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Treatment for Dissociative Identity Disorder aims to integrate diverse narratives into a coherent whole. However, no compelling reason exists to privilege a cohesive narrative; in fact, treatment may at times introduce false memories in an attempt to construct such a narrative. This essay critically examines dominant conceptions of memory and consciousness based on logic and coherence in order to argue for the value and validity of fragmented narratives as a legitimate rhetoric.

> Or perhaps it would be more accurate to say that psychoanalysis doubled the absolute gaze of the watcher with the indefinite monologue of the surveyed—thus keeping in place the old asylum structure of a non-reciprocal gaze, but balancing it out, in a non-symmetrical reciprocity, with the new structure of a language without response.
>
> —Michel Foucault, *History of Madness* 488

Says a young woman called Mairi as she methodically pets a cat perched in her lap, "I love the fact that I'm pretty and I love the fact that I'm a lesbian and I really love the fact that I'm a good librarian. I love the music I create, but mostly I just really love my spirit."[1] Mairi is one of several fascinating interviewees featured in Allie Light's 1993 Emmy Award winning documentary film *Dialogues with Madwomen*. It is not difficult to imagine how the film won such a prestigious award. Light's impressive filmmaking employs artistic reenactments

to fill in visual and auditory riches at the backdrop of the women's self-narrations. Women are shot in serene settings—Mairi in her comfortable-looking living room. These settings stand in sharp contrast to the harried segments that make up the reenactments of their pasts, which suggest that trauma and abuse led to their conditions.

Mairi, viewers learn, has been diagnosed with Dissociative Identity Disorder (DID), the illness formerly known as Multiple Personality Disorder. DID is commonly characterized as a pathology in the sense that multiple alters,[2] evidenced largely by their unique narratives, are viewed as problematic, and treatment aims to integrate narratives into a coherent whole. However, no compelling reason exists to privilege a cohesive narrative; in fact, treatment may at times introduce false memories in an attempt to construct such a narrative. This essay seeks to critically examine dominant conceptions of memory and consciousness based on logic and coherence and to argue for the value and validity of fragmented narratives as a legitimate rhetoric.

Fictional and nonfictional representations of DID lend hyperbolic performativity to postmodern subjectivities and pay homage to the more creative elements of psychoanalytic thought. Moreover, these narratives often form familiar arcs where good prevails over evil. Mairi's self-affirming utterance, for example, follows a series of disturbing confessions to memories of abuse. Mairi's memories were once sequestered in the deep recesses of the difficult-to-chart brain regions where the unthinkable content of childhood goes to hide until the psychotherapeutic excavator recovers them in order to aid integration.

Most representations of DID highlight the importance of integration for mental wellness. Describing her experiences, for example, Mairi recalls her seven-month-old self leaving the house and walking into the street.[3] When she is brought back inside, Mairi realizes she is not able to escape. She creates her first alter to stand in for her and to endure the constant abuse she'll sustain throughout her young life. Whenever Mairi encounters a new obstacle, she creates a new alter to cope. However, through diagnosis and integration, Mairi comes to understand the alters she's made and their separate life narratives as fictions—as symptomatic of an illness, and although she is emphatic that she "did not want to integrate" since it felt like parts of her were "dying," she also suggests that the integration was necessary for wellness. Hearing her story makes it is easy to condemn the nefarious persons responsible for her troubled upbringing and ultimate dissociation. As well, the astute caregivers who've made her difficult journey to recovery possible emerge as exceptionally expert knowers capable of charting the difficult topography of the human brain via language. Once Mairi can compose an aggregate account of dissociation and eventual integration, she is healed. Narrative coherence becomes the mechanism through which a frightening past is

finally rendered definitively knowable, and thus conquerable. As Foucault points out, "[W]hether excluded, or secretly invested with reason, the madman's speech, strictly, did not exist. It was through his words that his madness was recognized; they were the place where the division between madness and reason were exercised" ("The Order of Discourse" 53). In the same way, DID is constructed via language.

