the absence of a patient. The Tuesday evening lecture-demonstrations at the Salpêtrière were as much an enactment of medical power and authority as they were a display of female irrationality.
Kahn and Breed (1995) note that in casting for a play, actors must be chosen who are "as close as possible to the playwright's ideal" (p. 23). This was true for Charcot, who selected for Tuesday evening performances those hysterics whose enactments most closely paralleled the classic hysterical attack comprised of the four phases he himself had identified. In addition to a vocation, the hysteric's role might suggest a kind of conferred identity. Hysteria is not something the individual has; rather, it is something she is. Goffman (1959) suggests that self is a product of performance in social contexts, maintaining that "The self . . . as a performed character, is not an organic thing that has a specific location . . . it is a dramatic effect arising from a scene that is presented" (p. 253). The hysteric of the 19th century adhered to the prescriptions of her role as delineated by Charcot, yet that role allowed for some expression of elements unique to her. In Goffman's (1974) terms:

There is a relation between person and role. But the relationship answers to the interactive system -- to the frame -- in which the role is performed and the self of the performer is glimpsed . . . Just as the current situation prescribes the official guise behind which we will conceal ourselves, so it provides for where and how we will show through, the culture itself prescribing what sort of entity we must believe ourselves to be in order to have something to show through in this manner. (p. 573)

Another aspect of hysteria as theatre relates to the use of gesture. As Bronfen (1998) and Faber (1997) have noted, the phases of a hysterical attack were characterized by a variety of dramatic contortions. During the third phase, that of the "attitudes passionelles" (Faber, p. 283), the hysteric placed her hands in a gesture of supplication, accompanying this prayerful posture with an upward gaze and beatific smile, or mimed a scene of crucifixion, arms extended outward, wearing a facial grimace. One of Charcot's most renowned performing hysterics, Augustine, was frequently photographed in these poses (Bronfen, 1998). Helbo, Johansen, Paris, and
Ubersfeld (1987) maintain that the use and interpretation of gesture is contingent upon socio-cultural context, and that gesture is "coded" (p. 159) to transmit the intention of the performer to the audience. The interpretation of hysterical "passionate attitudes" on the part of members of the medical profession – the audience – took place in a social context that supported their construal as pathology. Given that the expressive dimension of the hysteric's performance occurred largely in the paralinguistic domain, gesture remained the primary mode of communication with her audience.

One of Charcot's students, Paul Richer, a physician and artist, produced a number of drawings and etchings that highlight the gestural aspects of hysteria (Micale, 1995). These portrayals, depicting a single female figure in each of the nine postures most commonly associated with the four phases of the hysterical attack, were published in 1885 in a volume entitled *Etudes Cliniques sur la Grande Hysterie*. Hunter (1998) has interpreted the poses characteristic of the passionate attitudes as "an angry game miming a contradictory drama of submission, seduction and retreat" (p. 4). Hunter further holds "that a spectator was built into the movements, and that the represented figure [in Richer's sketches] signaled a desire to communicate, but wished to baffle her observer" (p. 4). In this way, the hysteric preserves some small measure of control over the medical practitioner. This is consonant with a view of hysteria as an act of both submission and defiance. As Ender (1995) notes, "the hysteric's body is merely the visible form given to the secrets of a consciousness. The riddle represented in her symptoms goes back to a consciousness inflected by gender" (p. 23).
Social Life as Theatre: The Theory of Erving Goffman

The work of sociologist Erving Goffman (1959) provides a framework within which hysteria may be further understood as a performance. Employing a theatrical metaphor in his efforts to describe human interactions, Goffman conceives social behaviour in dramaturgical terms. He holds that persons are actors who are continually engaged in the management of the impressions they hope to make on others. Actors are invested in convincing others that they are who they claim – and appear – to be, are perpetually "on stage," and rely on an audience to provide feedback that aids in assessing the credibility of the portrayal and makes future performances more convincing (Mitchell, 1978). Goffman's theory owes much to a conception of self as a product of social congress. For Goffman, it is during the social "act that both meaning and self are established" (Mitchell, 1978, p. 93). With respect to performance, there is a constant tension between a "real" self, that is, the self behind the actor, and self-as-performer. This tension is brought into focus by the tacit demands for consistency in presentation. As Goffman (1959) asserts:

The expressive coherence that is required in performance points out a crucial discrepancy between our all-too-human selves and our socialized selves. As human beings we are presumably creatures of variable impulse with moods and energies that change from one moment to the next. As characters put on for an audience, however, we must not be subject to ups and downs. . . . A certain bureaucratization of spirit is expected so that we can be relied upon to give a perfectly homogeneous performance at every appointed time. (p. 56)

For Goffman (1959) these performances take place in "front regions" (p. 107). An example of this would be the lecture/theatre at the Salpêtrière. The concept of front, however, is for Goffman considerably more complex than the mere location of a performance. He relegates aspects of front to one of two categories, "appearance" and
"manner" (p. 24). Appearance provides the audience with information about the social status of the performer. Manner functions to cue the audience to the nature of the role the performer is about to enact. It is the consistency between appearance and manner that affords the expressive coherence crucial to a successful performance. Front also includes aspects of the physical demeanour of the actor, including gesture, facial expression, and attire. The gestural aspects of hysteria discussed previously function as part of the performer’s front, as do features of the hysteric’s dress. Patients were frequently photographed scantily clad in nightclothes, or with bosom exposed as in the Brouillet lithograph of Blanche Wittman. Further, the hysteric’s manner is submissive, deferential and, above all, obedient. She complies with Charcot’s demands, responding on cue with her presentation of the phases of the attack.

Goffman (1959) further elaborates the necessary constituents of a performance. "Setting" (p. 22) refers to those items used in drama that provide support for the scene to be played out, such as stage props and scenery. In Goffman’s view, a “setting tends to stay put”, that is, the performers who come to the scene of the presentation, “cannot begin their act until they have brought themselves to the appropriate place and must terminate their performance when they leave it” (p. 22). This suggests that aspects of the setting provide cues for both performer and audience, which support a specific and a congruent interpretation of the events of the performance. The Brouillet lithograph reveals features of the setting in which Charcot’s hysterics performed each Tuesday. The walls of the theatre are lined with photographs of hysterics in various phases of the attack. On a table at the front of the room rests a flask and what appears to be other medical paraphernalia. A bed stands close by; the room is crammed with chairs on which are seated men who lean forward peering intently at Wittman, who has fainted into
the arms of Charcot' assistant. A woman, perhaps another hysteric, stands behind Wittman with hands outstretched ready to support her if necessary. All of these features combine to produce both a specific construal of the meaning of the attack and a specific set of expectations on the part of the audience. It is expected that the hysteric will require medical aid at some point during the attack, hence the presence of the male assistant and the unidentified female. It is expected that the patient will be incapacitated upon termination of the attack, hence the presence of the bed. The whole setting functions to medicalize hysteria: to pathologize it, to theatricalize it, and to remove it from the realm of the normative and into that of the abnormal, the deviant, the aberrant . . . the feminine.

Goffman (1959) accords the audience a special role in the performance, maintaining that "hints" (p. 234) are provided to the performer regarding which aspects of their presentation are less than convincing and, thus, affording the actor the opportunity to modify her performance in line with audience expectations. He uses the term “tact” (p. 229) to refer to those behaviours of audience members which function to facilitate a successful performance. For example, an attentive stance on the part of members of the audience encourages the performer, puts her at ease. A willingness to suspend judgement during contradictory elements of a performance – a willingness to forgive – provides a climate that fosters the refinement of ensuing performances. Tact thus both sustains the present performance and shapes succeeding ones. Audiences are primed to behave in a tactful manner for many reasons, one of which is “to ingratiate themselves with the performers for purposes of exploitation” (Goffman, 1959, p. 232). This has particular application to hysteria, given the exploitation of female symptoms by male medical practitioners such as Charcot, with the ulterior motive of elevating their own
professional status and perpetuating, in the public view, their authority over their infirm female patients.

Another concept used by Goffman (1974) in his elaboration of the theatrical metaphor for social life is that of “frame” (p. 10). Goffman's definition of frame in his 1974 publication, *Frame Analysis*, is opaque. Branaman’s (1997) interpretation of this definition is more comprehensible. She offers that frames may be understood as “principles of organization which govern the subjective meaning we assign to social events” (p. lxxiv). Frames provide contexts within which we are able to interpret everyday behaviour. Goffman (1974) carries this idea further, however, in contending that “frameworks or schemata of interpretation” (p. 21) involve implicit rules that guide human behaviour. Crucial for a discussion of hysteria as theatre is recognition of the role that audience expectation plays in how the motive behind a particular behaviour will be assessed, and the way in which framing of that behaviour determines the nature of the expectation. In essence, hysteria is a performance of shared meanings.

**Summary**

An examination of the history of hysteria reveals that its symptoms have been variously viewed over the centuries as uterine pathology, as evidence of bewitchment, as the product of a lax and bourgeois lifestyle and, more recently, as the bodily manifestation of psychic trauma. The form taken by the disorder has been coloured by social expectancy, by prevailing attitudes about women, and by religious forces. A number of researchers (Micale, 1990; Ng, 1999; Shirali & Bharti, 1993) have articulated hysteria as a form of social protest. The disorder may also be viewed as a kind of somatic narrative, a bodily text the script of which is grounded in cultural process. This
script is enacted by women in a patriarchal context, has prescribed elements that found expression in the late 19th century in the distinct and predictable phases of a hysterical attack, and has its origins in centuries-old beliefs about the inherent irrationality and passivity of women. Hysteria as scripted behaviour finds its contemporary counterpart in DID.
CHAPTER 3: DISSOCIATION IN CULTURE

Introduction

Misdiagnosis of psychopathology in clients of culturally diverse backgrounds remains a critical issue for contemporary clinicians. Experience is embedded in systems of meaning that are grounded in cultural practice, including religious ritual, cultural beliefs, such as monotheism or polytheism, and language, which constrains the expression of subjective feelings of distress. The assessment of an individual’s experience as pathological both informs treatment in line with a disease model and influences the ways in which he or she is viewed by other members of the cultural group. Such an interpretation belies the fact that dissociation is regarded not only as normative but also as socially desirable in a myriad of cultural contexts, and in viewing its many manifestations through Western eyes, there is risk of pathologizing where pathology may not exist. In this chapter, I will review the literature on dissociation in non-Western cultures, examining its social functions and discussing the meaning of dissociative symptoms in the context of religious ritual. Many non-Western societies hold a belief in the self as non-unitary, which affects their attitude toward dissociative experience as something that is both desirable and pleasurable. I will briefly discuss the relationship between the Western conception of self, the social construction of DID, and the perception in North American culture of dissociation as pathological. Dissociation wears many masks, and this chapter is an attempt to reveal what lies behind them.
Social Constructionism

While the term “social constructionism” designates an extensive body of theories and tenets, a number of common themes emerge. One of these is a belief in the primacy of social process in the learning and development of the individual. The personal meanings we create are negotiated through social interaction, with language serving a central role in the development of shared understandings (Cromby & Nightingale, 1999). Consider the example of the evolution of a sense of personal identity. DeVos, Marsella, and Hsu (1985) note “that the self is not a static concept, a reified entity, but that selfhood is something that is continuously defined in one’s experience in interaction with others, and that it is this interactional process that contains the meaning of social experience” (p. 10). Another theme is that of cultural and historical specificity. The subjective experience of individuals will vary in accordance with the constraints of their culture and the extent to which language limits the options open to them in terms of responding to life events. This connection is exemplified by the experience of the 19th century hysteric, whose behaviour was socially and culturally circumscribed, and whose language was primarily somatic. Social constructionists further contend that knowledge and social action go together. Different constructions of knowledge invite different responses in terms of social action. For example, the construction of DID as pathology implores a different action from its construction as a normative response to severe life stressors.

A number of authors have articulated DID as socially constructed (Hartocollis, 1988; McHugh, 1995; Martinez-Taboas, 1991; Merskey, 1992). According to a social constructionist perspective, a wide variety of personal experiences are seen as modified
by cultural belief. These beliefs may have to do with what constitutes “health” or “illness,” with religious conviction, or with the importance of the individual’s needs, wishes, and goals as opposed to those of the wider social group. A discussion of the concepts of individualism and collectivism provides a backdrop against which dissociation may be viewed through a social constructionist lens.

**Individualism and Collectivism**

According to Alarcón, Westermeyer, Foulks, and Ruiz (1999):

Culture is defined as a set of meanings, behavioural norms, and values that determine the unique view of human groups and societies about the world and about themselves. Culture also influences the development of personality and individual behaviour styles through parental attitudes, child rearing methods, and through the use and transmission of language. (p. 465)

In individualistic cultures, ties between individuals are loose. People are expected to look after themselves and members of their immediate family. Collectivism refers to “societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people’s lifetime continue to protect them in exchange for unquestioning loyalty” (Hofstede, cited in Kim, Triandis, Kâğıtçıbaşı, Choi, & Yoon, 1994, p. 2). Collective cultures place emphasis on “ascribed” (Kim, 1994, p. 22) relationships, including those associated with family, community, and religious practice. These relationships anchor society, resulting in strong and highly cohesive in-groups. Group boundaries are firm and explicit, while self-group boundaries are relatively undifferentiated. According to Kim, the latter permit “thoughts, ideas and emotions to flow freely” (p. 34). In collective cultures, parental control is viewed as a way of encouraging and socializing a child to become a member of the in-group. This view is at variance with the individualist perception of parental control as something that interferes
with the development of autonomy and thus generates conflictual familial relations. Further, child-rearing practices in collective cultures reflect the emphasis on relationship. In Triandis’ (1995) view, “collectivist child rearing is warmer and also more controlling than individualist child rearing. . . . The ideal child is one that obeys” (p. 65). In collective cultures, priority is given to the goals and the needs of the group. Personal preferences and opinions are withheld if these are not likely to find affinity with those of other in-group members. Collectivism requires and fosters a special sensitivity to others’ needs. As Yamaguchi (1994) maintains, “As collectivists try to conform to the majority’s wish, it would be embarrassing for them to show their unique opinions” (p. 187). Conformity extends to the norms of the in-group, which are internalized in collective cultures to such an extent that norm-compliant behaviour becomes automatic (Triandis, 1995).

The values of collectivists focus on the harmony of interpersonal relationships. An emphasis on family security, respect for tradition, valuation of elderly family members and deference to the opinions of other group members predominate in collective cultures. Situational context is a strong determinant of social behaviour, and in-group members alter behaviour in accordance with context more frequently than members of individualist cultures. Politeness and the social appropriateness of behaviour are guiding forces in the lives of collectivists. According to Triandis (1995), morality in collectivist cultures is also highly contextual, “and the supreme value is the welfare of the collective” (p. 77). Morality is tied to the individual’s level of adherence to socially prescribed behavioural norms. If his or her behaviour reflects the rules of the collective, the person is considered to be of good moral character. In sum, in collective cultures, “individuality is subordinated to a collective identity through a socialization process which maintains
conformity through hierarchically oriented social systems, family economic systems, and social relationship patterns" (Marsella, 1985, p. 302).

Individualist cultures contrast with collective cultures on a number of dimensions. According to Kim (1994), individualism “emphasizes the values of freedom, independence, self-determination, personal control, and uniqueness” (p. 28). Laungani (1999) further notes that: “the philosophy of individualism has a strong bearing on the notion of identity” (p. 195). Similarly, Sampson (1994) holds that the concept of self in an individualistic culture is characterized by a “deep and rich interior” (cited in Kim, p. 28). Whereas the primary social sphere of the collectivist is comprised of ascribed relationships, these are de-emphasized in individualist cultures, which are characterized by a belief that individuals must distance themselves from these relationships. This is regarded as part of a necessary process that fosters the development of autonomy. Whereas collectivists focus on group needs and goals, individualists tend to focus on personal needs, rights, and capabilities (Triandis, 1995). There is a corresponding endorsement of the entitlement of the individual. Whereas in collective cultures there is a drive to conform to social norms, individualist culture is characterized by the desire to withstand social pressure and a need to stand out, to be unique, to be different. Thus, conformity to group norms is less prevalent than in collectivist cultures. Individualist cultures stress the importance of self-reliance and emotional detachment from in-group members. Consequently, any infraction of the cultural code becomes the sole responsibility of the wrongdoer. In contrast, collective cultures, this responsibility would be shared amongst members of the in-group (Triandis, 1995).
Carpenter (2000) and Triandis (1995) elaborate the constructs of individualism and collectivism in terms of “looseness” and “tightness” (Carpenter, 2000, p. 46).

According to Triandis (1995):

Tightness . . . refers to the extent members of a culture (1) agree about what constitutes correct action; (2) must behave exactly according to the norms of the culture; and (3) suffer or offer severe criticism for even slight deviations from norms. (p. 52)

In “tight” cultures, of which Japan is an example, there is a high expectation that norms will be adhered to and little tolerance for their violation. Such cultures are characterized by homogeneity regarding attitudes as to what constitutes appropriate behaviour. In contrast, in “loose” cultures, there may exist a myriad of behavioural options given a certain circumstance or context. In effect, there is a repertoire of equally appropriate behavioural responses to situational demands. In loose cultures, appropriate behaviours “are relatively more flexible and more freely chosen” (Carpenter, p. 41). Further, Carpenter posits a relationship between cultural tightness and self-concept. Carpenter holds that persons from collective cultures have a stronger social identity than do those from individualistic cultures. He maintains that the “independent self” constitutes facets of the person that are related to individual preferences and unique traits, while the “interdependent self” constitutes facets of the person that pertain to significant relationships with family or in-group members (p. 41).

Empirical studies also support the hypothesis that concepts of looseness and tightness are related to attributional style. Concepts of looseness and tightness are related to attributional style. In explaining events, individuals will resort to causal attributions tied to either internal factors (those pertaining to personality traits or individual ability) or to external factors (those pertaining “to situational constraints or to
contextual factors"; Carpenter, 2000, p. 42). Members of individualist cultures tend to display a "self-serving bias" (p. 42) in their attributions, considering themselves personally responsible for their successes, but attributing failures to external factors. In contrast, members of collective cultures "tend to regard internal factors as more causally significant than external ones in cases of failure, while they attribute external causes rather than their own efforts to cases of success" (DeVos, 1985, p. 148). Wittkower (1968) further holds that collective cultures may be characterized as "shame-based" (p. 813). Members of such cultures are predominantly guided by external authority (the opinions of peers and family members), while individualistic cultures are "guilt-based" (p. 813) in terms of the fact that their members have internalized societal codes with respect to morality and sense of duty to others.

Japan and India are two countries whose cultures are collective. Japanese culture is characterized by conformist views of the self, a need to cultivate similarity and self-discipline, and the subordination of individual needs to the needs of the group, be it family or members of the wider social sphere (DeVos, 1985). The self is rarely seen as autonomous. Rather, in Johnson's (1985) view, there is a denial of self evident in social encounters, which reflects the fundamental cultural norm of enryo, "an institutionalized and ceremonialized form of denial of self-importance" (p. 123). There is a high value placed on self-criticism and self-reflection (DeVos, 1985). The Japanese sense of self is directed toward immediate social purposes, rather than toward separating self out from others and keeping it distinct, as is the Western ideal. As Johnson asserts, "the acknowledgment of interdependence in family, work, and friendship relations is highly conscious and integral to successful social navigation in Japanese life" (p. 124). This dynamic, termed "amae" (p. 124), comes into play at an early stage. Following the birth
of a child, there is a period of prolonged symbiotic mothering (Roland, 1988), which results in an interdependent relationship between mother and child. There is a high degree of empathy in the mother's orientation toward her child. Japanese mothers are highly indulgent and, unlike their Western counterparts, do not enforce weaning, bedtimes, or early toilet training. As Kim (1994) notes:

> When a Japanese child is born, the mother remains close to the child to make the child feel secure, to make the boundary between herself and the child minimal, and to meet all of the child's needs, even if that means a tremendous sacrifice on her own part. (p. 35)

It is precisely this type of socialization that creates the bond of amae. In contrast to Western child-rearing practice, which encourages the progressive independence of the child from an early age, physical distance from the child may be used in Japanese culture to correct his or her behaviour; it is regarded by the child as a form of punishment. The strong identification with the mother is transferred by the child to other family members, to teachers, and eventually to members of the organization for which he or she will work. It is buttressed by the strength of the parental relationship. The Japanese marital dyad is more stable and cohesive than in North America. Married couples remain committed to the maintenance of family roles, the parameters of which are clearly defined (DeVos, 1985). In a very real sense, the mother-child relationship is the first manifestation of a pattern of role-delineation, which is socially and culturally reinforced.

Like the Japanese mother, the Indian mother is highly attentive to her child's moods and needs. Affiliative and self-esteem needs assume greater importance than those of self-assertion, independence, and self-expression of will. There are pervasive feelings of esteem regarding the honour and reputation of the family (Roland, 1988). In
Indian families, the interdependence of the father/son relationship is particularly stressed. A son, even as an adult, continues the process of identification with his father. The actions of each are expected to reflect well on the other (Roland, 1988). The elevation of the marriage bond, which is the most highly emphasized relationship in Western society, is discouraged, and interpreted as a threat to the continuity of the family. In Nath and Craig's (1999) view, "in Indian families, other intergenerational subsystems such as the mother-son dyad take precedence over the marital dyad" (p. 395).

A number of authors have discussed the Indian self in terms of boundaries (Bahrati, 1985; Marsella, 1985; Roland, 1988). As Marriott (1985) maintains:

Persons - single actors - are not thought in South Asia to be 'individual', that is, individual, bounded units, as they are in much of Western social and psychological theory as well as in common sense. Instead it appears that persons are generally thought by South Asians to be 'dividual' or divisible. To exist, dividual persons absorb heterogeneous material influences. They must also give out from themselves particles of their own coded substances - essences, residues, or other active influences - that may then reproduce in others something of the nature of the persons in whom they have originated. (cited in Bahrati, p. 220)

Similarly, Marsella (1985) articulates the difference between Western and non-Western cultural groups in terms of "reality boundaries" (p. 302), with reference to experiences of mystical states, episodes of depersonalization, and visions, holding that these experiences are tolerated (and as I will discuss at a later point, even encouraged) more readily in non-Western cultures.

In Western culture, the idea of separateness is more central than that of connectedness between members of a system. Social constructionist treatments of DID stress the differences between the configuration of the self in collectivist and individualist
cultures, again with particular attention to the boundaries of the self (Martinez-Taboas, 1991). As Geertz (1979) asserts:

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgement and action, organized into a distinctive whole and set contrastively against other wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world’s cultures. (p. 229)

This conception of self ascribes importance to qualities of autonomy, self-assertion, and self-expression of will, with simultaneous de-emphasis on the subordination of personal goals to those of a collective. There is a heightened significance accorded to self-determination, the realizing of one’s personal goals, and the uniqueness of each individual. This affects child-rearing practices and the balance of family relationships and obligations (Johnson, 1985). Children are socialized to respect the rights of others, but also to develop a “progressive independence” (p. 123). Self-expression and a high level of self-reliance are encouraged, with a concomitant emphasis on the social desirability of autonomy. It may be that the valuation of this uniqueness and separateness has an impact on the shaping of psychopathology, including DID. In Martinez-Taboas’ (1991) phraseology:

From a social constructionist view, MPD is most likely to take preeminence in a culture where the self is viewed as unique, dynamic, different, and separate. In other words, MPD is more congruent with a culture in which the self is individualistic. In this type of culture the self is expected to be rich in phenomenology and separate in experience. (p. 130)

**DID in India and Japan**

DID is relatively rare in India and Japan. The first case of MPD in India was reported in 1956, with the second recorded in 1981. Saxena and Prasad (1989)
screened the case records of 2,651 psychiatric outpatients for the presence of dissociative symptoms. After the exclusions of records that did not contain adequate information for diagnostic purposes, it was found that a total of 62 cases fit various *DSM-III* (1980) categories for dissociative disorder. However, none of these met the criteria for DID, or what was at that time termed multiple personality disorder (MPD). The remaining patients fell into the diagnostic subcategories of psychogenic amnesia, psychogenic fugue, depersonalization disorder, and atypical dissociative disorder. Of the 56 patients assigned to the category of atypical dissociative disorder, six were considered to have symptoms associated with possession syndrome. Features of this condition, according to Saxena and Prasad (1989) include:

1) short periods (a few minutes to a few hours) of change in the person's identity manifested by change in voice, mannerisms and behaviour – the new identity may be of a known person already dead or of a culturally accepted spirit, demon, god or mythical figure; 2) sudden onset and termination; 3) partial or complete amnesia for the new identity and events that occurred during the possession experience; 4) disturbance not due to an organic mental disorder; 5) associated features: attention seeking and dramatizing behaviour during the possession episode – may occur during religious ceremonies. (p. 261)

Adityanjee, Raju, and Khandelwal (1989) reported three cases of MPD seen over a 3-year period, and refer in their article to one other case managed by one of the authors in a teaching hospital. This suggests that: “multiple personality disorder is still a clinical rarity in India” (Adityanjee et al., 1989, p. 1608). No material appears to have been published that would indicate the prevalence of DID or the nature of its clinical phenomenology as it currently presents itself in this culture. The three cases documented by Adityanjee et al. involved amnesia and adoption of a new identity. In each case, symptom onset was associated with psychosocial stressors, including school examinations and scholastic difficulties, relationship problems and, in one instance,
reprimands by family members concerning a relationship of which they did not approve. While the authors maintain that "the clinical presentation of our cases, although not conforming to the classical description, was still fairly typical" (Adityanjee et al., p. 1608), each of the three patients whose cases were reviewed possessed only one alternate identity in addition to the primary identity, while it is noted in DSM-IV (1994) that half of the cases reported in North America involve 11 or more alternate identities. In the Indian cases, transitions were mediated by a state of altered consciousness; patients "switched" after a period of sleep.

A number of other authors have also noted the paucity of cases of DID in India (Castillo, 1994; Downs, Dahmer, & Battle, 1990; Varma, Bouri, & Wig, 1981). One reason for this may be that the phenomenon of dissociation is not considered pathological. Persons thus afflicted either choose not to seek treatment, avail themselves of the services of a faith-healer, or select some other indigenous curative. It may also be the case that the symptoms being experienced are subsumed by some other diagnostic category, such as possession syndrome, or that patients are believed to be suffering from some type of hysterical disturbance other than DID. Just as belief in the supernatural phenomena of witchcraft had flourished during the Christian middle ages, during which countless women evidencing hysterical symptomatology had been burned at the stake, so belief in possession holds sway in India, and it may be the case that instances of DID are construed as the intrusion of a spirit or other supernatural entity. Osterreich (1990) holds that the most prominent characteristic of possession is that "the patient's organism appears to be invaded by a new personality; it is governed by a strange soul" (cited in Downs et al., p. 1260). Downs et al. suggest that some types of possession are voluntary. This will be discussed at greater length in a later section of
this chapter. It may be that one of the major differences between DID and possession is the involuntary nature of the former. Adityanjee et al. (1989) further note that spirit possession in India occurs almost exclusively among illiterate women of lower socioeconomic status, and that possession states serve to refocus the family's attention on the possessed individual. Possession thus results in a "structural realignment of forces within the family [which] often improves the precipitating condition" (p. 1609). This restructuring process with respect to possession in other non-Western cultures and to a number of culture-bound syndromes will be discussed in an ensuing section of this chapter.

The first case of DID in Japan was reported in 1919 (Uchinuma & Sekine, 2000). Between 1920 and 1990, five more cases were reported. Since 1990, another 30 were reported at academic meetings or in the clinical literature. Takahashi (1990) reviewed the records of 489 inpatients at a Japanese medical school hospital using DSM-III (1980) and DSM-III-R (APA, Rev. 3rd ed., 1987) diagnostic criteria, but no diagnosis of DID was made. The methodology of this study has been criticized on the grounds that it used no structured diagnostic instruments and failed to control for sceptical bias among Japanese psychiatrists (Umesue, Matsuo, Iwata, & Tashiro, 1996). Nonetheless, Takahashi (1990) maintains that: "recent consensus among Japanese psychiatrists is that MPD is a very rare disorder" (p. 57).

More recent research on the status of DID in Japan (Berger, Ono, Nakijima, & Suematsu, 1994; Umesue et al., 1996) highlights the importance of an awareness of cross-cultural differences in the presentation of the disorder. These differences may reflect variations in beliefs concerning the forces that shape dissociative symptoms. Japan has a lower rate of child abuse than North America. The Japanese child may thus
be less likely to be exposed to inconsistent parenting, a stressful family environment and unpredictable exposure to repeated episodes of abuse. In line with this, Coons, Bowman, Kluft, and Milstein (1991) have maintained that: "There may be cross-cultural differences in the type and occurrence of child abuse" (p. 127). This may include differences in severity and frequency. Okano (1997) proposes a notion of "dissociogenic stress" (p. 151), a type of chronic stress in relationships, which occurs when the Japanese individual suppresses needs and emotions in order to maintain the relationship. This type of predisposing factor may be more likely than child abuse to engender DID in collective cultures.

**Culture and Psychiatric Diagnosis**

The disparate views of the self that exist in collective and individualist cultures, including opposing perspectives on the boundedness of the self, affect the labelling of certain experiences as either normative or pathological. The diagnosis of spirit possession in India, for example, where self-world boundaries are held to be permeable and self is viewed as non-unitary, may or may not be taken to indicate pathology, depending on the social status of the affected individual, the social function of the possession, and the type of possessing spirit. Possession syndromes, into which category many – or most – cases of Indian dual identity may fall, are understood in their cultural context as originating from without the individual. The alternate identity, in such cases, is understood to be a completely foreign entity (González & Griffith, 1996), whereas in Western instances of DID, multiple identities are considered to have their origin within the individual.
Inevitably, cultural beliefs must colour the expression of symptoms, be they dissociative or otherwise, yet inherent in the process of psychiatric diagnosis is the danger of finding pathology in behaviour and experience that does not exceed the indigenous bounds of normalcy. This pathologizing is perhaps especially true of dissociation, the symptoms of which are difficult to articulate, and the outward manifestations of which may seem unusual, exotic or frankly bizarre. The tool most frequently employed in Western medical circles in the assessment and diagnosis of dissociative disorders is *DSM-IV* (1994). An examination of the evolution of the *DSM* from its birth in 1952 to the present edition sheds light on efforts to render the manual more sensitive to cultural issues in diagnosis. *DSM-IV* claims an international applicability in view of recent additions to its text and diagnostic criteria, which take into account cultural factors affecting the diagnostic process.

Indeed, one of the more striking features of *DSM-IV* (1994) is its consideration of the relationship between culture and psychiatric diagnosis, manifested in a glossary of culture-bound syndromes and an outline for culturally sensitive case formulation. Thus, the introduction to *DSM-IV* includes a section on “Ethical and Cultural Considerations” (p. xxiv) which cautions the clinician against the pathologizing of experiences which may be unique to an individual’s culture yet also suggests that the *DSM* nosology has a “wide international acceptance” (p. xxiv) which makes it applicable to the description of mental illness world-wide. Additionally, each major diagnostic category contains a paragraph pertaining to “specific culture, age and gender features” (p. 667) that have a bearing on the process of assessment and diagnosis. With respect to the dissociative disorders, *DSM-IV* includes the nosological category “Dissociative Trance Disorder” (DTD; p. 490)
under the rubric of “Dissociative Disorder Not Otherwise Specified” (DDNOS; p. 490).

Dissociative Trance Disorder, according to DSM-IV consists of:

Single or episodic disturbances in the state of consciousness, identity or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviours or movements that are experienced as being beyond one's control. Possession trance involves replacement of the customary sense of personal identity by a new identity, attributed to the influence of a spirit, power, deity or other person, and associated with stereotyped "involuntary" movements or amnesia. Examples include amok (Indonesia), latah (Malaysia), pibloktoq (Arctic), ataque de nervios (Latin America) and possession (India). The dissociative or trance disorder is not a part of a broadly accepted collective cultural or religious practice. (p. 490)

Traditionally, Western psychiatry has conceptualized mental illness as having its locus within the individual, a position which ignores the relationship between psychopathology and social factors, and thus does not account for the manner in which mental disorder is constituted by family problems or economic status, nor for cultural influences on both the shaping of and the meaning accorded to symptoms. The DSM, first published in 1952, and its successor, the DSM-II (APA, 2nd ed., 1968), were psychodynamically oriented, reflective again of an emphasis on intra-psychic phenomena, and contained no information on culturally-sensitive diagnosis. Further, neither contained diagnostic categories for dissociative disorders per se. Rather, the 1952 publication of the DSM made provision for “Dissociative Reaction” (p. 32) characterized by "depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc." (p. 32), and for “Anxiety-Generated Conversion Reaction” (p. 32) in which “the impulse causing the anxiety is ‘converted’ into functional symptoms in organs or parts of the body” (p. 32). The psychodynamic roots of the manual are evident in the latter etiologically based notation. Both dissociative reaction and conversion reaction are subsumed in DSM (1952) under the major heading “Psychoneurotic Disorders” (p. 31).
Under the heading “Neuroses,” *DSM-II* (1968) groups hysterical neurosis, hysterical neurosis conversion type, depersonalization neurosis, and hysterical neurosis dissociative type (p. 39). These four subcategories account for many of the symptoms experienced by the dissociative individual, including episodes of depersonalization and de-realization, amnesia, fugue and alternating personality, and conversion symptoms. Further, under the heading “Personality Disorders and Certain Other Non-Psychotic Mental Disorders” (p. 41) there is a category for “Hysterical Personality” (p. 43), which is characterized ostensibly by behaviour that “is always attention-seeking and often seductive” (p. 43).

