The phenomenon is not as rare as one might think: healthy people deliberately setting out to rid themselves of one or more of their limbs, with or without a surgeon's help. Why do pathologies sometimes arise as if from nowhere? Can the mere description of a condition make it contagious?

by Carl Elliott

In January of this year British newspapers began running articles about Robert Smith, a surgeon at Falkirk and District Royal Infirmary, in Scotland. Smith had amputated the legs of two patients at their request, and he was planning to carry out a third amputation when the trust that runs his hospital stopped him. These patients were not physically sick. Their legs did not need to be amputated for any medical reason. Nor were they incompetent, according to the psychiatrists who examined them. They simply wanted to have their legs cut off. In fact, both the men whose limbs Smith amputated have declared in public interviews how much happier they are, now that they have finally had their legs removed.

Healthy people seeking amputations are nowhere near as rare as one might think. In May of 1998 a seventy-nine-year-old man from New York traveled to Mexico and paid $10,000 for a black-market leg amputation; he died of gangrene in a motel. In October of 1999 a mentally competent man in Milwaukee severed his arm with a homemade guillotine, and then threatened to sever it again if surgeons reattached it. That same month a legal investigator for the California state bar, after being refused a hospital amputation, tied off her legs with tourniquets and began to pack them in ice, hoping that gangrene would set in, necessitating an amputation. She passed out and ultimately gave up. Now she says she will probably have to lie under a train, or shoot her legs off with a shotgun.

For the first time that I am aware of, we are seeing clusters of people seeking voluntary amputations of healthy limbs and performing amputations on themselves. The cases I have identified are merely those that have made the newspapers. On the Internet there are enough people interested in becoming amputees to support a minor industry. One discussion listserv has 1,400 subscribers. "It was the most satisfying operation I have ever performed," Smith told a news conference in February. "I have no doubt that what I was doing was the correct thing for those patients." Although it took him eighteen months to work up the courage to do the first amputation, Smith eventually decided that there was no humane alternative. Psychotherapy "doesn't make a scrap of difference in these people," the psychiatrist Russell Reid, of Hillingdon Hospital, in London, said in a BBC documentary on the subject, called Complete Obsession, that was broadcast in Britain last winter. "You can talk till the cows come home; it doesn't make any difference. They're still going to want their amputation, and I know that for a fact." Both Smith and Reid pointed out that these people may do themselves unintended harm or even kill themselves trying to amputate their own limbs. As the retired psychiatrist Richard Fox observed in the BBC program, "Let's face it, this is a potentially fatal condition."

Yet the psychiatrists and the surgeon were all baffled by the desire for amputation. Why would anyone want an arm or a leg cut off? Where does this sort of desire come from? Smith has said that the request initially struck him as "absolutely, utterly weird." "It seemed very strange," Reid told the BBC interviewer. "To be honest, I couldn't quite understand it."
The True Self?

In 1977 the Johns Hopkins psychologist John Money published the first modern case history of what he termed "apotemnophilia" -- an attraction to the idea of being an amputee. He distinguished apotemnophilia from "acrotomophilia" -- a sexual attraction to amputees. The suffix -philia is important here. It places these conditions in the group of psychosexual disorders called paraphilias, often referred to outside medicine as perversions. Fetishes are a fairly common sort of paraphilia. In the same way that some people are turned on by, say, shoes or animals, others are turned on by amputees. Not by blood or mutilation -- pain is not usually what they are looking for. The apotemnophile's desire is to be an amputee, whereas the acrotomophile's desire is turned toward those who happen to be amputees.

I found John Money's papers on amputee attraction at the University of Otago, in Dunedin, New Zealand, shortly after the Falkirk story made the news. Money is an expatriate New Zealander, and he has deposited his collected manuscripts in the Otago medical library. I had come to Dunedin to write a book at the University's Bioethics Centre, where I'd worked in the early 1990s. I have a medical degree, teach university courses in philosophy, and write a fair bit about the philosophy of psychiatry, and I was interested in the way that previously little-known psychiatric disorders spread, sometimes even reaching epidemic proportions, for reasons that nobody seems fully to understand. But I had never heard of apotemnophilia or acrotomophilia before the Falkirk story broke. I wondered: Was this a legitimate psychiatric disorder? Was there any chance that it might spread? Like Josephine Johnston, a lawyer in Dunedin who is writing a graduate thesis on the legality of these amputations (and who first brought the Falkirk case to my attention), I also wondered about the ethical and legal status of surgery as a solution. Should amputation be treated like cosmetic surgery, or like invasive psychiatric treatment, or like a risky research procedure?

Reviewing the medical literature, one might conclude that apotemnophilia and acrotomophilia are extremely rare. Fewer than half a dozen articles have been published on apotemnophilia, most of them in arcane journals. Most psychiatrists and psychologists I have spoken with -- even those who specialize in paraphilias -- have never heard of apotemnophilia. On the Internet, however, it is an entirely different story. Acrotomophiles are known on the Web as "devotees," and apotemnophiles are known as "wannabes." "Pretenders" are people who are not disabled but use crutches, wheelchairs, or braces, often in public, in order to feel disabled. Various Web sites sell photographs and videos of amputees; display stories and memoirs; recommend books and movies; and provide chat rooms, meeting points, and electronic bulletin boards. Much of this material caters to devotees, who seem to be far greater in number than wannabes. It is unclear just how many people out there actually want to become amputees, but there exist numerous wannabe and devotee listservs and Web sites.