The use of a logically sequenced self-narrative as a mechanism through which one gains wellness is, of course, a longstanding tradition in psychotherapy. In the wake of prolific research in recent years into biomedical and pharmacological ways of understanding and treating mental illnesses, it is tempting to think that, perhaps, narrative imperatives are no longer a part of contemporary clinical practice. A recent anthology, however, has been entirely dedicated to outlining the use of writing and self-narration in clinical practice (L'Abate and Sweeney), and researchers have looked specifically at cohesive narration as a path to recovery from DID (Chlebowski and Gregory). Thus, using cohesive narratives as mechanisms through which dissociative patients are to be treated are still in use, and even when narrative is not specifically named, written emotional disclosure is gaining traction as a method for healing various ailments (see Fogarty; Duncan; Kersting; Ogle).

What rhetoric might lend to a critique of mental wellness via linear narration is a vantage through which the affordances of nonlinear narration might be considered; thus the assumption that cohesive narrative goes hand-in-hand with mental wellness might be called into question. As Foucault points out, "In every society the production of discourse is at once controlled, selected, organized and redistributed by a certain number of procedures whose role is to ward off its powers and dangers, to gain mastery over its chance events, to evade its ponderous, formidable materiality" ("The Order of Discourse" 52). It is my argument that linear narration is one instantiation of Foucault's theory of discourse and that DID, since it is constructed entirely via language and narrative, is especially suited to unpack this discursive hegemony.

In fact, the slippery dividing line between normalcy and lunacy has long been of interest to rhetoric scholars (see Lewiecki-Wilson; Prendergast; Price; Reynolds, "The Rhetoric of Mental Health Care" and *Writing and Reading*). These scholars have questioned, for instance, the proliferation of diagnostic categories, the rhetorical complexity of practitioner narratives, and the labeling of everyday behaviors as symptoms of illnesses. This proliferation is problematic because "as more and more people are declared to have and are then treated for an ever-expanding list of mental illnesses, more and more will become dependent on and vulnerable to the rhetoric, particularly the recorded rhetoric, of the mental health care professions" (Reynolds, "Rhetoric of Mental Health Care" 152).

These scholars thus open space to consider the migration of rich psychoanalytic theories into practical realms for which they are simply a poor fit. As Foucault explains, part of the project of psychoanalysis has been "allowing fantasy to take shape in language" so that it can become "a medium of exchange" (*History of Madness* 436). However, due to how psychoanalytic theories variously proliferate, patient language in self-narration is hardly taken as symbolic or exploratory. Instead, it is taken in a dangerously positivist sense—to represent reality in no uncertain terms.

It is in this context that people being pressed upon to tell their stories in linear ways becomes problematic. In the clip I describe above, for example, audiences recognize a narrative arc involving the inflexible trope of the abused women's life trajectory: Mairi is daunted by psychiatric distress, she undergoes some combination of medication and psychotherapy to recover and reassemble a cohesive, confessional narrative, and she emerges well. Through narrative, the women with DID in these discourses dissociate at last not from a lucid, intact personal history but from their aggressors and abusers. Predictably, this trope finds substantiation in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Lucille McCarthy and Joan Page Gerring use a rhetorical lens to demonstrate that the DSM is essentially a charter document for the psychiatric disciplines. Moreover, Fred Reynolds critiques the DSM's adherence to reality when he explains that "the DSM language system, a technical vocabulary of reductive labels with corresponding definitions, governs all of clinical diagnostics, assessments, evaluations, and recommendations," but it was originally conceived of as a document for the collection of "national data" ("The Rhetoric of Mental Health Care" 154). In his critique of the DSM's status as the quintessential diagnostic tool, Reynolds is ultimately concerned with the tendency to cast illness definitions onto healthy behaviors, which takes attention away from actual instances of illness and real human affliction. More importantly, though, Reynolds emphasizes the vulnerability-inducing power of psychiatric genres. Once a diagnostic label results from these genres, agency is given over to the psychiatric establishment. Likewise, those with rather ordinary psychiatric lives can be labeled ill with far-reaching consequences. Kimberly Emmons argues, for example, that the "now ubiquitous genres of the symptoms check list and the self-diagnostic quiz organize a complex, rhetorical relationship among . . . principle figures in the narrative of mental health and . . . help construct depression as an illness" (160). DID is similarly constricted as an illness via mental health genres such as the diagnostic criteria found in the DSM.