*DSM-III* (1980) represents a shift “from a psychodynamic and etiologically-based focus to one emphasizing descriptive and epidemiological considerations” (Cardeña, 1992, p. 287). Here for the first time appears a category, “Dissociative Disorders” (1980, p. 253), under which is subsumed the sub-categories of psychogenic amnesia, psychogenic fugue, multiple personality, depersonalization, and atypical dissociative disorder. In this addition of the *DSM*, while the dissociative disorders make their erstwhile debut, hysteria disappears from the diagnostic nomenclature. Essentially this manual represents the transmogrification of hysteria as a diagnosis into a wide variety of other nosological categories, including the dissociative disorders, borderline personality disorder, somatization disorder, and histrionic personality disorder. In fact, it is noted in *DSM-III* (1980) that histrionic personality disorder "is termed Hysterical Personality" (p. 314) in other nosological systems. The category of "conversion disorder (or hysterical neurosis, conversion type)" remains (p. 244). This was done in an effort to ensure “more reliable and valid diagnostic categories” (Orr, 2000, p. 61).
The next edition of the manual showed some improvement in terms of addressing cultural issues with respect to diagnostic procedures. It contained a section entitled "Cautions in the Use of DSM-III-R" (1987, p. xxvi) as part of the introduction. Therein, practitioners are advised that:

When the DSM-III-R classification and diagnostic criteria are used to evaluate a person from an ethnic or cultural group different from that of the clinician's, and especially when diagnoses are made in a non-Western culture, caution should be exercised in the application of DSM-III-R diagnostic criteria to assure that their use is culturally valid. (1987, p. xxvi)

The manual also exhorts sensitivity to issues related to language, values, behavioural norms, and idioms of distress that may be culturally contextual. However, as Smart and Smart (1997) have noted, "beyond these limited provisos, no other adaptations for culturally sensitive use were given" (p. 393). DSM-III-R (1987) contains, like its predecessor DSM-III (1980), a diagnostic category for "Dissociative Disorders (or Hysterical Neuroses Dissociative Type)", under which heading are subsumed multiple personality, psychogenic amnesia, psychogenic fugue, and depersonalization disorder, but there is no category for atypical dissociative disorder. Instead, DSM-III-R revised offers "Dissociative Disorder Not Otherwise Specified," which includes episodes of de-realization, trance states, and cases:

in which there is more than one personality state capable of assuming executive control of the individual, but not more than one personality state is sufficiently distinct to meet the full criteria for Multiple Personality Disorder, or cases in which a second personality never assumes complete control. (p. 277)

DSM-IV (1994) contains five new areas of culturally sensitive information (Smart & Smart, 1997). In addition to the glossary of CBSs and outline of cultural formulation, it describes culture-specific features pertaining to various mental disorders, a broader definition of Axis IV, which takes into consideration psychosocial and environmental
factors that may affect assessment and treatment, and the inclusion of culturally sensitive "V codes," such as "acculturation problem" and "religious or spiritual problem" (p. 24). Although these inclusions mark a significant improvement in the culture-sensitivity of the DSM, a number of authors (Lewis-Fernández, 1998; Lewis-Fernández & Kleinman, 1995; Smart & Smart, 1997) maintain that many of the original recommendations made by the Task Force on Culture and DSM-IV were omitted from the end product. In Lewis-Fernández and Kleinman's (1995) view:

The final version of DSM-IV . . . only incorporated a very small proportion of these recommendations. The cultural additions to the General Introduction and the "Cultural Features" of individual disorders . . . were cut down dramatically and their critical emphasis eliminated, typically resulting in superficial commentaries that are often empty of specific content. (p. 439)

DSM-IV (1994) has been further criticized on the grounds that "its format is intolerant of anthropological data and interested at most in cross-cultural variations in psychiatric phenomenology" (Lewis-Fernández, 1998, p. 396). Similarly, Aderibigbe and Pandurangi (1995) maintain that "the non-universality of cultural experiences in relation to psychiatric phenomenology" (p. 235) restricts the utility of DSM-IV. Differing cultural conventions regarding the nature of identity, socially sanctioned idioms of distress, and behavioural norms make universally applicable descriptions of psychiatric phenomena challenging, if not impossible. Mezzich, Kirmayer, Kleinman, Fabrega, Parron, and Good et al. (1999) hold that "the divorce of the glossary [of CBSs] from the body of the text and the exclusion of Western CBS has the effect of rendering the glossary a 'museum of exotica'" (p. 460). Western CBSs, such as anorexia nervosa, are omitted from the glossary, as is DID, although DSM-IV, in tentative phraseology, states that the prevalence of the latter disorder in the USA "might indicate that this is a culture-specific syndrome" (p. 485). The cultural formulation guidelines in DSM-IV (1994) are more
functional. The guidelines are distilled into five categories, including the cultural identity of the patient, cultural explanations for the patient’s illness, psychosocial and environmental aspects of the individual’s condition that may pertain to culture, cultural factors which may impinge on the relationship between patient and diagnostician, and “overall cultural assessment for diagnosis and care” (p. 844). Mezzich et al. assert that the development of these guidelines was a “crucial innovation” (p. 459). DSM-IV-TR (APA, Text Rev. 4th ed., 2000) contains no appreciable change in either the diagnostic criteria for dissociative disorders or the cultural formulation guidelines.

**Trance and Possession**

As previously noted, one reason for the low incidence of DID in India and Japan may be that the symptoms of the disorder as they are described in the North American literature are subsumed in those cultures under other diagnostic categories, such as trance or possession states, or are considered normative and/or socially desirable states. Grosso (1997) refers to dissociation as “creative and inspired” (p. 185), maintaining that: “inspiration is cognate to mediumship” (p. 186). This author writes of the relationship between dissociation and creativity, holding that many mediums produce artistic and literary works of extraordinary quality, and that dissociation fosters a psychological climate in which the individual is rendered capable of supernormal creative feats. Majumdar (1997) characterizes spirit possession in India as a transforming and healing experience, which facilitates the reconfiguration of the self. Many other cultures have a tradition of belief in spirit possession, which provides a vehicle for the expression of dissociative symptomatology but both presents and is experienced differently than DID. Richards (1990) describes dissociation as a phenomenon which frees the individual
from the confines of a unitary identity that constrains creative potential, and other writers celebrate as an “achievement” the fragmented self which typifies the post-modern subject (Rappoport, Baumgardner, & Boone, 1999). Common to DID and many possession states is the experience of trance. An examination of this phenomenon provides a foundation for the following discussion of possession in non-Western cultures.

Trance is defined by Krippner (1994) as “an altered state of consciousness with markedly diminished or selectively focussed responsiveness to environmental stimuli” (p. 341). Ludwig (1968) enumerates five different types of altered states of consciousness (ASCs), categorizing them according to means of induction. The first type of ASC is produced by a reduction of exteroceptive stimulation and/or motor activity that may be brought about by boredom, such as that associated with “highway hypnosis,” or by extreme social isolation, such as that practised by mystics or seers in the pursuit of religious enlightenment. The second type of ASC is produced by an increase in exteroceptive stimulation, motor activity, or emotion. Ludwig holds that these states result from “sensory overload” (p. 72) such as that produced by intensely rhythmic music or drumming. They include experiences of religious conversion at revival meetings, spirit possession states, hysterical conversion neuroses, and dissociative states. The third type of ASC, “increased alertness or mental involvement” (Ludwig, p. 73) is exemplified by what psychologist Mihaly Csiksentmihalyi terms “flow states” (Carlson & Hatfield, 1992, p. 339), conditions of complete absorption in a task to the point where individuals become unaware of the passage of time or of their surroundings. The fourth type of ASC, “decreased alertness or relaxation of critical features” (Ludwig, p. 74) involves states attained during meditation or during other activities during which self-conscious
awareness is diminished. The fifth and final type of ASC is induced by somato-psychological factors. These include pharmacological agents such as hypnotics or barbiturates, physical conditions such as hypoglycaemia, and states produced by hyperventilation.

Although methods of induction may differ, there are several features common to most ASCs. Ludwig (1968) notes alterations in cognition, alterations in the sense of time, a sense of losing control, and changes in affect manifested as extremes in emotion ranging from a sense of detachment to "ecstasy and orgiastic equivalents" (p. 78). Other common features include changes in body image experienced as feelings of depersonalization and de-realization, distortions in perception that may include hallucinations in the visual or auditory spheres, and alterations in the sense of the significance of experience such that it may take on the quality of an epiphany. ASCs have an ineffable quality, which makes it difficult for the individual to capture the experience in words. Further, they frequently involve "feelings of rejuvenation" (Ludwig, p. 81) and render the individual hypersuggestible such that he or she is vulnerable to direction by others. In sum:

*Altered states of consciousness are conditions in which sensations, perceptions, cognition, and emotions are altered.* They are characterized by changes in sensing, perceiving, thinking, and feeling. They modify the relation of the individual to self, body, sense of identity and the environment of time, space or other people. They are induced by modifying sensory input, either directly by increasing or decreasing stimulation or alertness, or indirectly by affecting the pathways of the sensory input by somatopsychological factors. (Bourguignon, 1979, p. 236)

In spite of these common features, however, a myriad of factors account for the fact that the subjective experience of an ASC differs from person to person. Influences such as cultural expectation and method of trance induction combine to produce a
psycho-physiological state that is unique to both the individual and the cultural matrix within which it occurs.

The qualitative shifts in the ordinary modes of mental functioning that characterize ASCs are operative in instances of possession. Anthropologist Erika Bourguignon articulates three types of possession, two of which involve trance (Coons, 1993). These include possession trance, trance, and possession. Possession trance is a spirit-induced altered state of consciousness in which the speech and behaviour of the possessing entity can be observed. This entity may be benevolent, as in the instance of a medium who uses a spirit guide to "channel" information from a deceased person to a living family member, or malevolent, as in the instance of an entity who speaks and acts in a troublesome manner through the body of the individual who has incorporated the spirit. Bourguignon (1979) notes that:

Possession trance is a performance. . . . A performance is carried out in front of an audience; indeed, it requires an audience, for possession trance typically is followed by amnesia, so without an audience no memory of the event is recorded. In fact, the audience may have to report the actions and words of the spirit to the impersonator. . . . The possession trancer . . . acting out a role before an audience, is involved in an active performance . . . the psychologically passive possession trancer's body is used as a vehicle by means of which the spirits interact directly with her audience, while she is psychologically absent. (p. 261)

Possession trance frequently occurs in the context of religious ritual. It is initially uncomfortable, but upon incorporation of the spirit or other possessing entity, the medium experiences a mild sense of euphoria and tranquillity, such that the experience is pleasurable. Coons (1993) asserts that trance possession and ritual trance possession have an international distribution, occurring as a regular part of religious practice in all of the world's major religions. Ward and Kemp (1991) hold that 90% of a worldwide sample of societies display "naturally occurring" (p. 161) states of trance and
possession. Thus these forms of dissociation are viewed as normative in many cultures, serving a number of social functions that will be discussed at greater length in a later section of this chapter.

Trance is an induced state of altered consciousness, which is not linked to cultural ideas of possession. It is, however, associated with experiences such as visions and visitations from supernatural beings. In Leavitt’s (1993) terms, trance involves “a continuity of consciousness of the experiencing subject (as in shamanic visions or mystical journeys)” (p. 52). Such experiences may involve going on a “spirit voyage” (Bourguignon, 1979, p. 245), or conversely may involve an invitation to spirits to visit. Thus, trance does not involve the incorporation of a spirit or other entity with resultant discontinuity of consciousness in the form of one-way amnesia between the host and the possessing agent. Further, there is no replacement of the usual self by a different one, with the result that there is a continuity of identity. The visionary trance is much sought after by members of some cultures, and represents an opportunity for power to be bestowed on the individual, often by a guardian spirit. Trance, in the absence of possession, is a male-dominated phenomenon. Bourguignon (1979) notes that trance serves a special function in societies whose economy is based on hunting, gathering, and fishing. It is her contention that the power acquired from an encounter with a guardian spirit during trance provides support for men and compensates for stress incurred by a socialization process which puts great pressure on them to be adequate providers, requires them to display a high degree of independence early in life, and encourages self-reliance. Trance thus “provides a remedy” (p. 254); it has a palliative and a curative function.
Possession involves the incorporation of a malevolent spirit in the absence of an altered state of consciousness (Krippner, 1994). The possessed individual is believed to be entered by a devil, demon or some other entity whose character is negatively evaluated by the host culture. As Halperin (1996) maintains, “a culturally defined manifestation of possession does not in and of itself certify that an actual trance, or physiologically altered state, has also taken place” (p. 36). Thus, possession may occur in the absence of trance; hence Bourguignon’s (1979) segregation of trance, possession, and possession trance. Possession is essentially a pathological condition resulting from the introjection of a malevolent entity into the mind and body of the individual. It may be caused by a “hex” (Krippner, 1994, p. 34) or curse by an enemy, and is both perceived and experienced as illness. Nonetheless, Leavitt (1993) asserts that:

Negatively valued trance and possession states are just as religious, just as culturally defined as positive ones, and in many cases are part of the same rituals and ceremonies. . . . If negatively valued trance and possession states are to be considered a disorder, then positive ones should be too. (p. 54)

Ward and Kemp (1991) delineate two types of possession. Central possession refers to possession experiences which are supported by cultural belief, and whose primary function is to uphold the established power of a society. An example of this type of possession is ritual possession, a voluntary and temporary form of trance behaviour, which is experienced by the individual in the context of religious ceremony and attributed to benign spirits. This type of possession is encouraged within the cultural context, and, in line with Bourguignon’s conception of possession trance, may be therapeutic, beneficial, and pleasurable. Additionally, it is not perceived as pathological by the host culture. Behaviour appropriate to a state of possession is learned at an early age.
Pressel (1974) describes the actions of children in the Umbandist possession cult in Brazil. The youngsters imitated, during the course of their play, the jerking movements of head and upper body used in the induction of trance. Pressel notes that:

They were imitating the adult behaviour they had learned for their own amusement. Their play acting was not discouraged. . . . Besides learning the stereotyped motor patterns [that accompany possession], the children had learned from their family the cultural concept of spirits that possess. (p. 194)

Central possession involves the incorporation of one of the primary deities of the culture. The medium is generally a well-respected member of the community, someone who is “socially mobile . . . and well-placed” (Lewis, 1971). Lewis (1971) describes a central possession cult, the Korekore Shona, of the Zambesi Valley in Africa. This cult is a shamanistic religion with an elaborate hierarchy of established mediums through the ranks of which the individual aspiring to senior shamanistic status must ascend.

Shamanism is virtually a male monopoly in Korekore, with mediums incarnating long-dead ancestors whose interventions are believed to control phenomena such as fertility and rainfall. Would-be shamans must be mentored by an established medium if they are to succeed in their aspirations. As Lewis (1971) holds, “the position is one that is reached by achievement rather than ascribed by birth” (p. 138). Central possession, then, is a socially desirable condition. It is voluntary, reversible, and short-term. It is, in Chandra shekar’s (1989) terms, “supported and encouraged by cultural beliefs and induced in ritual ceremonies . . . [it] is irrelevant to cultural concepts of illness. No curatives are sought” (p. 83). Central possession provides therapeutic benefits for members of the community, whose wishes and needs are communicated to guardian spirits by the shaman. Abel, Metraux, and Roll (1987) assert that in North and South American Indian cultures, the shaman occupies a highly specialized role, that of “curer,
visionary, seer" (p. 60), and that this position is advantageous to other members of the
society, who seek his services for purposes of healing or to obtain information from
spirits. The role is highly institutionalized and is culturally determined, providing a
resource for the community, and permitting an individual who might otherwise have
occupied a marginal position socially to operate as a respected and fully-functioning
member of society.

Suryani and Jensen (1993) provide another example of central possession in
Bali, where trance rituals and ceremonies play a crucial role in dealing with evil spirits
and witchcraft. In Balinese culture, "trance and possession states in ritual and dance are
socially approved, facilitated, and controlled" (Suryani & Jensen, p. 14). To the Balinese,
possession trance is a state bestowed by a God or spirit in which that entity acts through
the individual. As with the revelations of the guardian spirit to the Korekore of Africa, the
Balinese spirit may offer advice to village members through the body of the possessed
individual. Thus, possession serves a critical social function in terms of reinforcing a
sense of community and providing a commonality of purpose. In line with Ludwig (1968),
Coons (1993) notes that ritual trance is associated with a variety of methods of
induction, including hyperventilation, chanting, dancing, the playing of percussion
instruments, and the use of psychopharmacological agents. In Balinese ritual, trance is
induced via prayer, by music, or by over-stimulation in a ceremonial context. Mead
(1993) captures the flavour of a Balinese feast day pageant:

On feast days, the roads are crowded with processions of people in silks and
brocades, walking in easily broken lines behind their orchestras and their
gods; gods represented by temporary minute images seated in small sedan
chairs; gods represented by images made of leaves and flowers; gods which
are masks or bits of old relics. With the procession mingle people grimed
from work, hurrying lightly beneath heavy loads; and theatrical troupes, their
paint and fine costumes tucked away in little bundles, trudge wearily behind
the two-man mask, the patron dragon (Barong) who walks quietly with covered face. (cited in Suryani & Jensen, p. 14)

To this mêlée is added a chorus of men singing to the accompaniment of giant gongs, cymbals, and other instruments, crowds of people thronging the temple grounds, and priests casting holy water about, all of which serves to enhance an already-heightened level of emotion.

During such pageants, the Balinese become spontaneously possessed. It is considered an honour to have one’s body inhabited by a God or spirit, but while the Balinese may pray for this privilege, it is held to be a decision belonging wholly to the deity rather than to the supplicant. Upon incorporation of the God, changes in the possessed individual’s behaviour are attributed to the possession, and those who observe them will “not sanction or condemn” (Suryani & Jensen, 1993, p. 38). An individual may be possessed by more than one God simultaneously. Two or more possessing spirits may be observed to conduct conversations with each other, or may conduct a conversation with the host. While the level of trance varies from person to person, the trance achieved during ritual possession is usually deep. The Balinese exhibit a high tolerance for pain while in trance, engaging in such activities as walking over hot coals with no apparent ill effect. Further, they often display enhanced strength during trance, performing “extraordinary acrobatic feats. . . . Some possessed men may effortlessly scale a 2-metre concrete wall” (Suryani & Jensen, 1993, p. 38). The degree of amnesia for the possession experience varies with the depth of trance attained. Those in light trance may have partial memory of the events that occurred with the possession. Those who enter a deeper level of trance and participate in the more theatrical events of
the *Barong* drama, such as self-inflicting stab wounds, often have little or no post-trance recall.

Peripheral possession, in contrast, is “long-term and involuntary, and is negatively evaluated both by the culture and the individual, who subjectively experiences the condition as distressing” (Ward & Kemp, 1991). This type of possession provides no direct support of the moral code of the host culture, and is typically experienced by individuals who are socially marginalized. Similarly, central possession tends to occur in socially marginalized individuals, but as a culturally sanctioned form of possession, it elevates social status, reintegrating individuals into a social world from which they may otherwise have been in danger of exile. Lewis (1971) hypothesizes that peripheral possession occurs in those low on the social hierarchy who are experiencing high levels of psychological or interpersonal stress. This stress is often experienced somatically in symptoms such as headaches, which are believed to constitute the initial manifestations of possession. This type of possession is often chronic. Psychosocial stressors that recur in the life of the individual thus afflicted often lead to a recrudescence of symptoms.

Yet peripheral possession has a specific interpersonal utility. Spanos (1994) notes that: “the possessing spirit makes numerous demands that must be met by the family of the possessed” (p. 149). Peripheral possession occurs largely among women. Its social functions are related to the fact that many traditional societies are strongly patriarchal; women have few privileges and their behaviour is curtailed by numerous social restrictions. Possession provides an opportunity to improve life conditions, as certain privileges can be negotiated through the possessing spirit that might otherwise be unattainable. Lewis (1971) refers to peripheral possession as “an oblique aggressive
strategy" (p. 32), which is employed by the possessed person to obtain everything from special foods to new clothing. Possession may be used by a woman to obtain preferential treatment from her husband, for example. In such instances the societal code requires that he accede to her demands, as the requests are considered to originate with the possessing spirit, not from the possessed individual per se.

Lewis (1971) describes peripheral possession amongst Somali women, who become possessed by sar spirits, malevolent demons believed to be consumed by greed, and to be desirous of the accoutrements of good living, including jewellery, beautiful clothing, and culinary delicacies. The prototypical victim of sar possession is a married woman who is struggling to provide the most elemental of necessities for her family and feels ignored by, or alienated from, her husband. In this culture, divorce is common and easily obtained by men; with the result that marriage affords little to women in terms of stability and security. When possessed by sars, women demand clothing, exotic perfumes, special foods, and other concessions. Once again, these requests are presumed to originate with the possessing spirit, not with the victim.

Possessed individuals require curative ritual dances choreographed by a female shaman associated with the local sar cult. Such ceremonies, termed "beating the sar" (Wenegrat, 2001, p. 30) are expensive and time-consuming, and often ineffective. The husband of the possessed individual is obligated to pay for these rituals, and may accept financial responsibility for a number of them. If his patience wears thin, however, he may take matters into his own hands, beating his wife in an effort to drive out the sar spirit, or threatening her with divorce. Lewis (1971) notes that some Somali women who desire divorce may become repeatedly possessed until their husbands demand one. Thus, sar possession emerges as a device for the negotiation of change in living conditions or
marital status. Somali men would appear to be aware of the manipulative aspects of possession, viewing it “as yet another device in the repertoire of deceitful tricks which they consider women regularly employ against men” (Lewis, p. 76).

Trance and possession serve a number of other social functions. Voluntary spirit incorporation may serve to empower individuals who have few other ways of asserting control. Bartholomew (1994) describes an instance of mass possession in female Malaysian factory workers who utilized this cultural idiom to express their dissatisfaction with working conditions and effect social change. These women, having been socialized into a submissive, obedient gender role, found in episodes of possession a voice with which to confront their superiors, while deflecting attributions of blame. According to Bartholomew:

Episodes of ‘mass hysteria’ among Malay females undergoing oppressive capitalist discipline in multinational factories in Malaysia are actually a form of ‘ritualized rebellion.’ By their hysteria, the workers force witch doctors to rid the premises of evil spirits, and the witch doctors are able to negotiate with management and change practices that workers claim have offended the spirits. (p. 48)

Women in these workplaces often engage in boring, repetitive tasks for little pay under less-than-optimal working conditions. The factories in which they labour have antiunion policies that prevent the possibility of organized protest. Under such conditions, spirit possession becomes a way of venting frustration, obtaining time off work, and rebelling against authority figures. Further, it permits the deflection of blame from the victim to the possessing spirit.

Phoon (1978) describes such an episode in a Malaysian fish-processing plant staffed by 350 workers, 300 of whom were women. One morning a woman began weeping and screaming, becoming violent until several men had to restrain her. Two
other women followed suit. After a 4-day period with no further episodes, 10 women exhibited signs of possession, crying, and screaming, as had the first. Finally, a "bomoh" (Phoon, 1978, p. 23), or medicine man, was engaged to exorcise the evil spirits believed to be responsible for the outbreak of hysteria. But in spite of his ministrations, outbreaks continued to occur, and a second exorcism was carried out. Phoon notes that Malaysians have a strong tradition of belief in spirits and in spirit-possession and, in line with Bartholomew (1994), posits that episodes of spirit possession in Malay factory workers affords a kind of "safety valve" (p. 31). That is, women who have been socialized to avoid expressing anger or dissatisfaction are able, through mass spirit possession, to express these emotions without fear of condemnation. Rather, their behaviour "generates concern and sympathy on the part of parents, colleagues and perhaps even management" (Phoon, p. 31). Thus, possession offers the opportunity for secondary gain.

Cross-culturally, women demonstrate a greater propensity for possession experience than do men, which may reflect an underlying need for "prestige elevation" (Begelman, 1993, p. 204) in a male-dominated society. This may also be a factor in the female-dominated patient-hood of DID in North America. The elevation of social status previously discussed with respect to central possession also occurs among trance-healers in India (Crook, 1998). Spiritists, mediums, and healers are regarded as important members of society, respected, and even revered. Chandra shekar (1989) notes that: "the possession syndrome is closely associated with mental health in India" (p. 91). In fact, the Western assimilation of trance and possession to mental illness tends to be quite atypical, with one author asserting that Westerners have an "allergy to
dissociation" (Leavitt, 1993, p. 56). Whatever the reason, it is certain that the attribution of pathology to dissociative states is greatly influenced by cultural factors.

Although their social functions may be similar with respect to elevation of social status, DID and trance-possession states differ in important ways. DID occurs most frequently in North America where there is conscious and deliberate role-playing, and spirit possession in cultures where polytheism and beliefs in reincarnation hold sway. Thus, the idiom of distress is different. Western culture encourages experimentation with different personal identities. Varma et al. (1981) maintain that:

Twentieth century man, especially in North America, has shown a special fascination with role-playing. The role is adopted with some gain or favorable outcome in mind. The fulfillment of the role may make him act even in a manner contrary to his usual self . . . The role adopted, like in a multiple personality, does not attempt to copy a known, concrete individual, but represents an expedient or expected behaviour conceived for a particular setting. (p. 118)

This penchant for role-playing permits great flexibility in the formation of identity. Coupled with "a relative lack of belief in spirits, ghosts or demons interfering in the affairs or body of living persons" (Castillo, 1994, p. 156), this inclination manifests itself in Western culture as distinct and separate personalities. By way of contrast, in Indian society there are many alternative supernatural entities in the cultural repertoire. Thus, DID is a fragmentation of the self into multiple parts or identities, while spirit possession involves the incorporation into one body of another entity. This distinction is reflected in approaches to treatment. In the West, we integrate the multiple; while in non-Western cultures, the possessing spirit is extruded.
The Culture-Bound Syndromes

Hughes and Wintrob (1995) maintain that culture-bound syndromes “are commonly interpreted as patterned, pathologically exaggerated behavioural responses to culturally structured stress points, vulnerabilities, conflicts, or other socio-cultural features (e.g., dominant social values) of a given person’s environment” (p. 567). Linked as it is to specific features of Western society, such as individualism, and virtually absent from non-Western cultures, DID is held by some authors to be a culture-bound syndrome (CBS; Hughes, 1998; Mezzich et al., 1999). There are four CBSs in non-Western cultures of interest to me in undertaking this thesis in terms of the fact that I believe many of the forces that sustain them to be similar to the forces that sustain DID in North America. These CBSs are ataque de nervios, latah, amok, and kitsune-tsuki (fox possession).

Levine and Gaw (1995) trace the documentation of CBSs to the late 1700s, when Captain Cook noted the existence of amok in Malaysia. A century later, W. Gilmore Ellis, a Singapore government official, wrote of amok and latah, holding that these syndromes occurred almost exclusively amongst Malays. Near the turn of the 20th century, instances of koro, a genital retraction syndrome occurring primarily amongst Chinese males, were recorded. These syndromes were originally characterized by a variety of exotic labels, but in 1967 Pow Meng Yap, a cross-cultural psychiatrist, coined the term “culture-bound syndromes” (Levine & Gaw, p. 524) to refer to sets of symptoms which present themselves within specific geographical regions and within specific ethno-cultural groups. In Yap’s (1995) view, these syndromes constituted variants of Western psychiatric entities, yet he maintained that: “their symptom patterns are unusual and are
determined by cultural factors in both form and frequency" (cited in Levine & Gaw, p. 524). As Guarnaccia and Rogler (1999) observe, Yap "assumes that the major goal is to fit the culture-bound syndromes into the standard classification systems" (p. 1323). This denies an alternative approach: to investigate them in their own contexts and on their own terms, to maintain a critical stance with respect to assumptions of pathology, and to interpret them in light of their social/interpersonal utility.

According to DSM-IV (1994):

The term culture-bound syndrome denotes recurrent, locality-specific patterns of behaviour and troubling experience that may or may not be linked to a specific DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (p. 844)

Wittkower (1968) divides CBSs into three groups, including dissociative, fear, and anger states. He considers ataque de nervios, latah, and amok to be examples of each of these respectively. Further, he considers trance and possession states to be CBSs, categorizing them under the rubric of dissociative states. The same author also delineates a notion of what constitutes mental illness (Wittkower, 1968). Such a label may be applied to individuals if their perceptions and beliefs go beyond those that are culturally shared, if these engender psychological suffering and interfere with psychosocial function, and if their behaviour distresses or disturbs others.

Culture comprises the beliefs, values, and practices characteristic of a given ethno-cultural group. The cultural shaping of symptoms is termed "pathoplasticity" in the literature (Alarcón et al., 1999; Tseng, 1997). Pfeiffer (1982) outlines four dimensions
within which culture may operate as both a pathoplastic agent and a mediator of clinical symptoms. These include culture-specific areas of stress, culture specific shaping of conduct, culture-specific interpretations of symptom patterns, and culture-specific interventions. The first dimension, culture specific areas of stress, involves factors relating to “family and societal structure” (p. 203). An excellent example of a culture-based stressor of this nature is provided by Indian society. Pfeiffer (1982) cites the instance of child-brides in arranged marriages. These young women are thrown into a situation in which there is a forced estrangement from the family of origin, the exchanging of nuptial vows with a virtual stranger who may be at best polite and at worst indifferent, and the expectation that the bride will embrace her spouse’s family as her own and defer to their authority. As Castillo (1994) notes, “upon marriage, authority over a girl is transferred from her natal to her affinal family. Thus, her husband (or her husband’s father in an extended family) assumes absolute authority over the bride” (p. 153).

Further, young females are the least-protected group within Indian culture, lowest on the social hierarchy, and virtually powerless to protect themselves from abuse within the marital bond or family group. India is characterized by high levels of violence against females that begins literally “in the womb” (Castillo, p. 153). Amniocentesis is used by members of middle and upper classes to determine whether an unborn child is female. If this is the case, abortion is incurred to avoid payments of large sums of money in the form of a dowry when the girl would have reached marriageable age. If of a lower socio-economic stratum, female children are in danger of being killed by their parents. A young married woman must endure the threat of falling victim to a fatal “cooking accident” (Castillo, 1994, p. 153) unless demands for dowry are met. Females, subordinate as
they are, are socialized to be submissive, accepting, and uncomplaining. When it becomes impossible for them to tolerate the constant stress of their living conditions—including the threat of death or abuse within the context of the marital dyad—two options present themselves. Suicide is one; dissociation in the form of spirit possession is the other.

In addition to the pathoplastic effect of pressures associated with familial and societal agents, Pfeiffer (1982) cites the influence of environmental factors as a culture-specific area of stress, noting that: “under extreme ecological conditions people are forced to seek their subsistence in situations that strain the limits of their stress endurance” (p. 203). Foulks (1972) describes the phenomenon of “kayak angst” (p. 21) among Greenland kayakers which is precipitated by extreme sensory deprivation:

When hunters row out their kayaks in the still water, they are often becalmed with the sun’s bright glare reflected in their eyes, as if from a mirror. Suddenly, as they wait patiently for seals to rise to the surface, they are gripped with a paralysis that prevents their moving a muscle. They sit as if petrified, and they say they have a feeling that the water is rising over them, but they cannot lift a hand. Then, if a slight wind curls the surface of the sea, they are freed of the spell and come out of it. The poor victims often become so frightened that after one experience they never dare venture out alone again. (p. 21)

In line with Ludwig (1968), this condition may be likened to an altered state of consciousness induced by a reduction in exteroceptive stimulation. Once this state of sensory deprivation is fractured, the individual is able to re-orient himself. The experience is commonly followed by headache, nausea, and difficulty defecating or urinating. The victim of kayak-angst frequently becomes emotionally labile after the experience and exhibits an exaggerated startle response.

Pfeiffer’s (1982) second dimension involves the culture-specific shaping of conduct. Pfeiffer notes that “cultures not only stress certain situations as significant, but
they also make available specific patterns of behaviour for these situations" (p. 205). Most cultures provide opportunities for individuals to engage in behaviours that might be prohibited in other circumstances. For example, the Balinese feast-day pageants previously discussed provide the opportunity for spontaneous simultaneous spirit possession. As I will discuss in a subsequent section of this chapter, _ataque de nervios_ provides a vehicle for expressiveness and over-dramatization that might not be tolerated under different conditions. Thus, cultures provide for behaviours that might ordinarily be perceived as infractions of social norms or even as pathology by situating them in the context of ritual or of culturally sanctioned expressions of distress. The third dimension, culture-specific interpretations, is related to how an individual instance of distressing behaviour or experience is transformed into a diagnostic entity, which may be subsumed, by a medical or a folk classificatory system.

Guarnaccia and Rogler (1999) note that the salience of a culture-bound syndrome is demonstrated by its prevalence – by the proportion of people who recognize the syndrome and who have had personal experience with it. Further, it is necessary that the manifestations of the syndrome are structured and interpreted in line with local belief, tradition, or superstition. Social structural factors, such as socioeconomic status, level of social support, educational level, and social isolation identify those at risk for certain CBSs, and context often specifies instances in which the syndrome is likely to be manifested. _Latah_, for example, occurs only in large social gatherings. Just as cultural beliefs, such as belief in spirits or other supernatural beings, affect the form and content of symptom expression, so they also affect the assessment of those symptoms as normative (as in the case of Indian or Balinese central possession) or as pathological (as in the case of peripheral possession).
Pfeiffer's (1982) fourth dimension is that of culture-specific interventions. The response of the community to the behaviour of the individual exhibiting manifestations of a given syndrome, the labelling of that syndrome, and the curative measures to which the individual is subjected have far-reaching implications. Once again, this dimension may be elaborated with the example of spirit possession. Manifestations of a CBS may be interpreted as part of an individual's journey to a higher level of spiritual attainment. The description, previously cited, of visitations by a guardian spirit to the Korekore of Africa provides a representative illustration of this. Crook (1998) further cites the example of male trance healers in India, whose special talents are sought often by other community members. In both these instances the attitude of the communal group toward the “afflicted” individual is one of support and gratitude. No cure is sought by either the medium or other members of the host culture.

