

PARADIGM LOST/PARADIGM REGAINED

The Second Coming of Dissociation

by

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Paradigm Lost/Paradigm Regained

The Second Coming of Dissociation

ABSTRACT

This thesis is a semiotic analysis of the two psychiatric paradigms of dissociation; nineteenth and twentieth century. The concept of dissociation evolved over several hundred years of philosophical discourse. Late in the nineteenth century the name dissociation was appropriated into psychiatric nosology. The psychiatric paradigm of dissociation developed, gathering both credibility and terminology, until it was eclipsed by the Freudian programme of blaming the victim.

After a hiatus of half a century, dissociation has resurfaced in both psychiatry and society. As it accumulates credibility and terminology, the new paradigm resembles the old one in many ways. A significant difference between the two is that the new paradigm is being deliberately and self-consciously constructed. As any scientific discourse manufactures its own truths with its language, we may, by considering the discourse, have access to the changing nature of those truths.

Since language both reflects and orchestrates perception, diagnostic terms should be indicative of a hegemonic programme. Ideological shifts within a paradigm are both depicted and precipitated by linguistic restructuring. Acceptance of the paradigm of dissociation by mainstream psychiatry requires and precipitates a major ideological adjustment, both in psychiatry and in society.

This work is dedicated to Anne Hardy, and all those with whom she shares the mind.

A promise kept.

I have more people to thank than can be mentioned here, an index in itself of my good fortune. Thank you, first, to Devorah Greenberg, who contributed organizational skills as well as time, attention, superlative editing, and apparently limitless moral support. I thank Persimmon Blackbridge and Janisse Browning for editorial commentary, Martha Royea and Janet Beggs for meticulous editing, and Yvonne Johnson for technological support.

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Preface

When I was seventeen years old my mother was locked up in a psychiatric hospital and given ECT (shock treatment). My father said it was to help her, and my mother said it was to punish her for showing her dissatisfaction with their partnership. Thus began my interest in psychiatry as an agent of social control.

The “model of man” propounded by biological psychiatry is a parochial medical approach to psychopathology, but has vast implications for other disciplines, most notably the social sciences. In addition, it has significant public health, legal, and political ramifications. In the course of pursuing its goals, biological psychiatry claims for itself a scientific status based on empirical research, so that its findings are beyond criticism from any other discipline. Accordingly, these findings can only be criticized, according to biological psychiatry, from inside biological psychiatry - that is, through new information provided by fresh research, innovations in methodology, and reviews or reevaluation of old data. The nature of knowledge in the field has disturbing elements of ontological solipsism.

Colin Ross

Introduction

At the turn of the twentieth century dissociative disorders were frequently diagnosed. Then they disappeared. They are back now, and this time they may become a cornerstone of mainstream psychiatry, resulting in revised studies of biological markers, family studies, legal criteria for criminal responsibility, and a wide range of research in mental health.¹

In the last fifteen years of Western psychiatry there has been an exponential increase in the diagnosis of dissociative disorders, particularly multiple personality disorder.² Professional literature, conferences, workshops, meetings, journals, newsletters, and professional organizations dedicated to the study of multiple personality and dissociation have proliferated. More clinical books on dissociation and multiple personality were published in the decade between 1980 and 1990 than all books on any other disorders since the beginning of the psychiatric industry.³

The rapid expansion of the dissociative disorders paradigm will have far-reaching social impact. “Dissociative” is already becoming a common word in non-clinical settings. By the turn of the twenty-first century it may become how we discuss our conduct, and how we come to think of our responses, and consequently, how we perceive

¹ Colin Ross. *Multiple Personality Disorder: Diagnosis, Clinical Features, and Treatment* (1989) Toronto and New York: John Wiley and Sons. PP. 310-311.

² When DSM IV came out in May, 1994, the diagnosis “Multiple Personality Disorder” had been renamed “Dissociative Identity Disorder.” Why and how this change in the nomenclature occurred - and what the psychiatric and societal implications of that change are will be addressed at length in this thesis.

³ This assertion was made in many public lectures given in Vancouver in 1993 by Dr. Marlene Hunter.

ourselves and each other.⁴ We may come to accept dissociative states as a common occurrence and eventually as common sense.⁵

The diagnosis of a dissociative disorder assumes a trauma-based etiology, which challenges current mainstream thinking in psychiatry. Presently Western psychiatry operates largely within a paradigm known simply as the medical model - unofficially known as the broken brain model - in which the diagnoses of mental illness assume biological causes, and treatments are pharmacological. The medical model has been gaining currency in North American psychiatry since John B. Watson published "Psychology as the Behaviourist Views It" in 1913. (Psychology was more comparable to psychiatry at the birth of behaviourism, in 1911, than it is now.)⁶ While the behaviourist school of psychology and the medical model in psychiatry have many points of theoretical divergence, they are also ideologically more like each other than either of them is like the competing model of psychiatry, the psychodynamic model - or psychoanalytic psychotherapy model (what Henri Ellenberger calls dynamic psychiatry) - as popularized in North America by Sigmund Freud.

Historically, the psychodynamic and behavioral points of view have dominated American thinking, says Nancy Andreason, while European thinking has always been predominantly biological or Kraepelinian. Dr. Andreason, a member of the Task Force on DSM-IV, is also author of *The Broken Brain: the Biological Revolution in Psychiatry*. As Andreason points out in her accessible book, which provides a lucid partisan explanation of the efficacy of the medical model of psychiatry: "Freud, Kraepelin, and Watson are the

⁴ Dissociation will enter mainstream thinking (and pop-psychology self-diagnosis) if it lasts as a diagnostic paradigm in mainstream psychiatry. This thesis predicts that both those events will occur.

⁵ There are five dissociative disorders. This essay will focus on Dissociative Identity Disorder (DID) formerly known as Multiple Personality Disorder (MPD), because the public psychiatric discourse on dissociative disorders does so.

⁶ Daniel Sperber points out that psychology is no longer a domain of research, but a family of such a domain, an institutional association of loosely related enterprises. Psychology now, Sperber laments, is less the name of a science than of a kind of university department) See Dan Sperber "Anthropology and Psychology: Towards an epidemiology of Representations" the Malinowski Memorial Lecture, 1984, in *Man* (N.S.) 20, 73-89. P. 9.

prototypes for three quite different points of view concerning the understanding and treatment of mental illness.”⁷

Although psychiatric allegiance in North America is steadily defecting to the medical model, Freud rather than Kraepelin, is still considered the Father of Psychiatry in the United States - and therefore Canada.⁸ There is some contradiction here, as Freud is the founder of the psychodynamic model, which advocates ‘the talking cure’ rather than drugs. Freud’s methodology and perspective were immediately well received when introduced to the United States in 1910. They steadfastly gained currency for the next three decades and by the 1940s, psychoanalysis dominated psychiatric thinking in America.⁹

Behavioural psychotherapy, which was introduced in 1911, is based on learning theory. Psychological conditions are perceived to be the result of maladaptive response patterns that have been learned, or that have been conditioned into a person.

Behaviourism endorses de-programming as a practical, logical, and scientific alternative to psychotherapy. Behaviourism, however, is psychology, rather than psychiatry. While Watson and the Behaviourist school deserve mention here as a major contributor to the present amalgam doctrine of contemporary psychiatry, they will not be followed up in the body of the thesis.

The Kraepelinian or biological or medical model reflects the view held in antiquity, that mental aberrations of any kind are directly linked to a physical condition. The contemporary pharmacology industry has a stake in this perspective, as the treatment modality for the medical model usually involves the ingestion of drugs. Market driven by the pharmacology industry, the medical model started gaining ground in the United States

⁷ Nancy C. Andreasen, *The Broken Brain: The Biological Revolution in Psychiatry* (1984) New York: Harper & Row. P. 19

⁸ While, at the writing of this thesis, the two countries’ methods of payment for medical services are different, the mainstream medical doctrine in each of them is largely the same. With a few pharmacological, and a very few surgical, exceptions, what is considered sound medical - and (therefore) psychiatric - practice in the United States is viewed identically in Canada. As Canadian medicine incorporates more of the principle of free enterprise into its dispensation of services, the inconsistencies in the two countries’ medical practice may correspondingly decline.

at the end of World War II. A side effect of the pharmacology industry's commodification of mental illness was an influential introduction, in America, of Kraepelinian biological psychiatry.

By the publication of DSM-I (the Diagnostic and Statistical Manual of Mental Disorders, First Edition) in 1952, the medical model had gained much ground. The development of chlorpromazine (Thorazine) as an antipsychotic drug in the 1950s precipitated a major shift in psychiatric treatment, away from psychotherapy and towards pharmacology. Published in the United States by the American Psychiatric Association, the DSM is translated into many languages, for use in countries around the world. However, another diagnostic manual competes with it. ICD, the International Classification of Diseases, published in Geneva by the World Health Organization is also translated into many languages for use in countries around the world. ICD is a diagnostic manual of physical diseases. One chapter covers psychiatric disorders.¹⁰

There have always been known discrepancies between DSM and ICD; in diagnostic criteria, the assessment of those criteria, and in treatment recommendations. However DSM-II (APA 1968) was based on the mental illness chapter of ICD-8, and reflects the medical model in its recommendations for chemical pharmaceutical corrections. DSM-II carries a warning about cross-cultural mis-diagnoses (perhaps to mitigate its European origins) as have all subsequent volumes. When ICD 9 was in progress, the American Psychiatric Association decided to publish DSM III because "there was some concern that the ICD-9 classification and glossary would not be suitable for use in the United States."¹¹ However, until the public challenge presented by trauma-based disorders, this debate about etiology and treatment has been contained within the professional clinical community.

⁹ This section - on the distinction in the streams of psychiatry - is indebted for information to Nancy C. Andreasen (1984) PP. 10 - 25.

¹⁰ One of the implications, in having a chapter on mental illness tucked into a book on physical illness, is that mental illness appears not to differ morphologically from physical illness.

¹¹ DSM III, American Psychiatric Association (1980), P. 2.

By the publication of DSM-III in 1980, the medical model so dominated the North American field that it had simply become the truth. North Americans are now expected to understand and accept as common knowledge (and common sense) that the major psychiatric illnesses are diseases: medical illnesses not essentially different from diabetes, hemophilia, or any other congenital "abnormality." Biochemical, neuroendocrine and structural brain abnormalities cause mental illness. Because they are considered somatic abnormalities, conditions diagnosed as mental illness are prescribed somatic therapies.¹² Somatic therapies include shock treatment and psychogenic drugs.¹³

The paradigm of dissociation - or trauma-based disorders paradigm - could in one respect be considered backlash against the neo-Kraepelinians. While it refutes the broken brain model, the dissociative paradigm acknowledges an hereditary predisposition to dissociative ability. The notion of congenital predisposition is consonant with the medical model. Bennett Braun, founder of the ISSMP&D introduced what he calls the 3-P model, which focuses on the predisposing, precipitating, and perpetuating factors that are associated with the development of MPD.¹⁴ This model recognizes programming, which is a cornerstone of behaviourist theory. However, treatment modalities in the trauma based disorders paradigm also endorse therapeutic intervention through pharmaceuticals, which is a cornerstone of the medical model.

The precise nature of any scientific problem is determined by the methods used in its solution. The definitive identification of that problem is determined by the language in which it is discussed. The paradigm of dissociation uses methods from all three streams: behaviourism, dynamic psychiatry, and the medical model. At the same time, it presents symptoms that none of the schools can (or will) recognize, and that all have claimed are the confabulations of malingerers.

The theoretical basis of the re-surfacing paradigm of dissociation contradicts the broken brain model, refuting the biochemical "proof" on which it is based. Consequently,

¹² See Nancy C. Andreasen (1984) *Op. Cit.* for a full discussion of this matter.

¹³ Somatic therapies also include massage, chiropractic and a number of other treatments for the body. However, this thesis focuses on the treatments prescribed by doctors, and likely administered by them.

the measurable, empirical facts of psychiatry are suddenly in danger of appearing to be a set of cultural variables. A discipline claiming to be a hard science cannot use cultural variables for the basis of its hypotheses.¹⁵

Quantitative physiochemical analysis may be analyzing the result, and not the cause, of the problem. For instance, a person who is afraid will produce a measurable amount of adrenaline and noradrenaline. However, while chemically suppressing the production of adrenaline and noradrenaline would not remove the source of the fear, it might very well remove its physical symptoms. It would also exonerate the therapist from the social responsibility of recognizing that there may be an external source of the fear. Additionally, it would benefit pharmaceutical companies. The medical model is not designed to acknowledge social reality - or social responsibility. It is a scientific juggernaut; a world unto itself: Science.

Or Pseudoscience, according to Colin Ross. A past president of the International Society for The Study of Multiple Personality and Dissociation (ISSMP&D, now the ISSD, the International Society for the Study of Dissociation,) Ross points out that

As a logic system, the conceptual system of biological psychiatry is organized in a fashion similar to the personality systems of patients with dissociative identity disorder. The tautologies, positive feedback loops, closure to alternative hypotheses, pervasive overgeneralization, use of dissociation to eliminate cognitive dissonance, and other structural and functional properties of the system maintain it in a dysfunctional homeostasis.¹⁶

Psychiatrists who specialize in the dissociative disorders routinely treat people who have anomalous and inconsistent responses to neuroleptic (and psychotropic) drugs, people who present symptoms which none of the major streams in psychiatry recognize.¹⁷ They routinely diagnose them as having conditions that the other streams say don't exist.

¹⁴ There are, according to Braun, predisposing, precipitating and perpetuating factors in the etiology of MPD.

¹⁵ This argument of cultural variables has also been extensively used to demonstrate that MPD is iatrogenic.

¹⁶ Colin Ross (1995) "Errors of Logic in Biological Psychiatry" in *Pseudoscience in Biological Psychiatry* (1995) Colin Ross and Alvin Pam. Toronto: John Wiley and Sons. P. 127

¹⁷ *Taber's Cyclopedic Medical Dictionary* defines "neuroleptic" drug as "medicines which produce symptoms resembling those of diseases of the nervous-system."

It is one thing to come up with a new hypothesis. How does a theory produce patients? According to the unbelievers, these patients' symptoms have been incorrectly interpreted. Self proclaimed debunkers claim iatrogenic illnesses; that the patients' symptoms are a response to their therapists' belief systems.

To its supporters, the paradigm of dissociation is the 'new psychiatric testament,' a whole much greater than the sum of its parts. To its detractors it is a sensationalist return to psychotherapy, a shying away from the medical model (a European influence) in a conservative clinging to a more naïve set of values (possibly perceived to be a more American set of values.)

Pioneers in the field of dissociation believe that the Freudians are in denial about the state of society, and therefore they cleave to the Electra Complex and fantasies of a daughter's unrequited love, rather than face the social reality of child sexual abuse. The Neo-Krapaelinians, seen through the cognitive filter of dissociation's partisan believers, are mechanistic reductionists, who are unable to envision a complex causality, and numbly accept monocausal triggers. There is much at stake in this dispute as accusations of professional chauvinism, narrow-mindedness, vested interest, and (worst of all) non-science fly back and forth. Battle lines and battlefronts can be identified in many places. Personification of the argument could be made by identifying Colin Ross and Nancy Andreason as captains of the opposing teams.

John Beahrs cautions:

We need to distinguish between basic existence and our beliefs about this existence. Experiences are simply internal phenomena, aspects of what is. Only beliefs are subject to factual judgment. Two errors are commonly made along this continuum of experiences and beliefs: 1) to overexplain the unexplainable, which can lead to psychosis or elaborate belief systems that few others can relate to; and 2) to confuse unexplainability with nonexistence, common in scientific practice at its highest levels.¹⁸

¹⁸ John O. Beahrs. *Limits of Scientific Psychiatry: The Role of Uncertainty in Mental Illness.* (1986) New York: Brunner/Mazel. P. 142.

The ‘new paradigm’ debate in psychiatry¹⁹ is, on the surface, about etiology; about whether psychological damage (mental deviation) is innate or imposed. However it is also very much about whether psychiatrists can learn not to ‘confuse unexplainability with nonexistence,’ whether psychiatrists can work with what cannot be empirically measured and still call themselves scientists. This complex question is further complicated by three factors. The first is the language in which it takes place.

I call the elite language of psychiatry Clinique. Like all languages, Clinique has an ideology built into the words. The etiology debate in psychiatry has many implications for what happens to children in our culture, but it is, for the most part, inaccessible to ordinary people. As might be said in Clinique, the secondary and tertiary implications of the etiology debate generate a number of biopsychosocial dilemmas. The matter of clinical language will be addressed at some length in chapters one and five.

Marilyn Frye points out that trying to discuss any social movement without considering both capitalism and patriarchy is like trying to explain why a marble stops rolling without considering both friction and gravity.²⁰ Psychiatry in North America is, arguably, a product of the congress of capitalism and patriarchy. Western psychiatry can exist in its present form only at this confluence of forces, where bourgeois ideas of freedom of individual choice make it appear that failure to assimilate the values of the marketplace and “succeed” reflects a personal, individual problem rather than a large scale political one. Developments in psychiatry surface in complex symbiosis with changes in society. The culture in which a condition is acknowledged impacts greatly on how that condition is diagnosed.²¹ Where psychiatry, as an aspect of biomedicine, fits into the structure of a culture’s institutions cannot be ignored.²² Psychiatry in North America has many roles. One of them is as a lucrative industry in the Marketplace.

¹⁹ The New Paradigm Debate can be summed up in the question: Do dissociative disorders exist?

²⁰ Marilyn Frye (1983) *The Politics of Reality: Essays in Feminist Theory* New York: Crossing Press.

²¹ The American diagnostic profile Schizophrenia for example, is pretty much identical to the English diagnostic profile for Depression.

²² While the Cartesian dualism that is foundational to Western medical doctrine standardly separates the mind from the body, and would, by extension, separate psychiatry from biomedicine, North American psychiatry has (successfully) remedicalized itself by becoming preoccupied with the biology of mental illness.

The framework on which we build identity is in flux. The revolution in psychiatry both reflects and precipitates that flux. Another way of saying this is that the new paradigm is both initiated by and resultant from the movement we call postmodernism. Postmodernism in its social sense is the recognition that many different voices have a right to be heard. The trauma-based paradigm in psychiatry clinically legitimizes voices previously unheard; those of women and children. The paradigm of dissociation is expanding faster than can be recorded in a paper that does not have daily updates. The continuing paradigm shift dates all material before it can be published.

My thesis is a small study of the psychiatric (r)evolution, in contemporary society, (back) to the paradigm of dissociation. The major research tool of the study is a semiotic analysis of the turning paradigm.²³ In other words, this thesis will examine the production of meanings, in the developing paradigm, and will consider how those meaning relate to other kinds of social production, and to social relations. My exploration contributes to the debate about the new paradigm from a position at the theoretical confluence of three perspectives. Semiotics is the first intellectual framework I employ, considering clinical psychiatric literature about dissociation, and the anecdotal commentary that ineluctably accompanies it from a semiotic perspective. Medical anthropology and its subsidiary, psychiatric anthropology, provide the second cognitive filter; through which I regard the epistemological tradition that defines psychiatric practice. That is, I assume that the practice of scientific psychiatry is imbued with historical and cultural biases, and that the production of psychiatric classification is affected by these biases. Reflection on a shifting psychiatric paradigm also requires a working understanding of power and privilege. While this study is not explicitly a feminist critique, feminist theory (the study of power) is the foundation that supports the other two.

Chapter I, Salvation Through Science, provides a brief historical overview of the construction of the self in relation to science in the periods designated romanticism, modernism, and postmodernism. It reflects on identity and self and the changing relation

²³ Semiotics is a perspective (or cognitive filter) in the way that science is a perspective. The Fontana Dictionary of Modern Thought defines semiotics as the study of patterned human behaviour in communication in all its modes. This thesis uses 'semiotics' in the context commonly employed by Umberto Eco. That is, in this thesis, a semiotic study is a consideration of the hidden structures in social relationships.

of self to society, and discusses how psychiatry both influences and is influenced by that societal development

The Importance of Language discusses linguistic relativity. It introduces the concept of semiotic lag, and some alternative words which have different semiotic and therefore ideological denotations.

Chapter II, Apostolic Psychiatry, discusses how psychiatry is and is not medicine, introducing the site of the major arguments about psychiatry. It reflects on how psychiatrists are deified, and how that social status is supported. Although psychiatry's authority is undermined by postmodern sensibilities, the apostolic halo of psychiatry is such that, as a society, we have not noticed the contradiction.

Chapter III, In the Beginning, recounts the first development of the paradigm of dissociation from its genesis in France in the late 19th century to its disappearance thirty years later.

Chapter IV, The Second Coming, picks up where Chapter 3 left off, and traces and discusses the trauma based paradigm from its preliminary re-appearance in 1954, to the present. The subsection **The New Psychiatric Testament** identifies the prophets of the new psychiatric order. The section **False Prophets** makes inquiries into ritual abuse and discusses various aspects of the backlash against recovered memories.

Chapter V, Epiphany, concludes the discussion, began in Chapter I, on the symbiotic relationship between psychiatry and society with some final observations on the maintenance of social order; and the implications of accepting the paradigm of dissociation.

We slide around in a shifting terminology whose treacherous instability is disguised by a certain metaphorical virtuosity.

E. P. Thompson

Chapter I

Salvation Through Science

This thesis is concerned with the (re)discovery of the paradigm of dissociation. A new paradigm in psychiatry is being (re)born.¹ Trauma based disorders were nearly “real” once before. They were first introduced in the late nineteenth and early twentieth century: by Jean-Martin Charcot; by Pierre Janet; by Morton Prince; by Sigmund Freud.² In the second decade of the twentieth century, (the diagnosis of) dissociative disorders faded away, eclipsed by clinical practitioners’ interest in experimental uses of the new technology that was originally designed to study them.³ Dissociation and MPD disappeared from medical literature, almost entirely, for nearly half a century. Dissociation, the diagnosis, disappeared. Dissociation, the condition, in all its manifestations, did not. People still dissociated, but their presenting symptoms were indicative of other diagnoses.

An influential article published in 1944 brought the subject of multiple personality - if not of the whole paradigm of dissociation - back into the psychiatric discourse.⁴ Ten years later, the diagnosis of multiple personality re-surfaced again, when doctors Corbett H. Thigpen and Hervey Cleckley published the case history that became *The Three Faces of Eve*. This case history of Chris Costner Sizemore is a forerunner to the return of the paradigm. A more significant clinical and anecdotal beginning was in 1973, with the publication of *Sybil*. Dissociative disorders came back into fashion,

¹ Psychiatry is not to be confused with psychology, or unlicensed counselling, both of which have some clinical practices in common with it. *Taber's Cyclopedic Medical Dictionary* (1979, 13th edition) defines psychiatry as “the branch of medicine which deals with the study, diagnosis, and prevention of mental illness.”

² Freud's recantation of trauma-based disorders is famous. His early work on incest has now been disinterred.

³ In 1907 William James employed a galvanometer and kymograph to measure galvanic changes in skin, testing response to emotionally laden stimuli in apparently neutral words. James was looking for neurological differences in different alter personalities. This was the introduction of the notion of physiologically determined differences in alters, and was a major step in the study of dissociative states. However, over the next few years, the skin tests themselves became of more interest than the search for the alter personalities that the tests were originally invented to find. A materialist perspective was gaining currency in psychiatry. What was dissociated was not available to be measured. Therefore the study of it was not science.

⁴ W. Taylor and M. Martin. “Multiple Personality.” *Journal of Abnormal and Social Psychology*. 49:135-151,1954.

accruing credibility, acquiring terminology, and, particularly in the last fifteen years, gaining momentum.

This time, the paradigm is being deliberately and self consciously constructed. The paradigm of dissociation resembles a grassroots movement, with theories constructed in the clinical front lines rather than in academia.⁵ Many clinicians, concerned that it will disappear again, write and lecture about what conditions are necessary to stabilize it. While she was president of the ISSMP&D in 1991, Catherine Fine wrote in the organization's newsletter that "historical extinction" is the risk for the field of dissociation that most concerns her:

A look at the evolution of the recognition of dissociative disorders and MPD in the medical, psychiatric, and psychological literature suggests that dissociation remains at risk. A relapse into anonymity for this category of mental illness can be prevented with variety of interventions.

Keep a historical perspective in mind and do not allow the past to repeat itself. Do not allow covert forces to divide us. Acknowledge the ebb and flow of diagnosis as years come and go; then put into writing and into the literature as much as possible.⁶

Opinions differ about why dissociation - both the diagnosis and the paradigm - disappeared last time. Colin Ross, former president of the International Society for the Study of Multiple Personality and Dissociation (now the International Society for the Study of Dissociation) and a charismatic and evangelical leader in the paradigm construction, says it collapsed for lack of scientific evidence.⁷ Judith Herman, an associate professor of psychiatry at the Harvard Medical School, and author of the influential book *Trauma and Recovery* (1992), says its dissolution was due to lack of a political context.⁸ It may also have been lost through lack of language, as both scientific evidence and political context require new words to discuss new concepts. This thesis explores all three of these notions and discusses how psychiatrists justify their business in

⁵ Frank Putnam. Plenary Session, ISSMP&D Convention. Chicago, November 9, 1990.

⁶ President's comments, ISSMP&D News. Volume 9, number 4. August 1991.

⁷ Dr. Ross has put a great deal of work into supplying scientific evidence, so that the same shortage does not occur again, and his hard work has paid off. The clinical statistics for dissociative disorders, says Dr. Ross, can really kick butt. ("Kick butt" Dr. Ross explained, is a new clinical term.) Presidential Address: Fourth Annual Spring Conference of the ISSD, May 4, Vancouver, B.C. May 6, 1994.

the face of current cultural norms. Contemporary norms are heavily influenced by the 'marketplace', a conceptual rather than geographical site where ideology is sold with products; or where products are sold with ideology.

What contributes to the development of a new paradigm? What influences its decline? Much depends on the environment; the society in which it emerges. With the notion that it helps in figuring out where something might go to know where it has been, this chapter sketches the previous environments in which psychiatry operated, beginning with the Romantic period, continuing on through Modern era, and culminating in the Postmodern era. It discusses how we construct (and deconstruct) both the paradigm and the self, and the (r)evolution of those constructions. It briefly considers the contribution of psychiatry to the construction of modern identity, and makes a few necessary remarks about the contribution of modern identity to the construction of psychiatry, and then reflects on the contribution of psychiatry to the (re)construction of postmodern identity.

The Construction of Identity in Relation to 'Science'

It is probable that in every language there are resources for self-reference and descriptions of reflexive thought, action, attitude but this is not at all the same as making 'self' into a noun, preceded by a definite or indefinite article, speaking of "the self" or "a" self. This reflects something important which is peculiar to our modern sense of agency.⁹

We are, in Western culture, preoccupied with a very sophisticated intellectual construct: the unique individual self.¹⁰ Social constructions of the self come into being by tacit common agreement. That is, we make certain ontological commitments to the system. Over time, those commitments change. The constitution of personal identity, and

⁸ Judith Herman *Trauma and Recovery*. New York: Basic Books. P. 9

⁹ Charles Taylor (1989) *Sources of the Self* Cambridge: Harvard University Press. P. 113.

¹⁰ I paraphrase Pamela White Hadas (who, it seems, paraphrased Johan Huizinga) for a definition of self as the spectacle of Homo Ludens, rather than the probity of Homo Sapiens. The narrator, whose narrative contains a true "I" (the "true" I being the one that can say with conviction "I am alive" or trust in its own vision "the emperor has no clothes.") is the unique, individual self: the subject. (1987) "Because It Hath No Bottom: Self, Narrative, and the Power to Die" in *The Book of the Self*. Young-Eisendrath and Hall (Eds.) New York: New York University Press.

our understanding of the social, moral and legal rights and obligations of an individual change, as does the location of the dividing line between social adaptation and pathology.

If, as Benjamin Whorf maintained,¹¹ each culture creates its own world using language as the vehicle, western languages, with their subject/object/verb frame tend to create self as object as much as they create external people and phenomena as object. It is also possible to create the self as subject. The two creations of self; as subject and as object, are different aspects of being: the self created as object is the physical self, the body, and the self created as subject is the intellectual self; the mind. It is therefore possible to say “I and my body” and “I and my mind.” By “tautologies, positive feedback loops, closure to alternative hypotheses, pervasive overgeneralization, and use of dissociation to eliminate cognitive dissonance”, Western culture has developed a very concretized notion of what a self is.¹² Despite recognizing ourselves as the makers of narrative, despite constant striving towards an objective of ever-increasing agency, we habitually refer externally to the self as a static object, rather than a process in motion, a continually recreated subjective fiction.

The concept of the individual, of the central self, has become (socially endorsed) reality over the last hundred and fifty years. Prior to the eighteenth century Western people tended to define themselves more by their functions and categories - religion, family, class, occupation - and less by the accumulation of their opinions.¹³ Another way of describing this is that since the eighteenth century, an “I” has emerged as the central figure in each individual’s narrative. The struggle to establish a continuous and coherent account of personal identity over time has become a significant aspect of contemporary life in our culture.¹⁴

¹¹ Benjamin Whorf. (1964) *Language, Thought and Reality*. Cambridge: The M.I.T. Press.

¹² This string of symptoms was used by Colin Ross in a different context. The full quotation is on page 12 of this thesis. Colin Ross (1995) “Errors of Logic in Biological Psychiatry” in *Pseudoscience in Biological Psychiatry* (1995) Colin Ross and Alvin Pam. Toronto: John Wiley and Sons. P. 127

¹³ See Gergen (1991), and Lyons, (1978) for more on this matter. This paper concurs with Gergen on this and many other issues.

