

Rewriting the Soul

MULTIPLE PERSONALITY AND THE
SCIENCES OF MEMORY

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Introduction

MEMORY is a powerful tool in quests for understanding, justice, and knowledge. It raises consciousness. It heals some wounds, restores dignity, and prompts uprisings. What better motto for automobile license plates in Québec than *Je me souviens?*—I remember. Memories of the holocaust and of slavery must be passed on to new generations. Severe and repeated child abuse is said to be a cause of multiple personality disorder; the illness is to be treated through a recovery of lost memories of pain. An aging population is scared of Alzheimer's disease, which it regards as a disease of memory. In a most extraordinary venture into the mind by way of biochemistry, the central focus of research in brain science is memory. An astonishing variety of concerns are pulled in under that one heading: memory.

My curiosity is piqued exactly when something seems inevitable. Why are such diverse interests grouped under *memory*? One senior American philosopher, Nelson Goodman, as committed to the arts as to the sciences, has called himself skeptical, analytical, and constructionalist. I have those tendencies too. I wonder skeptically: why has it been essential to organize so many of our present projects in terms of memory? I wonder analytically: what are the dominating principles that lock us into memory as an approach to so many of the problems of life, from child rearing to patriotism, from aging to anxiety? And I wonder, what constructions underlie these principles? I am not looking for the trite wisdom that there are different kinds of memory. I wonder why there is one creature, "memory," of which there are so many different kinds.

I do not want, now, a grand reflection on memory, or its associated horrors such as genocide and child abuse. Skeptics are unenthusiastic about systems, about theories of everything. I propose to examine an entirely specific case of memory-thinking. Multiple personality is perfect for the purpose. This illness, which seemed as nothing twenty-five years ago, is flourishing all over North America. Amnesia has been built in to the official diagnostic criteria for what has just been renamed dissociative identity disorder. Dissociation into personality fragments is caused (on current theorizing) by abuse in childhood that had long been forgotten. Multiple personality is a paradigmatic, if tiny, memory-concept.

We can get some perspective on the question of how memory came

into play, because multiple personality, though florid now, is not new. One of its previous incarnations, beginning in 1876, took place when a whole new discourse of memory came into being. People have always been fascinated by memory. In classical Greece, and in the High Middle Ages, mastery of *the art of memory* was one of the most admired of skills. But the sciences of memory arose only in the second half of the nineteenth century. One of these sciences, especially developed in France, fixed on pathological memory, and multiple personality is a part of that new science. I argue that the way in which the sciences of memory evolved has much to do with the frontline memory confrontations of today.

As a research strategy I have always been much taken by what Michel Foucault named archaeology. I think that there are sometimes fairly sharp mutations in systems of thought and that these redistributions of ideas establish what later seems inevitable, unquestionable, necessary. I hold that whatever made possible the most up-to-the-moment events in the little saga of multiple personality is strongly connected to fundamental and long-term aspects of the great field of knowledge about memory that emerged in the last half of the nineteenth century. I can use multiple personality, then and now, as a microcosm of thinking-and-talking-about-memory, then and now. Hence in the middle of the book I open a narrow window looking out onto memory—and multiple personality—long ago. The venue is France 1874–1886. I choose it because that was the center of the span of time when the structure of the modern sciences of memory came into being.

It is by no means an accident that in precisely that period the word *trauma* acquired a new meaning. It had always meant a lesion or wound, but its meaning was limited to the physical, the physiological. Then suddenly the word got its most common and compelling meaning, a psychological hurt, a spiritual lesion, a wound to the soul. Some historical dictionaries direct us to Freud, in the early 1890s, for the first usage of the word in that sense. We must go back further than that, for Freud only deployed what had already become current. He did so in connection with memory, for it is memories of psychic trauma that transfix us. The idea of trauma was already intimately connected with multiple personality. So many striking changes in ideas occur in my chosen two decades that I become convinced that we are looking at a radically formative moment, even for the idea of memory itself. The very fact that we do not think about these changes—who wonders how trauma

became a lesion of the soul?—shows that we have come to think of them as inevitable, invisible, a priori.