In the penultimate version of the DSM, DID is described as "a failure to integrate various aspects of identity, memory, and consciousness" (526). Similarly, the criteria listed in the current version include a "disruption of identity characterized

by two or more distinct personality states or an experience of possession" with marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning" (American Psychiatric Association DSM-V). Discontinuity in sense of self as pathology indicates that a mentally well person might, instead, have a continuous sense of self and the attendant ability to recount a cohesive life story with coherent memories. Having a discontinuous sense of self leads, instead, to "recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting" (American Psychiatric Association DSM-V). Recent criteria for a diagnosis of DID, then, equate a normal ontological state with a clear and factual personal history, which includes lucid memories of any traumatic events and conscious knowledge of all thinking and knowing. These criteria assume that one's memory and sense of self ought to be tidy records of what actually happened in the past. However, memory, Sharon Crowley has shown, cannot afford individual persons this level of certitude; assuming that memory functions thus harkens back to long-critiqued current-traditional rhetorics. Jennifer LeMesurier offers a more flexible way to conceptualize the "elusiveness of memory" (377) when she suggests that a "rhetorical conception of memory that includes embodied knowledge results in a radical flexibility able to support the complexities of lived action and reaction" (366). For Crowley and LeMesurier, then, contemporary rhetorical theories render memory as a much more dynamic and open space for the legitimacy of fragmented and opaque life narrations.

Nonetheless, chronic mental illness narratives have taken up a stable space in the American popular cultural imagination for the past several decades (see Pryal, for example), and DID is a particularly well-represented illness in this regard. Examples include Robert Louis Stevenson's *Strange Case of Dr. Jekyll and Mr. Hyde*, the 1957 film *The Three Faces of Eve*, and the 1976 television miniseries *Sybil*. These earlier examples of successful DID narratives informed the debut of the winter 2009 Showtime series about a mother with DID called *The United States of Tara*. At first, this show saw much promise as a popular comedy-drama. Viewers were fascinated with this character, played convincingly by Toni Collette. Tara's alters included a compelling cast—"T," the rebellious and irreverent teenager; "Alice," the 1950s perfect housewife; and "Buck," a rough-around-the-edges and hyper-masculine war veteran. However, *The United States of Tara* lasted only three seasons precisely because it could not follow the narrative arc with which viewers have become accustomed especially where female characters with serious psychoses are concerned. In short order, the episodic potential of the show would be entirely foreclosed upon since Tara could not gain wellness from her DID symptoms.

The show could not last, that is, because it could not satisfy viewers' expectations that Tara would discover the details of her traumatic past, come to terms with abuse, and gain wellness. While all three seasons used the repressed memory of sexual abuse as the narrative device at the backdrop, it is clear that the forward movement of the series became a problem; as time went on, viewers wished to see the mystery of Tara's past solved at last. If it were resolved, though, viewers would also expect Tara to articulate her understanding of this past and to move on a whole and integrated individual—something that would negate the entire premise of the series.

This trajectory of wellness-inducing events, of course, is hardly limited to documentary and popular film and television. For example, the Sidran foundation, an organization dedicated to the study of trauma and dissociation, features Olga R. Trujillo's account of her experiences with DID and her path to wellness on its website. Trujillo, like Mairi, uses much of the language of the psychiatric establishment and of the various versions of the DSM to describe her experiences. Trujillo explains, for example, "I worked intensely with a psychiatrist to recover my memories and integrate them into who I am today" (3). Like others, Trujillo locates her first dissociative event within the context of a traumatic event involving incest and violence. She explains, "I would cognitively leave my body and observe the incident from outside myself" (3). Trujillo's narrative highlights the recovery of abuse memories and the integration of these into a larger account of her personal history using language and ideas from the DSM.