There are alternative explanations for an individual’s idiosyncratic behaviour that may be adhered to. It may be perceived as “an individual peculiarity” (Pfeiffer, 1982, p. 212), which is interpreted as a threat to the individual but not to his community. Conversely, it may be interpreted as a threat to the community at large. In the former instance, the disturbance is perceived as potentially harmful only to the stricken individual, and elicits support from both folk or medical healers and the ethnic community of the victim. In the latter, however, there is potential harm to the whole group. Pfeiffer offers the example of the “Windigo syndrome” (p. 213) amongst native Algonquins of Canada. The Windigo spirit is believed to be a cannibalistic entity, which possesses humans and produces a desire to eat human flesh. Members of the native community support the possessed individual in his struggle against this obsession but, if the victim acts on his desires, he is considered to have been fully transformed into a Windigo.
Traditionally, he would then have been “slain and burned” (Pfeiffer, p. 213) in order to render the spirit harmless.

**Ataque De Nervios**

*Ataque de nervios* is a phenomenon specific to Puerto Ricans. It is experienced predominantly by middle-aged women who are widowed, separated, divorced, or are experiencing marital problems and have low educational and socioeconomic status (Guarnaccia et al., 1996). Guarnaccia et al. consider the *ataque* to be a culturally normative expression of distress that is not regarded as pathological within the cultural context. Rather, it is a culturally sanctioned response to experiences of acute stress within the family, such as bereavement, accident or severe family conflict. Thus, *ataques* occur at socially appropriate times. The *ataque* is characterized by a variety of transient symptoms, including regressed behaviour, psychotic symptoms, episodes of uncontrollable weeping, and, as with hysteria, convulsions of psychogenic origin. The individual may strike out at those near her, and frequently there is amnesia for the events that occur during the *ataque*.

According to Steinberg (1991), the underlying process of the *ataque* is the same as DID, that is, dissociation. Major aspects of the *ataque* are a sense of being out of control and fears of “going crazy” (Liebowitz, Salmán, Jusino, Garfinkel, Street, Cádenas et al., 1994, p. 874), episodes of depersonalization, and fear of dying. The *ataque* is a response to a threat in the individual’s social world. That threat may take the form of the loss, by death or accident, of a family member or relationship, or the feared loss of one of these. As women carry the social burden of maintaining the integrity of the family, and have less overt power to control family relationships, they may be particularly vulnerable
to these threats. Thus, the *ataque* may serve any of a number of functions: to preserve homeostasis within the family, to provide an outlet for anger that otherwise may not be tolerated socially, and/or to reconfigure social relationships through the mobilization of support, thus altering the balance of power within those relationships. In the words of Guarnaccia et al. (1996), the *ataque* “reshapes the social world” (p. 359).

To understand the significance of an *ataque*, its meaning and social function, requires an appreciation of the position women occupy in Puerto Rican society and a grasp of the extent to which family relationships play a central role in their lives. Acosta-Belén (1986) notes that for Puerto Rican women, “the roots of sexual discrimination, job segregation, and ascribed sex roles based on male supremacy and female subordination, are ingrained in the socialization process itself” (p. 15). As with the 19th century European female, the role of the contemporary Puerto Rican woman is clearly circumscribed. Wifely and motherly duties prevail; she remains the centre of the home, primarily responsible for child rearing and for the management of family-related activities. Although a substantial proportion of women are enrolled in post-secondary educational programs, and although the public education system offers equal access to both males and females, the school curriculum remains oriented to the maintenance of traditional gender roles. The textbooks employed in the Puerto Rican school system reinforce stereotypical views of the female as passive, dependent, and technologically inept. These books depict women restricted to occupations that are viewed as “appropriate” for them, such as that of homemaker, and that “perpetuate rigid distinctions between the roles of men and women” (Acosta-Belén & Sjostrom, 1979, p. 65). As Pérez-Harranz (1996) maintains, “these confining definitions of the female gender favor men as they simultaneously oppress women” (p. 155).
Puerto Rican culture is intensely patriarchal. Males are socialized within the framework of a "machismo" (Christensen, 1979, p. 59) complex grounded in the assumptions that a man is the head of his household, that his masculinity must constantly be proven, and that his authority over his spouse must remain undisputed. For women, on the other hand, priorities include caring for children; executing the various tasks associated with maintaining the household, such as grocery shopping and preparing meals; organizing celebrations around special family occasions or holidays; and assisting other family members who may be infirm or experiencing crisis in their lives. While educational goals and career objectives are considered important by many Puerto Rican women, both school-related and vocational aspirations bring her into conflict with internalized cultural expectations with respect to the pivotal nature of her domestic role. According to Pérez-Harranz (1996), the nature of the Puerto Rican woman's family responsibilities has changed little in recent decades. For women employed outside the home as well, this means a "double burden of work" (p. 155). Given the centrality of the female role in terms of domestic responsibility, the crucial importance of mother-child bonding, and a sphere of social activity largely restricted to kinship-based events, the illness or death of a close family member can be seen as an occurrence which threatens not only family cohesion but the very sense of self.

While ataques de nervios are not indigenously perceived as psychopathology, some authors maintain that a significant proportion of those who experience an ataque meet DSM criteria for various psychiatric diagnosis (Guarnaccia, Canino, Rubio-Stipec, & Bravo, 1993; Guarnaccia & Rogler, 1999; Liebowitz et al., 1994). Liebowitz et al. suggest a relationship between panic disorder, agoraphobia, and the ataque, which is certainly in line with the "bias toward discovering cross-cultural similarities and
'universals' in mental disorder” (Kleinman, 1998, cited in Baxter, p. 71) that characterizes Western psychiatry. Oquendo, Horwath, and Martinez (1992) make the point, however, that the existence of diagnostic criteria for the ataque might facilitate reliable recognition of the syndrome, leading to earlier family interventions and perhaps eliminating the need for hospitalization or use of psycho-pharmotherapeutic agents in symptom relief. Steinberg (1991) posits that the ataque is “an acute dissociative reaction which can occur within a variety of psychiatric disorders, particularly hysterical syndromes” (p. 31), and suggests a relationship between the ataque and DID, citing an array of symptoms shared between the two syndromes.

However, a number of questions arise pertaining to the ataque and its position within a Western nosological scheme. What is the clinical utility of conceptualizing a relationship between atques de nervios and other diagnostic categories? Is the ataque merely a culturally inflected version of a pre-existing psychiatric entity? If the ataque is conceptualized as a mental disorder, what new insights might be gained in terms of understanding what constitutes mental health for Puerto Ricans? These questions point to the importance of viewing the ataque from an “emic” (Tseng, 1997, p. 20) perspective, from within the context of the cultural system, rather than an “etic” (p. 20) perspective, which assumes universals with respect to mental disorder and involves the examination of a phenomenon such as the ataque from a position outside the cultural system.

Adopting an emic approach in their analysis of the phenomenology of the ataque, Guarnaccia et al. (1996) underscore the importance of interpreting “emotion as lived experience within a cultural context rather than as an internal experience of an individual, as emotion is studied in American psychology, or as a symptom of disorder, as emotion is often studied in American psychiatry” (p. 343). This is an anthropological
stance rather than a medical one. The \textit{ataque} is experienced not only in the affective domain. As with the somatic grammar of 19\textsuperscript{th} century hysteria, the \textit{ataque} is a bodily metaphor, a vehicle through which social relationships are realigned and personal power reasserted. Guarnaccia et al. identify four dimensions across which the \textit{ataque} may be conceptualized, including "emotional expression, bodily sensations, action dimensions and alterations in consciousness" (p. 349). The emotional dimension is characterized by sadness and anger. The subjective experience of these feelings is often so powerful that it defies verbal description. The profuse weeping and screaming which accompany the \textit{ataque} are an embodiment of the force of the precipitating event. As Guarnaccia et al. (1996) observe, "there is no space between the triggering event and the expression of the emotion; rather the emotion explodes within the person directly from the power of the experience and then bursts forth into the social sphere" (p. 353). The bodily sensations most commonly experienced during the \textit{ataque} include heart palpitations and trembling. These symptoms are experienced as extremely intense. As Steinberg (1991) notes, the \textit{ataque} is also characterized by seizure-like, or convulsive, episodes. Guarnaccia et al. maintain that: "this fits a cultural pattern of expressing distress through bodily sensations. There is a highly developed somatic language of distress in Puerto Rico" (p. 355). The somatic symptoms of the \textit{ataque} constitute an expression of the power and significance to the individual of ruptures in family relationships, bereavement, or other events that represent loss or upheaval in her social world.

The action dimension of \textit{ataques de nervios} is characterized by aggressive behaviours directed toward self or others (Guarnaccia et al., 1996). Just as those possessed by spirits may demonstrate themselves capable of extraordinary feats of human strength, so those in the throes of an \textit{ataque} may strike out with a force they
would not ordinarily display. Aggression may take the form of "impulsive suicidal or
homicidal acts" (Steinberg, 1991, p. 31). Oquendo (1995) maintains that the expression
of anger is prohibited in Puerto Rican culture, and that the ataque provides a vehicle for
the expression of rage in women, which under other circumstances would be considered
an infraction of cultural norms. Further, the ataque may be an expected response given
certain conditions such that it is considered appropriate behaviour for a woman. As
Guarnaccia et al. hold, "women are 'allowed' to be aggressive during an ataque in ways
that would not otherwise be socially tolerated as long as the source of the anger or
sadness is seen as justified by those around them" (p. 357).

The fourth and final dimension of the ataque involves alterations in
consciousness. An altered sense of time, amnesia, and subjective feelings of
detachment from body and self are common. Three dimensions of the ataque are
illustrated by this excerpt of an interview with an individual who experienced an ataque in
the wake of devastating news:

My daughter was in the hospital. They told me that if after an hour, she did
not respond, I should entrust her to God. From then on I felt very nervous. I
went home. I was talking to a neighbour. . . . If she didn't react in an hour, I
couldn't count on her being there. She was very sick, after they operated on
her. . . . Well I was talking to my neighbour from my porch, she was on the
sidewalk, and I began to feel like things were piercing my head. Then I
began to tremble and tremble, and I began to scream. After that I don't
remember anything. Next thing I knew, I was in the hospital. I found myself in
the hospital and it was the next day that I realized I was there. And I began
to scream again in the hospital. (Guarnaccia et al., 1996, p. 358)

Construed in an emic light, the ataque constitutes a socially-sanctioned
expression of distress which provides disenfranchised women with an opportunity to
express anger, to exert some influence on significant others in her social or familial
sphere, and to voice the pain associated with events that threaten the very core of her
being. The Puerto Rican woman's construction of self is grounded in her roles as wife and mother, particularly in her ability to maintain cohesion in the family, and on her capacity to provide a safe haven for her children. The traditional gender role into which she has been socialized remains her primary source of self-esteem and comprises a crucial source of both self and social identity in a culture that provides few other opportunities for personal development or self-expression. Intense investment in the health and well-being of her family means that her sense of mastery over her environment is contingent upon her ability to prevent or to resolve family problems, to protect her children from harm, and to remain uncomplaining in the face of stress or conflict within the marital relationship. Guarnaccia et al. (1996) note that the ataque is an embodiment of “resistance to a multitude of forces that control working class and poor women’s lives in Puerto Rico” (p. 362). As with hysteria, the ataque is textual; as with hysteria, it gives voice to the lived experience of women who possess little power. In sum, the ataque is a behavioural “cry of protest” (Guarnaccia et al., p. 362).

**Latah**

*Latah* is a folk illness almost exclusively confined to Malayo-Indonesian cultures. It is a stereotypic, chronic, conditioned response to a variety of external stimuli ranging in nature from a loud noise, to the clapping of hands, to the sight of a snake (Bartholomew, 1994). The common thread amongst these precipitating factors is their unexpected nature. The stimulus provokes a startle response in the individual, which is succeeded by a variety of other symptoms, including echolalia, mimetic behaviours, coprolalia (the use of obscene language), automatic obedience, and hypersuggestibility. The latter two symptoms mean that the individual who is latah is particularly vulnerable to teasing by
others, who will gather around her, making elaborate gestures that she will copy, and instructing her to do things they might find amusing. *Latah*, therefore, has a theatrical quality, the quality of a performance. It occurs only in large social gatherings within which there are clearly defined boundaries with respect to whom may tease the *latah*, and within what limits (Baer, Clark, & Peterson, 1998).

Additionally, there are parameters around the instructions that may be given to the individual who is *latah*. Never is there instruction to do something that may be injurious or life-threatening. Thus, *latah* is a group phenomenon, with clearly defined roles for the *latah* and members of the social group. Like ataque de nervios, it is confined to socially marginalized women of middle age or older who startle in the presence of higher-status peers (Baer et al., 1998). As previously noted, there is a marked theatrical quality to the individual's behaviour, which provokes "spasms of laughter among the audience, and the subject pleads amnesia for her buffoonery when she comes out of her altered state of consciousness" (Bartholomew, 1994, p. 334). As with the ataque, *latah* is not perceived as an illness either by the individual or by members of her family or the wider social group. Further, there is no sign in the *latah* of mental illness outside the context of her episodes. Nonetheless, *latah* is viewed as entirely involuntary.

This CBS constitutes a socially supported transgression of Malay cultural norms in the presence of complete immunity from blame for the transgressor (Jenner, 1990). It is interesting to ponder the cultural themes that *latah* phenomena illustrate and exemplify. Malay cultural norms reflect an emphasis on the importance of compliance, appropriate social behaviour, and maintaining self-control. *Latah* is a direct violation of these norms. As with ataque de nervios, *latah* may provide disenfranchised women with
a voice, or may constitute a release of suppressed emotion. In Jenner's terms, *latah* may comprise a "ritual canalizing of aggression" (p. 198). Additionally, it may be part of a "power game" (p. 184) in culturally defined systems. If this is the case, then *latah* may function, as the *ataque* does, to stabilize relationships, thus preserving homeostasis. Its dramatic symptomatology may also serve to reintegrate the socially marginalized individual, so that she becomes, for a time at least, an integral part of the group. In essence, *latah* occupies in Malaysian culture an almost mythological status as a continuous reminder of the importance of self-control.

Two fundamental precepts influence Malay behaviour. The closer the tie between two individuals, the more important it is that behaviour is guided by politeness and respect. Those who do not comply with this are expected to feel deeply shamed. Further, elder family members are to be treated with deference. As Provencher (2001) notes, "the expectation that an older person involved in an instance of social interaction will be shown greater respect than a younger person, is one of the basic parameters of traditional Malay social organization" (p. 188). This extends to adult children, who are rarely openly critical of an elderly parent. Kinship ties are close and family relationships harmonious. Children are held to be "*harta*" (Strange, 1981, p. 56), or "wealth," and marriage is viewed as the most pivotal event in the life of a young adult. An institution so highly regarded that those who remain single are considered pitiable; it is the first step in locating the individual within a community whose traditions and behavioural standards infuse every aspect of daily life.

Rudie (1994) notes that marriage is a liberating event in the life of a young woman, and that "unmarried teenage girls used to be invisible in the economic and ceremonial life of the community" (p. 151). It is regarded in Malay culture as
inappropriate for a virgin to attend functions involving large groups of people. Her married status thus permits a woman to participate in events that were inaccessible to her as a single woman. Further, it facilitates contact with a sector of peers who exchange services and work to consolidate a social support network. These social relationships, in addition to kinship ties, play a critical role, as with Puerto Rican women, in terms of fostering self-esteem and a sense of common purpose. In essence, the peripheral status of the unmarried woman is altered after she weds. As Karim (1992) holds, “ritual power through matrimony and the accompanying standards of adulthood and seniority it provides . . . describe Malay ways of ascribing values in accordance with matrimonial status” (p. 131). The corollary, however, is that older women, who have lost their husbands through death or divorce – and who are over-represented amongst those who are latah – are returned, as newly single women, to their prior marginalized social status.

In addition to marital standing, socioeconomic factors render an individual more susceptible to latah. Rudie (1994) observes that poor families have a paucity of relatives within their neighbourhoods, as they may not “have enough land resources to realize the cherished ideal that families should stick together in close proximity” (p. 148). Family members may thus be disseminated geographically such that kinship ties are weakened, undermining the self-worth of elderly women who, as young married females, had found a sense of purpose and social self-esteem in their involvement with family.

_Latah_ finds a strong affinity with the hysteria of the 19th century in terms of its theatricality and the role played by the audience in the production and perpetuation of symptoms. While the literature focuses on the social function of the syndrome with respect to the performer, it is worth noting that, as a group phenomenon, _latah_ may well
meet the needs of audience members in similar ways. As Karim (1990) maintains, "latah refocuses an elderly woman in the nucleus of ritual relations, providing her with a status equivalent to magicians, midwives and shamans" (p. 18). In Malay society, the status of a younger or middle-aged woman of means embedded in a network of children, affines, and other relational ties contrasts sharply with that of an elderly woman with limited economic resources whose children have established their own families and who may live some distance from aging parents. Latah, like ataque de nervios, reconfigures the individual's social world, drawing her closer to other family members, and effectively reintegrating her into the family nucleus. As previously noted, it also provides a vehicle for the transgression of strict behavioural norms. This, however, is true not only for the latah but also for those group members who startle, and subsequently tease her, at large social functions. Latah is not a phenomenon that occurs in private. For audience members, it provides a socially-sanctioned arena for the disrespecting of an elder, a transgression which would not only not be tolerated under different circumstances, but would be expected to be accompanied by the most profound shame and self-loathing.

The syndrome also serves a social function with respect to humour. Teasing the latah, encouraging her displays of sexually suggestive behaviours, urging her to utter obscenities – all provide a source of amusement for the onlooker. Douglas (1990) notes that: “laughter and jokes, since they attack classification and hierarchy, are obviously apt symbols for expressing community in the sense of unhierarchical, undifferentiated social relations” (cited in Kenny, p. 136). The humour inherent in latah draws people together, provides a common purpose, and erodes social barriers. It is not only for the audience, however, that latah provides comic relief. Bartholomew (1994) comments on the case of one latah who, along with her audience, seemed “to heartily enjoy the paroxysms” (p.
333) of an episode, and holds with regard to those who tease hyperstartlers that they adopt the role of a coach in terms of orchestrating latah behaviour. Kenny (1990) asserts that women who are latah are frequently invited to weddings and other social events for the express purpose of providing entertainment. As a group phenomenon, the most pivotal social function of latah may well be that it provides opportunities for aggressive teasing, sexual humour, and amusement in a culture within which other forms of joking are severely restricted.

Amok

The amok phenomenon is a murderous rampage first described centuries ago in Malaysia (Lucas & Barrett, 1995). The term itself means “to engage furiously in battle” (Westermeyer, 1973, p. 873). Amok constitutes “a sudden paroxysmal homicide in the male, with evident loss of self-control, a prodromal period of mental depression, a fixed idea to persist in reckless homicide without any motive, and a subsequent loss of memory after the acts committed at the time” (Hatta, 1996, p. 506). The prodromal period is characterized by brooding in the wake of an insult or loss and is often accompanied by episodes of vertigo. The attack is frequently succeeded by a period of “deep stuporous sleep” (Carr & Tan, 1976, p. 1297). The victims of the assault may be strangers, friends, or the individual’s nearest blood relatives. The offender, or pengamok, strikes without regard for the age or gender of his victims. He tends to attack in the evening hours or on weekends, times during which streets are heavily populated. For the assault, a traditional Malay weapon is usually chosen. A parang, kris (bladed weapons), or a spear may serve this function. More recently documented cases of amok have been characterized by the use of a grenade (Westermeyer, 1973). The pengamok is
considered to be mentally ill, and if he is not slain during the course of the attack, he is subsequently incarcerated in a psychiatric facility.

According to Kon (1994), the origins of *amok* lie in military training which Malaysians patterned after strategies employed by Hindu soldiers in India. A common tactic of warfare was to charge forward, brandishing weapons while shouting "Amok! Amok!" This was intended not only to intimidate opponents, but also to bolster the courage and confidence of the attackers. The earliest reference to a solitary *pengamok* was recorded in the 15th century in Indonesia. Cases were common in the early 19th century. In 1846, however, a British surgeon, Dr. Thomas Oxley, cautioned against the over-dramatization of the syndrome, noting that:

> It is one of those few aspects of Malay life that has received attention at the hands of those writers whose object it is to make the tropics and other remote places more vivid and exciting in fiction than they are commonly found to be in facts... running amuck is with many English people their only idea of the Malays. (cited in Kua, 1991, p. 430)

By the turn of the 20th century, reports of *amok* became more sporadic. By the 1930s, it had become rare. Nonetheless, the syndrome still manifests itself in Malay culture. One study in the late 1970s examined 21 cases of *amok* in West Malaysia (Carr & Tan, 1976).

Most perpetrators are of low social status and poorly educated. They tend to live some distance from the village where they were raised, and to be or to have been in military service. Westermeyer (1973) offers the following profile of the typical *pengamok*:

> A young or middle-aged adult male, from peasant or lower-class origins and with little formal education has moved away from his birthplace to work at a job different from that of his father. While he has not had previous mental aberration, his past behavior patterns have evidenced immaturity, impulsivity, poorly controlled emotionality, or social irresponsibility... Following the loss of wife or girlfriend, a large sum of money, social prestige
(or rarely, for no apparent reason) he suddenly and unexpectedly strews death and injury about himself. (p. 706)

Amok outbursts, which increase during times of social, economic, and political upheaval, seem to be precipitated by events which highlight the marginalized social status of the individual, such as an incident of acute embarrassment, a rift in family relations resulting in a sense of abandonment, or an insult to self-esteem (Westermeyer, 1973). As previously discussed with respect to latah, Malay cultural norms are strict regarding issues of what constitutes appropriate social behaviour. An extension of this is an exceptionally strong sanction against confrontation and aggression. This means that amok violence is held to be virtually incomprehensible by most Malaysians.

While amok may be best understood when viewed through an emic lens, efforts have been made by several researchers to construe the phenomenon within a Western nosological system. Willkower (1968) holds that amok is phenomenologically consonant with a dissociative state. Gaw and Bernstein (1992) maintain that it fits the DSM-III category of "Isolated Explosive Disorder" (1980, p. 297). The description of this condition in DSM-III is as follows:

The essential feature is a single, discrete episode of failure to resist an impulse that led to a single, violent, externally directed act, which had a catastrophic impact on others and for which the available information does not justify the diagnosis of Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder. An example would be an individual who for no apparent reason suddenly began shooting at total strangers in a fit of rage and then shot himself. (p. 297)

This diagnostic category was deleted in subsequent editions of the DSM, although DSM-III-R contained a category for "Intermittent Explosive Disorder" (1987, p. 321). This category has been retained in DSM-IV (1994). Further confusing the issue of categorization within a Western psychiatric nosology, amok is considered by Hatta
(1996) to be subsumed in *DSM-IV* under the rubric of DDNOS, which includes
Dissociative Trance Disorder and Possession Trance, the criteria for which were outlined
in an earlier section of this chapter. Hatta (1996) maintains that *amok* shares certain
features with DDNOS, namely the narrowing of awareness of immediate surroundings
and the execution of movements that are experienced as beyond one's control. Gaw and
Bernstein (1992) propose a revision of the *DSM-III-R* criteria for "Intermittent Explosive
Disorder" (1987, p. 321), which accounts for multiple assaultive acts, to include single
episodes of aggression.

As previously discussed with regard to *ataque de nervios*, a number of problems
arise in trying to account for the culture-bound syndromes within a *DSM* nosology. In
construing the *ataque, latah, or amok* as minor exceptions to some dominant "universal"
classificatory system – in attempting to "force" them into a Western nosological scheme
– aspects of the cultural milieu in which they have their genesis are ignored. As Eguchi
(1991) notes, "illness which is given social and cultural meaning always transcends
clinical data and statistics" (p. 421). In assuming that such a system exists, it becomes
necessary to make comparisons between syndromes, which permit us to say that the
CBS in question is "actually" something else – that *amok*, for example, is actually an
instance of Intermittent Explosive Disorder, or that *ataque de nervios* is actually an
instance of DDNOS. As Eguchi maintains, this "translation" process is grounded in
ethnocentrism, and constitutes what is termed a "category fallacy" (p. 424). This fallacy
occurs because the utility of a classification system, such as the *DSM*, is limited by the
breadth of experience of its originators. It becomes operative "whenever a syndrome is
found that is totally unclassifiable by the diagnostic system or when a classified
syndrome's essence does not seem to be captured by the diagnosis one is forced to
make" (González & Griffith, 1996, p. 137). González and Griffith assert that the amok syndrome might best be located within DSM-IV as a variant of "Intermittent Explosive Disorder" (1994, p. 609), but note critically that "this would put it in a class of disorders whose unifying theme is that of not being classified elsewhere" (p. 141). Evaluations of amok and other CBSs from a Western perspective are based frequently on the premise that psychopathology has a biological basis, a "universal form," which is distinct from its socially and culturally derived "content" (Eguchi, 1991, p. 425). As Eguchi maintains, "attempts to fit culture-bound syndromes into a universal diagnostic framework, premising this form and content dichotomy, almost inevitably fail to consider their culture-based meaning-centred construction" (p. 425).

In accounting for amok within any classificatory system, it must be recognized that the syndrome is a response to loss or to a specific situation, which incurs shame. The impact of this must be appreciated, in the former instance, in light of the interdependent nature of relationships in a collective culture and, in the latter, in light of the immense stress incurred by deviating from the rigid cultural standards to which Malay behaviour must adhere. Additionally, as Gaw and Bernstein (1992) have noted, in constructing diagnostic criteria for any CBS, it must be demonstrated that "the behaviour is significantly more common in societies in which familiarity with the syndrome is part of the population’s cultural background" (p. 792). Thus, amok violence as a behavioural alternative must be present in the society. In Malay culture, there exists a specific form of mental illness termed "gila mengamok" (Carr & Tan, 1976). It is considered an extreme form of mental derangement caused by evil spirits, which is characterized by episodes "of violence and a superhuman ability to wreak destruction" (Carr & Tan, p. 1297). This category is consonant with Malay cultural superstitions about spirit
possession. Further, given the indigenous code around what constitutes appropriate social behaviour, it suggests that amok violence is an anomalous phenomenon. Such a conception of amok – that the individual would have to be either "crazy" or possessed in order to engage in such an act – finds a better "fit" in a cultural context in which politeness and respect for others are constantly emphasized and in which any kind of confrontation is viewed as, not only inappropriate, but inconceivable.

Although amok attacks appear to be indiscriminate and non-purposive, Lucas and Barrett (1995) maintain that Malaysian culture "contains subterranean forces of violence within the Malay person" (p. 300). In line with this view, Westermeyer (1973) holds that a combination of forces engender amok, including factors pertaining to the individual, such as insecurity and low self-esteem, and those pertaining to social variables, such as the culturally enforced suppression of anger. The amok phenomenon may also be understood in terms of the hypothesis, discussed in an earlier section of this paper, that collective cultures, of which Malaysia is one, are "shame-based" (Wittkower, 1968, p. 813), rather than "guilt-based" (p. 813). Malay culture elicits socially conforming behaviour through externalized shame rather than through internalized guilt. It may thus be that a distressed individual in this culture is more likely to direct anger in a way that damages his society, rather than to direct it against himself. One problem with this hypothesis is that amok violence may also be seen as a form of self-destructive behaviour, given that its perpetrator is likely to be killed in the process of the attack. Amok is a suicidal, as well as a homicidal, act. From a psychosocial perspective, it may be conjectured that while Malaysian women may employ latah as a socially prescribed outlet for stress, Malaysian men have no such counterpart in a non-destructive mode of self-expression. Thus, anger is expressed in a different arena. According to Mahathir
(1970), "amok represents the external physical expression of the conflict within the Malay which the perpetual observance of the rules and regulations of his life causes in him. It is a spilling over, an overflowing of his inner bitterness" (p. 118). Perhaps, as with ataque de nervios, the amok attack gives voice to accumulated stress of social and cultural origin, a behavioural cry of "I can't stand it anymore."

**Fox Possession**

Fox possession, or *kitsune-tsuki*, is the best-known and most common form of spirit possession in Japan, with cases being recorded from the 12th century (Eguchi, 1991). The predominant operative cultural construct in *kitsune-tsuki* is a belief in "soul replacement" (Chowdhury, 1993, p. 400), the intrusion into the self of an outside entity in the form of an ancestor, God, or animal. While many of the symptoms associated with *kitsune-tsuki*, such as night terrors, headache, backache, weariness, and changes in facial expression (believed to emulate those of the fox) are not considered pathological in and of themselves, the syndrome as a whole, including the meaning ascribed to it, is. In fact, the family of the affected individual may be ostracized by the rest of the community for fear that the malady may spread. Eguchi describes the evolution of *kitsune-tsuki* in a "mythopoetic context" (p. 432) in which ideas and beliefs pertaining to the fox pervade the daily life of the Japanese individual. Although sometimes encountered in urban settings, such as clinical psychiatric hospitals in large cities, *kitsune-tsuki* is most common in rural and mountain villages of Japan, much of whose social and cultural life is centred around spiritual practices. There are commonly religious ceremonies at which people gather to offer thanks to various animals, mountain Gods, and the patron Gods of the forest. The fox figures prominently among these
beings. Foxes are the subject of many children's folk-tales, so the Japanese literally grow up with their presence. Further, real foxes are often seen in the snowy mountainous regions of Japan. Hence, much of rural Japanese family life has its roots in the same mythological and spiritual substrate in which beliefs about fox possession germinate.

In addition to their prominent position in indigenous folklore, foxes have, in Japanese belief, long been implicated as a cause of illness. Their supernatural powers are extolled in early Taoist teachings, which were replete with tales of foxes that lived in subterranean lairs and were thus close to the "cosmic vital essence" (Prince, 1992, p. 126) of the earth. This force is considered responsible for longevity. Correspondingly, tradition holds that foxes enjoy exceptionally long lives. They are believed by the Japanese to be protean spirits, able to assume human form or that of other animals (Veith, 1965). Prince provides a quotation from a T'ang dynasty record that attests to this:

> When a fox is fifty years old, it assumes the ability to change itself into a woman. At a hundred it can assume the shape of a beautiful girl, or that of a sorcerer, or also that of an adult man who has sexual intercourse with women. At that age a fox knows what is happening at a distance of one thousand miles, it can change the human mind and reduce a person to an imbecile. When the fox is one thousand years old, it is in communication with Heaven, and is then called Heavenly Fox. (p. 126)

Many instances of kitsune-tsuki surfaced in the 17th century with an upsurge of belief in Inari, the fox deity. A multitude of deviant behaviours were attributed to those afflicted with fox possession, including fleeing into the mountains, eating materials such as gravel and ashes, and jumping into rivers. Treatment was normally undertaken by those of spiritual persuasion, and involved rituals designed to banish the fox from the body of the possessed individual. This included efforts to drive out the fox by beatings,
suffusing the victim in smoke, and reciting incantations (Eguchi, 1991). In addition to having power over the individuals whom they possess, foxes are also believed to be able to influence phenomena of nature, such as the weather. Generally, the fox is considered to be a malevolent spirit.

Eguchi (1991) presents a recent case study of a 35-year old homemaker, Fumie, afflicted with *kitsune-tsuki*. Born and raised in a rural village, she married at 25. Her husband frequently drank heavily, and would often beat her. She felt socially isolated. Her husband arrived home one evening to find her uncharacteristically agitated; she seemed angry, her face was contorted, and she engaged in unusual activities, such as making a number of random phone calls and pouring solvent into the bath. The next day she accused her husband of having an affair. She was hospitalized briefly. During her stay, she was uncommunicative. Fumie was discharged from the hospital but was soon readmitted; was discharged again and readmitted a third time. Between hospitalizations, she was urged by friends to return to her birth village, Kusuhara, to undergo an exorcism. Subsequently, she began to complain of hearing the sound of foxes, and claimed that this had been occurring since the night her strange behaviour had begun. Other villagers, friends, and relatives were equally convinced of her possession, referring to her condition as “Kusuhara Disease” (Eguchi, 1991, p. 437) and supporting the notion that spiritual, as well as medical, intervention was indicated. Although for a time after the exorcism she believed herself cured, she suddenly began engaging once more in socially inappropriate behaviour, and was hospitalized yet again. Her behaviour was alternately childishly dependent, or gave evidence of anger and frustration. Prior to her final discharge, Fumie disclosed her loathing of sex, and stated that her husband had frequently criticized her in this arena. During subsequent visits to the hospital as an
outpatient, however, she felt and seemed well, and the voice of the fox did not return to plague her.

Eguchi (1991) grounds his analysis of this case in an examination of the social, religious, and cultural practices of the villagers of Kusuhara. The village is small, and its inhabitants share spiritual ties, which serve to forge a strong sense of community. In Eguchi's terms, "religion in Kusuhara is not a hollow shell, but a living force recognized in traditional celebrations, treatment of illness at the shrine, folk tales, place names, a traditional kyōgen play, and every lucky and unlucky occurrence of daily life" (p. 431). The occupants of Kusuhara, as with those of other rural villages, have been steeped in folklore about the supernatural capabilities of the fox. The kyōgen play to which Eguchi refers is based on the story of a fox who transforms himself into a high priest, deceiving those around him. Eguchi holds that there exists in Kusuhara a "possession complex" (p. 439), which comprises an intricate interweaving of mythology with belief in the tangible presence of the fox spirit, manifested in behavioural changes, alterations in facial expression, and hallucinations in the auditory sphere. While Eguchi suggests that Fumie's psychiatric hospitalization constitutes proof of the inadequacy of indigenous treatment, it might also be maintained that the cultural and religious context in which her condition emerged gave a significance to her experience that would be absent from Western biomedical thinking. The exorcism that Fumie underwent provided a meaning-making framework for her experience. As Etsuko (1991) notes, "spirit possession in folk healing has as great a hold on reality as schizophrenia defined at a physiological domain" (p. 468).
An interesting perspective on the emotional constitution of those who fall prey to *kitsune-tsuki* is found in the 18th century writings of Kojima Fukyu, quoted in Veith (1965):

The fox is an animal of Darkness to the uttermost degree. Therefore the external evil [in the shape of the fox] enters people whose Light-spirit has diminished. In general, exaggeration of joy, anger, sorrow, pleasure, love, hatred and greed causes man to lose his original character and to become empty, and only possessed of the spirit of Darkness. How could it happen otherwise on such occasions but that bad demons should enter into him? (p. 91)

It is worth speculating whether those “whose Light-spirit has diminished” (Fukyu, cited in Veith, 1965, p. 91) might comprise, as with those who fall victim to *ataque de nervios*, *latah*, and *amok*, a marginalized social group. Additionally, other factors similar to those operative in the *ataque* and *latah* may be at play in instances of *kitsune-tsuki*. Eguchi (1991), in his case study of Fumie, describes how her husband and other family members rallied in support of her, and notes that the “social and psychological stability” (p. 439) she derived from this was instrumental in her recovery. Thus, *kitsune-tsuki* may serve a role similar to the *ataque* and *latah* with respect to the mobilization of social support. Further, in the same manner as *latah*, *kitsune-tsuki* requires the participation of a group. The phenomenon includes not only possessed individuals, but also the other members of the social group who consider them possessed. In Eguchi’s (1991) terms, *kitsune-tsuki* “is a shared experience, and if you call it mental illness, then there is more than one patient” (p. 426).

