

MULTIPLE PERSONALITY DISORDER/
DISSOCIATED IDENTITY DISORDER:
THE CLIENT AS ACTOR MODEL

by

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This dissertation is a philosophical analysis of Multiple Personality Disorder/Dissociated Identity Disorder. It investigates what the existence or presence of alter-identities in a client means, and critically analyzes the metaphysical basis of that existence or presence. This dissertation also has a major focus of concern with the therapeutic value of treating multiple personalities/dissociated identities as a disorder.

An analysis of the metaphysics of the prevailing conception of multiplicity (the alter model) is shown to have fatal logical problems. Moreover, the conception of multiplicity as a disorder is shown to have destructive consequences for the typical client who manifests multiplicity and whose therapy is based on the disorder conception. These problems and consequences provide the motivation for replacement of the alter model with one that is free of logical problems and that does not treat multiplicity as a disorder. A model of multiplicity as a form of acting provides the replacement conception. A

previous consideration of the acting approach (by some clinicians) in favor of the alter model was based both on a conception of acting as mimicry or faked feeling, and the idea of extreme dissociation experienced only as a psychopathology. This alter-actor comparison is referred to as the alter-actor distinction. However, this dissertation reconsiders the alter-actor distinction and shows how the alter model is contradicted by the testimony of some important actors, directors, and theoreticians and psychologists of acting. Moreover, consideration of how actors are counseled to protect themselves from the effects of extreme dissociation reveals that this advice is at odds with the advice and encouragement given to some MPD/DID clients about the emergence of multiple personalities/dissociated identities.

This dissertation urges that the alter model of multiplicity/dissociated identity be replaced by the actor model. The actor model overcomes the logical deficiencies of the alter model, and has improved compatibility with, and a more accurate understanding of, the continuum of dissociative experience. The actor model will thereby serve clients more effectively and less dangerously.

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A picture may still continue to exert a powerful influence even after we have come to recognize its flaws. We must also recognize its strength: that is, the ways in which it resonates with and illuminates aspects of human experience. We cannot escape from a picture until we understand the mechanisms whereby it has maintained its hold.... we will rarely give up one picture unless we are offered a relevant and seemingly better alternative. The notion of the lived body, I believe, is such an alternative. It can help us to be more attentive to experience, uncover phenomena that were concealed, explain what the Cartesian framework renders inexplicable.... (*The Absent Body*, 155)

DEDICATION

This dissertation is dedicated to the advancement of an understanding of the role that dissociation plays in the making of identity. It is also dedicated to the improvement of the lives of those diagnosed as suffering from MPD/DID, either through re-diagnosis or the re-direction of therapeutic methodology.

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CHAPTER I

INTRODUCTION

Three Radical Interrelated Claims

This dissertation is an analysis of the philosophical underpinnings of Multiple Personality Disorder (MPD), renamed in 1994 as Dissociated Identity Disorder (DID). This work enters upon a burgeoning discipline called philosophical psychopathology, which “offers insight into philosophical, conceptual, and empirical problems associated with the DSM specifically and with treatment strategies in general.”¹ In this dissertation I make three radical inter-related claims. First, multiple personalities/dissociated identities is not a disorder. Second, MPD/DID clients are importantly like poorly directed actors. And third, MPD/DID therapy is counter-productive to its own goal of singletonism (i.e., unified self).² This is because therapists encourage and guide clients to cathect alter-identities by using particular psychological techniques—the same techniques that actors are taught to guard against.

Who Am I To Make Such Claims?

At first I questioned whether I was qualified, as a non-licensed counselor, to make such claims against a long-established mental disorder. But with time, I came to see that the viewpoint I present—given my stance between and in both worlds of philosophy and psychology—would not likely be given by either a practicing clinician untrained in philosophy nor by a philosopher unpracticed in the ways of therapy. Besides, clinicians diagnosing and treating MPD clients have too much to lose by questioning their own actions; and philosophers run the risk of being accused of not being qualified to understand the complexities of diagnosis and treatment.

I have undergraduate degrees in both psychology and philosophy and have practiced both as a Qualified Mental Health Professional (QMHP—a county certified position) and as a Philosophical Counselor (not then licensable). Because I am not a licensed counselor I do not have to fear marginalization, censure, or license revocation for challenging the dictates of the American Psychiatric Association; or be concerned with being ousted from ‘the club’ of believers of MPD.³ And, unlike most clinicians, I am trained in philosophical analysis, including ethics, social/political philosophy, and in particular metaphysics. This combination of experiences contributes to a particular life history—one conducive to making the above claims.

Selection of the Dissertation Topic

This dissertation topic arose, not by first picking philosophical psychopathology as a focus, as it had not yet been publicized. Instead, I came by my topic on the job via observation of the diagnosis and treatment of MPD. While employed at a semi-independent living center for the chronically mentally ill, and while in the capacity as an associate (QMHA) I came to question the clinical interpretation of client behavior as being that of someone having many personalities or identities inside them.

Making my questions known made the clinical director uneasy. Some questions I asked included, "How do you know when you have accounted for the last hidden self?" and "How do you know which is the real/original self?" and "How do you know that the client is not acting?" and "Why is multiplicity a disorder and single personality something to help the client strive for?" The clinical director's answers were not satisfactory. Responses to my questions about MPD were either metaphysically troublesome, illogical, or, for the most part, not forthcoming.

This prompted research into both clinical and philosophical literature on MPD. The clinical literature only served to deepen my concerns and increase my questions and philosophical analysis on the topic of MPD was, at the time, almost non-existent. This left me with unresolved issues about MPD. It became apparent that MPD diagnosis was based solely on client self-report and observation by therapists with metaphysical biases about self and how many could exist in one human being. Having advanced to QMHP status, I

announced my reservations to the staff about diagnosing and treating a disorder that had so many unanswered questions surrounding it.

Clients were made aware of my position. This evidently created an open forum (of sorts) for clients on the topic of MPD. To my surprise, one MPD-diagnosed client approached me (in secret) to complain that she was being stripped of her moods in therapy—that she could not just be herself anymore. According to her, every time she had a mood change she was told a new personality was coming out, or she was pressured to name who the alter was that was presenting at the time. She questioned me as to whether I believed a person could really have multiple personalities inside them, especially hundreds or thousands of them. Her questions put me in a precarious ethical position as a QMHP because I was obligated to support (or at least not run contrary to) the dictates of her diagnosis and treatment regimen, yet, I felt compassion for what she must be experiencing with such valid questions.

Attempting to answer the client's and my questions about MPD proved difficult. For several years clinical literature was the only thing available for research and it triggered more questions than it answered. In addition, it was not until 1995 or so that some philosophers took the topic seriously enough to publish books on it. Prior to that only a couple of articles appeared (1988 and later). And when they did write about it, to my dismay it was to use MPD to make some other point, rather than to treat it directly and seriously in its own right. For example, Ian Hacking in his book, Rewriting the Soul, Multiple Personality and the Sciences of Memory⁴ uses MPD to further his investigations into both how things come to be as well as what kinds of things come to be considered as

objects of knowledge. Kathleen Wilkes, in her book, Real People, Personal Identity without Thought Experiments,⁵ uses MPD to test her definition of persons. Steven Braude (1995), in his book, First Person Plural, Multiple Personality and the Philosophy of Mind,⁶ attempts to give account of the kind of unifying principle it would take to make sense of the metaphysically problematic clinical view of multiple selves in one body. Nicholas Humphrey (theoretical psychologist) and Daniel C. Dennett (philosopher) in, “Speaking for Ourselves: An Assessment of Multiple Personality Disorder”⁷ (1989) use MPD to further Dennett’s contention that there is no such thing as an articulatable, comprehensible, self. And Owen Flanagan in his article “Multiple Identity, Character Transformation, and Self-Reclamation,”⁸ is interested in MPD/DID for what it has to offer for his conception of human narratives. He sees multiplicity in all of us and so is faced with explaining the supposed difference between normal people and those with mental disorder, which he does by suggesting that MPD/DID clients, unlike normal people, have limited unified control of their “multiplex” of personalities. The limited philosophical literature that analyzed MPD itself contributed to the difficulty of both the analysis of MPD/DID and the longevity of the writing of this dissertation (six years).

The approach to, and the analysis of, MPD/DID taken in this dissertation offers something new to both philosophy and psychology/psychiatry. In contrast to other philosophers’ works on MPD/DID, my work directly analyzes multiplicity as a disorder, questions the logicity of the diagnostic criteria of MPD/DID, and tries to make sense of dissociation (the foundation of MPD/DID) as both a normal experience (acting) and an abnormal experience (MPD). In philosophically analyzing the diagnostic criteria and

various clinical views of MPD, I have tried to make sense of certain similarities and discontinuities. In this way, my work adds a new dimension to the philosophical understanding of what is clinically meant by classifying multiple personality/dissociated identity as a disorder.

Chapter by Chapter Overview

MPD/DID, it seems to me, is about three things: *metaphysics*, *dissociation*, and *mental disorder*. These are the result of three particular questions about MPD: *metaphysics*—what does it mean to say there are real, separate, autonomous, multiple identities in a client?; *dissociation*—what is the difference between the dissociative experience of the actor and that of the MPD client, i.e., why do people insist MPD clients are not acting?; and *mental disorder*—why is having/being multiple personalities/dissociated identities a disorder? The following chapters will address these questions.

Chapter Two: To investigate these three things, I first needed to make sense of the various clinical views of MPD/DID. In this chapter, I try to give both a sympathetic reading of MPD, i.e., the Familiar View, as well as explain why the clinicians' diagnostic tools, i.e., the diagnostic criteria and the Casebook example, are too general, and have resulted in clinical divergence of opinion and industry tension over the validity and treatment of the disorder.

Chapter Three: I take a thorough look at dissociation—the foundation of MPD—and show the historical development that led to the clinical claim that clients are not actors, i.e., that their alter-identities are not merely enacted roles. I refer to this clinical claim as the alter-actor distinction.

Chapter Four: I compare and contrast alters and actors and present the MPD/DID Client as Actor Model. This is a direct challenge to the clinical alter-actor distinction. The client-actor model is put forth as a less problematic conception of client experience than that of the current diagnostic model.

Chapter Five: I give an accounting of the metaphysical illogicality we are left with in the clinical model of MPD/DID if the client as actor model is not preferred.

Chapter Six: I suggest that the clinical alter-actor distinction blinds therapists to the effects of their own attitudes and problematic treatment strategies. MPD/DID therapy may promote, rather than curb or cure, multiplicity/dissociated identity in clients. MPD/DID therapists may direct clients to become too absorbed in character roles (alter-identities) which leads to dissociative delusions, ‘switching,’ and forgetfulness.

Chapter Seven: A summary will be given of the main points of this dissertation, including a review of how the alter-actor distinction arises from dissociation as a continuum, and the importance of the distinction for maintenance of extreme dissociation as a psychopathology. Also included will be a reminder of the metaphysical-logical and therapeutic problems we are left with, as to the diagnostic criteria of MPD/DID, if the alter-actor distinction is maintained. Benefits of the less problematic Client as Actor Model will be addressed. Subsequently, suggestions for future research will be presented.

Notes

¹ Philosophical Psychopathology 1-332.

² Singleton is a word coined by people with MPD to refer to (what amounts to) the metaphysical status of normal (non-MPD) persons.

³ Humphrey and Dennett 92-3. They refer to proponents of MPD as exhibiting a "cliquish, almost cultish character of those who currently espouse the cause of MPD," saying that, "In a world where those who are not for MPD are against it, it is perhaps not surprising that "believers" have tended to close ranks."

⁴ Hacking 1-336.

⁵ Wilkes 100-28; 198-230.

⁶ Braude 1-315.

⁷ Humphrey and Dennett 68-98.

⁸ Flanagan 135-162.

CHAPTER II

MPD/DID

Since its inception more than one hundred years ago, most people have now heard about Multiple Personality Disorder (MPD), renamed Dissociated Identity Disorder (DID) in 1994. The media attention over the last 20 years has made people aware of the confusion over MPD/DID. The most often asked question is still, “is MPD/DID real—can a person really have other personalities or identities inside them?” Questions over what MPD/DID is, when it starts, and what starts it are unsettled. No one is sure whether an MPD/DID client’s mind has multiple separate personalities or less than one identity because his or her identity fractured into many parts. It is unknown how many selves can be present in an MPD/DID client. Some say as little as two. Others report alter-identities into the thousands. There is confusion over what counts as an alter-self. Is a personality a self? Is an identity a self? Where does a mood stop and a personality start? Are multiple personalities and a fractured identity the same thing? How do we distinguish between moods, personalities, identities, and selves? In addition, the language of MPD/DID is confusing. What is switching? What is dissociative amnesia? What are inner voices? And, what is interpersonality communication? The validity of the definition of these terms is still being debated.

The explanation of Dissociated Identity Disorder involves, in part, presenting the view most people are familiar with (the Familiar View). But, to present only the Familiar View in this chapter would leave you with a skewed understanding of MPD/DID in two respects. The Familiar view would misconstrue what MPD/DID is about—leading you to think that because it is timeworn it is time proven. It would also suggest to you that most clinicians accept the Familiar View. This is not the case. Clinical controversy over MPD/DID continues to grow.

In this chapter I present a fuller understanding of MPD/DID. This will involve a general overview and a dramatized story of the Familiar View, which will acknowledge the general psychological explanation of why a person's mind might split into many identities. I turn next to the question of how alter-identities get started, and I examine the drawbacks of being multiple or dissociated. It is important to understand how diagnosis occurs in order to understand the philosophical, metaphysical, and therapeutic dilemmas therapists are faced with when MPD/DID is suspected in a client. The diagnostic procedure will be explained. But to fully understand a therapist's task we need to take a look at a therapist's tools. There are two tools supplied by the APA, namely, the diagnostic criteria of DID, and the Diagnostic and Statistical Manual of Mental Disorders (DSM) Casebook example—a fictional account. Some problems that arise from the diagnostic criteria will be discussed. It will become clear why there is such divergence of opinion, even among clinicians, as to how to understand the phenomenon of MPD/DID. This will be followed by five clinical interpretations of the diagnostic criteria. These interpretations will reveal the divergence of opinion that comes from having too simple a

list of criteria. A summary of the chapter will remind us of the complexity of understanding MPD/DID and will lead us to question (in subsequent chapters) two of its pillars, i.e., dissociation, and the metaphysics of multiple/dissociated identities in a client's mind. These topics will help to give a fuller accounting of MPD/DID than the non-clinician is used to.

The Familiar View of MPD/DID

The horror that some children manage to live through is incredible. That some children endure physical abuse such as severe beatings, being thrown against the wall, or being tied to a chair for hours is unnerving. That toddlers survive tortures such as cigarette burns, electric shock, or the scrubbing of genitals with a wire brush is shocking and depressing. That children survive severe neglect such as being shut in dark closets for days, being left alone to fix their own food at age two, or simply not being responded to (treated as if they do not exist), is heart-wrenchingly sad. When children are used for sexual exploitation, for pornography, for the satisfaction of a father's or mother's sexual desires, or for a parent's retaliation toward a spouse, the physical and emotional pain of sexual abuse is endured, not just when it occurs, but for the victim's entire lifetime. These examples of abuse are not exaggerations; they are realities for many adults diagnosed with MPD/DID.

The children who suffer such torment survive physically but are left scarred emotionally. The child's life is forever altered and made more difficult, more complicated.

At the time when the child becomes an adult, past abuses may haunt him or her in unsuspecting ways. Trust, love, communication, relationships, work, child-rearing, etc. each, in its own way, can trigger negative associations, negative memories that victims do not want to think about, relive, or rehash. The adult child cannot easily heal these slowly festering psychic wounds. Inevitably, the triggers to the undesired memories occur.

Examples of triggers are, for example, odors such as the memory of an abusive father's after-shave, or visual stimuli such as the abusive mother's red sharp heels, but now any heels, or objects such as a hairbrush once used as a phallic tool, but now any hairbrush. Relationships too can be triggers, i.e., a person's abusive spouse repeating the pattern of the abusive father. Even furniture, such as the seat of any car, can become a constant reminder of being forced to sit on an abuser's lap in a car with his or her hand under the child-victim's panties. Or, the age of one's child can trigger abuse memories. Often, although many years of seeming mental health have passed since the days of abuse, when an adult victim's own children attain the age the victim was at the time of his or her abuse, memories of those incidents are triggered. Whether odors, implements of daily use, relationships, places, the birth or age of one's children, or proximity to others occur, the seemingly simplest of ordinary things can trigger the adult's childhood memories.

Allowing painful memories to surface (attending to—being willing to focus on painful memories) is supposed to help release the emotional and physical pain associated with the memory. Hidden memories, when brought into the light of consciousness and subsequently attended to, are said to become less painful—in recreating the past the memory loses its ability to manifest unwanted physiological symptoms. Clinically

speaking, it is the mind's way of cathecting (getting rid of) the somatic and psychic pain that accompanies the memories. Sometimes, though, the client is not ready to remember such horrors and so the attempt to cathect is interrupted. When this happens, the memories wait for another time when the client may be more emotionally prepared to face the reality of his or her childhood head on.

It makes sense that the adult victim would want to hide horrible memories from herself or himself. The adult victim, even after growing up and attaining a modicum or more of safety, faces the constant unwanted triggering of childhood memories with dysfunctional results. The triggers, or rather the avoidance of the memories the triggers drag forth, may surface as headaches, physical ailments, depression, nightmares, or as bits and pieces of disowned mental pictures. Unconscious forces or conscious desire to avoid remembering certain events may be so strong that the victim detaches from himself or herself completely in order to ensure no chance of coming into contact with the unwanted memories.

With complete detachment, the possibility of MPD/DID arises. In wanting so much to avoid the negative triggers, the victim is prompted to run away—not physically because this is sometimes not possible—but psychologically. The victim goes away into his or her mind—he or she dissociates. The victim recedes into the unconscious and hides there while an alter-identity comes out to take over dealing with the unwanted situation or triggers. At the time the person dissociates, another identity comes out to take over the victim's behavior. When this happens, the client appears transformed. He or she has “switched” places with another person, personality, identity, or self (depending on one's

view), in order to hide from experiences or memories he or she wishes to avoid. The alter-identity that is now “out” can deal with the victim’s avoided situation. The victim can keep from remembering the event because the alter-identity experienced the unwanted situation for the victim. The alter-identity now houses the memory of the unwanted situation. By having alter-identities that take over behavior, the client is protected from having to experience both the actual painful situation and its corresponding memory. Instead, the client experiences lapses in memory (those memories housed by alter-identities) and lapses in time (while alter-identities are out). These are symptoms indicative of MPD/DID.

How Multiple Personalities/Dissociated Identities Get Started

Dissociation, as used for the creation of alter-selves, starts in early childhood.¹ During the primary stage of social development, all children learn to create imaginary playmates. A child can pretend to be one of the playmates by dissociating—by fantasizing, i.e., by focusing on the imagined mental life of the playmate to the point of excluding the outside world altogether. This shutting out of the world can lead to the child believing that her fantasy life is reality. The young child’s use of dissociation in an attempt to cope with abuse or neglect, after years of practice, develops into the adult-child’s learned behavior of switching personalities to deal with unwanted situations.

When practiced, dissociation can be developed into a skill. Dissociating can be used for the fun and interest of creating a multitude of playmates or for the creation of and escape into a multitude of personalities or identities. The creation and personalization of these various identities or characters is seen as a sane way of dealing with insane circumstances. In a world of powerful, dominating adults, a child has little option available for escaping abuse. Rather than experience the pain of abuse directly, the child, having learned the skill of creating playmates by dissociating, improves on this skill. The child creates and pretends to be first one personality and then other personalities, i.e., other selves by which to live through the horror, unknowingly locking away abuse memories in the psyche of the created alter-selves. In this way, the child uses the skill of dissociation to protect the primary self from unacceptable memories.

If a trigger (an abuse association) jogs the victim's memory, a personality comes out to deal with the situation and unwanted memories. Usually a particular self comes out—a situationally appropriate alter-identity. [For example, the client's "bully" personality, as opposed to his or her "shy" identity, is more appropriate for dealing with the angry neighbor that reminds the client of his or her sexually abusive father.] If another trigger occurs, another situationally appropriate personality comes out to take the previous personality's place. In this way, the victim can continue avoiding abuse memories, switching from one situationally appropriate alter-self to another situationally appropriate alter-self—never having to cathect the awful events of childhood.

The Drawbacks of MPD/DID

Unfortunately, there is a cost to using dissociation as a coping strategy. The victim tends to continue to develop more and more personalities. After all, this method of avoiding unwanted events has proved effective for the client. And given the inevitable problems that life presents, and the abusive patterns that victims tend to be caught up in and suffer from, new personalities get developed with each daunting unwanted experience.

Another drawback is that the various personalities, including the primary self, may or may not be aware of the existence of the other selves or the memories the other selves hold. The number of secondary selves can range from two into the hundreds; with the victim's memories fractured into as many separate quadrants as there are alter-selves.

When a child uses extreme dissociation to create alter-selves he or she finds that practicing doing so makes it easier and easier to avoid unwanted experiences, but along with this benefit, he or she may suffer a form of amnesia from doing so. At some point in the development of the child and in the practicing of the techniques of dissociation, the created alter-selves seem to take on a life of their own—coming out (switching) at odd times and taking over the aging child's behavior. Switching among alter-selves results in dissociative amnesia—a loss of time and memory. Dissociative amnesia can be the result of extreme dissociation—an abnormal, dysfunctional way of coping with stressful events or psychologically negative environmental cues.

Dissociative amnesia makes for a disrupted life. The abuse victim with MPD/DID, while still not yet realizing he or she is multiple, starts to notice odd things occurring.

People start calling him or her by a different name. There is unaccounted for mileage on a car that only the victim drives. His or her wallet is empty after just being paid. The victim arises one morning with a completely different haircut, but does not remember going to the barber. There are odd style clothes in the closet that the victim would never buy and has no memory of buying. The victim wakes up sometimes in a different house and finds a stranger in the bed that claims to be the victim's spouse. The two children present tell the victim he or she is their parent. The missing memory and missing time that these victims experience is very disconcerting and disruptive of the continuity of a person's life.

These examples—indicators of extreme dissociation—are clinically interpreted in various ways as doubling of consciousness or divided or split consciousness, multiple selfhood, multiple personalities, dissociated mental states, or dissociated identities. Each dissociated identity is considered an alter-self. In sharing "time out," i.e., time in the body, each alter-self has only a sporadic life. The result of an on again, off again life is sporadic memory—interrupted existence. Not only does the client have dissociative amnesia, but also so do the, now autonomous and distinct, alter-selves. None of the identities have continuous continuity. They each suffer from severe dissociation

Because of MPD/DID, a victim's life is no longer his or her own, as the following examples will indicate. In having many identities and one body, the body becomes like a vessel shared by many selves because only one identity can be "out" at a given time. In having to share a body with so many personalities, victims are tired most of the time. Many identities want their turn out—want to add to their life—and may have made commitments that prompt them to come out more often—commitments such as school,

work, family, etc. Many MPD/DID clients are unaware that they work long hours at several jobs or job and school and become exhausted without knowing why.

Disagreements occur because some alter-identities do not want to go to therapy. They try to stop the others from attending therapy, by cutting the body or making inner voices louder or by not letting the identity come out that has the appointment. Living a life of multiplicity makes life difficult and dysfunctional, although alter-identities enjoy being out.

How Does the Diagnosis Occur?

Considering the client's lack of awareness of his or her alter-selves and considering that the only overt symptoms of MPD/DID may be, for example, headache, nightmares, or being called by the wrong name, how does a therapist come to the diagnosis of MPD/DID? The therapist observes the client's behavior and questions the client about his or her symptoms including alterations in conscious experience.² From the therapist's observations, he or she questions changes in client behavior, including changes in facial affect, body language, vocal timbre, dress, hairstyle, and self-reported or therapist-noted changes in psychic content such as personality/identity, memory loss, time loss, odd occurrences, etc. These types of symptoms—alterations to body, behavior, and mental content—lead the therapist to suspect MPD/DID.

The MPD/DID therapist works inside a dualistic system. It may seem overly simplistic to put it this way, but medical doctors are trained to treat the body and brain, and psychiatrists and therapists are trained to treat the psyche or mind. With this division

of labor in mind, when it comes to behavioral changes the treating person must make a decision. Behavioral changes can be due to things occurring in the physical body (i.e., brain) or the psyche (mind). It is important to determine the location of the symptoms. Symptom location determines diagnosis. Brain disorders are diagnosed and treated differently than mind disorders. Brain disorders are treated with therapeutic drugs or surgery and little to no mind therapy. Mind disorders, by contrast, are usually treated with no drugs, and lots of various mind therapies. If a disorder has both components, it is treated with both drugs and mind therapies. This dualistic system—the idea of the client as having a mind and a body—directs diagnosis and treatment. Through use of a dualistic system and methodology, psychological causes and medical (physical) causes can be assessed and treated separately.