¹⁴ This is a paraphrase of Polly Young-Eisendrath. (1987) Op. Cit. P. 67.

In the last century and a half, the construction of personal identities has gone through three distinct fashions, reflecting and reflected by the eras of Romanticism, Modernism, and Postmodernism. We have metamorphosed from indexical selfhood, constructed by our circumstances, to referential selfhood, in which the construction is more individualistic and autonomous.¹⁵ As we enter the postmodern era, notes Kenneth Gergen, all previous beliefs about the self are jeopardized, as are the patterns of action they sustain.¹⁶

The Romantic self might also be called simply the socially constructed self. The Modern self might be called the socially deconstructed self. The Postmodern self, in that case, identity hybrid that it is, would be the reconstructed deconstruction of the self, that is, the socially reconstructed, personally deconstructed self. Or is it the other way around?

This jeopardization of belief is standard in any paradigm shift. Because of the complex symbiosis between psychiatry and society, a serious discussion of a paradigm shift in psychiatry requires paying attention to any concurrent transformations in society.¹⁷ Kenneth Gergen's theory of conventions of warrant is helpful in the exploration of these issues.¹⁸ Gergen argues that the mental world, one's self-identity, becomes elaborated as various interest groups within the culture seek to warrant, or justify, their accounts of the world. Whose account is accepted as (most) true, or to use Gergen's terminology, who is granted a warranting voice, creates (for a while) the hegemony of world construction. The relationship between psychological mechanisms and social institutions is symbiotic.¹⁹

¹⁵ See Hope Landrine "Clinical Implications of Cultural Differences: the referential versus the indexical self" in *Clinical Psychology Review*, 1992, Volume 12, PP. 401-415, for a fuller discussion of this matter.

¹⁶ Kenneth Gergen *The Saturated Self* (1991) New York: Basic Books.

¹⁷ Speculation on whether the societal and psychiatric paradigm shifts are causal or simply covariant will surface throughout this thesis.

¹⁸ Kenneth Gergen "Warranting Voice and the Elaboration of the Self" in *Texts of Identity* (1990) London: Sage Publications.

¹⁹ See Jorge Larrain *The Concept of Ideology* (1979) Athens: The University of Georgia Press, pp. 83-91 for an elaboration of this relationship.

What a person accepts as normal influences how that person will strive to construct her identity in order to fit in (or not.).²⁰ We have, as members of a society, knowledge structures called schemas, that organize and simplify the constant information overload with which we are inundated. We rely on various types of schemas to help us to make sense of our experiences. They are our personal frameworks on which we organize social rules. Having the cognitive structures of the schema in place means that we can follow many of these rules without thinking about them. Some of us can and do follow the social rules without challenging, analyzing, or even thinking about them. That unexamined acquiescence constructs us as normal.²¹ What persuades a person to follow the rules or not is complex: how a person is influenced changes her self-construction, and the nature of her self-construction changes how a person is influenced. There are many choices. Gergen notes:

Given a range of competing constructions, and sufficient stakes in the outcomes, there may be brisk competition over whose voice is honored. Whose voice prevails in a sea of alternatives may be critical to the fate of the person, relationships, family life, community, and in a significant sense to the future of humanity.²²

We can see, in the last two hundred years of Western Culture, the changes in the warranting conventions (which in turn establish the cognitive filters through which we view the world.) We can see the evidence of those hegemonies in how we construct our selves.

The Romantic Self

The vicissitudes of dynamic psychiatry during the nineteenth century may be regarded as manifestations of the struggle between the Enlightenment (which stressed the cult of reason and of society), and Romanticism (which emphasized the cult of the irrational and of the individual).²³

²⁰ When sex-specific pronouns are required, and when they do not refer to a particular individual, this thesis will shift back and forth randomly between “she, her, and hers” and “he, him, and his”.

²¹ This is my interpretation of Thomas Scheff’s explanation of normality. See *Being Mentally Ill: a sociological theory* (1966) New York: Aldine Publishing Company, PP. 30-35 for the original description.

²² Kenneth Gergen (1990), *Op. Cit.* P. 73.

²³ Henri Ellenberger *The Discovery of the Unconscious.* (1970) New York: Basic Books P. 245. Ellenberger is also the main source from which information in the section on Romanticism is extrapolated. PP 199-205.

Romanticism is thought to have had its genesis in Germany in the late eighteenth century, spreading to France in the early nineteenth century, then to the rest of Europe, and finally crossing the Atlantic to the Americas. Romanticism was a social and political movement as well as a 'synthesizing temper' that transformed the character of art, sensibility, thought and self-perception. People were externally referenced, externally defined. *Who* they were was more determined by *what* they were as opposed to the postmodern method of defining *what* people are on the basis of *who* they are.²⁴

The Romanticists' world was natural: he believed that Nature had fundamental secrets, some of which could be discovered in the human soul. Discovering these secrets was part of attaining one's true essence. It was thought that a person unfolded, like a flower, revealing a central core that both supported and was protected by the outer petals. Individuals had an essence. So did nations and cultures, and the discovery - and celebration - of national essence was considered necessary to an authentic understanding of the constitution of individual citizens of a country.

The morality of the era can be characterized by the word 'must.'²⁵ The individual had deep feelings, and those feelings were of primary importance. Feelings were the glue that held the rest of the person together. (Feelings were also what drove spirits back into human bodies to coexist with the human host.) Both in the person and in the world, it was generally acknowledged that the whole (person, guild, community, nation...) was immeasurably greater than the sum of the parts.

The Romantic self was conceived to be a solid, unfragmented, coherent personality characterized by personal depth, passions, creativity, moral fibre and some evidence of a soul.²⁶ The Romantic lived with the daily expectation of miracles, produced by God, by angels, and possibly by a person in love. Sometimes miracles were produced

²⁴ An example of this is that eccentric wealthy people are eccentric, and eccentric poor people are crazy. Another example is that fat men are 'big' and bigness, for a man, is positive. Fat women are 'fat' and fatness, for a woman, is constructed as negative. In both of these examples, the assessment varies, not depending on the presenting symptoms, but on the person who is presenting them. (How such social constructions influence clinical assessments is addressed in the next chapter.)

²⁵ In the Romantic Era, an obsession was more likely to be seen as admirable than it is today. In the contemporary psychiatric purview, an obsession is the uncontrollable desire to dwell on an idea, or an emotion, or to perform a specific act is often considered a neurosis and/or a disorder.

²⁶ Kenneth Gergen (1991) *The Saturated Self*. New York: Basic Books. P. 20.

by an exorcist.²⁷ A person with a diseased brain could be instantaneously healed by a miracle, and one never knew when that might happen. In the common parlance of the time a brain disease had two possible etiologies: *Somatiker*, a physical cause, and *Psychiker*, an emotional one²⁸. Emotional illnesses were common. After about 1840, however, *Psychiker* was steadily (in a pattern of three steps forward, one step back) replaced by *Somatiker*, a sign of the usurpation of Romanticism by Modernism.

The Modern Self

There is much contention about when the era of Modernism started and ended. In the context of this discussion about the symbiosis between psychiatry and society, the Modern Period started in 1880, because in 1880, psychiatry was recognized as official medicine.²⁹ Modernism is dominated - in every possible sense of the word - by science and technology. Newly emerging 'scientists' established the Modernist conventions of warrant. The warranting voice was in every instance one of logic. Binary logic (true/false), was accepted as common sense. Any violation of this binary cognition and binary classification was suspect. Ambiguity and anomaly were incoherent and unacceptable, as they could disrupt the carefully constructed and impeccably orchestrated social order. The reductionist attitude that promotes this simplistic true/false equation is one of the basic ideological constructs of modernist society. The normative reductionist perspective reinforces that modernity is the best of all possible worlds.

The Modernist self³⁰ is characterized by the ability to reason, to have beliefs, opinions, and conscious intentions. The modernist personality inhabits the Modernist world, a place of reason, rationality, and commitment to the grand narrative of progress.

²⁷ Father Johann Joseph Gassner, a Catholic priest in the town of Ellwangen, in Württemberg was the most famous exorcist of his time. From about 1765 to 1775, he performed 'miraculous' exorcisms regularly. In 1775, Franz Anton Mesmer duplicated the miraculous exorcisms through a quasi-medical procedure called Animal Magnetism. While the same results ensued, exorcism was considered a miracle, and animal magnetism was not. Miracles were possible, but they were not produced by psychiatry.

²⁸ Ellenberger (1970) Op. Cit. P. 284.

²⁹ Ellenberger (1970) Op. Cit. P. 245.

³⁰ Charles Taylor argues that there were two versions of the modernist self, established by two, classbound, ethical outlooks. The bourgeois valued order, peace, and commodities. The working class valued virtuous citizenry and the willingness to fight for one's country. These complementary systems, note Taylor, are the prerequisite conditions for the birth of political economy. See *The Making of the Modern Self*. 1989. Cambridge University Press. pp. 285-6.

Essential truths can be achieved through the proper scientific approach. Science can provide everything, including ontological security and ultimate salvation. Science was grounded in the new notion that society was a self-regulating system.

Modernist psychiatry, therefore, regarded the human as an internally animated, organic machine. The mind was considered part of that machine: it could be quantified and measured and harnessed, if only its essential properties could be discovered.³¹ The individual, as a sum of parts, was a microcosm for the society, a sum of those individuals. The society was a structurally functional machine. Individuals, by their constancy of conduct, contributed to the reliability of that larger social mechanism. The machine functioned. Form, ideally, followed that function.

The morality of modernism could have been characterized by the word "should." One *should* strive to have certain values. One *should* present oneself in the world in a particular way, so that the society can also be as it should.³² If one could not present himself as he should, the cause was attributed to some sort of brain disease. In the Romantic era, by contrast, the cause might have been determined as spirit possession. An afflicted person would be sent to a religious practitioner. In the Modern era, a person was ill, and was sent to a medical practitioner.

In a kind of backlash response (a throwback to Romanticism) a new field, called *Hirnmythologie* (brain mythology) came into temporary being.³³ *Hyrnmythologie* was eclipsed by Emil Kraepelin's introduction of psychiatric nosology.³⁴ *Psychiker* came briefly back into fashion, and was soon replaced, again, by *Somatiker*. The psychiatrist (at that time called the alienist) had become a scientist, and his diagnosis, and proffered etiology, if there was one, was not to be argued with.³⁵ While hypnotism (though in decline) was still popular, it was practiced less by clergy and more by medical

³¹ In contemporary metaphor, the brain - and by some "logical" extension the mind - was thought to be a kind of computer: thoughts were software; references were made to how the nervous system was "hardwired". While the software differed individually, it was assumed that the hardware, from one person to the next, was essentially the same, and if it were programmed the same, it would function the same.

³² One might say that in the way that Romantic society was addicted to love, Modern society was addicted to electricity.

³³ Arguably, *Hirnmythologie* has been reintroduced in the 20th century. (More here about FMS)

³⁴ Kraepelin formulated *dementia praecox*, which was later renamed schizophrenia.

practitioners. Correspondingly, whatever surfaced in hypnotized subjects was less likely to be seen as a spirit and more likely to be seen as evidence of a pathology. As non-material, non-demonstrable mechanisms for human behaviour began to fall out of fashion again, the use of hypnotism in any context became dubious.

At the turn of the century, the concept of determinism was gaining momentum. Freud assisted its rise in psychiatry by striving to make the unconscious conscious, so that the entropic forces of the subconscious could be subdued by the rational mind.³⁶ Behaviourism gained currency. In 1910 Freud gave a series of lectures to an audience of physicians and psychologists in Boston, Massachusetts, introducing psychoanalysis and explaining patterns in human behaviour to intensely interested audiences. Freud's influence grew steadily in the U.S., and psychoanalytic institutes were created around the country over the next thirty years. Experimenting with consciousness, rather than tissue like some of his now-famous contemporaries (Broca, Wernicke, Golgi for example) Freud had discovered certain developmental patterns, and his proffered etiology for these patterns was early childhood trauma; specifically sexual abuse.³⁷

Accounts of what happened next conflict, except for the historical fact that Freud had stopped using hypnosis in 1892 and had repudiated his *Aetiology of Hysteria* in 1898. Perhaps, as Judith Herman explains, Freud had backed away from incest because he could not single-handedly undo the ontological closure towards the unrecognized reality of women's lives.³⁸ To ally himself with the nascent feminist movement was unthinkable for

³⁵ Nineteenth century psychiatrists were not only all men, the ethnobiologically essentialist mindset of the time made it likely that they were white men of German descent. All sex-specific pronouns referring to them, then, are male.

³⁶ Eugene Bliss (1986) *Multiple Personality, Allied Disorders, and Hypnosis* New York: Oxford University Press p. 42.

³⁷ Nancy Andreason offers a synopsis: "Freud desperately wanted to share in this exciting research,[neuroscience] and to obtain a university position that would permit him to explore the brain sciences. He was prevented by anti-Semitism and lack of independent means. His Jewishness made an academic appointment unlikely, and his need to earn a living and support a family drove him into private practice....Once in private practice, with the technology of the university closed to him, Freud applied his curiosity about the working of the human brain to understanding the maladies that his patients experienced." (Nancy Andreason, 1985) *Op. Cit.* PP. 12-13.

³⁸ He retained the sofa, however, and continued to have his patients lie down, as he had become comfortable with the postures - and perhaps with the power structure - of a supine patient and an erect doctor.

a man of Freud's political beliefs and professional values.³⁹ By the time he came to America Freud's etiology of hysteria absolutely exonerated any putative perpetrators.

Freud's inquiries into the sexual fantasies of children were received as a happy alternative to the newly emergent trauma-based paradigm. The study of women's and children's sexual oppression began to lose its political support. Without the political support, the scientific support immediately waned as practitioners were leery of financially jeopardizing themselves by continuing to research an area considered dubious. By 1915, scientific materialism (a triumph of modernism) was at its peak.

The Postmodern Self

Postmodernism's appeal is broad and varied, and difficult to identify. Part of its magic is that its open-endedness and lack of specific definition is at once attractive to the affluent, the desperate, and the disillusioned of this world.⁴⁰

Postmodernism can perhaps be best characterized by its absences. Postmodernism has no criteria of what one should be, strive to be, or do, to rectify not being any one particular thing.

Progress in the Modern sense brought us into the 'delirious pluralism of the marketplace.'⁴¹ The Modern structural logic of binary existence yes/no; (it exists or it doesn't, it's right or it's wrong), started to be replaced with either/or. Derrida introduced to this logic of identity the Postmodern logic⁴² of the supplement: both/and.⁴³

The notion of Postmodernism infers a whole range of material conditions that are no longer consonant with the dominant rationality of modernism and its technological commitment to finding solutions in every sphere of social and cultural life. Postmodern sensibilities revive the vestiges of personal revolutions in self-liberation and communal participation initiated by the countercultural movements of the sixties. Postmodern

³⁹ Judith Herman. (1992)*Trauma and Recovery*. New York: Basic Books. P. 18.

⁴⁰ Pauline Marie Rosenau (1992) *Postmodernism and the Social Sciences*. Princeton: Princeton University Press. P.11.

⁴¹ Stuart Ewen (1988) *The Politics of Style in Contemporary Culture*. New York: Basic Books.

⁴² "Postmodern logic" may be an oxymoron.

⁴³ Edward Sampson (1990) "The Deconstruction of Self" in Schotter and Gergen. *Texts of Identity*. London: Sage Publications. P. 20.

refutation of a single subject in the centre of a discourse is a response to the dramatic, postwar restructuring of capitalism in the West and in the multinational global economy. The Postmodern society is constantly rocked by the everyday effects of the new media and communication technology, which, in turn has contributed. to a great redistribution of power, population, and wealth that has accompanied new structures of commodity production. ⁴⁴

While opinions clash on when the Modern period ended and the Postmodern Period began, there is agreement on there being a period of overlap. How much overlap depends on the discipline, and even within disciplines is a source of conflict. In the context of the symbiosis between psychiatry and society, I trace the beginning of the Postmodern period to 1957 when Thigpen and Cleckley published *The Three Faces of Eve*, a popularized case study they had previously published in 1954. Although neither the case study nor the book made much impact on the public at the time, the conjunction of a case-study of a woman diagnosed with multiple personalities, and a popular book about her by the same author is very much a harbinger of the new paradigm. Employing Modernist logic that any 'real' phenomena or state can be measured, Thigpen and Cleckley had tried to document differences among "Eve's"(Chris Costner Sizemore's) three personality states using electroencephalogram (EEG)⁴⁵. They reported a measurable difference in muscle tension between the three states, and acknowledged them as three discrete personalities housed in one body.⁴⁶The notion of three personalities housed in one body is not consonant with the logical and mechanistic modernist world.⁴⁷ As the boundaries of perception are largely created by the limits of belief, the discovery of these other, alter(nate) personalities was both a symptom and a cause of the coming of the new age.

⁴⁴ Andrew Ross. (1988) in *Universal Abandon? The Politics of Postmodernism* Minneapolis: University of Minnesota. P.10.

⁴⁵ True to Modernist sensibilities, science and technology dominated all branches of medicine, including psychiatry.

⁴⁶ Frank Putnam. (1989) The Scientific Investigation of MPD in. *Split Minds Split Brains* Jacques Quen, editor New York: New York University Press. P. 111.

⁴⁷ As a religious theme, the three-in-one notion had enough momentum to carry itself through the modernist period, although within that time there were some very strong philosophical objections. I think that the idea of Sizemore's multiplicity was acceptable because it was introduced as three-in-one. In the actual clinical record, Sizemore was documented as having sixteen personalities.

George Bernard Shaw said that it is not reasonable to wish to change your society, and therefore, all social change is brought about by unreasonable people. Perhaps why Shaw thought the desire for change unreasonable is because change has to start somewhere, and those on the forefront of it are routinely ostracized.

One of the important social rules of our society is that we desire uniformity. Difference is not neutral. Depending on the milieu, differences are seen as crimes, sins, or diseases. Diseases - or clinical pathologies - are diagnosed when ordinary conduct, or 'normal' presentation of self is taken to an extreme. Seeming like a different person, depending on the situation can be considered good social adaptability. Further down the continuum it may be considered excessively moody. Further still, it could be diagnosed as a personality disorder. The reverse perspective, then, is that any pathology, when backed down its continuum, becomes normal (ordinary) conduct. If multiple personality, as a clinical diagnosis, is a pathology, then some less extreme version may appear as 'normal.' In the Postmodern world fragmentation may be normal. It is normal to have different presentations of self in different circumstances.

In 1959 Irving Goffman published *The Presentation of Self in Everyday Life*, introducing the idea that people present different aspects of themselves in different situations. The external situation governs which aspect is presented. In ordinary life, different aspects - or fragments - of the self are employed in different situations. Wetherell and Potter endorse the notion that the self is a social product:

"People are not 'natural' characters, they are performers capable of dissembling. The individual is fragmented into a multiple set of possibly discordant identities; insincerity arises from being aware of the requirements of society."⁴⁸

We all experience this self-inconsistency. We are all "different people" at different times and places. The matrix of people, culture, and society within which the self is situated is not a static entity. Neither is it a completely stable one.⁴⁹ The self is routinely divided: mind/body, thoughts/feelings. Social functions are fragmented. The contextual is

⁴⁸ Margaret Wetherell and Jonathan Potter "Narrative Characters and Accounting for Violence" in *Texts of Identity* Shotter and Gergen, eds. (1990). p. 207.

⁴⁹ Colin Ross (1989) notes that the history of Western civilization contains a fundamental theme of dissociation.

no longer so separate from the fragment that it produced. The person, the self (I), is not the centre of the universe - and that person, self (I), cannot ignore the shift. Sampson notes:

"Person has been decentered by its relationship to the symbolic order. The relationship is the centre. This symbolic order is governed by the endless process of [Derridian] differance [. So that the identity of the person is established, not internally, but by fixing the place of the person in the culturally constituted symbolic order."⁵⁰

We don't know how to describe ourselves, either to ourselves or to each other. In the modern(ist) world, the inability to describe ourselves was viewed as an intellectual - and possibly psychological - problem. In the postmodern world, it is one of the few conditions that can be possibly characterized as "normal."

In *Unity and Multiplicity* John Beahrs (1982) concludes from his research that every person is a "multiplicity, rather than a unity." Beahrs, a psychiatrist and hypnotherapist, uses a "conductor-orchestra" model for human consciousness:

Like the overall Self, the orchestra is a complex whole with a personality of its own. Like any multicellular organism or social group, it is composed of many component parts or orchestra members, each with its own sense of identity and unique personality, but all of which function together in a coordinated cooperative endeavour to the advantage not only of the whole, but of all the parts.⁵¹

No assumption of unification of identity is made in a postmodern society. Each person is considered to be made up of myriad parts, each part moving, so to speak, to a different orchestration. In order to function, then, we each systematically disengage - or dissociate - whatever parts of ourselves are not relevant to the task at hand. In terms of Beahrs' analogy, while we are playing a particular instrument, or engaged in a particular task, we each dissociate the music for the other parts, so that we can focus on the task at hand. Because the word dissociate already exists as a clinical term with pathological implications, I will use dyssociate (dyssociate, like dysfunction) to describe the non-

⁵⁰ Sampson, in Shotter and Gergen. Op. Cit. p. 14.

⁵¹ John O. Beahrs (1982) *Unity and Multiplicity* New York: Brunner/Mazel. P. 7

pathological (that is, undiagnosed) kind of activity.⁵² The dyssociated self, then is only part of the person, with the cognitive capacity of the whole person, and the operational knowledge base of the part appropriate to the situation at hand. We are, in contemporary parlance, all dyssociated. We have to be, to be able to function in our fragmented society.

Behrs continues:

While the music is made entirely by the composite of parts, which transcends being a mere algebraic sum, it is held together and organized by the leadership of an executive, the conductor. Although s/he makes none of the actual music, the conductor is in charge - at one level a fundamental paradox, at another simple commonsense knowledge available to all of us.⁵³

The dyssociated fragments operate almost autonomously in their separate circumstances. A person may have five or six presentations of self depending on the situation: work at job 1; work at job 2 (consulting); home 1, with the ex-partner and the child; home 2, with the current partner and the partner's child; out with friends from the previous job; on a weekend with the parents; dinner with the parents of the current partner. The different selves may span different classes, different sexual orientations, different values.⁵⁴ Influenced intellectually and morally by entirely too many sources of input, none of which has, anymore, a warranting voice⁵⁵ that subsumes all the others, we split ourselves up to accommodate as many of them as possible. The idea of a single, continuous (correct) way to be, act, think, is an anachronism, a holdover from the Modern Era. Without a stable, constant self, there cannot be a single proper choice.

Ways of proceeding that had seemed natural, such as following rules, lose their authenticity. What convention of warrant established these rules? What part of the person is assenting to them? In our hypochondriac culture, we are in the habit of paying close

⁵² In *The Absent Body* Drew Leder makes a distinction between the disappearing body and the dysappearing body. (PP. 83-99) My usage here of dyssociate is similar but not the same as Leder's use of dysappear.

⁵³ John Behrs (1982) Op. Cit. P. 7.

⁵⁴ Paraphrased from Kenneth Gergen. (1991) Op. Cit. P. 180-183.

⁵⁵ Kenneth Gergen (1990) "Warranting Voice and the Elaboration of the Self" PP. 70 - 81 in *Texts of Identity*. Shotter and Gergen, 1990. Gergen explains that certain voices, as reconstructed by our own subconsciousness, have warrant, or authority. We accept what those voices say as truth. Whose voice has warrant: that is, who one recognizes in the world as speaking with authority and telling the truth, changes. Gergen calls this the conventions of warrant. In the modern era, the warranting voice, by convention, was Science.

attention to our phenomenological states.⁵⁶ For the dyssociated self, such attention is merely confusing. Which part should pay attention to what? The utterance of "I" may no longer be a moral act. It no longer asserts any consistent relationship to the universe. We have compartmentalized ourselves. As compartmentalized, conglomerate collages, we are no longer committed to any single utterance. It is not that the self is no longer the centre, but that it never was, and it now has the opportunity to realize this.

One of the tenets of postmodernism is that the label of science is no longer enough to make something true. Good evidence, valid proof, even the reasonableness of a hypothesis depends on the cognitive filter through which one is looking. What is objectively true depends on who is asking - and answering - the question, and the context in which the communication is taking place. We see it when we believe it.

If we no longer know what we believe, what do we perceive? Is there an ultimate reality under this patchwork cloak of Hyperreality? What if we no longer believe in "underneath?" Like that tree that falls in the forest with no-one to hear it, if no-one believes in "underneath" and no-one perceives it, does underneath still exist? Did it ever?

While this confusion about who we are, and what we are to think, feel, want, perceive, is not new, there used to be both less sources of input, and less apparent aspects of the self to target. Now, with new developments in technology, the bombardment of contradictory perspectives is relentless. There are many possible sources of relief from the constant demands for us to make choices, including alcohol and both recreational and prescription drugs. However, a simple and reliable source of relief may be deliberate compartmentalization.

The parts take shifts. Each dyssociated part can be made more comfortable by discouraging comparisons of information among the fragments, and by not thinking about the other parts. While dyssociated, it is not rational for this fragment to view the rest of the self, as it would undermine the purpose of the dyssociation. However, as the multiplicitous demands of the postmodern world continues, the cognitive part of each self

⁵⁶ See "Language Games and Texts of Identity" by Rom Harre in *Texts of Identity* Shotter and Gergen, 1990. (Op. Cit.) P. 22

develops its own parameter. With so many parts, so many options, what determines the 'true' self? Truth is relative. Alternate truths are, it seems, always available.

If we subscribe to the hermeneutic perspective that all understanding is interpretive, and reflect on how we construct our selves out of the necessity of our circumstances, we may have difficulty identifying an authentic self. Eisendrath and Hall concur:

A more skeptical approach to the study of self is to assume that self is essentially a construction or reflection, not a coherent experience of unity or continuity....The self may be a project of deception, a masking of discontinuity and disintegration. The "self" could then be interpreted as a facade, a construction based on language, a cultural point of view of human life, expressing a desire for unity in the face of dissolution and death. From what does the desire arise?⁵⁷

In the Modern world, people were considered 'sane' if their personal narratives were consonant with the metanarrative. People whose stories were not represented in the metanarrative were labeled disordered, if they officially existed at all. In the Postmodern world, the very constitution of which narrative is the metanarrative depends on one's perspective. How, then, can one tell if her personal narrative is consonant?⁵⁸ While we may agree that the warranting voices have been established only by convention, and that the basis for that warrant was spurious, without any kind of conventions to establish warrant, we have no way to determine any kind of hierarchy of truth.

Conventions of warrant establish who has the most authority, whose truth has priority, whose perceptions will be taken to reflect reality. Whose voice has authority in the Postmodern era? Is the voice of authority identified because it belongs to an individual? Or to a person in a particular position? Have we returned to the old means of identity: you are your profession? Who do we listen to? Doctors? Lawyers? Athletes? Musicians? Film stars? Economists? Psychiatrists? Clergy? Each other? Family and friends? Ourselves? All these voices together? Can we realistically hope to make any sense at all out of the cacophony? In multiple selves, can we still have a concept of

⁵⁷ Polly Young-Eisendrath and James A. Hall (eds.) (1987). *The Book of the Self* New York and London: New York University Press. P. 6

⁵⁸ This dilemma is not new. The original Mazoretic text of the Old Testament of the Bible reads "In a beginning there was the Word" Myriad possibilities, and their ideologies, were lost in the translation to an English version, which read "In the beginning") In new reprintings, concurrent with the present ideology, the original statement may be restored.

agency, or is agency assigned only to the 'real' self? Perhaps the concept of a real self is not a psychological problem but a logometric one.

Rose observes:

Persons are ephemeral, shifting; they change before one's eyes and are hard to perceive in any stable manner. The act of scientific observation - in the laboratory, in the clinic, in the consulting room or the psychoanalyst's office - makes the individual stable through constructing a perceptual system, a way of rendering the mobile and confusing manifold of the sensible into a cognizable field. And in this process of scientific perception the phenomenal world is normalized - that is to say, is thought of in terms of its coincidences and differences from values deemed normal - in the very process of making it visible to science.⁵⁹

The purported function of psychiatry is to make one's narrative coherent, so that it will fit within the boundaries of the established social order. As the dominant paradigm in psychiatry is the bio-medical model, a coherent narrative is, by definition, one that endorses the medical model as correct. Stephany Borges sees a secondary agenda operating here, in that "psychiatry in this way maintains the rational control of the individual under the rubric of caring and protection while perpetuating the dominant ideology of salvation through science."⁶⁰

What if one's narrative resists coherency? What if one can't sort out one's selves, because one cannot determine which kind of dissociated one is? It is increasingly common for a person to be unable to meet the basic standards for truth within a hermeneutic account of the self - unification, stability and acceptability. For the Postmodern self in the Postmodern society, this may not a problem; it may be simply a condition.⁶¹ As Erikson explains:

The patient of today suffers most under the problem of what he should believe in and who he should--or, indeed, might--be or become; while the

59 Nikolas Rose "Individualizing Psychology" in *Texts of Identity* Op. Cit. p. 124.

60 Borges, Stephany. "A Feminist Critique of Scientific Ideology" *Discourse and Institutional Authority: Medicine, Education, and Law*, Norwood: Ablex, 1986.