In preparing this work, feeling the tentacles of madness surround me, I was brought sharply to my senses in *The Musical Offering*, a café in Berkeley, California, which displayed a large and handsome poster of a rainy Paris street, “The World of the Impressionists, 1874–1886.” I had become so caught up in my strange tales that I had forgotten what all of us know about that time and place. We all have a vision of what that world looked like, at least to the chosen few. Let their world be my baseline. I ask you to imagine that I am talking about the world of the impressionists. Visually it was a new world, created not only by artists but also by the camera. The camera was truly objective because no human observer intervened between the object and the record. Alongside the impressions made with paint we must place the reproducible images captured by the lens. Toward the end of my chosen twelve years Jean-Martin Charcot, master neurologist, became fascinated by pictorial representations of hysteria, old and new. He and his students made this illness visual. Hysterics had to have some affliction that could be photographed. Multiple personality was thought to be a bizarre form of hysteria. The very first *multiple* personality—multiple meaning *more than two*—was photographed in each of ten personality states. Here they are in my hand, among the pages of a printed book, as faithful today as in 1885, when the poses were captured on the photographic plate.

Multiple personality became an object of knowledge in many ways. Photography was part of the initial rhetoric of multiplicity. Today quantitative tests of dissociation fill a similar role. My chief topic, toward the end of the book, will become the way in which a new science, a purported knowledge of memory, quite self-consciously was created in order to secularize the soul. Science had hitherto been excluded from study of the soul itself. The new sciences of memory came into being in order to conquer that resilient core of Western thought and practice. That is the bond that connects, under the heading of *memory*, all those different kinds of knowledge and rhetoric I have mentioned. When the family falls apart, when parents abuse their children, when incest obsesses the media, when one people tries to destroy another, we are concerned with defects of the soul. But we have learned how to replace the soul with knowledge, with science. Hence spiritual battles are fought, not on the explicit ground of the soul, but on the terrain of memory, where we suppose that there is such a thing as knowledge to be had.

Talk of the soul sounds old-fashioned, but I take it seriously. The soul that was scientized was something transcendental, perhaps immortal. Philosophers of my stripe speak of the soul not to suggest something eternal, but to invoke character, reflective choice, self-understanding, values that include honesty to others and oneself, and several types of freedom and responsibility. Love, passion, envy, tedium, regret, and quiet contentment are the stuff of the soul. This may be a very old idea of the soul, pre-Socratic. I do not think of the soul as unitary, as an essence, as one single thing, or even as a thing at all. It does not denote an unchanging core of personal identity. One person, one soul, may have many facets and speak with many tongues. To think of the soul is not to imply that there is one essence, one spiritual point, from which all voices issue. In my way of thinking the soul is a more modest concept than that. It stands for the strange mix of aspects of a person that may be, at some time, imaged as inner—a thought not contradicted by Wittgenstein's dictum, that the body is the best picture of the soul.

I am not writing about the soul in the way that you might expect in a book about multiple personality. I am preoccupied by attempts to scientize the soul through the study of memory. Some philosophers, and not a few clinicians, have wanted to make a quite different use of multiple personality. They argue that it shows something about what it is to be a person, or the limits of personal identity. Some have gone so far as to say that this disorder provides a window on the relation between brain and mind, or even contributes to solving the mind-body problem. I have no such illusions, no such intentions, no such problem.

I came to this topic when thinking about how kinds of people come into being. How do systems of knowledge about kinds of people interact with the people who are known about? The story of multiple personality is, in all too many different ways, a story about what I have called making up people.¹ I am fascinated by the dynamics of the relation between people who are known about, the knowledge about them, and the knowers. That is a public dynamics. There is also a more private one. The theory and practice of multiple personality today is bound up with memories of childhood, memories that are to be not only recovered but also redescribed. New meanings change the past. It is reinterpreted, yes, but more than that, it is reorganized, repopulated. It becomes filled with new actions, new intentions, new events that caused us to be as we are. I have to discuss not only making up people but making up ourselves by reworking our memories.

I dwell on these difficult matters at the end of the book. In the middle I excavate the sciences of memory that provide the ground for so many present concerns. I begin by describing some recent dynamics. I tell how multiples, theories of multiple personality, and experts on the disorder have been interacting in the past few years. I tell only enough to set my stage. The whole field of multiple personality is ripe for participant observation and sociological analysis. But that is a task for others. I have scrupulously limited myself to matters of public record.