**Summary**

Dissociation is variously considered as pathology or as a special gift. Each of these views is contingent upon the cultural context in which it occurs. Culture informs
beliefs about self as unitary or non-unitary, and these in turn influence our judgements about the meaning ascribed to dissociative symptoms. In many non-Western cultures, the capacity for dissociation is not only respected, but also revered. Dissociation plays a critical role in religious ritual and provides a vehicle through which information is "channelled" from guardian spirits or deceased ancestors to members of the host culture. It frequently occurs in socially marginalized individuals, with resultant elevation of social status. Thus, it serves the function of reintegrating individuals of peripheral status into a community from which they may previously have been exiled. Further, it provides disenfranchised individuals with a voice, furnishing them with a means of effecting social change, as in instances of mass possession in Malaysian factory workers who toil for little pay in substandard working conditions.

Dissociation may also be considered a group phenomenon. As with the hysteria of the 19th century, it requires the participation of individuals whose cultural beliefs support and perpetuate dissociative experience in a member of their cultural group. The culture-bound syndromes of latah and kitsune-tsuki provide examples of this. Dissociation may also provide a socially sanctioned outlet for distress, which is considered normative within the cultural context. In non-Western societies, it has social and political utility, and is associated with mental health. Although dissociation is perceived as pathological in North America, many of the functions it serves parallel those of other culture-bound syndromes. The social and cultural influences on the production and perpetuation of DID in North America will be discussed at length in a subsequent chapter.
CHAPTER 4: DISSOCIATION IN THEORY

Introduction

The foundations of dissociation in early theory, the evolution of hysteria as a diagnostic entity, and cross-cultural aspects of dissociation have been the focus of the first three chapters of this thesis. In this chapter, I will trace the historical roots of the biomedical discourse in which current research about DID is grounded, outline the DSM-IV (1994) diagnostic criteria for DID, and describe the experience of the dissociative individual. This chapter also presents an examination of the models of dissociation and theories of the etiology of DID adhered to by most contemporary clinicians in the field. This chapter will reveal the extent to which the medical model has influenced our present theoretical formulations of dissociation. This emphasis, evident in the scientific and individualistic nature of the models presented, reflects a failure to account for the degree to which social, cultural, and political factors have sculpted the presentation of DID in North America. These factors will be addressed at further length in the final chapter of this thesis.

The Medical Model

While the positing of organic bases for mental illness is scarcely a recent phenomenon, the 1800s saw a renewed interest in the search for biological causes of psychopathology (Kraepelin, n.d./1962; Sarason & Sarason, 1989). Nineteenth century researchers conducted post-mortem dissections on the brains of the insane hoping to
discover structural abnormalities. In his 1811 essay *Practical Remarks on Insanity; to Which is Added, a Commentary on the Dissection of the Brains of Maniacs; with Some Account of Diseases Incident to the Insane*, surgeon Bryan Crowther holds that, upon dissection:

> The general appearances of disease, consist in opacity of the arachnoid membrane, which was sometimes occasionally thickened; a preternatural determination of blood to the membranes, as well as the brain; together with an effusion of water between its membranes, its convolutions, and into the ventricles. (cited in Hunter & MacAlpine, 1963, p. 659)

On a cautionary note, Crowther maintains that “the appearances on dissection are not to be considered either cause or effect of insanity” (cited in Hunter & MacAlpine, 1963, p. 670), yet succeeds this assertion by stating that delirium must be considered to be of corporeal origin. Three years after the publication of this essay, another physician, Joseph Adams, produced a treatise on the hereditary properties of mental illness, holding that the responsibility for a mental disturbance that manifests itself in several children of the same biological parents rests in a constitutional “predisposition” (cited in Hunter & MacAlpine, 1963, p. 692).

During the mid-19th century, psychiatrist Wilhelm Greisinger championed this search for bodily causes of mental disorder, arguing that such afflictions were the result of a disturbance in brain function. Greisinger (1882) sought to strengthen the association between psychiatry and neurology, and proposed that specific mental disorders found their analogue in physical illness, comparing “mania and epilepsy, imbecility and paralysis” (Kraepelin, n.d./1962, p. 112). With respect to the etiology of mental illness, Greisinger (1882) queries:

> Are there not anatomical changes with whose existence it is always necessary that a marked disturbance of the mental faculties, a mental disease, should exist? This must be answered in the affirmative. Indeed,
there are certain structural diseases of the brain which always cause considerable anomalies in the mental functions, even insanity. . . . in particular, a comparison of the facts lying before us appears decidedly to support the view, that the most important and most constant changes in the insane consist in diffuse diseases of the external layer of the cortical substance – that is, of the surfaces of the brain and of the membranes covering them; and it would be justifiable, in many cases of insanity which correspond to palpable changes in the brain, to consider that the chief and essential disease is that of the periphery of the brain. (p. 293)

The significance of Greisinger's contributions notwithstanding, it was largely his successor Emil Kraepelin from whose work the biological model of psychiatry evolved (Andreasen, 1984; Sarason & Sarason, 1989). Like his predecessor, Kraepelin advanced the idea that mental illness is the product of some malfunction in the brain. Rejecting mentalistic explanations of psychopathology, Kraepelin's (n.d./1962) publication One Hundred of Psychiatry lauds "the victory of scientific observation over philosophical and moral meditation" (p. 111), forging the foundation upon which 20th century psychiatry would rest. This biological perspective, or "medical model" (Gleitman, 1981, p. 662) gained acceptance in the early- to mid-1900s as psychiatry sought to unburden itself of its psychodynamic heritage, reaffirming its position as a science and setting out in quest of etiological explanations of mental illness within a framework of reductionist thinking. As the "neo-Kraepelinian" (Marsella & Yamada, 2000, p. 6), or medical model, is a model of disease which is built on the core assumption that the pathology underlying mental disorder is organic, somatic treatments are often employed by proponents of this model to reassert normal brain function. Such "therapies" also are used in the management of symptoms associated with dissociation, and include minor tranquilizers, neuroleptic drugs, and even electroconvulsive therapy (ECT; Bowman & Coons, 1992; Braun, 1990; Kluft, 1984b).
Psychiatrist Gerald Klerman (1978) strongly supports efforts to re-establish psychiatry as a science and to re-assert its position within the field of medicine, maintaining that psychiatry should employ scientific methods and base its practice on scientific knowledge; that psychiatry treats those who are sick; that there is a clear division between those who are sick and those who are normal; that psychiatry is concerned with the biological bases of mental disorder; and that “there should be an explicit concern with diagnosis and classification” (p. 104). The field of psychology is scarcely exempt from this scientistic perspective. Phares (1988) notes that the training of North American clinical psychologists follows a scientist-practitioner model, which influences approaches to assessment and diagnosis and subsumes many of the assumptions that under-gird the medical model in psychiatry. Further, according to Sloan (1996), “most psychology training programs, research designs, and interventions view individuals as disconnected from their social, cultural, and economic contexts and seek solutions to human problems through scientistic schemes” (p. 40).

The medical model is so much a part of public discourse that it has become common knowledge. Andreasen (1984) outlines its fundamental tenets. As previously discussed, psychiatric illnesses are regarded as diseases analogous to other medical illnesses such as cardiovascular disease and diabetes. In line with Klerman's (1978) thinking, mental illness is held to be caused by “biochemical abnormalities, neuroendocrine abnormalities, structural brain abnormalities, and genetic abnormalities” (Andreasen, p. 30). This means that the physician, confronting such complaints as auditory hallucinations, amnesia, and a sense of the unreality of the environment undertakes a process of differential diagnosis to rule out various possibilities until an appropriate diagnosis is made.
The biological model stresses the management of severe mental illnesses the causes of which are presumed to be biochemical in nature. It locates mental illness within the individual rather than the environment, minimizing the impact of social influences such as parenting and the effects of culture on the development and shaping of symptoms. As such, it implicitly assumes that many forms of mental illness are pan-cultural. Because the underlying cause is presumed to be biological, such illnesses cannot be cured by “acts of will” (Andreasen, 1984, p. 31), which means that the patient is totally reliant on the medical practitioner to be relieved of his or her symptoms, thus greatly elevating the status of the physician as healer and underscoring the power differential between physician and patient. Additionally, the medical model has political implications, noted by Fee (2000):

Clearly, this is a time when biomedical and otherwise reductionist explanations and understandings of mental disorder are dominant in scholarly, scientific, and psychotherapeutic worldviews and practices. The pervasive viewpoint is that the only way mental illnesses can be recognized as “real” – and hence worthy of funded research, insurance coverage, rigorous study . . . is when they are anchored in the language of bio-physiology or possibly some other deep-seated individual factor. (p. 1)

This leaves no room for a conception of mental illness as influenced by socio-cultural factors, and hence none for a conception of DID as socially constructed.

**Scientism and Individualism**

Given that it resides in the context of a dominant economic and political power, North American individualistic cultural tradition exerts a significant force on our approaches to understanding and classifying non-normative behaviour and experience. The medical model adhered to by psychiatrists and psychologists is one instantiation of this tradition. Sloan (1996) notes that:
Psychological theory and practice embody Western cultural assumptions to such an extent that they primarily perform an ideological function. That is, they serve to reproduce and sustain societal status quo characterized by economic inequality and other forms of oppression such as sexism and racism. (p. 39)

Sloan’s observations bring into relief the fundamental assumptions of Western medical practitioners and other mental health professionals, grounded, again, in the medical model, and reflective of a de-emphasis on the role of cultural practices and social institutions in the production of mental illness: The individual brain and mind are the locus of pathology and, therefore, the individual brain and mind must be the locus of treatment. Further, as medical practitioners and psychologists strive to help people adapt to their circumstances by providing treatment at the individual level or at the micro-institutional level, such as within the context of the family, they may inadvertently contribute to “the stabilization of the larger social order and the preservation of existing inequalities and injustice” (Sloan, 1996, p. 40).

Reflecting this position, Conrad (1979) notes that the medical profession exerts a strong “jurisdictional mandate” (p. 1) over virtually any condition that might be labelled an illness. Similarly, Freidson (1970) maintains that: “the medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively” (p. 251). When medical definitions of non-normative behaviour dominate, competing definitions, such as those that might be framed in socio-cultural terms, are de-emphasized. The concept of medical social control refers to the construal of certain phenomena, such as those associated with dissociation, in medical terms (Conrad, 1979). Thus, in Western culture, dissociation is medicalized, politicized, and gendered. It is associated with illness and a high level of psychosocial dysfunction; it is widely believed to be engendered by incest and other forms of sexual
abuse; and it remains largely the province of women, the female-to-male ratio being 5:1, according to Putnam (1989). Clearly, a construction of the dissociative response to trauma as normal would relocate the pathology in the events that precipitated the response, rather than attributing it to some fundamental deficit in the biochemistry of the individual.

**The Evolution of Professional Discourse**

A discourse is a complex of metaphors, images, narratives, and statements that function to "produce a particular version of events" (Burr, 1995, p. 48). If we maintain that social constructionist and biomedical perspectives offer opposing views of the construction of disorder and of the construction of DID in particular, then each might be considered to have its own discourse, grounded in different sets of assumptions about the genesis of the condition, the significance of its symptoms, and their socio-political utility. A number of discourses – biomedical, socio-cognitive, social constructionist – surround DID, each claiming to say what the disorder really is. That is, each discourse holds a claim to "truth." Truth claims lie at the heart of issues of power and identity. The discursive practices in which they are embedded help produce and reproduce power imbalances in relationships, such as the relationship between the dissociative individual and her physician or therapist and, on a more global level, the relationship between the historically male-dominated profession of psychiatry and the historically female-dominated patient-hood of DID. Discourse is socially constitutive, a practice which both shapes and is shaped by the situations and institutions in which it is grounded. It both sustains and reproduces the social *status quo*. According to Merry (1990):
Discourses are aspects of culture, interconnected vocabularies and systems of meaning located in the social world. A discourse is not individual and idiosyncratic but part of a shared cultural world. Discourses are rooted in particular institutions and embody their culture. Actors operate within a structure of available discourses. However, within that structure there is space for creativity and actors define and frame their problems within one or another discourse. (p. 110)

Gunnarsson (1997) proposes that three dimensions underlie the construction of professional discourse. She describes these dimensions as "layers" (p. 100) and holds that their interaction forges a professional culture, that "written texts as well as spoken discourse are constructed as cognitive, societal, and social activities within the different professions" (p. 100). The cognitive layer pertains to the way in which a profession views reality, and accounts for the way in which individuals are socialized into a profession, taught to view the world through a particular lens, and acquire the language of the group. This language aids the individual in expressing his or her view of reality, and facilitates the sense of membership in the group. With respect to the societal layer, each group maintains a particular standing in relation to other professional groups. This layer is related to issues of status and power. Medical practitioners enjoy a high social rank in North America with the attendant privileges of the financial reward afforded by their profession. Freidson (1970) notes that: "physicians emphasize the value of the income and prestige connected with their occupation" (p. 178). Similarly, Hahn (1995) asserts that members of the medical profession place a strong value on "the accumulation of wealth" (p. 147). Thus, psychiatrists can have a vested interest in diagnosing individuals with DID, treatment of which demands a significant financial outlay on the part of the patient over a period of several years, as indicated by this excerpt from a transcript of an interview with an individual who was diagnosed with the disorder:
Even though I was told [therapy] would take several years, I thought if I worked hard and stayed motivated I could do it in less time. Those are basic requirements and it's still taking years. I wish I had known that treatment would keep me from working. . . . Treatment has wiped out my savings, put me heavily in debt. (Cohen, Giller, & Lynn, 1991, p. 50)

Regarding the social layer, Gunnarsson (1997) holds that every professional organization has a “group identity” (p. 101), which evolves from the establishment of an internal role structure, efforts to distinguish itself from other groups, and the creation of distance between “in-” and “out-” groups. A sense of “we-ness” evolves, a kind of collective consciousness. McDougall (1939) outlines the conditions that facilitate the formation of such a consciousness, which he terms “the group mind” (p. 1). They include the continuity of the existence of the group; the presence in the minds of group members of an idea of the nature, function, and purpose of the group; the interaction of the group with other groups possessed of different ideals and purposes; the existence of customs, behavioural norms, and traditions which determine the relation of each member to the other and to the group as a whole; and, finally, the organization of the group in terms of both division of labour within its ranks and subgroups of individuals that exist within it. In the mind of the individual, these factors define more clearly the whole of which one is a part, and thus delineate inter-group boundaries. Members of the group of psychiatrists and psychologists who routinely treat DID appear to consider themselves an elite sector of these professions. Hacking (1992) has reported, tongue-in-cheek, that when he subscribed to Dissociation, the official journal of the International Society for the Study of Multiple Personality and Dissociation, he received a document resembling a medical-school diploma and an accompanying flyer which adjured him to “Display your professionalism. Be proud of your commitment to the field of multiple personality and
dissociative disorders. Display your certificate in a handsome membership plaque” (p. 5).

Unsurprisingly, the clinical literature on DID is largely grounded in a biomedical discourse. It is a professional discourse which has emerged from efforts to create a knowledge base for the field, to position psychiatry as a science in relation to other professional groups, and to gain political power and influence over socioeconomic means. It has its own elite, and often imprecise, vocabulary, which reflects its Kraepelinian origins. It constructs a particular picture of the dissociative individual, while affirming the power imbalance between patient and physician and perpetuating centuries-old beliefs about the essential nature of women. Hacking (1992) has noted that one manifestation of “new professionalism” (p. 10) is the body of terminology, which characterizes it. The biomedical discourse surrounding DID is imbued with metaphors of “splitting” (Benner & Joscelyne, 1984, p. 99) and “shattering” (Glass, 1993, p. 46), terms which imply the existence of a “pre-morbid” integrated consciousness and underscore the conception of multiplicity as pathology: The more you split, the sicker you are. It offers a highly individualistic view of the process of dissociation, which is conceived by many contemporary authors (Putnam, 1989; Ross, 1989; Trueman, 1984) as an ego defence. It offers a mechanistic view of the process of transition from one to another alternate identity, labelling this a “switch” (Putnam, 1988, p. 27), and of the configuration of alternate identities in the individual with DID, characterizing this as a “system” (Ross, 1989, p. 123).

The literature is peppered with terminology, which suggests that dissociation is largely reducible to psycho-physiological origins, an inherited predisposition rather than a phenomenon that is shaped by social and cultural factors. The ensuing literature
review reflects the perspectives of authors whose views are an outgrowth of psychodynamic (individualistic) and biological (reductionistic) trends in psychology and psychiatry. In the final chapter of this thesis, however, I will argue that to conceive dissociation in purely intra-psychic terms is simplistic. DID is not spawned in a vacuum; rather, it is an artefact of social and cultural process, of influences largely beyond the individual, beyond the family, influences woven into in the fabric of the broader cultural milieu.

The DSM-IV Dissociative Disorders

DSM-IV (1994) lists five dissociative disorders. They are Dissociative Amnesia, Dissociative Fugue, Depersonalization Disorder, Dissociative Disorder Not Otherwise Specified (DDNOS) and DID. Four diagnostic criteria are presented in DSM-IV (1994) for DID, namely:

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about, the environment and self).

B. At least two of these identities or personality states recurrently take control of the person’s behaviour.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behaviour during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play. (p. 487)

The existence of alternate identities is the distinguishing feature of the disorder. According to DSM-IV, the primary identity is often “passive, dependent, guilty and depressed” (1994, p. 484). A number of other identities may exist within the individual
whose personality characteristics contrast markedly with those of the primary identity. The emergence of each alternate identity may be contingent on a particular context. Putnam (1989) holds that transitions, or “switches” between identities are usually abrupt, occurring within seconds or minutes. According to Ross (1989), the extent to which each identity is aware of others is contingent upon the existence and directionality of amnestic barriers. Some may be aware of all other personality states, while others may be totally unaware of their existence. Most are usually aware of periods of amnesia, a discontinuity in their experience, or of alterations in their perception of time. DID may be confused with other disorders characterized by cyclical fluctuations in mood or auditory hallucinations. One or more of the alternate identities may exhibit symptoms suggestive of a co-existing disorder, such as depression, or may display disturbances in personality which permit the concomitant diagnosis of Borderline Personality Disorder (BPD; Horevitz & Braun, 1984).

Although some experience dissociation as adaptive and even pleasurable, many find it bizarre and terrifying. They may have a sense of the estrangement of different body parts or the feeling that they have changed in size, and may experience feelings of remoteness, of disconnection from the world (Levy & Wachtel, 1978). Dissociative individuals may feel as if they are floating, or may experience a sense of “deadness.” In this excerpt from a transcript from the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1995), one individual with DID describes her experience of depersonalization in the following terms: “Sometimes I think I’m dead. That I’m not really here. That nobody can see me and stuff. I’m just walking, just walking, but nobody – just invisible. I guess like invisible” (p. 121). A feeling of the unreality of the surrounding environment may persist, and out-of-body experiences are common.
Alterations in perception, such as visual and auditory hallucinations may occur, along with dissociative disturbances of memory (Anderson, Yasenik, & Ross, 1993). In another excerpt from a *SCID-D* (Steinberg, 1995) transcript, a woman with DID discusses her experience of perceptual alterations with the physician who is interviewing her:

Interviewer: Have you ever felt as if your surroundings or other people were fading away?

Patient: You mean like in loss of vision? I have a distancing thing that happens where I lose . . . it's like I get very narrow like this [places palms next to each other] . . . this is all I can see. And then, and then I lose vision altogether . . . My eyes close and at the same time it's like a roaring sound. I thought everybody had it. (p. 161)

When dissociation fails, flashbacks may occur in the form of vivid memories of earlier trauma, experienced with all of their original affective charge (Spiegel & Cardeña, 1991). A sense of volition may be absent, as in individuals with DDNOS or DID, who may experience a sense of being controlled by an external agent. There is frequently confusion about personality identity, often experienced as an internal battle or conflict. The following excerpt from a *SCID-D* (Steinberg, 1995) transcript reflects this theme:

Interviewer: Have you ever felt as if there is a struggle going on inside of you?

Patient: Yes.

Interviewer: What's that like?

Patient: That person that wants to come out . . . He struggles, struggles with me. And this guy must think I'm nuts, if I'm gonna let him out. If I let him out, I'm never gonna get myself back in. And that's what scares me the most.

Interviewer: What's the struggle like?

Patient: It's like a tug of war. Pulling, pulling the rope, pulling, you keep pulling and pulling, and he pulls you back and you pull it forward, and he pulls you back, and you pull it forward, and
you want to say, "Hey, man. Take the damn thing." And I keep pulling that rope, and he keeps pulling it back, and I pull it again [raises voice and sounds very annoyed]. One of these days, he might win. (p. 222)

Individuals with DID may see one of their alternate identities perched on their shoulder like a parrot, or may experience themselves as being behind or inside the identity during periods of co-consciousness. This is reflected in the following excerpt from a SCID-D (Steinberg, 1995) transcript:

Interviewer: Do Andrea or Cindy or Jill ever take control of your behavior or your speech?

Patient: Oh yeah.

Interviewer: What's that like? How does that occur?

Patient: Um, I don't know how it occurs, but I go inside. Sally will have sex. Sally eats. Sally grocery shops, Sally has friends at the law school. Sally has had a relationship, a friendship, relationship with some junior professor from the law school. Um, things like that. (p. 243)

Typically, dissociative individuals have periods of amnesia during which time one of their alternate identities assumes control of their body. First-rank symptoms, including audible thoughts, hearing voices arguing inside one's head or commenting on one's actions, may be experienced; their content may be brutally deprecating (Kluft, 1987a).

While such symptoms, according to Ross (1991), "are clearly dissociative and post-traumatic in nature" (p. 514), their presence may be misinterpreted by mental health professionals as evidence of psychosis. A number of researchers (Coons, 1992; Fahy, 1988; Loewenstein, 1993; Rosenbaum, 1980) have indicated that dissociative individuals frequently present with a constellation of symptoms that are associated with affective disturbance and schizophrenia, and others have asserted that dissociative individuals frequently are misdiagnosed (Chu, 1991; Franklin, 1990; Ross, 1989).
Steingard and Frankel (1985) argue that dissociative episodes may be manifested as psychotic states. They use the example of a 17-year old dissociative girl who experienced visual and auditory hallucinations while in an auto-hypnotic trance.

Loewenstein (1993) groups dissociative symptoms into three categories including amnesia, auto-hypnotic, and “process” symptoms. Amnesia symptoms include episodes of time-loss, fugue states, reports of behaviours the patient cannot recall, chronic experiences of mistaken identity, amnesia for childhood events, and “micro-amnesias” during conversations with others. The latter is an example of one of the first-rank symptoms identified by Schneider in 1939. Auto-hypnotic symptoms include spontaneous trance, voluntary analgesia, out-of-body-experiences, spontaneous age-regression, and eyelid fluttering. According to Loewenstein (1993):

Dissociative process symptoms include complex dissociative multi-modal hallucinations, passive influence experiences [again, a first-rank symptom], the presence of distinct personalities or personality states, switching phenomena (transitions between these states), and linguistic changes such as referring to the self in the first-person plural or third-person singular. Dissociative individuals who do not meet full criteria for MPD often have a mixture of auto-hypnotic symptoms, amnesia for at least some parts of childhood, somatoform symptoms, and PTSD symptoms. . . . Commonly these patients will meet diagnostic criteria for dissociative amnesia or DDNOS with or without features of MPD. (p. 591)

Steinberg (1995) views de-realization and depersonalization as separate constructs, listing them as two of the five core dissociative symptoms in terms of which she defines DDNOS and DID. Depersonalization in the complex dissociative disorders is “recurrent and persistent” (p. 134) and is associated with high levels of stress, and psychological and social dysfunction. Further, “the distinguishing diagnostic feature of depersonalization in subjects with dissociative disorders is the ongoing interactive dialogues” (Steinberg, 1995, p. 134). Steinberg (1995) describes amnesia as “the
“building block” (p. 9) upon which other dissociative symptoms rest. It is characterized by rifts in the individual’s memory for periods of time “ranging from minutes to years” (p. 9). Some individuals with severe amnesia may be unaware of how frequently they experience time loss. Others may “come to” in an unfamiliar place, unable to recall how they got there. Moderate to severe identity confusion and identity alteration are the remaining two core dissociative symptoms identified by Steinberg (1995) and epitomized by the creation of alternate identities.

Ross (1989) proposes that DID be sub-typed into three forms of progressive complexity according to the number of alternate identities in the personality system: cases with fewer than 5, cases with 5 to 20, and cases of poly-fragmented DID. Alternate identities are differentiated from personality fragments by most clinicians. In Ross’ (1989) view, an identity must have been in executive control for a significant period during the individual’s life. In contrast, he conceives personality fragments as more limited states, which express a single feeling, contain a single memory, or perform some other function in the life of the individual. In cases of complex DID, the average number of alternate identities in the personality system is 13, but generally 7 or 8 have handled most of the life experience, and participate extensively in therapy (Loewenstein, 1993). Additionally, there may be a number of personality fragments with which the therapist may spend time throughout treatment. However, it is the patient with poly-fragmented DID whom Ross (1989) describes as having “taken the process of dissociation to its extreme . . . hundreds of experiences are split into separate pieces and given separate names and ages.” (p. 81)
Depersonalization and De-realization

Several authors expand upon the features of Depersonalization Disorder outlined in *DSM-IV* (1994). Levy and Wachtel (1978) list several secondary characteristics, among them a sensation of numbness, a loss of emotional responsiveness, feelings of calm detachment, a sense of being distanced from auditory and visual stimuli, and a slowing of the subjective sense of time. Simeon and Hollander (1993) describe other experiences associated with depersonalization. Depersonalized individuals may feel as if they are in a dream or trance, may be unable to recognize their own face upon looking into a mirror, may feel that their voice or behaviour is not under control, or may feel as if they are watching a movie of their own life. Putnam (1989) describes similar episodes of passive influence in his patients. Noyes and Kletti (1977), from their study of individuals who had experienced depersonalization in response to life-threatening danger, identify yet another cluster of symptoms. These include the expansion of time and space, the acceleration of mental processes, the heightening of imagery and sensation, and the simultaneous senses of loss of control and invulnerability. Of the 101 men and women who participated in their study, 72% described an altered awareness of the passage of time, commonly a sense of slowing; 61% experienced an acceleration of mental processes. Fifty-six percent described a blunting of affect, 51% alterations in sensory acuity, and 57% a feeling of their movements being mechanical. Thirty percent described a loss of volition such that they had a sense of being controlled by an external force. The most prevalent feature of the depersonalization experience was de-realization; 72% of respondents stated that they themselves felt unreal, while 30% applied the same description to the environment. Terms such as “weird,” “strange,” and...
"dreamlike" were used in an effort to characterize the experience; many respondents found its ineffable quality difficult to express (Noyes & Kletti, 1977, p. 380). The onset of depersonalization is usually abrupt, with recovery gradual (Putnam, 1989). Although widely reported in the literature, the prevalence of Depersonalization Disorder is unknown (Jacobs & Bovasso, 1992).

A number of clinicians have attempted to clarify the construct of depersonalization. Definitions of the term generally centre on the two main features subsumed under Criterion A, in DSM-IV (1994). Jacobs and Bovasso (1992) conceive depersonalization as a multidimensional construct. They outline five forms of depersonalization. Inauthenticity involves loss of the sense of genuineness in experiencing of self and other: Senses of awareness and presence in the interpersonal context are absent. De-realization comprises alterations in the perception of reality or familiarity of self, others, and objects in the environment. Self-objectification produces disorientation such that boundaries between self and objects become blurred. Self-negation refers to the loss of the sense of personal identity, while body detachment involves a sense of parts of the body being distorted or detached. Different forms of depersonalization are associated with different types of cognitive and emotional dysfunction.

Depersonalization Disorder is classified as a dissociative disorder because its symptom profile pertains to alterations in the sense of self (Simeon & Hollander, 1993). It is associated with a number of psychiatric disorders, including depression, certain personality disorders, such as BPD, and with the complex dissociative disorders, DDNOS and DID. Noyes and Kletti (1977) and Jacobs and Bovasso (1992) posit that the altered state of consciousness that constitutes depersonalization is preceded by extreme
anxiety, which causes a kind of implosion of intense affect and produces symptoms such as numbness or "deadness."

While Jacobs and Bovasso (1992) view de-realization as a symptom of depersonalization, other authors view the two as separate constructs. Trueman (1984) holds both to be significantly related to reported levels of anxiety, and explains them in psychodynamic terms. In his view, they become operative when anxiety threatens to overwhelm, functioning to protect the individual from an eruption of aggressive impulse. Levy and Wachtel (1978) contend that most explanations of depersonalization stress the part played by fantasy in the mobilization of the defence: "This is not real; this is not happening to me" (p. 294). This aspect of depersonalization plays a critical role in DDNOS and DID. According to Levy and Wachtel (1978), depersonalized individuals have detached themselves from a reality, internal or external, that is threatening, living out an unconscious desire to be dead, inanimate, or simply absent, which protects when higher level defences fail. Other theories have been proposed to account for the phenomenon of depersonalization. According to Noyes and Kletti (1977), "Janet explained depersonalization on the basis of altered attention" (p. 382). In line with this view, the authors recorded, during their own study, dozens of references by participants to the constriction of focus of attention. During the depersonalization experience, perceptual acuity was heightened, "while sensory impressions that were normally within the sphere of immediate attention . . . were excluded from awareness" (p. 382). This narrowing of the attentional field is characteristic of the highly hypnotizable individual, who displays an unusual capacity for intense concentration while in a dissociated state (Aldridge-Morris, 1989).
Psychodynamic theories attempt to explain depersonalization in terms of a poorly integrated ego. In psychodynamic terms, it is during the process of ego differentiation that representations of self and other develop (Frances, Sacks, & Aronoff, 1977). According to Kohut, the ego is “an observing, synthesizing, self and object defining and relating, and reality-testing group of functions which is relatively stable over time” (cited in Frances et al., p. 326). Self-constancy is the ego function, which establishes the stability of self-representations, resulting in a self that is both cognitively and affectively experienced as “me.” From a psychodynamic perspective, interruptions to ego development are seen as engendering inadequately integrated self and object representations, leaving the individual vulnerable to experiences which challenge self-constancy, the felt sense of connectedness to the self, and resulting in the self being experienced as “not me.” Depersonalization is thus triggered by a situation which highlights the disparity between “a new sense of the actual self and a previously held ‘average expectable’ self” (Frances et al., p. 327).

Frances et al. (1977) maintain that, as an enduring syndrome, depersonalization may be more prevalent in psychiatric populations because of poor ego integration, particularly in psychotic and borderline patients. In contrast, transient episodes of depersonalization may be relatively common among normal individuals in instances of natural disaster or life-threatening circumstances. While the ego of the normal individual may be better integrated than that of the psychotic, the threat of death certainly poses an enormous challenge in terms of reconciling what one perceives to be imminent with how one usually conceptualizes one’s self. In psychodynamic terms, such abrupt and unexpected changes in self-representation may precipitate depersonalization because
they cannot immediately be integrated by the ego within the existing self-structure (Frances et al.).

Biological theories propose an organic basis for depersonalization, which has been found to be associated with a number of neurological and physiological disturbances, including temporal lobe epilepsy, head injury, and migraine headaches (Simeon & Hollander, 1993). Some studies implicate serotonergic dysfunction (Hollander, Liebowitz, DeCaria, Fairbanks, Fallon, & Klein, 1990; Fichtner, Horevitz, & Braun, 1992). Other causes of depersonalization have been suggested. Trauma and stress theories emphasize the interaction between physiological and psychological mechanisms. An extensive body of literature links dissociative symptoms to trauma experienced in childhood. Depersonalization syndromes occur frequently in those who have experienced sustained periods of trauma, such as internment in a concentration camp or recovery from a severe spinal-cord injury (Putnam, 1989). Combat veterans provide perhaps the best examples of traumatically induced dissociative reactions. Other severe stressors, such as bereavement, may trigger the onset of depersonalization in mid-to-late life. However, a diagnosis of Depersonalization Disorder is made only when depersonalization occurs in the absence of another disorder that may account for its presence.

Models of Dissociation

The metaphors of splitting and shattering referred to earlier in this chapter disclose an underlying belief in the fundamental unity of human consciousness. This is contradicted by a number of researchers whose work points to the existence of the disunity of consciousness in normal individuals. Hilgard (1986) proposes that unitary
consciousness is an illusion, that multiple levels of consciousness are characteristic of both normal individuals and those who are highly dissociative. He outlines a "neo-dissociation" theory, which attempts to account for phenomena occurring under hypnosis. This theory is grounded in three assumptions. The first is that subordinate cognitive structures exist, which have a degree of unity and autonomy of function. While these systems interact, they also may become isolated from one another. They facilitate the numerous shifts of consciousness that occur during a given day, and are incompatible with the concept of a totally unified consciousness. They are exemplified by serial lapses of consciousness that occur, for example, while driving or playing a musical instrument. The second assumption is that there exists a sort of hierarchical control that manages the conflict and competition among these systems. Hilgard's third assumption is that there exists a monitoring controlling structure, which he terms "the executive ego" (1986, p. 40).

