

ANNE SEXTON:
IATROGENESIS OF AN
ALTER PERSONALITY IN
AN UNDIAGNOSED CASE
OF MPD

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Permission to reprint this chapter from Dr. Ross's book, *The Osiris Complex: Case Studies in Multiple Personality Disorder*, was provided by the University of Toronto Press.

ABSTRACT

Controversy about whether multiple personality disorder (MPD) is an iatrogenic artifact continues, but those proposing that the disorder is not valid have not described a single specific case of iatrogenic MPD. Anne Sexton, a Pulitzer Prize-winning poet who committed suicide, had MPD which was not diagnosed by her psychiatrist. Anne Sexton the poet appears to have been an alter personality created within the therapy and reinforced by the psychiatrist. The only clear example of the iatrogenic creation of an alter personality appears to have occurred in an undiagnosed case of MPD treated by a psychiatrist who suppressed the previously existing alter personalities in favor of his own iatrogenic artifact.

INTRODUCTION

Anne Sexton, a Pulitzer Prize-winning poet, was born in 1928 and committed suicide in 1974 (Middlebrook, 1991). I was only vaguely aware of her in late 1991 when her former psychiatrist, Dr. Martin Orne, became the subject of an ethical controversy in the American Psychiatric Association because he had released audiotapes of therapy sessions to Sexton's biographer. He had done this with the family's permission, but the Ethics Committee of the American Psychiatric Association was concerned that this might nevertheless be a violation of patient confidentiality. Apparently there was little or no content in the tapes which Sexton had not already made public through her poetry (Goodwin, 1991).

I decided to read Sexton's biography when I read a review of it in the December 1991 issue of the *American Journal of Psychiatry* written by Dr. Donald K. Goodwin. Goodwin writes, "Over the next eighteen years she had many diagnoses. She had suicidal depressions and mania, heard voices (at least once), went into trances, had amnesia and phobias, was hypersexual, neglected her children and sexually abused one of them, and had battered wife syndrome—all at the same time. She overdosed repeatedly and was in and out of nearly every

psychiatric hospital in the Boston area during the eight years that Orne saw her and the ten years that followed. Her Axis I diagnosis was probably bipolar disorder. Axis II? Anybody's guess. There probably should be a separate category for poets."

I realized, reading this paragraph, that Anne Sexton probably had undiagnosed MPD. Martin Orne is a leading figure in the hypnosis literature, editor of the *International Journal of Clinical and Experimental Hypnosis*, wrote papers prior to Sexton's death demonstrating that memories recovered during hypnosis can be true or false, and has always been interested in the potential of hypnosis to contaminate forensic cases (Orne, Dinges, and Orne, 1984). He was the first person to publish a paper of mine on MPD which appeared in a special issue of his journal devoted to MPD in 1984 (Ross, 1984).

I remember being very impressed by the intelligence and dedication of Orne's editing of my paper. I also recall being struck by his preoccupation with iatrogenesis in MPD: he was very concerned to emphasize this issue and ensure that I addressed it in my paper.

Much of the special issue was devoted to the Kenneth Bianchi Hillside Strangler case in which Orne had been an expert witness. Orne testified that Bianchi was faking MPD, and his persuasive testimony is reviewed in detail in the 1984 paper (Orne et al., 1984): Kenneth Bianchi's insanity defense based on MPD failed, and he was found guilty. In 1988, Orne participated in a debate at the American Psychiatric Association Annual Meeting in which he took the position that MPD is rare, and that most cases diagnosed in the 1980s are iatrogenic artifacts created when a suggestible hysterical patient is asked leading questions by a naïve diagnostician.

Orne's position is that true MPD is rare, that false positive iatrogenic diagnoses are harmful, cause regression, and should be discouraged by not feeding into the patient's role-playing. He is preoccupied with the idea that a diagnosis of MPD results in the patient not being held accountable for his or her behavior.

If Anne Sexton had undiagnosed MPD, I realized, and committed suicide because of failure to diagnose and treat her condition properly, and if Martin Orne were at some level aware of this, then his public position on MPD could be primarily defensive in nature and not truly an intellectual or scientific stance. I decided to read the biography specifically to see if I could find enough information to support a diagnosis of MPD. I expected to find, at best, scattered circumstantial evidence to support a diagnosis of MPD and was therefore unsure whether anything publishable would

come of my reading.

TWO COMPETING HYPOTHESES REGARDING ANNE SEXTON

I established two competing hypotheses before starting the biography: the first was Orne's, namely that it is important and therapeutic to discourage any tendency towards MPD in hysterics like Anne Sexton, who do not really have the condition. The second hypothesis was that Anne Sexton had true MPD and might have had a dramatically superior outcome if her alter personalities were brought into the therapy and her trauma uncovered and worked through.