Is It Real?

AS LONG AGO as 1982 psychiatrists were talking about “the multiple personality epidemic.”¹ Yet those were early days. Multiple personality—whose “essential feature is the existence within the individual of two or more distinct personalities, each of which is dominant at a particular time”—became an official diagnosis of the American Psychiatric Association only in 1980.² Clinicians were still reporting occasional cases as they appeared in treatment. Soon the number of patients would become so overwhelming that only statistics could give an impression of the field.

Ten years earlier, in 1972, multiple personality had seemed to be a mere curiosity. “Less than a dozen cases have been reported in the last fifty years.”³ You could list every multiple personality recorded in the history of Western medicine, even if experts disagreed on how many of these cases were genuine. None? Eighty-four? More than one hundred, with the first clear description given by a German physician in 1791?⁴ Whatever number you favored, the word for the disorder was *rare*.

Ten years later, in 1992, there were hundreds of multiples in treatment in every sizable town in North America. Even by 1986 it was thought that six thousand patients had been diagnosed.⁵ After that, one stopped counting and spoke about an exponential increase in the rate of diagnosis since 1980. Clinics, wards, units, and entire private hospitals dedicated to the illness were being established all over the continent. Maybe one person in twenty suffered from a dissociative disorder.⁶

What has happened? Is a new form of madness, hitherto almost unknown, stalking the continent? Or have multiples always been around, unrecognized? Were they classified, when they needed help, as suffering from something else? Perhaps clinicians have only recently learned to make correct diagnoses. It is far easier, they say, now that we know the most common cause of dissociated personalities—early and repeated sexual abuse in childhood. Only a society prepared to acknowledge that family violence is everywhere could find multiple personalities everywhere.

Or, as a majority of psychiatrists still contend, is there simply no such thing as multiple personality disorder? Is the epidemic the work of a

small but committed band of therapists, unwittingly aided and abetted by sensational stories in the tabloids and afternoon TV talk shows?

We at once arrive at what sounds like the big question: *Is it real?* That is the first question people ask me when they hear I am interested in multiple personality. It is not only amateurs who ask. The American Psychiatric Association staged a debate at its annual meeting of 1988: “Resolved That Multiple Personality Is a True Disease Entity.” For: Richard Kluft and David Spiegel. Against: Fred Frankel and Martin Orne. The debaters, all leading professionals, remain in bitter disagreement today. The rest of us, once we see how vehemently the two camps of experts oppose each other, are bewildered. Multiple personality has become the most contested type of diagnosis in psychiatry. So we bystanders repeat, rather helplessly: Is it real?

What is “it,” this controversial multiple personality? Not schizophrenia. Schizophrenia is often called split personality, so we reason that multiple personality = split personality = schizophrenia. Not so. The name *schizophrenia* was introduced at the beginning of the twentieth century. It is Greek for “split brain.” The metaphor of splitting has been used in many different ways—Freud, for example, used it in three distinct ways at different stages in his career.⁷ The idea behind the name schizophrenia was that a person’s thoughts, emotions, and physical reactions are split off from each other, so that the emotional reaction to a thought, or the physical response to an emotion, is completely inappropriate or bizarre. There are delusions, thought disorders, and a terrible range of suffering. It is unclear whether schizophrenia is one disease or several. One form of it develops in the late teens or early twenties, so that this disease was once called *dementia praecox*, or premature senility. Schizophrenia probably has neurochemical causes; some forms of it might be genetic. Since the 1960s there has been an increasing battery of drugs that radically improve the quality of life for many schizophrenics.

None of the things I have just said about schizophrenia is true of multiple personality. No medication has specific effects on multiple personality as such, although switches in personality, like any other exceptional behavior, can be damped down by mood-altering drugs. Multiple personality has most commonly been first diagnosed in patients over thirty years of age, not in adolescence. It is not characterized by a splitting of thought, emotion, and bodily response. Multiple personality may mimic schizophrenia, in that there may be short periods of “schizophreniform” behavior, but these episodes do not endure. I shall return to schizophrenia, but for the present we must put it to one side.