To determine whether a client is MPD/DID, the therapist first makes sure that symptoms, such as headaches, memory loss, etc., are not due to somatic, i.e. medical causes such as alcohol, drugs, epilepsy, or schizophrenia. This is not always an easy task. For example, therapists William N. Confer and Billie S. Ables, in their famous case study of Rene, found that Rene was first diagnosed with an organic disorder of epilepsy, then later rediagnosed as MPD/DID.

In their review of the literature of identified multiple personalities, Sutcliffe and Jones (1962) found a number of cases that appeared to be either epileptic or otherwise organic. In some of the cases reported, behavior resembling multiple personality, e.g., disturbed memory functions and automatic or regressed behavior, may have resulted from organic factors, as in the case of injury, which were clearly demonstrable. In some such cases, the organically determined behaviors may sufficiently resemble those of the multiple personality to lead falsely to this diagnosis. On the other hand, in some individuals with multiple personality, behaviors suggesting underlying organic causes, e.g., blackouts or seizure-like

behavior, may lead initially to the erroneous conclusion of organicity, when in fact such behaviors are psychogenic in origin and are manifestations of a multiple personality. Such was the case with Rene, [...] who was initially diagnosed as epileptic.³

A given diagnosis is always subject to review and re-diagnosis. Different therapists read symptoms differently. Ruling organic causes in or out is sometimes as difficult as ruling psychogenic causes in or out; and, if both are present diagnosis proves even more complicated. When Rene was thought to have seizures, she was diagnosed as epileptic. When it was later determined that these seizures were not seizures at all but really the transitional phase of switching to another identity, she was re-diagnosed as MPD. This illustrates how in determining a client to be MPD/DID the organic causes must be ruled out; otherwise diagnosis and treatment would fall to the organic discovery.

Once medical causes are ruled out, and only then, the therapist assumes the client's symptoms are due to psychological (mind) causes.⁴ Mental causes of disorder prompt therapists to investigate the client's consciousness (psyche). Dissociative disorders, especially that of MPD/DID, are considered disorders of the mind. "The linkage between the development of a dissociative reaction and the experience of overwhelming *psychic* trauma is most clear-cut in multiple personality disorder."⁵ MPD/DID is considered a disorder of the mind, not the body.

Because clients are often not aware of their alter-identities (and the hidden traumas housed in their psyche), therapists usually use hypnotherapy to delve into a client's psyche when MPD/DID is a possibility. If MPD/DID is suspected, then the therapist wants to check for the backlash of extreme dissociation—the splitting or doubling of

consciousness.⁶ Ross explains, “you don’t have a case of MPD until you have talked to the alters.”⁷ If the client’s consciousness has doubled (multiplied), alter-identities will be present. These alter-identities will speak to the therapist during hypnotherapy.

To test for the existence/presence of alter-identities, the therapist hypnotizes a client or gets him or her into a relaxed state and encourages an alter-identity to come out—to appear vocally and possibly behaviorally. Voices may occur as rational or irrational (crazy, incoherent, and unable to hold sensible conversation, etc., i.e., as in schizophrenic voices). It is a general diagnostic rule of those who diagnose and treat MPD/DID that each different rational voice represents a different alter-self, i.e. a separate, distinct, autonomous identity. Having ruled out organic causes, the explanation for divergent speech patterns is attributed to the presence of alter-identities. The existence/presence of at least one alter-self indicates MPD/DID.

The therapist, familiar with all classifications of mental disorders, compares the client’s symptoms to the diagnostic criteria of a particular, suspected, disorder in an attempt to find a match. The diagnostic criteria for all mental disorders are listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM).⁸ [As a supplement, if the therapist is new to diagnosing and treating MPD/DID, he or she can refer to the corresponding textbook example as listed in the DSM Casebook (DSMC). Or, the therapist may attend various training workshops or classes on diagnosing and treatment MPD/DID clients.] Regardless of magnitude or sparseness of training about diagnosis and treatment of MPD/DID, the therapist must consider the criteria set forth for diagnosing the disorder rather than make up their own criteria. The therapist usually uses the most

current edition, in this case the DSM-IV (fourth edition), for this purpose. Having now observed the client's behavior and reflected on it, the therapist compares the client's experiences, symptoms, and behaviors to the diagnostic criteria for MPD/DID. If a symptom to diagnostic criteria match is found, the therapist concludes that the client is suffering from MPD/DID.

The diagnostic criteria are of central importance to MPD/DID. Without the diagnostic classification and corresponding diagnostic criteria of MPD/DID, the client would be given a different diagnosis or combination of diagnoses, i.e., schizophrenia, borderline disorder, etc. But, if the classification of MPD/DID is available, and if client symptoms match the diagnostic criteria for MPD/DID, then the client is diagnosed as having or being multiple personalities/dissociated identities.

In general, disorders are considered to be in need of correction. In particular, diagnosis dictates the method and goal of therapy. So, following the diagnosis of MPD/DID, the client participates in various mind-therapies, i.e., usually hypnotherapy, with the therapeutic goal being to integrate (multiple personalities) or fuse the many dissociated identities into one unified identity or person.

More specifically, according to Colin Ross, both a MPD therapist and MPD therapist educator, once a diagnosis of MPD/DID is made, the first of three phases of treatment begins.⁹ Of first and utmost importance is "establishing trust and safety." The client must trust the therapist's interpretation of his or her behavior as due to the existence/presence of multiple personalities/dissociated identities within the client. There may be hesitancy towards this interpretation, but the therapist can not proceed until the

client agrees to think of his or her symptoms as being due to dissociated alter-identities. Once trust is accomplished, a treatment alliance between therapist and client is developed. This includes informing the client of “a stated goal of integration” of the consciousnesses of the alter-identities with the consciousness of the client. Therapy begins by “contacting alter-personalities.” There may be tens or hundreds of alter-selves. As alter-identities appear, it is important to begin mapping the personality system. This enables the therapist to keep track of each alter, i.e., to remember who is who, to map their functions and the memories they house for—and away from—the client. At this point “treatment contracts” are needed to keep everybody (client and alter-identities) on task. The client, and all alter-identities known about, or as many as possible, must agree to the therapy contract terms. Otherwise, the various alter-identities may want to set their own goals or inhibit or interfere with the stated goal of therapy.

Now that the therapist has the map of the personality system and has the alter-identities’ and client’s trust and agreement of the goal of integration, according to Ross, it is time to begin “establishing interpersonality communication.”¹⁰ One way this is done “is by modeling communication for the patient, which occurs when the therapist requests switches and debriefs alter-identities on conversations held behind amnesia barriers.” This may prove difficult. “The patient will most likely stall and resist the work toward interpersonality integration in countless ways.” Ross does not attribute this to the client’s hesitancy over or resistance to the acceptance of a bizarre metaphysical interpretation of his or her symptoms, or to a healthy ego wanting to maintain barriers between character roles in order to keep a coherent sense of self. Instead, he attributes resistance to the

client's attitude being "as it should be for someone who has survived extreme trauma thanks to dissociation." Mapping the system, talking to the alter-identities, facilitating interpersonality communication, and integrating the alters into a unified whole identity may not complete the healing process. In his summary Ross says, "If a new layer of alter personalities is discovered late in therapy, these techniques may be used again at that stage." A therapist never knows when additional alter-identities will be created or when old alter-identities will surface. This leaves the healing of the client open-ended.

At the foundation of the client's healing is a fundamental tool—the diagnostic criteria. As explained, the therapist must rely on diagnostic classification and its corresponding diagnostic criteria, like that in the DSM-IV, for the diagnoses of MPD/DID. Treatment methodology is based on the dictates of diagnosis. Therefore, interpretation of the diagnostic criteria for MPD/DID can not be too loose so as to overlap definition of other disorders, yet it can not be so rigid as to inhibit application to individuals with their myriad differences. Since diagnosis and treatment are fundamentally based on MPD/DID diagnostic criteria, it is paramount to understand what those criteria are, and what is clinically meant by those criteria. This will enable us to determine whether the diagnostic criteria are reasonable, understandable, logical, i.e. valid, and lead to a consensus about client behavior and best treatment protocol.

Diagnostic Criteria of DID

The Familiar View of MPD/DID that we started with in this chapter exemplifies the DSM-IV's diagnostic criteria for mental illness, code number 300.14 Dissociative Identity Disorder. But, the diagnostic criteria and DSM Casebook example are very general, supplying only the most common features of the disorder. Though this generality furnishes a flexibility that is sympathetic to individual differences to be expected among clients, it also leaves much room for interpretation.

To understand what is meant by MPD/DID, or at least to understand what tools the clinician may use in making decisions regarding alter-identities, we will take a look at both the DSM-IV diagnostic criteria for DID and the DSM Casebook example of MPD/DID since this is a supplemental diagnostic tool for the therapist. With these two clinicians tools we will begin to formulate some questions and problems to do with the diagnosis of MPD/DID. This rudimentary analysis will furnish a basis for understanding how and why clinicians have interpreted MPD/DID differently. The analysis will also lend explanation as to why most clinicians continue to defend both, the existence/presence of multiple personality/dissociated identity, and its status as a disorder.

According to the American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), the diagnostic criteria for 300.14, Dissociative Identity Disorder is as follows. [Throughout the dissertation these diagnostic criteria (DC) will be referred to by their corresponding capital letters (A, B, C, or D), for example DC-A.]

- A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.)
- B. At least two of these identities or personality states recurrently take control of the person's behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children the symptoms are not attributable to imaginary playmates or other fantasy play.¹¹

These are the diagnostic criteria (DC) for Dissociated Identity Disorder. [Please note that identities or personality states can not derive from brain events to be discovered later.

Once any organic cause (brain event) is found, the diagnosis must be changed to something other than a dissociative disorder due to diagnostic criterion D.]

The DC for Multiple Personality Disorder¹² (MPD) is similar to that of DID. The two main differences between MPD and DID are *existence of multiple personalities* versus *presence of dissociated identities*. This, to me, seems to point to a metaphysical difference in two ways: (1) existence versus presence, and (2) multiple personalities (the multiplication of many identities in one body), versus dissociated identities (one identity fractured into many parts or selves). These differences are of debatable consequence to this dissertation for two reasons.

First, due to dissertation focus and size constraints, I make the assumption that presence presumes existence in the context of the clinical meaning of MPD/DID. For example, an alter-identity may exist without ever making itself present to either the client or anyone, including the therapist. But, if an alter-identity is present, then therapists

diagnosing and treating MPD/DID make the assumption that alter-identities exist, continuously, in the client. It is presumed that if the client is MPD/DID, he or she has alter-identities whether those alters are speaking or not—the alters exist at all times whether they are present or not. To deny this and say that alters are present but do not exist, would be synonymous to claiming the client is only MPD/DID when he or she is hearing voices or switching personalities/identities. The diagnosis of MPD/DID is not sporadic—coming and going with the tide of voices. The client either is or is not MPD/DID.

The second reason that metaphysical differences between MPD and DID are of debatable consequence to this dissertation is that I am not investigating the considerable philosophical/metaphysical problems involved in the synonymous use of identities and personalities (and selves, consciousnesses, personality states, conscious states, minds, mental fragments, personality fragments, etc.). Most therapists and most literary reference materials use these words synonymously when it comes to talk of MPD/DID. Therapists may or may not show more caution with word choice in reference to other disorders, but looseness of terminology is used with explanation of MPD/DID. Because I am trying to give new explanation to MPD/DID client suffering and behavior, time constraints do not allow for investigation into the problems associated with the synonymous use of so many terms and subject this thesis to the problems associated with that practice.

In addition to any differences of opinion that MPD/DID terminological synonymy leaves therapists with, the diagnostic criteria do not clarify MPD/DID language either. The diagnostic criteria supply a definition of MPD/DID in general, but do not define

individual terms related to MPD/DID such as identity or self. The diagnostic criteria furnish problematic definition but no instructions. Therapists, untrained in philosophy or metaphysics, are left with no directions on how to determine a distinct identity or personality. There are no instructions for distinguishing between, for example, extreme moods, of one identity as opposed to the presence of a second identity. Also, with the notion of multiple selfhood, a question arises as to which identity is the client's. The diagnostic criteria indicate that alter-identities take control of the client's behavior—it is not the client that performs the switch. Since alter-identities can switch places with the client, how is a therapist to know which of the identities is the client's? In addition, since everyone forgets some personal information, there is no help provided concerning what amount of a person's childhood should be remembered, i.e., no method of determining allowable gap in memory is supplied. Since diagnostic criteria are not instructions, the therapist is left with a whole set of problems when it comes to diagnosing MPD/DID. [This may or may not be true of the DSM-IV as a whole—but it is true of MPD/DID.]

These questions, arising from the diagnostic criteria of MPD/DID, point to problems. Four problems are important and need to be singled out. They are substantial and are dealt with at length in chapter five. But since we are talking about problems stemming from the generalities of the diagnostic criteria of MPD/DID, I want to mention them here. First, there is the problem of who (which who is the real client). It arises from the label multiple personalities/dissociated identity disorder. Second, there is the problem of co-consciousness (how can shared consciousness involve distinct, separate identities). The problem of co-consciousness includes two related problems. It includes the problem

of interpersonality communication (if co-conscious and sharing a medium how can personalities have the necessary to communicate as distinct identities). In addition, the problem of co-consciousness includes the problem of the generation of inner voices (if alter-identities co-conscious with client's conscious how can alter-identities voices be generated separately). These problems arise from DC-A. Third, there is the problem of switching that arises from DC-B (i.e., how can a part of something switch with its intervening agency). And fourth, is the problem of dissociative amnesia that arises from DC-C (i.e., is identities are really separate, and distinct, how can they forget what they never experienced). For now, what is important about these problems, is that the therapist diagnoses and treats clients as MPD/DID either without being aware of them as problems, or the therapist is aware of them but ignores them in order to get on with the task of curing or helping the client with his or her multiplicity/dissociated identity.

We will now review the DSM Casebook case study of a fictional character named Mary Kendall and consider the questions that arise with its presentation. This will help to further demonstrate what clinicians, clients, their families, the media, and the general public face in receiving or considering a diagnosis of MPD/DID.

DSM-IV Casebook Example of DID

Because the DSM-IV diagnostic criteria for DID furnish a definition but no instructions or exemplification, the APA has supplied users with a clinical manual known as the DSM-IV Casebook: A Learning Companion to the Diagnostic and Statistical

Manual of Mental Disorders, Fourth Edition (DSM Casebook or DSMC). Like the diagnostic criteria, the Casebook example of DID does not furnish instructions for diagnosis. [Instructions for diagnosing and treating MPD/DID are usually learned about through MPD/DID how-to literature or how-to seminars, written about or put on by therapists who have developed their own techniques and strategies for same.] But, the Casebook does furnish a fictional example that hints at what clinicians should watch out for when considering a diagnosis of DID. It also leaves the reader with many unanswered questions.

The Casebook includes an imaginary case of DID which exemplifies the initial *covert* nature of the disorder's symptomatology and behavior (as given below). Because the traumatic memories are hidden both from the client and the therapist, the therapist must have some idea of what kinds of questions to ask, what kinds of answers (or lack thereof) to listen for, and what kinds of behaviors or behavioral changes to watch out for. The Casebook example is more than a definition but less than a how-to manual. Whether it is intended for the purpose or not, it serves as an aid for suggesting to therapists what they should look for in a potential DID client.

[For future reference each sentence is numbered. This means that paragraph divisions have been omitted though the words remain the same. Subsequent reference to these examples will appear as, for example, (S-32).]

Mary Quite Contrary

1. Mary Kendall is a 35-year-old social worker who was referred to a psychiatrist for treatment of chronic pain caused by a reflex sympathetic dystrophy in her right forearm and hand.

2. She had a complex medical history that included asthma, migraine headaches, diabetes mellitus, and obesity.
3. She was found to be highly hypnotizable, and quickly learned to control her pain with self-hypnosis.
4. Mary was quite competent in her work, but had a rather arid personal life.
5. She had been married briefly and divorced 10 years earlier, and she had little interest in remarrying.
6. She spent most of her free time volunteering in a hospice.
7. As a thorough psychiatric evaluation continued, she reported the strange observation that on many occasions, when she returned home from work the gas tank of the car was nearly full, yet when she got into car to go to work the next day, it was half empty.
8. She began to keep track of the odometer, and discovered that on many nights 50 to 100 miles would be put on the car overnight, although she had no memory of driving it anywhere.
9. Further questioning revealed that she had gaps in her memory for large parts of her childhood.
10. Because of the gaps in her memory, the physician suspected a dissociative disorder, but it was only after several months of hypnotic treatment for pain control that the explanation for the lost time emerged.
11. During a hypnotic induction, the physician again asked about the lost time.
12. Suddenly a different voice responded, "It's about time you knew about me."
13. The (alter) personality with a slightly different name, Marian, now spoke and described the drives that she took at night, which were retreats to the nearby hills and seashore to "work out problems."
14. As the psychiatrist got to know Marian over time, it was apparent that she was as abrupt and hostile as Mary was compliant and concerned about others.
15. Marian considered Mary to be rather pathetic and far too interested in pleasing, and said that "worrying about anyone but yourself is a waste of time."
16. In the course of therapy, some six other personalities emerged, roughly organized along the lines of a dependent/aggressive continuum.
17. Considerable tension and disagreement emerged among these personalities, each of which was rather two-dimensional.
18. Competition for control of time "out" was frequent, and Marian would provoke situations that frightened the others, including one who identified herself as a 6-year-old child.
19. The subjective experience of distinctness among some of the personality states was underscored when one rather hostile alter personality made a suicide threat.
20. The therapist insisted on discussing this with other personalities, and she objected that to do so would be a "violation of doctor-patient confidentiality."
21. The memories that emerged with these dissociated personalities included recollections of physical and sexual abuse at the hands of her father and others, and considerable guilt about not having protected other children in the family from such abuse.

22. Mary recalled her mother as being infrequently abusive, but quite dependent, and forcing Mary to cook and clean from a very early age.
23. After 4 years of psychotherapy, Mary gradually integrated portions of these personality states.
24. Two similar personalities merged, although she remained partially dissociated.
25. The personality states were aware of one another, and continued to "fight" with each other periodically.
26. It does not take much training in psychopathology to recognize this as a case of Multiple Personality Disorder, which in DSM-IV has been renamed Dissociative Identity Disorder (DSM-IV, pg. 487).
27. Mary apparently has several distinct personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.
28. At various times, one or another of these identities takes control of her behavior.
29. As is often the case, the clue to the presence of the disorder is gaps in the patient's memory—in this case substantiated by unexplained mileage on her car's odometer.
30. Almost invariably, as became apparent in this case, there is a history of childhood sexual or physical abuse.
31. There is considerable controversy regarding the validity of this disorder.
32. On the one hand, those clinicians that specialize in its treatment claim that the condition is much more common than generally recognized.
33. They point out that the diagnosis is almost always first made several years after the patient has had the symptoms, often having accumulated many different diagnoses because of the shifting nature of the symptoms.
34. On the other hand, there are some critics of the diagnosis who claim that most or all cases are either the result of the therapist's suggesting the symptoms or the patient assuming the characteristics of the patient in a famous case of the disorder, such as the Three Faces of Eve.
35. There may well be patients who are incorrectly diagnosed as having this newly fashionable disorder.
36. However, when one has observed in a patient the emergence of an alter with a completely different speech pattern and body language, one becomes convinced of the validity of the diagnosis.¹³

From reading this Casebook example, the clinician is made aware of the possibility that physical ailments may be psychosomatic in origin, that the client may not be aware of having alter-identities, that hypnosis may allow for the presence of alter-identities which in turn account for changes in voice and behavior and give explanation to a client's missing

time. At the same time, the Casebook cautions the therapist that MPD/DID is debatably iatrogenic. Claims of iatrogenesis often stem from the belief that alter-identities can be created during hypnosis or meditative states through therapeutic suggestion (hypnotic suggestion).

The diagnostic criteria and Casebook example use synonymous terminology to describe client behavior such as personality (S-16, 17), (alter) personality (S-13), personality states (S-19, 23), dissociated personalities (S-21), self (S-27), identities (S-28), and alter (S-36). Yet, neither the DC or Casebook explain how to distinguish an alter-identity from the real client (the client may not have been the initially presenting self), or from a self, a personality, a personality state, or from moods, normal fluctuations in personality, normal functions, i.e., character roles, a stress-response, or an act. The lack of instructions and the imprecision of synonymous MPD/DID terminology may add to the ease of mis-interpretation of client behavior and subsequent misdiagnosis of this “fashionable disorder.”

The Casebook indicates that merely experiencing the client’s transformation of identity is what will convince the observer of the validity of the disorder of MPD/DID. But, transformation of identity can occur through acting. Moreover, there are no instructions for distinguishing between clients with real MPD/DID and those clients who pretend to be MPD/DID (i.e., some clients fake MPD/DID because they want to please the clinician and have figured out that the clinician likes saying and having an MPD/DID client). And, there are no instructions for distinguishing between clients with real MPD/DID and those clients who act the role of an MPD/DID client for forensic reasons—

in order to blame a crime on an alter-self so as to be found innocent of criminal charges. The therapist is to somehow “just know” when a client’s alter-identities are real and when they are acted; there are no instructions to help make these kinds of decisions. The decision between real alter-identity and acted alter-identity is left up to the therapist’s interpretation of client behavior.

The DSM and Casebook example are very general, use synonymous language, and are open to interpretation. The following clinical views of MPD/DID will show the divergence of clinical opinion that results from this imprecision present in the diagnostic criteria and the casebook example.

Clinical Interpretations of Diagnostic Criteria and Casebook Example

In spite of there being one set of diagnostic criterion for MPD/DID, and one Casebook example, there are many clinical interpretations of multiple personality/dissociated identity. Lacking very much in the way of instructional material for diagnoses and treatment, except the DSM and DSMC, which are general and riddled with problems, clinicians have been left to intellectually “feel” their way through the diagnosis and treatment process.¹⁴

Alternatively, beginning MPD/DID diagnosticians can rely on learning from those few clinicians and theoreticians who took the time and effort to produce written works of case studies,¹⁵ theories,¹⁶ and how-to manuals, or how-to seminars. One would think that since clinicians trained each other or read each other’s works that there would be some

modicum of general consensus of interpretation of MPD/DID diagnostic criteria. Well, there is not (as may or may not be the case with other disorders).

Part of the problem stems from the synonymy of MPD/DID terminology, as indicated previously. It is not that any particular therapist has a problem using terms related to selfhood as synonyms. The point is that the synonymy of terms such as personality, identity, self, alter-identity, etc., bring about a divergence of opinion within the clinical industry as to what it meant by MPD/DID and whether it is valid. Therapists do not know, and argue over, whether alters are persons, selves, personalities, personality states, multiple consciousnesses, separate identities, or separate fragments of one identity. Some therapists have even considered that none of these options are true about alters and believe instead that the client suffers from delusions that he or she is multiple people in one body. [The name change from multiple personalities to dissociated identity disorder did not resolve the problem—many clinicians and clients still refer to the disorder as MPD.] Clinicians still disagree as to how to think about alters.

When it comes to MPD/DID synonymy of terminology is problematic because personality, selfhood, and identity are complex issues. They have social, moral, spiritual, political and metaphysical-ontological components. Clinicians cannot spend exorbitant amounts of time theorizing about selfhood. They need to grab on to a position on the matter and proceed forward with diagnosis and treatment (or so they are led to believe by their discipline).

Still, the topic of selfhood, as clinically unsettled and unattended to by therapists, has left them to interpret MPD/DID as they see fit. This has resulted in at least five

interpretations of whether alter-selves exist, how they exist, what they represent, and how they are to be therapeutically treated. The diversity is both surprising and, at the same time, not so surprising. It is surprising to see any diagnostic criteria—meant to delimit one disorder from another—result in such a wide range, in fact, a contradictory range of interpretations. The diversity of interpretation of MPD/DID diagnostic criteria is not so surprising in that multiplicity is, in part, about a slippery philosophical subject, i.e., metaphysics, as much as it is about psychology/psychiatry.