Evidence in Favor of Iatrogenesis in Middlebrook's Biography of Anne Sexton

I soon found circumstantial evidence supporting my clinical intuition. In the first page of the Foreword, Dr. Orne writes:

It is difficult to communicate fully how pervasive Anne's profound lack of self-worth was and how totally unable she was to think of *any* positive abilities or qualities within herself. When I pressed her to think hard about what she might be able to do, she finally revealed that there was only one thing that she might possibly be capable of—to be a good prostitute and to help men feel sexually powerful. [p. xiii]

This paragraph raises the possibility of childhood sexual abuse. Both the feeling of being a prostitute and the lack of self-worth are typical of victims of severe chronic childhood trauma. On the next page, we see that Anne Sexton presented a clinical picture inconsistent with the working diagnosis, another feature common in patients with undiagnosed MPD. Orne writes:

Originally, when Anne sought help following the birth of her second child, she had been diagnosed as having post-partum depression. When I first saw her in therapy in the hospital in August 1956, a year after the birth, her thoughts and behaviors were not really consistent with the presumptive diagnosis. As I began to get to know Anne, I realized that she was showing ideation that one might expect in a patient with a thought disorder. [pp. xiv]

On page 65, the different diagnoses Sexton received, again typical of undiagnosed MPD, are listed as "hysterical," "psychoneurotic," "borderline," and "alcoholic." It is evident from other passages that the inability of psychiatrists to make a clinically meaningful diagnosis lead to many complications. In her Preface, Diane Wood Middlebrook, the biographer, writes (pp. xix), "She conducted this career in the context of a mental disorder that eluded diagnosis or cure. Suicidal self-hatred led to repeated hospitalizations in mental institutions. She became addicted to alcohol and sleeping pills. By the time she committed suicide in 1974, misery had hol-

lowed her out and drinking had obliterated her creativity."

Martin Orne treated Anne Sexton for eight years, from 1956 to 1964, while he was in Boston and transferred her to another therapist when he moved to Philadelphia, where he currently is, at the Institute of the Pennsylvania Hospital. The reason Orne began audiotaping Anne Sexton's sessions was that she was unable to remember them. He had Anne listen to the tapes to try to recover memory of what happened during treatment. Orne's diagnosis is made in the Foreword:

As we continued to work together, it became increasingly evident that in addition to her tendency to absorb symptoms and mannerisms from those who impressed her, Anne's core problem was that she suffered from a severe difficulty of memory. While to some extent, each of us is selective in what we remember, Anne's selectivity was extreme in the sense that she literally remembered almost nothing of relevance from one session to the next. In short, for this and other reasons, it was clear that she had a condition that traditionally was known as hysteria. [pp. xv]

This description by Martin Orne establishes that Anne had a complex, chronic dissociative disorder, since she experienced recurrent episodes of psychologically-caused amnesia. This clinical information alone would warrant an aggressive diagnostic work-up for MPD at any contemporary Dissociative Disorders Clinic. Orne describes other dissociative symptoms later in the Foreword:

There is one aspect of Anne's life that has not been clarified, that is, her tendency to become uncommunicative in a self-induced trance, which could last minutes, hours, or, in a few rare circumstances, even days. Typically, the trance episode could easily be ended by a therapist familiar with the symptom. But in therapy and out, the problem persisted: when Anne was extremely angry, she was given to entering a trance and becoming unresponsive. Treatment helped to decrease these events, but they were never eliminated. Anne also had a remarkable fascination with death, and it seemed likely that she used some of these trance episodes to play out the role of dying, which perhaps helped her not to suicide. [pp. xvii]

Recurrent episodes of both trance and amnesia establish that Anne had either dissociative disorder not otherwise specified (DDNOS) or MPD. Research I have done with the Dissociative Disorders Interview Schedule (Ross 1989) and the Dissociative Experiences Scale (Bernstein & Putnam, 1986) involves comparing 166 cases of clinically-diagnosed MPD to 57 cases of clinically-diagnosed DDNOS: the finding is that DDNOS is a milder variant of MPD related to less severe but still significant childhood trauma (Ross et al., 1992). By the end of the Foreword, it is clear that Anne Sexton was at least three-quarters of the way out the dissociative spectrum

to MPD.

Orne's hypothesis is that Anne Sexton role-played dying in order to avoid actually killing herself. An alternative hypothesis is that the trance was an autohypnotic protective withdrawal designed to shut down murderous rage, rage that was directed towards her children and finally towards herself in completed suicide. We will see extensive evidence in favor of the second hypothesis below.