So what is multiple personality? I will begin by being quite formal, using official guidelines. There are two widely used standard classifications of mental illness. One is part of the International Classification of Diseases, published by the World Health Organization in Geneva. The tenth edition of 1992, called *ICD-10*, does not have a separate category for multiple personality, although it does have an extended classification of types of dissociation.⁸ *ICD-10* is used primarily in Europe, where most psychiatric establishments are disdainful of the multiple personality diagnosis. Another classification is the *Diagnostic and Statistical Manual of Mental Disorders*, authorized by the American Psychiatric Association. It sets the standard in North America and, despite *ICD-10*, is widely used overseas. In its third edition of 1980, called *DSM-III*, the diagnostic criteria for multiple personality disorder were:

- A. The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time.
- B. The personality that is dominant at any particular time determines the individual's behavior.
- C. Each individual personality is complex and integrated with its own unique behavior pattern and social relationships.⁹

These criteria, abstract as they are, matter to both research and practice. The great American psychiatric journals require that results be written up according to the classification of the current *Diagnostic and Statistical Manual*. Insurance companies and publicly funded health plans reimburse doctors, hospitals, and clinics according to a schedule coded by the current *DSM*.

The criteria were made less restrictive in the revised *Manual* of 1987, *DSM-III-R*, where condition C was deleted. The personalities no longer had to be complex and integrated, or to manifest distinct social relationships.¹⁰ Hence more individuals could be diagnosed with multiple personality. But in research at the National Institute of Mental Health, Frank Putnam insisted on criteria more stringent than *DSM-III*, not less. "The diagnosing clinician must: (1) witness a switch between two alter personality states; (2) must meet a given alter personality on at least three separate occasions to assess the degree of uniqueness and stability of the alter personality state; and (3) must establish that the patient has amnesias, either by witnessing amnesic behavior or by the patient's report."¹¹ The amnesia condition, as we shall see, was built in to the criteria of *DSM-IV* in 1994.

The changes do not seem to matter to the pressing question: whether

there is such a thing as multiple personality. The straightforward answer is plainly yes. There were patients who satisfied the criteria of 1980. More satisfied the criteria of 1987. Some satisfy Putnam's more stringent protocol. No matter what criteria are used, the rate of diagnosis has been growing apace. There are plenty of questions about what multiple personality is, and how to define it, but the simple conclusion is that there is such a disorder.

So that's the answer? There really is such a thing as multiple personality, because this or that book of rules lists some symptoms, and some patients have those symptoms? We should be more fastidious than that. To begin with, the question "Is it real?" is not of itself a clear one. The classic examination of the word "real" is due to the doyen of ordinary language philosophers, J. L. Austin. As he insisted, you have to ask, "A real *what?*" Moreover, "a definite sense attaches to the assertion that something is real, a real such-and-such, only in the light of a specific way in which it might be, or might have been *not* real."¹² Something may fail to be real cream because the butterfat content is too low, or because it is synthetic creamer. A man may not be a real constable because he is impersonating a police officer, or because he has not yet been sworn in, or because he is a military policeman, not a civil one. A painting may fail to be a real Constable because it is a forgery, or because it is a copy, or because it is an honest work by one of John Constable's students, or simply because it is an inferior work of the master. The moral is, if you ask, "Is it real?" you must supply a noun. You have to ask, "Is it a real *N?*" (or, "Is it real *N?*"). Then you have to indicate how it might fail to be a real *N*, "a real *N* as opposed to what?" Even that is no guarantee that a question about what's real will make sense. Even with a noun and an alternative, we may not have a real anything: there is no such thing as the "real" color of a deep-sea fish.

The American Psychiatric Association debate asked whether multiple personality "is a true disease entity." Colin Ross, a leading advocate of multiple personality, says that "the APA debate was incorrectly titled because MPD is not a true *disease* entity in the biomedical sense. It is a true psychiatric entity and a true disorder, but not a biomedical disease."¹³ The APA provided a noun phrase ("disease entity"), and Ross offered two more terms ("psychiatric entity" and "disorder"). Do they help? We need to know what a true or real psychiatric entity *is*. A true or real disorder *as opposed to what?*

One question would be: Is multiple personality a real disorder as opposed to a kind of behavior worked up by doctor and patient? If we have

to answer yes-or-no, the answer is yes, it is real—that is, multiple personality is not usually “iatrogenic.”¹⁴ That answer of course allows for some skepticism, for it might still be that many of the more florid bits of multiple behavior are iatrogenic.