61 If something has a solution, it is a problem. If it has no solution, it is not a problem; it is a condition - or a conundrum.

patient of early psychoanalysis suffered most under inhibitions which prevented him from being what and he thought he knew he was.⁶²

It is remarkable that psychiatry can function at all in a postmodern society. Psychiatry depends for its social effectiveness on the warranting conventions that recognize it as a science, as medicine, and as participating in the practice of healing individuals. Effective psychiatry depends on transference, “the mental process whereby a person transfers patterns of feelings and behaviour which had previously been experienced with important figures such as parents or siblings to another person.”⁶³ In order for transference to work, the psychiatrist must be seen both as someone who can be absolutely trusted, and at the same time as an authority figure. We have no reason to assume that the convention in which psychiatrists are figures of absolute authority, who somehow work in the simultaneous interests of both the patient and the state will - or can - continue to have warrant. Presently, psychiatrists still speak in the voice of authority. Some of that authority comes from the specific words they construct.

The Importance of Language

As psychiatrists and psychologists try to explain undesirable behaviour, they generate a technical vocabulary of deficit. This language is slowly disseminated to the public at large, so that they too can become conscious of mental-health issues. As people acquire the vocabulary, they also come to see self and others in those terms. They judge themselves and others as superior or inferior, as worthy or not of admiration or commitment.⁶⁴

Terms that psychiatrists use to describe states of mental illness - and mental health - have radically changed in the last thirty years. The developments of new paradigms in psychiatry can be monitored by attending to the correlative development of the DSM. With the publication of DSM IV in 1994 the vocabulary of human deficit has undergone enormous expansion.⁶⁵ Our conceptual repertoires of the range of our possible cognitive and affective inadequacies are much expanded. If we wish to disparage ourselves and our

⁶² Erik Erickson.(1964) *Childhood and Society*. Second Edition, revised.New York: Norton. P. 242.

⁶³ Transference definition from *Taber's Cyclopedic Medical Dictionary* (1977), Clayton Thomas, Editor. Philadelphia: F.A. Davis Company. P. T-59.

⁶⁴ Gergen (1991) Op. Cit. PP. 14, 15.

⁶⁵ The “vocabulary of human deficit” is Kenneth Gergen’s expression.

conditions, there are many new words with which to do it. While not knowing what we are supposed to be, we somehow retain an understanding of what is unacceptable.⁶⁶

Gergen explains:

a spiraling cycle of enfeeblement is set into motion. For as people come to view themselves in these ways, they also come to see the professional as essential for cure. And, as the profession is asked for answers to life problems, it is pressed into developing a still more differentiated and expanded vocabulary. The new vocabulary enters the culture, engendering still further perceptions of illness, and so on in a continuing spiral of infirmity.⁶⁷

This cycle of enfeeblement is good for business, if one is a psychiatrist.⁶⁸ It is also, generally, an effective mechanism of social control. We are as we describe ourselves. Sampson notes that societies create both the types of character essential to societal reproduction and the ideologies necessary so that those characters will function to achieve reproduction."⁶⁹ Much of this hegemonic manipulation is achieved through language.

As Benjamin Whorf has suggested, each culture creates its own world, and its own relationship to the people within that world, with its language. While Whorf's theories apply to whole languages (and assume a correlation between one's language and one's world-view) the principle of "linguistic relativity" might well be applied to any set of technical jargon that has a common linguistic stock of ideas.⁷⁰

We can learn a great deal about what our culture values, what it accepts, and what it abhors by studying these specialized discourses. One such discourse is used in psychiatry. The psychiatric discourse intersects with universities, hospitals, the work of

⁶⁶ Arguably, the faithful in some sects of Christianity are faced with a similar requirement, of having to extrapolate from what is wrong a conjectural notion of what must therefore be right.

⁶⁷ Kenneth Gergen Op. Cit. P. 15.

⁶⁸ Psychologists, psychotherapists, and ordinary counselors also benefit monetarily from the linguistic cycle of enfeeblement. However, they are not the subject of this discussion.

⁶⁹ Edward E. Sampson. "The Deconstruction of the Self" in *Texts of Identity* Op. Cit. P. 10.

⁷⁰ Benjamin Whorf.(1964) *Language, Thought and Reality* Cambridge: The M.I.T. Press. P. 41

the coroner's office, private psychiatric practice, and mental hospitals, with open linkages into the general textual discourse of the intelligentsia and the mass media.⁷¹

I call the language used in psychiatry "Clinique." Far from being simply linguistically efficient in transmitting medical (empirical) concepts, Clinique transmits an ideology. It judges as it describes. The language of psychiatry is used as epistemological artillery in class and gender struggles over the making of meaning.⁷² While all languages implement a point of view, the perspective implemented by Clinique seems excessively narrow - and elitist.

Translation into English from Clinique is difficult. Translation is not a matter of substituting words in one language for words in another language. Real translation of meaning requires saying in one language what someone speaking the other language would say in the same situation. The more unlikely that situation is in one of the languages, the harder it is to find an expression which corresponds in the other.⁷³ If an activity is fairly common in a culture, that culture's language may have a single word to describe it. Another language may require many words to describe the same activity, if it is uncommon to its speakers.⁷⁴ In this way, we can see how language can precondition perception.

The bottom line of psychiatry is diagnosis. Psychiatrists are deciding who we are - and may be - as they work out the taxonomy of disorders. The DSM is the creation of the language and the symptomology, that defines the culture by what it should not be. Resembling a syllogism in formal logic, in which the conclusion is contained within the premise, psychiatric diagnosis is a model of logical positivism. In Clinique, the meaning of a proposition *is* its method of verification. That is, the correct meaning is that meaning which observation shows. A condition is a disorder because it is *named* a disorder.

⁷¹ Dorothy Smith (1990) *The Conceptual Practices of Power*. Boston: Northeastern University Press. P. 193 used this sentence in a difference context.

⁷² Perhaps Clinique is simply hermeneutic artillery.

⁷³ This statement was made, in a slightly different form, by Suzette Hayden Elgin. See *Earthsong*. (1994) New York: Daw Books, Incorporated. P. 9.

⁷⁴ For instance a culture whose language has one word for "to be tortured to death" may be considered more autocratic than a culture (such as ours) whose language requires five words for the same concept. A culture which simply does not torture people to death may require dozens of words to transmit the meaning of the concept. A culture which does torture people to death but does not admit it may have a number of slang or colloquial expressions to describe being tortured to death, but no single word that names the activity.

Disorders are psychiatric conditions. Therefore, anyone diagnosed as having a disorder is not psychiatrically sound. In the tradition of formal logic, its truth value in the outside world is irrelevant. Within the domain of discourse, in this case psychiatry, it is internally consistent, and therefore true. Diagnosis is based on this premise.

There is a causal relationship here. When Clinique words (or the words of any technology or discipline) enter the popular discourse - and frequently they do - they carry ideologies with them. Social and political contexts are both engendered and sustained by the words in which we describe them. As English adopts Clinique words, then, our culture reifies the assumptions on which the words were coined.

The nomenclature of (any) science is not a set of isolated words. Each word is a part of a conceptual network, and while it can be appropriated, it is never completely divorced from its original meaning. Language shapes the operations of reason. Or misshapes it, as is often the case with Clinique.

It may be, then, that people who habitually speak Clinique undergo a transformation of their worldview in the course of their careers. Arguably, Clinique is designed, as is any scientific lexicon, to limit the scope of inquiry, as well as to foreclose possibilities of ambiguous or alternative interpretations. The goal in Clinique is not communication, but assertion. Translating out of Clinique into plain English, then, may have emancipatory potential. It may also be exceedingly difficult to do. Clinique words may require the invention of new English words, or an entirely new use for existing English words.

Dr. Richard Kluft, editor of the journal "DISSOCIATION: Progress in the Dissociative Disorders muses about MPD (when it was *called* MPD): "If the language and metaphors of division and splitting are abandoned, this implicit reification and the difficulties that spring from it cease to be as vexing."⁷⁵

Is this possible? *Can* the language of splitting be abandoned? What would be left of the study of dissociation, without this particular set of linguistic constructs? In 1994,

⁷⁵ Richard Kluft. "The Phenomenology and Treatment of Extremely Complex MPD" in *Dissociation*, vol. I, no. 4. p. 49.

after at least five years of members' complaints that the name MPD was unsuitable, Multiple Personality Disorder, (MPD) was renamed Dissociative Identity Disorder (DID). At the writing of this thesis, it is too early to predict the multifarious ways that this name change will affect the whole paradigm.⁷⁶ However, we might speculate on a single aspect: the media response. Multiple Personality Disorder has a lot of sensationalist possibilities. Dissociative Identity Disorder may have considerably fewer.

At the Seventh Annual Convention of the ISSMP&D in 1990, Richard Kluft warned the Saturday morning plenary session that the media may not always deal honestly, and that "the simple solution is to regard the media as an aggregate of prostitutes and scoundrels, to be avoided at all costs."⁷⁷ Perhaps, when choosing a new name, the aspect of media-repellant figured as prominently in the decision as the clinical considerations. As Ian Hacking says, names organize our thoughts.⁷⁸ We cannot afford to ignore either the language of diagnosis or the critiques of it. As Young-Eisendrath and Hall note, any occasion in which we make a study of our lives is one for acute linguistic concern.⁷⁹ We have cause for concern because of Clinique's leakage into English, but also because of how language functions. Edward T. Hall explains:

Language is not (as is commonly thought) a system for transferring thoughts or meaning from one brain to another, but a system for organizing information and releasing thoughts and responses in other organisms.⁸⁰

Because of the symbiosis between psychiatry and society, when new psychiatric studies are undertaken and new psychiatric paradigms developed, the whole society is influenced. It may be in the interests of society, then, that the paradigm of dissociation (or any other major project within the psychiatric industry) develop unambiguously. If the boundaries of the normative are being redefined, it may be in our interests to be able to interpret the edict which delineates the new borders.

⁷⁶ Chapter 4 documents this name change, and chapter 5 speculates on its impact.

⁷⁷ Richard Kluft. Plenary Address, Seventh Annual ISSMP&D Convention. November 10, 1990. Chicago, Illinois.

⁷⁸ Hacking. (1994) Op. Cit. P. 17.

⁷⁹ Polly Young-Eisendrath and James A. Hall, editors. *The Book of the Self* New York and London: N.Y.U. Press. 1987. p. 1

Those engaged in the paradigm construction and its arguments over nomenclature might be assisted by John Deely's notion of semiotic lag:

The phenomenon wherein the terms used in articulation of a newer, developing paradigm inevitably reflect the older ways of thinking in contrast to which the new development is taking place, and hence constitute a kind of drag on the development, until a point is reached whereat it becomes possible to coin effectively a fresh turn of phrase reflecting precisely the new rather than the old. The new terminology has the simultaneous effect of ceasing the drag and highlighting what in fact was developing all along.⁸¹

Will changing the name from Multiple Personality Disorder (MPD) to Dissociative Identity Disorder (DID) help the new paradigm develop? In the intended direction? We may know this by the publication of DSM IV-R.

Before the name change, I began to develop an alternative, non-clinical lexicon to discuss dissociative disorders. There is a difference between multiple personality and "Multiple Personality Disorder." Multiple personality is not necessarily the medical entity MPD. It is also a condition of perception. It is also an adaptive response pattern, created in infancy or early childhood, by a person who was subjected to severe and ongoing trauma. As well, it is a clinical syndrome; a collection of signs and symptoms. There are as many manifestations of multiple personality as there are people that have multiple personalities. All of the manifestations are by definition adaptive. By clinical definition, all manifestations are also pathological. This may have more to do with the definition than with the manifestation. As Michael Kenny notes: "Much of what is called disorder is logically bound to the canons of orderliness....An idiom of distress is a semiotic concept that must be seen as part of the greater order that we associate with culture itself."⁸² If language does indeed precondition one's perceptions, then changing the language changes the perception - which therefore changes the thing. Clinically the name MPD has been changed to DID. However, Dissociative Identity Disorder is still a disorder, which still defines the person as being out of control. As Ian Hacking explains:

⁸⁰Edward T. Hall (1976) *Beyond Culture* New York: Doubleday and Co. P. 57.

⁸¹ John Deely (1990) *Basics of Semiotics* Bloomington: University of Indiana Press.

⁸² Michael Kenny. *The Passion of Ansel Bourne* Washington: Smithsonian Institute. 1986. P. 185.

very seldom is definition the right concept in psychiatry. The linguists' idea of a prototype is more serviceable.⁸³

What if it had a name that didn't include the word 'disorder'? When the condition was labeled MPD, I renamed it "Multiplexity." "Multiplexity" is an electronics term used primarily in telecommunications and broadcasting. In telecommunications the technique which is called multiplexing consists of the sharing of a transmission line by many telephone channels.⁸⁴ Therefore a person with multiple consciousness is multiplexed, and a person with singular consciousness (should that exist) is uniplexed. These are meant to be non-clinical, non-judgmental terms, so that a perspective on someone's consciousness can be discussed without classifying that person as having a disorder. The clinical classification of disorder means that the person is assessed, in some regard, to be out of control. Dropping the appendage of disorder means also relinquishing the authority to make that judgment about another. The diagnosis Dissociative Identity Disorder constructs the disorder differently, but it is still a disorder.

Taking into account the many complaints I heard from psychiatrists at ISSMP&D conferences about the terminology they were obliged to use to discuss MPD, I set about developing a non-clinical lexicon for all aspects of dissociative disorders. I ran headlong into the translation problem, that for a word to make a leap from one culture to another, the concept must in some way exist. Many critiques of psychiatry are based on the accusation that the psychiatric industry brings the concepts into existence by inventing the words. I was, then, possibly transmuting the concepts, by developing non-clinical words for equivalent, non-clinical concepts. Is de-medicalizing what is claimed to be a medical invention seditious? I needn't worry about it. My creative process has been interrupted by the name change. Such are the hazards of entering the discourse of a paradigm that is still under construction.

⁸³ Ian Hacking, (1995) *Rewriting the Soul: Multiple Personality and the Science of Memory*. Princeton: Princeton University Press. PP. 82-3.

⁸⁴ This sharing can be done on a frequency basis, (frequency-division multiplex), and/or on a time basis, (time-division multiplex.) These two kinds of sharing could be used to describe the cognitive experience(s) of a multiplexed person. Frequency-division multiplexing is co-consciousness. Time-division multiplexing is sequential executive control with amnesic time-loss sequences.

One of the key strategies of the mechanistic-reductionist philosophy that dominates twentieth-century medicine is to define the reductionist model of medicine as the medical model. This is a clever, though unconscious, strategy because it implies that all other models of medicine are non-medical: reductionism has claimed a monopoly, in effect, over medicine, and has borrowed the prestige of science to cloak itself in an aura of power, sobriety, and rationality. Colin Ross

Chapter II

Apostolic Psychiatry

This chapter will explore the medical and social function of psychiatry, while reflecting on some of the dichotomies and contradictions made evident by critiques of psychiatry in the last twenty years. Is psychiatry medicine? Science? An agent of social control? Can it be all of these things simultaneously? Do scientific rightness and medical belief go together? What if they don't? What if a psychiatrist must choose one or the other? What about medical rightness and scientific belief? What does a psychiatrist do if they clash? This chapter will consider these questions.

Drawing a connection between the rise of therapy and the secularization of Western culture, Anthony Giddens refers to 'therapeutic control', which functions to maintain a certain level of adequate social functioning in settings where the voice of religion no longer has the warrant to delineate the guidelines. "In previous times," says Giddens, "unhappy people sought solace in their church. Now, unhappy people seek therapy."¹ In secular society therapy can help mold people to be successful in the marketplace, from which may come self-esteem and the respect of others. If higher moralities, previously the province of organized religion, enter the picture, it is because the client associates them in some way with the psychiatrist. Many clients do so. The psychiatrist is a scientist. For some people, this helps make the psychiatrist a kind of apostle. We know from the Western biblical scripture that apostles have the power to remove the extraneous parts of a person's psyche.² If they know what to remove, they must know what is wrong.

"Apostolic function," according to Michael Balint, "means that every doctor has a vague, but unshakeably firm idea of how a patient ought to behave when ill. It is as if the

¹ Anthony Giddens. (1991) *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Cambridge: Polity Press. P. 179.

² Matthew. 10:2.

doctor had the knowledge of what was right and wrong for the patient to endure, and, further, as if he had the duty to convert to his faith all the ignorant and unbelieving among his patients.”³

Psychiatry is (in addition to being evangelical) apostolic. The psychiatrist and the patient make a covenant. The psychiatrist knows what is right and proper and what is not, and may well know how to transfer his value system onto his patient. Much of the reason that this can happen is because of the phenomenon of transference. According to the Harvard Guide to Modern Psychiatry, transference is the transfer of feelings about authority figures in one’s childhood and past onto the therapist. George Ganaway refers us to Greenson’s definition of transference as “the experience of feeling, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present.”⁴

These displaced or transferred feelings distort the patient’s perception of the therapist, inflating his power and authority. “This phenomenon of transference ... gives rise to some of the most intense, colourful, complex, perplexing, potentially destructive, and eventually most therapeutically useful aspects of the entire therapist-patient relationship.”⁵ ‘Therapeutically useful’ may mean that the psychiatrist has a great deal of power over the patient.

Professional warnings about abuse of that power are common in psychiatric literature. They tend to be well received. Books and lectures on transference and countertransference are always in demand. In keeping with this tradition, Dr. David Thomasma, who was then chair of the Ethics Committee of the International Society for the Study of Multiple Personality and Dissociation (since renamed the International

³ Michael. Balint.(1957) “The Doctor, His Patient, and the Illness.” Cited by W. Timothy Anderson. “The Apostolic Function of the Dentist” in *Discourse and Institutional Authority: Medicine, Education, and Law*. Fisher and Todd, eds. (1986) Norwood: Ablex. P. 8.

⁴ R. Greenson, cited by George Ganaway “Transference and Counter-Transference: Shaping Influences on Dissociative Syndromes” in *Dissociation: Clinical and Theoretical Perspectives*. Lynn and Rue, eds. (1994) London: Guildford Press. P. 318.

Society for the Study of Dissociation), cautioned his colleagues at a plenary session of an ISSMP&D conference that the power of the therapist and the adjunctive therapy team is almost unlimited:

The doctor really is like God in trying to design a human person. When we are shaping and designing a life we place our belief in the scientific model....We have so much power to redesign who they are going to be. We must always, then, cleave to scientific rightness and medical belief.⁶

Psychiatry, with its ideology of salvation through science, contributes to the maintenance of the social order by defining which cognitive structures are legitimate for members of society to use when making sense of their experiences. In contemporary secularized society, psychiatry (and therapy generally) is not replacing religion, but substituting for it. Psychiatry is an expert system, which grants all expertise to the psychiatrist, under whose code the relationship will take place.⁷ If we think of power in terms of access, a very powerful person has various kinds of access: to goods and services and things, and also to people. Doctors in North America, by this definition, have a great deal of power. They have the power (access) that comes with wealth, and they also have a certain power over their patients because they have access to information about those people and their health. They also have a gatekeeping prerogative over the accesses of their patients. They can decide to broaden the health options of certain people, while narrowing the health options of others.

Psychiatry carries a moral, as well as medical weight. Psychiatric diagnosis can define the carrier as bad in addition to sick (an interesting internal contradiction, as, according to the medical model, the sickness precludes the possibility of moral choice on the part of the diagnosee.)⁸

⁵ *The Harvard Guide to Modern Psychiatry*. (1980) Armand M. Nicholl, Jr. (Ed.) Cambridge and London: The Belnap Press of Harvard University Press.

⁶ Dr. David Thomasma, at a plenary session of the Seventh Annual Conference of the International Society for the Study of Multiple Personality and Dissociation, Chicago, November 10, 1990.

⁷ For more about expert systems, see Anthony Giddens (1991) *Op. Cit.* PP. 137-141.

⁸ Pedophilia is an example of a psychiatric diagnosis in which the person is also considered morally wrong.

For centuries, religion, and the peer pressure that came with it, bound people to the social order.⁹ People knew how to behave by process of elimination. Certain behaviours were sinful, and engaging in those behaviours could condemn one to Hell. A priest, whose voice had warrant because of the referent power of his institution, could recognize and authenticate someone's behaviour. He could also possibly save a person from damnation by using his influence to change the person's behaviour. In addition, he could offer the person the opportunity to take moral refuge in the intervention of the institution he represented. The sinner was not really to blame. The devil was influencing his behaviour.

In the secularized and medicalized present, disruptive or unpredictable or apparently inappropriate behaviours are listed in DSM IV, and engaging in those behaviors could condemn one not to Hell, but to a psychiatric institution. A psychiatrist, whose voice has warrant because of the referent power of his profession, can recognize and authenticate the behaviour, and can prevent the person from being institutionalized by deciding that institutionalization is not indicated. In addition, he can offer the person the opportunity to take moral refuge in the intervention of the institution he represents. The deviant is not really to blame. The neurotransmitter breakdown is influencing her behaviour.

Is this sufficient to conceptualize psychiatry as a kind of cult? Only metaphorically. Cults are groups of people who share a common vision and who see themselves as separate from the rest of the world.¹⁰ One of the distinctions we might make between a religion and a cult is that religiously motivated changes are expected to benefit the person who accommodates the changes while also benefiting the institution of that religion; while cult motivated changes are expected to benefit the cult, and whether or not the person experiences any gain may well be secondary. Arguably, psychiatry fits this criteria of a cult masquerading as a religion. A person is expected to conform to an

⁹ The Latin base of the word religion is *religare*, which means to bind.

¹⁰ In the same way that deviant behaviour is measured, not intrinsically, but from the outside, by the social opprobrium it incites, I recognize only external differences between a cult and a religion: religions tend to be accepted as a 'given'. Cults, when they are considered at all, tend not to be accepted.

externally imposed set of rules, from which, that person is told, she will benefit, while the institution imposing the rules also benefits.

Is the psychiatric patient really expected to benefit, or is the promise of benefit to the person just a promise? If the person believes that he will benefit from psychiatry, psychiatrists are assured a constant supply of customers. Quite an industry can be generated by the ensuing professional relationships. The psychiatric industry requires books, audiotapes, videotapes, and a tremendous assortment of heuristic toys, ranging from sandtrays to sponge rubber bats. Paula Kaplan points out, for example, that:

The DSM is also big business for its publisher, the APA [American Psychiatric Association]: A recent revision yielded nearly a million dollars in revenue, since each time a new edition appears, libraries and many practicing therapists - both psychiatrists and other mental-health researchers - have to buy the updated version. Related products are also marketed, including various casebooks, tape cassettes, minimanuals, workshops, interview protocols, and computer programs.¹¹

The biggest adjunct business, however is the pharmaceutical industry, which generates billions of dollars annually. Combined, these industries also employ thousands of people. While psychiatry's primary function - at least in the popular myth - may be to cure the mentally ill, its economic and social impact in the marketplace is a major 'side effect'. Perhaps there are other 'benefits' to society as well.¹²

Dr. David Thomasma (at an ISSD, then ISSMP&D conference) used as an example a patient of his, whom he had diagnosed as having Dissociative Identity Disorder (then called Multiple Personality Disorder.) The patient had many discrete personality states, or alter(nate) personalities: one held a black belt in a marshal art and had a confident attitude about her own value; one could operate and repair farm equipment; one played team sports and excelled in football. Many of this woman's personalities were strong and assertive and had what still are (for a woman) non-traditional skills. Only one of her personalities, Dr. Thomasma said, was meek and self-

¹¹ Paula J. Kaplan (1995) *They Say You're Crazy*. Don Mills: Addison-Wesley Publishing Company.

¹² In the unpublished paper "The Book of Martyrs Transformed" (1994) Devorah Greenberg refers to 'incredulous quotation marks.' When these are used, such as around the word *benefits*, the reader may assume that the writer doubts the claim.

effacing, with more traditional (secretarial) skills. Dr. Thomasma explained that after deliberation, he decided to integrate all the consciousness fragments (or alter personalities) into the secretary, making that meek and self-effacing persona the dominant aspect of the person. He explained: "We always need good secretaries." Dr. Thomasma went on to advise his audience that psychiatrists working with dissociative patients are in a unique position, because they can assist the society and participate in its construction by creating individuals with appropriate temperaments, attitudes, and skills.¹³

The ideological relationship between the psychiatric industry and the contemporary marketplace is mutually reinforcing.. The marketplace ideology of the self requires individuals to interpret social ills as psychological ills, requiring a person who doesn't measure up to the projected image of what she should be to bear personal responsibility for correcting her own problems, often with the help of a psychiatrist. As in religious idealism, no-one measures up to the projected image of what she should be. The Marketplace is constructed so that measuring up is not possible. It only *seems* possible.¹⁴

As in the case of religious absolution, temporary relief is usually all that can be expected from psychiatry. Although a person leaving the confessional is exonerated and considered 'clean,' the doctrine of Original Sin guarantees that he will sin again, and will have to come back the next week to be absolved again. In the same way, a person who has been cured by a psychiatrist is categorized--and stigmatized--as a mental patient, and by definition, may need to be back. Ironically, having been a mental patient stigmatizes people, making them seem, in Goffman's words, tainted, and less desirable.¹⁵ As defined by Ricky Sherover-Marcuse, who founded the organization Bridges, which gives "Unlearning Racism Workshops" around the world, oppression is the systematic and pervasive mistreatment of individuals on the basis of their membership in target groups, which are groups of people targeted for oppression. Mental patients and ex-mental patients become members of target groups.

¹³ Dr. David Thomasma, at a plenary session of the Seventh Annual Conference of the International Society for the Study of Multiple Personality and Dissociation, Chicago, November 10, 1990.

¹⁴ The analogy of religion can be extended to the marketplace, where the consumer is told in many ways that it is possible to buy [at least a taste of] paradise.

¹⁵ See Erving Goffman (1963) *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs: Prentice-Hall for a full discussion of this matter.

An inability to deal with the social opprobrium of being a mental patient may bring ex-patients back to psychiatrists. Or perhaps, once one has begun the cycle of 'healing', one develops ever loftier ideals about what can be achieved. Perhaps, in both cases, it is simply dissatisfaction --on which the marketplace and psychiatry depend -- that brings people back for more. Permanent satisfaction does not get repeat customers. Customers come back because the fulfillment is only temporary.¹⁶ Dissatisfaction is a kind of loss of Grace, that keeps the faithful coming back for re-instatement. Whether or not people are 'cured' depends on one's perspective. In order to be cured, does one have to have been ill? This question raises the debate about psychiatry and the social construction of illness, and also the debate about diagnosis.¹⁷

A psychiatrist is expected to restore , or, if necessary create, the client's sense of being able to make a conscious, deliberate choice, rather than feeling driven to do, or abstain from, a particular kind of action. In the best case condition, psychotherapy builds or restores the essence of a person, which is assumed lost or buried. The person's experiences can be re-framed by the introduction of new words, which carry new concepts.¹⁸

There are two major conceptions of mental illness; positivist, and cultural relativist. For positivists, illness is the presence in an organism of disease that inhibits the proper functioning of the organism. The cultural relativist position challenges the very notion of a universal definition of proper functioning for organisms, claiming that normal for any example of this particular organism--a human being--depends on cultural

¹⁶ At the 7th Annual conference of the International Society for the Study of Multiple Personality and Dissociation in Chicago in 1990, a psychiatrist leading a workshop noted that ninety percent of people in North America come from dysfunctional families. If only ten percent of the population measured up to the model, perhaps, I suggested, it was not useful. Perhaps, like the DSM, the model needed to be updated every few years? No, I was told. The model is fine. It is the ninety percent who have the problem, and it is the social and moral responsibility of the psychiatrists to "remold" that ninety percent. I was further told that I did not seem to appreciate how seriously they take that responsibility. Where was my faith in the scientific model?

¹⁷ People may also go to psychiatrists because they are perceived to be the only legitimate place that one can take one's problems. A person may continue to see a psychiatrist, not because he is being 'helped', or 'cured', but because the patient has no other place to go, no other institution to which he can turn.

¹⁸ Polly Young Eisendrath and James Hall "Ways of Speaking of Self" in *The Book of the Self* (1987) New York and London: New York University Press.

context.¹⁹ Cultural variation in what is considered 'normal' are enormous. There are just so many possibilities of what a person can be.

Many expressions of what a person can be are diagnosed by psychiatrists as pathologies. Terms that mental-health professionals use to describe states of mental illness - and mental health - have radically changed in the last 30 years. The developments of new paradigms in psychiatry can be monitored by attending to the correlative development of the DSM.²⁰ By accepting DSM diagnoses as fact, individuals learn to interpret social ills as psychological ills, creating psychological subjects obliged to bear enormous burdens of responsibility for correcting their own problems.²¹ These heavily burdened people then go to psychiatrists to have their loads lightened.

What psychiatry empowers and enables its practitioners to accomplish, and who benefits from those accomplishments are questions both inside and outside the field. Dr. John Beahrs, author of an early (second wave) influential book on multiple personality says in *Limits of Scientific Psychiatry*:

For psychiatry to merit stature as a rigorous scientific discipline, nothing is as imperative as that it recognize, define and delineate its limits, beyond which its tools are useless, self-contradictory, of simply irrelevant. A first step towards knowing what something is, is to know what it is not.²²

The limits of psychiatry's mandate are defined differently by different practitioners. The majority consign themselves considerable authority. David Ingleby points out that classic psychiatry is modeled on positivism, rather than on medicine.²³ The

¹⁹ See Peter Conrad (1981) "On the Medicalization of Deviance and Social Control" in *Critical Psychiatry: the Politics of Mental Health*. David Ingleby, ed. (1980) New York: Random House PP. 103-108 for a fuller discussion of this matter.