In a series of experiments, Hilgard (1986) found that "hidden observers," dissociated aspects of the individual, were present and aware of what had taken place during hypnosis. Subjects who took part in one experiment in which hypnotic hearing loss was induced gave clear evidence of covert hearing during the experiment. Hilgard posits that these latent subsystems, which he considers to be dissociated parts of the ego, are accessible via hypnosis and that they are present in normal, as well as dissociative, individuals. The function of the hidden observer is to take note, objectively, of what occurs, as if in a waking state. Thus, Hilgard argues that: "divided consciousness is familiar in ordinary waking life" (p. 185).

Lester (1992), in a study in which college students were asked to identify their different selves and describe their characteristics, found that 84% of the respondents
were able to identify a number of different sub-selves, assigning them particular qualities and using role-related labels and sets of adjectives to characterize each. Beahrs (1982) has also proposed that the concept of multiple consciousness is unavoidable, that each of us is split into various parts, roles, and ego-states, and that the mind must therefore be viewed as a complex whole constituting multiple part-selves. Rather than viewing the self as a single unified entity, Beahrs sees it as a hierarchical organization of part-selves. For Beahrs, the unconscious comprises those parts of the individual's mind of which the "usual self" (p. 60) is not aware. Each of these parts, or part-selves, has its own consciousness, of which the other part-selves may be aware. These multiple levels of consciousness are organized by what Beahrs terms "the executive" (p. 60), whom he likens to the conductor of an orchestra, which is in turn composed of other part-selves. Beahrs (1982) thus seems to argue for an inherent degree of disunity of consciousness, contending that all individuals are, at least to some degree, multiple selves. He considers the concept of co-consciousness, first proposed by Prince (1914), to be a definitive aspect of human experience. The postulation of separate components or parts of the ego necessitates that they be regarded as experiencing entities with whom communication is possible. However, Beahrs makes a distinction between functional co-consciousness and a dissociative consciousness in which rigid and impermeable amnestic barriers prevent communication between and among ego states. In line with this view, he proposes that the goal of therapy is not to integrate multiple parts, which are always present even in normal individuals, but rather to achieve a healthy level of co-consciousness.

Tinnin (1990) proposes a model of consciousness rooted in the assumption that normal consciousness is the result of an "illusion of mental unity" (p. 154) created by
certain cerebral processes, and that when this system of processes, the "governing mental system" (GMS), relinquishes dominance, an altered state of consciousness results. Additionally, he holds that during that state, a new mental system, or alternate ego-state, may be formed, which will become dissociated upon termination of the altered state. Finding affinity with Beahrs (1983) and Hilgard (1986), Tinnin asserts that consciousness is not unitary, and that normal consciousness constitutes the mental image of the unitary self in the world, reflective of the capacity to locate one’s self in past, present, and future. The extent of organization required to threaten this sense of unity varies from one individual to the next, but involves properties of identity, volition, sequential time, and perception of reality. In the dissociative individual, amnestic barriers function to preserve the illusion of a unified consciousness.

Dissociation is conceived as a continuum by a number of authors, including Braun (1988), Putnam (1989), and Ross (1989). At one end are normal dissociative behaviours, while at the other lie increasingly pathological dissociative phenomena culminating in poly-fragmented DID. Everyday dissociative experiences, such as daydreaming and the tuning out of conversations, lie at the benign end of the continuum. So does automatic behaviour, such as that exhibited by the individual who is able to drive a car and simultaneously conduct a conversation (Putnam, 1989). Ross regards Dissociative Amnesia as the most common and least complex of the dissociative disorders, placing it along with normal dissociative experience, at the far left (the benign end) of the continuum. He locates Dissociative Fugue and DDNOS roughly one-third to one-half the way along, and DDNOS with features of DID in the middle. To the right are progressively more complex forms of DID. Ross does not place Depersonalization Disorder on the continuum. Although it is presented in DSM-IV (1994) as a discrete
diagnostic entity, he disagrees with this classification, holding that depersonalization is not a disorder, but rather a symptom which may also characterize the experience of the individual with DID. While Dissociative Amnesia and Dissociative Fugue do find a place on Ross' continuum, classical descriptions in the literature emphasize the dramatic, florid forms of both disorders. This differs, in Ross' view, from the presentation of amnesia and fugue as symptoms in cases of DDNOS and DID.

Braun (1988) proposes that dissociation is state-dependent. The fundamental tenet of state-dependent learning is that information encoded in a given neuro-psycho-physiological (NPP) state is most easily retrieved while in the same state. Braun regards behaviour as shaped by environmental contingencies. In his view, if that shaping takes place in the context of an event that occurs while the individual is in a sufficiently disparate NPP state, the memory of that event will not be available while in another NPP state. State dependency is associated with arousal levels, and is sensitive to a wide range of environmental stimuli. Retrieval of information encoded under one NPP state is contingent upon cue. The greater the resemblance of contextual stimuli to the conditions under which the encoding occurred, the more likely it is that this information will be available to recall (Van der Kolk & Van der Hart, 1989). Braun maintains that if a number of events occur under the same NPP state, the information learned in that state will be chained. This chaining of knowledge, memory, sensation, and affect forms an alternate ego-state "with its own response patterns, life history, and range of affect" (Braun, 1988, p. 5). DID is thus, according to Braun, the result of repeated state-dependent dissociations which occur over an extended period of time, and which engender highly discrete states of consciousness. Separating these states are amnestic barriers that constitute extreme forms of state-dependent memory.
The model of dissociation most frequently cited in the literature is Braun's BASK model. Conceptualizing the phenomenology of dissociation along dimensions of behaviour, affect, sensation, and knowledge, Braun asserts that these processes "function on a time continuum" (p. 5). In normal individuals, the experience of an event is simultaneously integrated across all four dimensions. They have knowledge of the event, and behaviours, affect, and sensation associated with it (Fine, 1989). In dissociative individuals, any BASK component may be separated from any, or all, of the others. Braun uses the example of hypnotic anaesthesia, in which sensation and affect are dissociated from the patient's behaviour and knowledge that a surgical procedure is taking place.

Braun (1988) accounts for all five DSM-IV (1994) dissociative disorders in light of the BASK model. In Dissociative Amnesia, there is a dissociation of all four BASK components. In localized amnesia, there is loss of all events during a circumscribed period. In generalized amnesia, almost all memory is lost prior to a given event. Systematized amnesia involves the loss of memory for a specific event. Other memories during that period are available. Continuous amnesia almost always has an organic etiology. In this type of amnesia, "each successive event is forgotten as it occurs" (Braun, p. 7). Dissociative Fugue, like hypnotic anaesthesia, involves a dissociation of affect and sensation from behaviour and knowledge. In Depersonalization Disorder, from a BASK perspective there is an association of behaviour, affect, and knowledge, while sensation is distorted. For some patients, there is a high level of anxiety associated with episodes of depersonalization. For others, however, dissociation is experienced as adaptive, as can be seen from this excerpt from a SCID-D (Steinberg, 1995) transcript of
a conversation between physician and her patient, a woman who suffered chronic physical pain:

Patient: I always refer to my body as third person and, um, I always have. . . . It's great in a way. It has some advantages because I can cope with a lot of pain that I have because I just dissociate from my body and I don't feel it.

Interviewer: In the same respect does it feel as if part of your body was disconnected or detached from you?

Patient: The whole body seems disconnected. . . .

Interviewer: Can you describe what that experience is like?

Patient: Well, it's like, sometimes it is just sort of floating away, like when I was a child and I had a lot of pain in my legs and stuff. Um, I just kind of severed things at the waist and my lower body would just kind of float away. It's a neat trick. (p. 96)

Braun (1988) also describes de-realization in BASK terms. He maintains that sensation is altered as with Depersonalization Disorder, but with respect to the environment, rather than the self. Steinberg (1995) concurs, as can be seen from this excerpt from a SCID-D transcript of an interview with a young woman who experienced a loss of familiarity during her de-realization episode:

Interviewer: Have you ever felt as if familiar surroundings or people you knew seemed unfamiliar or unreal?

Patient: Probably unreal.

Interviewer: Who seemed unreal?

Patient: People that I should know. People that I looked at and I kept thinking, "I know those people, why am I scared to death?" That type of thing. My parents. Especially my mother. (p. 155)

To describe how DDNOS would be represented in the BASK model, Braun (1988) uses the example of sleepwalking, which he places slightly past the mid-point of the dissociative continuum. Affect is dissociated from behaviour and knowledge of
ongoing events is missing. Behaviour and sensation are present but out of the individual's awareness. In DDNOS with features of DID, periods of dissociation and thought processes become chained, but do not meet the criteria for alter personalities, qualifying instead as personality fragments. According to Braun, in classic DID, each BASK element is encoded as an element of a separate alter personality. Even knowledge is fragmented. These are patients who, in Braun's view, may not initially appear to be dissociative because there is no apparent disruption of knowledge.

**Etiology of the Dissociative Disorders**

Kluft (1984a, 1984b) has proposed a 4-factor theory which, in his opinion, explains the development of DID. Viewing it as a chronic post-traumatic condition whose origins lie in childhood, he hypothesizes that the disorder is the result of a variety of contributing influences, which interact in various combinations. Factor 1 is an innate, possibly inherited bio-psychological capacity to dissociate, reflected in the individual's capacity for auto-hypnotic trance experiences. Factor 2 consists of traumatic life experiences that overwhelm the child's non-dissociative ego defences. Factor 3 accounts for those psychosocial and other extrinsic influences that determine the final form taken by the dissociative defence. Factor 4 is the absence of healing, nurturing, restorative experiences with significant others in the face of continued trauma.

Braun (1987) proposes a “3-P” model of the etiology of DID which echoes the elements in Kluft's model. The predisposing factors in this model include an inborn capacity for dissociation in combination with a family atmosphere permeated by stress, inconsistency, and abuse. The precipitating factor is a stressful event that overwhelms the individual's defences, leading to the activation of dissociation and the creation of
new, or reinforcement of existing, personalities whose role it is to cope with the stress. Perpetuating factors are recurrent family stress and physical, emotional, and/or sexual abuse, causing repeated dissociation that leads to the development of a life history for each personality. In Braun's (1987) view, dissociation alters the sense of self to the point that the trauma seems to happen to someone else. It provides an escape from the constraints of reality and contains, or compartmentalizes, overwhelming affect and memory outside conscious awareness. Further, it produces analgesia, literally, a kind of hypnotic emotional anaesthesia, the dissociation of affect and sensation from behaviour and knowledge.

Dissociation is held by a number of authors (Braun, 1987; Kluft, 1984b; Ross, 1989) to be strongly associated with trauma sustained within the context of the family. Experiences of transient trance states, depersonalization, and de-realization have been linked by a number of researchers to extreme stress (Noyes & Kletti, 1977; Spiegel & Cardeña, 1991). Braun (1987) highlights the excessive inconsistency and contradictory expectations of the child demonstrated by parents of young dissociators, describing the family atmosphere of the child who develops DID as "a simmering pressure cooker ready to explode" (p. 306). On the surface, the family appears normal, and presents a unified facade. Internally, however, it is stress-permeated and conflicted. Parents may be aggressive and over-controlling, or may assume a stance of passivity and helplessness. In Braun's (1987) view, the former type of parent is generally the more inconsistent, while the latter is often fully aware of physical, psychological, and/or sexual abuse being perpetrated on their children, yet does nothing to intervene. Children may be placed in situations that stress their reality testing, such as witnessing one parent being beaten by the other and then being told that: "nothing happened." They may be
exposed to alternating displays of what Braun (1987) terms "appropriate love" (p. 308) and physical or emotional abuse. They may be placed repeatedly in double-bind situations, such as being told that they are loved and treated as if they are worthless.

Non-abusive trauma is also held by Putnam (1989) to be implicated in the genesis of the complex dissociative disorders. Putnam (1989) describes cases of DID in children who came from war zones and had witnessed the massacre of other family members. One adolescent with the disorder had seen her parents die in a minefield explosion, her grandfather shot, and a sibling beheaded. Another young man had been confined for years in a series of body casts and had undergone repeated surgery with resultant chronic pain. Near-death experiences associated with drowning and subsequent resuscitation also have been related to the development of DID. Paley (1988) describes the relationship between dissociation and psychological trauma, stressing that dissociation is an adaptive response that permits the child to function in a relatively normal way for the duration of the trauma, while leaving a large part of the personality unaffected by the traumatic event.

**Types of Alternate Identities**

It is Putnam's (1989) position that there are several dimensions along which alternate identities may be differentiated in the individual with DID. Predominant affect is one; some identities will be depressed, others hostile, yet others light-hearted and positive in outlook. Observable behaviours also discriminate one identity from another: "there will be differences in both spontaneous and elicited behaviours" (p. 105). Personality states themselves will perceive that they have different self- and body-images, values, ages, sexual orientations, and/or gender. Broad categories of alter
personalities have been identified by a number of authors (Fitke, 1990; Kluft, 1985; Putnam, 1989; Ross, 1989). Characterizations of types of alternate identities are circumscribed by the functions they serve and by the affect and memory they carry.

The primary identity is usually the one who enters therapy. Most references in the literature describe him/her as suffering from a variety of somatic and psychiatric complaints, including severe headaches, vertigo, nausea or other gastrointestinal distress, mood swings, depression, anxiety, and/or rapid fluctuations in level of function. Yet not all authors agree on a common set of presenting factors. Loewenstein (1993) states that: “many MPD patients are warm, complex, self-observant, creative, imaginative, and humorous individuals . . . despite their difficulties” (p. 587). It is Ross’ contention that the primary identity may present with no awareness of other identities, and a sense of being overwhelmed by the circumstances of his or her life. Child and adolescent personality states are the most common types of alternate identities, and are often the first ones encountered by the therapist during treatment. According to Fitke (1990), they originally emerged to perform a particular task or function, such as to cope with feelings that were intolerable to the primary identity or to experience a specific type of abuse.

Ross (1989) holds that protector personality states are those whose original function it was to buffer the primary identity from external threat. They may serve as a kind of internal counterbalance within the personality system to guard against self-destructive behaviours. Ross further maintains that protectors that form before age 10 frequently are adolescents. Some are calm and rational, others aggressive, relying on less mature coping strategies. The latter type may exhibit a range of antisocial behaviours that impede the progress of therapy. Adult protectors “may be excellent
consultants to the therapist" (p. 114). However, they may also prove difficult to work with if they are made to feel that their role within the personality system is being threatened. According to Putnam (1989), persecutor personality states exist in roughly half of all individuals with DID. They see themselves as being in conflict with the primary identity and may attempt to harm him/her or other identities. In Ross' (1989) view, they may perceive a degree of separateness from other personality states that leads them to believe they can damage the shared body by cutting or burning without injuring themselves. Their attitude toward the therapist is typically derisive, and they may attempt to interfere with treatment.

Putnam (1989) holds that the internal self-helper (ISH) is a type of personality state appearing in up to 80% of those with DID. An ISH may take the form of an idealized figure in the life of the patient, or a non-human image, such as an angel. The ISH is generally serene, passive, and devoid of affect, with the function of providing information about the inner workings of the personality system. A dialogue between therapist and ISH may produce valuable information about primary or other identities, and may furnish the therapist with ideas about how to proceed with certain aspects of treatment. Moreover, an ISH may offer insight into which personality state is likely to respond best to a particular type of intervention. As Caul (1989) states:

The therapist must not be afraid to "horse trade" with the ISH, who will always be protective of the personalities and will see to it that therapy is provided and that the personalities will get the best deal possible. If the therapist becomes stymied, it is recommended that the therapist inform the ISH that special help is needed from that source in order to proceed with the therapy. The ISH will almost never play all of his cards at once. The therapist must learn and understand that for the most part the ISH can do more and exert more influence than the therapist realizes. (cited in Putnam, p. 203)
Putnam (1989) and Ross (1989) maintain that identities of the opposite sex are common in those with DID. In a female patient, male personality states usually serve a protective function. In a male patient, a female personality state may be chronologically older, a maternal figure who offsets the aggressive behaviour frequently seen in males with DID. In addition, identities may exist whose sexual orientation differs from that of the patient. This is potentially troublesome for the patient, who comprises the system of alternate identities taken as a whole. As Fitke (1990) puts it, "the sexual behaviours of the multiple personality system depends upon the preference of the alter personality with executive control of the body, which, if the multiple personality system is uncooperative, can cause serious problems in relationships" (p. 987).

Fitke (1990) contends that promiscuous identities are frequently found in female patients. These may be prostitutes, who embody the sexuality of the patient, or simply personality states with a penchant for setting the stage for an intimate encounter and disappearing "inside," leaving the confused and often sexually frigid primary identity to extricate herself from the situation. Finally, demon or other non-human identities have been observed in individuals with DID (Ross, 1989). Often viewing themselves as omniscient, they are usually are created to provide safety for the body. They may be benevolent or malicious, and may be worked with in treatment as a therapist might work with an ISH or persecutor identity, respectively. According to Putnam (1989), the awareness one identity has of another varies according to the degree of amnesia between them. Some personality states, such as the ISH, will claim cognizance of the entire system. Some may be co-conscious with a limited number of others. Others, like the primary identity, may be entirely unaware of the existence of other personality states.
Absent from these accounts of varying types of alternate identities, however, is any consideration of the role played by culture in the form taken by these entities. An earlier chapter of this thesis was devoted to an extensive discussion of dissociation in non-Western cultures. Among the dissociative syndromes reviewed was that of fox possession. Rural Japanese social and religious practices exert a powerful influence over the manifestations of dissociation in this culture. Alternates in instances of fox possession evince qualities, which are held by the Japanese to be those of the fox, including changes in facial expression and bestial behaviours such as the ingestion of unusual substances. Fox possession thus provides an example of the ways in which the character and behaviour of an alternate identity are culturally and socially defined and constrained. The possessing entity in instances of Indian and Balinese possession is drawn from the available repertoire of spirits, Gods or demons whose existence is supported by religious and cultural belief. In Western culture, where the existence of non-human entities is, to a great degree, not consonant with cultural belief, alternate identities in the individual with DID take a predominately human form. When non-human alternates do manifest themselves, such as the ISH in the form of an angel described by Putnam (1989) or the demon alternates delineated by Ross (1989), they are largely confined to individuals “raised in strict religious settings” (Dorahy, 2001, p. 158) that support the viability of such a being. Thus, the form taken by alternate identities in the West is circumscribed by culture, no less than it is in Japanese, Indian or Balinese societies.

The contention that culture exerts a powerful influence on the formation of alternate identities is further upheld by the prevalence, in Western society, of promiscuous alters in female patients with DID. The Madonna/whore dichotomy that
prevails in Western medical treatises, literature, and art was discussed in an earlier chapter of this thesis. The frequency with which promiscuous alters occur in Western instances of DID supports the idea that such personality states, occurring as they tend to in women who are sexually frigid, constitute an embodiment of this very dichotomy. The lesbian and homosexual alternates described by Fitke (1990) and Ross (1989) provide yet another example of the production of culture-specific personality states. In none of the cross-cultural literature reviewed for this thesis was the issue of sexual preference addressed. The very absence of such material suggests, once again, that for the formation of such an alternate to occur, homosexuality and lesbianism must exist in the cultural repertoire as behavioural alternatives. This is very much the case in North America.

Culture may also play a role in the degree to which alternate identities view themselves as separate and distinct from other identities in the personality system of the individual with DID. The characteristics of individualist culture, of which North America is one, have been detailed at length in a previous chapter of this thesis. Putnam (1989) and Ross (1989) have articulated the degree to which persecutor alternates view themselves as distinct from the primary identity to the extent that they may actually attempt to harm him or her, oblivious to the fact that this also would constitute an act of self-injury. The philosophy of individualism in Western culture may be considered to engender the perception of discrete boundaries between self and other. These boundaries may well be reflected in the degree to which alters perceive themselves to be autonomous individuals.
The Switch Process

Franklin (1990), Putnam (1988), and Ross (1989) conceive transitions from one to another alternate in largely intra-psychic terms that leave little room for a consideration of social or cultural factors which might impinge on the emergence of a specific alternate identity or contribute to the switch process itself. According to Ross, switches from one alternate identity to another may occur within the parameters of rules peculiar to the system of the patient, with clearly defined sequences apparent, or may occur in a seemingly random and uncontrolled fashion. Ross holds that switches are triggered by the internal dynamics of the patient’s personality system. Clearly, however, there are factors external to the individual, which are operative during a switch, as most references in the literature suggest that an identity appropriate to the circumstance at hand is usually the one to appear. Putnam (1988) describes efforts to delimit the precise moment of a switch as analogous to attempting to “observe the exact moment of transition between waking and sleeping” (p. 27). In his view, the switch is a process, a metamorphosis from one alternate identity to another, which may last anywhere from a few seconds to a few minutes. Most occur in less than 5 minutes.

According to Franklin (1990), Putnam (1988), and Ross (1989), switching is a psycho-physiological process related to state-dependent variables such as affect and cognitive style. Once again, this is a position that emphasizes intra-psychic factors, as though the switch process occurs in a vacuum. Franklin holds that switches are reflected in changes in interpersonal relatedness, motor activity, speech rate and modulation, facial expression, and other variables. Franklin further maintains that switches may be indicated by changes in posture and vocal intonation. A rapid fluttering of the eyelids
may occur, and the patient may enter a trance-like state. According to Putnam, the majority of patients display common features, exhibiting:

Either a burst of rapid blinking or one or more upward eye rolls at the beginning of the switch. This may be followed by a transient “blank” or vacant gaze. . . . There is a disturbance of ongoing autonomic regulatory rhythms, particularly heart rate and respiration, together with a burst of diffuse motor discharge. On videotape, one can see a rearrangement of facial musculature that coincides with the motor discharge. The facial rearrangement often occurs in a step wise fashion as a series of grimaces. As the new alter personality state stabilizes, there are often postural shifts. (1988, p. 28)

Putnam (1989) asserts that many dissociative individuals are experts at disguising switching behaviours, covering their faces with their hands, looking away, or timing the emergence of an alternate identity at a moment when the therapist is looking in another direction. After new identities have emerged, they may exhibit “grounding” behaviours during which they glance around the room, touching their face or the chair in which they are sitting in an effort to orient to what is, for them, a new situation. Frequently the new identity will make notable efforts to distinguish him- or her-self from the preceding alternate.

**Subtle Signs of Dissociation**

Franklin (1990) describes DID as a “pathology of hiddenness” (p. 4) because the majority of patients do not exhibit overt pathology but instead take pains to conceal their condition. Many fear that they will be diagnosed as psychotic if their symptoms are revealed. It is Franklin’s position that, in spite of efforts to disguise their condition, many DID patients evidence subtle signs of dissociation in the form of transient changes in vocal modulation, facial expression, and posture, and in thoughts, feelings, and behaviours. Such signs should, in Franklin’s view, lead the clinician to probe for further
evidence of discrete ego-states in order to confirm – or disconfirm – a diagnosis of DID. In one series of 73 DID patients, 15% dissociated openly during assessment, 40% were “highly disguised”, 5% were self-diagnosed, and 40% displayed “subtle forms of classic signs” (p. 5). Patients with both typical and atypical forms of DID may initially present covertly. Even in those with classic forms of the disorder, pathology may seem “subdued during periods when their alters are influencing or suppressing each other or functioning smoothly without emerging overtly” (p. 6). Franklin further holds that many patients who present covertly will, over time, display clear indications of dissociation, which permit them to be placed on the dissociative continuum in accordance with the degree of dissociation they display.

In Franklin’s (1990) view, subtle signs of dissociation are inferred from shifts and discrepancies in the patients’ presentation. Franklin identifies a number of such indicators of dissociation. A clinician sensitive to these may be able to detect the possible presence of DID in an individual who does not display more obvious signs of the disorder. Among them are sudden changes in affect; fluctuations in developmental level; inconsistencies in behaviour, attitude, opinion, and memory; signs of transitions between alter personalities; signs of one alter’s influence over another; and rapid variations in vocabulary. Many of these indicators are portrayed in videos about DID which are readily accessible to the lay viewer. A number of these films will be reviewed in the final chapter of this thesis. The presence of different alters may cause the behaviours and attitudes of the patient to appear inconsistent. She may express sadness at something one moment and behave as if it doesn’t matter the next. The patient’s developmental level may appear to change; she may display differences in vocabulary, sentence structure, and vocal intonation that suggest a shift from an adult to
a child alternate. Transitions between alternate identities may be overt, as described by Putnam (1988), or may be covert; one identity may blend with another. The influence of one alter on another may take the form of co-presence, in which two of more identities influence the affects and behaviours of each, and which "may be evident in rapid changes in posture or facial expression or may be inferred from the patients' contradictory statements, paradoxical behaviour, or confusion about what they feel or think" (Franklin, 1990, p. 9). Co-consciousness involves two or more alternate identities' awareness of each others' thoughts and feelings. Once again, both of these phenomena are portrayed in media depictions of DID, and are addressed in the following chapter.

Franklin (1990) holds that the significance of subtle signs of dissociation must be evaluated in light of the patients' overall symptom picture. The clinician may find that criteria for psychiatric diagnoses other than DID are met only by specific alternate identities and do not serve to account for the patients' total profile. In Franklin's view, Schneiderian symptoms in the absence of other symptoms such as the flat affect and loose associations that are characteristic of schizophrenia should raise the clinician's index of suspicion for DID. One identity may be hypo-manic, another depressed, giving the overall impression of bipolar disorder. However, Franklin maintains that multiple mood swings within the context of a single session are more likely to indicate DID. Additionally, the clinician should be alert to the patient's experiences of altered states of consciousness that cannot be accounted for by other medical conditions.

**Summary**

This perusal of the clinical literature on DID reveals the biomedical roots of its authors' thinking. The etiological theories of dissociation proposed by Kluft (1984a,
1984b) and Braun (1987) refer to biologically based qualities that predispose the individual to dissociation. Elsewhere, Braun (1988) holds that dissociation is grounded in a "neuropsychophysiologic" (p. 5) process. Braun and Sachs (1985) maintain that: "the ability to dissociate has been proposed to have biological determinants" (p. 43).

Similarly, Ganaway (1989) holds that "various biological predispositions" (p. 206) underlie the dissociative response, while Kihlstrom, Glisky, and Angiulo (1994) maintain that a "premorbid vulnerability" (p. 117) to dissociative disorders provides a connection between personality and psychopathology.

While the models of dissociation proposed by Beahrs (1982), Hilgard (1986), and Tinnin (1990) point to the normalcy of dissociation in everyday life, they do not account for socio-cultural factors that shape the presentation of dissociative symptoms. Kluft's (1984b) 4-factor model of the etiology of dissociation affords some consideration of the effects of social support in mitigating trauma, yet the model itself is highly individualistic.

As Dorahy (2001) asserts, "little work on the genesis of DID has gone beyond interpersonal stressors. The role of traumatic experience emanating from cultural, ethnocultural, and social conditions on DID development is still to be explored" (p. 162).

Further, scant attention is given in the literature to the role played by the media in providing prototypes of the disorder to the general public. The ready availability of media depictions of DID means that most of us have some sense of what it means to be multiple, and contributes to the apprehension of multiplicity as a possible way of being.

The following and final chapter of this thesis is devoted to a discussion of the social, cultural, and political factors which have contributed to the burgeoning increase in the diagnosis of DID, the issues of iatrogenesis and malingering, and the accessibility of media presentations of the disorder.
CHAPTER 5: THE SOCIAL CONSTRUCTION OF DISSOCIATIVE IDENTITY DISORDER

Introduction

The emergence during the 1960s of child abuse as an urgent social concern, the rise of feminism, and the difficulties experienced by veterans of the Vietnam war were among the factors responsible for creating a socio-political climate in which DID would flourish in later decades. In this chapter, I will review feminist contributions to public awareness of the sequelae of civilian trauma in addition to some of the early literature on child abuse and combat neuroses. It is my contention that DID is an artefact of social and cultural process, a position that demands an examination of the influence of the media on the presentation of the disorder in North American culture. The availability of representations of DID in film and the popular press means that the lay public has a sense of what it would mean to be "multiple," further ensuring that prototypes of the disorder are readily accessible to those with a mind to malinger. In view of this, I will address the issues of iatrogenesis and faking of DID. Many forces have converged to sustain the existence of the disorder in North America. This chapter is an attempt to explore some of them.

Social and Political Influences

A number of factors have combined during recent decades to render DID more visible in the public view and more viable in the clinical sphere, not the least of which
was the emergence of child abuse as a socio-political cause during the early 1960s (Hacking, 1999). In 1962, paediatrician C. Henry Kempe and four colleagues wrote what Gelles (1975) has termed a "breakthrough" (p. 369) paper on the battered child syndrome, raising public and professional awareness of the problems of neglect and caretaker-inflicted injury. The paper, which was published in the *Journal of the American Medical Association*, was entitled "The Battered-Child Syndrome." In it, Kempe, Silverman, Steele, Droegemueller, and Silver (1962) detail the results of a "nation-wide survey" (p. 105) in which hospital records were examined for evidence of child battery. Maintaining that "it is frequently not recognized or, if diagnosed, is inadequately handled by the physician because of hesitation to bring the case to the attention of the proper authorities" (p. 105), Kempe et al. underscore the diagnostic challenges posed to physicians who may have great difficulty apprehending the existence of child abuse even when faced with overwhelming evidence, in the form of radiological and neurological data, that it has occurred.

It is not difficult to imagine the impact the article had in an era in which the possibility of the existence of child battery was either doubted or denied outright. The article itself is horrifying. In it, Kempe et al. (1962) presented two case studies of children aged 3 and 13 months, respectively, who had been abused by their mothers. The former child evidenced a fractured femur, convulsions, and was discovered to have "bilateral subdural hematomas" (p. 107). Additionally, she had experienced spells of unconsciousness. The latter infant had a fractured skull and displayed evidence of central nervous system damage. A week after discharge, she was brought back to the hospital with another skull fracture. Kempe et al. noted that "psychiatric knowledge pertaining to the problem of the battered child is meager, and the literature on the
subject is almost nonexistent" (p. 106). Further, they maintained that physicians must have a high index of suspicion for child abuse in instances where a child presents with failure to thrive, soft tissue injuries, such as severe bruising, or unexplained fractures. This publication was attended by significant media coverage, including newspapers, television, and weekly tabloids. Three years later, "the Index Medicus added child abuse to its list of medical categories to be catalogued" (Hacking, 1999, p. 136).

A succeeding volume, The Battered Child, edited by Kempe and his colleague Ray Helfer, was published in 1968 and became the seminal work on the subject. This book is devoted primarily to the medical and forensic aspects of child abuse, although it contains a chapter by Steele and Pollock (1968) about the psychiatric aspects of the problem. This chapter is heavily psychodynamic in orientation, and does not address social or cultural factors related to child abuse. However, the book underwent four subsequent revisions, the most recent of which was in 1997, introducing material which gives some consideration to the relationship between social factors and child abuse, and includes chapters entitled "The Role of Economic Deprivation in the Social Context of Child Maltreatment" (Garbarino, 1997) and "Children in a World of Violence: The Roots of Child Maltreatment" (Ten Bensel, Rheinberger, & Radbill, 1997). All in all, the impact of Kempe's work was 3-fold: to educate and inform medical practitioners about the reality and prevalence of child maltreatment, to raise public awareness of its existence, and to underscore the inadequacies of the social service resources available during the 1960s to deal with the problems of the abused child and those who had perpetrated the abuse.

Absent from academic and media discussions of child abuse and neglect in the 1960s, however, was mention of sexual maltreatment in the context of the family
The first significant media treatment of this topic was a lead story in the April, 1977 issue of *Ms Magazine*, entitled "Incest: Child Abuse Begins at Home." The article, written by Ellen Weber (1977), opens with statistics pertaining to the prevalence of sexual molestation, the locations where it most commonly occurs, and the percentage of victims who knew their assailant prior to the attack. Weber observes that:

Molestations by a stranger are generally one-time occurrences, but in the case of incest or sexual abuse by a known assailant, the victim may be trapped in a relationship for years. And while the guilt and shock of a sexual encounter with a stranger are often defused by supportive parental reaction, the family of a sexual abuse victim often fails to intervene on her behalf. (p. 64)

The article outlined the emotional sequelae of incest, underscoring the reluctance of young women to reveal the fact of the incest to figures of authority, and the resultant secrecy in which the violation of this most fundamental of social taboos was shrouded. This article reached thousands of subscribers, and its inflammatory nature heightened public sensitivity to what subsequently would become a highly politicized social issue.

Courtois (1988) has noted that during the period of time following Freud's repudiation of incest as a factor in the genesis of hysteria, "public ignorance and misperception" (p. 7) about the subject was rampant. With the rise of feminism, however, many concerns relating to women were brought to the forefront of the public consciousness. These became the focus of much political activism during the 1970s. Wall (1982) notes that: "there were campaigns around daycare, women's work both inside and outside the home, the oppression of women within institutions such as schools and universities, and sexism" (p. 19). The advent of rape relief centres and shelters for battered women signalled a growing concern with issues of emotional and physical safety both within and without the domestic sphere. These developments
fostered a climate in which women who had been victims of sexual abuse felt safe to verbalize their experience, a trend that has continued to the present day. In Hartocollis' (1998) terms:

In contemporary American society, sexual abuse stories have become paradigmatic stories of family trauma; stories with what seems to be great explanatory power especially when it comes to describing women's suffering. Women who have been victims of abuse are encouraged to speak up and the public are encouraged to listen and believe; in short, the issue has become politicized. (p. 163)

Another factor that increased public awareness of dissociation and other effects of trauma was the Vietnam War. In 1970, psychiatrists Charim Shatan and Robert Lifton organized a series of discussion groups in which Vietnam veterans could share what they had endured in combat and the psychosocial difficulties they were experiencing in its wake. Similar groups sprang up across the United States and, with their inception, a network of mental health professionals formed whose primary concern was the dissemination of information about the effects of the war on the psychological well-being of its veterans. Research on combat-related psychological problems, a huge volume of which was published during the late 1970s, "drew attention to the potentially devastating impact of actual overwhelming experiences" (Van der Kolk & Van der Hart, 1989, p. 1531).