Like Robert Smith, I have been struck by the way wannabes use the language of identity and selfhood in describing their desire to lose a limb. "I have always felt I should be an amputee." "I felt, this is who I was." "It is a desire to see myself, be myself, as I 'know' or 'feel' myself to be." This kind of language has persuaded many clinicians that apotemnophilia has been misnamed -- that it is not a problem of sexual desire, as the -philia suggests, but a problem of body image. What true apotemnophiles share, Smith said in the BBC documentary, is the feeling "that their body is incomplete with their normal complement of four limbs." Smith has elsewhere speculated that apotemnophilia is not a psychiatric disorder but a neuropsychological one, with biological roots. Perhaps it has less to do with desire than with being stuck in the wrong body.

Yet what exactly does it mean to be stuck in the wrong body? For the past several years I have been working with a research group interested in problems surrounding the use of medical interventions for personal enhancement. One of the issues we have struggled with is how to understand people who use the language of self and identity to explain why they want these interventions: a man who says he is "not himself" unless he is on Prozac; a woman who gets breast-reduction surgery because she is "not the large-breasted type"; a bodybuilder who says he took anabolic steroids because he wants to look on the outside the way he feels on the inside; and -- perhaps most common -- transsexuals whose experience is described as "being trapped in the wrong body." The image is striking, and more than a little odd. In each case the true self is the one produced by medical science.

At first I was inclined to think of this language as a literal description. Maybe some people really did feel as if they had found their true selves on Prozac. Maybe they really did feel incomplete without cosmetic surgery. Later on, however, I came to think of the descriptions less as literal than as expressions of an ambivalent moral ideal -- a struggle between the impulse toward self-improvement and the impulse to be true to oneself. Not that I can see no difference between a middle-aged man rubbing Rogaine on his head every morning and a man whose discomfort in his own body is so all-consuming that he begins to think of suicide. But we shouldn't be surprised when any of these people, healthy or sick, use phrases like "becoming myself" and "I was incomplete" and "the way I really am" to describe what they feel, because the language of identity and selfhood surrounds us. It is built into our morality, our literature, our political philosophy, our therapeutic sensibility, even our popular culture. This is the way we talk now. This is the way we think. This is even the way we sell cars and tennis shoes. We talk of self-discovery, self-realization, self-expression, self-actualization, self-invention, self-knowledge, self-betrayal, and self-absorption. It should be no great revelation that the vocabulary of the self feels like a natural way to describe our longings, our obsessions, and our psychopathologies.
This leads to larger questions about the nature of identity. What prompts people to conceptualize themselves as amputees? And at a time when identity seems so malleable, when so many people profess uncertainty about who they really are, is it possible that the desire for this particular identity might spread?

"I Knew I Didn't Want My Leg"

The question to be answered is not only why people who want to be amputees use the language of identity to describe what they feel but also what exactly they are using it to describe. One point of contention among clinicians is whether apotemnophilia is, as John Money thought, really a paraphilia. "I think that John Money confused the apotemnophiles and the acrotomophiles," Robert Smith wrote to me from Scotland. "The devotees I think are paraphilic, but not the apotemnophiles." The point here is whether we should view apotemnophilia as a problem of sexual desire -- a variety of the same condition that includes pedophilia, voyeurism, and exhibitionism. Smith, in agreement with many of the wannabes I have spoken with, believes that apotemnophilia is closer to gender-identity disorder, the diagnosis given to people who wish to live as the opposite sex. Like these people, who are uncomfortable with their identities and want to change sex, apotemnophiles are uncomfortable with their identities and want to be amputees.

But just what counts as apotemnophilia is part of the problem in explaining it. Some wannabes are also devotees. Others who identify themselves as wannabes are drawn to extreme body modification. There seems to be some overlap between people who want finger and toe amputations and those who seek piercing, scarring, branding, genital mutilation, and such. Some wannabes, Robert Smith suggests, want amputation as a way to gain sympathy from others. And finally, there are "true" apotemnophiles, whose desire for amputation is less about sex than about identity. "My left foot was not part of me," says one amputee, who had wished for amputation since the age of eight. "I didn't understand why, but I knew I didn't want my leg." A woman in her early forties wrote to me, "I will never feel truly whole with legs." Her view of herself has always been as a double amputee, with stumps of five or six inches.

Many devotees and wannabes describe what Lee Nattress, an adjunct professor of social work at Loma Linda University, in California, calls a "life-changing" experience with an amputee as a child. "When I was three years old, I met a young man who was completely missing all four of his fingers on his right hand," writes a twenty-one-year-old woman who says she is planning to have both her arms amputated. "Ever since that time, I have been fascinated by all amputees, especially women amputees who were missing parts of their arms and wore hook prostheses." Hers is not an unusual story. Most wannabes trace their desire to become amputees back to before the age of six or seven, and some will say that they cannot remember a time when they didn't have the desire. Nattress, who surveyed fifty people with acrotomophilia (he prefers the term "amelotasis") for a 1996 doctoral dissertation, says that much the same is true for devotees. Three quarters of the devotees he surveyed were aware of their attraction by the age of fifteen, and about a quarter wanted to become amputees themselves.