A second question would be: 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. This entire book is about the relationships between multiplicity, memory, discourse, knowledge, and history. It must allow a place for historically constituted illness.

Throughout the history of psychiatry, that is, since 1800, there have been two competing ways to classify mental illness. One model organizes the field according to symptom clusters; disorders are sorted according to how they look. Another organizes according to underlying causes; disorders are sorted according to theories about them. Because of the enormous variety of doctrine among American psychiatrists, it seemed expedient to create a merely symptomatic classification. The idea was that people of different schools could agree on the symptoms, even if disagreeing on causes or treatment. From the very beginning, American *DSMs* have tried to be purely symptomatic. That is one reason for their limited relevance to the question of whether multiple personality is real. A mere collection of symptoms may leave us with the sense that the symptoms may have different causes.

We need to go beyond symptoms, and hence beyond the *DSM*, to settle a reality debate. In all the natural sciences, we feel more confident that something is real when we think we understand its causes. Likewise we feel more confident when we are able to intervene and change it. The questions about multiple personality seem to come down to two issues, familiar in all the sciences: intervention and causation.

Intervention is serious indeed. Does it help a sizable number of clients, who satisfy suitable criteria, to treat them as if they suffer from multiple personality disorder? At present such therapy often involves coming to know numerous personality states, and working with each in order to achieve some sort of integration. Or is that strategy virtually always a bad one—even when someone walks in off the street and claims to be controlled, successively, by three different personalities? The skept-

tics say that fragmenting should be discouraged from the start. Instead of eliciting more alter personalities and thus causing the patient to disintegrate further, we should focus on the whole individual and help one person deal responsibly with immediate crises, dysfunction, confusion, and despair. Advocates call that “benign neglect” and say it is ineffective in the long run. But more cautious multiple clinicians do discourage fragmenting, even when they are willing to diagnose multiple personality in the long haul.¹⁵

The argument is not only about how to interact with some troubled people. The working clinician is seldom a total empiric; disease and disorder are identified according to an underlying vision of health and of humanity, of what kinds of being we are, and what can go wrong with us. That is why, as we shall see, the multiple personality field is so full of models of dissociation. We want to understand as well as to heal: practice demands theory. One kind of theory is causal, and so we pass from intervention to causation. The multiple personality field has been solidified by the causal idea that multiplicity is a coping mechanism, a response to early and repeated trauma, often sexual in nature.

When seen to be connected with child abuse, multiple personality prompts strong opinions about the family, about patriarchy, about violence. Many therapists of multiples are also feminists who are convinced that the roots of a patient’s trouble came from the home, from neglect, from cruelty, from overt sexual assault, from male indifference, from oppression by a social system that favors men. It is no accident, they say, that most multiples are women, for women have had to bear the brunt of family violence from the time they were infants. Dissociation begins when babies and children are abused. A commitment to multiple personality becomes a social commitment. What kind of healer do you want to be? That is not only a question about how you conduct your practice: it is a question about how you want to live your life.

We hear moral conviction on all sides. Psychiatrists who reject multiple personality are accused of complacently dismissing the victims, the abused, the women and children. Is that true? Do the majority of doctors need to have their consciousness raised? There are less inflammatory explanations for their opposition. One has to do with institutions, training, and power. There has been a populist, grassroots air to the multiple personality movement. Many of the clinicians are not M.D.’s or Ph.D. psychologists but hold another credential—a master of social work degree, a nursing qualification, right down (in the pecking order) to people who have taken a couple of weekend courses in memory regression

and are in no strict sense qualified at all. There is a motley of believers drawn from the rich mixture of eclectic therapies that run rampant in America. Hence the more skeptical psychiatrists distrust the feminism, the populism, the New-Age babble that they hear. These doctors, most of whom are men, not only are at the top of their profession's power structure but also see themselves as scientists, dedicated to objective fact, not social movements. They resent the media hype that surrounds multiple personality. They are dubious about the sheer scope of the epidemic. How can a mental disorder be so at the whim of place and time? How can it disappear and reappear? How can it be everywhere in North America and nonexistent in the rest of the world until it is carried there by missionaries, by clinicians who seem determined to establish beachheads of multiple personality in Europe and Australasia? The only place that multiples flourish overseas is in the Netherlands, and that florescence, say skeptics, was nourished by intensive visiting by the leading American members of the movement.¹⁶