It is common for adult women in treatment for MPD to describe evidence of MPD in one or both parents, which can include clear descriptions of switching and names of parental alter personalities. I kept an eye out for such descriptions of Anne's parents and found the following about her father:

Forgiveness came very hard to Anne. She retained distressing memories of her father's drinking binges, partly because in childhood she didn't recognize them. "He would just suddenly become very mean, as if he hated the world," she later told her psychiatrist. "He would sit and look at you as though you had committed some terrible crime. He hated everyone! Mostly I remember the expression on his face." It seemed that he singled her out for verbal abuse when he was drinking, complaining that her acne disgusted him and that he could not eat at the same table with her. She felt invaded by his expressions of revulsion, and it seemed that no one tried to shield her from these attacks. [p. xiv]

This is a typical description of switching in an alcoholic father with undiagnosed MPD, but it is not conclusive for the diagnosis. Amnesia and abrupt changes of behavior are usually written off as due to the alcohol in men with serious alcohol abuse problems, when often the alcohol is actually triggering the emergence of abusive alter personalities. In such men, a careful psychiatric history will reveal periods of recurrent amnesia going back into childhood, "alcohol black-outs" when the person has not been drinking, and abrupt emergence of violent behavior during periods of sobriety, accompanied by a history of serious abuse in childhood, auditory hallucinations starting before the alcohol consumption, and other classical features of MPD.

One can suspect but not conclude that Anne's father had MPD. Could it be that she felt "invaded" by incestuous rape, not just by verbal abuse, and that this was the "terrible crime" her father expressed in his face, and projected onto her when he looked at her? If true, this would be the typical blame-the-victim psychology of an incestuous pedophile. These were my thoughts as I read the paragraph about Anne's father, not expecting to find more conclusive evidence of paternal incest. The passage establishes serious emotional abuse of Anne by her father.

What about Anne Sexton's mother? She was also an abuser, as documented on page 14, in discussion of psychosomatic symptoms in Anne arising directly from the abuse:

Arthur Gray Staples [Anne's maternal grandfather] died in April 1940, and during the following summer Anne was hospitalized at the Lahey Clinic for

severe constipation. Anne later recalled this as a very traumatic period in her life, remembering her mother routinely inspecting her bowel movements and threatening her with a colostomy if she didn't cooperate with efforts to regulate her elimination [p. 14].

Anne's mother also abused her sexually:

Sexton was to raise the question of whether she was "normal," by which she meant heterosexual, early in her psychiatric treatment, and later to explore it in the context of sexual intimacy with women. Behind that question were other memories that troubled her self-esteem, focused on genital inspections by her mother. From the earliest period of toilet training, she had to report to her mother daily and show her the stool before flushing it away. This was a common child-rearing practice at the time. But Sexton also recalled another humiliating experience, from about her fourth year: her mother laying her down on the bathroom floor, pulling her legs apart, and inspecting her vulva, "looking at me and saying how we had to keep it clean and musn't touch—there was something she looked at and it was growing, and I know—I don't remember, I know—I had a little cyst—they had to operate and take it off." As Dr. Orne commented, "In many ways, her mother was a dangerous relationship." [p. 59]

The point is, the veracity of the incest narrative cannot be established historically, but that does not mean that it did not, in a profound and lasting sense, "happen." It is clear from many sources that Sexton's physical boundaries were repeatedly trespassed by the adults in her family in ways that disturbed her emotional life from girlhood onward. As she put it: I have frozen that scene in time, made everyone stop moving. I thought I could stop all this from happening. That's what I want to believe—when I'm in that hard place—that's not what I believe now, just when I'm that child in trance. I can't grow up because then all these things will happen. I want to turn around and start everything going backward. [p. 59]

This is not conclusive, but is suggestive of the existence of a child alter personality stuck in the past at the time of the trauma, and constantly reliving the trauma internally. If such a child existed, it might have been contacted and healed in an active MPD psychotherapy. Is there any direct evidence of the existence of alter personalities in the biography?

The subsequent quotations, in my mind, conclusively establish the diagnosis of MPD. The first of them, though, is merely suggestive. The way in which I built up the diagnosis of MPD in reading Anne Sexton's biography is much the same as the way I build it up during a diagnostic assessment in the clinic: I look for suggestive evidence and indirect clues, then keep them in mind as I pursue the history, waiting to see how they link up with other details and whether they

lead to a definite diagnosis.