The following five clinical views of MPD/DID are very general. I will present sketches of the differences—just enough to contrast the pertinent points of interpretation of multiplicity/dissociated identity as a disorder. Diagnosis and therapy go hand in hand. A variation in view means a variation in treatment. Variations in interpretation may take the form of what to do about the multiplicity and may not be just about the existence of the phenomenon. An overview of each of the five views will be given, followed by a brief explication of each. I say “brief” because to present, compare, and contrast each view could take a chapter. That is unnecessary for the task at hand, which is to show that the diagnostic criteria, in their generality, result in diverse clinical interpretation and disagreement about the metaphysics of alter-selves.

The following is an overview of the five clinical interpretations of MPD/DID:

- (1) Alter-selves are multiple persons, i.e., are literally separate, real persons in one body. MPD/DID is trauma caused. Multiplicity needs to be corrected by cathecting these traumas to facilitate integration of the many selves.
- (2) Alter-selves really exist, but are not persons—they are rather personalities, personality states, states of consciousness, or multiple consciousnesses. MPD/DID is trauma caused. The multiplicity needs to be corrected by integration or fusion therapy.

- (3) Multiple personalities/dissociated identities really exist as dysfunctional dissociated states. The problem is not that the client is more than one person—he or she is rather less than one person due to these dissociated states, i.e., due to a fractured self. The fracturing is trauma caused, but multiplicity should not be the main focus of therapy. MPD/DID should be declassified as a superordinate disorder because therapeutically addressing other features of the client's dysfunction results in a more rapid cure.
- (4) Alter-selves are not real, are not persons, or personality states. MPD/DID is trauma caused. Use of the language of alter-selves, etc. is metaphorically helpful in describing the client's experience. The descriptors of MPD/DID are metaphorical tools useful for moving the client toward mental health.
- (5) Alter-selves are iatrogenic artifacts. Alters are real in that they are acknowledged as existing by client and therapist. Therapists cause the multiplicity. If alters are not treated or acknowledged they quickly disappear. This group believes that multiple personality/dissociated identities should be declassified as a superordinate disorder and not reclassified as an ordinate disorder because multiplicity is brought on by therapeutic intervention.

It will help to verify these five clinical camps of thought on MPD/DID by referring to some specific psychiatrists who hold each of these views.

(1) There are those, like Dr. Robert A. Phillips, Jr., therapist for Truddi Chase¹⁷ and her "Troops," who believes that multiple personalities are real and that they are persons. This group believes MPD/DID is caused by early childhood abuse. Phillips vacillates between referring to Truddi's people metaphorically and literally, but most of the time is adamant that Truddi has people inside her. First, he says Truddi survived long-term, extreme childhood abuse "and, in effect, she became many persons housed in one body."¹⁸ But then, Phillips affirms that alter-identities are persons when he says that the story of Truddi's troops "is in actuality the story and creation of the many persons who cluster within her."¹⁹ He reaffirms the literal view that alter-selves are persons when he says, "The growing body of data indicates that the personalities (or "persons," as some

multiples prefer to call them) are quite different and in fact are unique individuals.”²⁰ And again he says, “Since each personality is significantly different from the others (and Dr. Putnam has demonstrated that the differences are measurable), what we see are the reactions and actions of different people.”²¹ Though Phillips, and many in this group seem confused about alter-selves, they often do refer to them as persons and treat them as persons, i.e., autonomous, temporally continuous flesh and blood human beings. This group believes the multiplicity/dissociated identity needs to be corrected by integration of the various persons.

(2) Next, those who believe alter-selves are real, not persons, but rather separate, distinct, autonomous, identities, selves, personalities, personality states, or states of consciousness of one individual, include believers of the Familiar View. Identity, self, personality, personality state, and states of consciousness are not individually defined by this group, leaving much room for confusion. But, this group insists that alters are not persons (though person is undefined). For group two believers there is only one person, i.e., the client-proper. The Familiar View is the classic APA view as presented in the DSM-IV and in the DSMC. This group believes in correcting the multiplicity/dissociated identity by integrating or fusing the personalities into one complete whole, if possible.

(3) A third group, like MPD/DID specialist Frank Putnam, believes in a deeper explanation of the Familiar View as a literal self (a singleton), but one fractured or dissociated into actual, separately functioning, states of consciousness (of one person), prompted by dissociation from abuse experiences.

Therapists in this group, unlike groups (1) or (2), do not take sides as to the status of the alters—as to whether they are real people, real personality states (identities, selves, personalities, etc.), “as-if” personalities, or metaphoric constructs. And unlike groups (1) and (2), these therapists believe that the multiplicity should *not* be the primary focus of treatment. They believe that the presenting symptoms of the MPD/DID client are more indicative of other superordinate disorders such as Schizophrenia, Post Traumatic Stress Disorder (PTSD), Bi-polar Disorder, Obsessive-Compulsive Disorder (OCD), or a combination of disorders and syndromes. Putnam says, “At present we conceptualize this condition as a complex form of posttraumatic dissociative disorder, highly associated with a history of severe trauma usually beginning at an early age.”²² This group believes dissociated identities should be classified as an ordinate disorder. Ordinate disorders are extenuating problems—they exist in conjunction with or because of a primary or super-ordinate problem. The therapeutic contention is that if the super-ordinate problem is alleviated then the ordinate problem(s) (e.g. dissociated identity) will be alleviated at the same time. This group believes that direct treatment of multiple personality is misguided and not in the best interest of helping the client heal in the quickest way possible. They believe, for example, that treating Post-Traumatic Stress Disorder will alleviate both post-traumatic stress and the co-active symptoms of multiplicity/dissociated identity as well. Some of these therapists want the APA to delete the classification of DID in order to give preferential treatment and super-ordinate status to other (currently ordinate) symptoms.

(4) The fourth camp believes multiple personalities are not real, but are instead metaphors that provide a way of talking to clients about their given sets of experiences.

This group assumes all persons are single individuals ("singletons"), i.e., that each client is one mind and one body in a one-to-one relation. These therapists acknowledge that clients often believe themselves to literally be multiple identities or multiple persons in one body. Since the client already believes this about him or herself, therapists in camp four believe there can be no harm in using the client's language of multiplicity metaphorically. Group four therapists believe that metaphorical descriptions about the client's behavior are useful; it makes it easy for the client to understand his/her problems rather than trying to explain it using psychiatric jargon. This group also believes abuse is the cause of the multiplicity/dissociated identity.

There is a division of thought within this group between believers of using any metaphors that will help and those that believe that only those metaphors that are client-derived are useful, (designated 4-A and 4-B, respectively).

Some therapists (4-A) believe it ethically acceptable to use any metaphysical metaphors to describe client behavior. These therapists find metaphors helpful in educating the client about his or her disorder. Ellen Y. Siegelman's work on Metaphor and Meaning in Psychotherapy includes many examples of this trend for therapy in general.²³ These therapists believe there is no harm in the metaphorical use of words like personality, personality state, identity, alter-self, alter-consciousness, self.

The alternate perspective within this group (4-B) involves therapists who believe it is only ethical to use client-perpetrated metaphors.²⁴ These therapists believe in not imposing metaphors of selfhood on the client but rather using whatever metaphors the client brings to therapy. Group 4-B is unsure of the ethics of imposing an outside

language of selfhood on the client. So, for example, if the client talks about the *persons* inside her, then this is the language the clinician adopts during therapy. Or, if the client speaks of his or her personalities, or alters, or of the many identities in her body, etc., this is the language the therapist adopts to help the client heal. These therapists believe it is psychologically safer to adopt the client's metaphysical metaphors rather than imposing the therapist's own choice of metaphors on the client.

Now, depending on one's view of metaphor, the question might arise as to whether metaphorical talk can be about real entities,²⁵ i.e., real alter-identities. It could be that alters really exist as separate, distinct, autonomous identities housed in the mind of the client. It would be subject to debate whether these identities, when spoken of metaphorically, refer to something real or instead refer to something "as if" it is real. This depends in part on one's definition of metaphor. It could be the case that a client knows he has real alter-identities inside him, believes metaphors can be about real entities, and so refers to his real alter-identities metaphorically. But, for the purpose of understanding group 4-A and 4-B, these therapists do not believe the client's alter-identities are real, and so to them the word 'metaphor' is meant as a figure of speech in which one thing is spoken of as if it is another. This suggests there could be a case wherein, at the same time the client is speaking in metaphors and referring to something real the therapist is using the same metaphors but referring to something not real. However, in practice diagnosis and treatment is done usually from within a patriarchal system, and it is the therapist's interpretation of events that holds sway.²⁶ And in this case, both camps of therapists (4-A

and 4-B), since they believe alters are metaphoric tools, talk about the client as-if he or she has multiple personalities, and do not really believe in multiple selves in one body.

This is not to be confused with 'as-if' personality—wherein a client pretends to be MPD/DID. The view of metaphor of those perpetrating MPD/DID is irrelevant for the purpose of explaining group four's view. But, counter to this, if the client believes he or she has real entities inside him or her, the group four therapists, in believing alters do not really exist, interpret the client's talk as indicative of hallucinations. As far as group four is concerned, metaphors refer to imagined or hallucinated identities.

It should be noted that, some therapists' views could be placed in more than one camp. For example, Ross's view is a combination of camps (3) and (4). As in camp (3) he believes that there is only one self, but understands that, as in (4), clients believe themselves to literally be multiple persons in one body. This, Ross says, is a result of dissociative delusions (the false belief that one is many people). Ross agrees with (3) that the client is more quickly helped by focusing on Post Traumatic Stress Disorder (PTSD).

(5) The fifth clinical camp regarding MPD/DID is comprised of those individuals who believe multiplicity is not "discovered" but is rather "created" by therapists. Camp five believes multiplicity/dissociated identity is not caused by childhood abuse but is rather a result of misguided diagnosis and treatment, i.e., is an iatrogenic disorder. This group believes that the therapist creates the multiplicity by encouraging clients to answer questions and act as though they are multiple. Therapeutic directives such as hypnotic suggestions, leading the client, asking metaphysically presumptive questions, therapeutic interaction with proclaimed alter-identities, inner voices, moods, and treating the person as

multiple are believed to prompt clients into coming to see and define themselves in terms of having or being multiple personalities/dissociated identities.²⁷

Paul R. McHugh is a prime proponent of this view.²⁸ He believes multiplicity/dissociated identity is a therapeutic artifact—that multiplicity is “forged” by the therapist as an artisan forges a sculpture. This view is like that of the French psychologist, Pierre Janet, who came to believe that naming alternative behavior could “crystallize” or personalize behavior in the client’s thoughts in a way whereby the behavior is subsequently viewed by the client (and others) as a real self or person. For McHugh and Janet, MPD/DID is real, i.e., lived as real by the client, but created by therapists.

The cure for artifactual MPD/DID, according to McHugh (and Janet), is to discontinue treating the multiplicity by ignoring alters presented by the client. In other words, leave the personalities alone and they disappear. A personality requires an audience to be acknowledged and allowed to thrive. An additional way to accomplish cessation of alter-identities (besides ignoring them) is, according to McHugh, to declassify MPD/DID as a superordinate disorder. The goal of treatment for a disorder is aligned with the classification of a disorder. By stepping MPD/DID down from superordinate status, the focus of treatment gets rerouted from MPD/DID to the new superordinate classification—for example, post traumatic stress disorder (PTSD). This would mean that the new focus of treatment would, for example, be recovery from PTSD rather than the exposure and integration of alter-identities. This group believes that a reclassification of client symptoms would result in therapists ignoring multiplicity. Iatrogenic alter-identities of persons currently classified MPD/DID would then disappear through lack of attention.

What is interesting about these various divergent clinical views of MPD/DID is that they all share some things in common. First, all of them maintain that MPD/DID is real—either to both the therapist and client or at least to the client, i.e., (a) either literally real (alters are real persons), (b) alters are real personalities/identities but are not persons, (c) alters are metaphorically real (real for the client only, re-affirmed and sanctioned as real by therapists' use of metaphors), or (d) delusion-based (the client's reality, i.e., fantasy logic). Secondly, all of the views maintain that multiple personality/dissociated identity is a disorder, whether it is real, metaphoric (as-if real), or iatrogenic. Thirdly, all views hold that multiplicity/dissociated identity needs to be corrected, either overtly by fusion or integration therapy, or covertly, by treating other more important client symptoms while ignoring iatrogenically created alter-selves. And fourthly, at the heart of all of the views is not merely an intellectual exercise, but rather a genuine concern over what is the correct, i.e., the most healthy, way to describe and treat clients' suffering. Even though these various camps of thought may result in varying conceptions of the particulars of MPD/DID therapy, therapists in all camps are striving for a healthy approach to alleviation of the superordinate problem of MPD/DID.

Please note that some therapeutic disciplines do not lend themselves to sympathetic interpretation of MPD/DID and so have not been included above. One example will suffice to make this point. For example, I have not included views that some might consider materialistic, such as that of therapists who classify themselves as psychopharmacologists. The word psychopharmacology is a fairly recently coined, combination word. It seems to me to be indicative of an attempt to put back together the

mind and body dualism used by therapists. The word “pharmacology” is the science of drugs or the art of preparing medicine, while “psycho” has to do with the mind (the psyche), as in the case of a “mentally” disturbed person.²⁹ The word psychopharmacology has to do with how drugs affect the mind. While therapists make a division between mind-therapy and brain-therapy (i.e., drug therapy), psychopharmacologists do not. Remaining true to the tenets of *psychopharmacology*, i.e., that drugs can affect the brain as well as the mind, would adversely affect the meaning of MPD/DID. One would have to presume, for example, that a client’s inner voices were caused by a *psychophysiological* alteration (such as a chemical change in the brain) rather than being the articulation of a purely psychological experience (i.e., mental state or mind event) indicative of an alter-identity. Attributing a psychophysiological alteration to an inner voice would prompt the psychopharmacologist to treat the inner voice with a medication rather than to treat it as a separate, distinct, autonomous identity. A psychopharmacological interpretation of inner voices runs counter to the dictates of DC-D and the treatment of inner voices by medication runs counter to DC-A, DC-B, DC-C. In other words, a psychopharmacologist, confronted with making a diagnosis of MPD/DID and subsequently treating that disorder, must choose between remaining true to the dictates of his or her discipline and remaining true to the diagnostic criteria of MPD/DID, for the two run contrary to each other.

As pertains directly to this dissertation, another very important and under-developed, under-investigated, point remains—one that was mentioned briefly, earlier. It is generally agreed among clinicians who diagnose MPD/DID, that multiplicity/dissociated identity exists for the MPD/DID client. These clinicians believe that the client is not

putting on an act, nor pretending to have multiplicity, the client is not faking or acting “as-if” he or she is multiple, nor enacting a role—he or she is really suffering.³⁰ This point is fundamental to the reality of MPD/DID. I have named this clinically accepted belief about MPD/DID the alter-actor distinction. All five views believe in the alter-actor distinction.

Secondly, all views believe that because the client is not able to control his or her switching and its subsequent dissociative amnesia, multiplicity/dissociated identity is a disorder. In other words, multiple personality/dissociated identity is a mental illness that needs to be corrected.

Both points, that MPD/DID is real (not acting) and that it is a Disorder, are of primary considerations that must be addressed. Ross is the only therapist I know of who even attempts to bridge the alter-actor gap. He is the only clinician or philosopher who has overtly considered MPD/DID clients to be acting. Even so, Ross claims a difference remains because clients are importantly unlike professional actors in certain respects. (Ross’ view is presented more fully in chapter four.)

The disagreements among clinicians over MPD/DID have to do with the genesis of the phenomenon, clinical classification of it, superordinate versus ordinate status, and treatment strategy. All of them make a distinction between multiplicity/dissociated identity as a real (existing or created) condition of the client or as a delusion of the client. These disagreements are substantial considering they all stem from one set of diagnostic criteria.

But even though clinicians diverge in their interpretation of the diagnostic criteria for MPD/DID, the focus of this dissertation is on problems that arise from what they all assume to be the case. Even though these clinicians disagree on some details about the

diagnosis and treatment of MPD/DID, they all agree it is (or becomes) real and in need of correction, either by therapeutic intervention or else by therapeutic disacknowledgement of alter-identities. For that reason, this dissertation is involved with what it means to clinically say that MPD/DID is real, not faked.

Summary

In this chapter, reasons were explored as to why multiplicity/dissociated identity not only seems plausible, but probable. But the plausibility of multiplicity presents us with the problem of how to encapsulate and articulate the psychopathological transformation from single identity to multiple identity. MPD/DID diagnostic criteria and the Casebook, two tools of the clinician, did not help in this, in part because of their generalities and ill-defined synonymous language of selfhood. Five different clinical interpretations of MPD/DID were presented to demonstrate this fact.

In summary, it is what these various interpretations have in common that is subsequently being investigated in this dissertation: that multiplicity/dissociated identity can and does exist; that it is the result of long-term use of extreme dissociation; and that it is a disorder; that multiplicity/dissociated identity is about mind (not brain), and that clients are not acting, i.e., MPD/DID is real, not faked. It is what each of the various views have in common that is substantive to arriving at a new explanation, a much needed and less problematic explanation, of client behavior.

Notes

¹ Putnam, "Dissociation. . ." 76-77. "In the vast majority of recorded cases, the first splitting off of an alternate personality appears to occur within a window of vulnerability extending from age six months to approximately 12 years." He cites himself, 1983; Greaves, 1980; Bliss, 1980; and Stern, 1984.

² Frischholz 104-05. According to Frischholz, "During the 1920's through the 1950's, psychology was heavily influenced by the behaviorist views of Watson, Hull, and Skinner. As a result, many psychologists preferred to focus on fluctuations in observed behavior rather than reported alterations in conscious experience. This turning away from the study of experience may have contributed to facilitating psychologists' misdiagnosis of multiple personality disorder. [. . .] renewed attention paralleled a rise in the influence of the humanistic school of psychology, which accepted a person's description of his or her conscious experiences as valid scientific data." The presentation I am giving is a combination of schools derived from talks with therapists and various literary sources involving case studies. It is meant as a general overview and not representative of a specific school of thought or specific therapeutic method.

³ Confer and Ables 25.

⁴ Frischholz 104-5. It is important to note that when the radically dualistic psychiatric system and method diverged away from the initial analysis of MPD/DID as a mind event, to behaviorism as a behavioral event, the incidence of diagnosis decreased. The incidence of diagnosis increased again when humanist psychology started paying attention to MPD/DID as mind, i.e., consciousness oriented. The metaphysical assumptions underlying the disorder of MPD/DID matter to it's incidence, recognition, description, assessment, and treatment.

⁵ Putnam, "Dissociation. . ." 77 (emphasis added).

⁶ Ross 187, 192. "Everyday dissociation occurs at a more mundane level. [. . .] Divided consciousness is required [. . .]." So, whether we are speaking of normal people or mentally ill people the doubling of consciousness is necessary for dissociation to occur. Dissociation means doubling of consciousness. Ross explains that, "The goal of the treatment of MPD is not to produce someone who never dissociates." Ross later goes on to say that, "The MPD patient also needs to learn how to be a single person." As can be deduced, the difference in the divided consciousness of the "normal" person's dissociation and that of the MPD patient is that the patient's dissociation has resulted in the

consciousness becoming more than momentarily divided. Having dissociated for long and short periods of time the consciousness permanently or semi-permanently divided and created me/not-me barriers between that states of consciousness. These barriers encapsulate the various personalities. The patient then needs help fusing or integrating these states of consciousness—these identities—into one. The patient can, through the process of integration, learn how to be a single person again or for the first time—or so the theory goes.

⁷ Ross 103.

⁸ Frischholz 105. “DSM-III facilitated the study of multiple personality disorder by identifying it as a dissociative disorder distinct from the hysterical neuroses, and establishing diagnostic criteria.” It may seem a simple point but it is an important one, that without the diagnostic classification and criteria of MPD/DID there would be no diagnosis of it. It would be either disacknowledged or called and treated as something else.

⁹ Ross 220-242.

¹⁰ Ross 242-46.

¹¹ DSM-IV 487.

¹² DSM III and DSM III-R.

¹³ DSM Casebook 56-58.

¹⁴ As late as 1979, almost a hundred years since the first official diagnosed case, information on diagnosis and treatment was beginning to surface in the academic realm. For example, Colin Ross, MD, says in the preface of his book Multiple Personality Disorder, Diagnosis, Clinical Features, and Treatment (1989), “I must acknowledge that I launched into my first case without adequate training or supervision: I hope that this book will be helpful for clinicians who find themselves in a similar situation.” Ross’s first case of MPD was in August of 1979.

¹⁵ For example, Morton Prince’s case study of Miss Beauchamp in 1908, the story of Sybil, or the story of Eve Black, etc.

¹⁶ For example, William James became known as the father of dissociation because of his work (a result of conversations with Pierre Janet) on the psychology/phenomenology of secondary selves in his two-volume set of The Principles of Psychology. James’s work has been cited in several books as supporting MPD/DID.

¹⁷ Chase viii, xi.

¹⁸ Chase xi.

¹⁹ Chase viii.

²⁰ Chase x.

²¹ Chase x.

²² Putnam, "Debate Forum. . ." 960.

²³ Siegelman 1-183.

²⁴ For example, Pam Birrell, University of Oregon Professor of Psychology and MPD/DID counselor, expressed to me in a personal conversation that she limits her metaphysical metaphors to those of the client. (1993)

²⁵ Johnson, Mark. Clarification prompted by note to author. 26 Oct. 1999.

²⁶ Brown 203-04, and Ross 225-26.

²⁷ This reminds me a bit of Hacking's view of retroactive redescription and the looping effect of human kinds though there is no time to effectively compare and contrast the two.

²⁸ McHugh 957-63.

²⁹ The Merriam-Webster Dictionary

³⁰ Humphrey and Dennett 93. "Multiplicity is seen as a semi-inspired, semi-heroic condition: and almost every claim relating either to the patients' abilities or to the extent of their childhood suffering is listened to in sympathetic awe."

CHAPTER III

THE DISSOCIATION CONTINUUM

Dissociation is the foundation of MPD/DID. It is the basis for each of the four diagnostic criteria of the disorder. Diagnostic criterion A (DC-A) refers to dissociated identities, DC-B refers to switching identities which involves the experiential process of dissociation, and DC-C has to do specifically with “dissociative” amnesia (psychological amnesia resulting in time gaps and hidden memories). [DC-D is the qualifier that excludes non-dissociative amnesias from MPD/DID.] Clinically speaking, it is the experience of a particular degree of dissociation that results in multiplicity, its corresponding behavior, and its negative side effects. The particular degree of dissociation required for MPD/DID is extreme.

Degrees of dissociation suggest the existence of a continuum of experience. Dissociation is a widely diverse phenomenon. It is clinically talked about along an experiential continuum. Normal dissociation is healthy, even necessary, for daily functioning, while an extreme level of dissociation is considered abnormal and dysfunctional. The dissociation continuum is helpful in conceiving of how normal childhood playacting can be used to an extreme to block out the pain of abuse. But, when dissociation is talked about in terms of both normal and definitively, classifiably, abnormal

(extreme) behavior, this means that at some point on the continuum a line occurs between the two degrees/levels of experience. I refer to this as the dissociative continuum normal/abnormal demarcation line.

So, with the concept of dissociation as a continuum arises a question—what normal experience of dissociation immediately precedes abnormal dissociation? Clinical literature does not say or even suggest an answer. Is the experience of a first time mother dissociating momentarily from motherhood and leaving the house without her new baby indicative of normal (non-diagnosable) but borderline extreme dissociation? Or, does the case of a new employee arriving at work, only to realize he has arrived at his old job, count as that nearly extreme dissociative experience? Or, since MPD/DID starts in childhood, with the child using normal dissociation to pretend to be someone else, is it more likely that acting precedes psychopathology on the continuum? What makes the adult version of childhood playacting (alter-making) abnormal and, for example, professional acting normal? When MPD/DID clients switch identities, their behavior, voice, facial expressions, etc., transform who they are. But then, actors, too, experience these transformations when performing and switching characters. Does acting require the use of dissociation? Does it require the use of the same level of extreme dissociation as alter-making? Supposedly unlike actors changing roles, alter-identities take control of a client's behavior. But then, actors sometimes talk of being overcome by the characters they play. MPD/DID clients sometimes have difficulty returning to their 'regular' self during therapy after an alter-identity has come "out." But, actors too, report of difficulty coming out of character and returning to their 'normal' way of being. Actors' spouses

complain of actors bringing their work home in the form of changed personality. Yet, acting is considered normal while alter-making is considered abnormal. Does acting require just enough less of dissociation that it results in normal behavior whereas alter-making results in a psychopathology? If so, in what does that lesser degree consist? What is the difference between alter-making and acting? And, although acting is not the main focus of this chapter, the question of where it falls on the dissociative continuum is important to understanding dissociation as a continuum and to understanding MPD/DID as a psychopathology.