One crucial earlier contribution had been made by American psychiatrist Abram Kardiner who, in 1959, published a chapter on war neuroses, in the American Handbook of Psychiatry. In this chapter, entitled "Traumatic Neuroses of War," Kardiner (1959) conceptualizes war neuroses as functional, rather than organic afflictions, much as 19th century psychiatrists had conceived hysteria. Indeed, many of the manifestations of war neuroses outlined by Kardiner bear close similarity to the primary stigmata of hysteria.
These include epileptiform symptoms – in Kardiner’s terms, “a recurrent paroxysmal syndrome accompanied by syncope and sometimes preceded by an aura” (p. 150). This syndrome is analogous to the seizures and subsequent loss of consciousness experienced by the hysteric. Kardiner also lists “fugue states” (p. 249) and an exaggerated startle response – common dissociative symptoms – as symptoms of war neuroses. Additionally, Kardiner holds that the sufferer of combat trauma may experience “an altered conception of [himself] in relation to the outer world” (p. 249). This symptom is referred to by contemporary researchers (Levy & Wachtel, 1978; Noyes & Kletti, 1977; Steinberg, 1995) as depersonalization/de-realization, and is considered by Steinberg (1995) to be a core feature of DID.

Just as Charcot had identified a series of phases of the hysterical attack during the late 1800s, so Kardiner (1959) identified stages of the traumatic syndrome found in combat veterans. The acute phase is characterized by fatigue, an inability to relax, hyper-arousal, insomnia (largely as a result of recurrent nightmares), loss of appetite, and fear at the sound of artillery. Kardiner also notes the presence of amnesia and irritability as defining features of this initial phase during which a symptom profile consolidates. It is during the second, chronic phase that symptoms become entrenched and that those of a more highly dissociative nature appear. Kardiner underscores the extreme level of psychosocial dysfunction which afflicts those suffering from combat neuroses, holding that they evidence a disinterest in activities once found pleasurable, and that “diminished states of awareness” (p. 249) may occur. These may be likened to the narrowing of the attentional field found in dissociation and hypnotic trance states. Other elements of the chronic phase may be cast in dissociative terms. Kardiner refers to “the proclivity to explosive aggressive reaction patterns” (p. 249), which he maintains
may occur while the individual is in a fugue state. In Kardiner's view, cases of combat neurosis that have remained acute for a period of 6 months may be considered chronic, signalling a poor prognosis.

Shatan and Lifton were heavily influenced by Kardiner's publication. Perusing the medical charts of hundreds of Vietnam veterans as well as drawing on the available literature on Holocaust survivors, they compiled a list of over 24 symptoms common to sufferers of traumatic neuroses (Van der Kolk, Herron, & Hostetler, 1994). In the late 1970s, they developed a classification system for post-traumatic symptoms. Professional recognition of the long-term impact of trauma sustained during combat was reflected in the inclusion of Post-Traumatic Stress Disorder (PTSD) in DSM-III (1980). This had far-reaching implications, for, as Gleaves (1996) notes:

The body of research that followed [the Vietnam war] drew attention to the effects of trauma on adults but also brought the recognition that the same set of symptoms exists in individuals exposed to civilian trauma including rape. . . and child abuse. . . . Many of the symptoms of PTSD (e.g. flashbacks, depersonalization, and emotional numbing) are now recognized as clearly dissociative in nature, and many clinical researchers have made a strong argument that DID should be conceptualized as a form of childhood-onset PTSD. (p. 51)

Other events of the 1970s contributed to the increase in public and professional awareness of the emotional impact of trauma. For example, the “rape trauma syndrome” (Van der Kolk et al., 1994, p. 593) was identified in 1972 by Linda Hohlstrom and Anne Burgess at Boston City Hospital. These two researchers noted that the flashbacks and night terrors experienced by victims of rape bore resemblance to the symptoms experienced by combat veterans. Other researchers made similar connections between civilian trauma and the trauma of war. In 1979, Lenore Terr published the first of what was to become a major series of papers on the Chowchilla kidnapping, which afforded a
developmental slant on the effects of trauma on the psychological functioning of children (Van der Kolk et al., 1994). In her article, which is written from a psychodynamic perspective, Terr describes the kidnapping, which took place in 1976, and details the results of extensive interviews with each of the children who were involved. Noting that the Chowchilla incident presented a unique opportunity for the study of the effects of psychic trauma upon children and their families, Terr recounts the experiences of the children during their 16-hour incarceration in a buried truck-trailer, from which they were eventually able to escape. A number of the children had visual hallucinations during the ordeal. Many feared they would die; others found everyday anxieties, such as concern about an asthmatic attack, magnified by the stress of the situation. After the incident, a number of symptoms and fears were manifested by the children including fear of another kidnapping, panic attacks, and fears of mundane ordinary stimuli, such as noise, strangers, or unfamiliar vehicles. A number of the children developed dissociative symptoms, notably “distortions in the sense of time” (Terr, p. 572). The Chowchilla incident was widely publicized and in concert with Terr’s series of articles concerning the kidnapping, heightened public and professional sensibilities with respect to the impact of trauma on child development, a theme which would be recapitulated by other late 20th century researchers regarding the long-term effects of childhood sexual abuse.

Mardi Horowitz’s book, Stress Response Syndromes, published in 1976, was devoted to the subject of the psychotherapy for those who had suffered particularly stressful life experiences. In this volume, Horowitz explores the impact of civilian trauma, including bereavement, accident, and “multiple stress events” (p. 196). In line with Putnam (1989), who cites non-abusive trauma as a factor in the genesis of DID, Horowitz describes symptoms of depersonalization in an individual who had experienced
a number of major life stressors other than sexual abuse. In 1978, Dr. Henry Krystal, a Holocaust survivor and psychoanalyst, published a paper entitled *Trauma and Affects*, in which he explored the effects of trauma on the ability to verbalize experience. Like Terr (1979), Krystal construes the after-effects of trauma within a psychodynamic paradigm. An earlier work edited by Krystal, the 1968 publication *Massive Psychic Trauma*, dealt with the trauma experienced by concentration camp survivors and other victims of persecution. In a co-authored chapter of this book, Krystal and Niederland (1968) identified “the survivor syndrome” (p. 328), which includes anxiety, dissociative disturbances of memory, impaired cognitive function, and chronic depression. Each of these works lay at the forefront of what was to become a landslide of literature examining the relationship between exceptional human experience and post-traumatic psychological functioning.

In the wake of this groundbreaking research, individuals in recent decades have felt free to speak out about their experiences of abuse and, as a result, the advocacy of those seeking help for post-traumatic symptoms has taken on the characteristics of a social movement. Lynn and Pintar (1997) note that, in particular, identification with DID was encouraged by:

the political climate of ‘identity politics’ during the 1980s, when it became fashionable and politically expedient to identify with membership of a group with a grievance. As survivors of sexual abuse organized, so did the subgroups who identified themselves as multiples or as survivors of satanic abuse. (p. 5)

Shared emotional distress provided the motivation for these individuals to find a collective voice and to identify themselves with a community of others having had similar experiences. Many contemporary clinicians still encourage these associations, holding that identification with other survivors and the development of a therapeutic alliance with
them provides the opportunity to re-establish a healthful level of trust in interpersonal relationships. Hegeman (1995) maintains that group therapy for survivors of sexual abuse – including those with DID – reduces feelings of isolation. Spanos (1994) notes that many individuals with DID participate not only in facilitated therapy groups but also in their own “self-help” (p. 155) groups, which provide validation for the diagnosis and function to socialize new members into the role of “multiple.” Thus, from the late 1970s to the present time, the legitimation of DID has carried with it a social dimension which precludes its apprehension as merely, or solely, an intra-psychic phenomenon. The disorder is constructed, and performed, in the context of social relationships, perhaps most notably the therapeutic relationship, as was the hysteria of the 19th century. As with hysteria, it also constitutes a kind of conferred identity. As Lynn and Pintar (1997) note:

To be pronounced a multiple by a medical authority involves a sanction of the spoken word, in much the same way that a priest can pronounce a couple to be married. With that kind of power a psychiatrist can ‘create’ a multiple, at the moment of diagnosis, in the same way that the leader of a possession cult can decide whether a possession is authentic by identifying and authenticating the appearance of a particular spirit. The ‘diagnosis’ confers upon the individual a change of status within the cult. The combination of medical and religious structure makes the therapeutic relationship into a powerful mechanism of socialization. (p. 6)

The successful “enactment” (Spanos, 1994, p. 146) of DID is contingent upon the existence of an audience whose members cue the production, and foster the perpetuation, of multiple selves. The role of the audience in the sustaining of hysterical attacks in the 19th century was discussed at length in Chapter 2 of this thesis. I contend that a similar role is currently performed by members of the DID patient’s family, her social network, her therapist, and members of the DID “subculture” to whom the diagnosed individual has access via therapy groups and the internet. However, as with hysteria, the socio-cultural influences on DID are of wider scope. The perpetuation of the
phenomena associated with DID rests on broad cultural conceptions about the nature of identity, and the complexity of contemporary instances of the disorder is related by some researchers (Lachmann, 1996; Lifton, 1993) to the fragmentation of the self in postmodern times.

**Postmodernism, Selfhood and Multiplicity**

I have noted in earlier chapters of this thesis that the very idea of dissociation is predicated on the existence of a cohesive, unified, intact self; that to dissociate, one must first have been associated. A number of contemporary writers (Gergen, 1991; Kellner, 1992; Lachmann, 1996; Lifton, 1993), however, assert that the autonomous being – Geertz's (1979) “bounded, unique, more or less integrated motivational and cognitive universe” (p. 229) – has become a thing of the past. These authors claim: “that in post-modern culture, the subject has disintegrated into a flux of euphoric intensities, fragmented and disconnected” (Kellner, 1992, p. 144). Gergen (1991) terms this state of being “multiphrenia” (p. 16), and maintains that technological advances and “social saturation” (p. 49) during the latter decades of the 20th century have provided a model for multiplicity, making possible the apprehension of the individual as one who is populated by latent selves, potentiating a myriad of behavioural options by facilitating the enactment of whatever role seems most suited to a given situation, and rendering multiplicity normative, even desirable. Neimeyer and Raskin (2000) hold that postmodern views of the self constitute a “celebration” (p. 5) of multiplicity. The self in postmodern theory is, like the body of the 19th century hysterics, hyperfluid, hypersuggestible; it metamorphoses in different contexts, much as the DID patient possesses different alternate identities each of which “comes out” in response to a different situational
demand. The self in this view is thus mutable; it takes on different roles, manifests a variety of different attributes. It is penetrated by the kaleidoscopic montage of social and technological change.

Lifton (1993) has characterized the post-modern self as “protean” (p. 5) after Proteus, the Greek God of the sea, who was able to transform into numerous non-human creatures. This mythological being provides a metaphor for post-modern identity, capturing its fluidity, its malleability, its transformative capacity. Yet Proteus, in spite of his changeable nature, retains some essential qualities of his original form; his very changeability requires that there is some cohesive form from which he changes. Postmodernism has much to teach us about the capacity of the individual to accommodate to the rapid social and technological change which has typified late 20th century and early 21st century life. Similarly, “by demonstrating the capacity of the self for extreme divisions and for literal multiplicity” (Lifton, 1993, p. 209), DID has much to teach us about the adaptive nature of dissociation and its implications for the understanding of self-process. Nonetheless, it must further be noted that, as with Proteus, DID does not suggest that some degree of unity of self does not exist. Indeed, as Lifton notes, multiplicity itself may paradoxically be seen as an effort to maintain some sense of unity by preserving, intact, a core self. One additional point needs to be made. DID is regarded by Lynn and Pintar (1997) as a “trendy diagnosis” (p. 5) and by Van der Hart (1990) as a “high status disorder” (p. 66). Richards (1990) holds that dissociation is less a disorder than a talent, which permits the individual to transcend the limits of normative boundaries of human creativity and spiritual attainment. Similarly, Lynn and Pintar maintain that “a diagnosis of DID also provides a boost of self-esteem since multiples are supposed to be creative individuals with high IQ’s” (p. 5).
However, while post-modern authors laud multiplicity as celebratory, I contend that care must be taken not to romanticize dissociation, for clearly post-modern views of multiplicity paint a portrait that is inconsistent with the subjective experience of dissociation in Western culture. It remains, in North America, largely associated with subjective distress and psychosocial dysfunction, and largely considered an intra-physic phenomenon. As with hysteria, however, the social and cultural factors that shape its presentation are part of a broader and more malignant dysfunction, which lead to the question as to whether there are aspects of the post-modern social structure that contribute to the production of DID by creating conditions that increase the likelihood of violence and abuse. As Glass (1993) notes:

One may choose multiple tastes and interests; one may decide for whatever reason to be different or eccentric or to hold values that counter established assumptions and preferences. One does not choose, however, to possess a multipie or fragmented identity: these effects, either in multiple personality disorder or schizophrenia, are the products of a social and psychological violence that rips apart, terrorizes the self, and brutalizes the body. The multiplicity of identity or personality is a commentary on some of the most pathological aspects of a deranged modernity that idealizes paternal authority and the violent imposition of power. (p. 60)

**Media Influences on Dissociation**

The technological revolution in which post-modernism has its roots has ushered in an era of media saturation which is reflected in a proliferation of popular press books, films, and television shows, and virtually unlimited access to information on a virtually unlimited variety of topics by way of the internet. All have contributed to the broad dissemination of information about dissociation. As Knauer (1995) notes, “conduits such as professional journals, conferences, television talk shows, movies, popular books, and of course, People Magazine, have all been used to spread the word about MPD” (p.
Thus, information about the disorder is no longer solely the domain of the mental health professional. Like the medical model, it has attained the questionable status of common knowledge. However, the relationship between the media and DID is circular. The more people know about the disorder, the more they talk about it; the more they talk about it, the greater its exposure; the greater its exposure, the greater the likelihood that individuals may interpret certain aspects of their experience as suggestive of DID. The motif of multiplicity, dominant in academic literature since the late 1970s, has also predominated in paperback books accessible to the general public.

Much of the self-help material on the mass market centres on the so-called "healing" of the "inner child." According to Whitfield (1989), the inner child constitutes our "Real Self – who we truly are" (p. 1). Although the concept of the inner child is a metaphor, it has been reified by many writers, including Bradshaw (1990) and Whitfield (1989) himself. The latter author states that the inner child, also termed "the child within" (p. 57), "feels and expresses feelings" (p. 57). Further, he describes different "parts" (p. 132) of the self, and delineates different subtypes of the inner child – indeed, he names them – much as the dissociative client may have alternate identities assigned to different roles. Additionally, Whitfield uses the term "integration" (p. 199) repeatedly in his book in much the same sense that clinicians apply the term to the fusion of a client with DID. The inner child is part of a broader movement characterized by a landslide of "pop psych" and self-help literature. With the resurgence of interest in dissociation during the past 2 decades, there has been a concurrent wave of fascination with "recovery" from the deleterious effects of the intra-familial discord and emotional wounding which, in the view of one best-selling author (Bradshaw, 1990), affects 98% of the North American population.
The recovery movement and, along with it, the concept of the inner child, have their early roots in the tenets of an organization formed in 1951 by the wives of recovering alcoholics (Haaken, 1993). Al-Anon was devoted to the idea that the excessive caretaking demonstrated by spouses of alcoholics was in itself a form of pathology. Al-Anon provided a model for another 12-step group that would become the cornerstone of the recovery movement. Founded in the early 1980s, at the time DSM-III (1980) added multiple personality disorder to its nosological roster, Adult Children of Alcoholics (ACOA) espoused the view that alcoholism is systemic — a family illness. Its malevolent nature was held by many therapists to be manifested in family secrets kept hidden from outsiders by an intricate web of rules that are internalized by children in efforts to please their parents and maintain some degree of homeostasis within the family system. Eventually, these children grow up to have families of their own, and their children, in turn, evidence similar behaviours. Adult life, in the ACOA view, constitutes "a re-enacting of your childhood" (Irvine, 1999, p. 20) with the same rules, the same secrets, the same conflicts perpetuated generation upon generation. With the publication in 1983 of Janet Woititz's book entitled Adult Children of Alcoholics, the term "adult child" (Irvine, 1999, p. 20) entered public discourse. The book became a New York Times bestseller. It was published by Health Communications, a leading recovery movement publisher. The same company published Whitfield's (1989) book, Healing the Child Within, 6 years later. The recovery movement, whose flagship concept is that of co-dependency, was born.

As Eastland (1995) notes, "the broad applicability of the current movement is evidenced by the enormous popularity of recovery literature" (p. 296). Melody Beattie (1987), John Bradshaw (1990) and Charles Whitfield (1989) are but a few of the best-
selling authors whose work has contributed to the popularly-held view of co-dependency as a widespread "illness" and of the inner child as constituting the "authentic" (Bradshaw, 1988, p. viii) self. Co-dependency is described in these books as a "disease" (Irvine, 1999, p. 26), which originates in "dysfunctional" (Bradshaw, 1988, p. 31) families where children develop elaborate strategies to overcome parental failings and "develop an excessive sensitivity to the needs of others" (Haaken, 1993, p. 322).

Beattie (1987), however, glibly notes that: "there are almost as many definitions of co-dependency as there are experiences that represent it" (p. 29). Her book contains a 234-item self-administered checklist for co-dependent behaviours. Maintaining that co-dependents may "worry" (p. 39), "get confused" (p. 40), or "get frustrated and angry" (p. 40), Beattie pathologizes a range of what would seem to be normative human behaviours and emotions. Not surprisingly, many of these are traditionally associated with women vis-à-vis the 19th century hysteric and her so-called excessive emotionality. Approximately 80% of the ACOA membership is female (Haaken, 1993), which, interestingly, parallels the female-to-male ratio of DID noted by Putnam (1989). As Haaken (1993) points out, "co-dependence has become big business" (p. 323). Self-help books are promoted by many recovery-movement authors, as the royal road to self-discovery, emotional equanimity, and the healing of the inner child. As Farmer (1989) suggests in his own self-help guide, Adult Children of Abusive Parents: A Healing Program for Those Who Have Been Physically, Sexually, or Emotionally Abused, one should:

Go to a bookstore or library and browse through self-help books. Take your time and read parts of any that attract you. Then, make a list of those you'd like to read. Number the books in the order you'd like to read them. Set a goal of reading at least one of these books every three to four weeks — and then do it. (p. 116)
The preponderance of women in ACOA groups suggests that co-dependency may have become a new channel for the exploitation of female distress, dissatisfaction, and insecurity, which have thrived under conditions of oppression in a male-dominated society. For example, the literature, while touting the importance of developing the ability to acknowledge and express feelings (Farmer, 1989; Whitfield, 1989) also pathologizes depression (which may be viewed as a normative response to an untenable situation, such as in the instance of a woman who lives with physical violence in her relationship), anger, frustration, and worry. Further, the literature locates the source of these "co-dependent" behaviours and feelings within the individual, affording scant attention to the social structures within which this "pathology" resides. Like hysteria, co-dependency is a female disorder, and like hysteria, its scripting is of social and cultural origin. As Haaken (1993) notes, "although the [recovery movement] literature legitimizes women's pursuit of greater autonomy, it identifies dependency conflicts as stemming from women's 'disease', thereby depoliticizing the difficulties that pervade women's lives" (p. 323). The social context of the pathogenic affects identified by Beattie (1987) and other recovery-movement authors is minimized. Although the terms "emotional abuse," "physical abuse," and "sexual abuse" are tossed around freely in the literature, and while difficulties such as over-dependence and remaining in abusive relationships are identified as "core issues" (Whitfield, 1989, p. 72), there is little emphasis on the ways in which men are encouraged to act out against women or on the emotional costs of women's economic dependence on men. In the absence of an explicitly political and social analysis of the factors responsible for the expression of discontent and distress in co-dependent symptomatology, co-dependency, like hysteria, becomes a woman's
disease whose genesis lies in some fundamental inherent constitutional female weakness rather than a manifestation of oppression and exploitation.

While any cogent analysis of the relationship between a broad social context and the difficulties experienced by those who identify themselves as co-dependent is absent from the recovery movement literature, the spectre of the inner child is omnipresent. Bradshaw (1990), Chopich and Paul (1990), Farmer (1989), Potter (1994), and Whitfield (1989) are just a few of the authors whose work extols the healing of the inner child as the surest, if not the only, route to emotional well-being. As Putnam (1989) and Ross (1989) identify different types of alternate identity, such as the protector personality and the internal self-helper (ISH), so recovery-movement writers identify different "parts" (Whitfield, p. 132) of the self. Farmer identifies the "Hurting Child" (p. 54), the "Natural Child" (p. 55), and the "Controlling Child" (p. 55). In maintaining that the "Hurting Child is the abused, traumatized, deprived part of your Inner Child that split from your consciousness when you were abused" (p. 54), Farmer invokes the language that has become so much a part of the discourse on multiplicity. Similarly, Bradshaw employs the concept of "splitting" (p. 11) in survival-strategy terms. A number of other recovery-movement authors name parts of the self. Whitfield offers the "Feeling Child" (p. 130), the "Thinking and Reasoning Child" (p. 131), the "Struggling and Growing Child" (p. 131), the "Creative Child" (p. 131), the "Compassionate Child" (p. 132), and the "Unconditionally Loving Child" (p. 132). From Bradshaw we have the "Inner Infant" (p. 93), and from Potter the "Protector-Controller" (p. 44) and the "Offender" (p. 49).

While theoretically a metaphor, the inner child appears in the work of these authors as a tangible manifestation of the divided self. The unifying theme in these typologies is that of function, and in this respect they come perilously close to suggesting
a degree of multiplicity, which bears the stamp of reification. In Farmer's (1989) work, for example, the function of the “Hurting Child” (p. 54) is to carry “the anger, rage, hurt and fear you experienced [when you were young]” (p. 55). The “Controlling Child” (p. 55) is analogous to Ross’ (1989) protector personality; its function is to guard the individual from further harm. This function is mirrored by Potter’s (1994) “Protector-Controller” (p. 45). In Whitfield’s (1989) work, the “Struggling and Growing Child” (p. 131), which is roughly analogous to a non-human alter such as the angel described by Ross, provides a connection to the spiritual realm, while the “Thinking and Reasoning Child” (p. 131) serves a function similar to that of the ISH as described by Putnam (1989).

In delineating different parts of the self, the work of these recovery-movement authors suggests the presence of boundaries similar to the amnestic barriers described in the academic literature on DID. Further, Whitfield (1989) uses the term “integration” (p. 120) in his book *Healing the Child Within* as a DID therapist might refer to the fusion of a client with DID. According to Whitfield, “to integrate means to make whole from separate parts” (p. 120). The process of integration, in Whitfield's view, takes between 3- and 5-years, roughly the same length of time a DID patient might be expected to remain in treatment. Potter (1994) carries the inner child “metaphor” yet further into the realm of multiplicity in describing how she works with clients who are “in recovery.” Note the use of language associated with DID, and the leading questions posed by this recovery-movement therapist:

> Sometimes, another part will come out while I am talking to the Protector-Controller. I pay close attention to changes in tone of voice, facial expression and body posture. Those non-verbal cues give me hints that another part has “come out.” I might then say, “I noticed that you became a little tearful (or... your voice changed... or you started jiggling your foot) when you said that. How old do you feel right now? (Or... who is talking now? ... or...
. . who just came out?). I ask them to move to a different place in the room and become that part to continue the session. (p. 46)

The terminology employed here and the direction of the interrogation leave little to the imagination. Clearly Potter is eliciting what she believes to be discrete and separate aspects of the client that are utterly evocative of dissociation. Further, she invokes many of the strategies outlined by Franklin (1990) with respect to the assessment of subtle signs of dissociation, discussed at length in Chapter 4 of this thesis.

The advice offered by Price (1995) to clinicians who choose to use the inner child motif as a therapeutic model finds affinity with Potter’s (1994) approach. Maintaining that the inner child is a part of the individual who was “left behind” (Price, p. 71) when she was growing up in a chaotic family environment, Price suggests that, after instructing the client on how to enter formal trance and inducing hypnosis, the therapist should:

Ask the patient to visualize a chalkboard and ask the chalk (“which writes answers for the unconscious mind”) whether there has been left behind an inner child. If the answer is “no,” ask the chalk about the source of the troublesome behaviour/feeling in question . . . . If the answer is “yes,” give suggestions for the adult self to look around inside (e.g. “Imagine walking down a hallway in your mind, checking doors, or you might even find yourself looking out of doors”) for the inner child. If found, ask the adult to describe its appearance, age, emotional state, etc. These instructions should be very open ended. The adult should be instructed to introduce him/herself to the inner child: “Indicate that you are a grown up part of her, and that you did not realize you left her behind. You have come back to take care of her, to meet her needs and hear her story.” If the inner child is not found, a note can be left on the chalkboard addressed to the inner child that the adult cares and will return later to search again. (p. 72)

Such delving for dissociated parts of the self is also recommended by Bliss (1986), who states that in working with hypnotized clients:

I then suggest that the patient look into the back of his or her mind to see if there is anyone or anything there. If anything or a person is identified, I want to know what or who it might be. Should a person be found, I often ask to
talk to him or her. When the patient has auditory hallucinations, I ask to talk to the voice. It is surprising how often a personality can be rapidly identified in this way. (p. 196)

This passage reveals the insistent probing for dissociated aspects of the self that is reflected not only in the recovery-movement literature but also in much of the academic literature about DID. The parallels between the inner child and the models of multiplicity, described by Beahrs (1982), Hilgard (1986), and Tinnin (1990) and discussed in Chapter 4 of this thesis, are inescapable. One can only imagine the effect of these explorations on a client who has been "educated" by the therapist early in the session about the concept of the inner child, who is suggestible, and who is struggling to make meaning of her distress. In sum, there can be little doubt that the inner child is a metaphor for outright multiplicity.

The only caveat put forth by Price (1995) with respect to inner child work pertains to the use of the motif in a group setting, that it is ill-advised because "the potential is so great for activating more than the format or individual can handle" (p. 72). A number of other authors, however, urge further caution with respect to "inner child work." O'Neill (1995) stresses that efforts to accelerate the exploratory process with clients by the premature use of "trance work" (p. 77) is not only "invasive and controlling" (p. 77) on the part of the therapist, but irresponsible in terms of constituting a risk to the safety of the client, and that it may in fact recapitulate the client's experience in a family environment permeated by stress and abuse. In Kluft's (1996) view, a client who is already demonstrating a propensity for dividedness may become further fragmented if exposed to the therapeutic techniques espoused by Price (1995). Olson (1996) further holds that underlying inner child work is the implicit assumption that such an entity indeed exists, and underscores the fact that in highly suggestible clients who seek to please the
therapist, an ego state may be created "in order to accommodate the perceived demand" (p. 74). At the very worst, inner child work may cause further fragmentation in a patient identified as having DID or as having strongly dissociative tendencies. At the very least, it may increase the likelihood that an individual will construe her inner experience in terms of multiplicity and contribute to the self-diagnosis of DID by clients or its mis-identification by mental health practitioners unaware of the dangers inherent in the application of the inner child metaphor.

Other mass-market books have contributed to the public perception of the multiple as an individual who overcomes seemingly insurmountable obstacles on a therapeutic journey infused with high drama and marked by the selfless ministrations of a patient, nurturing and dedicated clinician. North et al. (1993), in their publication *Multiple Personalities, Multiple Disorders: Psychiatric Classification and Media Influence* reviewed a total of 21 book-length biographical and autobiographical accounts of DID, which were available at the time their volume went to press. In addition to the well-known *The Three Faces of Eve* (Thigpen & Cleckley, 1957) and *Sybil* (Schreiber, 1973), the film versions of which will be discussed at length in a later section of this chapter, these include *Prism: Andrea's World* (Bliss & Bliss, 1985), *When Rabbit Howls* (Chase, 1987), and the more recent autobiography, *The Flock: The Autobiography of a Multiple Personality* (Casey, 1991). An internet search of available biographical and autobiographical accounts of DID yielded 16 titles published between 1993 and 2002 (see the Appendix).

*The Flock* is a prototypical exposition of life as a multiple and of the therapeutic process undergone by a DID patient. Its author was a high-school teacher and graduate student who claimed 24 alternate identities. This "flock" of personalities included one
alter named Reneé from whose perspective the narrative unfolds. The book comprises an interweaving of the author’s reflections upon difficulties past and present with case notes provided by Casey’s therapist. Casey was what Kluft (1986) would term “high-functioning” (p. 722); she was able to work and to pursue her graduate studies while in treatment, although her support system, with the exception of her therapist (and her therapist’s husband) seems to have been limited. She had an extensive history in therapy, having seen a total of eight practitioners prior to engaging the therapist who finally “discovered” her DID and with whom she subsequently worked toward the goal of integration.

Unlike some autobiographical accounts of DID, which recount in lurid detail the abuse perpetrated on the victim, Casey’s book is fairly benign in this respect. She provides little information about her family background. The reader is led to assume that it was fairly chaotic, however, from hints that Casey’s father was a heavy drinker and that her mother had a highly dysfunctional family background herself, being raised in a series of step-families and having been abused by boyfriends of her mother’s. Midway through the book episodes of paternal incest are revealed. Casey evidences a number of behaviours associated with borderline personality disorder (BPD), including self-injury, suicidal ideation, and a number of attention-seeking manoeuvres designed to lure back her estranged husband. In Casey’s (1991) own terms, “people said I had a flair for the dramatic” (p. 17). She underwent several successive hospitalizations for mysterious neurological symptoms including problems with co-ordination and equilibrium. Tests revealed no organic cause for these symptoms.

Casey (1991) reveals experiences typical of de-realization/depersonalization, contending that “sometimes I could sit on my shoulder and watch. Sometimes I watched
with interest, sometimes with apathy, while a detached part of me talked to the therapist" (p. 5). She also makes reference to periods of co-consciousness, during which she becomes aware of one of her alternate identities speaking with the therapist: “I relaxed and allowed the unrehearsed monologue to continue. I hadn't heard this before” (p. 9). She makes a number of references to the experience of switching, holding that “I relaxed and let my inside out” (p. 5) and “I go inside, but I’m nearby . . . . It's like I’m at the back of a theatre, watching a play” (p. 21). There is a reference in the therapist's case notes to the primary identity struggling as she “regained awareness” (p. 52) and to watching this personality “fight through amnestic fog” (p. 52). Casey herself records a number of extensive amnestic episodes in her book. In one instance, she "came to" in a Grade 10 psychology class with her last memory being that of being in a school washroom, in a different school, in grade 9.

Casey's personality system was complex, including alternates of the opposite sex and child alters (one 2-years of age), in addition to a number of adolescent and adult personalities. In the case records included in the book, Lynn, Casey’s therapist, notes with respect to a group of what one of the alters terms “autonomous personalities” (Casey, 1991, p. 75) that these “are truly well defined and complete enough as individuals to be able to function autonomously without the assistance of the others. Each appears to have as full a range of dispositions and capabilities as any individual person” (p. 75). Each of these identities is dealt with in treatment, and each is accorded a particular function within Casey’s personality system.

One of the most interesting – and telling – aspects of the book is the interspersing of the therapist’s case notes within the author's narrative. These reveal that the nature of the relationship between Casey and her therapist was intense and
prolonged. Casey’s treatment took 7 years. In the early stages, Casey attended two sessions a week. As her therapy progressed, however, she spent an average of 4-hours per day with Lynn. Lynn’s husband, Gordon, also took part in the treatment, essentially becoming a co-therapist, taking young male alters sailing, sharing his insights with his wife and participating in session-planning. Casey also maintained a social relationship with Lynn and Gordon. She had them over to her house for parties; similarly, they took her away for extended periods to their summer cottage. In one instance, Lynn invited Casey to her home on Boxing Day; in her terms, “Jo came to my home that afternoon and spent a couple of hours perched on a stool in the kitchen chatting with me while I worked” (Casey, 1991, p. 135).

This book is replete with information pertaining to experiential aspects of DID, including co-consciousness, amnesia, depersonalization, de-realization, and abrupt shifts in affect. Its terminology suggests some prior knowledge of DID on the part of the patient. The experience of amnesia and the confusion surrounding it are clearly detailed. Casey’s progressive reliance on the therapist and her husband is one of the most notable aspects of the book. It is difficult to imagine, given the level of involvement with this single patient, that Casey’s therapist could have managed much of a case-load in addition to this, her first multiple client. Lynn and Gordon seem to have viewed their involvement as a kind of “re-parenting.” To the academic reader, the excesses of nurturing on the part of Casey’s therapist transcend the bounds of reality, and the social interaction outside office hours borders on the unethical. Nonetheless, Casey’s autobiography functions as a template for the enactment of dissociative symptomatology; the roles of each of her alternates are delineated explicitly, and their unique and specific functions within the system are defined. One alter, Isis, is depicted
as having an almost otherworldly grace and serenity; a child alter, Missy, is described in tender terms, her vulnerability and naivété underscored. Transitions between alternate identities are described. As previously discussed, the experience of depersonalization/de-realization is delineated, and amnestic episodes are described. In sum, the book serves as a model for DID. Billed on the back cover as “an intense and enlightening view inside the fractured mind of a multiple personality,” it offers a window on virtually every aspect of the disorder, and is typical of the popular press material available on the topic.