²⁰ DSM was first published by the American Psychiatric Association in 1958. Revised versions, DSM-II, DSM-III, DSM-III-R, and DSM IV, were published in 1967 (and republished 1974), 1980, 1987, and 1994, respectively.

²¹ Edward E. Sampson. "The Deconstruction of the Self" in *Texts of Identity* Op. Cit. p. 10.

²² John Beahrs (1986) *Limits of Scientific Psychiatry: The Role of Uncertainty in Mental Health* New York: Brunner/Mazel P. XVII.

²³ *The Harvard Guide to Modern Psychiatry* (Harvard University Press, 1978) opens with the caution: "As twentieth century psychiatry encompasses knowledge from an increasing number of related disciplines, the boundaries of psychiatry become difficult to define." The descriptor 'classic' is Ingleby's. I assume it refers to the medical model. Psychiatry is defined in *Taber's Cyclopedic Medical Dictionary* as "the

two paradigms, medicine and positivism are “whole [different] systems of prejudice about what constitutes useful and respectable data, what form theories should take, what sort of language scientists should use, how they should go about their business, and so on. They correspond to different mentalities.”²⁴ The concern of positivism is with facts, rather than with values. The concern of medicine is with values rather than with facts. The conflict in these perspectives shows up in the issue of what constitutes data, and how it is collected, an argument constantly fueled by the changing fashions in “mental health” research.²⁵

Conflicts between medicine and positivism in psychiatry show up in the construction (manufacture) of diagnoses. Positivist science assumes that observations can be made objectively. The positivist assumption in psychiatry, the unlikely hybrid of the merger of science and medicine, is that this human science is not different from any other science. As in any other science, it assumes that measures can be defined operationally and applied precisely in a replicable manner. The criteria for diagnosis come from the data collected in experiments. It is assumed that diagnoses made from these data are objective and unbiased, even though they rely on cultural interpretation.²⁶ In psychiatry, cultural interpretation is apparently eclipsed by scientific paradigm. That is, cultural variation applies to the patient, and to the diagnosis, but the psychiatrist is somehow exempt, perhaps because he is a scientist.

The Diagnostic and Statistical Manual of Mental Disorders, which carries a disclaimer about cultural variables, is an American construction which is translated into many languages, for use in other countries. Paula Caplan notes that DSM III-R was

branch of medicine which deals with diagnosis, treatment, and prevention of mental illness.” (Philadelphia: F. Davis and Co. 1977: p. P-158)

²⁴ David Ingleby. “Understanding Mental Illness” in *“Critical Psychiatry: the Politics of Mental Health”*. David Ingleby, ed. (1980) New York: Random House. P. 25.

²⁵ In a system where a diagnosis is simply a diagnosis, and all diagnoses are made dispassionately, the diagnosis of ‘hirsutism’ is not socially or medically distinguished from the diagnoses for diabetes. Neither are distinguished from the diagnosis for bi-polar disorder.

²⁶ One of the big problems with “objective diagnosis” is etiology. Do parts of a person’s background contribute to their disorder? How does a psychiatrist look at a patient’s life events and identify the ones that qualify as contributing to the person’s current state? Alternately, even though it cannot be measured, how can the social aspect of a person’s life be simply disregarded? Further, how can the psychiatrist overcome his own social bias sufficiently to even be able to recognize how the social impinges on the physical?

translated into Chinese, Danish, Dutch, Finnish, French, German, Greek, Hungarian, Italian, Japanese, Norwegian, Portuguese, Russian, Spanish, Swedish, Turkish, and Ukrainian.²⁷ She doesn't claim, however that it is the 'bible' of psychiatry in those countries, as it is in the US and Canada.

Apparently the parameters of normality can be located without subjectivity or bias. Brown remarks that "diagnosis locates the parameters of normality and abnormality, demarcates the professional and institutional boundaries of the mental health system, and authorizes psychiatry to label and deal with people on behalf of society."²⁸

Normality, however, changes with time, location, and new trends in thought. Normality is a fluid concept, which, if it can be isolated and identified--which it often cannot--is perhaps found somewhere in the complex symbiosis between psychiatry and society. Most of what is defined as normal is, on closer scrutiny, merely that which is common in a particular culture. This makes an unbiased and authoritative diagnosis of what is abnormal quite challenging.

Diagnosis depends on data collection, and data collection rests on certain assumptions. A psychiatrist collecting data about Schizophrenia, for instance, starts with the assumption that Schizophrenia exists as an established fact and that the symptoms of Schizophrenia are known and fixed. Neither of these are the undisputed case. The existence of Schizophrenia has been in dispute for twenty years,²⁹ and the symptoms are culturally variable. The same diagnostic criteria that results in a diagnosis of Schizophrenia in the United States, which relies on the DSM will result in a diagnosis of Depression in England, which relies on the ICD (International Compendium of Diseases.)

Ingleby notes:

Psychiatric diagnoses can never aspire to objectivity in the natural-scientific sense, and to claim that they can is merely to conceal the tacit rules, conventions and biases which necessarily govern their application. Indeed, most diagnoses forfeit their claim to be objective descriptions for the simple reason that their basic function is not a descriptive one: in

²⁷ Paula J. Kaplan *They Say You're Crazy* (1995) Don Mills: Addison-Wesley. P. 17.

²⁸ Phil Brown "The Name Game: Toward a Sociology of Diagnosis, in *The Journal of Mind and Behavior*. Volume II, number 3 and 4 (combined), Autumn 1990. New York: Institute of Mind and Behavior.

²⁹ One might reasonably argue that Thomas Szasz has made a career out of disputing schizophrenia.

everyday psychiatric practice, a diagnosis represents an administrative decision, which is governed by many other considerations besides the actual state of the patient.³⁰

That diagnosis rests on the clinical judgment of the psychiatrist is both a simple fact, and the cornerstone of the dilemma of how to mix positivism and medicine without having them nullify each other.

In the hundred years since this riddle was first introduced by Emile Durkheim (in 1895), the same criticisms have arisen about every twenty years, without any substantial alleviation of the situation. The riddle is compounded by the proposition of objective assessment. Diagnosis is based on the clinical judgment of the psychiatrist, which is itself influenced by many professional and personal factors. Does being a psychiatrist exonerate a person from the subjective understandings of what is 'normal' that people in any society are socialized to understand? The DSM opens with a caveat about cultural norms, and that any behaviour assessed must be done within the standards of common-sense cultural understandings. Could it be that the person making the assessment is not assumed to be also operating within those common-sense cultural understandings? Have we worked out some way for the psychiatrist to stand outside society's influence during the time he assesses another person's states of mind ?

Some of the most respected psychiatrists in the field question the basis of their own authority. John Beahrs points out that in order for a belief, construct, or measure to be adequate, two features are needed. The first is the precision with which it is defined and the second is its relevance. In psychiatry, he cautions, the more precisely concepts are defined and constructs are formulated, the more likely it will be that contradictory data, which render the original understanding absurd, will emerge.³¹ That is, facts won't work, because they are not flexible. The system must depend on values. Yet, the whole function of DSM is to precisely define concepts and formulate constructs. Does this render the use of DSM absurd? Without DSM (and ICD) there can be no uniform national and international diagnosis. Diagnosis is the language of psychiatry, which ultimately determines the practice of psychiatry. Etiology is contained within diagnoses, as are the

³⁰ David Ingleby. (1981) Op. Cit. P. 33.

indications for treatment. Diagnosis can be a medical tool, and it can be a tool of social control. It is, I would argue, both things simultaneously. The power to name is the power to construct truth.

Diagnosis itself is politically charged. Medical model diagnoses are challenged, currently by proponents of trauma-based disorders, which by their very definition assign an external, social component to the etiology. There have been other challenges to the medical model as well. In 1990, the *Journal of Mind and Behaviour* devoted a special double issue to a critique of the medical model. Titled *Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental Health System*, it is dedicated to R.D. Laing³² Authors from ten different disciplines presented assessments of aspects of the medical model. For instance, Phil Brown, a sociologist explains:

The neo-Kraepelinian model ... disregards etiology and dismisses conflicting theoretical standpoints. The neo-Kraepelinians do not disregard etiology so much as history, whether personal or social. They would most likely be satisfied with some form of genetic and biochemical etiology, which is in fact what they aim for. The neo-Kraepelinians simply do not want to deal with any form of *social* etiology.³³

Assuming that a patient's presenting symptoms are based in somatic abnormalities defines the problem as personal and individual, rather than political. It calls for a personal, individual solution: to "fix" the person. By definition it does not address the larger societal problem to which an individual's symptoms may well be an adaptive response.

Social services have not previously been the province of psychiatry. The variegated problems of social etiology are held at bay by mental illnesses having a biochemical basis. The prerequisite acknowledgment of violence and abuse in society is the biggest obstacle that proponents of the trauma-based paradigm have to face. If psychiatry recognizes trauma-based disorders, it is implicitly recognizing institutionalized violence in the society, and the ongoing sexual and physical abuse of children. Then

³¹ John Beahrs. (1986) Op. Cit. PP 179-80.

³² Volume 11, Numbers 3 and 4; Summer and Autumn, 1990.

³³ Phil Brown. A Sociology of Diagnosis, in *The Journal of Mind and Behaviour* Vol. II, no 3&4 (special issue.) David Cohen, Editor.

what? Presently psychiatry is reactive: psychiatrists attempt to repair damaged patients. If external social factors are recognized in the etiology, will psychiatry be expected to become proactive? Will it be expected to become politically active in the domestic violence and incest prevention movements?

Becoming involved in the social and political issues that are implicated by the dissociative disorders is literally revolutionary. This perspective is guaranteed to meet with resistance, as it did in its first emergence. The last time the dissociative paradigm was presented, Sigmund Freud could not weather the social opprobrium of his colleagues, who did not see it in their professional (and perhaps personal) interests to have the etiology of their patients' disorders be social, rather than chemical. Under the pressure of the conservative backlash, and without the women's movement to fight for the recognition of the traumas of many children's lives, the trauma-based disorders disappeared. It became commonly accepted that all children wanted to have sex with their opposite sex parent, and new mental illnesses, based on genital dissatisfaction, appeared.

Making any kind of psychiatric diagnosis presents the problem of objective assessment. One of the ways this problem is addressed is by distinguishing between absolute diagnosis and differential diagnosis. Absolute diagnosis is a matter of deciding whether or not a patient is disordered. Differential diagnosis requires making decisions about the classification of a patient who has already been assessed as disordered. Neither of these processes works well unless the psychiatrist is seen as an objective -- and absolute -- authority.³⁴ The political processes involved in diagnosis may well make objectivity impossible. Ingleby explains that "most diagnoses forfeit their claim to be objective descriptions for the simple reason that their basic function is not a descriptive one.

³⁴ Colin Ross does presentations at ISSD conventions, on the high inter-rater reliability of the diagnosis of dissociative disorders. Inter-rater reliability refers to the extent to which two psychiatrists agree on a diagnosis. If the inter-rater reliability (called the kappa) is 1.0, the diagnoses are in perfect agreement. If the kappa is -1, there is no agreement at all. The threshold of reliable diagnosis is .6. Anything less than that, says Ross, is not a scientific fact, but an ideologically driven misconception. Patients diagnosed with MPD had an average kappa of 7.33. Ross said that kappa rates like that can *really* kick butt. (ISSD Convention, May 5, 1993, Dallas, Texas.)

In everyday psychiatric practice, a diagnosis represents an administrative decision, which is governed by many other considerations besides the actual state of the patient: the family situation, the treatment available, legal considerations, and so on.³⁵ The recent political arguments over whether LLPDD (Late Luteal Phase Dysphoric Disorder), PMDD (Periluteal Phase Dysphoric Disorder) or PDD (Premenstrual Dysphoric Disorder) would appear in DSM IV had more to do with power-plays between the psychiatrists than with whether or not women really are dangerously out of control and a danger to themselves and society just before and during menstruation.³⁶

Every new diagnosis for each new edition of DSM is the product of much debate. Such discussions are not available for participation, or even consideration, by most people, because of the language in which they take place. Speaking in a plenary session of a large convention of psychiatrists, Sherrill Mulhern said: "We have a semantic monopoly, which gives an aura of legitimacy. However, a semantic monopoly also distorts the research."³⁷ Such distortions are not available for public scrutiny. Ordinary people are excluded from this discourse, and are therefore dependent on the specialists to translate for them. In this way psychiatry maintains the rational control of the individual under the rubric of caring and protection while perpetuating the dominant ideology.³⁸ In this way psychiatrists maintain both the social order and the demand for their services.

If, as a society, we accept that only the psychiatrist really knows the problem, and therefore only the psychiatrist also knows the solution, then the problem remains localized in the person receiving treatment, and the other people in that person's life -- and the society -- are exonerated. The voice of the psychiatrist who is already a doctor and a scientist, is given even greater (apostolic) warrant by people who see it to be in their interest that the 'problem' stays localized in an individual.

³⁵ David Ingleby. (1980) Op. Cit. P 33.

³⁶ The process of how these classifications were proposed for DSM III-R and DSM IV is covered in detail by Paula J. Caplan in *They Say You're Crazy*.

³⁷ Sherrill Mulhern. "The Satanic Panic." Lecture delivered at the 7th Annual Convention of the ISSMP&D, November 9, 1990, Chicago, Illinois.

³⁸ Stephany Borges. "A Feminist Critique of Scientific Ideology" in *Discourse and Institutional Authority: Medicine, Education, and Law*. Norwood: Ablex, 1986.

Personalizing general social problems is a standard practice in psychiatric treatment, as is dictating that people who appear to respond overly well to their socialization (as do multiplexed people, for instance) are disordered. Medicalization is an efficient way of re-directing attention to individuals, which ensures that the larger social problems do not need to be addressed. An example of this concerns Post Traumatic Stress Disorder (PTSD.)

While PTSD is defined in DSM as an anxiety disorder, it is anecdotally lumped in with dissociative disorders in the discourse on dissociative disorders because it presents a model of the psychological processing of traumatic experience while it is happening (compared with several years later, as in most of the dissociative disorders.) PTSD was officially named when therapists started to compare symptoms of their clients who had been in Viet Nam. Until then, the signs and symptoms were called “shell shock.” As Judith Herman describes it:

the moral legitimacy of the antiwar movement and the national experience of defeat in a discredited war had made it possible to recognize psychological trauma as a lasting and inevitable legacy of war. In 1980, for the first time, the characteristic syndrome of psychological trauma [shell-shock] became a “real” diagnosis...“post-traumatic stress disorder.”³⁹

The diagnosis of PTSD is gaining ground and accumulating clinical studies and clinical and anecdotal literature almost as fast as MPD/DID. It is common, in literature on dissociative disorders, to find concerns about children in Kuwait, Bosnia, and other contemporary war zones, as well as in American inner cities growing up with PTSD.⁴⁰ However, the literature is about diagnosis and treatment. It does not discuss prevention.

Another example of focusing on the victim is found in the incest-survivor movement. To have “been incested,” a common colloquial term in support groups, removes even the *reference* to a perpetrator, and makes the mental health and feelings of

³⁹ Judith Herman (1992) Op. Cit. PP. 27-28.

⁴⁰ The proliferation of such remarks, and their ongoing association with dissociative disorders gives me expectations that PTSD may well change categories, and become a dissociative disorder in a future issue of DSM.

the victim the entire focus.⁴¹ This social response can be seen as the extension of the psychiatric response of medicalizing an individual's conduct, and ignoring any social factors that may have contributed towards it.⁴² Celia Kitzinger and Rachel Perkins call this process the privatization of pain, and warn that this reactive -- rather than proactive -- stance harms both the victim and the society.⁴³ Judith Herman explains how interpreting a trauma victim's response pattern as congenital rather than as a response to trauma further damages the victim:

The clinical picture of a person who has been reduced to elemental concerns of survival is still frequently mistaken for a portrait of the victim's underlying character. Concepts of personality organization developed under ordinary circumstances are applied to victims, without any understanding of the corrosion of personality that occurs under conditions of prolonged terror. Thus, patients who suffer from the complex after effects of chronic trauma still commonly risk being misdiagnosed as having personality disorders.⁴⁴

By assessing the site of the problem to be internal in the victim, psychiatry both exonerates itself from involvement in social movements, and insures its own continuance. The paradigm of trauma-based disorders operates in forbidden territory by publicly acknowledging system abuses of power. While damaging to individuals and deleterious to the society as a whole, the abuses of power to which dissociative disorders are an adaptive response are common.

Abuse stories sell well. Tales of psychiatric 'sicknesses' particularly multiple personality, make commercially viable journalism. Non-clinical books about psychiatric patients are common. Within the dissociative framework, a few of these books, especially the early ones, are famous. They have been reprinted many times, and three of them have

⁴¹ See Louise Armstrong "Surviving the Incest Industry" in "Trouble and Strife", No. 21, Summer 1991. Diss, Norfolk: The Trouble and Strife Collective. Pp. 29-32.

⁴² For more discussion on this matter, see "Changing Our Minds" by Celia Kitzinger and Rachel Perkins (1993) *Changing Our Minds*, New York: New York University Press

⁴³ Celia Kitzinger and Rachel Perkins. (1993) *Changing Our Minds*. New York: New York University Press, P.75.

⁴⁴ Judith Herman(1992) *Trauma and Recovery*. New York: Basic Books.

been made into films.⁴⁵ As part of the popular culture, they contribute to the construction of the myth that apostolic psychiatrists can intervene and save lost souls.⁴⁶

Most of the non-clinical books discuss the therapeutic process as unweaving and reweaving different threads in a multiplexed person's internal social fabric. The books are about the multiplexed person's life, but more, they are about the therapy; the patient/psychiatrist relationship, the psychiatrist's professional relationship with other multiplexed clients, the psychiatrist's personal relationship with other people who help sort out the multiplexed person's life; and even the psychiatrist's relationship to the journalist who is writing the book.

Prominently featured in all of these books is the journalist's opinion of the psychiatrist, and of his work with other clients, and how good and brave and philanthropic and erudite he is. These opinions are presented as part of the facts of the book, and contribute to the myth of psychiatrist as apostle. The journalist may also make some of her own observations, some of them clinical in nature, about this multiplexed client, and multiplexity in general, and its genesis in the terrible childhood abuse. The earlier books take the opportunity to make condemning remarks about the abuser, and indulge in some sociological commentary about the existence of the conditions in which such abuse could take place, implicitly suggesting that such circumstances are rare. The more recent books also tend to contain a bibliography of clinical literature that supports the views presented in the book.

Although flawed, both politically and journalistically, and probably clinically as well, these books are variously useful, functioning as case-studies to illustrate the theories presented in the clinical literature. If the psychiatrist's clinical books are well known, illustrations of how he dealt with a client--what the client said and how the therapist

⁴⁵ The three films are *Sybil*, starring Joanne Woodward as Dr. Wilbur, and Sally Field as Sybil, *The Three Faces of Eve*, starring Natalie Wood, and *When Rabbit Howls* (made for TV) starring Shelly Long. In the films the stars play the patients. In the books, the stars are the psychiatrists.

⁴⁶ Depictions of the kind of acts that are claimed to induce multiplexity in children are sold in plastic-wrap. People caught producing it are arrested. However, the guise of quasi-clinical journalism legitimizes describing terrible acts in explicit detail. Although the production of such literature may be socially, politically, and legally problematic, these descriptions serve many purposes. They help the reader to understand that humans are capable of enduring what seems impossible, while still managing, somehow, to function. They help multiplexed readers to begin to comprehend that such acts happened to others, too. They help therapists to understand that clients are not making up these stories. And they sell.

responded--function as case-history appendices for the clinical work. They also contribute to the legend about that psychiatrist.

An example of this is the work done by Dr. Eugene Bliss, whose book *Multiple Personality, Allied Disorders, and Hypnosis* (1986) is a major reference work in clinical literature. *Prism: Andrea's World*, also published in 1986, gives an account of Dr. Bliss's work with a multiplexed woman, showing Bliss's theories in operation. As is often the case in such accounts, the client's name is changed, and the psychiatrist's is not.⁴⁷

In the popular literature clients are believed and their causes championed. In contrast, the clinical literature often states that it is dubious and possibly dangerous to believe the accounts of a client. There is, one is constantly reminded, no proof of any events claimed by the patient. They may all be hallucinations. They may be iatrogenically inculcated falsehoods. In contrast to the disclaimers in clinical literature, the popular literature goes to considerable lengths to validate claims and produce evidence. Although anecdotal, the evidence provided by these books is valuable to the general public, as well as to the therapeutic community, who seem to rely quite heavily on this literature for model case-history information⁴⁸

Sybil was the first book about a multiplexed woman and her therapist to become really famous. Written by a journalist who was invited to sit in on five of the eleven years of therapy, and published in 1972, *Sybil* contains quasi-clinical speculative material which is now anachronistic, and which clearly functioned as a model for subsequent books, as well as for assumptions made by the psychiatrists who star in the subsequent books. *Sybil* has some distinguishing features, one of which is that it is the only book of its genre in which both the therapist and the journalist, as well as the client, are women. A woman's perspective is seen throughout the book. Because *Sybil* is a prototype, this distinction cannot be pointed out in the book. Neither is it noted in any of the books that

⁴⁷ This example shows another instance of the valorization of the psychiatrist. As well, under the guise of protecting the patient's anonymity, the psychiatrist is given voice through the book, and the patient is not.

⁴⁸ At various conferences of the ISSMP&D, I have heard psychiatrists discussing these popular books with each other. Occasional references are made to them in clinical sessions at the conventions, as well, and the majority of people present acknowledge having read them, and often having recommended them to clients.

use it as a model, in which the reader cannot be sure that the perspective is female, even though the patient is. The most notable distinction in *Sybil* however, is that the therapist is not apostolicized. Some of the psychiatrist's power, and ability to influence the client, come about through transference.

There is considerable discussion about transference in the therapeutic community. Transference, in which the client becomes affectively attached to the therapist as a surrogate caregiver and/or lover, is considered particularly risky when the therapist is dealing with a multiplexed person, because the social etiology of multiplexity is such that the multiplexed person, by definition, lacked sufficient ministrations from a caregiver in early childhood. Therefore, a certain amount of transference (and countertransference) is assumed. It appears that transference also occurs between the therapist and the documenting journalist. This may be the case in *Prism: Andrea's World*. Jonathan Bliss, the journalist (no relation to the psychiatrist) openly admires Dr. Eugene Bliss:

In his profession, Bliss was a maverick. Before it had been fashionable to espouse the physiological components of mental disease, he had been experimenting on the effects of stress on the endocrine system. Later he had investigated certain neuromediators in the brain. His work on anorexia nervosa resulted in a monograph on the subject, the definitive manual of the disorder for a time. ... After exploring a particular topic to his own satisfaction, he had the habit of moving on before the field became "hot," leaving the rest to others. He enjoyed splashing around in the overlooked eddies of psychiatry.⁴⁹

This passage about a psychiatrist, extracted from a eulogy that goes on for several pages, is a common occurrence, both in this book, and in this type of book. *Sybil* (the book) is the exception. Flora Schrieber does not portray Dr. Cornelia Wilbur either as a hero, or as the real star of the book. In the genre of literature that *Sybil* founded, however, the apostolic function of the psychiatrist is constantly reinforced..

While the paradigm of trauma-based disorders challenges some aspects of the doctrine of psychiatry, it reinforces others. For instance, it even further entrenches the authority of the psychiatrist. Under ordinary circumstances this might seem redundant

⁴⁹ Jonathon Bliss, and Eugene Bliss (1985) *Prism: Andrea's World*. New York: Stein and Day. P 104.

and even counter-productive, but in the Postmodern world, where warrant is no longer assumed, there is room for inflated claims.

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

Chapter III

IN THE BEGINNING

Consciousness, united with memory, gives rise to the convictions of personal identity. We know by means of this faculty that certain thoughts and feelings exist, and that they are the thoughts and feelings of the being whom I denominate I; myself. Memory connects these various testimonies of consciousness into a connected series, and thus we know that our intellectual acts, from our earliest recollection, proceed from the same being, and not another.¹

This chapter will briefly review the history of the Western study of dissociation. As the Western study of dissociation cannot be extracted (or dissociated) from either the medical model or the reductionist notion of Cartesian dualism, these concepts will make intermittent appearances. Any serious discussion of dissociation also includes references to hypnotism, and references to the history of that practice will also appear.

Dissociation is the process of paying attention to something to the exclusion of something else. To dissociate means to sever conscious association with a thing in favour of another. Dissociation is also the organizing principle that causes some systems to be disconnected from other systems. Dr. Marlene Steinberg, author of the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) is widely recognize as a clinical authority on dissociation. I quote at length from her synopses:

Despite the controversy about the theoretical processes underlying dissociative phenomena, there appears to be essential agreement among scholars about the overall phenomenology of dissociation. Nemiah (1991) describes dissociation as “the exclusion from consciousness and the inaccessibility of voluntary recall of mental events, singly or in clusters, of varying degrees of complexity, such as memories, sensations, feelings, fantasies, and attitudes.” Maintained in an unconscious state, these mental events may intrude into consciousness spontaneously or affect consciousness in the form of ego-alien symptoms. Dissociation is

¹ Frances Wayland, cited by Michael Kenny in *The Passion of Ansel Bourne* (1986) Washington: Smithsonian Institute Press. Notes for chapter 1. P. 190.

occasional, full dissociative episodes. When alcohol-induced, a dissociative episode is also known as a blackout. When done as part of a religious ceremony (such as have been practiced around the world for centuries) this kind of dissociation may include the substitution of another (alternate) state of consciousness for the one which abdicated. The next point on the continuum is the coalescing of these repeatedly recurring dissociative episodes into multiple personality states, many of which have amnesia barriers between them, so that the person does not have continuous consciousness, but fluctuates back and forth between the different states, or alters. This is generally known (in Western society) as multiple personality. At the extreme end of the continuum is fragmentation into hundreds of states and substates, such that continuous consciousness of any event is unlikely. This extreme condition is generally known as polyfragmented multiple personalities.

With the advent of psychiatry, this human capacity to disconnect the systems from each other has been studied, assessed and pathologized. Dissociation is now a set of identifiable pathologies. There is considerable dispute over the diagnosis of any dissociative disorder. As etiology and prognosis are contained within diagnosis, there is, of course, dispute over them, too. With the intention of clarifying the concepts, I will present the DSM brief definitions of how each of the dissociative disorders is characterized.

The essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.

Dissociative Amnesia:...an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

Dissociative Fugue:...sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity.

Dissociative Identity Disorder:... (formerly Multiple Personality Disorder)....the presence of two or more distinct identities or personality

states that recurrently take control of the individual's behaviour accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

Depersonalization Disorder:...a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing.

Dissociative Disorder Not Otherwise Specified:... is included for coding disorders in which the predominant feature is dissociative symptomatology, but that do not meet the criteria for any specific Dissociative Disorder.

Dissociative Symptoms are also included for the criteria sets for Acute Distress Disorder, Posttraumatic Stress Disorder, and Somatization Disorder. An additional Dissociative Disorder Diagnosis is not given if the dissociative symptoms occur exclusively during the course of one of these disorders.⁴

Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor. Because the symptoms themselves are the psychological response to processing trauma, they are of great interest to proponents of trauma-based disorders. If the paradigmatic takeover is flourishing, Posttraumatic Stress Disorder (PTSD) could be categorically reassigned and become a dissociative disorder, too.

Before dissociation was a psychiatric classification, it was a philosophical notion having to do with the association and dissociation of ideas, which, like consciousness, can be organized into discrete components. The medical concept of dissociation has become inextricably intermingled with the medical concept of multiple personality. While dissociation is an umbrella term for five different disorders, multiple personality disorder gets by far the most attention. The history of the development of dissociation as the foundation of a trauma-based paradigm and the medical and psychiatric accounts of multiple personality cannot be retroactively separated.

The history of clinical dissociation begins in 1791, when Eberhardt Gmelin, a contemporary of Franz Anton Mesmer, reported a case of what he called *umgetauschte*

⁴ DSM-IV. (1994) Washington: American Psychiatric Association. P. 477.

Persönlichkeit (exchanged personality). Gmelin's syndrome, as it became known in medical circles,⁵ had many documented appearances in the hundred and fifteen years between the labeling of this advanced form of dissociation and the first international meeting about it.⁶

In the context of constructing the new dissociative paradigm, the history of clinical dissociation begins with Pierre Janet, in 1898.⁷ Janet's term "dissociation" (*désagrégation*) is derived from the doctrine of association that was prevalent at the end of the nineteenth century. The beginning of the concept of dissociation is found in the concept of association and in the concept of memory. According to Janet, if memories are brought to consciousness by association of ideas, then any memories which are not available to association must be dissociated.

The notions of association and dissociation of ideas are figures on a theoretical ground of reductionism.⁸ Over the millennia the figures have transformed, as the ideas have developed. It has been three centuries since any substantial changes have happened to the ground. Colin Ross identifies Cartesian dualism as the basis of the Western cultural tradition that spawned MPD. The history of Western civilization, notes Ross, contains a fundamental theme of dissociation.⁹ The self is routinely divided: mind/body, thoughts/feelings. Social functions are fragmented. Binary logic, in which something is simply true, or simply false, in which a person can be simply good or simply bad is accepted as common sense. Our analogue sense of a continuum in which there were gradations of morality and perhaps of reality, is being replaced with a digital sensibility.

⁵ "Medical" is not quite the appropriate word here. "Psychological circles" is theoretically closer, but not historically verifiable, as the title "Psychology" had not yet been invented. The title "Psychiatry" was not in common use at this time either.