There are further grounds for professional caution. In the course of some types of therapy, multiples have been encouraged to recover ghastly scenes of long ago, painfully reliving them. Each alter, it is argued, was created to cope with some appalling incident, usually in childhood, and often involving sexual assault by father, stepfather, uncle, brother, baby-sitter. Any supportive therapist committed to multiple personality would, at least during therapy, accept such memories as they surface. But increasingly bizarre events are recalled: cults, rituals, Satan, cannibalism, innocents programmed to do terrible things later in life, adolescent girls used as breeders of babies intended for human sacrifice. These memories include allegations about real people, relatives or neighbors. The resulting accusations seldom stand up to police inquiry, or charges collapse when brought to trial. The credibility of the memory structure of multiples in therapy has thus become suspect, and hence the alters themselves come to look more like a way to act out fantasies.

Such doubts are now institutionalized in a False Memory Syndrome Foundation, established in 1992. This action group is dedicated to supporting accused parents, to litigation, and to publicizing the dangers of irresponsible psychotherapy. It accuses gullible clinicians, including those who work with multiple personality, of generating memories of child abuse that never happened. In return, activists on the other side say that the foundation is a support group for child abusers.

These events are unfolding day by day, but we should not ignore an older complaint about multiple personality. Multiples have always been

associated with hypnosis and hypnotic therapy. Some people are more readily hypnotized than others. Multiples are at the top of the scale. They are terribly suggestible. Isn't the elaborate personality structure of multiples unwittingly (or worse, wittingly) encouraged by all-too-willing therapists who use hypnosis or related techniques? Hypnosis is, and has always been, a notorious problem area for psychiatry and the allied arts. Doctors who have favored the use of hypnosis in therapy have tended to be marginalized. It does no good for advocates of multiple personality therapy to protest that multiples seem to develop in therapy in much the same way whether or not the clinician uses hypnosis, for multiple personality is irrevocably tainted with hypnosis. Advocates protest: the suggestibility of the patients is an important clue to their disorder. Multiple personality is only one extreme in a continuum of what are called *dissociative* disorders. Opposition scientists who study hypnosis reply that hypnosis is too complex to be arranged on a linear scale of hypnotizability, and there is no one continuum of dissociation to range alongside of it.¹⁷

The debate rages. We are not on purely medical terrain. We are deeply involved in morality. Susan Sontag has movingly described how tuberculosis, and then cancer, and then AIDS have been relentlessly inscribed with judgments about the characters of the diseased. Childhood trauma gives a whole new dimension to the morality of the disorder. The most sensational trauma of recent times is child abuse. Abuse, as trauma, enters the equations of morality and medicine. It exculpates, or passes the guilt up to the abuser. Not only is a person with multiple personality genuinely ill: someone else is responsible for the illness. Lest you think that I exaggerate the emphasis on morality and metaphor, consider the opening words at the 1993 annual conference on multiple personality: "AIDS is a plague which attacks individuals. *Child abuse* damages individuals and is the cancer of our society: all too often it flourishes unrecognized and metastasizes across families and generations."¹⁸ AIDS, plague, cancer, metastasizes: we do not need Susan Sontag to help us notice the hyperbolic moral metaphors of multiple personality.

Now let us complete the circle back from morality to causation. It is common, in some psychiatric practice, to diagnose a patient as suffering from several different *DSM* disorders. If we had a system of classification based on causes, that would mean that a person had problems arising from two or more distinct and logically unrelated causes. But *DSM* is symptomatic, so it is not surprising that the life and behavior of a patient should exhibit several different symptom clusters, such as depression,

substance abuse, and panic disorder, say. Now the clinician may suspect that one of these clusters gets at the heart of the problem. For example, a classical psychiatrist may give a primary diagnosis of schizophrenia and hold that other behavior—including, perhaps, multiple personality behavior—is subordinate to that underlying cause. Hence he will treat the patient with some cocktail of neuroleptic drugs. The real disorder, he may say, is schizophrenia. The disorder to which all the other disorders are subordinate is sometimes called superordinate. Primary treatment is for the superordinate disorder, and other symptoms are expected to remit, to some extent, as the superordinate disorder is relieved. Is multiple personality disorder a superordinate diagnosis? Is it the problem to be treated, in the expectation that other problems such as depression, or bulimia, or panic disorder are subordinate to it? Advocates are affirmative.¹⁹ Skeptics completely disagree. In the skeptical opinion, patients who evince multiple personality have problems, but the mutually amnesic personality fragments are mere symptoms of some underlying disorder. “The diagnosis of MPD represents a misdirection of effort which hinders the resolution of serious psychological problems in the lives of the patients.”²⁰