This chapter serves as a beginning for figuring out a problem central to this dissertation, that of whether the client is an actor. If both acting and alter-making involve extreme dissociation, then it needs to be determined whether MPD/DID clients are enacting various roles instead of splitting into “real” separate autonomous identities. Questions such as these need to be addressed before we can come to a conclusion about whether alters are actors. I refer to this problem as the alter-actor distinction. [The alter-actor distinction is the focus of the dissertation in general, and of chapter four in particular.]

The purpose of this chapter is to gain a deeper understanding of what is clinically and philosophically at issue in the clinical demarcation between acting as a normal dissociative experience and alter-making as an abnormal, psychopathological experience. The demarcation of some level of dissociation as a psychopathology forms the basis of the alter-actor distinction. To investigate the normal/abnormal dissociative continuum demarcation line, I will try to make sense of what is meant by dissociation, the dissociation

continuum, and the benefits and problems associated with thinking of dissociation as a continuum. In addition, consideration needs to be given to several aspects of the dissociation continuum. These include: discussion of the double bind problem that dissociation presents; problems of hierarchization of experiences of dissociation; the normal/abnormal demarcation line; the role that theories of split-consciousness play in the fluidity of the continuum; and one clinician's preference for a quadrant of dissociation over a continuum. These problems will be discussed in an attempt to help clarify where the phenomenon of acting is to be placed on the continuum/quadrant of dissociation in order to compare it to alter-making, and in order to question whether the normal/abnormal demarcation line has been appropriately drawn.

To understand what is philosophically at issue for dissociation as a continuum we will look at modifications of the definition of dissociation since its inception. A focus in our discussion will be given to the role that nature-nurture debates play in the concept's development as a continuum. This will lead to an understanding of how dissociation manifests as a continuum and in turn gives rise to the alter-actor distinction. Two theories of split consciousness will be investigated to show which one gives the most direct reason for the alter-actor distinction.

Lastly, there is a common thread—the technique of hypnosis, amongst the diversity of experience within the normal to abnormal continuum of dissociation. The possibility that the technique used to switch alters is the same as the technique used to enact character roles will be explored. Exploration of dissociative delusions as a *normal* (common) result of enacting character roles will help close the gap between alters and

actors. The discussion in this chapter will lead into the next chapter, which is entitled *Alters Versus Actors and The MPD/DID Client-Actor Model*.

Examples: Dissociation and Its Diversity

Dissociation involves a wide variety of experiences, making it a complex topic to analyze and discuss. Because of this we will start off with a general explanation of the phenomenon (and move to a more complex version by chapter's end). The difficulties of explaining dissociation will become evident throughout the chapter.

In general, dissociation is basically defined as doubling—doubling of consciousness, splitting of consciousness, or doubling of attention. It can also mean the opposite of association, i.e., dis-association, which is typified by doing two things at once while remembering only one of them. It is as though there were two consciousnesses, one focused on the first task, the other on the second task, but “you” only focused on one, which is the one you remember. The doing of the other task is forgotten partially or completely—a “dissociative” amnesia of the psyche or mind (not the brain).

The following experiences all have dissociation in common: you realize by the time you get to your car that you do not remember whether you locked the house door, because you were worrying about whether your car would start as you left the house; you do not remember whether you turned off the oven because you were thinking about the harsh words you just had with your child; you read a page and a half in a book, and then realize you do not know what you have read because one of the sentences sent your

thoughts off in another direction; you get almost to work and realize you do not remember driving through the tunnel you had to have passed through to get where you did; you were so engrossed in typing at your computer you do not remember you are cooking dinner until you smell the burning food; as a teenager returning home after spending two days with a friend you start talking like your friend without realizing it; you perform a character role in a play and afterwards continue to act like that character, forgetting for a few hours how to be yourself again; you find new clothes in your closet that only you could have put there but do not remember buying; you find unaccounted for mileage on the car only you have driven; some people call you Sally when your name is Sarah; you wake up after a night of drinking to find you have acquired an unknown bed partner; you wake up in bed, and do not realize that the man next to you is your husband of twenty-two years—you do not even remember getting married and you do not even think you are old enough to have gotten married; you do not remember that you were tied up and burned with cigarettes as a child; and you forget you were, as a child, continually sexually abused by your father. These very diverse experiences each have dissociation in common.

It is the diversity of dissociative experience that supports the notion of a continuum of dissociation. A clinical continuum involves a range of experience from normal to abnormal—in this case from normal dissociation to abnormal dissociation. We all dissociate every day, but some situations involve a greater degree of dissociation than others do.¹ Dissociation, according to many current day clinicians, is a common useful ability that can be taken to an extreme given unusual, long-term, fearful, or painful situations.² On the one hand, it is a necessary human ability that enables us to accomplish

many things. For example, the ability to ignore certain perceptual stimuli while intensely focusing on other stimuli is a dissociative technique. For example, humans are able to enjoy sex more fully if they can dissociate—concentrate on its pleasures by blocking outside interference such as the phone ringing, neighbors fighting, a messy room, or even the other's bad breath. Or, the ability to dissociate enables us to stop paying attention to the mechanics of driving the car in order to pay attention to other important considerations such as reading traffic signals and watching out for children who may be playing near the street. Dissociation can also be used to enter a meditative state. Or, it can facilitate such experiences as automatic handwriting, hypnosis, or trance states for pleasure, entertainment, or therapeutic reasons. More importantly for this dissertation, dissociation can be used to “detach” from one's self and subsequently appear to others as “someone” else. All of these experiences involve dissociation. It can be used to accomplish many tasks and to have pleasurable experiences, or to avoid pain.

When dissociation is abused or used habitually as a coping mechanism it can result in dysfunction. It is the most extreme use of dissociation that is clinically thought to result in MPD/DID. When someone is abused, it may be fortunate that he or she can dissociate to the point that he or she does not acknowledge the pain and suffering he or she is going through. Clinicians believe that dissociation can be used to create the alter-selves that will block out the pain of abuse and lock away its memories. The diagnostic view of MPD/DID in general is that extreme situations offer the necessary medium for the production of extreme dissociation which, in its extreme form, can result in what clinicians refer to as the splitting of the self into many consciousnesses, i.e., identities, selves, or

personalities. Each of these selves can then switch; alter-self can replace alter-self without the adult client being able to control the switch or even know about her alters until therapeutic intervention and education. Extreme dissociation is considered as being used in the creation and maintenance of alter-identities and MPD/DID.

All of these diverse behaviors, from the mundane to the extreme, are examples of dissociation and provide support for the notion of dissociation as a continuum. Some are of little consequence; others are shocking because of the abuse involved in triggering the dissociation. We normally think that extreme events would overtly imprint themselves into our memories forever, immediately available for recall. The fact that extreme events can occur and be forgotten, hidden, or repressed seems odd, but that these forgotten, i.e., dissociated, events have anything in common with mundane dissociation seems even more surprising. In addition, this makes it seem like we can control or choose what we want to repress and what we want to recall. Yet, repression has to do with lack of choice, i.e., with the inability to remember something. The common experience of dissociation can supposedly be taken to the extreme with troubling results for the user.

Still, in spite of the plausibility of a dissociative continuum and the ability of dissociation to play a role in exhibiting a multiplicity of identities, a problem arises as to interpretation of behavior. We can talk about changing behavior in various ways. We could say that dissociation can be used to enact multiple roles, as we do in our daily lives, and as actors do on stage or in the movies. Or, we could say that dissociation is used to create alter-identities and results in the diagnosis of MPD/DID as a mental illness.³ How the phenomenon of changing identities is characterized matters. It determines whether we

see MPD/DID as indicative of “real” separate autonomous identities, or merely as enacted character roles.

A Multiple of Continuums

MPD/DID is the most extreme form of dissociation. The extreme use of dissociation results in the creation of alter-identities. If the diagnostic criteria for MPD/DID are to be taken seriously as to the existence/presence of two or more distinct identities in a client, then a commitment must be assumed as to the reality of these alter-identities for the purpose of comparing them to actors character roles. Determining whether the level or degree of dissociation used to produce real alter-identities (abnormal dissociation) is the same as the degree of dissociation used to enact character roles (normal dissociation) is no straightforward task. Dissociation is a complex and complicated issue.

When dissociation is considered normal and natural, then the dissociation continuum may seem problematic. If dissociation is so common and even *necessary* for daily functioning, it is unclear how its extreme form can result in mental disorder. And, if dissociation is used for childhood playacting, it seems odd that the same degree of dissociation and its resulting behavior as an adult, i.e., continuation of the playacting, is considered, not socially abnormal, but instead mentally abnormal. But, it could be contended that childhood playacting does not involve the same degree of dissociation as MPD/DID alter-making, i.e., that childhood playacting may be one of the many

experiences on a dissociative continuum, but it is not equivalent to exhibiting the same behavior as MPD/DID switching. If childhood playacting, in its most serious form, is not the same behavior seen in adult MPD/DID, it seems curious that clinicians, and the American Psychiatric Association in particular, have determined that the ability to extremely dissociate is learned in childhood by pretending to be other people. It seems incongruent to say that childhood pretending is representative of normalcy and MPD/DID is representative of mental illness. This is a problem that needs to be investigated.

Though dissociation is believed to incorporate a continuum of experience, the continuum has not been formalized or articulated. Colin Ross disagrees with the accusation that an unarticulated dissociative continuum is problematic and believes the ordering of dissociation involves a “simple organizational principle” while admitting this principle is not yet supported by scientific data.⁴ But, as will be shown, differing continuums, scales, quadrants, etc., could be derived from the various definitions and aspects of dissociation, making the chore of designating and articulating only one continuum nearly impossible and maybe impractical.

We'll consider various continuum possibilities as regards dissociation in an attempt to understand what dissociation and its continuum clinically mean. When we think of a continuum, we most often imagine a flat line continuum with a pole at each end. In the case of dissociation, we might think of a horizontal line with normal dissociation at the left pole and extreme dissociation at the right pole. We then simply imagine that at some point on this line, normal dissociation becomes extreme, abnormal and dysfunctional. This flat line continuum of dissociation seems simple enough until fully considered.

For example, there could be an ascending continuum (rather than a horizontal one) representing either duration of hidden trauma or intensity of dissociative experience. Supposedly, the more traumatic an experience is, and the earlier in life that it is experienced, the more psychic content is involved in the memory and, hence, the more extreme the dissociative state can become. Forgetting, in general, is not dissociation. Forgetting can occur because of, for example, a brain malfunction such as Alzheimer's disease, or it can occur because of intoxicants that affect the brain. These are soma-based memory problems, and do not involve the kind of forgetting talked about as regards the dissociative continuum. Dissociation is a mind-based (psyche-based) type of forgetting. If you are doing or thinking about more than one thing at a time and only remember one of them, then dissociation has occurred—you dissociated from thinking about the one to focus your attention on the other, to the degree that the one not attended to is not remembered. Not remembering locking your front door because you were focusing and worrying about getting to an appointment on time may only momentarily cause you some grief. The door-locking example would appear at a lower level on the scale than, for example, forgetting for twenty years that your father abused you—an incident so traumatic that it requires hypnosis to be remembered. In this case, the continuum would represent duration of amnesia and would appear as an escalating line on the dissociation continuum.

But, the ascending continuum of dissociation is problematic because until memory is uncovered the duration of how long the memory was buried or hidden is unknown. Until all of a client's pertinent hidden memories are exposed (i.e., those resulting in

MPD/DID symptomatology), his or her level of dissociation as a duration of amnesia on a continuum can only be guessed at, or given in terms of “at least” a certain level. Since hidden memories, as regards MPD/DID, are expressed by the alter-identities that house those memories, until all alter-identities are exposed and their age of existence (not their portrayed age) revealed, the age of the memories that the alter-identities house can not be revealed. A client can seem recovered, until facing a new trauma, and then all of a sudden more alter-identities may appear that have never appeared before, but that claim to have existed for many years. It could be said that, as regards those memories revealed, that they occurred X years ago, and so it could be said that, at this point in time, the client’s duration of dissociative amnesia is X, subject to constant revision. This means that a client’s status on the continuum would change with each alter-identity revealed. As each alter is acknowledged, the therapist would reassess the client’s degree of dissociation—each time the therapist would have to qualify the client as even more deeply dissociated than originally thought. This is problematic in that the client may have had these alters all along (been deeply dissociated all along) yet appears, because of a continually modified dissociative status, as if he or she is getting worse. Dissociation as duration of amnesia on a continuum can not be determined accurately until all alter-identities and pertinent memories to MPD/DID symptomatology are revealed. And, since it can never be known for sure if all alter-identities have surfaced, the client’s level of duration of amnesia on a continuum can never be concluded, but could be reported in terms of “thus far” the level is “at least” X amount.

Or, as another example of a dissociative continuum, there could be an ascending continuum based on intensity of dissociative experiences, i.e. the deeper the dissociation the higher the line of the continuum. But, given the hidden nature of dissociative experience, there is never any way of knowing for sure whether all traumas have been brought to the surface in order to hierarchize them properly as to their experiential intensity. Relative comparisons as to intensity may be possible between individuals but these could only be based on those dissociative experiences revealed up to that point. At time one (T-1) a dissociative continuum based on intensity of dissociative experience may make Mary appear more dissociated than Janice is. But, after more of Janice's alter-identities and corresponding memories are revealed, at T-2, Janice then appears the more dissociated. This means that what is being ordered by intensity is revealed memories not repressed memories. This method of ordering results in unstable relative comparisons. Therefore, the client's dissociative states can not be hierarchized or ordered by intensity in useful way.

The ascending continuum of dissociation is open-ended because it can never be determined when all of one's hidden traumas have been recovered. Because of this, the ordering of memories by either duration of amnesia or by intensity of experience cannot be what is meant by MPD/DID as the most extreme form of dissociation. I have presented duration and intensity as two continuum possibilities. Yet, clinicians normally consider that the more painful an experience is or the longer abuse goes on, the greater the intensity of dissociation *and* the greater the difficulty in getting the memory to come to the surface (because it gets buried more deeply in the psyche). This interconnection between intensity

of dissociation and duration of amnesia makes it even more confusing what a single continuum of dissociative experience is meant to represent. Obviously, the ascending continuum cannot be what is clinically meant by a dissociation continuum because neither the level of dissociative intensity nor amnesic duration would be known in order to make a diagnosis of MPD/DID as the most extreme level of dissociation.

To reflect, let us assume that all that can be gleaned from an ascending continuum, based either on duration of, or intensity of, dissociative experience, is a resulting relative comparison between either client-A at T-1 and T-2 and T-3, or between client-A and client-B, C, D, and so on. The question then, is whether these relations are helpful in defining what is meant by a dissociative continuum? Relative comparisons may be helpful for some purpose, but they are not helpful for demarcating where normal dissociation ends and psychopathological dissociation begins. For example, at age fifty-five, Mary can recover a repressed memory of her father abusing her at age two. According to the ascending duration-based dissociative continuum, Mary should qualify as extremely dissociated, yet Mary is not MPD/DID. Or, according to the ascending intensity-based dissociative continuum, Mary's memory was very deeply buried because the pain of it was so intense. That is why it took so many years for Mary to remember it happening. The intensity of Mary's experience should qualify her dissociation as extreme, yet she is not MPD/DID. Neither duration nor extremeness of repressed memories, i.e., a type of dissociative amnesia, can be what is meant by extreme dissociation being a psychopathology.

There is still another possibility. There could be a horizontal scale depicting degree of function or dysfunction resulting from dissociation. Examples of this would range on a continuum from simple to complex and from functional/helpful to dysfunctional/harmful. The ability to dissociate can be functional and helpful. Consider the following: if you need to complete something by a deadline you may have to dissociate from feelings of hunger that would otherwise get in the way. If you are an athlete and need to shut out the screams and distractions in the audience in order to make that foul shot, dissociation can come in handy. At the opposite end of the spectrum, if your father is abusing you, and you have to endure the pain because you cannot get away, then to be able to dissociate from the experience is a godsend. Functional-dysfunctional dissociation is another continuum possibility.

The problem with a horizontal dissociative scale arises especially when it comes to MPD/DID, because psychological abnormality and dysfunction are clinically treated synonymously—normal equals functional, and abnormal equals dysfunctional. This also presents a problem for the idea of a single continuum. As the functional-dysfunctional continuum moves toward the complex, it usually is thought of as running parallel with the normal-abnormal continuum. The question is, should the degree of dysfunction be one continuum or two? Consider the following. Having to restudy a chapter for a test because of getting sidetracked by thoughts of last night's date is one mild example. Hurting your son's feelings because you attended his baseball game and did not respond to his home run because of being so absorbed in thoughts of undone work at the office is

another. These two examples are normal (common), but do not qualify as being cases of dysfunction.

Life problems become more serious when dissociation involves unwanted results and behaviors, such as weight gain caused by continued unconscious eating of whole bowls of popcorn while being absorbed in watching TV. Or, less commonly, but still not a mental illness, is the example of leaving the house without your new baby, having forgotten momentarily that you are a parent. This is a dissociative experience that is mostly limited to first-time parents, probably due, in part, to not being in the habit of parenting, and is more common than is publicly known. This is, in part, because first-time parents are embarrassed to admit such dissociative behavior, but sometimes do so at new-parent meetings.⁵ It may be hard to identify with this example. Each of us would like to believe we would never do such a thing. But, the parents in question, thought the same of themselves prior to having the dissociative experience. They too were appalled at having forgotten, even for a brief moment, that they were parents (or parent if only one parent dissociated). That is the funny thing about dissociation—one wonders how they could possibly have forgotten something so important, or so painful. Dissociating from parenting a first child is not a psychopathology, yet it is dysfunctional. Obviously, the functional-dysfunctional dissociation continuum can be separated from the normal-abnormal dissociation continuum. But, as rare or extreme as this example seems, it is unknown whether it involves extreme dissociation. We are still trying to determine that particular dissociative behavior which is normal, and just prior to psychopathological

dissociation—and psychopathological dissociation is supposed to be indicative of extreme dissociation.

To separate the functional-dysfunctional continuum from the normal-abnormal continuum is problematic for MPD/DID. Normalcy is relative to a population but normal refers to one who is free of mental illness or insanity. The word “functional” seems like it might refer to purposive behavior. But this is not the case. One can have purposive behavior that is dysfunctional, such as drinking until one passes out, or hitting a friend and destroying the relationship. Instead, functional refers to abilities or capabilities, relative to one’s age and intellectual and physical limitations. For the average person, the word “functional” refers to various endeavors including the ability to perform daily tasks, keep self and home clean and safe, or be responsible for self and others in one’s care. Functional can also refer to the ability to hold a job, to have an effective social life, to communicate one’s needs, and to formulate and implement life goals—all tasks and abilities that are considered normal. Mental illness classifications are representative of abnormality and dysfunction. Because of this, clinicians contend that multiplicity/dissociated identity itself is abnormal, that dysfunction results from having multiple personalities/dissociated identities, and that this dysfunction is part of what is abnormal about MPD/DID client psychological (diverse) behavior.

The problem for MPD/DID is that if the two continuums are separable three possibilities exist—dissociated identities could also be (1) functional but abnormal, (2) dysfunctional and normal, or (3) functional and normal. For example, when the MPD/DID adult as child, created imaginary playmates as a coping strategy to deal with

sexual or physical abuse, one might say that the child used a functional and normal ability to dissociate. In fact, in this case, what was abnormal/dysfunctional was not the child's dissociation, but the situation that the child could not escape from. It is only later, once the child becomes adult and MPD/DID⁶, that he or she is clinically considered as *inappropriately* using the coping strategy of extreme dissociation, since he or she is no longer being threatened with abuse. The client's ability to extremely dissociate is no longer needed. It is no longer being used functionally to cope with real abuse. The client's ability to extremely dissociate is being used in a dysfunction way, for example, to avoid dealing with unpleasant situations (rather than deal with them responsibly) or to avoid situations that trigger unwanted memories, demonstrating an inability to care for one's self in a healthy, productive, adult way. Hence, the clinical claim that MPD/DID is abnormal and dysfunctional is temporally bound.⁷

Normal/abnormal and functional/dysfunctional can be distinct continua. Each of them can be indicative of either a quality of the person such as stage of life (child or adult), or can point to the situation (abuse), rather than pointing to the client-child. It is, therefore, not clear what dissociation and its continuum is supposed to represent. Dissociation as expressive of both functional-dysfunctional and normal-abnormal qualities cannot then be what is meant by the dissociation continuum, for if it was it would not be clear which of the two continuums would be represented.

Dissociation—Responding to Hacking's Counter-Claim

Given dissociation's diversity, it is understandable why someone would begin to wonder, whether there is any one thing that dissociation points to. Ian Hacking in his book Rewriting the Soul: Multiple Personality and the Sciences of Memory, has criticized the concept of dissociation. Because many philosophers have read this book, they may wonder why I treat dissociation and its continuum as something plausible and worthy of such lengthy argument. I therefore feel prompted to explain why I would be compelled to untangle such a concept.

Hacking points out several problems with the concept of dissociation and with the idea of it as a continuum. His doing so is prompted by a concern as to how quantifying methods, such as the Dissociative Experiences Scale (DES), are used to make dissociation an object of knowledge, one used for scientific purposes. He uses MPD/DID as an example of questionable "scientific knowledge," since it is based on something so inarticulatable and imprecise as dissociation. He does not say dissociation does not exist. But, he points out that dissociation is too diverse to refer to any one thing; and, doubts that something as amorphous and hard to pinpoint as dissociation, by itself, can account for multiplicity as a disorder. Dissociation is clinically claimed as lying on a continuum of experience, in a continuum that clinicians have not articulated due to the difficulty in such an immense endeavor. Hacking contends that the major reason dissociation is difficult to put into any kind of continuum order is because it is not, by itself, scalar—it has magnitude but not direction.

Clinically speaking, dissociation needs to be scalar. If clinicians are correct that, when a common and necessary daily experience is used to the extreme it is abnormal, then qualifying dissociation as an extreme of a normal experience necessitates a scale or continuum. But, dissociation alone is not scalar. It is only when it is combined with something else that it appears scalar. As examples above have indicated, whatever dissociation is combined with affects its appearance. The major quality that has been combined with dissociation is mental health (normalcy) and mental illness (abnormality). But mental health/mental illness is tied to a function/dysfunction continuum, which in turn can be said of either a person or a situation, also as indicated above. As Hacking contends this complexity and interdependence of human qualities and situations makes any one thing a less likely candidate for aiding dissociation in a scalar model.

Hacking is concerned about what happens to certain experiences that are made into scientific objects of knowledge. He goes into detail as to how, sometimes, even hard to articulate and categorize experiences are made into objects of knowledge by creating clinical tests, collecting data from those tests, and then using the data to explain a client's behavior. Dissociation is an example of a particular type of experience turned into a scientific object, by the development and use of testing, and then counted as scientific knowledge on the subject of Dissociative Disorders. His concern is that this is a questionable process for concluding that knowledge has been obtained and he uses MPD/DID to support this idea. His additional concern is that these so-called objects of knowledge are then fed into the therapeutic relationship and affect what both therapist and client come to believe about client behavior. Client experience is, as Hacking puts it,

“retroactively redescribed” as dissociated and disordered. The concern is that the client, in believing these “facts” about him or herself, then goes on to act out this belief of being dissociated/multiple, creating what Hacking calls a “looping effect of human kinds.” In other words, dissociation may exist, but it is making it into a scientific object of knowledge that contributes to the client’s view and subsequent behavior of him or herself as dissociated/multiple.

Hacking’s critique of dissociation is both helpful and unhelpful in explaining MPD/DID. He is correct in his analysis of the problems associated with dissociation as a continuum. But, he quickly dismisses dissociation as the fundamental basis of MPD/DID, in search of a replacement explanation.⁸ In dismissing dissociation as something too broad spectrum to categorize, he also dismisses both the experience of dissociation and the hard cases of MPD/DID that involve the psychological avoidance of *actual* physical harm, torture, abuse, and severe neglect. His critique of dissociation rightly points out some of its problems; and gives us reason to suspect dissociation as the catalyst of MPD/DID and with it suspect the diagnosis of MPD/DID altogether.

Unfortunately, his use of MPD/DID for another purpose (to put into question what counts as scientific objects of knowledge and how those decisions are arrived at) leaves the client’s behavior and post-trauma suffering not sufficiently explained. It is one thing to think that a mild memory can be redescribed as abuse—such as a father bathing a two-year old, subsequently redescribed as sexual abuse. But, what of severe cases of abuse—for example, take the story of a four-year old child who is intentionally burned while being sexually abused with a broom handle. Having dissociated from the painful, traumatic

experience, she does not remember why she has burn-scars until she goes through therapy at age thirty-three. It does not seem sufficient to claim this as a case of MPD/DID due to retroactive redescription and the looping effects of human kinds. Her experience was torturous regardless of how it is retroactively redescribed.