In that vein, on page 16, I read a brief description of Anne's nanny, Nana, who was a maternal great-aunt, during a period when Nana was in an apparent delirium. I thought the passage might be evidence of Nana's being aware of the existence of alter personalities in Anne:

Anne, visiting her in her room, would often find her distracted and uncomprehending: "You're not Anne!" Nana would cry out. Anne remembered Nana calling her "horrible and disgusting" and once attacking her with a nail file. One night, before Anne's horrified eyes, Nana was carried off to a mental hospital. Electroshock therapy seemed to improve her condition and she returned home. "She wasn't like someone mad, she was suffering," Anne remembered. [p. 16]

As I made note of this passage as a clue to MPD in Anne, I thought to myself that I was stretching things. Nevertheless, I considered the possibility that Nana's "delirium" was really a dissociative state and that she and Anne had seen something about each other that the doctors had missed. Could Nana have had MPD, too? It is stated several times in the biography that Nana indulged in extended backrubs, hugging, carressing, and other sexualized behavior with Anne: Could there have been more? Could Anne Sexton have been sexually abused by her father, her mother, and her great-aunt? If this were truly a multi-generational incest family, this would be possible, and it would be possible that many members of the family had dissociative disorders.

On page 16, there is a further description of Nana's possible perception of Anne's MPD and an unequivocal description of an internal auditory hallucination. I suspect that this was the voice of a persecutory alter personality who eventually forced Anne to complete suicide. The passage also describes the extreme self-blame characteristic of incest survivors. Additionally, Anne's idealization of Nana suggests the possibility of terrible historical facts being covered up by the idealization:

After Anne Sexton's own breakdown, she worried about ending up in a mental institution like Nana. More important, she believed that she had personally caused her great-aunt's breakdown, and that Nana, who condemned her as "not Anne," but a "horrible and disgusting" imposter, had sentenced her to a breakdown as well. Nana's rage took root in Sexton as a frightening symptom, which she described as a "tiny voice" in her head "shouting from far away," telling her she was awful, often taunting her to kill herself. "[I] should never have left Nana. She'd never have gotten sick—then I'd always be just me." [p. 16]

One of the indirect clues to MPD is Schneiderian passivity experiences described by the German psychiatrist Kurt Schneider, but mistakenly thought by him to be symptoms specific for schizophrenia (Kluft, 1987). These experiences

are also called made actions, thoughts, and feelings, and involve the experience that one's actions, feelings, or thoughts are not one's own, that one is not the agent of one's own behavior, but is instead controlled by some outside power or force. In MPD, these experiences are due to the intrusion of unrecognized alter personalities into one's actions, thoughts, or feelings. Such experiences are suggestive of, but not conclusive for, the diagnosis of MPD. A classical description of Schneiderian passivity is given in Anne's own words at the bottom of page 26, as Anne talks about her husband, Kayo:

"When he's gone, I want to be with someone, I want lights and music and talk. When I say running I don't mean running from something, but something I express by action—people, people, talk, talk, wanting to stay up all night, no way to stop it. I don't really *want* to have an affair with anyone, but I have to; it's the quality of action. I first had this feeling, I suppose, when I was dating, after Kayo went into the service. Pound, pound, pound heart; makes me feel crazy, out of control." [p. 26]

My hypothesis about Anne Sexton having MPD was strengthened when I read a description of her by her close friend. This is a diagnostic clue overlooked by Dr. Orne, the *American Journal of Psychiatry* reviewer, who made a diagnosis of manic depressive illness, and the biographer:

Her closest neighbor, Sandy Robart, recalled that "Anne always dropped ten years or more in her mother's presence. She was overwhelmed—she was awed. I think it was probably an attempt to please. I can see her standing at the phone in the kitchen, talking to her mother, and feeling that Anne had turned into a little girl." [p. 30]

This is a naturalistic observation of a switch to a child personality outside therapy by someone who never considered the possibility of MPD and is evidence of switching of executive control outside therapy. It will seem to the skeptical reader that I am concluding too much from too little at this point, and seeing MPD everywhere, but the conclusive evidence to follow will confirm my contention.

Anne had many psychosomatic symptoms besides constipation, including "intense pains in her stomach, for which her internist found no physiological basis. She became prone to attacks of anxiety that left her panting and sweating" (p. 32). She also experienced Schneiderian rage attacks which are described on the same page: "Increasingly, Sexton became prone to episodes of blinding rage in which she would seize Linda and begin choking or slapping her. In later life, she recalled with great shame a day she found Linda stuffing her excrement into a toy truck and as punishment picked her up and threw her across the room. She felt she could not control these outbursts, and she began to be afraid she would kill her children."