Many of the news reports about the case at the Falkirk and District Royal Infirmary identified Smith's patients as having extreme cases of body dysmorphic disorder. Like people with anorexia nervosa, who believe themselves to be overweight even as they become emaciated, people with body dysmorphic disorder are preoccupied with what they see as a physical defect: thinning hair, nose shape, facial asymmetry, the size of their breasts or buttocks. They are often anxious and obsessive, constantly checking themselves in mirrors and shop windows, or trying to disguise or hide the defect. They are often convinced that others find them ugly. Sometimes they seek out cosmetic surgery, but frequently they are unhappy with the results and ask for more surgery. Sometimes they redirect their obsession to another part of the body. But none of this really describes most of the people who are looking for amputations -- who, typically, are not convinced they are ugly, do not imagine that other people see them as defective, and are usually focused exclusively on amputation (rather than on, say, a receding hairline or bad skin). Amputee wannabes more often see their limbs as normal, but as a kind of surplus. Their desires frequently come with chillingly precise specifications: for instance, an above-the-knee amputation of the right leg.

By calling apotemnophilia a paraphilia, John Money placed it in a long and distinguished lineage of psychosexual disorders. The grand old man of psychosexual pathology, Richard von Krafft-Ebing, catalogued an astonishing range of paraphilias in his Psychopathia Sexualis (1886), from necrophilia and bestiality to fetishes for aprons, handkerchiefs, and kid gloves. Some of his cases involve an attraction to what he called "bodily defects." One was a twenty-eight-year-old engineer who had been excited by the sight of women's disfigured feet since the age of seventeen. Another had pretended to be lame since early childhood, limping around on two brooms instead of crutches. The philosopher René Descartes, Krafft-Ebing noted, was partial to cross-eyed women.

Yet the term "sexual fetish" could be a misleading way to describe the fantasies of wannabes and devotees, if what is on the Web is any indication (and, of course, it might well not be). Many of these fantasies seem almost presexual. I don't want to be misunderstood: there is plenty of amputee pornography on the Internet. Penthouse has published in its letters section many of what it terms "monopede mania" letters, purportedly from devotees, and Hustler has published an article on amputee fetishism. But many other amputee Web sites have an air of thoroughly wholesome middle-American hero worship, and perhaps for precisely that reason they are especially disconcerting, like a funeral parlor in a shopping mall. Some show disabled men and women attempting nearly impossible feats -- running marathons, climbing mountains, creating art with prostheses. It is as if the fantasy of being an amputee is...
inseparable from the idea of achievement -- or, as one of my correspondents put it, from an "attraction to amputees as role models." "I've summed it up this way," John Money said, a little cruelly, in a 1975 interview. "Look, Ma, no hands, no feet, and I still can do it." One woman, then a forty-two-year-old student and housewife whose history Money presented in a 1990 research paper, said one of the appeals of being an amputee was "coping heroically." A man told Money that his fantasy was that of "compensating or overcompensating, achieving, going out and doing things that one would say is unexpectable." One of my amputee correspondents wrote that what attracted him to being an amputee was not heroic achievement so much as "finding new ways of doing old tasks, finding new challenges in working things out and perhaps a bit of being able to do things that are not always expected of amputees."

AM on the phone with Max Price, a graphic designer in Santa Fe, who has offered to talk to me about apotemnophilia. (He has asked me to change his name and the details of his life and history if I write about him, and I have.) Price is a charming man, articulate and well-read, and despite my initial uneasiness about calling him, I am enjoying our conversation. I had corresponded by e-mail with a number of wannabes, but had not managed to talk to any of them until now. The conversation has taken on an easy intellectual tone, more like a discussion between colleagues than an interview. Price is telling me about his efforts to get doctors to adopt some guidelines for deciding when a person with apotemnophilia should have surgery. I am tossing out ideas, trying out some of my thoughts, and I wonder aloud about a relationship between apotemnophilia and obsessive-compulsive disorder. I ask Price whether he feels that his desire is more like an obsession, a fantasy, or a wish. He says, "Well, it was definitely like an obsession. Until I cut my leg off, of course."

That brings me up short. I had been unaware that he had actually gone ahead with an amputation. "Ah," I say. I pause. Should I ask? I decide I should. "May I ask how you did it?" Price laughs. "It was kind of messy," he says. "I did it with a log splitter." He then explains, in a thoughtful, dispassionate manner, the details of his "accident" ten years ago -- the research he had done on anesthesia and wound control, how he had driven himself to the emergency room after partially amputating his limb, the efforts of the hospital surgeons to reattach it. He lived with the reattached leg for six months, he said, until medical complications finally helped him persuade another surgeon to amputate it.