Another type of mass-market book that offers an insider’s perspective on multiplicity is that which comprises a compilation of “stories” told by multiples and bound into a single volume. Reviews of a number of these were found on the internet (see the Appendix). Typical of these is *Multiple Personality from the Inside Out* (Cohen et al., 1991), a collection of poems and narratives by multiples and their friends and family members. The book is organized into sections under a number of rubrics, including “Diagnosis” (p. 1), “Pain” (p. 47), “Therapy Successes” (p. 99), “Therapy Disappointments” (p. 139), “Unification” (p. 169), and “Others’ Voices” (p. 205). Each of these and other sections contains disclosures pertaining to aspects of DID, such as its impact on self-concept, on psychosocial function, and on significant others in the multiple’s life; the stress associated with therapy; and its effect on the family members and friends who comprise the individual’s social support network. Much of the book is written in highly dramatic terms. In one contributor’s words:

> Treatment for multiplicity is hell. Of interest to therapists, we may seem “fun.” But we live in a hell where everything hurts. . . . I would have others know how incredibly difficult the therapy process is. Not fun. Not games. A battle to the end against the huge strangling, struggling dragon in our minds. A battle without armor or sword, only with fleetness of foot and thought to avoid the
searing heat of the dragon’s fire. Together therapist and patient enter the
terror of the mind’s forest, the dragon’s lair; to attack, then retreat, attack
again, run away, hide, attack and retreat... Each time bruised, scorched
and brutally exhausted. (Cohen et al., 1991, p. 82)

Entries in the first person plural abound: “Our therapist suspected we were MPD,
but we did not believe him. Then about two months ago, under hypnosis, he talked to
one of the voices” (Cohen et al., 1991, p. 37). Many of the entries underscore the
patient’s heavy reliance on the therapist: “Now all we can do is live for each therapy
session” (p. 38). There are references to the experience of depersonalization: “the little
girl would simply leave her body behind and go out on the swing to play” (p. 58).
Amnestic episodes and the discovery of the individual’s possession of items of clothing
and other objects foreign to her are described in many of the accounts. In sum, the
contributions in the book give voice to the subjective experience of dissociation, provide
a vocabulary for the disorder that is consistent with the academic discourse on DiD, and
detail an extraordinary amount of information pertaining to its symptoms. The book
serves one other purpose: to highlight the existence of a DID subculture comprised of
patients who have been diagnosed with the disorder and others who frame their
experience in those terms. In the words of one contributor:

I was not formally diagnosed with MPD. I came to it on my own, and I know
that it was right. ... at that time, I was seeing a psychiatrist who worked from
a fairly traditional perspective. ... it not occur to my then-therapist to look for
MPD, as he knew nothing about it. He became increasingly unable to
assimilate the tortures I was describing once I got beyond basic incest. ... 
Finally, one night at home, I was dealing with the first memory of ritual
torture – a satanic ritual murder memory. I was out of my mind with terror,
reliving the knife, the blood, the chanting, the people in black robes.
Suddenly I heard a voice in my mind saying “My name is Karen, and that
happened to me”. ... I had no literature, no supportive therapist, nothing
except one thing. I regularly attended an SIA (Survivors of Incest
Anonymous) group, and I had just two weeks before heard someone share
about MPD. I called her. A small new group was forming for those with MPD,
and I went to the second meeting. (Cohen et al., 1991, p. 140)
It is worthwhile pondering to what degree this woman's interpretation of her experience and subsequent self-diagnosis might have been affected by the meeting she had recently attended, and to what extent the content of her memories may have been influenced by what she had heard there. Merskey (1992) holds that no case of DID “can be taken to be veridical since none is likely to emerge without prior knowledge of the idea.” (p. 337). Similarly, North et al. (1993) maintain that: “the media have contaminated the public awareness with a great deal of specific detail about the presentation of the disorder” (p. 122). The ease of availability of books (most with a highly accessible reading level) and videos, in combination with public exposure to the disorder in the form of television talk-shows about the subject, support groups for those with DID such as the one described above, and computer web-sites for dissociatives, means that most of the public has formulated some idea of what “multiplicity” entails.

An enormous amount of information about DID is available through the internet. In addition to providing access to books and book reviews, as previously discussed, there are websites and newsgroups for self-styled dissociatives and those formally diagnosed with the disorder. The internet address http://www.faqs.org/faqs/by-newsgroup/alt/alt.support.dissociation.html yields information pertaining to the major dissociation newsgroup, and there are three other newsgroups related to recovery from abuse. There are numerous messages posted on these newsgroups, with contributions by some individuals on a daily basis. A number of major researchers in the field have websites, and numerous articles about dissociation can be accessed. The internet is thus a fertile source of information on every conceivable subject related to dissociation (e.g., symptoms, treatment, how to manage daily life as a multiple, how to locate a therapist), and provides access to a kind of DID “subculture” which functions as a
support group. In addition to mass-market books and the internet, the advent of home video has provided another conduit via which information about DID is disseminated. An examination of two popular early film depictions of DID provides clues about how these may have served as prototypes for symptom presentation, contributing to the proliferation of cases of the disorder in recent decades.

\textit{The Three Faces of Eve}

The film \textit{The Three Faces of Eve} (Johnson, 1957) was the first screen portrayal of DID since the dual personality enacted in numerous productions of \textit{Dr. Jekyll and Mr. Hyde} during earlier decades. The trailer for the film contends that it constitutes "the most completely documented case of multiple personality in the history of medicine", no small feat in the wake of Prince's (1930) extensive analysis of the case of Christine Beauchamp and the exhaustive case histories compiled by Janet and other clinicians of the late 19\textsuperscript{th} and early 20\textsuperscript{th} centuries. Claiming that there was no need to embroider the script, "the truth itself was fabulous enough" (Johnson), the producer himself touts the case of Eve as "the most fantastic personal story ever filmed" (Johnson) and concludes his introductory remarks with the dramatic statement that "in a literal and terrifying sense, inside this demure young woman two very vivid and different personalities were battling for the mastery of her character".

The film chronicles the story of Eve White, a placid reticent young mother and homemaker whose husband Ralph has brought her to the office of one Dr. Luther for a psychiatric evaluation. In the opening scene of the film, Eve sits, head drooping, white-gloved, as she states that she is "troubled with very bad headaches... terrible ones" (Johnson, 1957). She notes that the headaches precede "spells" which leave her
amnesic for ensuing events. She describes one incident during which she was playing with her daughter Bonnie, then “came to” the next morning with no memory of the intervening hours. During the assessment interview, it surfaces that she had “lost another baby about four months ago”. Following this interview, there was a marked improvement in her condition and she fared comparatively well for a year.

At this time, however, an incident occurs which propels Eve back into psychiatric treatment; her husband comes home from work to find a number of items of clothing of flashy seductive styles that were out of character for his wife. When Ralph accuses Eve of purchasing these, she denies it. When the stress of the ensuing altercation precipitates a headache in Eve, she subsequently switches to one of her alternate identities, who then tries to strangle Bonnie. The alternate then switches back to a confused and disavowing primary identity. In the doctor’s office, after this episode, Ralph describes a recent week-long trip of Eve’s to Atlanta, which she further denies stating, “I don’t remember doing it” (Johnson, 1957). She claims to have been hearing a woman’s voice for the past several months, a voice that sometimes sounds like her own, and which “tells me to do things” (Johnson) like take her daughter and leave her husband. At this point Eve switches, for the first time in her physician’s presence, to the alternate who had previously attempted to strangle Bonnie. This identity is the antithesis of the restrained and repressed Eve White; she loosens her hair, takes off her stockings (“I’m allergic to nylon”; Johnson), derides Eve’s husband, turns on the radio, and dances around the doctor’s office. She states her name to be Eve Black, and refers to Eve White as “she.” Asked by Dr. Luther if she is able to “come out” at will, Eve Black replies, “Sometimes I can, sometimes I can’t. She’s getting weaker, I’m getting stronger. She
doesn't know everything about me but I know everything about her". Eve is subsequently hospitalized.

During Eve's hospital stay, Ralph is introduced to Eve Black, and witnesses his wife switch repeatedly between host and alternate. After her discharge, Eve remains in a furnished room to be close to her psychiatrist, while Ralph moves to a different city to take up a new job and Bonnie is sent to stay with her grandparents. There is an interesting scene during which Dr. Luther broaches with Eve the subject of her diagnosis, of which she is apparently to date unaware asking, “Have you ever had the feeling that, deep down inside you, there might be somebody you couldn’t quite reach but nevertheless knew was there?” (Johnson, 1957). As Spanos (1994) notes, “highly leading and suggestive procedures have long been routine in the diagnosis of MPD” (p. 153). During another scene, we see Eve Black at a nightclub dancing with a serviceman. When he becomes insistent about having her spend the night with him, a switch occurs, and Eve White appears, quick to understand what had occurred although she apparently has no memory of it, and evidencing distress and a sense of futility upon apprehending the seductive behaviour of her counterpart.

At this point in the film, Ralph reappears, making an effort to convince his wife to come back to live with him. This request precipitates a transition to Eve Black, who agrees to this proposition. An altercation ensues after much suggestive behaviour on her part; Ralph hits her, and there is yet another transition back to Eve White. The next scene occurs in Dr. Luther's office; he is in consultation with a colleague, maintaining that: “this woman is in worse condition today then when she walked into this office two years ago” (Johnson, 1957). Eve is apparently now divorced from Ralph and experiencing time loss with great frequency. According to Luther, “Neither Eve Black nor
Mrs. White is a satisfactory solution. Neither of them is really qualified to fill the role of wife, mother or even a responsible human being".

In the next scene, Eve Black presents herself in Luther's office, proffering a bandaged wrist and explaining that she had saved Eve White from a suicide attempt by coming out after the first stroke of a razor. Eve Black then admits to having experienced "blackout spells" (Johnson, 1957), whereupon she is hypnotized by the physician and yet another alternate identity, who christens herself "Jane," emerges. There ensues a facile switching back and forth between Jane and Eve White, after which the doctor probes for memory of childhood trauma that might have precipitated the initial split. It emerges that at the age of six, Eve White had been forced by her parents to kiss the face of her dead grandmother, and this, the viewer is led to believe, constitutes the requisite traumatic episode. This scene is quite dramatic, with Luther's insistent probing culminating in an on-screen abreaction, in the wake of which Eve's three personalities are integrated and her memory of the events of her personal history is miraculously restored. In Eve's terms, "I can remember everything" (Johnson, 1957). The closing scene of the film depicts Eve fully restored to a "normal" life with her daughter and new partner.

This production constituted one of the first publicly-accessible templates for DID, following closely the book by two psychiatrists who had published the story of their dissociative patient (who later produced her own books!) earlier the same year. Although North et al. (1993) have noted that the symptoms experienced by Eve (in reality, one Chris Sizemore) are far more extensively detailed both in Thigpen and Cleckley's (1957) paperback account of their patient, and by Sizemore herself in her 1977 and 1989 books, the movie accentuates some of the more flamboyant aspects of DID, and links dissociation with trauma experienced during childhood. In the opening scene of the film,
it is apparent that the loss of her baby has precipitated Eve's dissociative symptoms. This is in line with the view of contemporary researchers who allege that stress during middle adulthood may "expose the multiple personalities lying beneath the surface" (Bryant, Kessler, & Shirar, 1992, p. 69).

The film depicts the kinds of disavowed behaviours (e.g., the purchasing of expensive and "flashy" shoes and clothing in styles not normally worn by the primary identity, and an out-of-town excursion lasting several days) that are considered by many researchers (Putnam, 1989; Ross, 1989) to be pathognomonic of DID. Eve's auditory hallucinations are another hallmark of DID; she experiences these as being simultaneously familiar and unrecognizable, at times seeming to be her own voice. Eve Black is allergic to nylon, hence she removes her stockings; while Eve White suffers no such allergy. There are portrayals of one-way amnesia between Eve White and Eve Black; the latter states in reference to Eve White that "she doesn't know anything about me but I know everything about her" (Johnson, 1957). Further, this alternate identity speaks about the primary identity in the third person a number of times during the course of the film.

The film provides a vocabulary for practitioners and patients alike. Eve herself refers to her transitions as "the switch" and Dr. Luther queries whether Eve Black can "come out" at will (Johnson, 1957). The transitions themselves are similar to those described by contemporary researchers (Putnam, 1988). When Luther asks to speak to a specific personality, the patient lowers her head, closes her eyes, and appears to enter a trance-like state, which persists for several seconds. Absent from the film, however, are any allusions to de-realization and depersonalization, two of the core symptoms of DID identified by Steinberg (1995). In fact, it constitutes a rather minimalist portrayal of
the disorder, depicting a case of relatively little complexity, treated over a relatively short period of time. The persona of Eve Black is developed as seductive, naughty, and attention-seeking, the absolute antithesis of the demure, withdrawn, and “proper” host personality. Jane is a kind of amalgam of the two, self-possessed, forthright, yet lacking Eve Black’s flamboyance. “Good girl” and “bad girl” are simplistically counter-posed in a recapitulation of the Madonna/whore dichotomy discussed in a previous chapter with respect to hysteria. As with the 19th century emphasis on the sexuality of the hysteric, there is in this film an emphasis on the seductiveness of one alternate identity.

**Sybil**

Based on the book of the same title by journalist Flora Schreiber (1973), the film version of Sybil (Babbian & Petrie, 1976) was released in 1976. The role of the therapist was occupied by Joanne Woodward, the same actress who had played Eve in the earlier film, The Three Faces of Eve. Sybil, a made-for-television portrayal of DID, garnered four Emmy Awards, and its airing coincided with the rising tide of public interest in the issues of child abuse and post-traumatic disorders. In the opening scene of the film, Sybil, a child-care worker and would-be art professor, is pictured in a park with her young charges. She hears a creaking sound, that of a swing in the playground, and experiences a brief flashback of being winched up on a pulley by a woman whom we later learn to be her mother. This precipitates a switch, and Sybil “comes to” standing in a pond, amnesic for what had just occurred. Arriving home after this incident, she locks herself in her apartment. Another flashback precipitates another switch, and Sybil, transformed into a young alter, puts her hand through a pane of glass in the apartment window. Next, we find Sybil in a psychiatrist’s office, talking in a “little girl” voice, then,
switching back to a primary identity, clearly amnesic for the events of the psychiatric assessment asking, “Have I hurt somebody? Have I done something bad?” The psychiatrist, a woman by the name of Dr. Wilbur asks, “Have you always lost time like that?” Sybil confirms this, adding that: “things have been getting a lot worse lately.” Wilbur suggests that Sybil’s symptoms are “a kind of hysteria”.

In an ensuing scene, Dr. Wilbur is awakened in the middle of the night by a phone call from “Vicky,” who summons her to a hotel room in which Sybil is staying. In this scene we see a young alter who identifies herself as “Peggy,” and refers to Sybil as “she.” Peggy describes herself as having “a little nose, and all my freckles, and my bangs. . . I’m only nine” (Babian & Petrie, 1976). Wilbur subsequently seeks the counsel of her former mentor, a psychiatrist who exhorts her not to become overly involved with Sybil. Wilbur describes Sybil’s “waking self” as “very troubled, repressed and grim”, and confirms for the viewer a diagnosis of DID. In the next scene Dr. Wilbur meets Vicky, the alternate who had called her to Sybil’s hotel room. Vicky is, we are informed, 13 years of age, very sophisticated, and passionate about people (“She’s afraid of people – I’m not, I simply adore people”). When Vicky crosses the room to look in a mirror, we see an image of a different girl - young, blond, thin, French-speaking. There ensues a discussion of the relationship between Sybil’s alters, Wilbur querying Vicky as to how they are related: “Tell me, are you related in some way, all of you? Are you all parts of the same person?” Vicky counters with a question of her own: “What’s love? We all want to know, all of us, everybody that lives with Sybil.” Wilbur asks, “Who’s everybody, Vicky? Are you seeing them now?” At this point, the camera pans a room filled with Sybil’s alters, including Vanessa, who plays the piano; two young boys sitting at a carpentry bench; Marsha, depressed and suicidal. When Dr. Wilbur asks about
them, however, Vicky says, "Can't tell, mustn't tell. . . there are guards around the palace."

The film now moves to a scene in which Richard Loomis, a young man to whom Sybil is attracted, invites her out for an evening to watch him perform as a street musician. Vanessa, who loves music, "comes out" to spend the evening with Richard. There follows, however, a switch back to Sybil, precipitated by a flashback triggered by the sight of a woman with silver hair and a silver-handled cane (in Sybil's mind, a memory of her silver-haired mother who abused her with a buttonhook). In a subsequent scene, there occurs the first reference, by Vanessa, to one of Sybil's male alters: "one of the boys came out because he wanted to play catch" (Babbian & Petrie, 1976). During the same scene, Peggy relives an incident during which Sybil's mother had tied her wrists with dishtowels, blindfolded her, and abused her. There is an ensuing transition back to Sybil, who says to Dr. Wilbur, "Oh, Dr. Wilbur, this is getting worse, this is getting a lot worse, isn't it?"

When Christmas arrives, it is experienced by Sybil as extremely stressful, which the film links to a traumatizing event experienced during a childhood holiday. Vicky presents Dr. Wilbur with a Christmas card, which Sybil had apparently made, then destroyed. Vicky, referring to the system of alternate identities says, "We rescued it. . . we tried to make it pretty" (Babbian & Petrie, 1976). Dr. Wilbur asks, "What about Sybil, is Sybil listening now?" This constitutes a clear reference to co-consciousness between alters. Two of the most dramatic of the film's scenes follow. In the first, Sybil relives an incident during which her mother had forced her inside a wheat crib, nearly suffocating her. The other depicts Vanessa having Christmas dinner with Richard. After falling asleep in Richard's arms, a nightmare precipitates a switch first to Sybil, who is amnesic
for the events of her Christmas day, and then to Marcia, who goes to the roof of Sybil's apartment building with suicidal intent but is prevented by Richard from jumping.

In the wake of these events, Sybil moves rapidly toward integration. There is a scene during which Sybil and Dr. Wilbur embrace, and Sybil is able to shed her first tears since Peggy's "birth." This is followed by the climactic abreaction of a childhood incident during which Sybil was bound and restrained while her mother tortured her with a disinfectant-infused enema and inserted objects into her vagina. Following the abreaction, Sybil and Peggy are fused; our protagonist cries, "I'm Sybil and I remember and I hate her; I hated her so much, I wanted her dead" (Babbian & Petrie, 1976). Dr. Wilbur soothes her: "It's all right, sweetie, you just accepted Peggy, her anger is your anger now. You can remember without Peggy." As with The Three Faces of Eve, the film ends on an optimistic note. The viewer has the sense that the worst of the trauma has been re-experienced and that Sybil is well on her way to a successful fusion. In the closing voice-over of the film, Dr. Wilbur states that her work with Sybil lasted 11 years amounting to a total of "2,534 office hours" (Hacking, 1995, p. 28), and that Sybil ultimately achieved her goal of becoming a college art professor.

Like The Three Faces of Eve, Sybil provided a prototype for DID. Unlike its predecessor, however, the film was spawned in fertile soil. It was released at a time of widespread public interest in the effects of childhood trauma and of heightened professional fascination with what was then termed multiple personality disorder. The film comprises the first on-screen portrayal of complex DID, that is, in Loewenstein's (1993) view, of a case involving 13 or more alternate personalities. Unlike Eve's case, which had involved only two alters in addition to the primary identity — one "born" during Eve's childhood, the other appearing, at least on the screen, to be the iatrogenic creation
of a frustrated psychiatrist – Sybil's case involved a total of 16 alternates. The cinematographic treatment of Sybil's case differs from Eve's on a number of other dimensions. Flashbacks, a common dissociative symptom, are peppered throughout the film, their abrupt and intrusive nature graphically depicted. It is evident that Sybil experiences these with all of their original affective charge. Dozens of switches from one to another alternate identity are portrayed. Most occur in a few seconds and are accompanied by the realignment of facial musculature described by Putnam (1988) and detailed in the previous chapter of this thesis. Amnesia, which in Steinberg's (1995) view provides the underpinning for all other dissociative symptoms, is frequent and severe. At one point Sybil describes having gone to sleep and awakened “two years older” (Babbian & Petrie, 1976). The most extensive amnestic episode depicted in *The Three Faces of Eve* was of 5-days duration.

*Sybil* depicts two of the other core dissociative symptoms identified by Steinberg (1995). De-realization is suggested in the scene in which the camera surveys a room filled with Sybil's alters. A special filter is used to create a suffused, dream-like effect. Depersonalization is evident in the scene during which Sybil has Christmas dinner with Richard; anxious about the evening, she says, “I feel all out here someplace, I feel like I'm floating around outside myself” (Babbian & Petrie, 1976). The subjective experience of depersonalization, discussed at length in Chapter 4 of this thesis, is commonly described in such terms (Noyes & Kletti, 1977). *Sybil* contains a number of scenes in which the primary identity, upon looking into a mirror, sees a very different image from her own; for example, when Sybil sees a reflection of Peggy, 9-years-old, freckled, with a different hairstyle. As with Eve, it is evident that Sybil's alters experience themselves as very different people. Vicky speaks French, while Sybil does not; Vanessa plays the
piano, while Sybil does not. Further, most of Sybil's personalities are children and adolescents; this is in line with Fitke (1990), who, as discussed in Chapter 4, maintains not only that child personalities (such as Peggy) are usually the first to emerge in treatment, but also that they often have a specific function. Peggy's function is to "hold" anger, an emotion intolerable to Sybil herself. Vicky functions as a kind of hybrid inner self-helper/protector personality. She, of all Sybil's alters, seems to have knowledge of all the parts of Sybil's personality system, seems to understand its workings ("There are guards around the palace"; Babbian & Petrie, 1976), and serves as a kind of informant to Dr. Wilbur.

Other aspects of this film distinguish it from *The Three Faces of Eve*. One is the quality of the relationship between Dr. Wilbur and her client. Wilbur is depicted as excessively sensitive, supportive, and caring, whereas Luther's relationship with Eve is cool and detached. Indeed, one wonders during the course of *Sybil* whether Wilbur has, in fact, other patients. She repeatedly refers to Sybil as "sweetie" (Babbian & Petrie, 1976), and there are several scenes during which she is seen to hold and hug Sybil or one of her alters while sitting in a large armchair. In the voice-over at the end of the film, Wilbur refers to her "own long motherhood," seeming to see herself as having re-parented Sybil. North et al. (1993) maintain that: "popular portrayals of MPD typically present the disorder in a relatively attractive light with high drama. . . . The protagonist in these depictions gains self-esteem and dignity and receives abundant sympathetic attention from significant others, and sometimes from highly recognized experts" (p. 118). *Sybil* most certainly portrays the relationship between the individual with DID and her dedicated, nurturing therapist in a most appealing light.
The nature and extent of the trauma experienced by Sybil, the sheer complexity of her personality system, and the temporal situation of the film meant that "Sybil became a prototype for what was to count as a multiple" (Hacking, 1995, p. 43). Like contemporary DID therapists, her therapist, although trained in psychoanalysis, made extensive use of hypnosis in treatment, and eschewed the strict patient/therapist boundaries which defined the relationship between Eve and Luther. Some differences exist between Sybil and the modern multiple, however. Sybil was abused by her mother, not her father. Late 20th century accounts of abuse centre on incest perpetrated by a male family member. Although the average number of alternate identities in late 20th century cases of DID is held by Loewenstein (1993) to be 13, other authors have reported instances of the disorder in which hundreds or even thousands of alters preside (Kluft, 1988; Ross, 1989). It would seem that since cases of dual identity recorded during the 19th century, such as that of Mary Reynolds, and those of relatively less complexity, such as that of Eve, DID has become progressively more intricate, more dramatic, and further, a more desirable diagnostic status. There can be little doubt that media representations of the disorder have contributed to this trend. As Spanos (1994) observes:

> Information about MPD is widespread in North American culture, and the major components of the role are now well-known to the general public. Popular TV movies like *Sybil* and popular biographies like *The Minds of Billy Milligan* (Keyes, 1981) provide extensive information about the symptoms of MPD, and MPD patients, along with their psychiatrists, are sometimes even featured on popular TV talk shows. In all of these sources, MPD patients are shown in an attractive light as people with dramatic symptoms who, with the help of devoted and empathic therapists, surmount numerous obstacles to eventually gain self-esteem, dignity, health, happiness and much sympathetic attention from high-status others. In short, the idea of being a multiple, like the idea of suffering from peripheral possession or demonic possession, may provide some people with a viable and face-saving way to account for personal problems as well as a dramatic means for gaining
concern and attention from significant others. The role of the media in fostering MPD was evident in a report by Gruenwald (1971) concerning a 17-year old, hospitalized female patient. This patient's first enactment of an alter personality occurred the day after seeing the movie *The Three Faces of Eve* on television. Relatedly, Fahy, Abas and Brown (1989) reported on a patient who presented symptoms of MPD and who had seen the movie *The Three Faces of Eve* and read the book *Sybil* (Schreiber, 1973). (p.154)

**Primal Fear and Identity**

While the two films discussed above are considered classic depictions of DID, a number of more recent films attest to the fact that certain core features of the disorder remain prominent in current cinematographic presentation and integral to plot structure. While *The Three Faces of Eve* and *Sybil* were among the first media portrayals of multiplicity and thus contributed greatly to public awareness of DID, other films released during the past decade continue to underscore certain pathognomonic aspects of the condition. These include the 1996 film, *Primal Fear* (Lucchesi & Hoblit, 1996), and the 2003 movie, *Identity* (Konrad, Cooney, & Mangold, 2003). Interestingly, both of these films highlight the more lurid, florid, and dramatic aspects of DID in a way that their predecessors had not. *Primal Fear* is the story of an altar boy charged with the brutal murder of a well-loved priest. The suspect, Aaron, is portrayed as a mild-mannered shy naive reticent young man who stutters and claims no memory for the murder of which he is accused. His lawyer, Martin Vail, undertakes a thorough exploration of the circumstances of the crime and, in doing so, locates a videotape in the office of the murdered Archbishop that portrays the priest orchestrating sexual acts involving Aaron, his girlfriend, and another altar boy. Vail engages a psychologist, Dr. Errington, to determine Aaron's ability to stand trial and to assess his current mental state.
In an initial interview, the psychologist questions Aaron about the events of the crime of which he is accused, saying, “Mr. Vail told me that there was a period of time surrounding the Archbishop’s death that you don’t remember. Is that right?” (Lucchesi & Hoblit, 1996). Aaron replies, “Yes – I lost time. I blacked out,” the first indication in the film of the symptom of amnesia. Further discussion ensues, during which it is revealed that Aaron has experienced similar amnestic episodes in the past, starting at the age of 12. Aaron’s father was “not a nice man,” an allusion, perhaps, to earlier episodes of abuse. During the second interview, Dr. Errington questions Aaron about his relationship with his girlfriend, Linda, upon which he begins to show signs of stress. He shakes his head, pressing his hands to his temples. During the third interview, Dr. Errington persists with her questions about the nature of the relationship between Aaron and Linda, saying “I want to talk more about your girlfriend Linda now. Can we?” Aaron responds in the negative, whereupon Dr. Errington queries, “Why not?” Aaron’s face appears blank; he sits motionless, as if in trance, then he asks “I’m sorry, do you think we can do this later? I’m just not feeling . . . I’m feeling a little tired, my head hurts.” As he says this, he again puts his hands to his temples and lowers his head. The psychologist makes an innocuous comment about the video machine with which the session is being recorded, and as she does so Aaron’s head snaps up, and he says in an aggressive tone with no trace of a stutter, “Well, how the fuck should I know. Jesus Christ!” There is then an abrupt switch back to the mild-mannered primary identity, who professes confusion about what the psychologist said about the video recorder, and is clearly amnesic for the events of the previous couple of minutes.

In a fourth interview with Vail present, the lawyer heckles Aaron, claiming that he has not been forthright about the events surrounding the Archbishop’s murder. Aaron
begins to pace, becoming visibly agitated, turning to face the wall, and switching to the alternate. He spouts a stream of epithets and, as if seeing Vail for the first time, asks, "Who the fuck are you?" (Lucchesi & Hoblit, 1996). Again, the stutter is absent. Further, the physical stance is aggressive and the facial expression very different from that of Aaron. The alternate slaps and shoves Vail. Claiming that his name is Roy, he admits to the murder of Archbishop Rushman, refers to Aaron's girlfriend as a "tramp" and claims to be "dying for a smoke." Aaron is a non-smoker. When Dr. Errington enters the room, there is an abrupt switch, during which Aaron again presses his hands to his head. In the climactic courtroom scene of the film, Vail badgers Aaron while he is on the witness stand, in an obvious effort to precipitate a switch. Aaron evidences signs of stress, clenching his hands, seeming to be dazed. When the prosecuting attorney, a woman, resumes her questioning of Aaron, her insistent probing triggers a transition to Roy, who leaps out of the witness box and assaults her. The final, stunning twist of plot appears at the end of the film. Aaron, in conversing with his lawyer, reveals that he has malingered the disorder, and that "there never was an Aaron," only a Roy.

The film, Identity (Konrad et al., 2003), is the most recent video depiction of DID. The plot is somewhat convoluted and opaque. The film portrays a group of people who come together, through a series of unlikely circumstances and mishaps, during a fierce storm, at a remote motel. These individuals are later revealed to be the alternate identities of the film's protagonist. One of the occupants of the motel is a police officer with his charge, a shackled criminal in transit to a detention facility. Another is a middle-aged actress, another a young woman accused by the motel owner as being of ill repute. There is a young couple with a 9-year old son, Timmy, an ex-policeman, and a man in his 20s accompanied by his girlfriend. In the opening scene of the film, the camera pans
newspaper headlines: “Boy abandoned at local motel. Tells manager he was waiting for mom in bathroom” (Konrad et al., 2003). Another headline reads, “Child found in local motel. Abandoned, abused.” We then see an image of a mugshot of one Malcolm Rivers, a man convicted of the slaying of six people, 4 years previously. Thus is established a history of trauma and neglect of this 30-something man who now awaits execution for his crimes. The first hint of the possible existence of DID in Rivers is offered at this point in the film. Rivers is conversing with his psychiatrist, who asks “Do you understand why you are talking to me right now?” Rivers responds, “Yeah, you’re supposed to be good with headaches. I need something more than aspirin.”

As the film progresses, the viewer is brought back to the motel at which the group of people have assembled during the storm. A series of murders occurs; the middle-aged actress is the first to be killed. As the motel occupants are systematically eliminated by an unknown aggressor, the remaining tenants try to determine whether there is a link between them, some connection of which they are presently unaware. It is discovered that they all have the same birthday. In one scene, one of the young women is talking with Edward, the ex-policeman, who states that he is on medical leave from the police force: “I started getting headaches and eventually started blacking out” (Konrad et al., 2003). This is the second reference in the film to dissociative symptoms. There are yet further murders in store, after the portrayal of which the film depicts Rivers, his psychiatrist, a police officer, and a lawyer in a room. The psychiatrist is presenting his assessment of Rivers in support of a stay of execution, holding that “My client is certifiable, Axis IV, dissociative. To this day he remains completely unaware of the crimes for which he was convicted.
The psychiatrist offers Rivers’ diary in support of his contention, stating that it is “important to note the spectacular changes in handwriting style, tone, point of view . . . what you are looking at are the private thoughts of several different people” (Konrad et al., 2003). According to the doctor, “There is no universally efficacious treatment for Dissociative Identity Disorder. In theory, one must attempt to move the patient towards integration, a folding, if you will, of the fractured psyche.” The camera then focuses on the client, whom, to the viewer’s surprise, appears not as Malcolm Rivers, a heavy-set heavy-jowled man, but as Edward, the ex-policeman of the earlier motel scenes. It is apparent to the viewer at this point that Edward is, in fact, one of Rivers’ alternate identities. Edward shakes his head, rubs his temples, while the doctor states: “You missed your last appointment.” The psychiatrist goes on to explain to Edward that: “When faced with an intense trauma, a child’s mind may fracture, resulting in Dissociative Identity Disorder. That’s exactly what happened to Malcolm Rivers. It’s a condition commonly known as Multiple Personality Syndrome.”

The psychiatrist shows Edward a picture of Malcolm Rivers, asking if he recognizes the man. Edward responds “No” (Konrad et al., 2003). The doctor states that Rivers had “a very troubled life,” and that “he murdered six people four years ago in a violent fit of rage.” He proceeds to explain that Rivers developed DID, and reveals to his client that he, Edward, is one of River’s personalities. The doctor hands his client a small mirror into which he peers, and to Edward’s obvious shock, he sees, not his own features, but those of Malcolm Rivers. The psychiatrist goes on to say that the success of the medical treatment for DID is contingent upon forcing all of the individual’s alternate identities to “confront one another for the first time.” He tells Edward that one of the alternate identities had committed the murders for which Rivers was convicted, and that:
This identity took control of Malcolm’s body as you have now, and released an unspeakable rage, and in 19 hours Malcolm Rivers will be put to death because of those actions unless I can convince that man [the lawyer present in the room] that the killer is gone. (Konrad et al., 2003)

This is followed by a series of what Putnam (1989) terms “revolving door” (p. 291) switches, rapid and frequent transitions from one to another personality state. These transitions occur between Edward and Rivers, apparently triggered by Edward’s full realization of what the physician is saying. This constitutes the climactic scene of the film.

Like The Three Faces of Eve and Sybil before them, Primal Fear and Identity offer a window on DID symptomatology in terms of some of the less subtle manifestations of the disorder. Like Eve and Sybil, Aaron and Malcolm experience intense and prolonged headaches that are frequently accompanied by a transition to an alternate identity. Aaron’s switches are preceded by periods of trance-like behaviour and are accompanied by a realignment of facial musculature that results in a marked change of expression. Transitions from one to another alternate identity in Identity are of a classic revolving-door nature. In Primal Fear, the primary identity is portrayed as self-effacing, bland, and devoid of affect, much like Eve White. Both films establish a trauma history early in the course of the narrative, and in both, switches are accompanied by a pressing of the hands to the temples. In Primal Fear, the primary identity stutters while his alternate does not. Identity depicts the dramatic changes in handwriting, which are considered by contemporary authors to be manifestations of different alternates. Such overt manifestations of dissociation are frequently portrayed in both videos, as are the marked differences in personality characteristics between primary identity and alternates. Extensive episodes of amnesia, considered pathognomonic of DID by most
contemporary researchers, are prominent in *Primal Fear* and *Identity*, as in the earlier films.