Dr. Orne's thoughts on the case appear again at this point in the biography:

Dr. Orne recalled that when he began treating Sexton, "She was very, very sick, but like many interesting patients, didn't fit textbook criteria. I did the diagnostic work on her when she was at the hospital, which indicated that she was a hysteric in the classic sense: like a chameleon, she could adopt any symptom. She experienced profound dissociation, and she had lesions of memory. Some therapists were convinced that Anne was schizophrenic. I don't doubt that hospitalized in a ward of schizophrenics she would exhibit their symptoms; that is why I discharged her as soon as possible from Westwood Lodge, where there were schizophrenic patients in treatment. But I never saw evidence in her of loose associations or formal thought disorders, or other major symptoms of schizophrenia. She certainly had a depressive illness for many years, which was never really resolved. One wonders whether the new anti-depressant drugs might not have successfully treated the more serious aspects of her depression." [p. 39]

There are several things to comment on in this passage. First, the statement that Anne never exhibited symptoms of schizophrenia contradicts Dr. Orne's statement in the Foreword that at times she had a thought disorder, and also contradicts the evidence of auditory hallucinations and Schneiderian passivity experiences in the biography. If these symptoms were dismissed as chameleon-like hysteria (assuming they were ever observed by Dr. Orne), why is it that the "depression" is thought to be genuine? And why did other therapists think Anne Sexton was schizophrenic if she never exhibited Schneiderian symptoms?

Anne Sexton's symptom profile from the biography, including the diagnostic confusion with schizophrenia, is classical for MPD and fits the description in MPD textbooks perfectly (Putnam, 1989; Ross, 1989). If the newer anti-depressants might have treated the "more serious aspects of her depression," this would presumably include her suicide: an implication of this position is that Dr. Orne could not be faulted for his patient's suicide because it was biologically driven and the necessary biological treatments did not come on the market for over two more decades.

The biographer echoes this viewpoint:

At the outset of Sexton's treatment, Dr. Brunner-Orne had noted the possibility that her difficulties derived from a post-partum depression; later notes, however, convey doubts that she had a "true" organically-based depression. Yet anecdotal evidence of breakdowns on both sides of the family suggests a genetic predisposition to a biologically-based illness, a supposition reinforced by Sexton's extreme physiological symptoms: wildly alternating moods, anorexia, insomnia, waves of suicidal and other impulses, rages, rapid heartbeat. It is possible that biochemical imbalances throughout her life intensified the underlying psychological vulnerabilities that were the primary focus of her psychotherapy. [p.37]

This hypothesis about mental illness is omnipresent in contemporary psychiatry. According to this biological hypothesis, no one is to blame for Anne Sexton's suicide except her bad genes. The other people in her life, including her mother, father, great-aunt, and doctors, are not at fault because biological psychiatry had not yet advanced to the point at which serotonergic anti-depressants were available, therefore, her biologically-based illness was beyond cure. In this reductionist model, Anne Sexton's suicide was as biologically based as cancer.

The biomedical model of mental illness may have facilitated wealthy families in institutionalizing their relatives in genteel, expensive, psychoanalytically-oriented mental hospitals, where the "schizophrenic" family members could wander the grounds and receive "humane" but ineffective psychoanalysis. How many of these "schizophrenics" had undiagnosed MPD and were hidden away from public view by multi-generational incest families?

Who is Dr. Brunner-Orne, you might have asked? Dr. Brunner-Orne is Martin Orne's mother. He first saw Anne Sexton while he was covering for his mother while she was away on holidays. Anne was originally referred to Dr. Brunner-Orne because she had treated his father for alcoholism. Dr. Brunner-Orne's notes are quoted on page 26 as stating that Anne had "difficulty controlling her desire for romance and adventure," suggesting that Dr. Brunner-Orne also missed the post-traumatic nature of Anne Sexton's acting out.

Feeling that the case for a diagnosis of MPD was still inconclusive at this point, I read the following:

Throughout the period of treatment annotated by Dr. Orne, Sexton referred casually and knowledgeably to concepts such as transference, resistance, defense, regression, acting out—all in the course of providing the doctor with "memories" that sound suspiciously like updated versions of Freud and Breuer's *Studies on Hysteria*. It seems likely that by 1958, Sexton had read the case history of the first hysteric in psychoanalytic literature and had found another namesake in the famous patient Freud and Breuer called Anna O. Moreover, Orne and Sexton were both taking notes on her case, he in longhand, she in poetry. As she was to tell him rather grandly later on, "therapy is a *minor* art, Dr. Orne!" [p. 55]

For whatever reason, a particularly dramatic development in her own case was the emergence during the summer and fall of 1957 of a flamboyantly naughty role she liked to play, called Elizabeth, and of a memory or fantasy, narrated in trance, about an incestuous experience with her father.

Early in Sexton's therapy, the Elizabeth persona began making appearances while Sexton was in trance by scrawling messages in child-like handwriting across pages torn from a lined notebook. Sexton told Dr. Orne how she had chosen the name. Leaving his office after an episode of automatic writing, she had become very despairing. She had walked

for a long time, thinking about suicide and trying to forget herself, and she had begun to be afraid that someone would notice her and ask her name. "Looked (for some reason) at the back of my watch [inherited from Elizabeth Harvey, her father's mother] and the initials E.H. were on it. So I thought, 'I must be E.H. [...] To [my] truthful knowledge, I had never been 'Elizabeth' before."