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I met Price through an Internet discussion listserv called "amputee-by-choice," one of the larger lists. At first I had simply prowled through the archives and listened to the ongoing conversation. I found many of the archived messages very creepy. Here were people exchanging photographs of hands with missing fingers; speculating about black-market amputations in Russia; debating the merits of industrial accidents, gunshot wounds, self-inflicted gangrene, chain-saw slips, dry ice, and cigar cutters as means of getting rid of their limbs and digits. When I introduced myself to the active electronic group, however, the discussion abruptly stopped, like the conversation in a village pub when a stranger walks in. For several days only a handful of new messages were posted. But I had invited wannabes to get in touch with me individually, telling them that I was a university professor working on apotemnophilia, and over the next few days a dozen or so people responded. Some, like Price, were insightful and articulate. Some had become mental-health professionals, in part as a way of trying to understand their desires. The few who had managed an amputation seemed (somewhat to my surprise) to have made peace with their desires. But others obviously needed help: they were obsessive, driven, consumed. Many seemed to have other psychiatric problems: clinical depression, obsessive-compulsive disorder, eating disorders, transvestism of a type that sounded anything but playful or transgressive. They did not trust psychiatrists. They did not want medication. They wanted to know if I could find them a surgeon. I felt like an ethnographer in a remote country, unfamiliar with the local customs, who the natives believe can help them. I began to understand how Robert Smith must have felt. I also began to wonder at the strength of a desire that would take people to such lengths.

By all accounts, the Internet has been revolutionary for wannabes. I can see why. It took me months to track down even a handful of scientific articles on the desire for amputation. It took about ten seconds to find dozens of Web sites devoted to the topic. Every one of the wannabes and devotees I have talked with about the Internet says that it has changed everything for them. "My palms were actually sweating the first time I typed 'amputee' into a search engine," one wannabe wrote to me. But the results were gratifying. "It was an epiphany," she wrote. When Krafft-Ebing was writing Psychopathia Sexualis, people with unusual desires could live their entire lives without knowing that there was anyone else in the world like them. Today all it takes is a computer terminal. On the Internet you can find a community to which you can listen or reveal yourself, and instant validation for your condition, whatever it may be. This same wannabe told me that she has never spoken about her desire for amputation with a friend, a family member, or a mental-health professional, and that she never will. Yet she is a frequent anonymous participant on the wannabe discussion listserv.

"The Internet was, for me, a validation experience," writes a wannabe who is also a transsexual. She says she found herself thinking less about amputation after logging on, because her desire was no longer such a dark secret. "When one is afraid of discovery, I think one thinks rather more about the secret in order to guard against accidental revelation." She also points out that the Internet helped her get information on how to lose her legs. Another wannabe, a therapist, says that discovering the Internet was a mixed blessing. "There was a huge hole to be filled," she told me, and the Internet began to fill it. To discover that she was not alone was wonderful -- but it also meant that a desire she had managed to push to the back of her mind now shoved its way to the front again. It occupied her conscious thoughts in a way that was uncomfortable. She says she knows wannabes who subscribe to as many as a dozen wannabe and devotee online mailing lists and spend hours every day wading through electronic messages.
The Gender-Identity Parallel

EVEN wannabes who describe their wish for amputations as a wish for completeness will often admit that there is a sexual undertone to the desire. "For me having one leg improves my own sexual image," one of my correspondents wrote. "It feels 'right,' the way I should always have been and for some reason in line with what I think my body ought to have been like."

When I asked one prominent wannabe who also happens to be a psychologist if he experiences the wish to lose a limb as a matter of sex or a matter of identity, he disputed the very premise of the question. "You live sexuality," he told me. "I am a sexual being twenty-four hours a day." Even ordinary sexual desire is bound up with identity, as I was reminded by Michael First, a psychiatrist at Columbia University, who was the editor of the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual*. First is undertaking a study that will help determine whether apotemnophilia should be included in the fifth edition of the *DSM*. "Think of the fact that, in general, people tend to be more sexually attracted to members of their own racial group," he pointed out. What you are attracted to (or not attracted to) is part of who you are.

It is clear that for many wannabes, the sexual aspect of the desire is much less ambiguous than many wannabes and clinicians have publicly admitted. A man described seventeen years ago in the *American Journal of Psychotherapy* said that he first became aware of his attraction to amputees when he was eight years old. That was in the 1920s, when the fashion was for children to wear short pants. He remembered several boys who had wooden legs. "I became extremely aroused by it," he said. "Because such boys were not troubled by their mutilation and cheerfully, and with a certain ease, took part in all the street games, including football, I never felt any pity towards them." At first he nourished his desire by seeking out people with wooden legs, but as he grew older, the desire became self-sustaining. "It has been precisely in these last years that the desire has gotten stronger, so strong that I can no longer control it but am completely controlled by it." By the time he finally saw a psychotherapist, he was consumed by the desire. Isolated and lonely, he spent some of his time hobbling around his house on crutches, pretending to be an amputee, fantasizing about photographs of war victims. He was convinced that his happiness depended on getting an amputation. He desperately wanted his body to match his self-image: "Just as a transsexual is not happy with his own body but longs to have the body of another sex, in the same way I am not happy with my present body, but long for a peg-leg."

The comparison of limb amputation to sex-reassignment surgery comes up repeatedly in discussions of apotemnophilia, among patients and among clinicians. "Transsexuals want healthy parts of their body removed in order to adjust to their idealized body image, and so I think that was the connection for me," the psychiatrist Russell Reid stated in the BBC documentary *Complete Obsession*. "I saw that people wanted to have their limbs off with equally as much degree of obsession and need and urgency." The comparison is not hard to grasp. When I spoke with Michael First, he told me that his group was considering calling it "amputee identity disorder," a name with obvious parallels to the gender-identity disorder that is the diagnosis given to prospective transsexuals. The parallel extends to amputee pretenders, who, like cross-dressers, act out their fantasies by impersonating what they imagine themselves to be.

