THE QUARRY

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Identity, Fractured

It's been almost eleven years since Ruth Tulloch was treated at the Royal Adelaide Hospital following a suicide attempt. Earlier in the year, Ruth had experienced a nervous breakdown and was treated at her local hospital for depression and chronic fatigue. She was discharged after two weeks in hospital, and started seeing a psychologist who noticed that instances of 'child-like' behaviour during their sessions. It was during this time that Ruth also began having strange 'dreams' at night, though she knew was still awake. She attempted suicide and was flown to the Royal Adelaide Hospital where the psychiatrists similarly noticed periods when Ruth didn't seem 'herself'. 'Yes, she dissociates, but keep her in the here and now,' they relayed to each other.

At the milder end of the spectrum, dissociation is a normal mental phenomenon that all of us will have experienced. Who hasn't 'spaced out' during a boring lecture or meeting, or conversely, been so engrossed in a movie or book that we simply lose all self-consciousness? Another common form of everyday dissociation is known as 'highway hypnosis' where, as a driver, you travel a familiar route and arrive at your destination with no recollection of the journey just undertaken. It's when the phenomenon defines our lives that it is no longer seen as normal, but a mental illness. This illness, known as

Dissociative Identity Disorder (DID), is probably better known by its old name, Multiple Personality Disorder.

Even via email, it's clear Ruth gets upset recalling the attitude of the chief psychiatrist at the Royal Adelaide Hospital. He told her, 'I don't believe there is such a condition as Multiple Personality Disorder. You must have researched it on the internet. You're just putting it on.' This attitude is illustrative of the divide in psychiatric circles toward this illness. On the one hand, we have psychiatrists who think the disorder is a form of attention-seeking, built up by media popularisation and legitimised, even created, by credulous therapists. On the other, lies some who think the incidence of the disorder may be as high as one percent of the population.

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), oftentimes billed as the 'bible' of psychiatry, devotes an entire chapter to dissociative disorders in its latest edition. DID is described as 'the presence of two or more distinct identities or personality states that recurrently take control of behaviour'. These states are called 'alters', which together form a 'system'. A person with DID switches between alters with no conscious control. In many cases, each 'alter' performs a particular role for the person, for example, one may emerge to deal with fear, another with anger, and so on.

Sceptics point at the inordinate rise in cases of DID, calling it a medical 'fad' and likening the condition to the 'fad' of hysteria in the 1900's. Before 1980, there were only 200 cases of DID reported worldwide, but by 1986 this had exploded to 6,000 in the U.S. alone.[1] This leap in diagnosis, some say, is the direct result of works that popularised the condition. The most cited example is *Sybil*, a best-selling psychiatric biography about a woman with '16 personalities' whose condition was traced to perverse childhood abuse. 'Sybil', the main presenting identity, had no memory of these terrible events. But her

[1] M. D. Feldman, J. M. Feldman, R. Smith, *Stranger Than Fiction: When Our Minds Betray Us*, American Psychiatric Press, Washington DC, 1998, p. 114.

alters remembered, and 'Sybil' could even love her mother, while some of her alters were consumed with hate.[2]

Psychiatrist Frank Putnam hypothesises that we are born with and develop in infancy 'discrete behaviour states' that become linked over time. These states might be referred to as 'alert activity', 'alert inactivity', 'crying', 'fussy', and so on. Over time, these states become linked, leading us to believe that we are a unified self. This belief is what underpins the confidence we have to navigate our lives, by imagining that we are in control of our hearts and minds. However, DID may result when something continually interrupts this developmental process.

Dr. Doris McIlwain, a personality researcher at Macquarie University, explains that a repeated split in an 'object', such as a parent who alternates from being loving and abusive, may cause a split in the 'subject', that is, the child. The child survives by compartmentalising the intolerable aspects of the relationship, leading to two identity states that Dr. McIlwain refers to as 'S1' (Subject 1) and 'S2' (Subject 2). 'In other words,' she explains, 'when I'm in my S1 state – my dissociative identity called S1 – all I can think about is my loving parents. If I went into therapy with you and I came in and was 'S1' today, you would say, 'How's your dad?' and I would go, 'He's so loving, he's amazing.' And then the next day I might come in and I'm in 'S2' state and you go, 'How's your dad?' and I go, 'I don't want to talk about him. He's horrible.' Because *that* part of my personality has a system of remembrance (as it's called), which includes an exploitative, violent and abusive father who doesn't protect. But my way of solving the problem, if I'm a dissociative person, is that I actually split within myself to keep separate the two fathers, as it were.'

While the *DSM* doesn't specify the etiology of the mental disorders it classifies, most studies have found that patients report extremely high rates of childhood sexual or

[2] I. Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory*, Princeton University Press, Princeton, 1995, p. 43.

physical abuse. My four interviewees, who I find over the internet, are unanimous on this point: each of them experienced chronic trauma in childhood. Laurie et al., as she refers to herself, was sexually, physically and emotionally abused as the youngest child and only girl to an 'alcoholic father, valium-addicted mother and four older brothers who were deeply addicted to drugs.' In 1983 Laurie et al. was in her early twenties, and working at a local hospital. Working in the admissions department, she canvassed the patients to find the best doctor and sought his help for her depression as well as a lifetime of ''blank' spots that blotted my existence.' The doctor performed regressive hypnosis on her but became frustrated because he seemed to be talking to several people during the hypnotic sessions. After some months, the doctor called in a consulting psychiatrist who specialised in DID, and she was given the formal diagnosis.

