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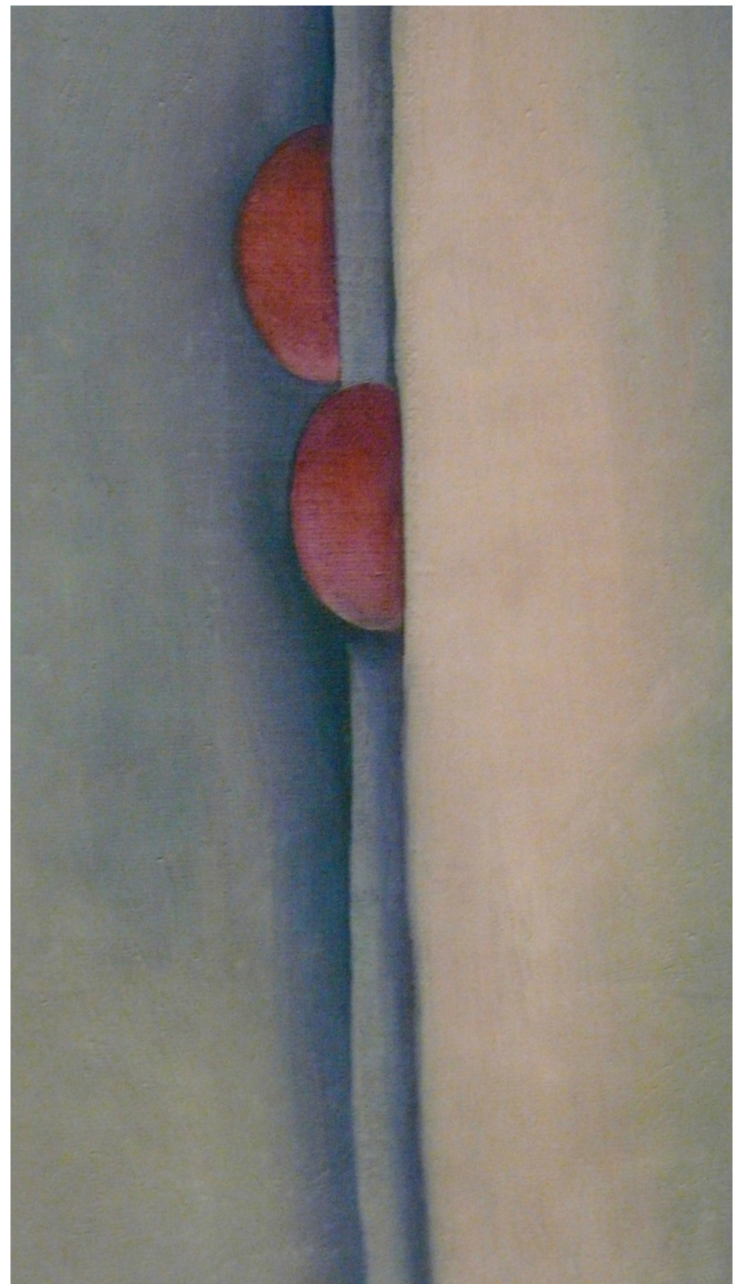
POSTMODERN DIAGNOSES: SELF BEFORE SCIENCE IN THE SEARCH FOR IDENTITY



"Postmodern Diagnoses: Self Before Science in the Search for Identity." In Narrative Matters 2004 Conference Proceedings. W. L. Randall, D. Furlong, & T. Poitras (Eds.). Fredericton, New Brunswick, Canada: Narrative Matters Conference Planning Committee, 2004: 514-523.