Hacking's view can not give an explanation as to how hard cases of trauma can be forgotten and contribute to multiple/dissociated behavior. His view can help clean up the cases of false-diagnosis of MPD/DID perpetrated by over-zealous therapists wanting to claim treatment of a "fashionable Disorder." Or, Hacking's view can explain those therapeutic cases of MPD/DID that contain false memories of abuse, or redescrptions of non-abusive behaviors/experiences, or examples of questionable abuse, spoken retroactively as abuse. But, his view can not explain the hard cases of real pain and suffering causing hidden memories (DC-C), or switching behavior (DC-B) that has occurred since childhood or the presence of multiple identities (DC-A) since childhood.

These hard cases are what necessitate the investigation of dissociation and its continuum—an investigation that can help answer the question of whether MPD/DID clients are acting. In turn, if switching alter-selves is a form of acting, this will give a reason to get rid of one of the scales compounding a dissociative continuum, i.e., the mental health, mental illness scale. Hopefully, this will help clarify what is meant by a dissociative continuum, even though the function/dysfunction component may still exist, but without its mental health/mental illness counter-part. In addition, being willing to wrestle with understanding what is meant by extreme dissociation as the fundamental basis of MPD/DID (in spite of dissociation's problems) can, in turn, help us understand why

clinicians cling to both the continuum and the imaginary demarcation line between two types of multiple identity—that of the actor and that of the alter. It can help unravel whether the dissociation involved in acting and the dissociation involved in alter-making is different or the same—whether the MPD/DID client is acting instead of alter-making. And, it can help determine whether multiplicity/dissociated identity is a Disorder or just indicative of running along a functional/dysfunctional continuum.

But, for now, extreme dissociation is considered a Disorder, and, as explained earlier, mental illness is clinically a subset of dysfunction (not every dysfunction is a mental illness). Because of this, I take it that the mental health/mental illness (i.e., normal/abnormal) scale is the one that overlaps the dissociation continuum. It is, after all, the normal-abnormal scale that facilitates the alter-actor distinction, i.e., MPD/DID client behavior is considered abnormal because they have or are (real) alter-identities, while actors' behavior is considered normal because their alter-identities are merely enacted (faked) character roles.

Hacking's point that dissociation, by itself, is not scalar does not adversely affect my thesis. For example, the ability to dissociate may not be scalar, i.e.; one either does or does not dissociate. Since childhood pretending (acting) is facilitated by dissociation then acting must be facilitated by dissociation. If childhood pretending is a predecessor to adult alter-making then both acting and alter-making must involve the use of dissociation. Clinicians would not argue with this. But, for example, if dissociation can be used inappropriately or become habituated as a coping skill, then dissociation could be combined with a functional/dysfunctional scale. If dissociation depends on something else

to be scalar, as Hacking says, this point can be used to lend credence, in a certain respect, to the claim that alter-making is acting—acting and alter-making each involve the use of dissociation; either may result in functional or dysfunctional behavior. It is only the normal/abnormal clinical scale imposed on dissociation that makes alter-making and acting clinically *appear* different, i.e., alter-making as mental illness, and acting as normal.

Hacking is correct that dissociation is not scalar. But, just because people impose scalar judgements on the experience of dissociation does not negate the possibility that actors, and MPD/DID clients, experience multiple/dissociated identities because of dissociation.

Definitions (Nature versus Nurture Debates)

The clinical conception of dissociation as a continuum exists in the context of a historical development. The philosophical/metaphysical implications of the theory of dissociation have changed throughout the last hundred years. Reviewing the history of dissociation will help us understand what is at issue with the conception of dissociation and the claim that alter-identities are “real” and not faked or acted. Only the current view of dissociation as a result of both nature and nurture lends itself to the alter-actor distinction. The following historical overview will help make sense of why various theories of dissociation have been exchanged for other theories. This historical overview will aid in understanding how, and in what context, the alter-actor distinction came about.

Clinicians have come up with various interpretations of dissociation through the years. What dissociation is and how it is accomplished is colored by the school of thought

that a particular therapist is aligned with. Sometimes the definition of dissociation involves thought from a combination of schools. A very brief overview of several prominent theories will suffice to show what is at issue in the alter-actor distinction. The dissociation debate in part involves the nature-nurture argument—hence the longevity of the debate about dissociation and its continuum. Dissociation is as old as psychiatry itself and many variations have occurred during that time in explanation of dissociation.

The conception of dissociation was initially viewed as an abnormality of nature. The term dissociation was coined by Josef Breuer (1881-82), but first appeared in print in the words of Pierre Janet. Breuer believed that amnesia was a hypnoid state—a result of memories becoming unavailable for some reason and having “no special affective or impulsive significance.”⁹ This was counter to Freud’s subsequent view that memories are not available because they are repressed in the unconscious, and surface as physical symptoms.¹⁰ Janet used Breuer’s view of amnesia (modified) to account for clients’ unacknowledged performances of acting completely at odds with their normal selves or personalities. Because clients were unaware of their secondary selves or dissociated states, Janet decided it was as if parts of the client’s consciousness had split off and formed its own personality or identity that was able to refer to itself as a self while keeping itself hidden from the client-proper. It seemed as if for some reason in these cases consciousness had divided and multiplied into two or more consciousnesses. Dissociation became defined as a consciousness split by natural causes.

Janet believed that weakness of the mind (hereditary mental degeneracy) was the underlying cause of dissociation.¹¹ Janet and his colleague Jean-Martin Charcot believed

that a precondition for dissociation was nervous system degeneration, i.e., something physically disordered about the self.¹² Fixed ideas usually of traumatic or frightening events (bad memories) would be split off from conscious memory and replaced with a symptom (a secondary self). Hannah S. Decker, writing on Janet, explains that, unlike Breuer's hypnoid state and Freud's notion of repression, Janet believed that "(t)his replacement of a memory by a symptom was due to the narrowing of the field of consciousness, which in turn was the result of the mental weakness."¹³ Janet's conception of secondary selves was based on a view of dissociation as nature-caused.

Obviously Janet's view of degeneracy does not furnish us with anything remotely like the experience of acting, which involves a skill. The alter-actor distinction cannot arise from a purely nature-caused view of MPD/DID.

But, strictly nature-caused views of MPD lacked longevity. Something arising from *nature*, i.e. arising from the physical brain, cannot be corrected via psychiatric *counseling* (mental or psyche counseling), but instead requires the use of brain altering drug therapy. Yet, therapists were claiming that hypnotherapeutic techniques, i.e., mind-altering techniques, seemed to be helpful in bringing forth alter-selves, identifying them, and convincing them to integrate into one complete self. Because of psychiatry's focus on psyche, nature-caused views of MPD/DID ran counter to mind-therapy intervention.¹⁴

Although secondary selves were thought to be due to a mental weakness, Janet used hypnosis to look for subconscious fixed ideas. He looked on hypnosis as yet another type of dissociation—a hypnotic rapport that required the narrowing of the field of consciousness. Janet believed that this hypnotic rapport-dissociation was a willed

concentration upon the hypnotist, one induced by the hypnotist not the client, and that it was not to be encouraged because the mental weakness of the client was no match for the hypnotic control of the therapist. Janet later came to believe that secondary selves could be created iatrogenically by therapists because of their power over the client's degenerative mind. Janet subsequently ceased using and treating the diagnosis of MPD in favor of other disorders.

Janet's definition and the nature view of MPD were challenged. Morton Prince, the first MD to publish a case study of MPD (the famous Miss Beauchamp case), does not see dissociation as nature-caused, although he still relegates dissociation to phenomena of the abnormal. He says,

The principle of dissociation of the mind is very important. Only by thoroughly grasping it can one understand multiple personality and other phenomena of abnormal psychology. It underlies the great psychosis hysteria, as well as many manifestations of normal life, like absentmindedness, hypnosis, sleep, dreams, visions, etc.¹⁵

Prince disliked Janet's conception of literal mental degeneration, possibly because some of Miss Beauchamp's separate selves seemed so normal. It was the multiplicity itself that seemed out of place and in need of therapeutic intervention. Prince's case of Miss Beauchamp challenged Janet's nature view of dissociation and MPD.

Prince modified Janet's conception by moving the dissociation of MPD from brain soma to psyche. Prince equated dissociation with mental disintegration (not degeneration), saying that consciousness can divide, subdivide, and further subdivide, resulting in many cleavage lines and "producing various sorts of combinations of systems

of consciousness.”¹⁶ This is what Prince sometimes refers to as “a doubling of consciousness.”¹⁷ But, unlike Janet’s conception of divided consciousness, Prince’s version did not reflect a weakness of nature.

Prince made a distinction between disintegration and degeneration.¹⁸ In his view, degeneration results in insanity. It is the destruction of normal psychical processes—destruction that cannot be remedied by psychotherapy. In other words, mental degeneration is a destruction of nature. Contrary to this, disintegration is something that goes awry in one’s nurturing. Disintegration results in a functional dissociation, like that of a MPD person who has lost the complex organization of a normal self. By this, dissociation, Prince contends, MPD persons can be helped to re-associate their elementary psychical processes into a normal whole again. Prince’s distinction between degeneration and disintegration meant the difference between believing a client was doomed to multiplicity or believing an MPD client could recover via therapeutic intervention.

Although Prince’s move from degeneration to disintegration helped relegate MPD to the curable, it did not yet furnish a connection to common experience (or to acting). Even during Prince’s day, disintegration was something that happened to only a few people. As yet the cause could only be hypothesized.

By contrast with Janet’s view of hypnosis as the client’s willed concentration on the hypnotist, Prince contended that the client’s concentration is instead on the content of his/her psyche or soma (some specific aspect of the self). While the cause of MPD was as yet unknown, a more and deeper application of hypnosis was taking place and touted as therapeutic, though any unification of self lacked longevity.

Prince believed MPD could be helped or cured, even though others disagreed. Prince found hypnotherapy beneficial to identifying and unifying multiple identities (though problematically so). Against Janet's warnings of iatrogenesis of MPD, but with support by Prince's case study, hypnotherapy continued as treatment for MPD.

Prince equates deep hypnosis with dissociation.¹⁹ He explains that his view also runs counter to French psychologist Alfred Binet's view (which we will not explore) wherein disintegration occurs in the waking self of the systematized anesthesia subject.²⁰ Prince's view was, at the time, in line with the growing body of thought that dissociation occurs not in the waking self but rather in one's subconscious or unconscious. Prince considers dissociation as a "psycho-physiological law," not meaning nature-caused but meaning there is somehow a connection (though an unexplainable one) between the psyche (the unconscious) and its covert physiological manifestations.²¹ On Prince's view, both dissociation and hypnosis are initiated in the hidden recesses of the mind.

William James, expanding on Janet's view in the same year as Prince's publication, added support to the notion that dissociation is a subconscious event. James, while investigating the psychic phenomena of automatic writing, somnambulism, spirit possession, and the like, came to believe that subconscious personalities were themselves parts of secondary personal selves, the number of which were determined by the number of thoughts split off from the main consciousness.²² The co-occurrence of James' Principles of Psychology and Prince's The Dissociation of a Personality gave doubled support to the idea of both dissociation and its extreme manifestation of MPD.

Unlike Janet, James does not attribute dissociation to a deficiency of nature. Instead, he spends a great deal of time developing and explaining the importance of the concept of attention for personality and personality systems. According to James, dissociation can result in the presence of secondary selves. He considers the moment of dissociation to be, in his word, the moment of “inspissation”. Inspissation has to do with the creation of new personality systems.²³ By ‘inspissation’ James metaphorically means ‘to cause to thicken’, as when you boil a sauce and it thickens because the water is evaporating. Inspissation is, by analogy, the thickening or solidifying of the secondary self by the evaporation of the primary self. The primary self’s attention to itself evaporates as it inspissates or switches attention to the secondary self as it becomes absorbed in living the life of the secondary self.

The conception of dissociation takes a radical turn with James’s view of attention. Since inspissation, or dissociation, has to do with absorption of one’s attention to some particular thing, event, sensation, etc.,²⁴ James’s view suggests that dissociation may be a technique or manipulation, in this case a manipulation of the attention. James’s view of dissociation as a technique or manipulation suggests that it is something that can be learned, i.e., a skill.

The development of the notion of dissociation as a skill or technique is the beginning of the viewing of dissociation as a possible continuum of experience. Unfortunately, James’s investigations had been focused on psychic phenomena, such as mediumships, spirit-possession, somnambulism, and automatic handwriting. This focus resulted in multiplicity being relegated to the realm of the bizarre by those clinicians and

others unsympathetic to psychic phenomena. Nevertheless, dissociation as a skill that can be developed suggests the possibility that we could all learn to dissociate as well as the MPD/DID client. This, in turn, suggests the possibility that if we all dissociate, and are not all MPD, then there must be a continuum of the ability to dissociate, even though dissociation as a continuum was not yet articulated or explored during James's day.

A continuum of dissociation is what precedes and prompts the alter-actor distinction. Skipping ahead a bit in the history of dissociation, by 1972 the definition of dissociation took on a more scientific language and supported favoring a continuum and the nurture-caused side of the argument. William N. Confer and Billie S. Ables define dissociation by the [Eysench, Arnold, and Meili] 1972 model of MPD/DID as "a process by which some thought, attitudes, or other psychological activities lose their normal relationships to others, or to the rest of the personality, and split off to function more or less independently."²⁵ They openly admit, supporting Prince's hypothesis, that dissociation occurs outside of MPD, e.g., "in trances or religious experiences, as when speaking in unknown tongues [...] sleepwalking and fugue states."²⁶ This does not yet give a basis for dissociation as an uninterrupted continuum of experience. It only suggests dissociation is needed for some uncommon *normal* events.

Eysench, Arnold, and Meili's nurture-caused theory suggested conceiving of multiplicity as a normal, but as yet still uncommon experience, thereby moving it away from the conception of the MPD/DID client as a freak of nature (i.e., Janet), as well as away from the realm of bizarre psychic phenomenon (i.e., James). Eysench, Arnold, and Meili aligned dissociation, instead, with misused or misdirected *normal* function. But they

still could not explain what was involved in initiating the process of dissociation, leaving MPD/DID in the realm of unexplained phenomena.

Because neither the degeneracy-nature model nor the nurture-caused model of MPD/DID could account for the event of dissociation, the nature-nurture debate itself seemed less important than determining the actual process of dissociation. In 1977, a few years after Eysench, et al, E. R. Hilgard's "neodissociation" theory was introduced. Eugene Bliss subsequently expanded upon neodissociation in 1986, in his book Multiple Personality, Allied Disorders, and Hypnosis. Bliss explains that Hilgard's theory tries to come to an understanding about the process of dissociation by incorporating "modern cognitive theory and [. . .] concepts from recent research on information processing, divided attention, and brain function."²⁷ The focus on brain function moved the conception of dissociation away from the psychic realm and into the scientific realm. But, when MPD and dissociation is moved out of the realm of the psyche and into the realm of soma, the problems associated with natural causes of MPD again arise (remember Janet's degenerative model of dissociation), but this time with a focus on natural technique. Because of the problems associated with natural causes of MPD, the nature-nurture debate was set aside temporarily to focus on explaining the technique of dissociation.

Focusing on technique and not caring to come to a definitive answer about the nature-nurture debate of MPD/DID, both Hilgard's and Bliss's conclusions were that dissociation is *either* something organic (a trait) or learned (as in a skill). Further, some of us use or abuse this trait or skill more than others, i.e. some of us use it to an extreme and too often to an extreme, as do those with MPD/DID.

Leaving the trait-skill question unanswered, Bliss presents us with the following observation about the technique of hypnosis. It is here that we finally see the full expression of the need of a dissociative continuum.

When the patient is totally absorbed internally, when his or her focus is only on these mental processes, the external world and one of its components, the body, vanish, leaving only the mind. Somewhere in this sequence, what is termed hypnosis begins. Like all traits or skills, this one also displays every gradation in the population—only a small minority can reach the extreme of nothingness.²⁸

Bliss surmises that given that all of us experience some level of dissociation at some time, and considering what science has come up with about a neural model of hypnosis (which I will not explore),²⁹ it must be the case that hypnosis/dissociation is a trait or an acquired skill (we know not which), one ranging on a continuum from normal to extreme.

Bliss goes on to furnish what was needed for the idea of a normal to abnormal dissociation continuum of experience—drawing an imaginary line between the dissociation involved in acting, specifically childhood playacting, and that of alter-making. Even though he admits that dissociation in childhood is what enables the same dissociation in adulthood, he divides the continuum into normal and abnormal dissociation. He uses the conception of a level of “absorption” into one’s inner life as the point of departure from normalcy. Bliss uses a biographical account of a child getting spanked to make his point.

“[. . .] I didn’t want to be spanked, I wanted to disappear, just hide. When Dad came home, he didn’t spank me.” To which her personality retorted, “I got the spanking.”

This anecdote depicts the transition from a simple realistic imaginary playmate—the realism being a characteristic of a hypnotic state—to the next step, the dissociation of self-hypnosis, which can range from a simple detachment to total amnesia. In this case there was amnesia to cope with the spanking.³⁰

Bliss admits that, “in most cases it is benign and quite normal” to create and have imaginary playmates during childhood.³¹ Nevertheless, Bliss considers the ability to create normal imaginary childhood companions as the prototype of the ability to self-hypnotize to the point of amnesia, i.e., to a point of such intense detachment that an alter-personality remembers, in this case, the spanking. The normal ability to create childhood personalities by using the imagination, somehow develops (or is developed) into the dissociation of self-hypnosis—the dissociation seen in the adult condition of Dissociative Disorder. Bliss seems to be saying that the detachment that takes place during imagination is of a lesser intensity than that of the “next step” (self-hypnosis) wherein the detachment of dissociation can range from simple to total amnesia. He also seems to be saying that imaginary character making requires use of a “hypnotic state” and that this state is a step down from that of self-hypnosis. This is not clear. Both play-acting and alter-personality making require hypnosis—playmate creation requires a hypnotic state, and alter-personality making requires self-hypnosis. Yet, Bliss does not want us to think that adult MPD clients are play-acting or pretending, as they did in childhood. He seems to claim, without explaining how it is the case, that a hypnotic state is not dissociative, and self-hypnosis is dissociative—that the child is not absorbed into his or her inner life during normal play-acting to the same depth that he or she is during self-hypnosis. Over time, some undetermined thing happens between the childhood stage of prototype personalities to the adult MPD/DID stage of the existence/presence of alter-identities. A client’s symptomatology worsens over the years, transforming it from childhood play-acting to full-fledged MPD—possibly the technique to dissociate or the putting on of the

personalities becomes habituated, or possibly the prototype personalities become more fully developed and autonomous, it is unknown. But, Bliss does seem to want to draw a line of demarcation between play-*acting* and alter-making.

His avoidance of the client as actor model comes in the form of returning to the aspect of dissociative technique, claiming that childhood playacting is “divisible into two classes [. . .] children with limited or poor hypnotic capabilities” and “children with excellent hypnotic abilities.”³² According to Bliss, children who are excellent hypnotic subjects and who have been abused are also very motivated to dissociate and are subsequently successful at playacting. These are the ones, Bliss believes, that tend to end up becoming too absorbed in their character roles to the point of developing MPD.³³

Bliss does not specifically say, but evidently assumes, that adult professional acting does not involve the same level of internal absorption as is needed to develop the disorder of multiple personalities. Or it could be the case that on Bliss’s account the professional actor does not have the history of abuse that warranted learning to dissociate so deeply. What is confusing is that, as Bliss admits, dissociation is motivated as much by pleasure or fantasy as avoidance of pain. Yet, he sticks to his belief that MPD results in a higher level of absorption in a role than do stage or movie acting. It is the deep (i.e., extreme) degree of dissociation that Bliss believes produces the alter-selves that house the client’s hidden phobias. Bliss, in relegating multiplicity to strictly unconscious hidden forces, leaves an unexplained gap in the continuum between the dissociation in acting (dissociation for pleasure’s sake) and that of alter-making (dissociation for pain avoidance). The alter-actor distinction is therein established.

Colin Ross, an MPD/DID specialist, seconded the alter-actor distinction with a modification. Whereas Bliss favored the trait-based conception (neural model) of dissociation and admits the trait-skill debate is far from settled, Ross makes the bolder claim that dissociation depends on both nature and nurture. Ross says, "psychological and biological causation may coexist."³⁴ Where Bliss' psychiatry focused on psyche, Ross considers a broader explanation of dissociation. Leaving psychoanalysis, hidden phobias, and talk of the unconscious behind, he defines dissociation as "the opposite of association."³⁵ Where Bliss's form of psychiatry involved a radical dualism of mind and body with not much consideration of the importance of the interaction between the two, Ross's psychodynamic conception of dissociation is still dualistically based but demands attention to the interdependence of psychic elements to each other and to soma.

For Ross, "(d)issociation is an ongoing dynamic process in the normal psyche," which makes his view vulnerable to the accusation that MPD clients are acting.³⁶ He believes the desire to dissociate is built into our DNA but is also the development of a skill; "(t)he ability to create analogues of alter personalities is a capacity of the normal mind."³⁷ Clearly, if the capacity to create alter-selves is built into our DNA, since we all have DNA, this opens dissociation to the possibility that we can all create alter-identities.

If we can all create alter-selves and do so during childhood playacting, alter-making as a disorder is suspect. If alter-making is not a disorder, the imaginary demarcation line on the dissociative continuum between alter-making and acting is falsely placed. Without the demarcation line between acting as normal and alter-making as

abnormal, alters can be enacted roles, MPD/DID clients can be acting, and multiplicity, i.e., alter-making, is fundamentally the same as acting and is normal.

It could be, as John Lysaker suggests,³⁸ that if we were to “look at the matter functionally and statistically, [. . .] as a trait present across a population,” alter-making and acting would not appear the same. To determine this, actors’ ability to function appropriately on stage and post-performance would have to be investigated and compared to that of MPD/DID client symptomatology. This comparison (minus statistics) is done in chapter’s four and six, which discuss the important similarities between alter-making and acting.

If childhood play-*acting* (in conjunction with a motivating factor such as abuse) can lead to MPD then a connection between acting and MPD exists. Put another way, the dissociation involved in acting and MPD may be similar or the same. This remains to be investigated.

To review, the definition of dissociation has modulated over time. Regardless of this modulation, all views of dissociation seem to agree on the following. Multiplicity can be therapeutically helped and so can not be due to a disease of nature (an unavoidable, genetic or material cause). Multiplicity, therefore, has more to do with both nurture (learned behavior/skill) and nature (natural trait) together, rather than either one alone. It further seems to be agreed that “what dissociation most basically involves is the destruction of the unity of the person’s thinking and willing”; and with the exception of Breuer, that “hidden motives” can affect the person’s soma and psyche.³⁹ Multiplicity is seen as dis-unity (disintegration) and representative of mental illness. It is not spoken of

as acting until it is assessed as a skill (at the time of Bliss and Ross). Current views, in defining dissociation as a skill, seem to agree that dissociative experiences run along a continuum from mild forms (normal) to extreme forms (abnormal). All definitions seem to agree that Multiple Personality/Dissociated Identity is the most extreme form of dissociation, and all definitions still point to multiplicity as a disorder. But dissociation as a skill puts the alter-actor distinction into question and challenges whether alter-making is a disorder.

Since the interpretation of multiple selves/dissociated identities as alters not actors is directly connected to a belief in dissociation as a continuum from normalcy to abnormality, we need to take a closer look at problems connected with the continuum itself.

The Dissociation Continuum's Double Bind

As explained earlier, the purpose of the continuum was to tie dissociative phenomenon, such as MPD/DID, to human behavior in general. More specifically, the dissociation continuum enables clinicians to make a connection between early childhood development and adult behavior and likewise between early childhood trauma and adult MPD/DID. The ability to dissociate leads to the child's manipulation of playacting as an escape from abuse. The child develops this playacting to the point of facilitating the creation, maintenance, and switching of alter-identities as an adult. The continuum

accounts for how a normal behavior can, given extreme situations, result in abnormal functioning—normal behavior turned into mental disorder.

But, this explanation of dissociation presents a double bind for the continuum. On the one hand, the continuum is needed (as just explained). It helps take MPD/DID out of the realm of the bizarre by giving it a basis in normal human behavior and development. But, because the continuum is tied to normal dissociative ability as a trait and skill, the continuum is subject to the allegation that alter-making is a form of acting, i.e., playacting or pretending. Alter-making as a form of acting still remains to be shown. Clinicians and MPD/DID clients adamantly deny that MPD/DID is an act. But, if alter-making involves use of a trait and a skill, both the question of whether MPD/DID is normal and the question of whether it is acting arise. So, the very continuum that supports the current diagnostic view of MPD/DID is the same continuum that presents the disorder with its greatest challenges. The dissociation continuum puts into question both whether MPD/DID is real or faked, and whether it is representative of normalcy or mental illness.