But gender-identity disorder is far more complicated than the "trapped in the wrong body" summary would suggest. For some patients seeking sex-reassignment surgery, the wish to live as a member of the opposite sex is itself a sexual desire. Ray Blanchard, a psychologist at the University of Toronto's Clarke Institute of Psychiatry, studied more than 200 men who were evaluated for sex-reassignment surgery. He found an intriguing difference between two groups: men who were homosexual and men who were heterosexual, bisexual, or asexual. The "woman trapped in a man's body" tag fit the homosexual group relatively well. As a rule, these men had no sexual fantasies about being a woman; only 15 percent said they were sexually excited by cross-dressing, for example. Their main sexual attraction was to other men.

Not so for the men in the other group: almost all were excited by fantasies of being a woman. Three quarters of them were sexually excited by cross-dressing. Blanchard coined the term "autogynephilia" -- "the propensity to be sexually aroused by the thought or image of oneself as a woman" -- as a way of designating this group. Note the suffix -philia. Blanchard thought that a man might be sexually excited by the fantasy of being a woman in more or less the same way that people with paraphilias are sexually excited by fantasies of wigs, shoes, handkerchiefs, or amputees. But here sexual desire is all about sexual identity -- the sexual fantasy is not about someone or something else but about yourself. Anne Lawrence, a transsexual physician and a champion of Blanchard's work, calls this group "men trapped in men's bodies."

If sexual desire, even paraphilic sexual desire, can be directed toward one's own identity, then perhaps it is a mistake to try to distinguish pure apotemnophilia from the kind that is contaminated with sexual desire. Reading Blanchard's work, I was reminded of a story that Peter Kramer tells in his introduction to *Listening to Prozac* (1993). Kramer describes a middle-aged architect named Sam who came to him with a prolonged depression set off by business troubles and the deaths of his parents. Sam was charming, unconventional, and a sexual nonconformist. He was having marital trouble. One of the conflicts in his marriage was his insistence that his wife watch hard-core pornographic videos with him, although she had little taste for them. Kramer prescribed Prozac for Sam's depression, and it worked. But one of the unexpected side-effects was that Sam lost his desire for hard-core porn. Not the desire for sex: his libido was undiminished. Only the desire for pornography went away.
Antidepressants like Prozac are good treatments for compulsive desires, and clinicians also use them for patients with paraphilias and sexual compulsions. What is interesting about Kramer's story, though, is the way in which Sam came to view his desire. Before treatment he had thought of it simply as part of who he was -- an independent, sexually liberated guy. Once it was gone, however, it seemed as if it had been a biologically driven obsession. "The style he had nurtured and defended for years now seemed not a part of him but an illness," Kramer writes. "What he had touted as independence of spirit was a biological tic." Does this suggest that sexual desire is simply a matter of biology? No. What it suggests is that an identity can be built around a desire. The person you have become may be a consequence of the things you desire. And this may be as true for apotemnophiles as it was for Sam, especially if their desires have been with them for as long as they can remember.

Eccological Niches

One of the novels that occasionally pop up on devotee and wannabe book lists is Katherine Dunn's *Geek Love* (1989), the story of a carnival family conceived through the ingenuity of Al and Lil Binewski. Lil, the family matriarch, has ingested pesticides, radioactive materials, and a variety of drugs in order to produce children who are special: Iphigenia and Electra, piano-playing conjoined twins; Olympia, the bald albino hunchback dwarf who narrates the story; Chick, who has telekinetic powers; and Arturo the Aqua Boy, who was born with flippers instead of arms and legs. Arty, the undisputed star of the carnival, swims and frolics in an aquarium and then preaches dark, enigmatic sermons to his assembled admirers. "If I had arms and legs and hair like everybody else, do you think I'd be happy? NO! I would not!" he shouts to his audience. "Because then I'd worry did somebody love me! I'd have to look outside myself to find out what to think of myself!"

Arty's charisma eventually propels him into the leadership of an Arturan Cult, whose members tithe parts of their body in order to become more like him. His assistant, a rogue surgeon by the name of Dr. Phyllis, amputates the digits and limbs of enthusiastic Arturans. Off come toes and fingers, then hands and feet, and finally, as converts approach ecstatic completeness, all four limbs in their entirety. "Can you be happy with the movies and the ads and the clothes in the stores and the doctors and the eyes as you walk down the street all telling you there is something wrong with you?" Arty asks a blubbering fat woman in the audience, like a preacher making an altar call. "No. You can't. You cannot be happy. Because, you poor darling baby, you believe them...." Soon his caravan is trailed by thousands of armless and legless disciples, living in tents, begging for food, waiting patiently for another turn in the operating room with Dr. Phyllis.

*Geek Love* is an odd choice for a devotee or wannabe reading list. It is brutal in its mockery of amputee wannabes. Yet it makes sense of a darker side of American life that often goes unexplored in the mainstream media. The media generally treat the desire for body modification either as the well-worn terrain of fashion slaves and social strivers, who buy cosmetic surgery in an endless quest for beauty and perpetual youth, or as something bizarre and unexplainable, like genital mutilation or masochistic fetishes. *Geek Love* makes the desire for amputation plausible by setting it against the bland, cheery aesthetic of mainstream American beauty. *Geek Love* may mock amputee wannabes, but it does not mock them for their poor taste. The aesthetic sensibility of *Geek Love* comes straight out of a carnival sideshow. Its heroes are not "norms," as ordinary Americans are called in the book, but the freaks of the Binewski Carnival Fabulon. "We are masterpieces," Olympia says when asked if she would like to be a norm. "Why would I want to change us into assembly-line items? The only way you people can tell each other apart is by your clothes."