You may be beginning to think I’m of two minds, just a little bit split myself, when it comes to multiple personality. One moment I am sketching part of the general theory proposed by experts who take for granted that multiple personality is a real disorder. The next moment I am repeating grounds for skepticism about the very idea of multiple personality. What do *I* think? Is it real, or is it not?

I am not going to answer that question. I hope that no one who reads this book will end up wanting to ask exactly that question. This is not because I have some hang-up about reality or the idea of reality. There is a current fashion, among intellectuals who identify themselves as postmodern, to surround the word *reality* with a shower of ironical quotation marks. That is not my fashion. I do not use scare-quotes, and I am not ironical about reality. I expect that both advocates and opponents of multiple personality will find some of my discussion distasteful. I have no inclination to take sides. My concern is not, directly, with uncovering a fundamental timeless truth about personality or the relationship of fragmentation to psychic pain. I want to know how this configuration of ideas came into being, and how it has made and molded our life, our customs, our science.

My very neutrality makes me cautious about even the name of our

topic. Names organize our thoughts. Between 1980 and 1994 the official diagnosis was “Multiple Personality Disorder.” Most people involved in the field said or wrote simply “MPD.” I never do that, except when quoting—because there is nothing like an acronym to make something permanent, unquestioned. (I use only two acronyms systematically throughout this book, both for very real entities. One is *DSM*, abbreviating the name of the manual. The other is ISSMP&D, which stands for the original name of the multiple movement’s professional society, the International Society for the Study of Multiple Personality and Dissociation.) I shall talk about multiple personality, but very seldom do I even say “multiple personality disorder.” That is partly because I am wary of the word “disorder.” It is the standard all-purpose word used in the *DSM*. It is a good choice but it cannot help being loaded with values. The word is code for a vision of the world that ought to be orderly. Order is desirable, it is healthy, it is a goal. Truth, the true person, is disrupted by disorder. I am cautious about that picture of pathology. Others actively protest the very word “disorder” for multiple personality. These radicals suggest that perhaps we are all multiples really. A few established clinicians have gone almost that far, and one hears the same thing in some patient support groups.²¹

Another word has attracted more criticism than “disorder”—“personality.” In fact Multiple Personality Disorder has just gone out of existence. The official heading in the *DSM-IV* of 1994 is “Dissociative Identity Disorder (*formerly* Multiple Personality Disorder).” Personality has been bracketed. What is happening?

As early as 1984 Philip Coons warned, in one of the most scrupulous essays on the topic during that decade, that “it is a mistake to consider each personality totally separate, whole or autonomous. The other personalities might best be described as personality states, other selves, or personality fragments.”²² That was not at first agreed. In 1986 B. G. Braun suggested a nomenclature distinguishing alter personalities from “fragments.”²³ The meaning was that, yes, there are fragments, but there are also personalities.²⁴

There is one textbook of our subject, *Diagnosis and Treatment of Multiple Personality Disorder*, by Frank Putnam. It is humane and clear; at its appearance in 1989 it was up-to-the-minute. I shall occasionally take issue with Putnam’s work, but that is a sign of real respect, for he is the clearest and most careful authority in the field. In his textbook he emphasized a treatment that involves intensive interaction with all the

alters in a personality system. These alters, in his account, have very distinct characters and behaviors. One does get the picture of rather rounded “personalities.” He nevertheless issued a salutary warning:

Overemphasis on multiplicity per se is a common mistake made by therapists new to the disorder. MPD is a fascinating phenomenon that makes one question most of what one has learned about the human mind. A reading of the case report literature from the earliest cases to the present shows that one of the common impulses on the part of therapists is an attempt to document the differences among the alter personalities of their patients. This fascination with the differences of the alters sends a clear message to patients that these are what makes them interesting to therapists and to others.²⁵