The question of whether alter-making is acting is dealt with in chapter four. To determine if alters are actors, we need to understand more fully what is at issue with the continuum of dissociative experiences. In order to compare alter-making to acting it is necessary to assess what is meant by a polarized scale of dissociation from normal/healthy to abnormal/mentally ill.

The Ordering of the Continuum of Dissociative Experience

Where does acting fall in the order of experiences on the dissociation continuum? This question is still unanswered. In spite of current day overwhelming clinical belief that a continuum of dissociation exists, no one has attempted to arrange in some kind of order either normal dissociative experiences or a normal to pathological dissociative experiences continuum.

Ross, however, does attempt to hierarchize one aspect of the continuum—that of psychopathological dissociation. Ross describes a spectrum from simple to complex dissociation moving from left to right on the continuum line. On the far left is normal dissociation. [He does not say in his book why he includes normal dissociation in the “the Spectrum of Dissociative Disorders,” other than to connect MPD/DID behavior to normal behavior and skills.] Moving from the left pole to the right pole, normal dissociation is far left. Ross then leaves a huge gap, jumping from normal dissociation to abnormal dissociation, with the next item on the scale a psychopathology—that of Psychogenic amnesia-Conversion disorder. To the right of this is Psychogenic fugue-Atypical dissociative disorder, followed by Partial MPD, then Dual personality (cases of two to five alters), (he interjects later that cases of five to twenty alters should come next), then complex MPD (which he describes as cases of “twenty to twenty-five or more personalities, and personality fragments”) and at the far right, Polyfragmented MPD (by inference cases of more than twenty-five personalities with undetermined limit of alters but

often into the hundreds) as the most extreme form of dissociation.⁴⁰

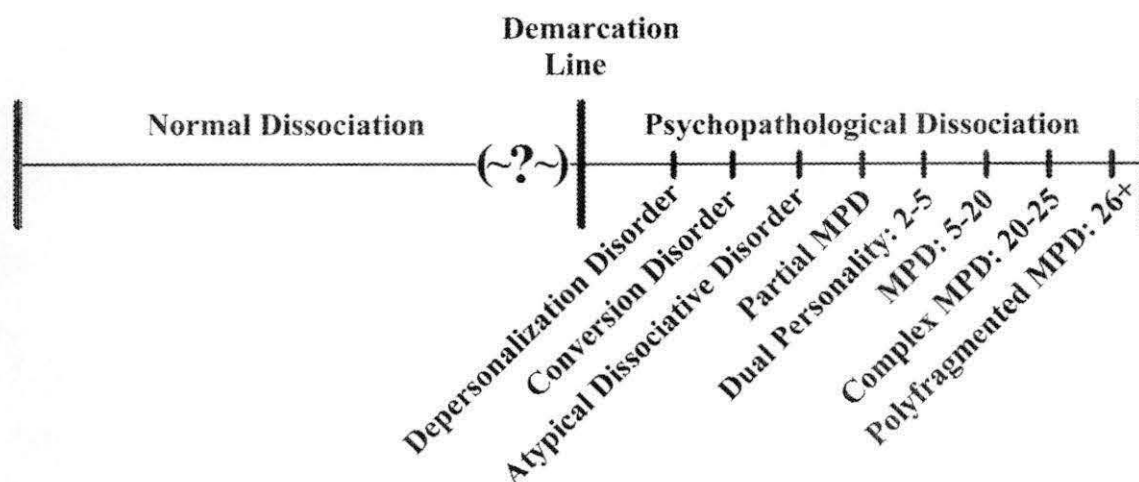


Fig. 1. The Dissociative Continuum and the Normal/Abnormal Demarcation Line
(a variation of Ross's "Fig. 4.1 The Spectrum of Dissociative Disorders," pg. 80)

Unlike this illustration, Ross does not include, for example, the experience of depersonalization on the continuum because he believes it "a symptom not a disorder."⁴¹

Considering that depersonalization is listed as a disorder, and has a DSM-IV classification of its own, and considering that it involves a level or stage of dissociation, this particular intentional exclusion is problematic. He seems to want to exclude it because it "occurs more commonly in partial complex seizures than in controls" and less in MPD than in other disorders.⁴² Because depersonalization occurs more often in seizures, this suggests a soma-based component rather than a psychological one. It is not clear whether it is because of DC-D (medical causes of dissociation, such as seizures, must be

ruled out) or the commonality of depersonalization symptomatology as to why Ross excludes depersonalization from the dissociative spectrum of mental disorders. In spite of this, Ross is the only clinician to attempt to put dissociation in some kind of order. Unfortunately, he did so only with the psychopathologies—tagging normal dissociation as a single to the left of the mental disorders—giving us no clue to which normal dissociative experience immediately precedes the abnormal variety.

Since acting is not clinically perceived as a disorder and since normal dissociation has not been hierarchized, it is still not discussed how close to abnormality acting is on the continuum or instead whether MPD/DID has been misplaced on the continuum.

The Dissociative Continuum's Normal-Abnormal Demarcation Line

Because normal dissociation has not been ordered into a continuum we are left to question what behavior or dissociative experience is positioned to the left but at the border of the first stage of psychopathology, i.e., the behavior that is normal and immediately preceding abnormality. This matters if we are to question whether the normal/abnormal division line has been correctly placed. Knowing which behavior fits the pre-abnormal position in the dissociative spectrum would allow us to compare and contrast the differences between the last state of normal dissociation and the first state of abnormal dissociation. If it turns out that alter-making is acting, i.e., that an MPD/DID client's switching identities is equivalent to an actor changing character roles then there is no need

for an abnormal/normal demarcation line on the dissociative continuum, because dissociation would not be a mental illness. In order to determine whether extreme dissociation is a mental illness we need to determine whether any normal experience of dissociation, such as acting, involves the use of extreme dissociation. It makes most sense, given the notion of a continuum of dissociative experience, to pick that normal experience immediately prior in order to the first level of psychopathological dissociation for this purpose. Since this information is not given, and since childhood playacting is said to transform into adult MPD/DID, one might assume that acting fills that pre-abnormal position on the dissociation continuum.

It is not known whether acting involves the same degree of dissociation as MPD/DID. This is what is being investigated. But, remember, *dissociation itself is not scalar. It is the clinical conception of mental health/mental illness that creates the scale.* Clinicians (at least Ross) think of actors as mentally well. But acting has often been referred to and stereotyped as a neurotic profession (“of actors as people who are unstable”) and actors have sometimes been called schizophrenic, referring to its older definition of split-personality.⁴³ Actors deny this portrayal of their profession and of themselves. But, assuming dissociation does involve split attention/split personality, and since MPD/DID is based on childhood playacting that requires the use of dissociation, and since acting involves the creation and performance of characters as does playacting, clinicians would be hard pressed to deny that acting, too, involves the use of some level of dissociation.

If clinicians were to deny acting is a dissociative experience, they would run the risk of undermining their claim that the dissociation involved in childhood playacting results in MPD/DID as an adult. They would risk undermining the nurture-based theory of dissociation that ties childhood abuse experience and development to MPD/DID. If the dissociative experiences of alters and actors result in altered personality or character, it appears that the dissociation continuum must be about something other than dissociation. Without the clinical scale of normalcy to abnormality, or some other scale, superimposed on dissociation, the dissociative continuum would not exist. Dissociation, by itself, is not scalar (as explained earlier). All dissociation would be normal. Of course, if all dissociation is normal then how do we account for the dysfunctional behavior of the MPD/DID client? Remember that mental illness is a subset of dysfunction, not the other way around. Many people have habits, i.e., behaviors they can not control or compulsions they can not stop. Other people have behaviors they perform at inappropriate times. Others have behaviors they do not remember performing. If switching alter-identities is habituated, or performed at inappropriate times, or results in dissociative amnesia, is this dysfunction or mental illness? It is only mental illness if it is behavior not common to the population, though it may still be dysfunctional. If alter-making and acting involve the same level of dissociation, then each, at times, may be dysfunctional, and at other times functional, but neither mentally ill. [Whether acting can be dysfunctional is addressed in chapters four and six.]

Still, some clinicians maintain that dissociation lies on a continuum from normal to extreme, that extreme dissociation is a psychopathology, and that it is not acting. To

understand Ross's, or anyone's, hesitancy to fill in the continuum gap between normal and abnormal, and to articulate the dissociative difference between alter-making and acting, we need to take a closer look at whether conscious or unconscious forces play a role in dissociation. Someone could contend that alter-making is spontaneously generated or hypnotherapeutically generated from the unconscious whereas acting is always a conscious decision on the actor's part and therefore alter-making and acting are not the same though the behavior appears the same. Conscious versus unconscious dissociation will be considered next.

Split Consciousness: Split Clinical Decision about the Dissociative Continuum

Ross believes that all dissociative disorders should be ordered "on a continuum of increasingly large amounts of dissociated psychic material" as can be seen from the continuum of psychopathological dissociation.⁴⁴ It is Ross's concept of "dissociated psychic material" that prompts a new consideration regarding a dissociation continuum and regarding acting. Alternatively, Bliss and others have suggested that it is the "depth" of hidden phobias that counts when it comes to MPD/DID. This brings up an important question for how one perceives the alter-actor distinction. The dissociative continuum could be arranged in two or more ways. Should the continuum be arranged by the amount of dissociated psychic material? The word "amount" could also be interpreted in at least two ways. It could refer to the *number* of alter-selves (from few to many) as Ross

suggests, or it could refer to the depth of character, i.e., the more psychic material the richer the character. Or, the dissociative continuum could be arranged by how *deep* the psychic material is buried in the unconscious as in the case of psychoanalytic views, i.e., by the amount of heterohypnosis necessary to uncover the alters, for example? From the little that is clinically written on the matter, the decision seems to be affected by the type of dissociative split one perceives to be occurring in consciousness.

Dissociation is equivalent to split attention. Ross equates dissociation with split consciousness and an ability to attend to or concentrate on doing two or more things at once.⁴⁵ Bliss, on the other hand, sees it more as a consciously focused, narrowed attention to only one thing, with everything else in one's attentional landscape ignored. Bliss and the psychoanalytic school of thought (i.e., Janet, Charcot, James, Prince, and others) generally support John Burnham's point that

while thoughts and memories are normally coherent, integrated, and available to conscious awareness, they can sometimes be split off or altered. In this abnormal state, the individual can engage in behaviors for which he or she has no explanation or memory. Though outside of conscious awareness, these separated thought processes continue to have power and can affect the actions and emotions of that person.⁴⁶

In the psychoanalytic view, thought processes are dissociated and affect behavior from the unconscious without the client being aware of why he or she is acting a certain way.

But important to note is that, the psychodynamic and psychoanalytic definitions of dissociation are based on differing views of consciousness. In Ross's view, dissociation or splitting of consciousness does not necessitate forgetting half of what was attended to, i.e., you can remember doing two or more things at once. In the psychoanalytic view,

dissociation, being of unconscious forces is indicative of repressed memories and of forgetting everything outside the focus of one's attention or until hypnosis is used to reattend to what was relegated originally to the periphery of attention. However, each of these therapists believes consciousness can be split. Their disagreement has been explained more aptly by defining consciousness as being able to be split in different directions.

Split consciousness can be viewed at least two ways—as being split vertically or horizontally.⁴⁷ The horizontal split, like in Bliss's view, represents repressed, i.e., buried, memories or traumas hidden below the threshold of conscious awareness. Ross's view favors a vertical split of consciousness whereby dissociated material is not buried but rather moved to the side and immediately available to awareness (as the dissociated material remains in one's conscious).

The horizontal split view presents a dilemma. As a nurture view, it depends on a causal connection to childhood skill of dissociation. A skill in use implies conscious action, at least until the skill becomes habituated or automatic. But once the notion of skill is considered, psychoanalysts face the question of how a skill—a conscious or once conscious action—plays a role in unconscious forces. Psychoanalysts face the problem of explaining diagnostic criterion B—how an unconscious, separate, autonomous entity or personality can take control of a conscious person's behavior. Consciousness as split horizontally gives plausible explanation to the childhood development of dissociation into an abused skill of enacting roles but, at the same time, has the task of explaining how this skill is manipulated by unconscious drives.

Even if we grant the psychoanalytic view the plausibility of once-conscious, now habituated skill as an unconscious force (an action no longer paid attention to and so not remembered), this still leaves them with explaining how or why dissociation is an unconscious force for MPD/DID clients but not for actors. After all, actors have practiced acting (often since childhood) just as MPD/DID clients practiced alter-making since childhood.

In addition, the idea of dissociation as a skill, even one that is now habituated and not attended to or remembered also presents psychoanalysts with the problem of explaining how a skill can transform into a separate, distinct, autonomous identity, i.e., a metaphysically separate self, rather than an enacted role. If the retort is that the identity is not really separate but only imagined as separate by the client, then the alter-actor distinction is compromised since what this amounts to is saying that MPD/DID clients are pretending, i.e., acting “as if” they are many people.

Ross’s view of dissociation trades in talk of the unconscious in order to deal with the possibility that clients are pretending. His view of dissociation as consciousness split vertically, wherein both halves remain available to conscious awareness, avoids the psychoanalytic problems. Ross interjects the notion of dissociative delusions, i.e., which the client is consciously aware of and deluded into thinking that his or her behavior is representative of many selves in one body. But in deleting talk of the unconscious, Ross is forced to consider whether alters are actors. He decides that alters are actors, but are unlike Hollywood actors. [This will be addressed in chapter four.]

Consciousness perceived as split vertically or horizontally challenges whether the continuum should be arranged by overt behaviors (indicative of repressed memories and of consciousness split horizontally) or covert behaviors (indicative of consciousness split vertically). The vertical-horizontal split pits the psychoanalytic school against the school of psychodynamics. Ross's psychodynamic view of consciousness as split vertically defies the traditional psychoanalytic conception of buried psychic material that makes itself overtly known through odd behaviors, affects, ticks, headaches, or the like. Ross's conception of a vertical split does not require these initial overt affects. In fact, he once treated a client with atypical dissociative disorder (not MPD) for two years before discovering the client as being MPD.⁴⁸ He says,

MPD often presents in a highly covert fashion [. . .]

MPD is an unusual disorder in that it can almost be diagnosed from a constellation of nonspecific signs and symptoms. The important word is almost. You don't have a case of MPD until you have talked to the alters.⁴⁹

He suggests that the motivation to talk to the alters is preceded by client comments of dissociative affects, i.e., missing time, being called by a different name, huge gaps in childhood memory, and the like. Ross counters the psychoanalytic horizontal split view, claiming instead that "(t)here is no need for "deep" exploration because the most important material is immediately available on the surface, though the surface is dissociated into separate compartments."⁵⁰ Ross's view, based on consciousness instead of the unconscious, is not subject to the psychoanalytic problem of explaining how a skill as a conscious or once conscious action plays a role in unconscious forces. But, it remains

debatable whether the dissociative continuum should be based on overt or covert behaviors.

Ross is clear that he does not favor the psychoanalytic view. He finds problems with the notion of therapeutically communicating with anything that is unconscious.

I remember a colleague saying to me that MPD is important because it proves the existence of the unconscious. I take the opposite view. For me MPD demonstrates that the so-called unconscious is not unconscious at all—it is wide-awake and cognitive in nature, but dissociated. The unconscious no doubt exists, but I don't deal with it much in therapy. I interact with the alters and find that I can do the work of therapy by sticking to what they consciously know.⁵¹

Ross sees no reason to speculate on the existence of an unconscious as the medium of the client's problems. From his perspective, multiplicity and dissociative affects are always witnessed as emanating from a conscious state.

If alter-identities can come out without going into a deep hypnosis, the possibility that alters are actors is increased. This is because, the view that MPD/DID clients consciously dissociate is seemingly more like the view that actors consciously change roles. But, conscious dissociation (as opposed to unconscious dissociation) also problematizes the alter-actor distinction. If MPD/DID clients are acting (though not like Hollywood actors), what is the difference between the two? It is Ross' emphasis on the normal to abnormal continuum of conscious dissociation that suggests MPD/DID involves some form of acting that subsequently strongly puts the alter-actor distinction into question.

Since Ross' vertical split view of consciousness poses the greatest challenge to the alter-actor distinction we should study his view more carefully.

Dissociation: Quadrant versus Continuum

Because of the many problems arising from the existence of a dissociation continuum, it seems that the concept of a continuum of dissociation may be too limiting. Ross found this to be the case. He believes that there is more than one type of dissociation and sees a possibility of defining the types with a quadrant (a circle divided into fourths by perpendicular lines). As the first clinician to actually state that alter-making is acting, but unlike Hollywood acting—a profound claim given the history of dissociation and MPD/DID—it is quite surprising then, that he does not explain which quadrant Hollywood type acting belongs in, to clarify how alter-making and acting are different. He does not address this oversight.

By contrast with the psychoanalytic view, Ross explains that dissociation can also be more than psychologically driven. Dissociation, according to Ross, can also be biologically or psychosocially accounted for, and can result in normal as well as abnormal behaviors. These four factors combine to form four sections of a quadrant.⁵² I have modified some of his examples, but Ross explains each section of the quadrant this way. Normal psychosocial dissociation is typified by daydreaming during a boring lecture. Abnormal psychosocial dissociation is exemplified by amnesia for incest. Normal biological dissociation is when you forget that you went to the bathroom during the night. These three are psyche or mind-based dissociation. Its counterpart, the abnormal biological example, is of concussion-caused amnesia—a soma or brain-based dissociation.

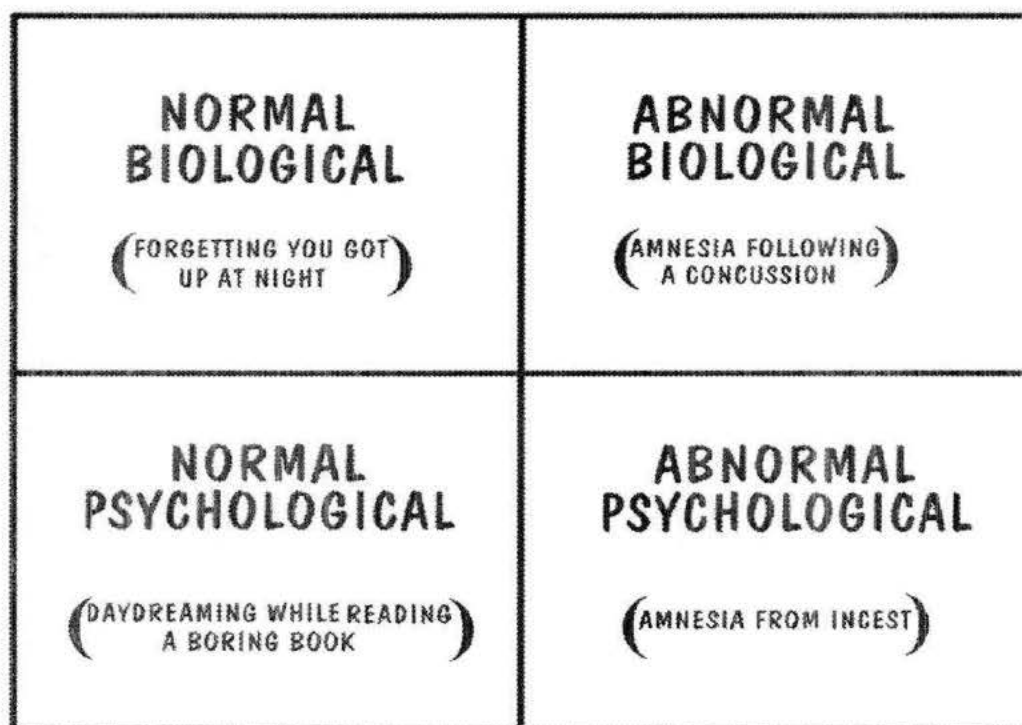


Fig. 2. Ross's Quadrant of Dissociative Experience
(a variation of Ross's "Figure 5.1 The Four Dissociative Quadrants," pg. 88)

So, "dissociation may involve the trivial or the traumatic" as well as the "psychological and biological."⁵³ Rather than a continuum, these four concepts present as a quadrant with the psychosocial pair divided on the top and the biological pair divided on the bottom of a horizontal line.

We are not told whether Ross believes the quadrant sections represent either/or possibilities for behavior, i.e., whether, for example, daydreaming belongs in the normal psychosocial section only or can overlap into another section, such as abnormal psychosocial. Since the DSM is a form of line drawing between normalcy and abnormality, and since therapists make a distinction between Disorders of psyche and

Disorders/diseases of soma, and since Ross made a point of ordering psychopathological dissociation on a continuum as separate from normal dissociation, one might assume that the sections do not, or rarely, overlap.

Since the quadrant does not furnish a specific box for professional acting, and since Ross believes actors are normal and MPD/DID clients are abnormal, one would have to assume that professional acting is relegated to the normal psychosocial quadrant. But this only makes sense if and only if actors do not experience the same type of amnesia during acting or switching roles that MPD/DID-clients experience and as is placed in the abnormal psychosocial quadrant. [Examples of professional acting, in chapter four, will raise a question about Ross's scheme. These examples will suggest that the negative ramifications of dissociation can be said of acting as well as alter-making.]

That a continuum of experience is needed to substantiate MPD/DID type multiplicity as being tied to childhood skill and abuse leaves open the possibility alters are actors. Childhood playacting suggests that MPD/DID alter-making and professional actors' character roles are merely two different forms of dissociation. Each is a result of the childhood skill of playacting by dissociating. The question is, do both MPD/DID clients and actors use the same dissociative techniques to acquire multiplicity? If so, they share dissociative technique in common. This leaves open the possibility that neither clients nor actors are abnormal in using these techniques unintentionally (habitually) or intentionally.

Dissociative Techniques—Hypnosis and Dissociation

In the examples of dissociation listed near the beginning of this chapter, many forms of dissociation were given in conjunction with the dissociation continuum. Since the forms of dissociation are varied from mundane to extreme, it obviously cannot be form that all dissociative manipulations have in common. If a continuum of dissociative experience is to exist, the various forms of dissociation must share the same process by which the dissociation occurs. The various dissociative forms may involve difference of degrees of dissociation but not difference of technique.

When it comes specifically to acting and alter-making the form is the same. Each is an alteration in appearance or behavior using some technique. Clinically speaking, the degree of dissociation is usually the variable. But since alter-making and acting result in the same form, it seems plausible that the degree of dissociation used to make alter-identities and that which is used to enact character roles are the same.

The important question for this dissertation then is, do actors use the same dissociative technique to acquire the same degree of dissociation that MPD/DID clients do when alter-making or switching alters? Do alters and actors both extremely dissociate? The alter-actor distinction will be more fully addressed in the Alters Versus Actors chapter. For now we need to come to some kind of best guess via clinical- and self-reports as to what degree of dissociation is involved in the experience of *appearing* as, and *feeling* like, a different self.

The technique involved in extreme dissociation is hypnosis or momentary trance. The stereotype of hypnosis is of a person putting someone under a spell and getting him or her to do things against his or her will. This is a naïve view of hypnosis and one not helpful to understanding the technique used for extreme dissociation. There is more than one type of hypnosis and it is debatable whether hypnosis requires a subordination of the will as will be explained.

Bliss tells us (while referring to MPD/DID clients) that “(t)o enter the domain of the personalities is simple. [...] The key to the door is hypnosis, and these patients are excellent hypnotic subjects.”⁵⁴ However, there are three kinds of hypnosis that can prompt dissociation—spontaneous hypnosis, autohypnosis, and therapy-induced hypnosis (also referred to as heterohypnosis) and we need to discuss each of them.

Bliss clarifies the three types of hypnosis. Heterohypnosis is hypnotist induced. Spontaneous self-hypnosis and autohypnosis are often used synonymously to mean simply self-hypnosis. This synonymy is incorrect according to Bliss. He defines autohypnotic experience as, “a trance consciously induced by a subject after he or she has been taught the technique by a hypnotist.”⁵⁵ Unlike hetero-and autohypnosis, Bliss explains that spontaneous self-hypnosis “is a rapid, unpremeditated withdrawal into a trance, a dissociation, untaught and instinctive, a primitive defensive reflex that people experience usually when anxious or fearful—often in response to some psychological or physical threat.”⁵⁶ This would mean, according to Bliss’s model, *if MPD/DID is tied to childhood dissociative playacting and abuse, then only spontaneous hypnosis can result in so-called real MPD/DID.*⁵⁷ [It is heterohypnosis and autohypnosis that most likely subject

MPD/DID to the accusation of iatrogenesis.] The three types of hypnosis are heterohypnosis, autohypnosis, or self-hypnosis, with self-hypnosis being the most likely explanation of the development of “real” MPD/DID.