What is left out in this narrative pattern and in the DSM definition for DID is room for the exploration of memory beyond current traditional epistemologies—as a dynamic and temporally complicated project wherein one might experience various levels of instable consciousness in epistemologically generative and ontologically imaginative ways that are always in flux. There is also no room for those who'd fluctuate identity depending on context as many people do to differing degrees—to re/de/construct ethos—in ways that would align with the intersection of sophistic rhetorics and postmodern subjectivities in a positive, transgressive and entirely healthy, if socially unacceptable, sense.[4] Not only would acceptance of DID as creative coping open space for other ways of living, but pressure for those with DID and related conditions to produce linear narrative accounts might do more harm than good. One example of this harm is when gaps in the narrative are filled in, via the powers of suggestion, with recovered memories of trauma and abuse that may or may not have actually taken place.[5]

Perhaps readers are wondering whether it ought to matter if DID narrative accounts of life events are accurate. However, when other persons are slated as abusers and aggressors in the process, the potential damage to an interpersonal life can be immeasurably negative—a reality worth considering further. In fact,

there is a sizable gap in thinking that emerges in the examination of the criterion to do with dissociating and the criterion to do with lack of remembrances in tandem. Although the criteria for DID itself do not indicate a formal, unilateral cause and effect relationship between dissociation and its treatment via the recovery of repressed memories, the way that representations of real-life suffering unfold for popular audiences build trope-ic arcs where trauma leads to repression, repression to psychosis, psychosis to psychotherapy, psychotherapy to recovery of repressed memories, and repressed memories to testimonials, blame, and, ultimately, healing—a recovery that is predicated on one's ability to identify and dissociate from one's assailants. A rhetorical vantage makes the stability of this trope and its consequences clear: These inflexible archetypes might persuade those who've experienced dissociation toward self-narrations that fill in with fabricated details where there are gaps in the narrative arc. If they were able, instead, to deliver fragmented narratives, the rhetorical effects would be quite different. A fragmented narrative, that is, might honor gaps and fissures in memory and might allow DID writers to explore the generative imperviousness inherent in self-narration in a richer way. This kind of narrative provocation might even be empowering instead of vulnerability inducing as linear narrative imperatives are for those with life stories that are marked by opacity.

The vulnerability-inducing rhetoric of suppressed memories, in fact, can lead to false memories that seem to be indefatigably accurate remembrances of an historically seamless past. There is little room in such a definition for the possibility that a person with a tendency to dissociate might have an entirely trauma-free and unremarkable history and might suffer not from personal traumas but from the much more difficult-to-chart, but no less nefarious, social ones. Indeed, memory (if it is not an accurate account of the truth of the past), consciousness (if it is not firmly rooted in discernable empiricism), and identity (if it is not definable in a stable way) are regularly pathologized in ways that leave suggestible, suppressed, and especially disenfranchised persons for whom ordinary life is perhaps daunting susceptible to pathogenic rhetorics. The consequences of the causal relationship suggested in this diagnostic category can be devastating and unjust to those with DID themselves and to the persons to whom they attribute their abuse and undoing.

DID is often understood as a response to some traumatic event or events; in fact, there is often a dual diagnosis of Post-traumatic Stress Disorder (PTSD) and DID. Moreover, DID patients report "having experienced severe physical and sexual abuse, especially during childhood," and while there is "controversy [surrounding] the accuracy of such reports, because childhood memories may be subject to distortion and some individuals with this disorder are highly hypnotizable and especially vulnerable to suggestive influences," the DSM-IV-TR authors

claim that the reports of abuse are "often confirmed by objective evidence" (527). However, it is difficult to imagine where this objective evidence might be found, particularly when therapists are not forensic experts with extravagant time and resources to investigate the validity of these claims. Moreover, when memory does not reflect the objective facts of the past, it is said to have become "distorted," implying that some memories are, in fact, clear and undisputable records of what happened. Therapists, then, might inadvertently inscribe the reality of factual trauma in the person's past in order to account for the DID manifestation. Since memory is a record of one's past, DID is a label for someone who cannot wholly access that record in linear and linguistic ways. Thus the therapist often engages in techniques designed to uncover repressed memories.