⁶ George B. Greaves (1993) "A History of Multiple Personality Disorder" in *Clinical Perspectives on Multiple Personality Disorder*. Catherine Fine and Richard Kluft (eds.) Washington: American Psychiatric Association.

⁷ Proponents of the New Dissociative Paradigm are accused by their detractors of distorting clinical data by taking facts out of context and stringing them together into new contexts. The historical disparities illustrated here are perhaps a non-clinical example of the genesis of such accusations.

⁸ Reductionism in this context is the philosophical notion that statements that apply to one type of entity are redefined in terms of concepts, or analyzed in terms of statements of another kind, generally with one kind considered epistemologically more basic. *Fontana Dictionary of Modern Thought*. (197) Op. cit. P. 530.

⁹ Colin Ross. (1989) Op. Cit. PP. 17-20.

On/off. Yes/no. True/false. Good/bad. Sane/crazy. The reductionism that promotes this binary reality is one of the basic ideological constructs of mainstream society. Anything which violates this binary cognition and binary classification is, in Western mainstream culture, suspect. Ambiguity and anomaly are unacceptable, as they may disrupt the carefully constructed social order.¹⁰

Aristotle defined "association of ideas" as something done in deliberation, the facility by which humans were distinguished from animals. Association of ideas had three parts: contiguity, similarity, and contrast.¹¹ A millennium later, Rene Descartes and his colleague Marin Mersenne contributed the notion that the human mind is separate and distinct from the body in a mechanistic universe. The Cartesian universe had no Gnostic content. It was conceived to be two (and only two) incompatible substances: consciousness and matter; no soul.

John Locke's 18th century *Essay Concerning Human Understanding* offers "The Association of Ideas." Locke uses this concept to show that aberrations in thinking are not organic and do not appear 'naturally'. Locke describes madness, for instance, as the joining together of ideas that do not naturally *belong* together.

David Hume further developed Aristotle's notion of the "association of ideas". In the third section of *An Inquiry Concerning Human Understanding*, called "Of the Association of Ideas", Hume discusses Aristotle's three principles of the association of ideas: resemblance, contiguity, and cause and effect. Hume's attempt is notable as an early effort to scientize philosophical speculation. Having concluded that some parallel of Newton's laws must apply to the mind, Hume reframed the notion of the association of ideas into laws. The *Law* of association of ideas shows associations between atoms of consciousness, which were not (to Hume) significantly different from atoms of matter.

¹⁰ Gender is a useful example of the social construction of binary reality. In this (patriarchal) society we recognize two discrete sexes and two discrete genders and we expect them to match up in a particular way. In the dualistic and biologically determinist model that we believe is "normal" we expect a male to be innately masculine and a female to be innately feminine.

¹¹ Eric Carleson. "The History of Dissociation Until 1880" in *Split Minds Split Brains* Jacques. Quen.(Ed.) (1989). New York: New York University Press. PP. 13-14.

David Hartley a physician--and what would now be described as a psychologist--wrote *Observations on Man, His Frame, His Duty and His Expectations* in 1749. *Observations* accounts for human nature based on a doctrine of the association of sets of ideas with sensations. Hartley claimed that these associations were made possible through connecting vibrations in the nervous system. All psychological acts were explainable by the law of association, as the vibrations create memory, and the reverberation of the vibrations stirs recollection¹².

Erasmus Darwin (the grandfather of Charles) wrote in 1794 of "associate tribes and trains of motions." Motion and association were the foundation of an elaborate hypothesis which Darwin attempted to use as the basis for most medical conditions.¹³ In common with Hume, Darwin reasoned that whatever laws can be applied to the body can also be applied to the mind. Explaining that theories are just theories, but that laws can be broken, Darwin made the notion of association of ideas into the Law of Association of Ideas. This breakable law governed the concept of trains of thought, which, Darwin said, can be "disunited" Trains of ideas can be suppressed, and this suppression can happen spontaneously, as well as deliberately, depending on the process of attention.

In Darwin's assessment, the process of attention can be enhanced by suppressing other trains of ideas. Alternately, other trains of ideas can be suppressed by increasing one's attention. Parallel trains can be willfully 'distanced' by the thinker. He also compared daytime reveries to dreams, as they both lack a linear sense of time, and regardless of how engaging one might find either a reverie or a dream, upon reflection, he might not remember the content -- or even that the episode had happened. Sudden recall could occur at some later time, however, when an analogous idea might re-introduce a forgotten train. Through such examples Darwin introduced the notion of separation of consciousness

¹² The contemporary version of this theory is the principle of "body memory" or proprioceptive recall. Proponents of this notion maintain that while the consciousness may dissociate a traumatic event, the body records the event and holds the memory. Stimulating that body memory into action will result in an abreaction, in which the person experiences the event in their body, as if it were happening at that later time.

Dr. Darwin had a seventeen-year-old female patient (whose name is not recorded) who had reveries which started with "convulsions," followed by a period of catalepsy. During her reveries, she would converse with people whom she alone could perceive. (Darwin noted that during these reveries his patient was unresponsive to painful stimuli, but he does not record the medical experiments that brought this to his attention.) When returned from her episode, the young woman would have no memory of it. If it had started in the middle of a conversation, she would pick up the conversation at the point of rupture, as if nothing had happened. She appeared, said Darwin, to possess two minds.¹⁴

Benjamin Rush, described by Samuel Wortis (his biographer) as the "best known American physician of Revolutionary times"¹⁵ is known as the Father of American Psychiatry.¹⁶ Following his mentor David Hartley, who gleaned ideas from Hobbes, Rush initially classified association as 'something' in the brain that sympathizes with other parts of the body. Rush explains: "although the phrase 'association of ideas' first occurs in Locke, the same concept occupies a most important place in the philosophy of his precursor, Hobbes. In Hobbes' view, all motion in the mind can be reduced to sense, thought, and train of thought."¹⁷

In his lectures on the mind, Rush described humans as "Thinking Machines, who are unable to stop the current of our thoughts."¹⁸ Extrapolating on Hartley's deductions that complex thought clusters can be understood if they are approached correctly, Rush tried to prove that psychology was a subtle kind of physiology. In doing so he made substantial contributions to psychological biology. Rush presented sixteen circumstances which

¹³ Eric Carleson. (1989) Op. Cit. P. 16.

¹⁴ Eric Carleson. (1989) Op. Cit. P. 19.

¹⁵ Benjamin Rush. *Medical Enquiries and Observations* New York: NY Academy of Medicine. 1962 (1812). Intro (by editor, Samuel Wortis)

¹⁶ In a different context Sigmund Freud is also known as the Father of American psychiatry. However, Rush's profile appears on the APA literature, which probably gives him some edge in any contest.

¹⁷ Eric Carleson, Jeffery Wollock, Patricia Noel, eds. *Benjamin Rush's Lectures on the Mind* Philadelphia: American Philosophical Society, 1981. pp. 489.

¹⁸ Carleson, Wollock, Noel, eds. Op. Cit. pp. 490-493.

influence the association of thought and ideas.¹⁹ His use of "dissociation" is the first documented *medical* usage of the word.

The first recorded use of the word "double consciousness" was applied to Mary Reynolds in 1816, by her doctor, John Kearsley Mitchell. Mary Reynolds vacillated between two personalities of two very different temperaments, one of whom was completely amnesic for the other. The first "truly objective study of multiple personality" (according to Henri Ellenberger) was undertaken by Antoine Despine in France, in 1836. Despine Sr., as he was known, studied a young girl named Estelle, who, he said, had "Alternate Personalities". An early case of "successive personalities" who were mutually amnesic²⁰ was that of Ansel Bourne, recorded by Richard Hodgson and discussed at length in 1860 by William James and in 1986 by Michael Kenny.²¹

The prototype of double personality is thought to have been introduced by Eugene Azam, a professor of surgery at Bordeaux Medical School. For the thirty-five years from 1858 to 1893 Azam studied a patient, 'Félida X.' He developed many terms to discuss her case, including *névrose extraordinaire, doublément de la vie, amnésie périodique, ou dédoublement de la vie, la double conscikence, and la double personalite*.²² In 1887 Azam published *Hypnotism, Double Consciousness and Alterations of the Personality* about Félida, and the hypotheses he formed through working with her.²³

¹⁹They are, in order: place, time, pleasure, pain, written words, event-related words, punned words, repeated words, single letters, arbitrary signs, certain sounds, certain degrees of heat and cold, odors, interest, ties of consanguinity, and custom and habit.(Rush, LOM, 495-503)

²⁰One of the clinical distinctions that determines multiple personality is whether or not the alter personalities know about each other and their experiences. Part of the DSM definition of DID is that there are amnesia barriers between the alternate personality states, such that some alters do not know of or remember the experience of others. In clinical diagnosis, the more plentiful and more complete the amnesia barriers, the further down the pathological continuum the person is assessed to be.

²¹Henri Ellenberger. *The Discovery of the Unconscious* New York: Basic Books, 1970. pp. 134-136. See also *The Passion of Ansel Bourne* by Michael Kenny (1986) Washington: Smithsonian Institute Press.

²²Ellenberger. Op. Cit. p. 136

²³Hannah Decker. In Quen. Op Cit. page 27.

Félida was initially referred to Azam because of his reputation for using hypnotism to inhibit pain.²⁴ Although hypnotism was at that time considered to be unscientific, Azam studied it, used it on his patients, and advocated the use of it to his colleagues. Félida exhibited signs of considerable pain, and many physicians were consulted. Only Azam's treatments were found to be therapeutic. The monograph finally published on this case, (and the force of Azam's professional reputation) substantially contributed to the resurgence of hypnotism in France.²⁵

Crossing over with the history of dissociation and multiple personality is the history of hypnotism. Considering hypnotism requires considering spiritism.²⁶ Spiritism, in turn, brings up the issue of possession states. At this point, the investigation has come full circle, as possession states might well be multiple personalities, depending on whether the diagnosis is religious or psychiatric. To the external view, possession and multiple personality have much in common, as both are entirely concerned with transformation of identity.

In the early days of 'hypnotism,' 1840 to 1860, many cases of "double consciousness" came to the attention of various attending physicians, mostly in France and in the United States. What they tended to have in common was the temperament of the alternating personas: the host personality tended to be sober, dour and dutiful, while

²⁴ The exact relationship between hypnotism and dissociation is still in dispute. A person who is hypnotized can more easily dissociate. Additionally, dissociative people are reputed to be easily hypnotized, and a measure of hypnotisibility is part of the diagnosis for dissociation. At any rate, the history of dissociation is intertwined with the history of hypnotism.

²⁵ This is Henri Ellenberger's account of Azam's professional and therapeutic relationship with Félida. It is disputed by Ian Hacking, who says "Azam did not even know about hypnotism when he met Félida; he experimented with her first because she spontaneously dissociated." (Rewriting the Soul, page 161)

²⁶ Spiritism is, literally, the belief in spirits - and in the notion that discorporate spirits can (variously) manifest on the material plane. One of the sites of manifestation is commonly thought to be a living person. When this happens, the person is "possessed". (Spiritism is currently having a renaissance, under new names. It is presently popular to invite possession. These days this practice is called "channeling", and has its own enthusiastic constituency. What channeling has in common with more traditional kinds of psychotherapy, besides its obvious lucrative rewards to the practitioner, is its dependence, with excessive cogency, on the good faith of all concerned. And, as in traditional psychotherapy, good faith may not be enough. Hypnotism may also be required.)

the alter tended to be carefree and vivacious. (This caused Janet to comment that it was the alter who was healthy, and the host that had psychological problem.)²⁷

Spiritualism, as a religious movement, has its beginnings in France, as does spiritism, which is a small, subset practice within the broader context. Both were stimulated by mesmerism, early in the 19th century, as was trance mediumship, which was considered a kind of voluntary possession - and which also meets all the DSM-III-R criteria for MPD, and half the DSM-IV criteria for DID.²⁸

Colin Ross points out many of the [clinical and phenomenological] properties possession states share with multiple personality. Possession is subdivided into two basic categories, depending on the presence or absence of one-way amnesia. In the somnambular type of possession, which is more common, and in which the "host" experiences a loss of consciousness, when the host says "I", this "I" is not the host, but the supposed intruder. When the host returns, he is amnesiac for the "takeover" time. In lucid possession, the second kind, the host's awareness is retained. The host experiences the presence of another consciousness within, who can speak and act. While the host is aware of this other agency he can neither prevent it nor interfere. After the episode, the host has full memory of what he (they?) did. In both kinds of possession, the "possessor" refers to the "possessed" in the third person.²⁹ There is a direct parallel in multiple personality. An alter refers to the host in the third person. In some kinds of multiple personality the host is not aware of the alter, and does not remember the takeover, and in other kinds, when the host has been "co-conscious" with the alter, she does.³⁰

²⁷ The overwhelming majority of these cases were women. Women in the mid nineteenth century had very few options, and none of them left time or reason to be carefree and vivacious. Among other things, the alter personality gave an irrepressible human spirit a place to have some expression.

²⁸ For the purpose of this paper, "spiritualism" refers to a movement known among white, European or European-based people, generally middle-class, often literate. Spiritualism in its broader context has been both revered and practiced for millennia, all over the world. It is outside the scope of this paper to address that broader context.

²⁹ Colin Ross. (1989) Op. Cit. P. 17.

³⁰ The formal diagnostic criteria for possession do not distinguish it from DID (formerly MPD.) According to the DSM-IV, the first two (of four) formal diagnostic criteria for MPD are A) The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving,

Hypnotism's predecessor was animal magnetism, developed by Franz Anton Mesmer. Mesmer studied theology and medicine at the University of Vienna. Influenced by the teachings of Paracelsus, Mesmer believed that the stars influence the health and general conditions of human beings by way of a subtle and invisible fluid medium, which could be harnessed by a person to heal others. This force, which Mesmer names "animal magnetism" was later called mesmerism. Mesmer worked with hysterical patients, and although he documents many successes, in 1778 he was obliged to leave his practice in Vienna, having been accused by the mainstream medical establishment of practicing magic.

There may have been some validity to the complaints. Histories of western Occultism include Mesmer in their chronicles of who's who. Kenneth Grant³¹ notes that Anton Mesmer and Count Cagliostro were among those who were initiated into the Order of the Illuminati.³² When Cagliostro formed a link between the Order of the Illuminati and the Martinist Order, Mesmer was recorded as being involved. The Illuminati linked itself to the Freemasons in 1778, and gradually gained control of the various secret occult societies that were operating in late 18th century Europe, creating an illuminized network of occult societies. Many occult histories link Mesmer's name to much of this organizational re-ordering.

Ellenberger attributes the beginning of Dynamic Psychiatry to a clash between Mesmer and an exorcist named (Father) Johann Gassner. Mesmer was able to produce the

relating to, and thinking about the environment and self.) B) At least two of these personalities or personality states recurrently take full control of the person's behaviour. (DSM-IV Op. Cit. p. 487)

³¹ Kenneth Grant. *The Magical Revival* London: Frederick Muller Limited, 1972.

³² The Comte di Cagliostro, born in Malta in 1743, was a controversial figure in the courts of France. Widely known for both his philanthropy and for his connection to a number of secret societies, Cagliostro was both much lauded and much maligned by his contemporaries. In occult history, Cagliostro is credited with the alliances made between the Knights of Templars, the Freemasons, and the Order of the Ruby Rose and the Golden Cross. This is a significant alliance, permanently changing the nature of western occultism. Cagliostro was arrested in Rome in 1786 for "attempting to found a Masonic Lodge in the Holy City of Christendom." He was sent to the Bastille for this crime. There are many conflicting reports of what happened to him after the French Revolution. It is generally accepted that he was spirited away by members of one of the many societies to which he belonged.

same effects with "animal magnetism" that Gassner did with exorcism.³³ Due to ever more fantastic stories of objective manifestations, externalizations of sensitivities, and tales of regressions into sex-alternating previous incarnations, the practice of or mesmerism was eventually "consigned to the level of a popular marvel."³⁴ In an attempt to redeem mesmerism, a nineteenth century Manchester physician named James Braid renamed it as scientific hypnotism, and attempted to base it on brain physiology. He was unsuccessful in convincing his colleagues that hypnotism had any relationship to science.³⁵

Eduard Van Hartmann published *Philosophy of the Unconscious* in 1869, which helped introduce theoretical aspects of the unconscious and started to distinguish between mesmerism and hypnotism. Pierre Janet developed the word "subconscious" to separate what he considered his scientific-psychological approach from the metaphysical-philosophical approach that Von Hartmann brought to the word "unconscious."³⁶

In the years 1870-1893, Jean-Martin Charcot, who created the neurological clinic at Salpêtrière, was considered the greatest neurologist of his time. Called "the Napoleon of Neuroses," Charcot is credited with the discovery of hysteria, hypnotism, dual personality, catalepsy, and somnambulism, as well as "hysterical ambulatory somnambulism."³⁷ Charcot defined hysteria a psychosis superinduced by ideation, and was the first practitioner to study it by using hypnotism. This resulted in Charcot studying hypnotism, where he found that hypnotic trance had three successive stages, lethargy, catalepsy, and somnambulism. When he delivered his paper "*On the Various Nervous States Determined by the Hypnosis of Hysterics*" to the French Academy of Sciences in Paris in 1882, hypnotism was restored and elevated to respectability.(Ian Hacking

³³ Henri Ellenberger, Op. Cit. p. 53

³⁴ Ian Hacking (1995) *Rewriting the Soul: Multiple Personality and the Sciences of Memory*. Princeton: Princeton University Press. P. 144.

³⁵ Ellenberger, Op. Cit. P. 83, and Hacking, Op. Cit. P. 144.

³⁶ Hannah Decker. *Non-materialism in Materialist Europe. Split Minds, Split Brains*. Op Cit. p. 48.

³⁷ Ellenberger suggests that why Charcot was credited with all these discoveries had as much to do with his already established and considerably celebrated reputation as it did with his actual work. (See Ellenberger, 1970, P. 95, for further discussion of this matter.)

remarks that French multiple personality was born under the sign of hysteria. All multiples were hysterics, usually with the extraordinary symptoms that Jean-Martin Charcot had made famous.)³⁸

Janet worked under Charcot at the Salpêtrière, where he interned, using his patients as experimental subjects for his theories on hysteria. What Janet diagnosed as hysteria is now called dissociation. It was Janet, rather than Freud, who discovered the "unconscious." Sir William Osler wrote of this mix-up: "In science the credit goes to the man who convinces the world, not to the man to whom the idea first occurred."³⁹

In 1889 Janet published *Psychological Automatism: Experimental Psychological Essay of the Inferior Forms of Human Activity*, which documents and discusses his work in psychopathology at Le Havre from 1882 to 1888. Janet had begun this work at the same time as Josef Breuer had started working with (the famous) Anna O. Both men simultaneously and independently arrived at a very similar set of observations about dissociation. Janet's book propounded the (then) novel thesis that hysterical symptoms are due to subconsciously fixed ideas that have been isolated and usually forgotten. Split off from consciousness, dissociated, they embody painful experiences. By virtue of their segregation from the consciousness, these painful experiences become autonomous, and the person who has them (the 'host' in contemporary parlance) has no awareness of them. Through hypnosis these experiences can be identified and claimed, and re-integrated into the consciousness.⁴⁰

In *Psychological Healing* Janet discussed the theories of hypnosis that were considered credible at that time. Janet recognized that hysterical symptoms could be replicated through hypnosis. He discounted the popular conclusion that hysterics were weak-minded, and therefore susceptible to suggestion. Like Charcot, he saw many parallels between hypnosis and hysteria, but also like Charcot, he made no precise

³⁸ Hacking (1995) Op. Cit.

³⁹Eugene Bliss, (1986) *Multiple Personality, Allied Disorders, and Hypnosis*. New York: Oxford University Press. P.38.

⁴⁰Bliss. Op. Cit. P. 38-9.

connection between the two. Janet proposed that it was the hypnotic process itself to which hysterics were susceptible. Although he concluded that hysteria was due to congenital weakness of psychological synthesis, Janet dismissed the assumption of weak-mindedness in the hysterics themselves. While largely ignored in its time, this assumption of genetic predisposition was an early contribution to the growing professional lore of organic mental illness; the notion that a substantial percentage of the population are simply born with broken brains.⁴¹

Janet developed a complex form of hypnotic therapy that worked to reintegrate into mainstream consciousness the traumatic dissociated memories. During this period Freud published his observations. Janet was publicly offended by Freud's failure to credit him. In 1895 Janet made a statement that Breuer's and Freud's publications of 1893 and 1895 were reiterations of his own material, which he had published in 1889. Freud's "unconscious" was Janet's "subconscious". Freud's "repression" was his "weakness of mental synthesis". Breuer and Freud's "abreaction and catharsis" were Janet's "making the subconscious conscious" by "reintegration, assimilation and liquidation."

Freud and Janet had come up with different words for what Janet claimed was an identical theory. He further claimed that the theory (of dissociation, which Freud called repression) was initially his. Janet claimed that much of Freud's material was actually his own. That which was really Freud's, Janet considered to be psychiatrically unsound. This included the Oedipus complex, psychosexual development (the oral, anal, phallic and genital stages) and the castration complex.

Foucault comments on the difference between Janet and Freud:

Janet enumerated the elements of a division, drew up his inventory, annexed here and there, perhaps conquered. Freud went back to madness at the level of its *language*, reconstituted one of the essential elements of an experience reduced to silence by positivism; he did not make a major

⁴¹ See Nancy C. Andreasen, *The Broken Brain: The Biological Revolution in Psychiatry* London: Harper and Row, 1984, for a contemporary hypothesis of organic mental illness.

addition to the psychological treatments for madness; he restored, in medical thought, the possibility of dialogue with unreason.⁴²

Determinism was gaining momentum at the turn of the century, and Freud's version of the unconscious both acquiesced to and reinforced this doctrine, in which the subconscious is understood to be a stormy place where malevolent forces attempt to subvert human reason. The solution is to make the unconscious conscious, so that these entropic forces can be subdued by the rational mind. "Free association and psychoanalysis would liberate human beings, allowing them the freedom to direct their own behaviour after the unconscious was revealed in therapy."⁴³ Following this new belief, Freud stopped using hypnosis in 1892.

Colin Ross comments on Freud:

Freud did to the unconscious mind, with his theories, what New York City does to the ocean with its garbage. Instead of listening to the tales his patients were telling him about childhood trauma, Freud projected his theories onto them to "explain" their symptoms. Freud wasn't fluent in the language of the unconscious, so he didn't hear what his patients were telling him. Or rather he heard, but he couldn't bear to listen.⁴⁴

Janet, contrary, continued using hypnosis, and continued working with "hysterics." He developed a theory of "artificial somnambulism", a deep hypnotic state for which he had three criteria: (1) amnesia upon awakening; (2) memory of previous hypnotic states during the hypnosis; and (3) memory of the waking state during hypnotic states.⁴⁵ At the extreme end of the continuum of these hypnotic states was that which Janet called "successive existences." The successive existences that would emerge during deep hypnosis were sometimes quite unlike the patient. They called themselves by different names, had different kinds of attitudes and behaviours, and were sometimes considerably younger than the patient, and called themselves by a nickname from the

⁴²Michel Foucault. *Madness and Civilization* New York: Random House, 1965.

⁴³Bliss. Op. Cit. P. 43.

⁴⁴ Ross (1989) Op Cit. P. 181.

⁴⁵ Ellenberger. (1970) Op Cit. P. 360.

patient's youth.⁴⁶ Janet interpreted these successive existences in his theory of "*désagréations psychologiques*," psychological dissociation. It is this theory, and Janet, that is credited with bringing the word and the concept "dissociation" into existence. Because of this, Janet is often considered the link between the first dynamic psychiatry and the newer system.

The two medical schools where hypnotism was practiced, one at Nancy, under the direction of Hippolyte Bernheim, and the other at Salpêtrière, under the leadership of Jean-Martin Charcot each influenced popular attitudes towards hypnotism - and towards multiple personality - differently. Charcot systematized hypnosis into three major categories or stages: catalepsy, lethargy, and somnambulism. These three stages, with their inherent characteristics became the hallmark of the Salpêtrière school of thought.⁴⁷

The more that hypnotism was practiced in clinical settings, the more there began to be recorded the emergence of "another self." The history of hypnotism and the history of the public emergence of multiple personality are inextricably twined together. Through hypnotism, a new model of the human mind evolved, based on the duality of conscious and unconscious psychism. Unconscious psychism was later modified to be understood as a cluster of subpersonalities underlying the conscious personality, and available through hypnosis. Some people, it was thought, had more than these clusters of subpersonalities. They had 'divided personalities', generally. After about 1880, divided personality was much discussed by psychiatrists and philosophers.⁴⁸ Hannah Decker explains that "the existence of multiple personality led especially English and French thinkers to conclude that literary, artistic, and scientific creativity was the coming into consciousness of an alternate personality or the eruption of subconscious material."⁴⁹

At the turn of the twentieth century Morton Prince was one of the chief speculators on the nature of dissociation and the subconscious. In 1906 Prince founded

⁴⁶ The description of successive existences could easily be a contemporary description of classic presentation of multiple personalities, as they emerge under hypnosis.

⁴⁷ Laurence and Perry. Op. Cit. p 197.

⁴⁸ See Ellenberger (1970) PP. 120-126 for a more detailed discussion.

⁴⁹ Hannah Decker. Op. Cit. page 46.

and edited *The Journal of Abnormal and Social Psychology*.⁵⁰ In 1910 he founded the American Psychopathological Association. There was confusion in intellectual nineteenth century America about the implications of the modern science of psychology. It had been commonly understood that the mind was an aspect of the soul working through a physical agency. Prince, a materialist, did not suffer from these confusions. To him, no unitary soul acted through brain and body; no unitary ego directed experience. Urges were of human origin. Nathan Hale describes Prince as having viewed personality “shorn of a unitary ego, as a mosaic of associated memories, emotions, and characteristics, some shifting, some constant.”⁵¹

Prince was also the doctor who treated Christine Beauchamp (a.k.a. Clara Fowler) who, as Prince's patient, become one of the most famous "cases" of multiple personality on record. Five hundred playwrights submitted scripts for the play of Prince's book about Beauchamp/Fowler *The Dissociation of a Personality*. The winning author's play, *The Case of Becky*, directed by David Belasco, ran for six months on Broadway and was also made into a silent film.⁵²

By 1910 there were two distinct and opposing schools of thought in abnormal psychology; a German stream that could be called Freudian , and a French one, that basically followed Janet. Prince was very much in the French camp. Janet's word *désagrégation* was translated into English as “dissociation” by William James, who was interested in French psychology and was an admirer of Janet. It was Prince who established the English usage of the word “dissociation” by using it in print in 1890. Prince's influence was such that his usage made it legitimate.⁵³

When psychoanalytic theory flourished, and dissociation was replaced by repression, Freud exulted:

⁵⁰ Decker. Op. Cit. P.86.

⁵¹ Nathan G. Hale, Jr. *Morton Prince: Psychotherapy and Multiple Personality: Selected Essays*. Cambridge: Harvard University Press, 1975. p.4.

⁵² Ian Hacking (1995) Op. Cit. P. 232.

⁵³ Hacking (1995) Op. Cit. p.44.

You will now see in what it is that the difference lies between our view and Janet's. We do not derive the psychical splitting from an innate incapacity for synthesis of part of the mental apparatus; we explain it dynamically, from the conflict of opposing mental forces and recognize it as the outcome of an active struggling on the part of the two psychical groupings against each other.⁵⁴

The psychoanalytic concept of repression is more like amnesia than it is like dissociation. Like dissociation, memories that were once available are no longer so, in the usual way. Like dissociation, they are recoverable by special techniques. The special technique to recover dissociated memories is hypnotism. The technique to recover repressed memories is psychoanalysis, starting with free association.⁵⁵ What is repressed, in psychoanalytic theory, is unacceptable impulses, which, also according to the theory, all humans have. Unlike dissociation theory, where what is dissociated is disturbing material that came from sources outside the person, early childhood trauma for example, repression theory assumes that the disturbing material is innate. Humans are not entirely all-right; they have 'dark sides'.

Under William James psychology ceased to be a kind of mental philosophy and became a laboratory science. James, (the brother of Henry) a physician, was much influenced by the philosopher Charles Renouvier, who had a distaste for the unknowable, and a reliance on the validity of personal experience. In embracing Renouvier, James moved entirely away from Determinism, both the scientific variety that had been inculcated by his medical training, and the theological variety that was popular in his time. When James was appointed instructor of physiology at Harvard in 1872, he brought his then radical views to the university. Rather than teaching physiology, James taught physiological psychology.

In 1890 James published *The Principles of Psychology*, which assimilated the mental sciences to the biological disciplines. In 1892 *The Principles of Psychology*

⁵⁴ Sigmund Freud. "Five Lectures on Psychoanalysis" (1909) in *The Standard Edition of the Complete Works of Sigmund Freud* London: Hogarth Press. Vol. XI, p 21.

⁵⁵ Janet, whose methodology was much incorporated by Freud, also used free association. He called it "automatic talking".

became a textbook, or perhaps more accurately, the textbook that influenced successive generations of psychologists. In a theoretical chapter on the consciousness of the self, James discusses multiple personality, noting that material, social, and spiritual selves can shift in their valences, resulting in multiple personality. Because James was so respected in his time, his ideas seriously influenced the attitudes of the other psychological theoreticians of his time.