It is estimated that one in three women and one in five men in the United States were sexually abused or exploited before they reached eighteen. This means roughly 70 million people have experienced some form of sexual abuse in America (Steinberg & Schnall, 2000, p. 17). However, it is difficult to make reliable estimates about the extent of child abuse, as most abuse goes unreported, and most people seem to avoid perceiving themselves as victims. In one study of adults who relayed accounts of physical assault by a parent, only 5 percent of the men and 9 percent of the women claimed they were "abused" (Ibid, p. 24). Given that so few see themselves as victims of abuse, it is believed that only the most severely mistreated ever receive psychiatric services. Nevertheless, survivors of childhood abuse make up an astounding 50-60 percent of psychiatric inpatients and 40-60 percent of psychiatric

outpatients (Herman, 1992/1997, p. 122). Only in the past thirty years have child abuse survivors received diagnoses that recognize trauma as the etiology of their psychological suffering. These diagnoses are: 1) posttraumatic stress disorder, a diagnosis shared with war veterans and victims of natural and mechanical disasters; and 2) dissociative identity disorder, a condition uniquely described as originating as a defense against extreme and chronic child abuse. For many years, dissociative identity disorder has been known as multiple personality disorder.

A psychiatric diagnosis is rarely a trivial classification of symptoms. It is likely central to the treatment process as a pedagogical tool used by practitioner and patient to address the (likely implicit) central question of Foucauldian ethics: *How should one govern oneself?* Michel Foucault associated this question with institutions like psychiatry that individuals use as *technologies of the self* to create a life worth living, a process Foucault described as the ways an individual "…delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral worth"(1990, p. 28). As a technology of the self, a diagnosis shapes and structures narrative acts of self-making, and for many, is a promise of salvation.

Having a psychiatric diagnosis can be a formidable tool for becoming without the *pathos* of a past self—the person one once was but hopefully will cease to become. For the person with a history of child abuse, change often involves becoming a survivor and thus no longer a victim. If this transition cannot occur, the correctness of a diagnosis may come into question. As Jerome Bruner observed, "only when we suspect we have the wrong story do we begin asking how a narrative may structure (or distort) our view of how things really are" (2002, p. 9).

In fact, many patients were diagnosed with other disorders before eventually being diagnosed with dissociative identity disorder. Patients often interpret dissociative identity disorder as recognition of their sanity and as rejection of clinical diagnoses such as schizophrenia, manic depression, and obsessive-compulsive disorder with which they are frequently misdiagnosed. Barbara G. interpreted her experiences with multiple diagnoses as

follows: *For as long as we can remember, we have seen an array of doctors as well as nine different therapists. Our description of difficulties remained the same, only the diagnosis differed among the professionals!* (Cohen, Giller, & Lynn W., 1991/2002, p. 40). Vickie G. stated: *When I think of all the cracks I slipped through over the years trying to get help, an anger stirs inside me. It took so long before someone finally knew what I was suffering from!* (Ibid, p. 35). Whatever difficulties were most prominent when initiating psychiatric care typically became the grounds for a diagnosis: panic attacks, mood swings, hallucinations, anxiety, depression, obsessive-compulsive behavior. Most patients spend seven to eight years receiving psychiatric treatment before childhood trauma is identified as the source of their suffering (Steinberg & Schnall, 2000, p.15).

When trauma is recognized as the origin of psychological suffering, what are regularly regarded as disorders in themselves—panic attacks, obsessive-compulsive behavior, mood swings, hallucinations—become symptoms of a psyche burdened by overwhelming memories of abuse. Beverly R. described the experience as follows: *I have been incorrectly diagnosed as having depression (occasional and severe), psychosis, neurosis…and the list goes on. I don't think Schizophrenia was ever used. Manic depressive was probably the most popular. All of the incorrect diagnoses are actually symptoms of MPD and characteristics of my many people* (Cohen, Giller, & Lynn W., 1991/2002, p. 54). When interpreted from the perspective of a diagnosis of dissociative identity disorder, mood swings become 'temper tantrums' from a child alter, or personality fragment, while the auditory hallucinations associated with schizophrenia are perceived as communication between alters (Steinberg and Schnall 22). One source estimates that ten percent of the general population suffers from dissociative identity disorder in some form (Steinberg and Schnall 21). This figure approximates the one-year prevalence rate for major depression and generalized anxiety disorder—two disorders that are often confused with dissociative identity disorder (Steinberg and Schnall 21).