A brief sketch of the nature of trauma and its status in contemporary culture will make my related point on the rhetorical impact of firsthand DID narrative imperatives clearer. As social anthropologist Didier Fassin and psychiatrist Richard Rechtman explain in *The Empire of Trauma: An Inquiry into the Conditions of Victimhood*, "Trauma was born in the late nineteenth century as a psychological category," and it brought with it, in its original form, "the medical notion of a corporeal injury," which "bears traces of this lineage still today, for one can speak as readily of a psychic scar as of a physical scar" (284). Thus, when trauma "reemerged at the end of the twentieth century, within a reworked psychiatric nosography," it began, but quickly exceeded, clinical practice. As post-traumatic stress disorder became easier to claim, moreover, there appeared to have been a positive change as those who'd been morally indicted for their victimhood were accepted as legitimate and blameless sufferers. However, the authors are clear, the "door may have been shut against moral judgment, but it found its way in through a window. Or rather, it never really left the scene at all" since trauma, today, "enjoys its current status more as a moral than as a psychological category" (284).

A shift, then, where the collective understanding of trauma is concerned occurred, but the specter of morality still hovers over trauma and its articulation in narrative arcs. While trauma as a construct allowed some victims to voice their experiences without fear of being blamed for what had been done to them, those slated as perpetrators picked up the moral indictment instead. As a result, highly complex circumstances, those that evade the victim/predator binary—were taken from shades of gray to stark black and white. Those accused of causing trauma become satanic figures fit for moral condemnation. At the same time, those who've voiced trauma experiences become one-dimensional, fragile, and broken sorts of figures who are incapable of any sort of range of complex human morality.

This is because traumatic victimhood "confers a form of social recognition before it is ever validated by any psychologist or psychiatrist," the authors explain,

since "trauma today is a moral judgment" (284).[6] It is not, however, given space to breathe in social forums as an illness proper—one for which etiological uncertainties might have kept it under constant reflection. It lives, accordingly, in the public sphere as a rhetorical trump card of sorts, as a way to put an end to deliberations over acceptable ways of being by suggesting that "strange" behavior comes from a clear trauma event and is thus a clear sign of pathology. Likewise, oversimplified trauma narratives circulate over time and subject those with diagnoses of DID to the heavy gaze of the voyeur who'd like to hear a trauma story, but will not likely want to hear very much else.

Fassin and Rechtman explain that the implications of trauma's moral status are that "few researchers distance themselves sufficiently to avoid taking trauma for granted and seeing victims as what they profess to be"; this inquiry opens up the question: "What does the process not allow to be said, and who are those whom it makes it possible to leave out?" (281). The traumatized speaker's complex personhood is ironically reduced to stability through trauma-speak. A related example emerged in the United States in the 1990s. Over the course of that decade, researchers became concerned with the increase in accusations to do with recovered memories of childhood sexual abuses in patients who'd not had any previous memories of abuse of any kind (Lindsay and Read 852). This phenomenon might have emerged in response to narrative imperatives in well-meaning clinical settings that operate under the assumption that psychological distresses are signs of personal trauma events rather than the result of massive social inequalities, such as deeply institutionalized misogyny. These larger-scale social traumas, though, could be convincingly deliberated in the spaces opened up by fragmented narration. The gaps and fissures implied in nonlinear narrative, that is, could function rhetorically to call into question the etiology of so-called "illnesses" such as DID since they do not lend themselves to traditional forms of interpretation. Nonlinear narratives could convince audiences that dissociation is likely a complex temporal project involving a number of ephemeral and opaque exchanges. Since fragmented narratives are much more difficult to address than linear narratives involving known players, though, these are dismissed in clinical settings.

One can hardly wonder why women in the context of deeply entrenched patriarchy, moreover, have suffered from emotional or mental distress, the sort that would lead them to a psychiatrist or psychologist office in search of answers. And since something must never come from nothing, because reasons are to be traceable and logical, the women were told their distresses were likely due to some form of past trauma. The family was explored, sexual abuse posited, the father or another male relative was implicated, and repressed memories accounted for the fact that the women had never felt or thought anything of the sort in the past. Psychological distress was suffered, a story told to account for it, and wellness and

wholeness were to follow. All too often, though, in these cases, a range of social problems were squelched under a single personal archetypal narrative—that of the abusive male adult ruining the purity of the innocent female child.[7]