By September, she was typing letters which she left unsigned, though "Elizabeth" appeared in the return address on the envelopes. Somewhat comically, the writer claimed that she had to type her introductory letter in the dark so Anne wouldn't read it. "Help me somehow," Elizabeth urges Dr. Orne. "There must be something you can do about this except sit there like a blinking toad." Anne would be more cooperative "if she were less afraid of what you thought [...] I'm the one who'll talk." Elizabeth explains that formerly, Anne "thought of me as a brother that died—she used to think about him all the time—there wasn't really any brother—but she liked to pretend about him—I'm not so different from her, but I would tell you what she doesn't dare think—She acts her life away. [...] I am part of her sometimes, but she is not part of me. [...] Nana knew I was not Anne."

Elizabeth wanted Dr. Orne to put Anne under hypnosis during therapy, so that she, Elizabeth, could speak openly: "If you give her time to get dissociated she will be willing... I know a lot," she promised. When Dr. Orne would not agree to hypnotize his patient, both Anne and Elizabeth began appealing for a session under sodium pentothal. Together "they" laboriously typed a letter, one line superimposed on another: "Only sometimes do I lie," says one; "it's me that wants pentothal," says another.

At several points in her therapy, Sexton made an association, while in trance, between the name Elizabeth and "a little bitch," the angry words her father once used when he was drunk and spanked her for some naughtiness. She also associated this phrase with a night, recalled several times in trance at widely-spaced intervals, when her father came into her room and fondled her sexually. [pp. 59-60]

In this passage, the child alter personality, Elizabeth, who holds paternal incest memories, is asking to come into therapy and disclose the trauma, and the adult host personality is co-conscious and agreeing to the request. If this is correct, then the proper response would be to work actively with Elizabeth in therapy. How do the biographer and Dr. Orne justify suppressing Elizabeth as a regressive role-play?

On page 57, the biographer devotes several paragraphs to doubting the reality of the sexual abuse, pointing out that Anne was reading about incest at the time she was making the disclosures, and adducing the family's denial as evidence

in favor of the memories not being real. What about Dr. Orne?:

Her "Elizabeth characteristics attracted approval, even though it was approval she didn't wholly respect; and she had now been able to associate these with the poetry class. [p. 60]

But Sexton's desire to give these characteristics a name and a personality signaled what Dr. Orne regarded as a dangerous tendency. Discussing Elizabeth later, he commented that after a brief initial interest in this manifestation, he observed that Sexton was perilously close to developing multiple personality disorder, so he disengaged himself from acknowledging Elizabeth as a person distinct from Anne. "It was helpful to let her play out the fantasy of Elizabeth, to develop aspects of herself that had been held in check. Let me emphasize that this was a fantasy: Anne did not have multiple personality disorder, though she could have been encouraged in that direction," he said. "Once my interest dropped, so did hers, and no doctor ever saw Elizabeth again." As therapy went on, Dr. Orne stressed the positive sides that Sexton expressed through this persona: her charismatic leadership, her sense of fun, her capacity for pleasure, her self-confidence. "Elizabeth" expresses a side of your childhood which showed you assets you never really owned," Dr. Orne told her. "The 'magic' you, 'Elizabeth,' is the one who involves people. But you don't view it as *you*." The focus of therapy as it pertained to Elizabeth was an effort to help Sexton realize and tolerate the feelings she wanted to split off and act out. [pp. 60-61]

Dr. Orne's hypothesis is that "Elizabeth" was a fantasy role-play that had to be suppressed before it got out of control. "Elizabeth" was a playful way of expressing aspects of Anne's character she wanted to disown and act out. It was good therapy, according to Dr. Orne, not to feed into this escape from reality. My understanding of the case is that Elizabeth was not a role for expressing pleasant abilities and feelings, but an alter personality who held abuse memories. The focus of Martin Orne's therapy was to suppress the information about the trauma and the feelings that went along with it, and his diagnosis was an example of reverse iatrogenesis: he suppressed Anne Sexton's MPD and her alter personalities by demand characteristics, therapist attitude, and direct instruction. The therapy reinforced pathological dissociation and, at the same time, invalidated the seriousness and efficacy of the patient's dissociative defenses. Elizabeth was told she was unreal and that the doctor did not want to talk to her anymore. It is remarkable how confident biographer and psychiatrist are about the correctness of their hypothesis, given the fact that Anne Sexton killed herself.