In this paper, I examine what is compelling about replacing a medical model of the self with the abuse-laden history that dissociative identity disorder addresses, and some might say, honors. Unifying this discussion will be Bruner's observation that "narrative acts of self-making are usually guided by unspoken, implicit cultural models of what selfhood should be,

might be—and, of course, shouldn't be" (65). I include suggestions for what makes dissociative identity disorder appealing to self and society during our postmodern era, given the uncertainty we generally experience about selfhood and the institutions that define it. Testimonies are from a project created by Barry M. Cohen, Esther Giller, Lynn W., and the Sidran Foundation. This project involved sending open-ended questionnaires to 2300 subscribers of *Many Voices*, a newsletter for persons with dissociative identity disorder. A primary focus of the questionnaire was their experiences with the mental health community. The results were compiled in a book titled *Multiple Personality Disorder from the Inside Out*. Like the testimonies from this book, I will refer to dissociative identity disorder by its predominantly patient-used name, multiple personality disorder, or MPD.

When the question, *How should one govern oneself?*, is asked in the Zeitgeist of the postmodern, psychiatry's institutional authority is implicitly challenged. During the first half of the twentieth century, before psychiatry's present emphasis on pharmaceutical intervention and the proliferation of 'boutique' therapies designed for full-time people (or part-time patients), psychiatry was primarily limited to long-term institutional care and the housing of individuals unable to fully integrate into modern society. In the limited and contained environment of the asylum, psychiatry offered patients less opportunities for self-making than it does today. In 1952, there were 112 diagnoses in the Diagnostic Statistical Manual, or DSM; in 1968, there were 163. The 1994 printing of the DSM listed 374 diagnoses. For some, the proliferation of diagnoses erodes the perceived rigor of psychiatric knowledge. Yet for others, the proliferation marks the end of an era during which patients' needs were often eclipsed by the shadow of institutional strategies devoted to the establishment of psychiatry as a medical specialty capable of producing scientific fact.

Psychiatry continues to exist as a modern institution despite signs of shifting to address the uniquely postmodern needs of its patients. It seems led by the assumption that society is sane and its responsibility is to return people to the shared social order, and away from their idiosyncratic conceptions of reality. When Pinel, Charcot, Freud, Janet, and others began this modernist project in the nineteenth century, psychiatry perhaps had the authority to assert that one model of the mind was normative and all others should be sacrificed. We, however, no longer live in their era, but at a time of transition in which what constitutes sanity

is as contentious as the legitimacy of the institutions that seek to identify it. According to David Levin, what makes our era postmodern is the recognition that modernity has failed and that something must replace it—although what, we are not sure. "Modernity ends, since it is, in part, a question of culturally shared consciousness, as people begin to realize that there is a critical distance that separates them from the thinking and living they have inherited…. But postmodern thinking also begins with a strong sense—articulated, however, only with difficulty—that we are living in a time of transition, a moment between two epochs: the known and the unknown" (qtd. in Fee 8). The DSM is caught in this confusion, interpreting postmodern suffering through modernist conceptions of the self. As Simon Gottschalk pointed out: "…if we posit postmodern selfhood as a mutable, liminal, multiple, interdependent, and interactive process, then relying on DSM-IV diagnoses will prevent us from understanding it, since DSM-type diagnoses rest on—and reproduce—the idea of a stable, self-contained, and isolated modern self" (Gottschalk 21). MPD is a contested diagnosis, and this status makes it a productive segue into the sociocultural influences on practices of self-making, particularly when trying to distinguish between the effects of modernity and postmodernity on institutionalized narrative structures. As Jo Anne M. stated: *If people would stop, look, and listen, then they could see that we are because of the real world—we reflect how it really is out there* (Cohen et al. 47).