But self-hypnosis may not just be a predecessor of MPD/DID—it may also be involved in acting, since the basic techniques of acting are learned during childhood playacting. Bliss assumes that self-hypnosis is an autonomic response. This runs counter to the notion of voluntary childhood playacting as predecessor of MPD/DID. Colin Ross admits that spontaneous self-hypnosis is used often for the enjoyment of it, without the preceding anxiety or phobia associated with multiple personality, i.e., the disorder.

But the careful scientist may object to general conclusions drawn [. . .] since all my subjects have been patients. Fortunately, there is a recent report by Wilson and Barber (289) based on a study of twenty-seven adult females with outstanding hypnotic abilities—“normal” individuals without multiple personalities or disabling symptoms. The authors reported, “We discovered that, with one exception, the excellent hypnotic subjects had a profound fantasy life, their fantasies were often ‘as real as real’ (hallucinatory). . . . It has been shown that there exists a small group of individuals (possibly 4 percent of the population) who fantasize a large part of the time, who typically ‘see,’ ‘hear,’ ‘smell,’ ‘touch’ and fully experience what they fantasize.”⁵⁸

Again, not only does this indicate that dissociation in general is normal but that the dissociation by spontaneous self-hypnosis can sometimes be intentionally fantasized as a functional and normal behavior rather than being relegated only to the unintentional, i.e., dysfunctional. Self-hypnosis may be an aspect of childhood playacting and therefore also an aspect of both alter-making and acting. Alters and actors may use the same technique to dissociate, i.e., self-hypnosis.

All three types of hypnosis can have three things in common: (1) outcome (publicly visible multiplicity or affected behavior), (2) technique (intentionally focused attention onto a fantasy, image, etc.), and (3) the same extreme degree to which the technique of self-hypnosis is used. Any type of hypnosis results in some degree or level of dissociation. All types of hypnosis resulting in changes in behavior are usually witnessed by "a pause or momentary blank spell" or a fixation of the eyes.⁵⁹ I say "usually" because Bliss notes that a blank stare may not always be necessary, as in cases reported by James Braid's work in 1843.⁶⁰ Braid had blind subjects concentrate on a single idea. The concentration alone was enough to produce the desired trance state.⁶¹ Of course, we do not know if the blind subjects were exhibiting a blank stare, just as we cannot be sure that a blank stare is accompanied by concentration on a single idea. The point is that switching alters or roles does not have to be a publicly visible transition, although it can be. As an observer, you may or may not notice that particular moment when a person goes into and comes out the other side of extreme or deep hypnosis, but you will notice the change in form or behavior that accompanies the technique.

Bliss tries to clear up whether concentration on a single idea is necessary for a trance state to occur. Concentration requires one's full attention. To concentrate on one thing, a person has to control her or his attention. Bliss compares attention with a flashlight beam. He says attention has "a concentration of luminosity in the center, which fades and grows gradually dimmer toward the fuzzy edges until finally there is darkness."⁶² What is unattended to is not a part even of the fuzzy edges of concentration—it becomes

part of one's unconscious. The question is, what is it that is being attended to in the case of MPD/DID dissociation?

When a child wants to flee from the pain of an abusive father, but physically can not get away, the child is left with the only alternative available—using the technique of playacting, i.e., pretending to be someone else. This multiplicity requires an ability to intensely focus the attention, i.e., to concentrate on the details of “being” someone else. The child attains the skill of pushing the pain into the outer darkness of the flashlight beam of concentration.⁶³ The child uses the technique of self-hypnosis to an extreme degree to accomplish the needed dissociation (dis-association) from abuse that “being” someone else supplies.

In Bliss's view, dissociative amnesia must initially have been an intention to forget. Bliss also informs us that dissociative amnesia is the failure to retrieve information hidden by spontaneous hypnotic experience. He considers how this intention to forget is accomplished, and decides it is facilitated by “the attention mechanism.”⁶⁴ [This runs counter to his view that self-hypnosis is a flight-response to danger or pain as mentioned earlier. This discrepancy in his view will not be dealt with herein.] The “retrieval process,” Bliss says, is what the attention mechanism is called when attention searches out and recaptures a memory.⁶⁵ Bliss's explanation for this “is that excellent hypnotic subjects can control this attention apparatus with unusual precision.”⁶⁶ Normally our thoughts are divided between awareness of the outside world and our inside thoughts. But hypnosis requires “an intensification of this inward attention [. . . while] external awareness

diminishes until the patient is primarily preoccupied internally, with only a faint awareness of external events.”⁶⁷

Focused attention can result in mild to deep trance states and a forgetting of what was experienced. Forgetting to turn left while driving because you are thinking about the movie you watched last night requires a mild, albeit short-term trance state. You had to “split” your concentration between your driving and thoughts of the movie. You performed the act of driving, which you do not remember, because the experience of driving was pushed into that dark realm of the luminosity of your attentional landscape. This is sometimes referred to as ‘multi-tasking’, and is a common experience, one necessary for daily living. Multi-tasking requires use of the normal ability to dissociate. In some sense, multi-tasking, i.e., splitting concentration, seems similar to what the abused child must do. The child must split attention—physically doing the acts necessary during the sexual abuse, while also attending to his or her imagination as an escape from experiencing (attending to) the pain of the situation. The child does not remember what was done to his or her body because his or her attention was absorbed on imagining being another person. Later, when the memory is recalled, the child’s memory is of the abuse happening to the alter-identity that he or she imagined him or herself to be at the time the abuse occurred. With narrowly focused attention one can detach from both abuse and the memory of abuse.

Likewise, even though abuse avoidance is not the motive for acting, the same technique must be incorporated for both cases. One possibility is that an actor must stop attending to his or her own desires, preferences, style, mannerisms, behaviors, etc., in

order to attend to the dictates of a particular character role. Alternatively, the actor may choose to select out, focus on, and use those desires of his or her own that lend believability to the character role in question. Acting, in needing to dissociate to change character roles, surely is (at least theoretically) subject to the same forgetting as accompanies MPD/DID. Whether acting results in dissociative amnesia will be addressed under the subheading Dissociation and Acting.

The difference between the driving example and the abuse example, in addition to the content of concentration, is the level of trance or hypnosis needed for the result. The driving example required little intensity of concentration. The child ignoring pain, as well as the example of acting, required what Bliss refers to as deep trance. The child, as well as the actor, not only had to imagine being the other person, he or she had to believe it totally—hence the so-called split in consciousness and the manifestation of various personalities/identities. The abuse example required the technique of extreme or deep self-hypnosis (trance) to accomplish the development of an alternative character or self. Acting, too, may involve this deep level of self-hypnosis and the forgetting that accompanies it.

It is the clinical conception that alter-making is not acting that initially undermines the possibility that the same level of self-hypnosis is used for each. Moreover, the belief that alter personalities are “real” autonomous, continuous entities moving in and out of consciousness gives rise to the psychoanalytic problem of accounting for the unconscious force of switching, i.e., the problem of accounting for “who” the unconscious controller of the switch is. Recall that psychoanalytic theory of the unconscious was superseded by

Ross's psychodynamic theory of vertically split consciousness because of this problem. It is Ross's theory of alter-identities as conscious identities that allows for the possibility of actors enacting various roles while maintaining a sense of their "real" self to return to after the character role is completed.

But, clinicians like Ross would say that, MPD/DID clients really believe they are many people and actors do not—that MPD/DID clients confuse fantasy with reality, and actors do not. In Bliss's model, deep trance involves what some scientists refer to as "trance logic," wherein fantasy seems plausible and real.⁶⁸ Deep trance, and its accompanying trance logic, are products of all types of hypnosis. In hypnosis a deep trance occurs wherein "the distinction between imagination and reality is lost, and rational control of behavior is suspended."⁶⁹ The lost imagination-reality distinction occurs because the person narrows the focus of attention on mental activity to the exclusion of all else—even to the exclusion of bodily sensation and intense pain. Bliss explains the many facets of hypnosis that must occur in multiple behavior.

Any theory of hypnosis [...] must encompass the many facets of the phenomenon, including realistic role enactment (230); the redistribution of attention; the loss of initiative; vivid images, realistic memories, and realistic fantasies; the reduction in reality testing—trance logic; and increased "suggestibility"—the many feats potentially possible in hypnosis, including amnesias.⁷⁰

In Bliss's view, multiplicity involves trance logic and can result in amnesias. Any theory of dissociation must include hypnosis because somewhere during the person's narrowly focused attention, a hypnosis begins.

If hypnosis is necessary for the dissociation of multiplicity, and if everyone dissociates, then everyone must experience some level of hypnosis and its accompanying trance logic when acting out various identities or roles. Childhood playacting, which supposedly all children do around ages two to five, requires self-hypnosis. But the dissociative techniques learned in normal childhood are continually used into adulthood (hence the continuum of dissociation).

As children, the subjects studied by [S. C.] Wilson and [T. X.] Barber lived in a make-believe world much of the time. "Dolls and stuffed animals seemed to be alive," and these objects had "their own things to say" and "their own feelings." As children, most believed in fairies, elves, and guardian angels. They played and interacted with imaginary companions whom they clearly saw, heard, and felt as living people or animals. Some could later read books and become one of the characters. Through fantasy, they could become someone else—an orphan, a princess, or Cinderella.

As adults these subjects continued to spend much time in fantasy—about 50 percent of their day.⁷¹

As can be seen, Bliss (via Wilson and Barber's research) shows us examples of "normal" children creating alter-selves, i.e., creating multiplicity via spontaneous hypnosis, i.e., dissociation. It is also indicated that children continue to extremely dissociate into adulthood as a *normal* aspect of daily life.

If all of us dissociate using various levels of the same technique—hypnosis (with its accompanying trance logic)—then why is it that some forms of dissociation cross the continuum's invisible demarcation line into the realm of mental illness? According to Bliss, mental illness has to do with the depth of the trance state: "[. . .] the dimension of depth for subjects primarily involves the degree of their inner absorption, the extent to

which they relinquish the external world and the body until finally they seem to disappear altogether.”⁷² According to this quote, inner absorption reflects mental illness.

In light of what Bliss says about the mechanism of attention, his explanation is confusing. On the one hand, he makes it seem like the degree of depth or degree of inner absorption must directly have to do with intensity of concentration or attention to one thing, i.e., narrowing the flashlight beam of attention into a very narrow band of concentration. But this cannot be the case because dissociation is a technique; inner absorption is a result.

In other passages mentioned earlier, he makes it seem as though the degree of inner absorption has to do with other facets of the phenomenon, such as realistic fantasies, i.e., a lost sense of reality. This suggests it is not intensity of concentration but rather belief in the reality of the fantasies concentrated on that represents mental illness. Bliss does not clear up this point, but Ross does.

Ross unknowingly addresses Bliss’s mistake. Ross refers to this fantasy-reality confusion as “dissociative delusions.”⁷³ He equates a deep degree of inner absorption with these delusions. MPD/DID clients become so absorbed in their alter-selves, i.e., their inner worlds, that they “‘see,’ ‘hear,’ ‘smell,’ ‘touch’ and fully experience what they fantasize.”⁷⁴ Bliss further explains that a difficulty distinguishing between “events in the real world and those in the hypnotic world” are a source of recurring client complaint.⁷⁵ This is because clients can switch personalities (enact various roles) and by doing so “are literally living in another world.”⁷⁶

It is this ability of using hypnosis to narrowly focus one's attention, to get rid of the outside world or the contrast between outside reality and inner world fantasy, that enables a person to successfully confuse an alter-self (a character role) with real life. To do so requires the attainment of a deep trance state. MPD/DID clients are said to be good at this. They can use spontaneous hypnosis or autohypnosis to literally enter another world. In doing so, the memories created in one world are somehow (according to some clinicians, like Bliss) split off from each other *as if* the individual is really separate personalities rather than the person merely having Rossian delusions about the alter-selves.

Bliss explains that attention can be controlled with unusual precision by excellent hypnotic subjects.⁷⁷ This statement by Bliss (counter to his notion of hidden memories) and Ross's vertical split view suggest that memories are not hidden but just unattended to. Bliss even says that MPD/DID clients keep memories hidden by avoiding to attend to them as memories sporadically surface. Clients stuff them down—rebury them, to use Bliss' psychoanalytic conception.

A further consideration is how the fully conscious subject, not under hypnosis, can avoid these unconscious memories.

Excellent hypnotic patients under tranquil conditions are not usually in trances. [W]hen their peripheral attention detects a threat, they can instantaneously enter the hypnotic mode, using their potential capability, and alert to the danger can avoid it. [T]he patient alerts to an internal danger—the appearance in consciousness of the repudiated memory.⁷⁸

This means that clients have to control their switching identities by implementing the dissociation (hypnosis) needed to avoid remembering. Bliss' notion runs counter to the more traditionally psychoanalytic diagnostic criterion B—that the client's alters

sporadically take control of the client's behavior. In this respect, Bliss's view seems more like Ross's. In Ross's view, memories are simply ignored until focused on.

Bliss could have left us believing that only MPD/DID clients are excellent hypnotic subjects. Doing so would have further supported the psychoanalytic notion that only MPD/DID clients can become too absorbed in a fantasy world of character roles because of childhood trauma. But Bliss's own research challenges this theory. He puts the general traditional theory of hypnosis in jeopardy by making the following conclusion about Wilson and Barber's "normal" excellent hypnotic (dissociative) subjects. Bliss found that according to Wilson and Barber, non-mentally ill, normal, people also hone their skills of focused attention (hypnosis).

[...] the following conclusion seems plausible. Many people are not excellent hypnotic subjects, hence their realistic worlds are restricted to the real Newtonian world and to dreams while they are asleep. But excellent hypnotic subjects have the added dimension of a third "real" world---that of hypnosis. Some can live normal lives, with only vivid realistic fantasies. Others, due to noxious circumstances, unwittingly exploit their hypnotic skills and create personalities, amnesias, and a plethora of symptoms.⁷⁹

But as you can see, Bliss still wants to distinguish between normal vivid realistic fantasies and the creation of personalities.

Even though Bliss admits that people use dissociation from childhood into their adult lives for pleasure (not just to avoid pain), and even though to do so requires the same technique (whether child or adult), he and other clinicians still want to make a distinction between alter-making and acting.

It appears that what the adult or actor who uses extreme dissociation is guilty of is having a rich fantasy life. Adults, according to our society, are supposed to grow up, detach from such things as fantasies, and trade them in for rational, reasonable beliefs—and not pretend and believe they are someone other than who they are. But acting involves just that—pretending.

As Marlon Brando says, we each contain within us the seeds of all characters we will ever play. Actors do not play ‘autobiography’, they build from observation and imagination as well as personal experience. Individual life-patterns can be transcended, albeit temporarily, by actors, and in their place they can reach into the depths of themselves to produce new people—it is this ‘Everyman’ ability [. . .]⁸⁰

Each of us, in having this ‘Everyman’ ability, has the ability to extremely dissociate and suffer the repercussions of a vivid imagination, i.e., inner absorption and dissociative delusions. This view will be explained more thoroughly, and supported using research findings and examples from an acting psychologist as well as referring to self-reports by actors and directors, in the next chapter on *Alters Versus Actors and The MPD/DID Client-Actor Model*.

Summary

Dissociation is not just one experience, easily defined as split consciousness or the opposite of association. It is a host of experiences ranging from the simple to the complex, the mundane to the seemingly bizarre, and the normal to (clinicians contend) the psychopathological. It can be done for pleasure or to avoid pain. Children as well as

adults can bring it about. And it can be done intentionally (consciously) or unintentionally (unconsciously/habitually). Having so many facets makes a continuum of dissociation (rather than a simple definition) rather necessary, as its historical development reveals.

Some people, like Hacking, claim dissociation is about so many things as to be unreliable as a basis of any disorder. Yet, proponents of MPD/DID insist that they know it when they see it and that its most extreme form appears as multiple personality/dissociated identity disorder. Those who ignore its existence as an experience just because it is hard to articulate, run the risk of leaving all those clients diagnosed with MPD/DID without a better explanation of their divergent behavior, forgetfulness, time lapses, etc. At the same time, those who believe dissociation, i.e., a skill or trait, can develop into separate, distinct, autonomous, identities leave the client, observers, and even some clinicians questioning the bizarre interpretation of many selves in one body.

The dissociation continuum attempts to alleviate the bizarre picture of MPD/DID, by tying it to normal behavior. Putting it on a continuum of experience defies the possibility of MPD/DID as a brain disease. Even if a disease could exaggerate one's potentials, this would be considered a soma or brain-based dissociation and would be disqualified from the category of Dissociative Disorders, i.e., "mental" Disorders. As long as MPD/DID is considered as a psychologically-based or psychodynamically-based experience, it runs the risk of being compared to acting. The continuum that aids MPD/DID in its plausibility as an extreme form of a normal trait or skill, is the same continuum that demands a demarcation between normal dissociation and its extreme counterpart.

Still, there does appear to be something different between MPD/DID clients and actors—a level of dysfunctionality. Alters seem to have problems functioning on a daily basis and are sometimes suicidal or homicidal whereas actors seem to do okay and even enjoy living. To investigate this difference we need to better understand the alter-actor distinction. We need to compare the experiences of MPD/DID clients' alter-making with those of professional actors enacting character roles. The next chapter will investigate the alter-actor distinction more fully, putting into question whether it contains a justified and warranted conclusion.

Notes

¹ Ross 185-89.

² Ross 177-89.

³ The concept of enacted roles lacks the metaphysical implications that the concept of the creation of alter-identities carries with it. For the metaphysical ramifications of MPD/DID see chapter five.

⁴ Ross 79.

⁵ Evidence for this can be obtained by attending post-birth Lamaze classes and listening to new, first-time-parent stories, or by talking to directors of new-parent support groups. Incidence is seemingly rare per individual couple but more common among first-time parent couples in general.

⁶ There is current debate and consideration over a mental illness classification for childhood MPD/DID.

⁷ I have read somewhere, but can not remember the citation, that some MPD/DID therapists are currently attempting to implement a diagnostic classification for childhood MPD/DID. This would involve an attempt to distinguish between the normal childhood use of extreme dissociation involved in pretending, effectively, to be other people, and the extreme dissociation used post-abuse or dysfunctionally, at inappropriate times—inappropriate to the child's age and ability.

⁸ See Hacking's conceptions of retroactive redescrptions and his conception of the looping effect of human kinds.

⁹ Decker 51.

¹⁰ Decker 51.

¹¹ Burnham 78.

¹² Burnham 78.

¹³ Decker 49.

¹⁴ Later, psychodynamic theory takes a more sympathetic account of the interaction between mind and body than psychotherapeutic theory did in the early stages of the historical development of MPD/DID.

¹⁵ Prince 75.

¹⁶ Prince 75.

¹⁷ Prince 22.

¹⁸ Prince 3.

¹⁹ Prince 75.

²⁰ Prince 69, 76. Prince refers to Binet as M. Binet rather than A. Binet citing his work, Alterations of Personality, Trans. Helen Green Baldwin. 1986. 301, 303.

²¹ Prince 75.

²² James Vol. I, 227.

²³ Webster's.

²⁴ James Vol. I, 227-28.

²⁵ Confer and Ables 18.

²⁶ Confer and Ables 18-19.

²⁷ Bliss 99.

²⁸ Bliss 105-06. [Bliss refers us to Hilgard's works.]

²⁹ Bliss, himself, is torn by these two views but personally favors the trait-based conception of dissociation as being something hardwired into our physical systems.

³⁰ Bliss 127.

³¹ Bliss 126.

³² Bliss 128.

³³ Bliss 105-35.

³⁴ Ross 89.

³⁵ Ross 87.

³⁶ Ross 87.

³⁷ Ross 187; 60.

³⁸ Lysaker, John. Dissertation comment to author. 26 Oct. 1999.

³⁹ Burnham 78.

⁴⁰ Ross 80.

⁴¹ Ross 80.

⁴² Ross 80.

⁴³ Bates 55-56.

⁴⁴ Ross 79.

⁴⁵ Ross 69. Some clinicians would refer to this as multitasking, not dissociation. But, Ross thinks that "splitting and dissociation are synonyms" and he believes divided attention is synonymous with splitting.

⁴⁶ Burnham 143.

⁴⁷ Bliss 99. Bliss makes reference to Hilgard as to this point.

⁴⁸ Ross 84.

⁴⁹ Ross 84; 103.

⁵⁰ Ross 217.

⁵¹ Ross 217.

⁵² Ross 89.

⁵³ Ross 89.

⁵⁴ Bliss 134.

⁵⁵ Bliss 70.

⁵⁶ Bliss 70.

⁵⁷ Iatrogenic MPD/DID would have to occur from heterohypnosis and its subsequent autohypnosis—a possibility that remains to be considered elsewhere. The counterpoint position would claim that auto- and heterohypnosis bring alters out in cases of clients who are unaware of their multiplicity. This brings up a question of how to distinguish between autohypnotically induced alter-selves and spontaneous hypnotically induced alters. Hence, the rightfulness of the claim of MPD/DID as iatrogenic.

⁵⁸ Bliss 73.

⁵⁹ Bliss 139.

⁶⁰ Bliss 25-27.

⁶¹ Bliss 102.

⁶² Bliss 100.

⁶³ This brings up a problem that is dealt with more fully in chapter five, i.e., the chapter on the metaphysical disorderedness of MPD/DID. If something did not get paid attention to it cannot become a memory. You cannot have amnesia about events you never witnessed or noticed. You can only remember what you attend to. This point presents a problem for dissociative amnesia.

⁶⁴ Bliss 105.

⁶⁵ Bliss 105.

⁶⁶ Bliss 105.

⁶⁷ Bliss 105.

⁶⁸ Bliss 107.

⁶⁹ Bliss 98.

⁷⁰ Bliss 99. Role enactment (230) is his reference to T.R. Sarbin's contributions to role theory.

⁷¹ Bliss 73-77; an unquoted table by Bliss lengthened the number of pages; emphasis added.

⁷² Bliss 67.

⁷³ Ross 109. The belief that one is many persons, he refers to as imaginary, and hallucinatory (61, 107).

⁷⁴ Bliss 73.

⁷⁵ Bliss 143.

⁷⁶ Bliss 135.

⁷⁷ Bliss 105.

⁷⁸ Bliss 111-12.

⁷⁹ Bliss 73-8.

⁸⁰ Bates 83-4.

CHAPTER IV

ALTERS VERSUS ACTOR AND THE MPD/DID

CLIENT-ACTOR MODEL

In the last chapter on *Dissociation And Its Continuum*, MPD/DID was clinically reported as the most extreme form of dissociation, i.e., dissociation as a mental disorder. The historical path of dissociation led us to the conclusion that psychological dissociation is not something caused by an anomaly of or degeneration of nature (a disease or genetic disorder), but is instead the result of both nature (a trait) and nurture (a skill). Some of us learn to dissociate to a greater degree; yet not all of us are diagnosable as MPD/DID. If we all dissociate, but we are not all MPD/DID, some qualitative differential exists between normal and abnormal (extreme) dissociation. Clinicians (like Eugene Bliss or Colin Ross) believe that this difference has to do with *degree or level of absorption into a fantasy or character role*. MPD/DID clients become deeply absorbed by the identities they play and suffer dissociative delusions from doing so—actors do not. Extreme dissociation is a psychopathological experience—not an experience of the actor. MPD/DID client alter-identities are real (or perceived by the client as real), whereas actors' characters are

mimicked (i.e., faked, pretended, lack real feeling) and are acknowledged by actors as not real. I refer to this group of differences as the alter-actor distinction.

I contend that the alter-actor distinction is not valid. Its main support rests on a naïve view of acting as mimicry (imitated feeling). Reports from psychologists of acting, actors themselves, and directors of acting, as regards experiences of acting, can be used to both (1) challenge the validity of the clinically perpetrated distinction between alters and actors, and (2) support the contention that the MPD/DID client is an actor (i.e., the MPD/DID client as actor model). The alter-actor distinction is the result of three clinical conceptions: (1) the conception of client behavior as real identities, (or at least real to the client, i.e., dissociative delusions), (2) the conception of acting behavior as mimicked or fake feeling, and (3) the belief that extreme dissociation is indicative of mental illness and not of normal and common experience. The validity of MPD/DID rests on the claim that actors do not engage in the behaviors indicative of MPD/DID diagnostic criteria while switching and portraying character roles. If actors can suffer the same negative symptoms of changing roles as clients do in switching alter-identities then the distinction between alters and actors loses its basis, and reasons exist to believe the MPD/DID client is a type of actor. [This may, potentially, seem like bad news for actors. But, actors are aware of, and most choose to guard against, the dangers of acting, i.e., of 'living near the edge' of psychological danger (which is addressed under that subheading later in this chapter.))] If the alter-actor distinction is invalid, then multiple personality/dissociated identity is not a mental illness (though MPD/DID clients may suffer from some other problems).