Why did Dr. Orne decide to suppress the "Elizabeth" role while encouraging the poet role? How did he decide that the poet persona was more real or healthy than the

child one? The answer to this might seem self-evident, namely that "poet" was a functional adult role which brought meaning to Anne Sexton's life and a respected position in the adult world.

Unfortunately, this is not the psychological reality of Anne Sexton's life. The poet persona was, in fact, an artifact of therapy: the poet alter personality was deliberately fostered and encouraged by Martin Orne at the expense of the other alter personalities in the system, including Mrs. A.M. Sexton the mother and wife, Elizabeth, the angry voice that instructed suicide, the promiscuous personality, and any other personalities not described in the biography. Anne Sexton the poet was stimulated by the therapy to a level of malignant hypertrophy, resulting in exacerbation of the neglect and abuse of Anne's children, extensive frustration and suffering for her husband described in the biography, failure of her marriage, alcoholism, and eventual suicide.

The evidence in support of this contention begins with this passage:

Writing put her into a state similar to a trance, making her dangerously inattentive to her children, she was aware. Being in an institution full-time, she thought, might ease the burden of guilt she felt about ignoring her family. "Only time I am there is when I am thinking about poetry or writing—shuffling between methods of escape—liquor, pills, writing—I don't have anything else."

Just as the act of writing took Sexton out of herself, into what she felt was another identity, so the finished poem conveyed meanings she had no consciousness of intending. [p. 61]

The last sentence could apply to any writer, but in Anne Sexton's case the phenomenon was due to switching between alter personalities who were partially or fully amnesic for each other. The biographer's understanding of Anne Sexton is that she transmuted her ability to concoct pseudomemories into art, developing a true and meaningful identity as a poet. Actually, Anne was socialized in her therapy to believe that her trauma memories were not real and not worthy of serious sustained psychotherapeutic exploration.

Two passages, the first from page 62, the second from page 63, convey the basic principles of both the therapy, the poetry career, and the biography:

For the next month, spurred by distress over Dr. Orne's plans and the increasing extravagance of what she now called "truth crimes"—"lies" that she had been dealing with as "memories" in trance—Sexton typed about fifteen single-spaced pages of this personal record. "I do not understand why I must do these things—it makes me lose sight of any true me": this was her main theme. "I suspect that I have no self, so I produce a different one for different people. I don't believe me, and I seem forced to constantly establish long fake and various personalities." (She doubted even the sincerity of her two suicide attempts; these were, she suggested, atten-

tion-getting acts. But her worst "truth crime" was the invention of Elizabeth. "I made her up—I think I did. [...] Any element of truth about her is just a certain freedom of expression, a lack of sexual [I guess] repression. I could say 'she feels' but not, or never me." Sexton also admitted having faked the "total amnesia" about Elizabeth she had been professing to Dr. Orne. "I would feel better, less guilty, if I thought Elizabeth were true—I would rather have a double personality than be a total lie.") [p. 62]

Yet all that was "sick" or "hysterical" about her behavior in day-to-day life could be turned into something valuable through the act of writing poetry. Poetry, too, required a trance-like state for its disclosures. "Only in that funny trance can I believe myself, or feel my feeling," Sexton observed. If in therapy trance led to lying, at her typewriter it led to art. She could draw a simple equation: in trances she was a channel of lies; at her typewriter she was a channel of poetry. "Think I am a poet? False—someone else writes—I am a person selling poetry." [p. 63]

Anne Sexton's literary world failed her as well. The poets, editors, critics, and others in that milieu lacked the serious literary-critical standards, the serious ability to read which should have made it evident, obvious in fact, that the poetry is morbid, unhealthy, and extremely limited in range, rhythm, emotional depth, and energy. Anne Sexton's work is the poetry of a single alter personality and of an organism heading to suicide: it taps only a tiny subregion of the whole human being's memory, experience, thought, and feeling. The world might be more enriched if it had a volume of Elizabeth's writing to read.

The fact that Anne Sexton was only an alter personality, and that she represented an escape from the serious work of life and therapy, is supported by the following paragraph:

This was a decisive change of identity, and she had firmly achieved it by the end of 1957, when she discontinued the practice of submitting her poems for publication under the name Mrs. A.M. Sexton and began signing them "Anne Sexton." Later she would comment, regarding her first book, "By God, I don't think I'm the one who writes the poems! They don't center in my house—I can't write about Kayo, nothing—I was very careful about the picture on my book: didn't want it to look suburban, wanted just to be a face, a person whose life you couldn't define." Renaming herself was a stage in her symbolic reconstitution: she annulled the "Mrs." that indicated her dependent relationship to a husband and stepped forth in a euphonious triad of syllables all her own. [p. 65]