There are features of the two recent films, however, which distinguish them from their older counterparts. The most salient of these is the focus on physical violence and aggression in the male protagonist. *Primal Fear* and *Identity* reinforce cultural stereotypes about men to the point that they essentially portray a parody of masculinity much as the 19th century hysterical constituted a parody of femininity. Both Roy and Malcolm are presented as cold-blooded killers who release pent-up aggression in uncontrolled attacks of physical violence. As hysteria had, from the 17th century onward, portrayed the female as inherently wanton, so these recent films portray men as inherently violent, controlling, physically menacing, and wont to express these qualities by violating the most fundamental of social norms – that of respect for human life. The two films are highly dramatic, almost lurid; in both, the viewer is invited, in an almost voyeuristic sense, to view the male multiple as deranged, depraved, yet ultimately not responsible for his actions by virtue of the affliction from which he suffers. *Identity* reiterates the metaphor of the shattered mind, which is prominent in the academic discourse on DID, with its frequent references to the “fractured” (Konrad et al., 2003) mind of the multiple. In doing so, it reinforces a disease model of multiplicity in its implication of the unified mind as normative. The violence in both films is excessive. In *Primal Fear*, the Archbishop is stabbed 78 times, his fingers amputated, and a series of numbers carved into his chest with a butcher knife. In *Identity*, six people are ruthlessly stabbed to death in a single killing spree. Both assaults occur in a sudden frenzy of hitherto suppressed rage. The two films portray the dark side of DID, and in doing so,
manage not only to represent violence as the province of men, but also to portray men as helpless victims of their own uncontrollable and innate aggression.

In sum, these more recent depictions of DID support my contention that the popularizing of the more overt aspects of the disorder continues in contemporary film, and renders such features readily accessible to be learned and enacted. Further, however, they emphasize a dichotomy analogous to that of the Madonna/whore dichotomy that has pervaded Western medical writings, literature, and art with respect to both hysteria and DID. Women with hysteria or DID are innately passive, nymphomaniacal, deceiving, emotional labile, and ultimately responsible for their illness due in large part to their very femininity. Men with DID are aggressive, domineering and powerful, and not responsible for their illness because these innate qualities force them past the limits of their self-control.

**Malingering and latrogenesis**

This thesis would not be complete without a brief discussion of two issues to which much attention is given in the literature. Charges that DID can be successfully faked abound. Some researchers have claimed that it may be malingered as a way of covering up personal failings and inadequacies, suggesting that a childhood fraught with familial dysfunction and abuse may be used as a way of accounting for present difficulties (North et al., 1993). Chu (1991) reports the case of a woman admitted to a psychiatric ward who “reported ongoing dissociative symptoms, including ‘blackouts’, and the existence of six alternate personalities, including depressed, suicidal, angry and child personalities” (p. 202). The woman later admitted to having fabricated her history of childhood abuse and dissociative symptoms in order to avoid dealing with a problem of
substance abuse, and confessed to having created her story by piecing together bits of information from other patients on the ward.

While Kline (1990) aligns himself with a view of DID as a valid diagnostic entity, he also states that he is “still struck by the play-acting quality of many of these patients. It’s as if the whole presentation is a monumental ‘put-on’” (p. 538). While much of the academic literature (Ganaway, 1989; Kluft, 1987b; Spiegel, 1988) focuses on concerns for the credibility of the field and differences between “true” and malingered cases of DID, perhaps the most critical issue with regard to the faking of the disorder is that malingerers are educated in the ways that it is appropriate to be dissociative in this culture. As discussed in earlier sections of this thesis, popular press publications, the internet, and video depictions of DID combine to produce ready accessibility of the more overt features of the disorder, such as headaches and amnestic episodes. Further, conventional types of alternate identities, such as those claimed by Chu’s (1991) patient, are clearly depicted in both video and autobiographical accounts of the disorder. There is thus both a behavioural repertoire associated with DID which is readily reproducible, and a vocabulary which is readily accessible in books, in internet articles, and on video. The core features of DID have achieved the status of common knowledge thanks to a variety of media conduits. As with the hysteria of the 19th century, our culture provides a script which facilitates the successful enactment of dissociative symptoms, be they malingered or otherwise.

The issue of iatrogenic creation of alternate identities similarly occupies a good deal of space in the literature on DID, where the schism between sceptics versus believers is evident. Sceptics assert that DID is created in the context of therapy, and that alternate identities proliferate as therapy progresses. Believers maintain that the
disorder has its roots in childhood trauma, not in the clinical setting. McHugh (1995) disagrees with the latter stance, maintaining that:

> Countless numbers of personalities emerge over time. What began as two or three may develop to 99 or 100. The distressing symptoms continue as long as therapeutic attention is focused on finding more alters and sustaining the view that the problems relate to an intriguing capacity to dissociate or fractionate the self. (p. 958).

Evidence that an astounding number of alternate identities may be identified in a single patient is borne out by Kluft (1989), who claims to have treated a woman having more than 4,500 alternate identities, each of which was “remarkably full” (p. 53). Ross (1989) contends that: “there is not a single case of false positive MPD reported in the entire world literature” (p. 295). Setting aside for the moment the Sisyphean task of combing “the entire world literature” in search of a lone case study, Ross’ (1989) claim is refuted by Merskey (1992), who maintains that “suggestion, social encouragement, preparation by expectation, and the reward of attention can produce and sustain a second personality” (p. 337). Hacking (1991) agrees, holding that “It takes two to multiply” (p. 860). Patients do not come to the clinician’s office with an array of alternate identities; “they are painstakingly ferreted out” (Hacking, p. 860).

The crucial point with respect to the issue of iatrogenesis, however, is whether clinicians make the diagnosis of DID in ways that engender and sustain the disorder. A good deal of space was devoted in an earlier section of this thesis to some of the techniques employed by recovery movement therapists in the eliciting of the inner child. Similar strategies are used by therapists in the diagnosis of DID. It is not difficult to imagine the potential impact of these approaches on a suggestible client who is eager to please the therapist, has been exposed to media depictions of DID, and is desperate for some framework from within which to construe her symptoms. Braun (1989) suggests
that the therapist ask the hypnotized client "whether there is another process, part of the mind, person or force that exists in the body" (cited in Putnam, p. 223). Implicit in such a leading question is the belief that such a "force" or "person" indeed exists.

Further, clinicians may have a vested interest in the identification of DID in a client. Therapy for DID is an extensive process, taking on average several years. It is thus a lucrative undertaking for a practitioner. If the most innocuous of symptoms, such as headache, are held by the clinician to be suggestive of DID, and if there is potential gain involved, the clinician may treat the client as if she has the disorder, and the client may attempt to fit the interviewer's preconceptions as to what is characteristic of the condition. As Fahy (1988) notes, the therapist may provide information to the client about what constitutes a typical presentation of the disorder, or may reward the production of specific symptoms, such as the emergence of a new alternate identity, increasing the likelihood that this trend will continue. The relationship between the therapist and the production of the disorder is thus circular, much like the relationship between the media and DID discussed in an earlier section of this thesis: The more you look for it, the greater the likelihood that you'll see it. The more you see it, the greater the likelihood that the symptoms observed will be interpreted in light of dissociation, and be considered confirmatory of a diagnosis of DID. One further point is worth making. DID practitioners consider themselves an elite sector of the therapeutic profession, and the status of those who treat the disorder is thus greatly elevated. This, like the relationship between the 19th century medical practitioner and the ailing hysterical female, may also be a factor in the perpetuation of DID in Western culture.
Summary

During the latter decades of the 20th century, many factors have converged to create a socio-political climate in which narratives of sexual abuse are taken seriously both by clinicians and by lay-persons. Research on child battery, the identification of the rape trauma syndrome, and studies of combat neurosis have contributed to the apprehension of dissociation as a viable response to traumatic events. Media representations of DID tend to portray the dissociative individual in heroic terms, as she struggles valiantly to overcome a legacy of devastating life events. Film depictions of the disorder provide templates for the enactment of dissociative symptoms. Further, these symptoms are described in detail in mass-market biographies and autobiographies of individuals diagnosed with DID. The recovery movement, at the heart of which lies the concept of the inner child, has contributed to the public perception of multiplicity as a trait inherent in all individuals, and the publications of its proponent authors encourage the application of the inner child motif in the clinical context, increasing the likelihood that clients may construe their experience in dissociative terms, and thus the likelihood of self-diagnosis by susceptible, and suggestible, individuals. Mass-market publications and home video depictions of DID also provide a vocabulary for the unwary consumer which is consistent with the academic discourse on DID.
POSTSCRIPT

In this thesis, I have examined some of the social, cultural, and political factors that shape dissociative symptoms. I have reviewed the contributions of early theorists, including the British empiricists, to the concepts of association and dissociation, and posited that their work has perpetuated the notion of a fundamental and inherent unity of consciousness. I have discussed the history of hysteria from a feminist perspective, developing the idea of the disorder as scripted behaviour, as a decipherable text and, metaphorically, as a form of theatre. I have explored some manifestations of dissociation in other cultures in an effort to identify some of the factors that perpetuate culture-bound syndromes bearing dissociative features. In doing so, I have tried to view these syndromes, as much as is possible for a Western researcher, in light of specific indigenous cultural factors which impinge on their expression.

I have traced the development of the medical model in North American psychiatry, discussed the evolution of the professional discourse surrounding DID, and outlined the major contemporary theoretical formulations pertaining to the disorder, including models of consciousness, theories of etiology, and the dissociative continuum. I have presented the views of a number of contemporary researchers with respect to the symptom profile of DID, in an effort to provide the reader with some sense of the subjective experience of dissociation. I have delineated some of the factors which I believe to have been responsible for creating a socio-political atmosphere in which DID would thrive in the late 20th and early 21st centuries. I have identified some of the media influences on the proliferation of cases of the disorder, and have presented positions on
the issues of iatrogenesis and malingering of DID as they are maintained by both sceptics, and proponents, of this very baffling, most intriguing, and highly thought-provoking diagnostic entity. In achieving these objectives, I have adopted a broad, contextual approach, locating the phenomenon of dissociation, not on an intra-psychic level, where it is most commonly conceived, but within more expansive, more encompassing, social, cultural, and historical spheres.

My review of the current literature on dissociation, both in North America and other cultures, points to a number of critical issues that suggest directions for future research. One of these pertains to human agency. Dissociation is widely perceived to be experienced as non-volitional. Periods of amnesia provide an excellent example of this: There is an implicit assumption of a lack of volition associated with time-loss. Yet, if we consider the dissociative individual to be cloven into separate sub-selves, and if we consider that frequently, these alternate identities emerge to perform a specific function in his or her life, then dissociation may be considered highly agentic. In McCann's (1998) view:

The true center of agency lies in exercises of what is often called the will—that is, the mental faculty of voluntary behaviour. Exercises of the will include such things as the activity of concentrating one's attention on one or another item of mental content; the act of deciding, through which intentions are formed; and the activity of volition, by which intentions for overt action are usually executed. (p. 172)

It may be hypothesized that the relinquishing of control in the form of transition from one state of consciousness to another constitutes an act of will, as suggested by one woman with DID, who states “I manage work quite well with the assistance of one other alter. The rest are not appropriate to the setting and have agreed to ‘not go to work’ with me” (Cohen et al., 1991, p. 94). Volition is also evident in this excerpt from an
interview with one of the alternate identities of another woman diagnosed with the

disorder:

How do we decide which alter comes out? It is quite simple, though it can be
complex due to vanity or rivalry among us. The presenting personality is
either the one most adept at handling the current situation, or one who wants
or needs to express something. (Cohen et al., p. 23)

There are implications here of agency both on the part of the primary identity and
on the part of the alternate identities as evidenced by the cooperation among them. They
choose an alter appropriate to the social context; they decide which one would be most
adept at negotiating its demands. It may be further hypothesized that the switch process
itself is a volitional act, as the emergence of an alter is timed to occur in response to
specific environmental conditions. It may be, however, that the role of volition in DID is a
more complex issue, related to personal authority and to power. Alternate identities may
well embody the volition that women are socialized against exercising. That is, DID may
constitute a socially-sanctioned outlet for the expression of power in a society which
imposes constraints on the political, economic, and social resources available to women,
limiting their capacity for exerting power in a positive and personal way. Conditioned to
believe that power is inextricably linked with “ruthlessness and abuse” (Caplan, 1985, p.
227), women have been, in the words of Jean Baker Miller (1985), “led by the culture to
believe that their own self-determined action. . . must be destructive” (cited in Caplan, p.
226).

In line with this conception, Young-Eisendrath and Wiedemann (1987) note that
passivity as a lifestyle and a mode of feminine behaviour is idealized in North American
society. Agentic behaviour in women in the context of “sickness” can be assimilated by
our culture, for the mentally ill individual is expected to act in unusual, bizarre, or even
outrageous ways. DID may be a manifestation of personal power and agency in a paradoxical form: It's okay to exert one's will if the illness supports it, but not okay if you are not sick. There is a gap in the literature with respect to philosophical issues of this nature. How do we reconcile the concept of human agency with a disorder that is considered by most researchers to be of a non-volitional nature?

Another issue with respect to DID is raised by Hacking's (1995) question "Is it real?" (p. 8). The validity of the diagnosis is championed by some, scorned by others, and remains a topic to which much space is devoted in the literature. The problem in dealing with this question, as Hacking (1995) rightly notes, is that it raises philosophical concerns pertaining to the meaning of the word "real." If DID is real, it must be real as opposed to something else. But what is that "something else?" An iatrogenic condition? Deliberate fakery? Is DID something tangible, as opposed to, amorphous? If it is a cultural artefact, as I have argued in this thesis, rather than a bio-medically-based disease entity, does that make its existence any less compelling, any less worthy of clinical attention, any less deserving of rigorous investigation? The inconsistencies and illogicalities in some of the literature published to date do little to ameliorate a view of DID as somehow "artificial" (Hacking, 1995, p. 12) if not downright nonsensical.

Contemporary clinicians ground their judgements regarding whether an individual "has" the disorder on the extent to which the diagnostic criteria in DSM-IV (1994) are met. With respect to these criteria, however, problems of definition arise even when they are viewed from the scientistic perspective whence they originate. For example, DSM-IV urges the delimitation of DID from other disorders characterized by "cyclical mood fluctuations" (p. 487). Essentially, some of these, such as Bipolar Disorder, are state-change disorders. Yet, what exactly constitutes a "state-change?" DSM-IV states that
the defining feature of DID is "the presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)" (p. 487). The term "alternate identity," however, is defined differently by different authors, ranging from Ross' (1989) view that "personalities are relatively full-bodied, complete states capable of a range of emotions and behaviours" (p. 81) to that of Putnam (1989), who does "not think that anyone really knows what ultimately constitutes an alter personality" (p. 103).

The literature is strewn with terms like "unique entity," "structured entity," and "ego-state phenomena" in the absence of clarification that would permit each to be understood independently of the other. One clinician's "ego-state" may constitute another clinician's "personality fragment." Moreover, clinicians have opposing views as to what constitutes a typical presentation of DID. Some assert that the phenomena associated with the disorder are presented "vividly and overtly, and thus make possible the first-hand examination of psychic functions, with less need to speculate on processes that are covert and disguised" (Kline, 1990, p. 539), while others maintain that "multiple personality disorder rarely presents as florid" (Kluft, 1991, p. 605), and that the vast majority of patients display only the most subtle signs of dissociation or try to hide it completely. Kluft (1987c) points out that more overt presentations of DID are the exception rather than the rule; most patients actually dissimulate, and the core phenomena of the disorder are covert. He refers to the expectation that DID will be presented openly "and be played up for secondary gain" as misleading (Kluft, 1987c, p. 125). Another clinician (Dell, 1998) also maintains that few DID patients dissociate openly, that most present only very subtle indicators or camouflage their symptoms completely.
Ross (1989) contends that while some DID patients display clear-cut identities with obvious switching, and highly structured personality systems with rigid amnestic barriers, others “present more of a shifting sea of partial presences and uncertain identities” (p. 110). What, precisely, is a “partial presence?” This characterization would seem to run counter to the *DSM-IV* (1994) Criterion A, which states that an essential aspect of DID is the distinctness of alternate identities. Ross also describes a polyfragmented patient “with over 300 named personalities and fragments” (p. 93), while according to Kluft (1991), “the presence of many similar alters diminishes the likelihood that their switches will attract attention” (p. 614). This suggests that alternate identities may be so alike (i.e., so ill-defined) as to render differences in their presentation impossible to detect even by the clinician! Yet Kluft (1988) also claims to have treated a patient with over 4,500 alternate identities. Ross (1989) describes personality fragments as “relatively limited psychic states that express only one feeling, hold one memory, or carry out a limited task in the person’s life” (p. 81). Another clinician maintains that “the distinction between a personality and a personality fragment can be difficult to make” (Putnam, 1989, p. 104) and actually states that “a given entity may be characterized as a fragment at one point and as a personality at another” (p. 104). He solves the problem of distinction between fragment and alternate identity by maintaining that it doesn’t really matter which the clinician is working with; the fundamental therapeutic approach is the same for both.

Piper (1995) maintains that imprecision and inconsistency in defining “alternate identity” call into question the dramatic increase in numbers of identities found in contemporary cases of DID. In the 19th century nearly every reported case was of dual identity. According to Piper, the number of personality states that may be unearthed is
limited only by the therapist's enthusiasm and his or her subjective sense of what constitutes an identity. Other questions arise from the vagueness and disparity of different definitions of the terms "alternate identity" and "personality state." If the personality state appears only during sessions with the therapist or only when the patient is experiencing extreme stress, is the definition satisfied as per DSM-IV (1994) criteria? At what point is the clinician to conclude that what he or she sees is a "personality fragment" rather than an "alternate identity?" According to DSM-IV, "at least two of these identities recurrently take control of the person's behaviour" (p. 487). What exactly does it mean to "take control of the person's behaviour?" How can the degree of control be accurately assessed by the clinician? What does "recurrently" mean – once a day? Once a week? For how long?

Questions arise regarding the flexibility of diagnostic criteria. French (1987) maintains that "it is not uncommon for one therapist to diagnose Multiple Personality objectively, using strict criteria, while another, using the same criteria will not be able to diagnose the disorder in the same patient" (p. 124). Unresolved issues such as these continue to plague the field, and contribute to the conflict and controversy which have accompanied the diagnosis of DID since it was first described in Mitchill's (1816) early case study of Mary Reynolds. How are clinicians to make sense of these inconsistencies and problems of definition? Yet the credibility of the field, and the therapeutic efficacy of contemporary practitioners, demands that we must.

The existence of DID raises other issues related to our conceptions of the nature of identity and the adequacy of existing models of psychotherapy. Since the 17th century, the concept of "I" in Western psychology has constituted the affirmation of an essential self-existence: The awareness of self as an individual with an identity separate and
distinct from that of others. DID challenges the notion that self is essential. Rather, it suggests that self is processual, ever-evolving, socially and culturally constituted. Modern conceptions of self reflect a belief in its fundamental unity and autonomy, portraying the individual as rational, immutable, and predictable, displaying consistency across time and across context. With the advent of postmodernism, however, this notion has been challenged by a view of self as decentred, lacking in substance, devoid of depth and, perhaps above all, inconstant. DID is possibly the quintessential manifestation of such a perspective, representing as it does the antithesis of the integral, unitary, contained entity posited by modern theorists. Such a revolution in thinking makes it clear that the systems of knowledge and meaning within which we apprehend the nature of self are socially and historically defined and constrained. Yet the depthless pastiche of the post-modern self, susceptible as it is to change, constituted, as it is held to be by its proponents, entirely by social and cultural process, denies the critical importance of a sense of personal continuity – a kind of intact, central self – in terms of being able to engage in life fully, freely, and with certainty. As Glass (1993) notes:

From a clinical point of view, a fractured identity lacks a center, a cohesiveness that might provide for the self an orientation or stability in a world that in its political, cultural, and social manifestations is chaotic enough. . . . Is, in fact, the concept of a unitary self restrictive and debilitating? One can live with a healthy postmodern skepticism toward truth, absolutes, causality and rationality yet at the same time acknowledge and recognize how critical a core sense of self is to the project of life itself. (p. 7)

Post-modern theories of self rest on a belief in the desirability of multiple selves (Neimeyer & Raskin, 2000). This, as discussed in an earlier section of this chapter, constitutes the romanticization of a state which, in its most extreme form, results in a high level of psychosocial distress, affecting the ability of the individual to engage in vocational pursuits, maintain healthy and rewarding interpersonal relationships, and take
pleasure in the simplest of daily activities. Moreover, by deconstructing the self into narrative forms and structures, it denies the role of human agency in the expression of a disorder like DID – a condition which, almost by definition, is highly volitional. Our conceptions of self evolve with the ever-changing social and historical landscape. In fact, they may not be understood independently of the social, cultural, and historical contexts in which they are embedded and have their origins. The same is true for a disorder such as DID.

Clinicians are faced with a particular challenge with respect to the understanding of DID within the framework of the current nosological system. This challenge relates to the fact that DSM-IV (1994) is grounded in and perpetuates the assumption that self is a kind of bounded, bordered monad, a stable, consistent, and self-contained entity. It is against this backdrop that practitioners evaluate an individual in terms of whether or not he or she deviates from this standard, and to what degree. In this respect, DID can again be seen as the ultimate deviation, for the dissociated self is neither stable, nor consistent, nor self-contained. The normative assumptions inherent in DSM-IV (1994) and the constructions of psychopathology employed in Western psychology and psychiatry implore the clarification of a distinction between illness and distress. In fact, the changing face of dissociation over the historical periods reviewed in this thesis is evidence that DID is difficult, if not impossible, to account for in terms of a disease perspective.

From a clinical standpoint, feminist therapy may be one of the most valuable of frameworks from within which to make sense of multiplicity. While the dominant psychotherapeutic models used in the treatment of DID locate pathology on an intra-psychic or micro-institutional level, this model intersects with social constructionism on
two important dimensions. First, it speaks of distress rather than disease, and rejects essentialist explanations for mental illness, thus eschewing the taken-for-granted "knowledge" that the bases for such conditions are necessarily biological. Second, it speaks in terms of pathology residing not within the individual, but rather within the social and political institutions, which perpetuate conditions under which violence and abuse thrive. Additionally, and perhaps most importantly with respect to a condition like DID, it speaks of distress as "a reasonable response to unreasonable events" (Brown, 2000, p. 298). Such a therapeutic model would mesh well with dissociation, and certainly poses a viable alternative to those reflective of an espousal of the reigning paradigm in psychiatry.

One final issue of major importance emerges from a contextual study such as this. Mental illnesses are not the fixed, objective, pan-cultural, and trans-historical entities that many researchers, in an era in which the medical model holds sway, would have us believe they are. Rather, they are fluid, changeable. Like the Proteus of Lifton's (1993) metaphor, they are able to assume different forms over time, susceptible to the influence of a myriad of factors external to the individual, and subject to the vicissitudes of the individual's own interpretation of his or her experience. As Knauer (1995) notes, "MPD is an example of how both psychiatric illnesses themselves, and the way we perceive those illnesses, can potentially change and evolve in tandem with the culture and its social structure" (p. 132).

Considering the evolution of DID as a diagnostic entity in light of the historical, social, and political forces that have shaped its presentation in North America, and examining the manifestations of dissociation in other cultures, reminds us that there is no single picture of a clinical entity such as DID which holds the status of a claim to
"truth." It is not the case that our understanding of such a disorder comes into better focus with more advanced theoretical knowledge and "improved" or revised nosological systems. Rather, such theoretical formulations and diagnostic criteria are *themselves* products of social and cultural forces beyond the level of the intra-psychic, residing in the very macro-institutional structures that give form to the clinical entity which is the object of investigation. Both compelling and confounding, there is little doubt that DID will continue to engage the attention of researchers for decades yet to come. The study of dissociation remains the province of those whose primary interest lies in a deeper understanding of the human condition.
REFERENCES


Descartes, R. (1968). The meditations and selections from the principles of René Descartes (John Veitch, Trans.). San Jose, CA: The Open Court Library of Philosophy. (Original work published 1641)


Jorden, E. (1971). *A disease called the suffocation of the mother.* Amsterdam: Da Capo Press. (Original work published 1603)


Mitchell, S. L. (1816). Double consciousness, or a duality of person in the same individual: From a communication of Dr. Mitchill to the Reverend Dr. Nott, President of Union College. Medical Repository, 185-186.


APPENDIX

Browse by Title

Follow a linked title below to see details of that book.

The titles are sorted by publication date, from oldest to newest. Books which have no listed publication date are given first. This list can also be sorted alphabetically.

- No date known: Adolescent dissociative experiences scale (1 review)
- No date known: Angel child: a novel based on a true story (1 review)
- No date known: Boundaries, precious boundaries
- No date known: Diary of a survivor in art and poetry
- No date known: Disconnect: understanding and living with MPD/DID
- No date known: Dissociative experiences scale (1 review)
- No date known: Dissociative features profile (1 review)
- No date known: Looking inside: life lessons from a multiple personality in pictures and words
- No date known: Managing our selves: building a community of caring
- No date known: More than one: an inside look at multiple personality disorder (2 reviews)
- No date known: Multiple personality: an outcome of child abuse (1 review)
- No date known: Multiple personality disorder: selected bibliography & resource guide for mpd and ritual abuse (1 review)
- No date known: Shatter: the true story of Kathy Rolo's eight separate personalities and her struggle to become whole
- No date known: Taking charge of change
- No date known: Treating the dissociative client
- No date known: Trouble with feelings, The
- No date known: Understanding dissociative disorders and addiction
- No date known: When rabbit howls (85 reviews)
- 1957: Three faces of live, The (10 reviews)
- 1973: Sybil: the true story of a woman possessed by sixteen separate personalities (24 reviews)
- 1978: I'm Live (10 reviews)
- 1979: Divided Self
- 1982: Minds of Billy Milligan, The (11 reviews)
- 1983: Childhood antecedents: multiple personality
- 1986: Divided consciousness: multiple controls in human thought and action (expanded edition) (1 review)
- 1986: Multiple personality, allied disorders, and hypnosis
- 1986: Prism: Andrea's world (2 reviews)
- 1987: Michelle remembers (6 reviews)
- 1987: Trance and treatment: clinical uses of hypnosis
- 1988: Healing the incest wound: adult survivors in therapy
- 1988: Voices (2 reviews)
- 1989: Diagnosis and treatment of multiple personality disorder (4 reviews)
- 1989: Mind of my own, A (1 review)
- 1989: Suffer the child (17 reviews)
- 1990: Katherine: it's time: the incredible true story of the multiple personalities of Kit Castle (8 reviews)
- 1990: Multiple personality disorder: diagnosis, clinical features, and treatment (2 reviews)
- 1990: Through divided minds: probing the mysteries of multiple personalities - a doctor's story (8 reviews)


9/22/03
- 1990: United we stand: a book for people with multiple personalities (6 reviews)
- 1991: Assessment and treatment of multiple personality and dissociative disorders (1 review)
- 1991: Cry of the invisible: writings from the homeless and survivors of psychiatric hospitals (1 review)
- 1991: Multiple personality disorder (MPD) explained for kids
- 1991: Multiple personality disorder from the inside out (10 reviews)
- 1991: Multiple personality gift: a workbook for you and your inside family (1 review)
- 1991: Treatment of multiple personality disorder, The
- 1991: Uncovering the mystery of MPD: its shocking origins its surprising cure (7 reviews)
- 1992: Can I look now? Recovering from multiple personality disorder (1 review)
- 1992: Family inside, The: working with the multiple (3 reviews)
- 1992: Flock, The: the autobiography of a multiple personality (14 reviews)
- 1992: Living with your selves: a survival manual for people with multiple personalities (3 reviews)
- 1992: Out of darkness: exploring satanism and ritual abuse (1 review)
- 1992: Treating PTSD: cognitive-behavioral strategies (1 review)
- 1993: Bunny: a storybook for children who have a parent with multiple personalities (1 review)
- 1993: Clinical perspectives on multiple personality disorder
- 1993: Dissociative disorders: a clinical review (1 review)
- 1993: Fractured mirror, The: healing multiple personality disorder (8 reviews)
- 1993: Many minds: information for people who have multiple personalities (1 review)
- 1993: Mending ourselves: expressions of healing and self-integration (3 reviews)
- 1993: Moira
- 1993: More than survivors: conversations with multiple personality clients (4 reviews)
- 1993: Mother I carry, The: a memoir of healing from emotional abuse (3 reviews)
- 1993: Multiple personality disorder: psychiatric classification and media influence
- 1993: Multiplicity personality and dissociation: understanding incest, abuse and MPD (2 reviews)
- 1993: Obsidian mirror, The: an adult healing from incest (2 reviews)
- 1993: People in pieces: multiple personality in milder forms and greater numbers
- 1993: Posttraumatic stress disorder: a clinical review (1 review)
- 1993: Shattered selves: multiple personality in a postmodern world
- 1993: Thirteen pieces: life with a multiple (1 review)
- 1993: Trauma and recovery (4 reviews)
- 1993: Trauma and survival (post-traumatic and dissociative disorders in women) (1 review)
- 1994: Dissociation: clinical and theoretical perspectives (1 review)
- 1994: Getting through the day: strategies for adults hurt as children (5 reviews)
- 1994: Little girl fly away: haunted by the demons within her: one woman's true story (6 reviews)
- 1994: Multiple's guide to harmonized family living, The: a healthy alternative (or prelude) to integration (2 reviews)
- 1994: My Mom is different (2 reviews)
- 1994: My Mom is different activity book, The (1 review)
- 1994: Osiris complex, The: case studies in multiple personality disorder (1 review)
- 1994: Safe passage to healing: a guide for survivors of ritual abuse (3 reviews)
- 1994: Satanic ritual abuse: a therapist's handbook (1 review)
- 1994: Silver boat II: the journey (1 review)
- 1994: Someone I know has multiple personalities: a book for significant others-- friends, family, and caring professionals (3 reviews)
- 1995: Beyond integration: one multiple's journey
- 1995: Broken child (21 reviews)
• 1995: Diagnosis and treatment of dissociative disorders
• 1995: Dissociative identity disorder : theoretical and treatment controversies
• 1995: First person plural : multiple personality and the philosophy of mind (1 review)
• 1995: Handbook for the assessment of dissociation : a clinical guide (1 review)
• 1995: Healing the divided self : clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions
• 1995: Mosaic mind, The : empowering the tormented selves of child abuse survivors (4 reviews)
• 1995: Multiple personality : an hispanic perspective
• 1995: Rewriting the soul : multiple personality and the sciences of memory (4 reviews)
• 1995: Telling without talking : art as a window into the world of multiple personality (1 review)
• 1995: Women who hurt themselves : a book of hope and understanding (2 reviews)
• 1996: 37 to one : living as an integrated multiple
• 1996: A cry in the night
• 1996: As you desire me : the psychology of a multiple personality
• 1996: Cross a dark bridge : a novel
• 1996: Dissociative identity disorder : diagnosis, clinical features, and treatment of multiple personality (3 reviews)
• 1996: Magic daughter, The : a memoir of living with multiple personality disorder (7 reviews)
• 1996: Nine sisters dancing : a novel
• 1996: Sexual abuse/sacred wound : transforming deep trauma
• 1996: Trance and possession in Bali : a window on western multiple personality, possession disorder, and suicide
• 1996: Treating dissociative identity disorder (1 review)
• 1997: Becoming one : a story of triumph over multiple personality disorder (1 review)
• 1997: Internal Family Systems : Therapy
• 1997: Jekyll on trial : multiple personality disorder and criminal law
• 1997: More alike than different : treating severely dissociative trauma survivors (2 reviews)
• 1997: Silencing the voices : one woman's triumph over multiple personality disorder (1 review)
• 1998: Amongst ourselves : a self-help guide to living with dissociative identity disorder (5 reviews)
• 1998: Dissociative child : diagnosis, treatment, and management, The
• 1998: Magic castle, The : a mother's harrowing true story of her adoptive son's multiple personalities - and the triumph of healing (7 reviews)
• 1998: Nightmare : uncovering the strange 56 personalities of Nancy Lynn Gouch (1 review)
• 1998: Our House
• 1998: Rebuilding shattered lives : the responsible treatment of complex post-traumatic and dissociative disorders
• 1998: Sorcery of survival : memoirs of a multiple
• 1999: Coping with trauma : a guide to self-understanding (1 review)
• 1999: First person plural : my life as a multiple (20 reviews)
• 1999: Hidden selves : an exploration of multiple personality
• 1999: Minds in many pieces : revealing the spiritual side of multiple personality disorder
• 1999: Multiple journeys to one : spiritual stories of integrating from dissociative identity disorder
• 1999: Multiple selves, multiple voices : working with trauma, violation, and dissociation (2 reviews)
• 1999: My name is legion (1 review)
• 1999: Voices in the storm : a personal journey of recovery from mental illness
• 2000: Body scripture : a therapist's journal of recovery from multiple personality (1 review)
• 2000: Life after MPD
• 2000: Shared grave : therapists and clergy working together (1 review)
• 2000: Silver boat (4 reviews)
- 2000: Silver boat coloring book
- 2000: Stranger in the mirror, The: dissociation: the hidden epidemic (1 review)
- 2001: Big Marcia H (1 review)
- 2001: Dissociation of trauma: theory, phenomenology, and technique
- 2001: Dissociative identity disorder sourcebook, The (6 reviews)
- 2001: Myth of sanity, The: divided consciousness and the promise of awareness (3 reviews)
- 2001: Safe Eyes - A Story of Healing
- 2001: Treating dissociative identity disorder: the power of the collective heart
- 2002: A god called father: one woman's recovery from incest and multiple personality disorder
- 2002: Attachment, trauma and multiplicity: working with dissociative identity disorder
- 2002: From ghetto to glory: a memoir (1 review)