Having had his say in psychology and in the process, having set up the first demonstrational psychological laboratory in the USA, James returned to his pursuit of philosophy and metaphysics. His lab employed a galvanometer and kymograph to measure galvanic changes in skin, testing response to emotionally laden stimuli in apparently neutral words. James was looking for neurological differences in different alters. This notion, of physiologically determined difference was a major step in the study of dissociative states.

In the next few decades, the skin tests themselves became of more interest to clinicians than the search for the alter personalities that the tests were originally invented to find. The materialist perspective was gaining currency in psychiatry. What was dissociated was not available to be measured. Therefore the study of it was not science. The backlash to the age of European Romanticism had begun and Materialism was the new order of the new day.

Materialism teaches that all facts -- including facts about human thought, facts about the course of history, facts about the meaning of life -- are reducible to physical processes. Mental events are really physical events. Mental processes are determined by physical processes. What *is* can be measured. Disincarnate consciousness is not possible. Public observation, not private intuition, is the only reliable, and to a materialist perspective, the only *rational* source of information.

The new developments in psychopathology had (as they frequently do) quite an impact on the popular culture of the time, with (as is also the established pattern) some time lag. Materialism had begun its ascent in psychiatry, while in the popular culture, the

ideas of Romantic science were still being established. The notion of double consciousness or split personhood was a common theme in the last two decades of the nineteenth century. In 1886 Robert Louis Stevenson published *The Strange Case of Dr. Jekyll and Mr. Hyde* in the USA. The next year Oscar Wilde published *The Portrait of Dorian Gray* in England, and five years later, in 1893, Paul Lindau's play *The Other* was produced in Vienna.⁵⁶

The doubling of character was understood as a way of expressing moral conscience. Battles were seen to rage within human minds. It was assumed that the good (that is, social order) would prevail. It was also assumed that the evil, the shadow, the other, had to have some way to express itself. Hypnotism brought this shadow into the light, only to discover that it wasn't a shadow in the expected sense.

In the early 1880's, hypnosis became a highly developed technique of the new abnormal psychology. Hypnotism was a normal phenomenon that sometimes disclosed abnormal conditions. The study of hypnotism and the study of multiple personality have many places of convergence. Various "psychopathological conditions"⁵⁷ could be explored through hypnotism and - according to William James - a number of iatrogenic ones may have been formed, including spontaneous somnambulism, lethargy, catalepsy, multiple personality, and hysteria.⁵⁸

Austin Spare, an early twentieth century occultist who may have belonged to the same secret societies as Mesmer (if Mesmer did belong to secret societies) put forth various propositions about "genius." He contended that a person can not *be* a genius, but that a person may *have* a genius. The genius, then, may be the other consciousness, the "well one" as Janet would say, or what Ernest Hilgard now calls the "hidden observer." Hypnotism allows the hidden observer to speak to the outside world.

⁵⁶In the new paradigm, popular culture also reflects psychiatric discoveries. Television programs such as *Herman's Head*, in which four fully articulated people live and argue inside a person's head, affecting all his decisions abound. The popular series *Star Trek NG* has an episode about the many in the one.

⁵⁷ This is Hannah Decker's description. (Decker in Quen, page 42). The labeling, from this distance particularly, of conditions as psychopathological is one of the dubious legacies of the psychiatric mindset. This reference is included for that reason.

What is now known as parapsychology used to be a branch of spiritualism. The American Society for Psychological Research was founded in 1882, to explore supernormal faculties of the human personality. Whatever supernormal faculties were hypothesized to exist, it seemed that they were more likely to be available for demonstration through hypnosis. Parapsychological research, then, became part of the process that brought hypnosis into medical and psychiatric usage. As well, there was a crossover of personnel in the two fields, psychiatry and parapsychology, the most notable of whom was William James.

There persists, in the study of dissociation in its various forms, a school of thought in which the incidence of multiple personality is entirely iatrogenic. William James worried about this, basing his concern on the apparent rise and fall of the recorded clinical incidence of multiple personality. Many cases were reported between 1850 and 1910, and suddenly the reports dropped off. George Greaves says of this difference:

I have been known to speak at length on the events that led to multiple personality being regarded as an uncommon but by no means rare condition in the 19th century-while being regarded as an anomaly and annoyance through much of the 20th century. Such lectures can be reduced to a single statement: French speaking psychiatry dominated the English-speaking world during the 19th century; German-speaking psychiatry has dominated much of the 20th.⁵⁹

Hypnosis was replaced by psychoanalysis. Did this mean that people stopped dissociating?⁶⁰ It was, at least, renamed and re-defined, altering the perception of any diagnostician, if believing something exists is a prerequisite for seeing it. In the highly materialist period of the early twentieth century, psychotherapists didn't use hypnotism, and didn't "believe" in multiple personality. Consequently, no clinical incidents of multiple personality are recorded for a couple of decades. That is, incidents of what would now, retrospectively, be diagnosed as dissociation and multiple personality were

⁵⁸ Decker. Op. Cit. p. 42.

⁵⁹ George Greaves. A History of MPD" in *Clinical Perspectives on Multiple Personality Disorder*. (1993) Op. Cit. P. 357

⁶⁰ Among the many sites of struggle over the construction of diagnosis are believers of the theory that dissociation is, indeed, directly resultant from hypnosis, and that if people were not hypnotized, they would not dissociate (and form alter personalities.)

assessed, recorded, and diagnosed as something else. For instance in *A Textbook of Psychiatry*, produced in 1924, Eugene Bleuler says:

It is not alone in hysteria that one finds an arrangement of 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 delving into those rare though most demonstrable hysterical cases, we can produce the very same through hypnosis.⁶¹

What the clinical record shows is not what happened, but what it was fashionable in psychiatry and psychology to believe at the time. George Greaves uses inoculation theory to account for how influence is established. Roughly speaking, inoculation theory proposes that meaning is constructed by the party that speaks first, because the first accounting sets the stage for whatever follows. In psychiatry, the strongest stake that can be made in the construction of meaning is the diagnosis itself. Once the diagnosis is established, all subsequent discussion is about that diagnosis.

By about 1910, the patient lost all access to the discussion about diagnosis. Psychology was going to be a science now, and science is not the province of psychiatric patients. It was considered unscientific to include the perspective of someone who, by the fact that he was visiting a psychotherapist, was suffering from a pathology. The doctors were not interested in their patients' points of view. Rather, they gave their patients the Rorschach Inkblot test, and discussed the results, and what they might mean, with each other. William James sighed that in philosophy and psychology, "Souls have worn out both themselves and their welcome, that is the plain truth"⁶² Biological determinism had arrived.

Colin Ross says of *Studies in Hysteria*:

"One can see the cases in *Studies in Hysteria* represent a range of dissociative disorders. There are some cases of full MPD....In the theoretical sections of the book both Freud and Breuer build a theory of trauma-driven dissociation. There are numerous references to splitting of

⁶¹ Eugene Bleuler.(1924) *A Textbook of Psychiatry*. Translated. Cited by Greaves (1993) Op. Cit. P. 359

⁶² William James.(1909) *A Pluralistic Universe* London: Longmans. P.10. Cited by Burnham in Quen. Op. Cit. P. 80.

consciousness, dissociated states, autohypnosis, and a spectrum of increasing severity and complexity of dissociation.⁶³

Ross is of the opinion that Freud's repudiation of seduction theory was a major factor in the discrediting of dissociative disorders. Freud abjured the reality of his patients' childhood trauma, and instead constructed "an elaborate theoretical explanation of [the patients'] symptoms. For many decades, MPD patients were rarely diagnosed....Their symptoms were misunderstood in terms of incorrectly applied psychoanalytical theory. As a result, they received either no treatment or the wrong treatment."⁶⁴

Societal confluence of events caused a metamorphosis in American psychiatry. The rise of Nazis to power in Germany brought a stream of German Jewish philosophers, scientists, and doctors to the United States. Working from the (relative) sanctuary of American universities and hospitals, this group of immigrants produced an intellectual wave that washed over American psychiatry. Riding that wave were the traditions of Kraepelin, Blueler, and Freud.⁶⁵

Carl Gustav Jung's initial interest had been in further research on the split-off parts of the unconscious; work started by Janet; but this interest became subsumed in Ziehen's (then) new material on emotionally loaded representation complexes. Jung moved from Ziehen to Freud.⁶⁶ When he moved on, Jung developed work that emphasized resolving immediate conflicts, rather than uncovering the conflicts of one's childhood. While he devised an entire system of therapy that concentrated on creating cooperation between the conscious mind and the unconscious mind, dissociation theory did not fit into his construct. Dissociated personality to Jung was by definition a neurosis. The investigation of this particular neurosis was not of interest to him. Jung's focus was

⁶³ Ross. (1989)Op. Cit. P. 34.

⁶⁴ Ross.(1989) Op. Cit. PP. 35-36.

⁶⁵ See George Greaves (1993) Op. Cit. P. 361

⁶⁶ Jung, even in his most passionate following of Freud's work, never did accept the theories off Oedipus or Electra Complex.

elsewhere, and given the enormous influence he had in his field, his silence contributed to the further decline of the study of dissociation.

The greatest influence, however, and the greatest contribution to the decline of the study -- and therefore the apparent existence-- of multiple personality and dissociative states was undoubtedly Freud's. People with dissociative behaviour were diagnosed as suffering from unrequited incestuous longings. A whole school of psychiatric interpretation was constructed on the principle of blaming the victim.

According to the newly constructed popular legends about the second coming of dissociation and multiple personality, dissociation, the diagnosis, disappeared. That may not be the case. In 1944, Taylor and Martin published the article "Multiple Personality" in the *Journal of Abnormal and Social Psychology*.⁶⁷ It was a landmark paper; the most quoted source on the history of multiple personality for the next thirty years. However, it doesn't fit the popular myth, and so, of the many histories of dissociation, few refer to it.

Dissociation, the condition, in all its manifestations, did not disappear. People still dissociated, still fragmented, but the symptomology that we now know as multiple personality was then called Oedipal Hysteria, and later renamed Schizophrenia. Schizophrenia, which means literally split mind, from the Greek *schizo*(split) and *phren*, (mind), was originally called *dementia praecox*.⁶⁸

Much confusion is generated by the nomenclature. Schizophrenia is widely thought to be an organic malfunction, more closely related to Alzheimer's than to dissociative disorders, although a biochemical basis has not been proven. DID (MPD), which is not organic, in the sense that it cannot be instantaneously chemically reorganized, was initially treated like an organic disorder because of the deductions made from its name. Ross comments:

The problem in contemporary psychiatry [because of ideology] is the inability of many psychiatrists to make an accurate diagnostic

⁶⁷ *Journal of Abnormal and Social Psychology* 39:2810300, 1944.

⁶⁸ Colin Ross (1989) *Op. Cit.* PP. 38,39.

discrimination between two groups of illnesses (organic brain syndromes and posttraumatic dissociative disorders), which have different etiologies, treatments, and prognoses.⁶⁹

The thirteen years after the publication of Taylor and Martin's influential paper is what George Greaves calls 'blackout time.' In the public discourse in psychiatry, Dissociation did not come up.

⁶⁹Hilgard (1977) Op. Cit. P.3.

We have been familiar with psychological “movements” ever since madness was medicalized, and certainly since the advent of psychoanalysis. No one hesitates to speak of the movement founded and orchestrated by Sigmund Freud. Multiplicity has no founding and controlling parent, but if there ever was a movement, it is the multiple personality movement.

Ian Hacking

CHAPTER IV

THE SECOND COMING

The diagnosis of MPD, from my standpoint, is obtained like any other scientific fact, and is sustained by observation. Therefore, I tend to consider the individuals who do not make the diagnosis of MPD, from time to time, as very poor observers, or simply ignorant.

-Cornelia Wilbur, Sybil's

psychiatrist

This chapter will bring the story of the (re)construction of the (re)new(ed) paradigm up to date. When making its debut into Western psychiatry late in the nineteenth century, the paradigm of dissociation (trauma-based disorders) was supported by some data and empirical evidence, but had little specialized language and no meta-language in which to discuss it. In its second debut, it has both. This time dissociation is, according to Colin Ross, the most documented psychiatric disorder in the written history of psychiatry.¹

It is sometimes difficult to identify which paradigm, old or new, is being documented, as there is chronological crossover in many accounts, between the end of one and the beginning of the next, as well as dispute about whether the old paradigm ever really ended, and if so when it did so, and when the new one began. I will start it in 1954: As referred to in Chapter 1 of this thesis, doctors Corbett H. Thigpen and Hervey Cleckley published "A Case of Multiple Personality" in *the Journal of Abnormal and*

¹ Ian Hacking says that this won't help. "Fortunately, the paradigm shift that Ross envisages will not take place." (1995, P.141). The claim about what diagnosis is the most documented is in dispute. Speculation on what will and will not happen concerning the re-emergent paradigm of dissociation is the major thread of this thesis.

Social Psychology,² which Morton Prince had founded in 1906 to provide himself with a forum to talk about double consciousness.³

A Case of Multiple Personality, Thigpen and Cleckley's original article, did not get much response; it was just another journal article in which two psychiatrists had argued that something is real because it can be measured with a machine.⁴

Ian Hacking postulates that the report had a low initial impact in the scientific community because the concept of multiple personality needs a larger cultural framework within which it can be explained and located. Hacking suggests that that framework was child abuse, and that the publication of *Eve* preceded child abuse becoming 'an American obsession.'⁵ Hacking's assessment is consonant with Judith Herman's argument; that the first launch (19th century) of the paradigm of dissociation did not last because it lacked the appropriate political context.⁶ Without that context to provide a foundation to the problem, no effective psychiatric solution is possible. There was much experimentation, much discussion, but few journal articles, and no known success stories. No one knew what to do.⁷ In his account of meeting his first multiplexed person in 1972 and needing clinical assistance, Ralph Allison had nowhere to turn. "Theoretically", Allison says, "I could have turned to the psychiatric literature and looked up the names of doctors who

² *Journal of Abnormal and Social Psychology* (49:135-151.)

³ It is also the journal which, ten years previously, had carried the Taylor and Martin article that was still considered the standard for its field.

⁴ Drs. Thigpen and Cleckley had tried to document differences among "Eve's"(Chris Costner Sizemore) three personalities using electroencephalogram (EEG). They reported a measurable difference in muscle tension between the three personalities. See Frank Putnam.(1989) *The Scientific Investigation of MPD* in Quen. Op. Cit. p. 111.

⁵ Hacking, (1995). Op. Cit. P. 39-40.

⁶ See Judith Herman; *Trauma and Recovery* (1992) New York: Basic Books, P.9 for more on this argument.

⁷ There are various analogies for the spectacle of approaching a problem from an absurdly inappropriate angle. One of these illustrations involves a cone and the (conscious and reasoning) surface of a basin of water. The surface of the water tries to discover the nature of the cone. When it is dipped in slightly and straight down, the water perceives a disk.. When the cone is dipped further, the water perceives a bigger disk. When the cone is dipped obliquely, the water perceives a hyperbolic ellipse. When the cone is dipped another way, the water perceives a parabolic ellipse. When the cone is submerged, the water perceives nothing. All the assembled data that the water collects about the cone will not reveal its three-dimensional reality. That understanding must come from an expanded horizon of perception. For the answer to be "a cone," the water must learn to ask a less reductionist and more complex question.

had successfully treated such people. But I had looked over the literature and it was obvious that other doctors didn't really know what they were doing."⁸

Certainly it is unlikely that a trauma-based condition can be recognized in a society which does not acknowledge early childhood trauma. Trauma-based disorders started to become a psychiatric possibility again in the early 1970s, as the feminist movement began to break through the ontological closure against incest and child abuse.

In 1954, when Thigpen and Cleckley's article was first published, child sexual abuse was considered extremely rare, and female children under the age of twelve who were found to be 'non-virginal' could be charged with the crime of sexual immorality and taken to a maximum security juvenile detention facility. The conditions were unsuitable for trauma-based disorders. With so many social systems blaming the victim, it would be awkward indeed if psychiatry broke ranks.

In this frosty climate, Hervey Cleckley rewrote the case-history into a book. *The Three Faces of Eve* was published in 1957.⁹ George Greaves offers a synopsis:

Cleckley's pen is everywhere in *Eve*. It is an evenhanded description of what he and Corbett Thigpen experienced. There is no hype, no misplaced optimism, no treatment plan, no promises. *Eve* the book reads as the faithful monitoring of two psychiatrists, senior and junior, who haven't the slightest idea how to treat the patient and who dismiss her at the end, when she is somewhat stabilized, wishing her well, and knowing that she still experiences amnesia.¹⁰

The book was a 'sleeper', which became more popular after the film was made. The book and film, however, added the diagnostic label of multiple personality disorder to the vocabulary of the general public. Knowing the name of something is the proverbial inoculation that introduces the concept into a system. However little we might understand of a concept, once we know its name, we can no longer be unaware of the possibility of its existence. A nebulous rendering of the clinical concept of multiple personality entered the popular imagination.

⁸ Ralph Allison and Ted Schwarz. (1980). *Minds in Many Pieces*. Toronto: McClelland and Stewart Ltd. P.44.

⁹ C.H. Thigpen and H. Cleckley (1957) *The Three Faces of Eve*, New York: McGraw-Hill.

¹⁰ George Greaves "A History of MPD" (1991) Op. Cit. P. 362.

Colin Ross says that by the time the report -- and the book -- on Eve was published, multiple personality had sunk so far into psychiatric (that is, clinical) oblivion that "Eve White was thought to be the only living case."¹¹ After the film *The Three Faces of Eve* was broadcast on television in 1957 however, multiple personality (although what Ross calls 'an extravagantly rare curiosity'), gained some cultural (and by retroactive extension, psychiatric) significance. Some critics of the notion of multiple personality claim that *Eve* may have had a cultural and even clinical influence that cannot be directly measured. They claim that this film may have functioned as a model for dissociative children in abusive homes; that it was an education of sorts on how to form alternate personalities, and that when it is done this way, there is a 'good one' and a 'bad one.' This assumption fits well into the binary Cartesian reality that has become the primary cognitive filter of biomedicine.¹²

THE NEW PSYCHIATRIC TESTAMENT

The 1960s were a turbulent time. Psychedelic drugs, the war in Southeast Asia, the civil rights movement in the US, the gay rights movement in the US and Canada, and the women's liberation movement in many Westernized countries, contributed to societal shifts. There were also psychiatric shifts. Because the relationship between society and psychiatry forms such a complex symbiosis, there are often what seem to be covariant movements between the two.

Where the ties are clear is in the relationship between the war in Viet Nam and the psychiatric development of Posttraumatic Stress Disorder.¹³ Dissociative Identity Disorder is assessed to be the maladaptive adult result of adaptive response to childhood trauma. An English translation of the Clinique theory is: that a young child (preverbal, in contemporary clinical theory) is subjected to terrible and ongoing trauma (perhaps, for

¹¹ Colin Ross (1986) Op. Cit. P. 90.

¹² While Western medical doctrine operates on the reductionist principles of Cartesian dualism, arguably, the new paradigm in psychiatry is being constructed on Viccian principles instead. Giovanni Vico says in *The New Science* (1744) "The world of civil society has certainly been made by men and its principles are therefore to be found within the modifications of our own minds." According to Vico, only God can know Nature. Men (sic) can know only their own creation: the civil world.

¹³ Although PTSD is an anxiety disorder, and not (yet) a dissociative disorder, it is an important part of the construction of the new paradigm.

instance, chronic, sadistic, sexual abuse by a parent.) The child is small and powerless. She can't effectively fight back; she can't make it stop; she can't get away; and she can't die. Without any basis for a sense of her own agency, she must endure the unendurable. Her only ally in this situation is her own consciousness. It fractures, and the parts take shifts, providing the child with some relief; as to each of the fractured parts of the consciousness, the horror is intermittent. Are there correlations in response patterns when an adult is forced to endure the unendurable? As the prime research material for investigation of this matter is soldiers, there is never any shortage of study sites.

Judith Herman describes the shattered illusion of "manly honour and glory" in the first world war:

Confined and rendered helpless, subjected to constant threat of annihilation, and forced to witness the mutilation and death of their comrades without any hope of reprieve, many soldiers began to act like hysterical women. They screamed and wept uncontrollably. They froze and could not move. They became mute and unresponsive. They lost their memory and their capacity to feel.¹⁴

This condition, originally thought to be a physical rather than psychological response, was initially named "shell shock." When the condition was reassigned a psychological basis, the name shell shock remained. In the same way that women diagnosed hysterical were often thought to be morally deficient, soldiers diagnosed with shell shock were often thought to be moral invalids. Both groups received the dubious medical treatment considered suitable at the time to the morally bankrupt.¹⁵

Psychiatric interest in shell shock rose and fell with the number of soldiers suffering with it. It did not accumulate enough momentum to warrant a large-scale investigation until the 1970s. After the war in Viet Nam and Cambodia, organized groups of adversely affected American soldiers demanded their right to proper medical and psychiatric diagnosis and treatment. As a result of the soldiers' political organizing,

¹⁴ Judith Herman.(1993) Op. Cit. P. 20.

¹⁵ Women diagnosed hysterical were often subjected to brutal 'curative' treatments ranging from tying a woman to a chair and beating her into unconsciousness, to subjecting her to 'vaginal exploration' in a medical class, in front of several hundred (male) students, to surgically removing her ovaries. Similarly, soldiers suffering from shell shock were harangued, beaten, and subjected to electric shock.

Posttraumatic stress disorder (PTSD) came into official, American-Psychiatric-Association-sanctioned reality in 1980.

As it became apparent that response *patterns* of adults and of children subjected to ongoing horrors had many similarities, the study of PTSD became part of the study of dissociation, and was included in the paradigm. In addition to the responses being similar, it appeared that ‘the talking cure’ would help victims of trauma to recover, regardless of when that trauma was experienced.¹⁶ The talking cure was also the foundation of treating dissociative disorders. Perhaps the most famous of these talking cures took place between Cornelia Wilbur and Sybil Dorsett.

In 1973, Flora Rheta Schreiber, a journalist, published *Sybil*, the fictionalized narrative account of ten years of therapy sessions between Sybil Dorsett, who had sixteen personalities, and her doctor, Cornelia Wilbur. After failing to get clinical accounts of her work published, or even being taken seriously by her colleagues, Wilbur engaged Schreiber, a journalist, to write an account appropriate for the general public.¹⁷

Cornelia Wilbur went on to become a consultant for psychotherapists. Richard J. Loewenstein, a past president of the ISSMP&D and the director of the Dissociative Disorders program at Pennsylvania Hospital, says: “Cornelia Wilbur is the originator of the modern conceptualization of multiple personality disorder. All of us who work with MPD patients are her intellectual offspring.”¹⁸

¹⁶ Judith Herman explains that there is no such thing as “traumatic memory”, which she says, is merely a linguistic convenience. Memory, says Herman, is a story we tell ourselves, in the ongoing internal narrative of our lives. . . As the story and the self is different every day, memory is also different every day. Trauma, however, is not part of the narrative, as trauma is not stored as linguistic concepts, but as visual ones. Trauma is pictures in our heads, and unlike the narratives of our lives, the pictures are static and always the same. In order to recover from trauma, says Herman, the traumatized person must find a way to incorporate the pictures into his story. Making the pictures into their own stories, and incorporating those stories into the larger narratives of a life mitigates the trauma and turns the victim into a survivor. See Judith Herman (1993) Op. Cit. PP 15-30, for more on this matter.

¹⁷ This section, about Dr. Wilbur’s therapy with Sybil, is based on Dr. Wilbur’s condensed narrative in “Cornelia B. Wilbur, MD in Her Own Words: Excerpts from Interviews and an Autobiographical Reflection” in *Clinical Perspectives on Multiple Personality Disorder* (R. Kluff and C Fine, eds.) (1993) Washington: American Psychiatric Press. PP.xxv-xxxi.

¹⁸ Richard J. Loewenstein (1993) Posttraumatic and Dissociative Aspects of Transference and Countertransference in the Treatment of Multiple Personality Disorder” (R. Kluff and C Fine, eds.) Op. Cit. P. 51.

While the social and clinical impact of *Sybil* is difficult to measure, it certainly is documented. It was referred to anecdotally (rather than clinically) in nearly every non-clinical account of multiple personality that was written in the next twenty years after its publication. Psychiatrists speculate about how much the book *Sybil* functioned (subconsciously) as a model for people who were, potentially multiple.¹⁹ Dr. Wilbur says of her work “I think that *Sybil* and I have contributed to the recovery of a good many MPD patients and to fascinating and ongoing research.”²⁰ Dr. Wilbur has been accused of creating *Sybil*’s alter personalities. There is bitter controversy about iatrogenic MPD, including accusations against Dr. Wilbur for inculcating personalities in *Sybil* and thereby creating a prototype, both of the “bright, exceptionally verbal Caucasian woman”²¹ who is the stereotypical MPD client and of the pattern of personalities (exceeding a dozen) who present themselves.

If doctor-caused splitting is iatrogenic MPD, would literature-caused splitting be literagenenic MPD?? *Sybil* is often accused of this literagenenic phenomenon. Psychiatric speculation about why multiplexed people have more personalities than they used to often points to *Sybil* as the subconsciously utilized model. Colin Ross argues in 1986 (before the advent of the False Memory Syndrome Foundation) that “there is not a single supporting study of iatrogenesis, not a single documented case of false positive iatrogenic MPD reported in the entire world literature. Yet iatrogenesis is probably the most widespread accepted etiological theory in psychiatry,”²²

Hacking explains:

Sybil became the prototype for what was to count as a multiple. She was an intelligent young woman, with a promising career, who experienced substantial periods of lost time. She had fugue episodes; she would

¹⁹ *Sybil* was referred to anecdotally by many of the speakers at the 7th Annual ISSMP&D convention in Chicago in 1990.

²⁰ “Cornelia B. Wilbur, MD in Her Own Words: Excerpts from Interviews and an Autobiographical Reflection” in *Clinical Perspectives on Multiple Personality Disorder* (R. Kluft and C Fine, eds.) (1993) Washington: American Psychiatric Press..

²¹ See Frank Putnam’s “Dissociation in the Inner City” in *Clinical Perspectives on Multiple Personality Disorder* (1993) Op. Cit. P.180 for more about this stereotypical assumption.

²² Ross (1986) Op. Cit. P. 301

recover herself in a strange place with no idea how she got there. But other features are more important. Patients in the past had tended to have two or three or even four alters. Sybil had sixteen. There were child alters. There were two alters of the opposite sex. Some alters knew about others. They argued, fought, tried to help or destroy each other. This idea of dynamic relationships between different personalities had been glimpsed before, but it was the reports of Sybil that made them prominent. Above all, the etiology of her disorder was writ large. She really had been abused as a child. "Sybil," the main presenting personality, had no memory of those sorry events. But her alters did remember. Indeed they had been created in order to cope with horror.²³

The publication of *DSM-III* signalled the clinical launch of the new paradigm in mainstream psychiatry. The 1967 edition, *DSM-II*, does not list dissociative disorders, and multiple personality is classified as an hysterical neurosis. In *DSM-III* (1980) there are five categories of dissociative disorders. *DSM-III-R* (1987) also lists five, one of which is different from *DSM-III*. (*DSM-III-R* also returns to the sub-classification of hysterical neurosis, dissociative type.) *DSM IV* (1995) lists five dissociative disorders as well, three of which are different from *DSM-III-R*. Most notable is the renaming of Multiple Personality Disorder (MPD) as Dissociative Identity Disorder (DID). The paradigm of dissociation, still under construction, is also steadily undergoing renovations.

Some of the early rebuilding work was done by Ralph Allison, who is cited by Ian Hacking as being one of the three people whose achievements stand out in laying the foundation for the new paradigm.²⁴ In 1980, a landmark year for dissociative disorders, Allison, a Stanford-trained psychiatrist who made no pretense of being an expert in dissociative disorders, published *Minds in Many Pieces*.²⁵ Allison appears to be more concerned for the well-being of his patients than with his professional image. However, his partisan account of what constitutes well-being, based in Theosophist philosophy, undermined his professional credibility. Hacking explains:

²³ Hacking (1995) Op. Cit. P. 43.

²⁴ The other two people are Henri Ellenberger, who, in 1970, published *The Discovery of the Unconscious*, and Cornelia Wilbur, Sybil's psychiatrist. See Hacking (1994) p. 40, for more of this discussion.

²⁵ *Minds in Many Pieces* is co-authored by Ted Schwarz. As it is a story told in the first person by Ralph Allison, Schwarz's contribution, although substantial, is less evident.

The last thing that an emergent science wants is intimations of Madame Blavatsky, so Allison has been slightly marginalized. In retrospect he is honoured as the pioneer of the first protocol for treating multiple personality disorder, a suitable scientific sounding achievement. But it was his proselytizing that fired up the movement.²⁶

The next precipitating factor in the establishment of the new order was Milton Rosenbaum's publication of "The role of the term schizophrenia in the decline of the diagnosis of multiple personality" in the *Archive of General Psychiatry*.²⁷ Rosenbaum proposed that Gmelin's syndrome was perhaps being inadvertently misdiagnosed as schizophrenia. As a diagnosis of Gmelin's syndrome indicated psychotherapy and a diagnosis of schizophrenia indicated neuroleptic pharmacology, a misdiagnosis would misdirect the whole course of treatment. Rosenbaum's article might be considered the beginning of the backlash against biological psychiatry.