The patient in our postmodern world tactically manipulates and diverts totalizing discourses, creatively using diagnoses to give structure to narrative and self. Armed with a diagnosis, the patient averts power and danger, copes with chance events, and evades the materiality of existence and thus survives. The 'truth' of her condition, however, is not the postmodern patient's shield. Truth has become multiple, distributed, and localized in our postmodern era. A diagnosis is 'true' when it leads to the creation of a certain type of person, or the attainment of a life the individual finds worth living. It becomes true when a person can use it to protect against a life they find threatening, or a past self they no longer want to be. As Foucault pointed out: "When an unforeseen event or misfortune presents itself, we must be able to call upon the relevant true discourses in order to protect ourselves; they must be at our disposal within us" ("The Hermeneutics of the Subject" 100). To attain this state of truth as self-defense, new narratives like MPD have become necessary that show who and how to be within a matrix of sociocultural norms, institutional knowledges, and technologies for

self-making that are alternatively rigid and mutable, depending on whether they reflect a modernist ideology or are driven by our postmodern condition. Self-defense is especially important to the person raised in a violent household only to find herself set free to a potentially violent world. Navigating freedom often requires creating a self able to distinguish between imagined threats and remembered tragedies. Cynthia S. relayed the following: *I must accept that the way I experience the world has been shaped by abuse. The fragmentation served a purpose, but now as an adult I can decide if the purpose of fragmentation serves me. Do I need that protection? At first I did. Now I don't. But I needed to grow to that place* (Cohen et al. 26).

There is much contention about the truth-value of the MPD diagnosis. Many in the mental health sciences, as well as laypersons, conceive of MPD as *iatrogenic*, "…unwittingly created by the physician or therapist, and aided by the subject's heightened suggestibility and desire to please…"(Braude 38)—two traits often associated with patients diagnosed with MPD. Yet not all those that agree with the validity of the MPD diagnosis believe that at issue is the existence of multiple personalities. For instance, Margo Rivera believes that 'alters' are not actual identities but rather a way of talking about problems. Ian Hacking describes this perspective, stating: "if they come to talk in multiple language, and in the personae of alters, then that is their way of expressing their problems" (Hacking 74). This perspective is well-aligned with a conception of MPD as a technology for self-making and method for self-governance.

Most persons with a history of childhood trauma never receive a diagnosis of MPD. Psychiatrists infrequently pose questions about childhood trauma, and evidence that abuse occurred is largely ignored. The psychiatrist Colin Ross described his clinical training as follows: "the 'clinical material' I worked with was a veritable tidal wave of trauma. Yet trauma was basically ignored as a theme, factor or cause of the patients' problems.… It was as if 80% of the patients were Nazi concentration camp survivors. I was actively taught to ignore this fact, and to concentrate on my work as a doctor, which was to make diagnoses and prescribe medication. My training was typical then and would be typical today" (13).

Psychiatrists are not alone in the denial of abuse, as it is also a sociocultural norm. Often we are afraid of our pain and grief, resisting it like slow drowning. Indeed, T. M. Luhrmann had described grief as “like the beginning of acute mental illness” (279). In reality, it is likely the grief for a lost self, or a self that could have been but never was, which causes so much suffering in psychiatric patients and abuse survivors. Healing from past wounds can require a profound letting go of defenses, coupled with a need for the world to be safe. Changing the chemical composition of one’s brain through medications may ease the burden, and may be necessary for survival, yet it has not shown outstanding success in returning people to themselves or to the lives they desire to live. In part, this is due to the limited stories they can tell about themselves when they attempt to articulate who they are in terms of their biology. For the person who has fragmented, and lost parts of herself to abuse, regaining the self through acceptance is more healing than a dialectic of the normal and the pathological that requires rejecting parts of the self (the pathological) so that the normal self can thrive. It is this dialectic that forms the narrative structure of biological conceptions of mental suffering as medical diseases and which many persons with abuse histories eventually reject.

In many regards, clinical diagnoses like manic depression and schizophrenia are less stigmatizing than MPD, and are sanitized by representations of mental illness as biomedical diseases. Manic depression is “just a disease,” and as such, is beyond the will of the patient. Georges Canguilhem described disease in the late twentieth century as “…no longer related to individual responsibility; no more imprudence, no more excess to incriminate…. as sick men we are the effect of universal mixing, love, and chance” (278). MPD, however, lacks this cloak of innocence. Bounded by shame and silence, many abuse survivors spend years untangling their feelings of culpability from society’s need to repress the voices of victims—an experience that may be reminiscent of their original victimization.