*Geek Love* may help us understand the cultural context that produces conditions like apotemnophilia. Why do certain psychopathologies arise, seemingly out of nowhere, in certain societies and during certain historical periods, and then disappear just as suddenly? Why did young men in late-nineteenth-century France begin lapsing into a fugue state, wandering the continent with no memory of their past, coming to themselves months later in Moscow or Algiers with no idea how they got there? What was it about America in the 1970s and 1980s that made it possible for thousands of Americans and their therapists to come to believe that two, ten, even dozens of personalities could be living in the same head? One does not have to imagine a cunning cult leader to envision alarming numbers of desperate people asking to have their limbs removed. One has only to imagine the right set of historical and cultural conditions.

So, at any rate, suggests the philosopher and historian of science Ian Hacking, who in a series of strikingly innovative books and articles has attempted to explain just how "transient mental illnesses" such as the fugue state and multiple-personality disorder arise. A transient mental illness is by no means an imaginary mental illness, though in what ways it is real (or "real," as the social constructionists would have it) is a matter for philosophical debate. A transient mental illness is a mental illness that is limited to a certain time and place. It finds an ecological niche, as Hacking puts it -- an idea that helps to explain how it thrives. In the same way that the idea of an ecological niche helps to explain why the polar bear is adapted to the Arctic ecosystem, or the chigger to the South Carolina woods, Hacking's ecological niches help to explain the conditions that made it possible for multiple-personality disorder to flourish in late-twentieth-century America and the fugue state to flourish in nineteenth-century Bordeaux. If the niche disappears, the mental illness disappears along with it.

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Carolina woods, Hacking's ecological niches help to explain the conditions that made it possible for multiple-personality disorder to...
Hacking does not intend to rule out other kinds of causal mechanisms, such as traumatic events in childhood and neurobiological processes. His point is that a single causal mechanism isn't sufficient to explain psychiatric disorders, especially those contained within the boundaries of particular cultural contexts or historical periods. Even schizophrenia, which looks very much like a brain disease, has changed its form, outlines, and presentation from one culture or historical period to the next. The concept of a niche is a way to make sense of these changes. Hacking asks, What makes it possible, in a particular time and place, for this to be a way to be mad?

Hacking's books *Rewriting the Soul* (1995) and *Mad Travelers* (1998) are about "dissociative" disorders, or what used to be called hysteria. He has argued, I think very persuasively, that psychiatrists and other clinicians helped to create the epidemics of fugue in nineteenth-century Europe and multiple-personality disorder in late-twentieth-century America simply by the way they viewed the disorders -- by the kinds of questions they asked patients, the treatments they used, the diagnostic categories available to them at the time, and the way these patients fit within those categories. He points out, for example, that the multiple-personality-disorder epidemic rode on the shoulders of a perceived epidemic of child abuse, which began to emerge in the 1960s and which was thought to be part of the cause of multiple-personality disorder. Multiple personalities were a result of childhood trauma; child abuse is a form of trauma; it seemed to make sense that if there were an epidemic of child abuse, we would see more and more multiples.

Crucial to the way this worked is what Hacking calls the "looping effect," by which he means how a classification affects the thing being classified. Unlike objects, people are conscious of the way they are classified, and they alter their behavior and self-conceptions in response to their classification. Look at the concept of "genius," Hacking says, and the way it affected the behavior of people in the Romantic period who thought of themselves as geniuses. Look also at the way in which their behavior in turn affected the concept of genius. This is a looping effect. In the 1970s, he argues, therapists started asking patients they thought might be multiples if they had been abused as children, and patients in therapy began remembering episodes of abuse (some of which may not have actually occurred). These memories reinforced the diagnosis of multiple-personality disorder, and once they were categorized as multiples, some patients began behaving as multiples are expected to behave. Not intentionally, of course, but the category "multiple-personality disorder" gave them a new way to be mad.

**Contagious Desire**

I AM simplifying a very complex and subtle argument, but the basic idea should be clear. By regarding a phenomenon as a psychiatric diagnosis -- treating it, reifying it in psychiatric diagnostic manuals, developing instruments to measure it, inventing scales to rate its severity, establishing ways to reimburse the costs of its treatment, encouraging pharmaceutical companies to search for effective drugs, directing patients to support groups, writing about possible causes in journals -- psychiatrists may be unwittingly colluding with broader cultural forces to contribute to the spread of a mental disorder.

Suppose doctors started amputating the limbs of apotemnophiles. Would that contribute to the spread of the desire? Could we be faced with an epidemic of people wanting their limbs cut off? Most people would say, Clearly not. Most people do not want their limbs cut off. It is a horrible thought. The fact that others are getting their limbs cut off is no more likely to make these people want to lose their own than state executions are to make people want to be executed. And if by some strange chance more people did ask to have their limbs amputated, that would be simply because more people with the desire were encouraged to "come out" rather than suffer in silence.