Coincident with Rosenbaum's work, George Greaves published a review and analysis of the known world's literature on the subject of Gmelin's syndrome in *The Journal of Nervous and Mental Disease*. Greaves' "Multiple personality 165 years after Mary Reynolds" replaced Taylor and Martin as the standard reference in the field.²⁸ In the first eighteen months following its publication Dr. Greaves received requests for more than five thousand copies, from fifty-five countries.²⁹

In 1981 Daniel Keyes published *The Minds of Billy Milligan*. Billy Milligan was the first person in United States history to be tried and found not guilty by reason of insanity because of having multiple personalities. *The Minds of Billy Milligan* tells a sympathetic story of a person victimized by his parents, the legal system, and the psychiatric industry. His capacity to dissociate allowed him to survive all of these ordeals, although not intact. It is also one of the few public cases where the multiplexed person under discussion is a man. Milligan's doctor was David Caul, who consulted on

²⁶ Hacking (1995). Op. Cit. P. 47.

²⁷ Milton Rosenbaum (1980) "The role of the term schizophrenia in the decline of the diagnosis of multiple personality" *Archive of General Psychiatry* 37:1383-1385.

²⁸ Greaves (1980) "Multiple personality 165 years after Mary Reynolds" replaced Taylor and Martin in the *Journal of Nervous and Mental Disease* 168:577-596, 1980.

²⁹ George Greaves "A History of MPD" (1991) Op. Cit. P. 362

the case with Cornelia Wilbur.³⁰ For a few years it seemed that the same few doctors were consultants for every new practitioner in the United States who published an article about dissociation. It was beginning to look as though that small coterie of psychiatrists were going to have a busy few years.

Doctor William Confer and Billy Ables published *Multiple Personality: Etiology, Diagnosis and Treatment*, a clinical book which, for unknown reasons, goes virtually uncited.³¹ Perhaps it was 'before its time'. Also in 1983 Frank Putnam presented a series of 100 cases of MPD at the annual meeting of the American Psychiatric Association, and *The American Journal of Clinical Hypnosis* published a special issue on Multiple Personality. Three professional journals, in addition to *The American Journal of Clinical Hypnosis* published special issues on Multiple Personality in 1984. They were *The International Journal of Clinical and Experimental Hypnosis*, *Psychiatric Annals*, and *Psychiatric Clinics of North America*. Ross notes:

With the appearance of these four special issues Richard Kluft (1982, 1983, 1984a, 1984b, 1984c, 1985d, 1985e, 1985g, 1986a, 1986b, 1986c, 1986d, 1986e, 1987a, 1987b, 1987c, 1987d, 1988a, 1988b, 1988c, 1988d, 1988e); Kluft, Braun, & Sachs, (1984); Kluft, Steinberg, & Spitzer, (1988b), Braun & Sachs, (1985) established themselves as the leaders in the field.³²

Bennett Braun, Richard Kluft and Roberta Sachs were at the hub of a what appears to have been a tight network. They published articles in many anthologies, cross-referencing each other, and taking turns being the editor.³³ They were constructing the

³⁰ The journal DISSOCIATION: Progress in the Dissociative Disorders is dedicated to Dr. Caul.

³¹ Another foundational paper also goes virtually uncited. In 1971 Margareta Bowers and six other authors published "Therapy of Multiple Personality" in the *International Journal of Clinical and Experimental Hypnosis*. In George Greaves' words, "Even in its accuracy, the paper fell stillborn from the press. ...It fell through the cracks, like so many advances published before their time. (Greaves, 1991, Op. Cit. P. 363)

³² Colin Ross (1989) Op. Cit. P. 48.

³³ For instance, contributors to Kluft's influential book (1985) are Braun, Coons, Frischholz, Goodwin, Hicks, Kluft, Putnam, Sachs, and Wilbur. Contributors to Bennett Braun's influential book "Treatment of Multiple Personality Disorder(1986) are Barkin, Braun, Caul, Kluft, Putnam, Sachs, Spiegel, and Wilbur. As Ross (1989:51) notes, the contributors cross-reference each other extensively. There is the possibility here of forming a juggernaut, as well as a paradigm.

foundations of the paradigm of dissociation. Colin Ross offers a perspective on why their work was so compelling.

MPD is the most important and interesting disorder in psychiatry, which is why I study it. I believe it to be the key diagnosis in an impending paradigm shift in psychiatry, because MPD best illustrates the characteristic response of the human organism to severe psychosocial trauma, and because trauma is a major cause of mental illness, from a public health point of view. Trauma, I believe, is a major underlying theme in much mental illness, including depression, eating disorders, personality disorders, substance abuse, psychosomatic illness, and all forms of self-abuse and violence.³⁴

The International Society for the Study of Multiple Personality and Dissociation (ISSMP&D) had its first annual convention in Chicago in 1984. Organization of the society and its early conventions were spearheaded by a steering committee³⁵ which included Bennett Braun, who also established the Dissociative Disorders Unit at Rush-Presbyterian-St. Luke's Medical Centre in Chicago.³⁶ In 1988, the ISSMP&D decided to have its own journal. The first issue of *DISSOCIATION: Progress in the Dissociative Disorders* was published in March, 1988. The editor, Richard Kluft, wrote in the first editorial, called "A New Voice for a New Frontier:"

DISSOCIATION will chronicle contemporary clinician's and scientific investigators' discoveries about dissociation and the dissociative disorders. It will also witness the dissolution of what Boorstein (1893) has described as "the obstacles to discovery-the illusions of knowledge". In this dialectic it will eschew the premature closure of scholarly debate and encourage both a diversity of points of view and an informed pluralism.

This is an ambitious liberalism, among clinical professionals who are cautioned not to speak to the press, not to publish work in non-scientific journals, not to "believe"

³⁴ Colin Ross (1994) *The Osiris Complex: Case-Studies in Multiple Personality Disorder*. Toronto: University of Toronto Press. P. xii.

³⁵ The membership of the steering committee differs with different accounts. It seems that the members were George Greaves, Richard Kluft, Frank Putnam, Roberta Sachs, David Caul, Marlene Hunter, Jane Yates, John Burns, Jackie Damgaard, Helen Coale, Jeffrey Brandsma, Jane Dubrow and Chris Sizemore.

³⁶ See Ross (1994) PP 44-51 for further discussion of this development.

the phenomenological manifestations of their clients, and not to practise counselling without a Ph.D.³⁷

The first issue of DISSOCIATION contains articles by six of the seven members of the Dissociative Disorders Committee that made up the DSM-III-R.³⁸ One of the articles, by three of that committee (Richard P. Kluft, MD, Marlene Steinberg, MD, and Robert L. Spitzer, MD) discusses the reclassifications in DSM-III-R. Entitled *DSM-III-R Revisions in the Dissociative Disorders: An Exploration of the Derivation and Rationale*, this article's introduction says it is "edited for readability."

Editing for readability appears to have faded out, as the journal has gathered momentum. Professional gatekeeping features prominently. There is real power here, the power to grant credibility to certain points of view, and having accomplished that, the power to decide what criteria define what is normal, and who fits those criteria.

Over the course of its first year, discourse in the journal became more and more esoteric. Previous articles are cited so often that one does not feel informed unless one has read every article since the beginning. Despite the "informed dialectic" that was promised, controversial articles by unfamiliar authors are reviewed and critiqued by an increasingly familiar committee that starts to look like an in-house gang of gatekeepers in their own right - just like any other discipline. In Volume III, no. 2, Yoshitomo Takahashi, MD wrote a speculative article *Is MPD Really Rare in Japan?* He concluded that it *is* rare. In the same issue, Braun and Frischholz, founder and director of research, respectively, of the Dissociative Disorders Program at Rush-Presbyterian-St. Luke's Medical Centre, reviewed the article. They chastised Dr. Takahashi for insufficiently bridging the cultural gap between Japan and the US, noting that he and his colleagues don't really seem to know what they are talking about, and still conclude that Japan might be different, and therefore conditions in Japan might be different.³⁹

³⁷ All but the last of these cautionary remarks were made by Richard Kluft at the 7th Annual Convention of the ISSMP&D, in Chicago 1990. The last remark, that all counsellors should have PhDs, was made by Roberta Sachs, also at the 1990 Annual Convention in Chicago. Both doctors spoke on November 11, 1995.

³⁸ Interestingly, DSM-IV does not have a dissociative disorders subcommittee.

³⁹ That it might be different is an entirely tautologous statement. If it wasn't like this, it might be different: a gratuitous remark that might well be made about anything at all.

"In conclusion, I am inclined to think that Takahashi's negative findings are probably the results of the study's methodology rather than the absence or rarity of MPD in Japan, and that, also, they provide a striking illustration that the clinical incidence of MPD is going to be lower in those cultures where children, the self, and human relationships are socially constructed in a more harmonious way."⁴⁰

Besides the faithful reiteration of the warning in DSM-III-R about culture-bound pathology, the excerpt, above, shows an interesting linguistic twist. Multiplexed people habitually refer to themselves in the first person plural; we. Here, an article is written by a committee. The committee refers to itself in the first person singular: I.⁴¹

In 1990, the president of the ISSMP&D, Walter C. Young (quoting Richard Kluff) said that they could tell that the field was expanding because the core group of psychiatrists who are promoting dissociative diagnoses no longer recognized the names of all the contributors to it. "This reflects the entry into the field of a second generation of therapists and theorists."⁴²

Many of that second generation attended the seventh annual conference of the ISSMP&D in Chicago in 1990, where they heard Dr. David Thomasma, head of the ISSMP&D ethics committee announce that the committee had determined that "a person in a dissociated state is not a 'person', in the medical sense. They are human beings," Dr. Thomasma said, "but there is no 'person' present, because dissociation causes a disruption in the ability to make moral judgments."⁴³ The distinction between a person and a human being is part of an ongoing philosophical discourse. Dr. Thomasma was proposing an application of this philosophy to human lives. There could be unforeseen 'side-effects.'

Might this 'disruption in the person's ability to make moral judgments' also make it impossible for that person in a dissociated state to be perceived as capable of giving or

⁴⁰ "Reflections on Takahashi's methodology and the role of culture on MPD" DISSOCIATION Vol III, no 2, June 1990.

⁴¹ E Unibus Pleurum becomes E Pleuribus Unum.

⁴² Walter Young. Editorial comment in the ISSMP&D News. Volume 8, No. 3, July 1990.

⁴³ Dr. David Thomasma Plenary Session of the 7th Annual ISSMP&D Convention, titled "Ethical Issues of Treatment of Dissociative Disorders," November 10, 1990.

withholding consent?⁴⁴ Dr. Thomsma's assessment could be seen to have sinister implications for the civil rights of those people diagnosed as multiple.

At this same conference Dr. Bennett Braun, founder of the ISSMP&D and a member of the dissociative disorders committee for DSM-III-R, announced that eighteen percent of the general population is dissociative, and one percent of the general population has some form of multiple personality disorder. According to Dr. Thomsma's pronouncement, then, there may be no 'person' present in fully one percent of the society. Who, in the new world order would be responsible for these 'non-person' people"? What would their rights be? Who would decide? On what criteria?

In thirty-six years the number of hypothetical cases of multiple personality had gone from one in the world to one in a hundred. When Chris Costner Sizemore (Eve) was diagnosed in 1955, she was thought to be the only multiplexed person in the world. In 1958, Sybil was diagnosed, and then there were two. Twenty-three years later the ISSMP&D was implemented because a number of doctors and psychiatrists had figured out that they were working with multiplexed people. In 1983, when they started the organization, they thought that one person in five thousand was multiple. In 1987 the ISSMP&D, figured that 1 person in three thousand was multiple. In 1990 Bennett Braun announced that one person in one hundred is multiple, and that eighteen people in one hundred are inherently dissociative. Would they *all* need keepers?

To the dismay of the promoters of the new paradigm, stories of ritualized abuse, and of Satanic ritual abuse also started to emerge. Therapists who specialized in dissociative disorders started reporting patient disclosure of horrendous tales of ritualized torture.⁴⁵ The number of personalities a ritually abused person would present might be

⁴⁴ There is a philosophical difference between a person and a human being. Being recognized as a person depends on others' perception. For a full discussion of this matter, see Catherine McCall (1990) *Concepts of Person*. Aldershot: Avebury Press.

⁴⁵ In his capacity as the program director of the Ridgeview Institute, George Ganaway, raised concerns about the apparent high incidence of Satanic Ritual Abuse and its accompanying dissociative states at the 1990 ISSMP&D conference in Chicago. Ganaway fretted that the clients' symptoms might be entirely iatrogenic; caused by the therapist having read a book and accidentally leaking the symptoms, such that the client emulates them.

ten or twenty times that of a multiplexed person who had been abused ‘only’ by a family member or two (and occasionally their friends.)⁴⁶

Ritual abuse posed quite a dilemma for members of the ISSMP&D.⁴⁷ They wanted to believe their clients, but at the same time, they were reluctant to risk any of their newly-established and hard-won credibility with uncritical acceptance of all that survivors claimed to have survived.⁴⁸ As Frank Putnam noted, the controversy about ritual abuse (RA) spread far beyond mental health professionals working in abuse recovery and attracted the attention of sociologists, anthropologists, and professional debunkers.⁴⁹

Dissociation, and the social theories that accompanied it, was already controversial. The paradigm of dissociation assumes a systems model, which rests on a particular political perspective. A systems model assumes that identifying and classifying the patient’s disorders is important, but that identifying a condition is not the same as explaining what creates and perpetuates it. An individual model, in contrast, assumes that if the psychiatrist can discover all the patients’ disorders, he will know the definitive cause of the patient’s condition.

Not only can quantitative physiochemical analysis (the medical model) not reveal the definitive etiology for a psychiatric condition, it may not reveal the definitive etiology for any physical condition. Medical science has not discovered, for example, what causes tuberculosis, although we know that the tubercle bacillus is an essential ingredient. While many people live in harmony with the tubercle bacillus, some, inexplicably, do not. Doctors are still ignorant about many of the forces that govern the conditions they treat. Family systems theory defines relationship variables that are assumed to be important in

⁴⁶ Until the terms “structured” and “reactive” were developed to describe people who were deliberately made multiple (ritually abused) as children from those people who (accidentally) multiplexed as an adaptive response to severe, ongoing trauma, the distinction was made by referring to “garden variety” incest and ritual abuse.

⁴⁷ Jean Goodwin, who later became head of the ISSD Taskforce on Ritual Abuse, said at the 1990 conference that the term ‘Ritual Abuse’ was problematic, that it creation logical cognition problems, because by the nature of the label, it focuses on motivation rather than behaviour. (Chicago, November 10, 1990.)

⁴⁸ Richard Loewenstein. In the ISSMP&D News. Volume 9, No. 1, February, 1991. P. 6.

⁴⁹ Frank Putnam. In the ISSMP&D News. Volume 6, No. 5, November, 1990.

the creation and perpetuation of all clinical dysfunctions. Assigning cause to a single variable, or even to a group of them, is antithetical to systems thinking.⁵⁰

As the paradigm of dissociation can not exist outside of systems theory, then acceptance of the paradigm necessitates acceptance of the notion of trauma-based disorders, and therefore of early childhood trauma, and therefore of the larger social picture, in which a substantial number of adults -- many of them parents -- are getting away with systematically traumatizing children -- many of them their own.

If the paradigm of dissociation, of trauma-based disorders, becomes mainstream, psychiatric diagnosis and treatment really will have to become biopsychosocial.⁵¹ Psychiatric assessment will not be able to continue its narrow focus on mechanism. John Beahrs points out:

Two unspoken assumptions dominate most contemporary clinical practice in contradiction to the basic premise of the biopsychosocial model to which we pay lip service. The first is reductionism, or the attempt to reduce two of the events to the third, which is presumed to be most basic. The trouble here, besides gross inaccuracy, is that few people agree on which level should be considered most basic....The second assumption is a belief that whatever level is considered the most fundamental is the level at which intervention must occur if the resulting change is to be considered "real" change. Both assumptions are natural outgrowths of the type of linear causal thinking of classical mechanics or the science of billiards, and both have unfortunate consequences in the practice of psychiatry.⁵²

Members of the ISSMP&D promote the multiple causality model at every opportunity. The ISSMP&D has a bi-monthly newsletter, the front page of which carries a message from the current president. Richard Loewenstein's message in 1992 remarked on the negative repercussions of the cutbacks in health care in the United States, making

⁵⁰ Some of the information in the last two paragraphs, particularly the reference to tubercle, paraphrased from Michael E. Kerr's letter to the editor in *the Atlantic*. January, 1989. P. 9. Boston: the Atlantic Company.

⁵¹ George L. Engel (1980) "The Clinical Application of the Biopsychosocial Model" in the *American Journal of Psychiatry* 137;5 PP. 535-544. Although this article makes no specific reference to dissociation, it is a fair assessment to say that it is the prototype approach on which the paradigm of dissociation is modeled.

⁵² John Beahrs.(1987) *Limits of Scientific Psychiatry: The Role of Uncertainty in Mental Health*. New York: Brunner/Mazel. P. 17.

it more difficult for poor people to get medical care, particularly the long-term attention that is required to sort out the extreme dissociation of an adult who was a severely traumatized child. He also remarked on the warfare in what was then still Yugoslavia. The result, Loewenstein warned, would be “another population of traumatized children, men, and women, whose posttraumatic difficulties may or may not be recognized as they seek treatment later on.”

It is at times like these, Dr. Loewenstein explained, that it is all the more critical for members of the ISSMP&D to continue their efforts:

to help develop awareness of MPD, other dissociative disorders, and the sequelae of severe psychological trauma. Many in the mental health professions continue to demonstrate hostility and scorn toward MPD. Despite this, increasing numbers of clinicians are becoming aware that dissociative disorders are common, treatable conditions related to trauma. We are continuing to develop a solid body of clinical and research scholarship that supports the existence of MPD and dissociation as valid constructs.⁵³

By 1992, the ISSMP&D was moving from its ‘cottage industry phase’ to one of a modern international organization with a large and disparate membership.⁵⁴ The April, 1992 newsletter announced that as an added benefit of membership, the newsletters would now carry lists of dissociative disorder specialty units and programs. (A specialty unit is a physical plant and program, including specially trained staff, exclusively dedicated to treating dissociative patients.) As well, newsletters carried ever-lengthening lists of new books about trauma, dissociation and MPD, and addresses to order instructional videotapes, audiotapes of past conferences, and other relevant newsletters. While the ISSMP&D may have outgrown the cottage industry component of MPD, the cottage industry itself is thriving. In 1991, Carol Gottman and George Greaves published *Multiple Personality and Dissociation, 1791-1990: A Complete Bibliography*, which contains three thousand entries.

⁵³ Richard Loewenstein in the President’s Message. ISSMP&D News. Volume 10, number 1, February, 1992. Page 1.

⁵⁴ Richard Loewenstein in the President’s Message. ISSMP&D News. Volume 10, number 2, April, 1992. Page 1

Did these books have anything in common amongst them all? While the historical assessment of what is of significance in the rise, fall, and rise again of the paradigm of dissociation differ, depending on who is recounting the events, a storyline is recognizable from one narrative to the next. The phenomenal mushrooming of the paradigm provided many people with material for journal articles, and quite a few of them with enough material for a book. According to Greaves, the rate of annual (clinical) publications about MPD rose six thousand five hundred percent (65 times) over the period of 1791 to 1970. Between 1971 and 1980, the rate of publication increased another thousand percent over the accumulate publications up to that point. Goettman and Greaves' bibliography sold out through two printings. In 1992 they published a supplement.

In the introduction, Dr. Greaves accounts for the necessity for the book, explaining:

1) interest in MPD and dissociation, as a field, declined with the advent of Eugen Bleuler's (c. 1910) conceptualization of schizophrenia (Rosenbaum, 1980);

2) previous interest in MPD and dissociation reached its last peak at the turn of the century (c. 1890-1910), under the influences of William James, Morton Prince, and Pierre Janet (Greaves, in press);

3) current interest in MPD was spurred by a curious confluence of major articles, all appearing in 1980, in widely-read, highly-refereed psychiatric journals and books (American Psychiatric Association [DSM-III], 1980; Bliss, 1980; Coons, 1980; Greaves, 1980; Rosenbaum, 1980); [Greaves, in press]⁵⁵

4) MPD and dissociation will likely remain a permanent topic in the field of psychiatry, owing to the unparalleled intensity of its study, the voluminous current writings on the subject, the tight organization of the field of clinical and scientific research in these areas, and the rediscovery of the 19th Century French scientific literature on the subject [Greaves, in press].

Another sign of growth that year was that the first International Conference on Multiple Personality and Dissociative States was held outside North America. In May, nearly five hundred people from eight countries attended a meeting in Amsterdam.

⁵⁵ Carol Gottman and George Greaves (1991) *Multiple Personality and Dissociation, 1791-1990: A Complete Bibliography*.

American biopsychosocial psychiatry, and the new paradigm of dissociation, was being successfully marketed in Europe, among proponents of the medical model. Blocking expansion, the committee responsible (in 1993) for final decisions about what would go into DSM-IV ruled against the ISSMP&D's justification for the diagnosis of childhood dissociative disorders.

When DSM-IV came out in 1994, Multiple Personality Disorder (MPD) had been renamed as Dissociative Identity Disorder (DID). The DSM-IV diagnostic criteria for DID is very similar to the DSM-III-R diagnostic criteria for MPD.

Opinion about the name change was sharply divided in the ISSMP&D. Supporters of the name-change applauded it. Detractors argued that it undermined the therapeutic process. The ISSMP&D Executive Committee appealed to David Spiegel, whose decision would determine the name in DSM-IV, expressing their dismay over both the proposed name and the process by which it had been chosen. The executive committee thought that the new name was vague and possibly misleading, and would also widen the gap between DSM and ICD, as ICD-10 would continue to use MPD.

The decision was put to a straw-poll in a conference call, in which not all members of the committee had been included, and which contained two people who were openly hostile towards the idea that MPD even existed. By what criteria was inclusion or exclusion determined? The executive committee expressed their concern that construction of the DSM was already perceived as a "political, value-laden enterprise, not a scientific endeavour."⁵⁶ They cautioned that this change, abrupt and last minute, could exaggerate the political-instead-of-scientific image. They asked that their concerns be presented to the American Psychiatric Association Assembly, so that the decision makers for DSM-IV could make an informed choice.

Dr. Spiegel responded to their concerns somewhat testily, saying that he had carefully and deliberately chosen doctors of a broad range of opinion on dissociative disorders to be on the name-change committee. For this he made no apology. The

⁵⁶ Letter from the Executive Council of the ISSMP&D to David Spiegel, c/o American Psychiatric Association. May 17, 1993. Published in the ISSMP&D Newsletter, Volume 11, Number 4, August, 1993.

constitution of the committee, however, was not the deciding factor. David Spiegel cast the deciding vote:

My main reason for changing the name, not well articulated in your letter, is that I think there is a widespread and fundamental misunderstanding of the essential psychopathology in this dissociative disorder, which is a failure of integration of various aspects of identity, memory, and consciousness. The problem is not having more than one personality; it is having less than one personality....⁵⁷

Dr. Spiegel was also concerned about the marginalization of people working with dissociative disorders, and thought that the name change might mitigate some of the perceived professional disparities. In any case, the name-change committee was only advisory, Dr. Spiegel wrote. The decision was his, and he had made it. MPD became DID.

The International Society for the Study of Multiple Personality and Dissociation (ISSMP&D) became the International Society for the Study of Dissociation (ISSD). A major piece of the paradigm (re)construction (and renovation) had been accomplished.

George Greaves, a past president, and producer of the Bibliography, was very unhappy with both decisions. "A good name is the equivalent of a famous trade name in the business world," Greaves fumed. Concerned about the negative impact of the name in the Marketplace, Greaves made comparative references to sports teams, ice-cream and breakfast cereals. "What if we had Macy's-Quaker oatmeal? Or DuPont-Ben & Jerry's ice-cream?"⁵⁸ While appreciating the new name, which he found more appropriate than multiple personality disorder, which he had dismissed as a ridiculous concept, Greaves was concerned that the new name would not sell like the old one. We must always think of our market, and of our words. "The crucial importance of how an observable (empirical) entity is described and how is it classified is one of Aristotle's ultimate contributions to science. How our use of language influences how we think and act (i.e.,

⁵⁷ David Spiegel, in written response to the Executive Council. May 20, 1993. Published in the ISSMP&D Newsletter, Volume 11, Number 4, August, 1993.

⁵⁸ Letter to the Editor of the ISSMP&D (still) Newsletter. Volume 12, Number 2, April 1994. P. 9.

how the use of language affects the outcomes) is the great contribution of the 20th-century school of British analytical philosophy.”⁵⁹

The new disorder (still, notably, a disorder) challenges the concept of identity, as the old disorder (MPD) challenged the notion of personality. In either case, it is questionable that the whole person is viewed, and taken into account. Is someone diagnosed with Dissociative Identity Disorder assessed as capable of making a continuous moral judgment? No pronouncements have yet been made.

What will it take for the paradigm of dissociation to maintain a hold in mainstream psychiatry? International recognition? While the *British Journal of Psychiatry* continues to publish articles critical of the diagnosis of MPD (as the name was changed in DSM, but not in ICD), the number of practitioners treating people with diagnosed dissociative disorders is growing steadily. International endorsement and acceptance is followed by backlash. Britain also has the British False Memory Society (BFMS), which boasts well-known and well-respected advisors. The backlash to the backlash is a rival organization called Accuracy About Abuse. However, the likelihood of mainstream psychiatry dismissing dissociative disorders as an American problem appears to be declining.⁶⁰ Dissociative disorders appear also to have ‘arrived’ in clinical practice in Britain.

Perhaps they will ‘arrive’ in popular culture in Britain as they have in the US. The flow of information and influence between psychiatry and popular culture is interactive; the relationship is a complex symbiosis. The paradigm of dissociation in psychiatry has multiple reflections in popular culture. Books, films, television shows and TV talk shows with characters who have more than one personality began to proliferate in the mid 1980s.⁶¹ They had a long run (for popular culture) lasting solidly for at least eight years,

⁵⁹ George Greaves. “A History of MPD” in *Clinical Perspectives on Multiple Personality Disorder*. (1993). Op. Cit. P. 359.

⁶⁰ George A. Fraser. ISSD Newsletter. Volume 13, Number 2. April, 1995. P. 3.

⁶¹ Ritual Abuse survivors with huge numbers of personalities - or their therapists - were particularly popular on talk shows. On October 25, 1988 Geraldo Rivera's television special: "Devil Worship: Exposing Satan's Underground" focused on the ritualized abuse of children. It drew the largest audience of any television program in its timeslot, and was the most popular Geraldo Rivera show ever to have been broadcast.

and beginning to recede only in about 1993, not because the clinical paradigm was faltering, but because it just wasn't news anymore.

While early shows and talk shows were titillating because their subject matter (MPD) legitimated consumption of stories that might otherwise be considered pornographic -- stories of horrendous child abuse; of rape and torture -- eventually even that aspect of it became commonplace, and popular culture moved from interest in the 'garden variety' kind of incest that precipitated multiple personalities to the more sensationalist ritual abuse, which further moved the outer limit of what can be said aloud.

FALSE PROPHETS

The ideology that people are basically good, and society basically just, contributes to the maintenance of the social order. Defining which cognitive structures are socially legitimate also establishes individual ontological commitments to the system. When someone's experiences don't make sense, when they don't fit within the established social norm, then those experiences are not among the ontological commitments and therefore, they must not have happened.⁶²

Humans beings need order in their lives, a way of making sense of their experiences. The need for order is satisfied by having a belief system. A belief system is a cognitive framework, an intellectual apparatus that provides a conceptual repertoire of what we believe to be useful, what we believe to be true.

Each society makes (more or less) the same set of ontological commitments to 'the system.' People believe that there are things that can not happen -- and therefore, believe that they do not occur. We are incapable of perceiving what we do not believe. We do not arrive at our belief systems independently. What seems reasonable, what does and does not make sense, (common sense), is developed in each of us in tandem with society. We are variously motivated to make ontological commitments to a system, are encouraged to accept what is collectively assumed to be "real," and to individually

⁶² This page and the next contain passages that also appear in my paper "Trespassing on the Boundaries of Belief." (1990) Simon Fraser University. (unpublished)

recognize, within those parameters, what is believable. We are surrounded by sources of information and beliefs, constantly exposed to attitude-conditioning processes.

Many of our beliefs and opinions are based on second and third hand information. So much information is available these days that we can not think critically about what it means to receive information secondhand and prefiltered. We simply accept it. Opinions of people we don't know, filtered through people we do know, become "facts." Through television and newspapers, we acquire more "facts." We develop subjective norms, based on these facts.

We have, as members of a society, knowledge structures called schemas, that organize and simplify the constant information overload with which we are inundated. We rely on various types of schemas to help us to make sense of our experiences. When we perceive an event or action that conflicts with how we have ordered our reality, that is, schema-inconsistent information, we become confused. We have a need to reduce the tension caused by this confusion. We reduce the tension by marginalizing the event/experience/information that jars us, making it irrelevant. We marginalize whatever we do not wish to believe, easily and often. It becomes "propaganda." We don't believe it. We "know" better.

Sometimes the facts we acquire conflict with the facts we already know. Rather than weigh the new information against the old, considering the source and method of acquisition of each, then analyzing which set of information is more likely to be true, we simply hang the new facts on the cognitive structure that we have already developed to store such information. We insert the information into the appropriate schema. If the new information is inconsistent with the schema that we have, if it won't hang easily on the framework, we find a way to make it inconsequential, or to perceive it as not true. We marginalize the information. If the information concerns a group of people, we marginalize the whole group. That group must be, in our perception, deviant. Their conduct does not represent to us a significant current in the mainstream of society. Who they are, what they do becomes insignificant -- and eventually, perhaps, not "real."