Elizabeth Loftus and colleagues have studied the phenomenon known as "false memory syndrome" for decades. Loftus explains that, syllogistically, repressed memories work on the premise that if an adult exhibits signs of childhood sexual abuse and claims to have no memory of such abuse, then this adult must have been abused and suppressed all conscious memory of abuse due to the trauma involved in the experience. Loftus cautions: "[V]ivid, confidently held beliefs about painful experience can be induced even when they happen to be false," and "false memories can be highly vivid, internally coherent, and contain many low-frequency perceptual details" (Loftus and Ceci 354, 353, 355). Similarly, Harold Merskey asserts that one must be cautious in working with the concept of repressed memory because it raises a myriad "ethical issues" when it is related to dissociation in particular since "practices of subtle and overt suggestion, employed in recovered memory treatment, give rise to false memory syndrome in which individuals who have undergone various levels of suggestion, accuse their parents and others of childhood sexual abuse" (334).

Because Loftus herself suffered from childhood sexual abuse, she is not oblivious to the suffering that follows that experience. In response to attacks on her work as having nefarious ends, moreover, Loftus has pointed out that repressed memories that have been recovered do not necessarily constitute lies, and therapists are not intentionally deceiving their patients or attempting to ruin relationships. Instead, these well-meaning practitioners believe these things to be true (*The Myth of Repressed Memory*). However, Loftus is clear, that does not mean that these abuse incidents actually happened. Her rather large corpus of work is concerned with the fact that those in positions of power and authority establish the authenticity of remembered events, and this reality might lead to the inadvertent creation of fictive narrative accounts with real consequences and to leading questions that produce false accusations (Loftus, Kaasa, Cauffman, and Clarke-Stewart). I am not suggesting that many accounts of repressed sexual abuse are not, in fact, true. However, Loftus's work gives way to a fuller critique of linear narrative mishandling in general since she highlights the role of the ethos of expertise in the creation of false memories—even when diligent and hard-working professionals whose daily working lives involve admirable attempts to ease the suffering of some of our world's most vulnerable are at the helm.

What Loftus lends to conversations on mental illnesses such as DID and the practices of therapy (that have, as I've argued above, grown out of diagnostic criteria in the DSM that assume causality and transcendental truth) is the possibility for the manifestation of what might be read as "mental illness" to be

present in a patient without a clear and traceable cause—one that can be pinned down in time and space. This addition is highly rhetorical and sophistic as it allows for relative truth in a productive way. As N. Katherine Hayles's work demonstrates, too, contemporary neuroscience maps out the complex neurological procedures at play in the flux-ridden terrain that serves as the site of the re/de-creation of memories—processes that elide the clear trajectory posited in psychoanalytic and other clinical practices for treating dissociation and trauma that rely on the creation of clear personal histories and on the premise that there are brain regions where unspeakable memories go to hide—a hypothesis that is inevitably complicated through theories that fall under the broad rubric of neuroplasticity. Memories do not behave like video recordings of one's past that can be stored in hidden brain spaces that are largely dormant until they are dug up and replayed. Instead, Hayles explains, synaptogenesis indicates that the brain is a series of live connections that are either actively firing for one set of purposes or taken over and reshaped to function for another.

In all cases, sensitivity to environment creates stronger or weaker connections between synapses, and those synapses that die off in infancy due to lack of use are not part of the complex brain terrain at all. Only those synapses that are turned on remain on, and while some become weak from disuse, these same linkages can be reignited and strengthened for repurposing. The brain, dynamic and changeable, then, is not the simple and unilateral suppository for experience it would need to be to make the recovery of coherently rendered suppressed memories of trauma for which one has no prior recollection seem all that feasible. Memory and cognition, in any case, are far more complicated than one would have to find them to be if one were to believe in memories finding hiding spaces of one form or another. As well, synaptogenesis suggests that the powers of suggestion could create conditions under which one might respond to the therapeutic environment in ways that would render them susceptible to suggestion. In order to explore this very possibility, Hayles outlines the results of a study in which participants' dispositions were altered via the either negative or positive content of experimentation. In short, Hayles's work maps out a theoretical frame in which it is plausible for one to come to believe in the truth of a trauma experience even if such an event happens never to have happened.