I'm not so sure. Clinicians and patients alike often suggest that apotemnophilia is like gender-identity disorder, and that amputation is like sex-reassignment surgery. Let us suppose they are right. Fifty years ago the suggestion that tens of thousands of people would someday want their genitals surgically altered so that they could change their sex would have been ludicrous. But it has happened. The question is why. One answer would have it that this is an ancient condition, that there have always been people who fall outside the traditional sex classifications, but that only during the past forty years or so have we developed the surgical and endocrinological tools to fix the problem. But it is possible to imagine another story: that our cultural and historical conditions have not just revealed transsexuals but created them. That is, once "transsexual" and "gender-identity disorder" and "sex-reassignment surgery" became common linguistic currency, more people began conceptualizing and interpreting their experience in these terms. They began to make sense of their lives in a way that hadn't been available to them before, and to some degree they actually became the kinds of people described by these terms.

I don't want to take a stand on whether either of these accounts is right. It may be that neither is. It may be that there are elements of truth in both. But let us suppose that there is some truth to the idea that sex-reassignment surgery and diagnoses of gender-identity disorder have helped to create the growing number of cases we are seeing. Would this mean that there is no biological basis for gender-identity disorder? No. Would it mean that the term is a sham? Again, no. Would it mean that these people are faking their dissatisfaction with their sex? No. What it would mean is that certain social and structural conditions -- diagnostic categories, medical clinics, reimbursement schedules, a common language to describe the experience, and, recently, a large body of academic work and transgender activism -- have made this way of interpreting an experience not only possible but more likely.
Whether apotemnophilia (or, for that matter, gender-identity disorder) might be subject to the same kind of molding and shaping that Hacking describes is not clear. One therapist I spoke with, an amputee wannabe, believes that the desire for amputation, like multiple-personality disorder, is often related to childhood trauma. This is only one person's hypothesis, of course, and it may be wrong. But it is clear that sexual desire is malleable. It doesn't seem far-fetched to imagine that amputated limbs could come to be seen more widely as erotic, or that given the right set of social conditions, the desire for amputation could spread. For a thousand years Chinese mothers broke the bones in their daughters' feet and wrapped them in bandages, making the feet grow twisted and disfigured. To a modern Western eye, these feet look grotesquely deformed. But for centuries Chinese men found them erotic.

Ian Hacking uses the term "semantic contagion" to describe the way in which publicly identifying and describing a condition creates the means by which that condition spreads. He says it is always possible for people to reinterpret their past in light of a new conceptual category. And it is also possible for them to contemplate actions that they may not have contemplated before. When I was living in New Zealand, ten years ago, I had a conversation with Paul Mullen, who was then the chair of psychological medicine at the University of Otago, and who had told me that he was a member of a government committee whose job it was to decide whether pornographic materials should be allowed into the country. I bristled at the idea of censorship, and asked him how he could justify being a part of something like that. He just laughed and said that if I could see what his committee was banning, I would change my mind. His position was that some sexual acts would never even occur to a person in an entire lifetime of thinking about sex if not for seeing them pictured in these books. He went on to describe to me various alarming acts that, it was true, had never occurred to me.

Mullen was of the opinion that people were better off never having conceptualized such acts, and in retrospect, I think he may have been right.

This is part of what Hacking is getting at, I think, when he talks about semantic contagion. The idea of having one's legs amputated might never even enter the minds of some people until it is suggested to them. Yet once it is suggested, and not just suggested but paired with imagery that a person's past may have primed him or her to appreciate, that act becomes possible. Give the wish for it a name and a treatment, link it to a set of related disorders, give it a medical explanation rooted in childhood memory, and you are on the way to setting up just the kind of conceptual category that makes it a treatable psychiatric disorder. An act has been redescribed to paired with imagery that a person's past may have primed him or her to appreciate, that act becomes possible. Give the wish for it a name and a treatment, link it to a set of related disorders, give it a medical explanation rooted in childhood memory, and you are on the way to setting up just the kind of conceptual category that makes it a treatable psychiatric disorder. An act has been redescribed to make it thinkable in a way it was not thinkable before. Elective amputation was once self-mutilation; now it is a treatment for a mental disorder. Toss this mixture into the vast fan of the Internet and it will be dispersed at speeds unimagined even a decade ago.

Michael First, the editor of the Diagnostic and Statistical Manual, is quite aware of this worry. When I asked him how the DSM task force decides what to include in the manual, he told me there were three criteria. One, a diagnosis must have "clinical relevance" -- enough people must be suffering from the condition to warrant its inclusion. Thus more data must be gathered on apotemnophilia before a decision is made to include it in the next edition. Two, a new diagnostic category must not be covered by existing categories. This may turn out to be the catch for apotemnophilia, because if the data suggest that it is a paraphilia, it will be subsumed into that category. "People have paraphilias for all kinds of things," First says, "but we do not have separate categories for all of them."

Three, a new diagnostic category must be a legitimate "mental disorder." What counts as a disorder is hard to define and, in fact, varies from one age and society to the next. (Consider, for example, that homosexuality was defined as a mental disorder in the DSM until the 1970s.) One way DSM-IV marks off disorders from ordinary human variation is by saying that a condition is not a disorder unless it causes a person some sort of distress or disability.