In a 1992 talk Putnam candidly stated that “very little is known about the alter personalities and what they represent.”²⁶ His increasing reservations about alter personalities are shared by an influential group of psychiatrists within the multiple movement who have long held that the emphasis on personalities is wrongheaded. In 1993 David Spiegel, chair of the dissociative disorders committee for the 1994 *DSM-IV*, wrote that “there is a widespread misunderstanding of the essential psychopathology in this dissociative disorder, which is 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.”²⁷ Spiegel asked who originated this aphorism on being less than one personality. One is reminded of Alice (in Wonderland), “for this curious child was very fond of pretending to be two people. ‘But it’s no use now,’ thought poor Alice, ‘to pretend to be two people! Why, there is hardly enough of me left to make *one* respectable person!’”²⁸

The emphasis on treating alter personalities almost as persons has not, however, gone away. In 1993, the same year that Spiegel made the comment I have just quoted, a clinician and a clergyman were describing the problems of treating a patient who was a devout Christian. Her alters were not. “Because some alter personalities have experienced so little religious involvement, their questions often require very basic religious education.”²⁹ Although there is no inconsistency, it is hard to think in terms of giving religious instruction to a mere fragment.

An emphasis on fragments as opposed to whole personalities is having its effects. The replacement name “Dissociative Identity Disorder” is intended to dispel simplistic ideas that go along with “multiple personality.” As Spiegel put it,

I want to in a sense mainstream this disorder—I don't want it to be seen as some kind of circus sideshow. I want it to be considered as seriously as any other mental disorder. And we took great pains to make the language consistent with that of other disorders. But I felt that the important thing was to emphasize that the main problem is the difficulty in integrating disparate elements of memory, identity and consciousness, rather than the proliferation of personalities.³⁰

Spiegel has been strongly criticized for railroading the name change. "The primary constituency of the Dissociative Disorders field is abused men, women and children, and the professionals who treat them."³¹ And that constituency was not consulted! Will not the American Psychiatric Association be accused of "acting in a sexist and/or political manner"? The leaders in the movement quickly acknowledged the lay of the land. There was no longer such a thing as multiple personality to study, so the International Society for the Study of Multiple Personality and Dissociation had to change its name. This was done by overwhelming vote at the spring meeting in May 1994; we now have the International Society for the Study of Dissociation.

According to Spiegel, "the name change does not correspond to any change in diagnostic criteria."³² Yet that is not strictly true. In 1994 the criteria became:

- A. The presence of two or more distinct identities or personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person's behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). *Note:* In children the symptoms are not attributable to imaginary playmates or other fantasy play.³³

The final "note" has a subtext. Many advocates wanted a new diagnostic category of childhood multiple personality disorder. They did not succeed but got their foot in the door. They hope to open the door wider in *DSM-V*.

Subtle differences in definition can be a surprisingly useful way to

begin to understand how the disorder itself is changing.³⁴ *DSM-III* required the *existence* of more than one personality or personality state. In 1994 we require only the *presence*. What's the difference between existence and presence? Spiegel explained, "We felt that *existence* conveys some belief that there really are twelve people, when really what we want to underscore is that they experience themselves that way."³⁵ This tiny change in wording moves us away from actual multiple personalities to an experience that the patient has. Second, "presence" is the word used for the delusions characteristic of the schizophrenias. The parallelism was deliberate. Thus the alters of a multiple personality are, through the change of a mere word, made more analogous to delusions. Spiegel is, in effect, saying that multiple personality is not the main disturbance. The problem is disintegration of the sense of identity. We shall find over and over again that multiple personality is a moving target. Perhaps it has just moved out of sight.

Yet two things are constantly in view, memory and psychic pain. Whether the illness involves more than one personality or less than one, whether we have dissociation or disintegration, the disorder is supposed to be a response to childhood trauma. Memories of the early cruelties are hidden and must be recalled to effect a true integration and cure. Multiple personality and its treatment are grounded upon the supposition that the troubled mind can be understood through increased knowledge about the very nature of memory. I do not intend to question beliefs in multiple personality. I intend instead to find out why it is so taken for granted, by both sides, that memory is the key to the soul.