The consequence of the link, in the end, between the exhibitions of DID and the assumption of suppressed traumatic abuse have consequences for individuals, and a rhetorical vantage on linear narrative makes it clear that this genre plays a role in the creation and sustaining of this link. In other words, the patient has sought out psychological or psychiatric help because she is troubled by the alters that "disturb" her attempts at "normalcy." Just as one suffering from a physical ailment often is bewildered unless the medical doctor can offer a real physical

reason for the pain, those in psychological treatment likewise want their therapist to tell them *why* they are as they are. Since the therapist, like the medical doctor, enjoys the status of one imbued with expert knowledge, what he or she says about the link between DID manifestations and supposed suppressed abuse might suggest abuse that did not actually occur.

Referencing a study of how clinicians deal with the accuracy or not of memories that emerge in clinical practice, Loftus comments, "The conclusion from this small study was that therapists believe their clients and often use symptomatology as evidence" ("The Realities of Repressed Memories" 535). At times, false memories that become inextricably woven into patients' personal histories in clinical settings happen not to be true. In the aftermath of these false memories becoming solidified in patients' psyches, innocent persons can be accused of heinous crimes. Perhaps situations like these would be avoidable if an alternate vantage were considered—if DID could be framed as inventional play or as the work of heuristic reimagining; such creative rethinking of this mental "illness" offers a way to figure DID patients as capable of unconscious creativity instead of limiting them to reactionary maladaptation. If some people have many personalities, in fact, maybe they are using what cultural geographer Michel de Certeau has called "tactics." Alters, that is, might constitute people's instinct to "use, manipulate, and divert" the material world over and against the ordinary instinct to "produce, tabulate" and "impose" on it orderly, cohesive narratives. Within this frame, DID patients might be performing lived responses to conditions of considerable constraint. Perhaps they have found creative ways to make singular situations flourish into plurality and have attempted to move through the world as "sly as a fox and twice as quick" (de Certeau 29, 30). Rhetorical lenses allow for this possibility as well as for questions to emerge like: How might people use language to impart dissociative states of being in ways that resist pathologization? Nonlinear, fragmented, opaque narratives could be a start.

If dissociative ways of knowing were valued differently, perhaps fewer people would land in spaces meant to heal them by "integrating" them. Imagine those who are already troubled and distressed (as is evidenced by their presence in therapy) come to perhaps falsely remember loved ones abusing them. The fact that they will only become more distressed and troubled seems obvious. Moreover, they will likely feel compelled to cut ties with those they believe have abused them, and these innocent persons might have offered support. Suffering will, thus, be prolonged instead of alleviated.

This is what the opposite of empowerment looks like, and rhetoric makes it clear that something as harmless as storytelling can lead to this very outcome. Perhaps more poignantly, people might experience trauma of abuses engendered in false memories as if they were real, which will undoubtedly lead to more

pain and, as a consequence, more therapeutic intervention. So just as feminist researchers have uncovered the fact that many obstetrical interventions actually occasion the necessity for more interventions in the natural process of birthing (see Lay; Rapp; Shanner), perhaps psychotherapy and its various shadows in popular accounts similarly produce the occasion for more therapy and more distress within the natural phenomenon of people dissociating from a culture rather hostile to them. Importantly, both groups of experts have good intentions for their patients. It is, therefore, unproductive to simply pass on blame. Instead, this kind of analysis calls on rhetoricians to continue the project of uncovering various tacit and overt displays of misogyny and related forms of discrimination in the American cultural fabric. It also calls on thinkers to reexamine contemporary personhood from a dynamic and multidimensional standpoint.

An important question that emerges out of this discussion, in other words, is, If a person has DID manifestations and she or he did not suffer significant childhood trauma, where does the condition come from? Scholarship on the posthuman gives way to a generative alternative to the linear causal chains the traditional way of understanding trauma and psychosis make available. Kristie S. Fleckenstein's work on cybernetics, for example, supports the possibility that the precursors of distress might simply not be reducible to some isolated causal moment in time. As she puts it, "Instead of a small cause resulting in a small effect, small causes in cybernetics can result in very large effects" (14). That is, a number of seemingly innocuous forms of, say, sexism, could add up to a very real consequence—massive dissociation.