The biomedical model of mental illness requires the organization of the self according to the dialectic of the normal and the pathological. In this dialectic, self-rejection becomes necessary for eradicating parts of the self that might threaten what is deemed the ‘normal’ self. Narratives are organized according to vigilance, the symptomatology of disease, and the perpetual possibility of the illness’s return. For example, Mike Wallace took a vigilant

stance towards himself when looking for the symptoms of depression in his thoughts, behaviors, and emotions, while anticipating the return of himself that he rejected as abnormal and ill: *The effects of it diminished, and diminished, and diminished, but you know that you've had it for a couple of years. At least, I found that is true of me. I don't know that you're ever back totally to normal, because you're always looking out the corner of your mind, thinking "It is laying over there someplace?" And every once in a while, you say, "Ooh, wait a minute, is this the depression coming?"*(Cronkite 18-19).

These premonitions became warning signs for Wallace when he experimented with stopping medications prescribed to treat his depression. Once the diagnosis and treatment were in place, the proximity to depression became measured in relation to the medications and the implicit understanding that to avoid illness, disease must be treated repetitively and chronically: *I still take [a very small dose of] a very, very mild antianxiety, antiwhatever. The last two summers, I tried to kick it. After a while, I began to get those warning signs of depression, and I said, "It's not worth it"*(Cronkite 19).

Wallace's manipulation of his medications is an example of a technology of the self, *askesis,* or testing one's knowledge, that Foucault associated with Ancient Greece and conceptions of the good life. According to Foucault, *askesis* includes "exercises in which the subject puts himself in a situation in which he can verify whether he can confront events and use the discourses with which he is armed. It is a question of testing the preparation. Is this truth assimilated enough to become ethics so that we can behave as we must when an event presents itself?" ("Technologies of the Self" 35-36).

Askesis is also a central practice of the diagnosis of MPD. Yet rather than organized according to self-rejection, as biological models of mental disorders require, MPD is based on a model of radical self-acceptance in which the goal of therapy is to recognize and validate the different alters and identify their roles as parts of a self that exists as a system. Integration is not necessary for a person to heal from MPD, and for many patients, such a goal is envisioned as repressive and self-rejecting. Whatever the stance on the endpoint of therapy, an endpoint is considered possible. This is contrary to biological models of mental illnesses for which pathology is perceived to exist throughout the life course. This belief in

the lifelong occurrence of pathology is in part inferred from a conception of mental illness as genetic and thus inherent to the individual.

MPD's radical sense of self-acceptance evades modern practices of selfhood that compare the self to an external model, a practice that Nikolas Rose claims "suggests that selfhood is more an aim or a norm than a natural given" (Rose 4). Alice O. stated: *I wish I had known originally that MPD cases are as individual as fingerprints. Even though I knew all people are different, I didn't entirely understand the wide variety of presentations of MPD* (Cohen et al., 34) Anne C. was equally confused by the lack of a rigid model for MPD: *I wish I had known that developing MPD was a normal response to trauma; that being able to leave my body allowed me to endure the abuse. I compared myself to Hollywood-type MPD and denied having the condition because I was not/am not flamboyant* (Cohen et al. 40).

When treatment addresses what Marsha Linehan refers to as the original "invalidating environment" of childhood as MPD does, self-acceptance is defined as "…teaching clients to fully accept themselves and their world as they are in the moment." "The acceptance advocated is quite radical," Linehan stated. "It is not acceptance in order to create change." Annette K. made the following comment about the self-acceptance promoted by a diagnosis of MPD: *We have learned that all people are a product of their history—of their life. Since no two multiples had to survive exactly the same circumstances, people with MPD will experience and use their multiplicity uniquely. Simply put, just as no two people are the same, no two multiples could possibly be the same. It was a relief to find out that we didn't have to fit in a "box," bound up by a diagnosis* (Cohen et al. 2).