Moral panic is a concept which, according to the *Encyclopedia of Communication Concepts*, highlights the processes of interplay between forces of social reaction and control, the mass media, and certain forms of deviant activity. Moral panics are the process by which members of a society and culture become aware of (or acknowledge) and become morally sensitized to the challenges posed to their values by groups defined as deviant. If the moral panic is to be sustained, it is up to the media to ensure that the outgroup is ongoingly perceived as deviant. Moral panics also serve to link structured public awareness to the institutional forms of control which are generally mobilized to address such problems.⁶³

Given the definition, Satanic ritual abuse (sra) is a perfect model of moral panic. The deviants are the Satanists, whose conduct is unacceptable to the larger society. Psychiatry becomes the institutional social control that can intervene and sever the lines that create the generational cycles of abuse, if, indeed, there are generational cycles of abuse. The False Memory Syndrome Foundation (FMSF) would have us believe that sra is a subjective fiction created by a patient for secondary gain.⁶⁴

Ironically, the FMSF is, itself, an ideal illustration of moral panic. This time the deviants are not the putative perpetrators, but the putative victims. Their unacceptable conduct is that they go to therapists, and, apparently, grow new pasts; subjective fictions created by a patient/therapist conspiracy, for secondary gain. The FMSF itself then becomes the institutional social control which intervenes on society's behalf.

Psychiatry's power comes out of its power to define, its power to name. If Foucault is right that power is war, then the capacity to name is psychiatry's heavy (epistemological) artillery in that war. The FMSF's power is also the power to name; the

⁶³ John Hartley and John Fiske (1984) *Key Concepts in Communication and Cultural Studies*. London and New York: Routledge.

⁶⁴ The name "False Memory Syndrome" was coined by Peter and Pamela Freyd. The False Memory Syndrome Foundation is a top down grassroots organization (which means that a handful of zealots organized a following) formed to dispute claims of reassociated memories of sexual abuse, which were made by several of the adult children of members.

power to define. Naming can create the production of truth in a discourse which is neither true nor false.⁶⁵

Managing power is part of the job of being a psychiatrist. In the best-case scenario, a psychiatrist is hired by a patient to influence him in ways that will improve the quality of his life. It is quite appropriate, then, that a psychiatrist should influence her patient's ontological commitments to the system. As Moshe Torems, chair of the Department of Psychiatry at Northeastern Ohio's University's College of Medicine, reminds his students; therapy *is* iatrogenic. It has to be, to be of any use.

Does the FMSF object to the power a psychiatrist has to influence a client's ontogeny? It depends on what that (re)constructed history is considered to contain. Certain memories, the FMSF says, are evidence that the client has False Memory Syndrome, in addition to whatever took her to a psychiatrist in the first place.⁶⁶

A syndrome is a collection of signs and symptoms that tend to occur together. The typical medical questions asked about a syndrome are: How common is it? What are its characteristic symptoms? What happens to these symptoms over the course of weeks, months, or years? (Do they get better or worse? Are they episodic or chronic? How much does the condition affect the person's ability to work, to have a normal family life, to think clearly and have well-tuned emotional responses? How well does the condition respond to the treatments currently available?⁶⁷

Is it appropriate to apply these terms and conderations to False Memory Syndrome? We could pursue this inquiry by inventing a parallel syndrome, and creating claim to authenticity for it, on the same grounds that the FMS Foundation uses. Let us consider False Belief Syndrome, and the foundation of false belief syndrome, as established by psychiatry. Let us begin with the claim that false belief syndrome is a

⁶⁵ Michel Foucault. *Power/Knowledge*(1977) New York: Pantheon Books. P. 113.

⁶⁶ The FMSF maintains the impossibility of 'repressed memories.' The ISSD have never made any statements about repressed memories. Dissociation is in many ways antithetical to the very notion of repression.

⁶⁷ Nancy C. Andreason.(1984) *The Broken Brain*_New York: Harper and Row. P.35.

syndrome in the clinical sense; a collection of signs and symptoms. False memory syndrome, notably, is not.⁶⁸

Let us explain that the inculcation of False Belief Syndrome into patients is both a way that psychiatrists express power, and a way that they sustain it. We will mention that among the few Postmodern notions on which anyone seems able to agree is that ‘power’ is not a thing. Power is a discourse. Power is a field.

The foundation of biological reductionism on which psychiatry rests, that there is a centre, and the medical model is in it, is occasionally challenged. However, not only is the intellectual reductionism that makes psychiatry’s biological reductionism possible rarely, if ever, challenged; it is not, generally, even recognized. One of the characteristics of being intellectually reductionist is that we do not notice that this is the case. How did we manage to miss the experience of seeing our intellectual horizons shrinking?

We are insulated from uncomfortable discoveries about ourselves by False Belief Syndrome. I propose that False Belief Syndrome has been deliberately inculcated by psychiatrists, and that through a phenomenon called hysterical contagion, it has spread to people who have not been to see psychiatrists.

The ‘broken telephone game’ is a kind of metaphor for how False Belief Syndrome has spread. In the broken telephone game I tell the person beside me a story, and she tells the person beside her, and he tells the person beside him, and the story proceeds, changing slightly with each telling, depending on the listening ability and the creative imagination of each person who receives and transmits it. By the time it returns to its source, the original story may not be recognizable. However, if the person who made up the story in the first place knows a lot about the dynamics of this game, and a lot about the people who will be retelling the story, that original creator may be able to start with a story that transmutes well.

⁶⁸ At the 1994 Spring Conference of the ISSD, in Vancouver, B.C. Richard Loewenstein suggested that “False Memory Syndrome” should be called “Disputed Memory Syndrome” since the memories are not empirically proven to be false, just as they have not been empirically proven to be true.

In a process similar to the ‘broken telephone game,’ False Belief Syndrome filters through from psychiatry into society in general, it becomes common, ‘garden variety’ ideology. From the implantation of False Belief Syndrome comes our sustained belief that power emanates forth from the centre. From the implantation of False Belief Syndrome by psychiatrists comes much of the false consciousness that causes North American Mainstream Society to cleave to the ideals of patriarchal capitalism, and to hold onto its faith in the Marketplace, despite all evidence that this system is in every way asphyxiating us all. The implantation of false memories by counselling professionals is a currently commonly accepted proposition. Newspapers often carry stories and exposés about False Memory Syndrome. An international foundation that is often in the news has recently made the notion of the implantation of false memories quite credible. The False Memory Syndrome Foundation has ‘proven’⁶⁹ that memories of false events can be engendered by ideologically committed therapists⁷⁰.

If false memories can be inculcated, it only stands to reason that false beliefs about other matters can be as well. This inculcation of false beliefs is different at its source, different from ideology, in that ideology is knowledge that is seen to be natural, generally applicable, and picked up by some sort of osmotic process,⁷¹ whereas this set of false beliefs - that psychiatry infallibly dispenses medicine for the mind and the spirit, and that if people whose minds or spirits are sick go to psychiatrists they will be healed, and that going to a psychiatrist is a socially responsible thing to do - is deliberately taught and learned.⁷² It is also flagrantly culturally (and economically) specific. When it trickles down and becomes more general knowledge, it is diluted into mere ideology. Part of the ideology is that mental health is a commodity that can be purchased.⁷³

⁶⁹In the unpublished paper “The Book of Martyrs Transformed” (1994) Devorah Greenberg refers to “incredulous quotation marks.” When these are used, such as around the word *proven*, the reader may assume that the writer doubts the claim.

⁷⁰ Ian Hacking “Memoro-politics, trauma and the soul” in *History of the Human Sciences*, vol. 7, No. 2, p.29.

⁷¹ See “Key Concepts in Communication and Cultural Studies” O’Sullivan et al.

⁷² This logic is based on the False Memory Syndrome model.

⁷³ The medical model is a constructed figure of truth, and the ground on which it stands is the commonly accepted notion that humans, as a species, have two conflicting traits in common: the desire for social

It might be in some organization's interest to create a moral panic about people who lack this perspective. The False Belief Syndrome Foundation could be the agent of social control this time. Working in cooperation with the media, it could underscore the necessity, for the good of society, of seeing psychiatrists as apostles. The media could articulate as deviant anyone who did not agree with psychiatrists having a disproportionate influence on society.

Is False Belief Syndrome credible? Is it any less credible than False Memory Syndrome? Does it appear to have any fewer vested interests?

In the contemporary marketplace it is possible to sell -- or buy -- almost anything. A person can buy a few minutes of a doctor's attention, and get a medical opinion. If she doesn't like the opinion, she is entitled to see another doctor for a second opinion. The second opinion may corroborate the first, or it may contradict it. Kappas vary with the diagnosis.

However, there may be a vested interest in the diagnosis going a certain way. One of the functions of the DSM is to act as a billing manual. Since treatment indications are part of a diagnosis, then a person receiving a particular diagnosis will also be assessed with a particular course, and time, of treatment. A person diagnosed with a major disorder such as MPD may expect to be in intensive therapy for the next four or five years. If an insurance company is paying the bills for this therapy, they may wish the person to be diagnosed with something less dramatic, which doesn't take so long to treat. Since MPD is a trauma-based disorder, if a person reporting early trauma could be shown to have false memory syndrome, there would be a possibility of rescinding her diagnosis. Perhaps the insurance company could hire an independent medical examiner to dispense a second

order, and the love of freedom. It is the contradiction between these two traits that allows the ideology of the medical model to have such power. I wish to add a third trait: that we are a species which casts out the different. It is this third trait that legitimates psychiatry as medicine, and allows it to be included in the medical model. It is this third trait that makes False Belief Syndrome possible. Very few people are willing to take the risk of being different. False Belief Syndrome makes choosing marginality even more difficult which, from a mainstream and Marketplace perspective, makes it a very desirable cognitive filter for the general population to have.

opinion that might be more conservative than the first opinion. If that were the case, that second opinion would be a good investment.

The dissociative disorders in psychiatry have turned out to be a cottage industry with a considerable market share. The response to the new paradigm-builders are a whole other cottage industry. Independent Medical Examiners have sprung up all over the US. Medical Insurance companies (and car insurance companies) can purchase a second medical opinion about any claim at all against the insurance, whether for physical or psychiatric conditions. Disputes about the new paradigm, which percolate at many different levels, and on many sites of struggle, will likely continue for as long as sales hold.

The proponents of competing paradigms practice their trades in different worlds Practicing in different worlds, the two groups see different things when they look from the same point in the same direction. Both are looking at the world, and what they look at has not changed. But in some areas they see different things, and they see them in different relations one to the other. That is why a law that cannot even be demonstrated to one group of scientists may occasionally seem intuitively obvious to another.

Thomas Kuhn

Chapter V

Epiphany

Interesting philosophy is rarely an examination of the pros and cons of a thesis. Usually it is, implicitly or explicitly; a contest between an entrenched vocabulary which has become a nuisance and a half-formed new vocabulary which vaguely promises great things. Richard Rorty.

We live in a society whose ideology conceptualizes us as the proprietors of our own personalities; as free individuals with the personal capacity and social freedom to exercise individual choice about our identities. “Identity, [however, is only] what you say you are, out of the choices of what they say you can be.”¹ The choices are delineated by the boundaries of normality. At a social level, normality is an index of one’s ability and desire to follow the rules.² In this context of enforced social homogeneity ability and desire have a complementary rather than equal relationship, as ability to conform is fundamental, whether or not one has it changes the significance of one’s desire to conform. A person who *wants* to follow the rules, but lacks *ability* to do so may be labeled with some sort of disability, and is eligible for (and perhaps will be urged to seek) medical and/or psychiatric attention. For argument’s sake, there can also be a person who cannot follow the rules and does not want to learn how, and a person who can follow the rules and does so.³ If a person has a cognitive capacity to recognize the rules, but is disinclined to follow them, s/he has a considerable social mobility, and may have access to membership in any number of subcultures, as well as to the mainstream.

Anthony Giddens explains that “normal appearance means that it is safe and sound to continue on with the activity at hand with only peripheral attention given to

¹ Jill Johnson made this statement well-known in the women’s liberation movement of the 1970s.

² These are the same unwritten rules referred to in Chapter 1. There are understood rules of human conduct, which vary from one culture to another, and more subtly, within each culture vary from one subcultural subset to another. The rules are very complex and very specific, and are the (often unexplained) structural part of a person’s acquisition of culture.

³ There are subsets of these, of course. There is also, for instance, the person who can and does follow the rules, but strives to be someone who does not want to do so. The many more possibilities are not directly relevant to the argument.

checking up on the stability of the environment.”⁴ What we construct as normal in this society is the person who can and does follow the rules. We have two ways of explaining normal behaviour; in moral terms and in medical terms. Psychiatry medicalizes what would otherwise be moral judgments, causing the two to be interpellated in a way that gives the warrant of moral authority to the already medically powerful voice of psychiatry.⁵ Thus the person who can follow the rules but doesn't want to may be labelled deviant in some way, but may not be considered bad. Therapy might be indicated.⁶ The person who cannot follow the rules but wants to may be labelled disabled or dysfunctional. Therapy is definitely indicated, and pharmaceuticals may be prescribed. The person who cannot follow the rules and does not wish to learn how is labelled bad, and assigned the category of diseased. Therapy is indicated; pharmaceuticals are very likely; and incarceration becomes a real possibility.

Peter Conrad (citing Talcott Parsons) explains the difference between crime and illness in the designations of the ‘sick role.’ Illness is deviance in Parson’s assessment because it threatens the stability of a social system through its impact on role performance. While crime and illness violate (respectively) social and medical norms, the attributions of cause are different. “When deviance is perceived to be willful, it tends to be defined as a crime; when it is seen as ‘unwillfull’, it tends to be defined as illness.”⁷

⁴ Anthony Giddens. (1991) *Modernity and Self Identity*. Cambridge: Polity Press. P. 58. In making this statement, Giddens is paraphrasing Irving Goffman.

⁵ Economic stature, in our society, is considered not only a direct measure of a person’s ability and desire to follow the rules, but evidence that she plays the game very well. However, accumulation of wealth is considered an index of moral strength rather than evidence of a person’s ability to manipulate the rules in her own interest. Accordingly, lack of wealth might be misinterpreted as lack of moral strength. Therefore a person’s economic status might be factored in to a general psychiatric assessment. Perhaps it is the double authority (moral as well as medical) of psychiatry that causes the logic in these assessments to be challenged so rarely.

⁶ There is precedent for pathologizing social and political rebellion. Benjamin Rush, considered the founder of American Psychiatry (and whose profile is featured on American Psychiatric Association literature) developed the diagnosis “Anarchia,” which was a form of insanity in which people were unable to recognize that the state was functioning in their interest. See Thomas Szasz (1970) *The Manufacture of Madness: a comparative study of the Inquisition and the Mental Health movement*. New York: Delta. Pp. 138-149 for more on this matter.

⁷ Peter Conrad (1981) “On the Medicalization of Deviance and Social Control” in Ingleby, (Ed). (1980) New York: Random House P. 107.

Psychiatry contributes to the maintenance of the social order by defining the place on the social continuum where the presentation of self in society ceases to be normal. It does this, apparently, for the good of the individual even though disinclination to follow the rules may be reassessed as incapacity and assigned a biological basis. Legitimized by tradition, sanctioned by science, and articulated by law, the social policies of psychiatry maintain rational control of the individual.⁸

An example of how psychiatry functions as social control is offered by Ronald Leifer, who points out that in Western society individuals are encouraged to talk to God. We have many institutions which will assist that quest, by providing buildings in which to pursue the relationship, and intermediaries who will help people to pray, as “it is considered sane to pray to an invisible God whose existence has not been objectively demonstrated. If God answers back, however, it is a symptom of mental illness.”⁹ Here, then, is a distinction between sanity and madness. Sane behaviour can be described within the moral model as socially meaningful. Insane behaviour can be described within the medical model as internally referenced, and therefore disordered, out of [the state’s] control. While the construction of self has been steadily shifting from indexical to referential, it is not presently perceived to be in the state’s interest to have that construction shift too far down the continuum. It is therefore in the state’s interest to have the medical/moral aggregate accepted as common sense, as this allows psychiatry’s assistance of the individual to function as an agent of social control.

One of the indicators that we have entered the Postmodern era is that the choices of identity have greatly increased. Giddens offers a description:

In the post-traditional order of modernity, and against the backdrop of new forms of mediated experience, self identity becomes a reflexively organized endeavour. The reflexive project of the self, which consists in the sustaining of coherent, yet continuously revised, biographical narratives, takes place in the context of multiple choice as filtered through abstract systems. In modern social life, the notion of lifestyle takes on a particular significance. The more tradition loses its hold, and the more

⁸ This is a paraphrase of Thomas Szasz’s sentiments in “The Psychiatric Will” *American Psychologist* vol. 37, no 7.

⁹ Ronald Leifer. “The Medical Model as the Ideology of the Therapeutic State” in *The Journal of Mind and Behaviour*. Summer and Autumn, 1990, Volume 11, Numbers 3 and 4. P. 252[6].

daily life is reconstituted in terms of the dialectic interplay of the local and the global, the more individuals are forced to negotiate lifestyle choices among a diversity of options.¹⁰

Individuality, as a social statement, is in style. As (certain kinds of) marginality become commodified, people who are able to follow the rules but are disinclined to do so have become the new darlings of the marketplace.¹¹ It is cool to be 'different.'¹² A person may indicate difference by what he owns. In the marketplace, the discourse about possessions inserts itself into the discourse about identity. Style, as delineated by particular consumption patterns, has become a signifier of individual, autonomous achievement. In a triumph of superficiality, consumption and display has become not only a way of living, but a way of interpreting the meaning of life. Despite many shortcomings and problems, market-driven ideology concerning individuality, autonomy, freedom, and style, has precipitated many larger changes in society.¹³ Individuals are now 'free' to 'choose' identities and lifestyles that were previously unavailable.

The available choices in sexual orientation may provide a useful example. Homosexuality used to be considered a disease. It is listed in DSM I (1952) as a disorder. DSM II (1968) also listed Homosexuality as a disorder.¹⁴ The North American gay liberation movement officially started in 1968, in New York City, with the Stonewall riot.¹⁵ Our society went through a considerable metamorphosis in its attitude towards homosexuals and lesbians. In 1974, after selling out nine printings and three hundred and fifteen thousand copies, the American Psychiatric Association re-issued DSM II.¹⁶ with

¹⁰ Anthony Giddens. (1991) Op. Cit. P. 5.

¹¹ In a marketplace sense, then, postmodernism is the commodification of liberal humanism.

¹² It is cool to be 'different.' as long as that difference is the expression of style, and not of content. That is, the very notion of this difference is still based in an ethnobiologically essentialist notion that it is 'normal' to be a white man of German descent.

¹³ See Edward E. Sampson. (1990) "The Deconstruction of the Self" in *Texts of Identity*, Op. Cit. For a further discussion of this matter.

¹⁴ In Canada, until 1967, it was (also) against the law to engage in homosexual acts.

¹⁵ New York City police officers harassed a crossed-dressed man in the Stonewall Bar in New York City. The patrons forced the police officers to leave the bar. The police returned, with reinforcements, to find that the patrons had also found reinforcements. The two sides clashed in what became known as the Stonewall Riot, which in turn, became known as the genesis of gay liberation.

¹⁶ Technically, this revision would be DSM-II-R, but no clear indication of revisions of any categories was indicated in the title.

an errata insert that reclassified Homosexuality as Sexual Orientation Disturbance.¹⁷ DSM III, published in 1980 lists ego-dystonic homosexuality as a disorder. That is, by 1980 homosexuality was no longer a sickness in and of itself. It was a disorder only if the person was unhappy with his sexual orientation. DSM III-R does not list ego-dystonic homosexuality. Neither does DSM-IV.

Over the course of thirty years, then, a disorder disappeared. The condition, previously considered a pathology, did not disappear with the removal of the disorder from the DSM. Rather, it came into official existence as a legitimate lifestyle. Because of the imposition of medical assessment on common (moral) sense, however, removing the diagnosis did not remove the social opprobrium that the diagnosis had helped to establish.¹⁸ Homosexuality, here to stay, is no longer considered a psychiatric problem, and people formerly ‘afflicted’ with it no longer require a psychiatric solution. It is now just another facet of the human condition, albeit one which is taking some time to establish itself morally.

Might a similar process be impending for multiplexity? Legends abound in the gay subculture about how lobby groups of gay lawyers worked together to have homosexuality decriminalized. The equivalent scenario is lobby groups of multiplexed psychiatrists working together to have Dissociative Identity Disorder re-ordered. This might not be as far-fetched as it may seem. Colin Ross reported to his colleagues at a conference in 1993 that according to his projections based on his recent research, fifty-eight percent of the surveyed therapists in the ISSMP&D had early histories of trauma, as compared with twenty-five percent in the general population. Between five and eight percent of psychiatrists are multiplexed, said Ross, as compared with one percent in the

¹⁷ “SPECIAL NOTE-SEVENTH PRINTING. Since the last printing of this Manual, the trustees of the American Psychiatric Association, in December 1973, voted to eliminate Homosexuality *per se* as a mental disorder and to substitute therefore a new category titled Sexual Orientation Disturbance. The change appears on page 44 of this, the seventh printing. In May, 1974, the trustees’ decision was upheld by a substantial majority in a referendum of the voting members of the Association.”

¹⁸ Slowly but surely, the marketplace is ameliorating the social opprobrium against same sex orientation. A substantial percentage of d.i.n.k.s (double income no kids) are gay male couples. Dinks have shown themselves to be high-end consumers, not a market segment to be alienated by showing disapproval of their lifestyle choices.

general population.¹⁹ If Ross's results *are* representative, then if multiplexed psychiatrists band together as a special-interest lobby group, they could represent a considerable political force.

It is also apparent that the political influence of a multiplexed lobby group doesn't (necessarily) need the referent power of medical degrees. Multiplexed people who are consumers of the mental health system already have extensive support networks, which include the regular publication of journals such as "Speaking For Our Selves" and "Survivorship," and ongoing support groups, some in person, and others on-line.²⁰

The official position of the ISSMP&D used to be that multiplexed clients were to be heavily discouraged from coming to their conferences. Multiplexed therapists were sometimes explicitly asked not to attend particular sessions, and were occasionally asked to leave.²¹ Not only has that attitude softened and its attendant practices changed, but the registration brochure for the Fourth Annual Spring Conference of the ISSD, in May, 1994, in Vancouver, offered encouragement in the form of a discount in the fee to "multiple attending members."²²

Perhaps that change was the result of patient-group lobbying. Some patient groups are already politically mobilized. At the fall convention in Chicago in 1990, George Greaves complained about the many strong and well organized patient support networks for multiplexed people, the like of which, Dr. Greaves said, he had never seen.²³

¹⁹ Colin Ross, at a Plenary session of the Third Annual Spring Conference of the ISSMP&D, in Dallas, Texas, May 5, 1993.

²⁰ I have belonged for three years, with researcher status, to an on-line, twelve-step support group for adult survivors of severe childhood abuse, in which multiplexed people are particularly welcome. The group, called "More Than Survival," is moderated by Jeff Brooks. For more information contact Recovery@wvnm.vnet.edu or jeff@wvnm.wvet.edu.

²¹ I was present for at least one instance of each of these instances at the Annual Convention in Chicago in 1990.

²² Asking multiplexed people not to attend certain sessions was always represented as protectiveness of the fragile equilibrium of the people involved. Those sessions would just upset them. This example could function as a microcosm of how psychiatry interacts with multiplexed people in the larger society. That is, they are told that the decision is for their own good -- and it may be. An argument can be made, however, that the real beneficiaries of the decision are the other conference-goers, who then do not have to be distracted by the presence of multiplexed people.

²³ Consultation session with George Greaves. Seventh Annual Convention of the ISSMP&D, November 9, 1990, Chicago, Illinois.

Individuals in Postmodern society are fragmented into multiple sets of possibly discordant identities: the daily requirements in each person's life dictate which identity is interactive. Kenneth Gergen coined the word "multiphrenia" to describe cognitive capacities required by ordinary 'normal' people in order to live in Postmodern society, where we are constantly bombarded with choices of truths, all of which are contextual, and contingent on which voices have warrant. Giddens explains:

The reflexivity of [post]modernity operates, not in a situation of greater and greater certainty, but in one of methodological doubt. Even the most reliable authorities can be trusted 'only until further notice'; and the abstract systems that penetrate so much of day-to-day life normally offer multiple possibilities rather than fixed guidelines or recipes for action.²⁴

Over the course of our days, each of us must be many different selves. We have to be dyssociative and dyssociated to be able to be fully present in any of our facets. How far down the continuum does dyssociated become dissociated? Currently, DSM-IV delineates a point at which the coping mechanism of paying attention to something to the exclusion of something else is identified and classified as a dissociative disorder. In the Postmodern world, however, as constant sensory overload becomes a generic circumstance of day-to-day life, the ability to pay attention to something to the exclusion of something else becomes more and more of an asset. The point at which diagnosed pathology begins might start sliding further down the dissociative continuum. Because diagnosis is evaluative, shifting the point of pathology would not even require new diagnostic instruments.

DSM-IV-R (due in about in 2001) could carry the classification Ego-dystonic identity dissociative disorder, which assumes that there is nothing inherently negative about being dissociative, but if you are multiplexed and *wish to be* uniplexed, various kinds of therapies are available.²⁵

Multiplexity could become simply one of the accepted ways of being: our society might simply accept (medically and morally) that a percentage of us are multiplexed.

²⁴ Anthony Giddens. (1991) Op. Cit. P. 84.

²⁵ There would have to be some restrictions, of course. Aversion therapy, for example, which is commonly done with Electro-shock, could cause multiplexed people to further fragment.

Colin Ross muses: "It is possible that dissociation is the strategy par excellence for coping with severe trauma and that even otherwise nondissociative individuals will mobilize their evolutionary ability to dissociate if the trauma is extreme enough."²⁶ If the ability to dissociate is innate in all humans, as Ross's statement implies -- and as hypnosis experts such as Ernest Hilgard assert -- there may be a way to learn to do it without the trauma. If that were the case, people might want to acquire the skill.

Being able to dissociate could become desirable; a way of being unavailable in a noisy, overcrowded environment where your attention is assumed to be for sale. Where there's a market, a product will appear. The ISSD could offer adjunctive courses in creative dissociation, for people who have difficulty staying present because they are perpetually distracted from within by the complexities of their lives, in the same way that it presently offers adjunctive courses in clinical hypnosis.

In the complex symbiosis between society and psychiatry, we may have already taken the first step towards the depathologizing of dissociation. Replacing "Multiple Personality Disorder" with "Dissociative Identity Disorder" makes the diagnosis seem much less exotic. In a Postmodern culture, where there is no such thing as a non-partisan worldview, confusion over identity might be common. If it is normal to be confused about your identity, how far down the continuum does it become pathologized?²⁷ In order for someone to be deemed irrational, there must be a standard of rationality, to which he fails to measure up. Postmodernism is gauged by its absences. One of the characteristics that it lacks is rationality.

In this context, where does psychiatry delineate the borders of normality? A vignette from a Tom Stoppard play can offer an analogy:

A man breaking his journey between one place and another at a third place of no name, character, population or significance, sees a unicorn cross his path and disappear. That in itself is startling, but there are precedents for mystical encounters of various kinds, or to be less extreme, a choice of persuasions to put it down to fancy; until "My God," says a second man, "I must be dreaming, I

²⁶ Colin Ross. Op. Cit. p. 146.

²⁷ In the statistical frequency model of normality, when an experience -- or cognitive condition -- is shared by a very high percentage of a population, it is, by definition, normal. Psychiatry mediates the possibilities of what is available as a normal experience.

thought I saw a unicorn." At which point, a dimension is added that makes the experience as alarming as it will ever be. A third witness, you understand, adds no further dimension but only spreads it thinner, and fourth thinner still, and the more witnesses there are the thinner it gets and the more reasonable it becomes until it is as thin as reality, the name we give to the common experience..."Look, look!" recites the crowd. "A horse with an arrow in its forehead! It must have been mistaken for a deer."²⁸

A disorder disappears when it is shown, somehow, to be in society's interest to have that condition be recognized as 'normal.' It was in society's interest (and no detriment to psychiatry to have homosexuality be normalized, for instance. However, that was in 1974. The marketplace is different in 1995. Is it in contemporary psychiatric interest to have Dissociative Identity Disorder normalized into multiplexity? What about the cottage industry built up around it? The marketplace is full of conflicting interests.

In whose interest does psychiatry operate? Does it assist the individual? Does it assist the society? Are these three sets of interests entirely separate, or might there be points of intersection? Are different interests served when psychiatry undergoes a paradigm shift?

Many factors influence the creation of a new paradigm in psychiatry: social pressure for reform of the definitions, political pressure from big names in the field, economic pressure from players in the marketplace, changing dynamics in the interplay between psychiatry and popular culture. All these factors affect how psychiatric paradigms are formed. In investigating the self-conscious construction of the paradigm of trauma-based disorders, then, there is really only one question to ask. In whose interest is it that I think this?

* * *

²⁸ Tom Stoppard.(1966) *Rosencrantz and Guildenstern Are Dead*. London: Oxford University Press, P. 32.

- For all we know it isn't even true.

- For all anyone knows, nothing is. Everything has to be taken on trust; truth is only that which is taken to be true. It's the currency of living. There may be nothing behind it, but it doesn't make any difference so long as it is honoured. One acts on assumptions. What do you assume?

Tom Stoppard
Rosencrantz and Guildenstern are Dead

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