Social issues, then, in their everyday and difficult-to-trace minutiae could cause the sort of fragmentation seen in DID. This fragmentation, though undeniably negative in many ways, might be recuperated as a positive trope as it is a way for a person to live many lifetimes in one. It is an eloquent and creative way of "making do" (de Certeau 30). While the fact that each alter must share space in one body is ultimately unpleasant and perhaps destructive in the hyperbolic renditions of DID found in popular iterations, and while there are no doubt cases in which DID makes life unlivable for some, there is a distinct epistemological advantage and rhetorical savvy to the fragmented subject that acknowledges and lives a fractured lifetime as she or he resists the basic tenet of psychoanalysis, which seeks to create a cohesive narrative of a life. A fragmented subject might, moreover, deploy a certain version of self (let's call it an alter) as a form of ethos depending on the context and the aim of his or her discourse.

A DID body, moreover, has the potential to be a dynamic one as it could become a lifetime that resists linearity. Peter Moe has argued similarly that "revealed, rather than concealed, disability unsettles in fruitful ways traditional conceptions of rhetoric and the body, claiming the rhetorical body—disabled or

otherwise—as a potent available means of persuasion" (456). Likewise, while DID likely grows out of the various latent social discriminations written in a deeply complex American semiotic (which might explain the "disorder's" pervasiveness here and its relative rarity elsewhere), it might nonetheless be appropriated, in theoretical terms, to describe a phenomenon in which a person can reimagine life in ways that will offer powerful alternatives to the constraints found in the archetypes offered by a set of circumstances.

As Cynthia Lewiecki-Wilson explains, "[W]hat is disabling about impairments resides in culture rather than in a natural consequence of an impairment. This move does not mean that impairments do not exist but that the disability is always experienced through the attitudes, social arrangements, and technologies of a particular culture" (158). Fred Reynolds explains that "writing and reading in psychiatry, psychology, social work, pastoral counseling, and other forms of 'therapy' are rhetoric; they are choices in contexts, complicated interpretive procedures climaxing in rhetorical definition, and we should study them. . . . People's pay checks, professions, and lives—not to mention their mental health—depend on those words and those silences" ("The Rhetoric of Mental Health Care" 156). Along these same lines, I'd like to suggest that rhetorical analyses of DID reveal a sleight of hand through which dominant ideologies are reified at the expense of space for critiques of deeply entrenched social issues. DID, in fact, is uniquely suited to rhetorical analysis since the basis for diagnosis hinges on language and storytelling; alters, after all, are defined precisely by their separate and disparate life narratives. Accepting nonlinear narration might also make room for more diversity of consciousness and perceptions of reality to enter the popular fray. If this "disorder" is never understood as an affordance, though, complexity is lost. In the end, then, Mairi might very well "love her spirit," but I have to wonder how much richer life might have been if she weren't convinced of the necessity of integrating, if she weren't instructed to stamp out her alters.

Notes

[1] I thank Kim Hensley-Owens, *RR* reviewers Michael Zerbe and Fred Reynolds and editor Theresa Enos for their generative and helpful feedback.

[2] The *DSM-V* defines "alters" as "two or more distinct personality parts."

[3] Mairi might be misremembering the age of this event, as a seven-month-old is not likely to be able to walk yet.

[4] Sophistic rhetorics, as Susan Jarratt's work has demonstrated, allow for the possibility of relative and multiple truths, for temporal fluidity, and for acceptance of tentative conclusions to do with the past and its recollections and how these memories serve as the mechanisms through which one might piece together a fluid identity. Gorgias's well-known *Encomium to Helen* is his attempt to make the weaker argument the stronger via rhetorical savvy born of relative truth.

[5] For a compelling example, see Debbie Nathan's *Sybil Exposed: The Extraordinary Story Behind the Famous Multiple Personality Case.*

[6] This line of reasoning is not meant to negate the positive move toward more trauma sufferers sharing their experiences and fighting for justice. Instead, I am emphasizing the complexity of trauma and its consequences over and against simplified accounts of injury and injustice.

[7] This is not to imply, of course, that many people who'd reported childhood sexual abuse during this decade did not, in fact, experience abuse of some form or another. Instead, I mean to point out that there were researchers concerned with overdiagnosis of this particular cause of psychic distress.

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