The possibility of an emphasis on self-acceptance in the pathology-driven DSM is likely the result of the relatively recent multiplication of conceptions of the self in mainstream America. The diagnosis MPD did not come into prominence until the 1970s, after nearly 60 years of neglecting multiple personalities as a possible explanation for behavior. Likely relevant to its validation is the support of women's experiences that began around the same time and recognition of women's differences from then normative models of the self as masculine, centered, autonomized, and independent. The civil rights movement and the validation of the African American experience as different and equal compounded incredulity that there was

one 'right' way to live. A similar celebration of difference was seen in gay and lesbian communities as well. Together, these very different models challenged the heterosexual, white American male as a normative and universalizable model for the proper experience of subjectivity. Elizabeth Groz observed: "…if bodies themselves are always sexually (and racially) distinct, incapable of being incorporated into a singular, universal model, then the very forms that subjectivity takes are not generalizable..." (qtd. in Rose 7), thus reopening the door for the existence of more than one self within a body and the reemergence of MPD as a mental disorder.

Another aspect of our present era that has likely made MPD a possible diagnosis has been the characterization of the postmodern era as beginning after World War II, a period distinguished by high levels of trauma. For over fifty years, Americans have been inundated with trauma, both real and fictionally portrayed. Violence is regularly witnessed in the media as a local phenomenon, as rape and hate crimes are depicted as common to most American communities. Violence is also experienced as a global phenomenon, as seen in regular media portrayals of the decimation of communities through genocide and continual civil wars resulting in Diasporas. Arguably, these types of events have occurred throughout recorded human history. The postmodern era is different from modernity in that sociocultural conditions have become organized around trauma. Trauma and its effects are constantly witnessed—if not readily experienced—in our era due to the globalization of society, the media, mass communication, and time compression resulting from easy and relatively affordable travel. Danger is no longer far away, as 9/11 so painfully demonstrated. This lesson was brought home in a different manner in the 1960s when the Vietnam War was televised and the trauma of war was brought to America, its violence uneasily stirring with the violence already present in many American homes.

MPD is not a 'truer' diagnosis than schizophrenia, manic depression, or any other mental disorder listed in the DSM. Each recognizes aspects of suffering and creates selfhood in meaningful ways. Yet, there may be an increased need to dissociate in a society in which violence is perceived as commonplace. This may be particularly challenging for a child abuse survivor for whom repetitive and random acts of dissociation threaten to overwhelm an already overextended system. Similar to modern institutional strategies, MPD becomes a

method of tabulation and control for what might otherwise be experienced as chaotic, unexplainable responses to a world that is potentially violent or reminiscent of past violence. Navigating what is present, past, or fiction can be a Herculean task for the abuse survivor, and the identification of alters associated with specific instances of violence, or types of violent acts, creates some control over overwhelming fear and anxiety, and is one of the ways a MPD diagnosis might contribute to self-governance in a postmodern world.

I conclude here with testimony from Judith D. and her reflections on why MPD is preferable to schizophrenia and her hopes for survival: *It didn't hurt and there were no expectations to change in the world of Schizophrenia. But the door to our world has been unlocked. As days have become weeks and weeks have become months, my need for the old diagnosis has diminished…. And now as I begin this journey of getting to know those pieces, and putting the puzzle together, I know that we have a chance to realize our full potential. But the most important thing is that we see ourselves as being sane. It is the first time in thirty-four years that our picture of ourselves is one of sanity. At times, when the memories and pain get too great, we still retreat into our world. But slowly as we re-emerge we learn how to see the world from others' eyes and learn to see the newness as a beginning.*
And so we know the soul has survived.
And so we are working hard to survive (Cohen et al. 29).

Endnotes

1. Low self-worth, shame for the abuse, and distrust of authority also are believed to impede help-seeking behaviors to relieve suffering associated with an abuse history, as well as a failure to make connections between present difficulties and a history of child abuse.
2. "The mantra one hears through psychiatry is that both psychotherapy and psychopharmacology have the same crude success rate: a third of the time, they work well; a third of the time, they have some impact: a third of the time, they don't work at all" (Luhrmann 208).
3. While Linehan made these remarks with regard to her treatment program, dialectical behavioral therapy, which was created to treat persons diagnosed with borderline personality

disorder, the underlying assumption of the program is that many of these patients were abused as children. Indeed, one study of borderline patients found 71 percent had a history of physical abuse; 68 percent had a history of sexual abuse; and 62 percent had been exposed to domestic violence as children (Wirth-Cauchon 66).

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