Hence lays another criticism of the sceptics. As Dr. Joel Paris writes, 'the use of hypnosis, and the memories it creates, is a particularly worrying element. It has long been established that hypnotic trance is, in some ways, a form of socially constructed role play. He argues that patients may provide memories of trauma on demand and increase their number of alters over time 'possibly because of a wish to keep therapists interested.'[3] It is noteworthy that Sybil and her psychiatrist became friends, went for long rides in the country, and even lived for a while in the same house. Her treatment added up to a staggering 2,534 office hours – her psychiatrist said it took so long because there was simply no knowledge about the disorder in the 1960's.[4] Paris says that transcripts of the therapy sessions 'clearly show' that Sybil's therapist imposed the abusive childhood narrative on her, and that she may have been willing to go along with it because their relationship was the most important one in her life. This narrative of childhood abuse, in Paris' view, is what catapulted the condition into the limelight. More than 15 years prior to *Sybil*, two psychiatrists treated a woman who seemed to have three personalities. They published a book about the case, *The Three Faces of Eve*, in 1957, but after *Sybil* came

[3] J. Paris: 'The Rise and Fall of Dissociative Identity Disorder' in *The Journal of Nervous and Mental Disease*, 2012; 200, p. 1077.
[4] Hacking, *Rewriting the Soul*, p. 42.

out, the patient reneged on her doctors. 'Eve' ended up claiming that she had discovered more than 20 personalities as well as her own hidden history of abuse.[5]

Whatever the truth about 'Sybil' and 'Eve', sexual abuse and therapy became public issues from the 1970's onwards, culminating in some high profile U.S. lawsuits that rested on little else but memories of abuse that had resurfaced during treatment. The tide turned when some of these plaintiffs realised that their memories were false, launching a second wave of lawsuits against the therapists themselves. At the height of the furore, Elizabeth Loftus, an American cognitive psychologist and a pioneer in memory research, demonstrated that false memories could be created by exposure to cues such as misinformation. Loftus went on to become an advocate for those who were accused of child abuse by their adult children, accusations based solely on the retrieval of repressed memories.[6]

There was no reported link between plaintiffs and DID, but the taint of these scandals seems to have travelled over due to the condition's high association with childhood abuse. It also seems to have left a lasting impact on the way mental health professionals deal with these sorts of issues in their practice. 'I do think it's theoretically quite possible for people to have been sexually abused but not to remember it until something changes in therapy, which enables them to be strong enough to be able to face and bear the facts of the past,' Dr. McIlwain says. 'But I think therapists have to be very careful not to put suggestions into their client's head...If the therapist picks up that the person coming into therapy has got a bit of confusion, they're not sure of what's real and what's not real, that's a kind of clinical marker (that they're dissociative). And then you go very, very gently, you wouldn't be suggesting things like, 'Do you remember any inappropriate touching in your childhood?' You wouldn't ask that question because they might go, 'Yes, I do' and you wouldn't be sure if it was the truly the case or if it was because you'd suggested it. I think if the therapist is incredibly careful and just waits till

[5] Hacking, *Rewriting the Soul*, p. 41.
[6] James Randi Educational Foundation Forum, http://forums.randi.org/showthread/php?t=230111, retrieved 20 September 2013.

the person gains (strength in their self and certainty about their past and if he or she then) says, 'Do you know what? I've just realised that a series of dreams that I always thought were nightmares about monsters, I've realised that the monster was an aspect of my father,' and the therapist has been squeaky-clean in their technique, I would say 'recovered memory'.'

Ruth was forty-eight when she experienced the harrowing dissociative symptoms that led to her hospitalisation and eventual diagnosis. Since then, she says, it has been a gradual and often painful experience of learning about an abusive past that she was previously completely unaware of. She says that one of the hardest things she has had to come to terms with is the fact that what she thought was a 'happy, normal' upbringing was suddenly like 'one big lie'. 'It is not an easy journey and not one you would 'make up' just to get 'attention' as I have been told at times.' Lonnie Mason, who writes about her condition online, tells me, 'I would give anything to *not* be DID. Every day is a challenge; I just want to get on with my life.' Sarah K. Reece, another blogger with a dissociative disorder, emphasises that it is a patient's history that contains the strongest rebuttal against the notion that the condition is manufactured during therapy. The most common evidence, she says on her blog, includes journals containing different handwriting, having different names in different social networks, chronic amnesia, and hearing internal voices.[7]

Indeed, Lonnie first realised she was different when she discovered that not everyone could hear voices. She initially joined a support group for voice hearers, but most of them had schizophrenia, whose voices affected them differently to her own. She found some information on the internet about her specific symptoms and sought professional help. Lonnie says that with the help of a psychiatrist and psychologist, her alters have started to feel safe enough to gradually reveal some of the memories they have kept at bay. Sarah's experience has been somewhat different in that she her alters share what's known as 'high co-consciousness'. She is never shocked by a memory because

[7] Reece, Sarah K: *Is DID Iatrogenic?* http://skreece.wordpress.com/2012/06/10/is-did-iatrogenic, retrieved 07 October 2013.

information is shared across all of her alters, but the significance and emotion attached to certain memories are kept by different alters.

At first, the idea that a person's identity might be splintered into parts seems like a foreign concept, but the more I mull over it, the more I realise perhaps it's not so unfamiliar. For instance, we tend to wrestle with ourselves over key decisions in our lives, where one part of us often thinks we *should* do something while another part just wants to do something else. Sometimes we might not even be aware of why we do certain things, but we continue nonetheless. Peter, a middle-aged man who I meet at an informal group discussion on matters of psychology, says that he has always had an inexplicable fear of travelling over water. Several years ago, he told his sister about his phobia, who said, 'Well, I expect that's because of the time when our father threw you into the water and you couldn't swim.' Peter can't recall this childhood incident, and his father isn't alive to verify the story. But the story suggests that young minds are more than capable of storing away trauma. The question remains, how much more so when the trauma is chronic?

Note: The names of some interviewees are pseudonyms.

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