However, the fuzziness around the borders of most mental disorders, along with the absence of certainty about their pathophysiological mechanisms, makes them notoriously likely to expand. A look at the history of psychiatry over the past forty years reveals startlingly rapid growth rates for a wide array of disorders -- clinical depression, social phobia, obsessive-compulsive disorder, panic disorder, attention-deficit hyperactivity disorder, and body dysmorphic disorder, to mention only a few. In trying to pinpoint the causes for this expansion one could, depending on ideological bent, point to the marketing efforts of the pharmaceutical industry (more mental disorder equals more profits), the greater diagnostic skills of today's psychiatrists, a growing population of mentally disordered Americans, or a cultural tendency to look to psychiatry for explanations of what used to be called weakness, sin, unhappiness, perversity, crime, or deviance. But the fact is that none of these disorders could have expanded as they have unless they looked a lot like ordinary human variation at their edges. Mild social phobia looks a lot like extreme shyness, attention-deficit disorder can look a lot like garden-variety distractibility, and a lot of obsessive-compulsive behavior, as Peter Kramer told me, "verges on the normal." The lines between mental dysfunction and ordinary life are not as sharp as some psychiatrists like to pretend.

Which makes me wonder how sharply the lines around apotemnophilia can be drawn. The borders between pretenders, wannabes, and devotees do not look very solid. Many wannabes are also devotees or pretenders. A study published in 1983, which surveyed 195 customers of an agency selling pictures and stories about amputees, found that more than half had pretended to be amputees and more than 70 percent had fantasized about being amputees. Nor do the lines look very clear between "true" apotemnophiles (say, those for whom the desire is a fixed, long-term part of their identities) and those whose desire has other roots, such as an interest in extreme body modification. We also need to remember that even if a core group of people with true apotemnophilia could be identified, their diagnosis could come only from what they report to their psychiatrists. There is no objective test for apotemnophilia. People seeking amputation for other reasons -- sexual gratification, for example, or a desire for extreme body modification -- could easily learn what
they need to say to doctors in order to get the surgery they want. Specialists working in gender-identity clinics were complaining of something similar with their patients as early as the mid-1970s. Intelligent, highly motivated patients were learning the symptoms of gender dysphoria and repeating them to clinicians in order to become candidates for sex-reassignment surgery.

**The Elusiveness of "Help"**

I WILL confess that my opinions about amputation as a treatment have shifted since I began writing this piece. My initial thoughts were not unlike those of a magazine editor I approached about writing it, who replied, "Thanks. This is definitely the most revolting query I've seen for quite some time." Yet there is a simple, relentless logic to these people's requests for amputation. "I am suffering," they tell me. "I have nowhere else to turn." They realize that life as an amputee will not be easy. They understand the problems they will have with mobility, with work, with their social lives; they realize they will have to make countless adjustments just to get through the day. They are willing to pay their own way. Their bodies belong to them, they tell me. The choice should be theirs. What is worse: to live without a leg or to live with an obsession that controls your life? For at least some of them, the choice is clear -- which is why they are talking about chain saws and shotguns and railroad tracks.

And to be honest, haven't surgeons made the human body fair game? You can pay a surgeon to suck fat from your thighs, lengthen your penis, augment your breasts, redesign your labia, even (if you are a performance artist) implant silicone horns in your forehead or split your tongue like a lizard's. Why not amputate a limb? At least Robert Smith's motivation was to relieve his patients' suffering.

It is exactly this history, however, that makes me worry about a surgical "cure" for apotemnophilia. Psychiatry and surgery have had an extraordinary and very often destructive collaboration over the past seventy-five years or so: clitoridectomy for excessive masturbation, cosmetic surgery as a treatment for an "inferiority complex," intersex surgery for infants born with ambiguous genitalia, and -- most notorious -- the frontal lobotomy. It is a collaboration with few unequivocal successes. Yet surgery continues to avoid the kind of ethical and regulatory oversight that has become routine for most areas of medicine. If the proposed cure for apotemnophilia were a new drug, it would have to go through a rigorous process of regulatory oversight. Investigators would be required to design controlled clinical trials, develop strict eligibility criteria, recruit subjects, get the trials approved by the Institutional Review Board, collect vast amounts of data showing that the drug was safe and effective, and then submit their findings to the U.S. Food and Drug Administration. But this kind of oversight is not required for new, unorthodox surgical procedures. (Nor, for that matter, is it required for new psychotherapies.) New surgical procedures are treated not like experimental procedures but like "innovative therapies," for which ethical oversight is much less uniform.

The fact is that nobody really understands apotemnophilia. Nobody understands the pathophysiology; nobody knows whether there is an alternative to surgery; and nobody has any reliable data on how well surgery might work. Many people seeking amputations are desperate and vulnerable to exploitation. "I am in a constant state of inner rage," one wannabe wrote to me. "I am willing to take that risk of death to achieve the needed amputation. My life inside is just too hard to continue as is." These people need help, but when the therapy in question is irreversible and disabling, it is not at all clear what that help should be. Many wannabes are convinced that amputation is the only possible solution to their problems, yet they have never seen a psychiatrist or a psychologist, have never tried medication, have never read a scientific paper about their problems. More than a few of them have never even spoken face to face with another human being about their desires. All they have is the Internet, and their own troubled lives, and the place where those two things intersect. "I used to pretend as a child that my body was 'normal' which, to me, meant short, rounded thighs," one wannabe wrote to me in an e-mail. "As a Psychology major, I have analyzed and reanalyzed, and re-reanalyzed just why I want this. I have no clear idea."

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