Complications of the Iatrogenic Creation of a Poet Personality

Anne Sexton's renaming herself was not a stage in a symbolic reconstitution, it was a stage in a progression towards

suicide. The malignant overtaking of Anne Sexton's life-space by one alter personality, reinforced by her psychiatrist and her literary friends, was protested by her husband, who is made to look possessive and petulant in the biography. Elizabeth probably concluded that Dr. Orne didn't want to talk to her because she was a bad girl, a confirmation of her guilt and self-hatred which would have been compounded by her doctor's leaving her to move to Philadelphia. Besides the costs borne by Anne Sexton herself, there was a heavy price paid by the family:

On a typical day, as she described it, she would "take half an hour to clean the house," then rush to the typewriter, not moving until Linda came home from nursery school at lunchtime. "Linda eats, then I put on a record or put her in front of television and go back to my desk. At moments I feel so guilty I read her a story... I'm always willing to cuddle, but I won't bother to prepare food: there I sit." Sexton realized that she was being neglectful, but the pressure angered her, too. "If I didn't have [Linda] there to reflect my depression, it wouldn't be so bad," she told her psychiatrist. "Any demand is too much when I'm like this. I want her to go away, and she knows it." Nothing she was learning about herself in therapy seemed to help her function as a mother, and she struggled with shocking feelings of rage toward Linda. "I've loved Joy, never loved Linda... Something comes between me and Linda. I hate her, and slap her in the face—never for anything naughty; I just seem to be constantly harming her... Wish I didn't have a mother-in-law at my every move. They act as if I were crazy or something when I get angry." Sexton felt as though she were leading two lives, one in treatment, and one in the midst of her family. [p. 73]

The therapy was reinforcing undiagnosed MPD rather than assisting Anne towards integration. Given the fact that incest tends to keep being transmitted from generation to generation in multi-generational incest families, in the absence of effective treatment, one realizes that Anne Sexton's children were at risk for sexual, emotional, and physical abuse, and neglect. The following passage about Anne's daughter Linda is particularly poignant, given that Linda is now, in identification with her mother, a published novelist:

As Linda neared puberty, she had begun to dislike her mother's intrusiveness more than ever. For several years, she had been pretending to be asleep when her mother got into bed with her and clung to her. But one night, when Linda was around fifteen, Anne had insisted that she come to the big bed and spend the night. Kayo was away on a trip, and Anne didn't want to be alone. They watched television for awhile, then Linda fell asleep. In the middle of the night, she woke, feeling that she couldn't breathe. It was dark, but she realized that

her mother was lying astride her, rubbing against her and kissing her on the mouth. "I felt suffocated. I remember pulling out of bed and throwing up. Mother followed me into the bathroom and soothed my head." [p. 324]

CONCLUSION

With that final quotation, the argument in favor of Anne Sexton having MPD is difficult to refute. The purpose of this chapter has not been to single out Martin Orne for attack, nor is it to speculate about his reasons for making the audiotapes of his sessions with Anne Sexton public. Martin Orne has had the courage to state his opinions in public and to make his therapy available for public scrutiny. It was not an expected standard of psychiatric practice to be able to diagnose MPD in the Fifties and Sixties, therefore, Martin Orne cannot be charged with diagnostic incompetence or failure to practice to reasonable standards. In fact, he is much more receptive to the diagnosis of MPD than are many psychiatrists.

We should try to learn from Martin Orne's mistakes so that they can be avoided in the future.

I suspect that many potentially treatable people with undiagnosed MPD have committed suicide. For instance, although I have no evidence to support such a diagnosis, Sylvia Plath, a poet Anne Sexton knew, also wrote morbidly about sex and death, and might have had a dissociative disorder. Sylvia Plath committed suicide, as did Virginia Woolf, a victim of childhood sexual abuse whose writings could be reviewed for evidence of a dissociative disorder.

The main point of this paper is to present a compelling argument for the iatrogenic complications of failing to diagnose MPD. Anna O also had MPD. Her diagnosis can be supported convincingly by quotation from Breuer and Freud's case history in *Studies on Hysteria* (1986), as I did in my book *Multiple Personality Disorder: Diagnosis, Clinical Features, and Treatment* (Ross, 1989). Anna O, whose real name was Bertha Pappenheim, decompensated when forced to nurse her dying father, who may have sexually abused her; however, there is no mention of childhood sexual abuse in the case history.

Anna O achieved a healthier adjustment than did Anne Sexton. She became a social worker and ran a home for teenage prostitutes and unwed mothers, most of whom were probably sexual abuse victims. Anna O was able to undo in her professional life some of the long-term consequences of the paternal incest she probably experienced in her own childhood. Bertha Pappenheim's diagnosis of MPD is certain, but her incest history is speculative, unlike Anne Sexton, for whom both are certain. ■

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