To analyze whether alters are actors it needs to be made clear what view of MPD/DID we are comparing acting to. The importance of the diagnostic criteria in the distinction between alters and actors also needs to be taken into account. Then, two clinicians' attempts at establishing the difference between alter-making and acting will be analyzed. Colin Ross makes a theoretical distinction between alters and actors, while Frank Putnam attempts to substantiate the alter-actor distinction with scientific investigation and hopefully significant findings of the physiological differences between alters and actors. Both clinicians ignore the 'paradox of acting' and the significance of the actors' conception of the hidden observer. Next, when acting psychology and actors' self-reports are considered, a similarity between acting techniques and extremely dissociative experience will be found. This alter/actor similarity will sufficiently blur the normal-abnormal demarcation line in the dissociation continuum and put into question the validity of multiple personality/dissociated identity as a disorder. This is because, if actors dissociate to the same degree as MPD/DID clients, then MPD/DID clients are not significantly different than professional actors. Multiple personality/dissociated identity is therefore not a disorder.

It should be noted that, exposing the moderate view's conception of acting as naïve will not make all distinctions between alters and actors fade.¹ But, the differences that remain will not shore up the alter-actor distinction. Some of the differences that will remain between alters and actors have to do with the range of emotions accessed, the quality of acting, and the psychological safeguards of acting, i.e., healthy versus unhealthy acting techniques (often directed by therapists), and will be addressed in chapter six.

The Alter-Actor Distinction

There are two distinct clinical views behind the alter-actor distinction—what I refer to as the extreme and moderate views of MPD/DID. There may be more than two views supporting the distinction, but only the two views mentioned will be presented herein. The extreme view incorporates those believers of MPD/DID that contend that alters are real, separate, distinct, autonomous, personalities, persons, identities, or selves, and that inner voices are indicative of these real identities. The moderate view includes those believers of MPD/DID who claim that alters are not real but rather imagined, felt, and believed, as real by the client whether the realness was arrived at by self-hypnosis or iatrogenic means. The moderate view interprets inner voices as hallucinations/delusions.

Both the extreme and moderate views stem from the diagnostic criteria of MPD/DID. The diagnostic criteria represent those behaviors that are considered indicative of mental illness.² Whether clients (DC-A) really have multiple identities or instead have dissociative delusions (i.e., really believe they have or are multiple people), clinicians contend that MPD/DID clients can not control (DC-B) the ‘switching’ and coming ‘out’ of alter-identities. Both views agree that clients, not actors, suffer (DC-C) dissociative amnesia. Clients exhibit the symptoms listed in the diagnostic criteria for MPD/DID; professional actors do not.

The extreme view is that MPD/DID clients really “are” or “have” alter-selves. As Eugene L. Bliss puts it, “The crux of the problem is whether patients are consciously playing a role or *are* someone else.”³ What Bliss and other therapists of the extreme view

want us to believe is that, “Whether these behaviors are to be judged as real or feigned ultimately depends on what is happening within the black box of the mind.”⁴ This approach presumes that the problem takes place in the client’s mind rather than somewhere else, such as either (1) in the client’s brain (i.e., DC-D contends that MPD/DID is not organically based) or (2) a result of a clinical misconception of client behavior. The extreme view ignores these possibilities and states that MPD/DID alter-identities are real; acted identities are not real.

The focus of the analysis of the alter-actor distinction will be on the moderate view. The extreme view that alter-identities are real cannot be dealt with herein. The extreme view involves a metaphysical claim of identities as distinct, autonomous mind-only events, with numerous accompanying metaphysical-logical problems. These problems are dealt with at length in the next chapter (chapter five). Repudiation of the alter-actor distinction will be based on the moderate view of MPD/DID, as put forth by Colin Ross and as scientifically tested by Frank Putnam.

Colin Ross’s Claim

As a general overview, the moderate view of MPD/DID considers clients are acting but not in the way professional actors do. In the moderate view, alter-identities are dissociative delusions—clients do not have alter-identities but rather merely strongly believe they have many people inside them. This is clinically put forth as contrary to professional acting—actors do not have delusions about ‘who’ or how many ‘who’s’ they

are. MPD/DID clients really feel the parts they act while professional actors only mimic the feelings of character's played. MPD/DID is an involuntary behavior, with accompanying psychological mental problems and psychophysiological behavioral manifestations. MPD/DID's involuntary quality implies that clients are suffering—they are not mimicking or faking MPD/DID, i.e., they are not acting in the same sense as professional actors. In the moderate view, MPD/DID clients suffer from switching identities, are dysfunctional because of their multiplicity/dissociated identity, and are mentally ill, whereas professional actors do not suffer from changing roles, are not dysfunctional because of their acting, and are not mentally ill.

Colin Ross's view is the epitome of the moderate view. He contends that "MPD is not acting in the sense that Hollywood actors perform a role."⁵ Ross believes dissociation is a developed skill that we all have—MPD clients and actors alike. Ross says "MPD is based not on defect but on talent and ability."⁶ According to Ross, "the ability to create alters is common," and starts during early childhood development.⁷ The transformative quality of moving from one identity to another is common in childhood.

There are countless myths and legends from around the world that make use of transformation of identity...children in our culture are familiar with transformation of identity from comics, movies, television, and books. Who has not watched a child zooming around on the sidewalk or in the backyard, pretending to be a superhero or some other figure? Who can doubt the child's intensity of imaginative involvement in this transformation? I think it is reasonable to say that the normal child partially believes in this transformation on a transient basis.

It is not necessary to wonder where the MPD child gets the idea of creating someone else inside to cope with the abuse. The strategy of transformation of identity to gain strength, ability to cope, and invulnerability is readily available in the child's environment.⁸

His view is straightforward. All of us can pretend to be someone else. "The building blocks of MPD must be present in most if not all cultures." (Pg. 12) By building blocks Ross means the cognitive capacity for making use of transformation of identity, i.e., extreme dissociation. All children, and hence adults, have in them the ability to act to use dissociation to acquire other identities while suspending disbelief they are those people.

That we can all pretend does not mean that all children that play-act are, or become, MPD/DID. According to clinicians, it takes an extreme level of dissociation (usually used over a long period of time) for MPD/DID to occur. Clinically speaking, it means that all children, if put in threatening, harmful, or painful situations, especially those that take place long term, may use play-acting in an extreme way that can (though it does not have to) manifest as MPD/DID in adults. Clinicians believe that the level of extreme dissociation that results in MPD/DID occurs only when playacting is a response to something negative such as neglect or abuse. In other words, pain is an extreme motivator that prompts use of extreme measures, (i.e., dissociation) in order to attain complete detachment from 'being' the one feeling the pain. The belief is that MPD would not result from playacting for fun or pleasure because these create delightful memories, whereas, alter-identities are clinically interpreted as housing *unwanted* memories of pain and suffering. MPD/DID is the result of extreme dissociation, whereas acting is not, because acting is clinically believed to be devoid of the motive of pain/suffering avoidance. In spite of the fact that we can all act (pretend), Ross insists that MPD is "a true psychiatric disorder."⁹ We can all *act* like this or that imaginary person, but not all of us are motivated to take it to the extreme level that the MPD/DID client does.

Ross's admission that we all create and imagine ourselves as alternative characters in childhood, leaves open the possibility that MPD/DID clients are just good actors—like professional actors. This admission prompts Ross to clarify the difference between childhood playacting turned into adult disorder, and childhood playacting turned into adult professional acting.

Ross considers there to be “a lot of drama in MPD,” just as there is in professional acting.¹⁰ For the purpose of distinguishing between dissociation as a psychopathology and dissociation as acting, Ross contrasts MPD/DID clients as actors to Hollywood actors.

The patient is acting *as if* she is more than one person, but she isn't. This is different from Hollywood acting because the patient is so *absorbed* in the different roles that she believes in their reality. When I discussed this point with a drama professor, he said that acting students, who become too absorbed in their roles, become poorer actors. MPD is not acting in the sense that Hollywood actors perform a role.¹¹

This quote is more of a commentary than evidence as to the distinction between MPD/DID client-actors and professional actors. Ross does not go into detail or make distinctions between stage, movie, or TV series performances (though differences for actors as to levels and types of dissociative experiences may exist among types or longevity of performances). Because he is speaking in terms of the MPD/DID client as acting (in some sense), I assume that he uses the word Hollywood to distinguish between clients and professional actors. It appears to be his intention that the phrase “Hollywood acting” be indicative of all types of acting and all types of performances. With this in mind, the notion of becoming “too absorbed” in a character role and thereby coming to

believe “in their reality” plays a fundamental role in the clinical distinction between alter-making and professional acting.

When Ross’s view is analyzed, he appears to be claiming (though he does not itemize his claims) that there are five clinical differences between alter-making and acting. MPD/DID clients experience the following, but actors do not: (1) extreme dissociation, (2) role absorption, (3) dissociative delusions, (these first three items are indicative of diagnostic criterion A), (4) initial lack of control of alter-identities coming out (i.e., DC-B), and (5) dissociative amnesia (i.e., DC-C). What this amounts to is the claim that MPD/DID diagnostic criteria oppose acting. Acting does not result in behaviors indicative of the diagnostic criteria of MPD/DID—acting is not a psychopathology, but MPD/DID behavior is. Whether Ross is correct, that items one through five are not indicative of professional acting, remains to be investigated.

It should be noted that by lumping all types of acting and performances together as Hollywood acting might problematize his claim. Role absorption may occur more easily in some types of performances and acting styles and not at all to others. For example, as Jack Watson, theater professor, pointed out to me, “Film acting is quite discontinuous and does not easily lend itself to the sort of role-absorption” experienced by long-term enacted roles (referred to later), whereas “stage acting requires less ‘switching’ between character and actor and might make a better comparison” for challenging the alter-actor distinction.¹² For now, these possibilities will be put aside, because if some actors using any style of acting or type of performance suffer the MPD/DID symptomatology in question, the alter-actor distinction is compromised.

Unlike acting, MPD/DID is the result of “extreme” dissociation. Clients become *too absorbed* in their characters to the point of believing they are those characters. Clients suffer *dissociative delusions* about who and how many people they are. Actors, Ross believes, do not experience dissociative delusions about which ‘who’ they are because they do not extremely dissociate, and so cannot become absorbed in the roles they play. Both alter-making and acting come out of childhood playacting, but MPD/DID clients learned to present multiple identities (DC-A) by using playacting to an extreme degree as a response to something negative, and thereby suffer character role absorption and dissociative delusions that they are many people, whereas, actors do not.

MPD/DID also involves abnormal; i.e., uncontrollable, dissociation or switching (DC-B), while professional acting involves controlled dissociation (changing roles). Regarding the alter-actor distinction and an actor’s ability to maintain control during his or her workday, Ross says,

An actor has to do many takes, jump from scene to scene numerous times in a day, start and stop acting instantaneously, make minute adjustments in his posture, tone, and facial expression, and carry out numerous other *highly controlled actions*.¹³

In other words, actors control their behavioral changes (their switches) and MPD/DID clients do not. [Note that jumping “from scene to scene,” etc. may be more like film acting than stage performance. Each may affect the alter-actor claim differently, as expressed earlier.] Ross believes that an actor’s switching characters and the accompanying changes in posture, tone, expression, etc., that are needed to portray those characters are in his or her control. Contrary to professional acting, Ross, in agreement

with DC-B, indicates that an MPD/DID client, at least prior to and during the initial phases of therapy, does not start and stop an identity switch intentionally—it is the identity that takes over control of the client. [Therapy, in part, is geared toward helping the client get control of, and hence cease the unwanted switching, the existence/presence of alters and the accompanying inner voices.] For Ross, the issue of control appears to be an either/or situation—professional actors do not lose control of acting, and MPD/DID clients have difficulty learning how to gain control. Because Ross has said that alter-making is a type of acting, he is pressed to state, at least hypothetically, that if actors did lose control of their acting they would exhibit MPD/DID symptomatology.¹⁴ He says this tongue in cheek, not really believing it can happen.

MPD/DID clients also suffer dissociative amnesia (DC-C); actors do not. If actors extremely dissociated as MPD/DID clients do, actors, too, would become perplexed (would experience dissociative amnesia) about who and where they are and about what they are doing. Ross says, “If the actor really felt like a cowboy or science fiction hero, he wouldn’t be motivated to act and would probably be perplexed as to where he was and what was going on.”¹⁵ The clinical claim is straightforward. MPD/DID clients, not actors, suffer negative effects of their acting—one of them being dissociative amnesia.

To review, the difference between alters and actors, according to Ross, is that alter-making and alters are indicative of MPD/DID diagnostic criteria; professional acting is not. MPD/DID clients extremely dissociate which results in them becoming too absorbed in various alternate roles which in turn contributes to the client having dissociative delusions that he or she is many people (DC-A). MPD/DID clients have

formed a coping habit of extreme dissociation to the point clients lose control of their switching roles (DC-B). This results in the client experiencing dissociative amnesia (DC-C) while acting as other people—while extremely dissociating. Ross's claim is that actors experience none of these symptoms when they act—actors maintain control while they play various roles, and they know which *who* they are.

Ross's claim may seem extreme—questions of degree may seem pertinent here. But Ross, in not seriously believing that alter-making and acting are alike, except for the dramatic effects, does not delve into the matter more deeply. It must be remembered that the majority of MPD/DID therapist believers fall into the extreme view category. Ross, as explained in chapter three, by entertaining the notion of consciousness split vertically, wherein alter-identities are available to conscious awareness, transformed the conception of alter from real, autonomous, separate, distinct, identity, to that of a dissociative delusion—a belief in an otherwise false reality. Ross's how-to manual for the diagnosis and treatment of MPD, published by the Interlibrary of Science, is a major work in the field. His claim that alters and actors have something in common involved taking a bold step. It put a new slant on what is meant by the reality of, or presence of, distinct alter-identities (DC-A). And, because of his prominence, it deserves to be seriously addressed.

The Actor's Paradox

Ross's view of actors as not experiencing extreme dissociation (and its negative psychological effects) involves what in theater literature is called the paradox of acting.¹⁶

What Ross neglects to make note of or explain is that the actors' paradox is the subject of a huge debate in the acting industry. The paradox of acting has been debated since at least the early 1700's, before psychiatry even existed.

The paradox of acting has to do with "self-control" over the created personality by a hidden onlooker (a dissociated but conscious part of one's self). [One of the negative symptoms of MPD/DID that are mentioned above has to do with loss of control over switching behavior.] If the hidden onlooker loses her position as onlooker and becomes "too absorbed" into the stage character (i.e., extremely dissociates), she loses both herself and with it her ability to be a great actor. The paradox is that one must "be" two identities at once. The actor must be both the person (the actor) and the enacted character at the same time, in order to perform well. But, must the actor be both the enacted character and the observer in order to avoid suffering the psychological dangers of acting? In other words does having a hidden observer help protect one from suffering psychological dangers that may accompany acting? Does having a hidden observer keep an actor or a client from becoming too absorbed into a character role? The answers to these questions will unfold as we continue and may turn out to depend on what type of role is being performed or which acting techniques are used, and not just depend on the existence/presence of a hidden observer.

As regards MPD, you would think, then, that clients do not manifest this paradox since they lack "self-control" over their created personalities. Likewise, you would think they would lack a hidden observer. Supposedly, to maintain a hidden observer is to maintain the self-control of the actor's paradox, thereby avoiding deep absorption into a

character role and its accompanying dissociative delusions. But, surprisingly, clinicians speak of MPD clients as having hidden observers.

Hidden Observers: MPD Alter-Identities or Actors' Paradox

Talk of hidden observers also appears in MPD/DID literature. But, Ross does not speak of the hidden observer in terms of the actor's paradox. He speaks of it as regards mental illness (MPD). In reviewing the clinical history of the hidden observer, Ross notes that Alfred Binet (1890) acknowledged that a man named Richet (first name not given) was "the first person to identify the hidden observer."¹⁷ But, evidently unknown to Ross, Denis Diderot spoke of the hidden observer in connection with acting in the early 1700's. This oversight suggests that before psychiatry began, which importantly is also before MPD/DID was conceptualized, both acting and the behavior now referred to as alter-making were not distinguished from each other. It is not possible to know whether Ross would have maintained the alter-actor distinction had he known about the actor's conception of the hidden observer.

Contrary to Ross's conception of a hidden observer as a psychopathological phenomenon, Binet's observation included normal, highly hypnotizable individuals. Binet says of Richet,

He has brought out the fact, that in hysterical persons and *in a great many individuals reputed normal*, there exists a sort of permanent semi-somnambulism; in other words, there is, in these subjects, an unconscious ego, an unconscious activity, which is constantly on the watch, which contemplates, which gives

attention, which reflects, which forms inferences, and lastly *which performs acts*—all unknown to the conscious ego.¹⁸

Somehow, over the years since the late 1900's, it seems to have been forgotten by clinicians that Richet and Binet's notations included normal people's ability to have a hidden observer. According to Ross, Binet also observed "that experimental alters can be produced in normal highly hypnotizable subjects," and noted "that these alter personalities were transient and incomplete analogues of full MPD."¹⁹ Ross's interpretation of Binet's comments is subsequently colored by Ross's forgetting the commonality of having a hidden observer. He assumes that what Binet's view amounts to is a claim that hidden observers are predecessors of, or the beginnings of, alter-identities which have not yet fully developed into MPD in the normal client.

Ross again stresses the connection between psychopathology and the hidden observer when he reminds us of a case of MPD, i.e., Breuers's case study, Anna O., whose "clear-sighted and calm *observer* sat, as she put it, in a corner of her brain and looked on at all the mad business".²⁰ In addition, Ross claims there exists

a connection between inner self-helpers and the hidden observer (Hilgard, 1984). [...] The hidden observer is an experimental artifact of hypnosis experiments rediscovered by Hilgard and rigorously studied by him.[...] In Hilgard's opinion, which is scientifically cautious, it is a mistake to extrapolate too quickly from his experiments to the phenomenology of MPD. However common sense dictates that there must be a connection.

By disregarding scientific caution, he ignores the warning signs that the hidden observer may be an "Everyman ability", one that is common to hypnosis (or trance states). Ross trades scientific caution for common sense to arrive at his belief that hidden observers and

inner self-helpers are connected in some way. Ross believes that more than a connection exists. He actually believes that “inner self-helpers,” are MPD/DID client alter-identities, and hence that alters might be hidden observers. In his subchapter on *Features of the Personality System in Multiple Personality Disorder*, and in particular under the subheading of *Protector Personalities*, Ross says,

Inner self-helpers are both observers and protectors, although some only help by knowing, not by doing. The observers seem to represent a dissociation of memory, but they usually have only a part of the full phenomenon of memory available to them. They have only the information component, not the feeling, the physiological arousal, or the sensory intensity of the memory. These aspects are parceled out to the children and others.²¹

“Children and others” refers to alter-personality functions and alter-personality types, of which there can be many. Ross considers hidden observers to be one of the functions of the MPD/DID client’s personality system, i.e., a protector personality. Clearly, Ross equates hidden observers with alter-identities. And, since alter-identities are a product of extreme dissociation, hidden observers get relegated to those who extremely dissociate—individuals with psychopathologies, i.e. not actors.

According to Ross’s understanding, it supposedly is the case that not keeping a hidden observer while acting would subject the actor to becoming too absorbed by the character played. Ross explains that *anyone* becoming too absorbed in a role would suffer dissociative delusions—MPD/DID client and actor alike.

The actor who became too absorbed in his role would be disoriented and dysfunctional, like the MPD personality who comes out of a blank spell in a bar, surrounded by strangers.²²

But this statement is said with a sarcastic tone, as if it is something to be taken for granted that actors do not do this. Still, it should be noted that, according to Ross, *anyone* not adhering to what amounts to the actor's paradox is subject to role absorption and dissociative delusions, even though he believes this will only happen in MPD clients.

Other clinicians have come to the same conclusion about alter-making and acting. In an attempt to prove that alter-identities really exist or are present and that alters are different from enacted roles, one clinician, Frank Putnam, developed and implemented scientific tests to distinguish between the two.

Frank Putnam's Claim

According to Colin Ross, whose theories of MPD/DID are based mostly on client self-report, Frank Putnam's psychophysiological work provides "a bridge between anecdote and valid, reliable diagnosis and clinical assessment."²³ Ross's belief that MPD/DID clients become too absorbed in their roles is another way of saying that clients really "feel" the role of alter-identities; actors only mimic feeling. Recall that Ross was earlier quoted as saying, "If the actor *really felt like* a cowboy [. . .]he wouldn't be motivated to act [. . .] and would be disoriented and dysfunctional, like the MPD personality [. . .]."²⁴ Ross's belief in Putnam's psychophysiological work as being some kind of "proof" of, or validity for, the difference between alters and actors, suggests that Ross believes that a difference exists psychophysiologicaly between alter-making and acting. In other words, "real" psychological identities, like those of MPD/DID clients,

manifest themselves physiologically, whereas “mimicked” ones do not appear as a noteworthy or scientifically significant psychophysiological experience. The clinical assumption, then, is that professional actors do not really feel the parts they play, and that these mimicked alter-identities, therefore, do not register significant physiological changes. But, if actors were to become absorbed in a role by really “feeling” the part, then even actors may suffer MPD/DID symptomatology or disorientation, such as not being able to follow a script, having dissociative delusions, experiencing dissociative amnesia, and a change in their physiological make-up. This possibility of an actor falling prey to MPD/DID symptomatology is only hypothetical for both Ross and Putnam.

Putnam ponders what it means to say that alter-identities are real or really felt by MPD/DID clients.

Do they really have different bodily physiologies? What does this say about the influence of “personality” on the body, the nature of personality, or the structure of consciousness?”²⁵

Rather than attempting to answer these metaphysical questions, he moves on to the *assumed* psychophysiological differences between alters and actors (as I will do—leaving the metaphysics for chapter five). He explains the extremes of psychophysiological changes exhibited by MPD/DID alter-identities:

There are numerous anecdotes of observed physiological differences among alternate personalities of individuals with MPD. These observations include changes in handedness; different responses to medications, drugs, or alcohol; different allergic sensitivities; and different somatic symptoms. The relatively large number of reports of physiological changes across alternate personalities compared to the total number of reported cases in the literature suggests that indeed something unusual is happening with these patients. The degree to which these

observed physiological changes are unique to multiple personality disorder remains, however, to be determined.²⁶

It is Putnam's conception of alter-identities as separate, distinct, autonomous "real" identities of the mind that prompts his interest in how identities *psychophysiologically* affect behavior, i.e. how mind or *psyche* affects soma or *physiology*. It is these types of changes that Putnam (and Ross) believes are indicative of the presence of real alter-identities; extreme dissociation, character role absorption, and that promote dissociative delusions. And it is these types of psychophysiological changes that are believed to not be present in actors' enacted roles. Another way of saying this is, MPD/DID client's traumatic memories are hidden in his or her mind—particular memories are housed by the alter-identities that live them. The physiology of the client changes when an alter-identity comes out. Counter to this, actors, as mimics of feelings, supposedly have no need to access traumas hidden deep in their psyche. Actors do not have memories hidden behind amnesia barriers, in their psyche, in the form of alter-identities that manifest themselves physiologically differently. Because actors are not getting in touch with real feelings or memories when they perform, no alter-identity will come out of the actor's mind to alter the physiology of the actor.

Assuming alter-identities promote physiological changes in a client, Putnam wants to scientifically test whether a difference exists between alter-identities and enacted character roles. He considers whether *proof* of the *realness* of alter-identities might be accomplished by scientific testing. He hypothesizes that if alter-identities are real and actors' character roles are pretended, then the psychophysiological differences between

MPD/DID clients switching identities and actors changing character roles will be significantly different.

But, Putnam acknowledges that there may be a fundamental problem of comparing MPD/DID clients switching identities to actors changing character roles.

The choice of appropriate control groups against which to compare MPD patients, is also a complex question. The first studies have tended to use groups of simulating control subjects who create and act out "alternate personalities," who were treated in the same fashion as the MPD alternate personalities. One criticism of this method focuses on the competence or skill of the simulating controls. Are they comparable "actors" to the MPD patients, who have had longer to "rehearse" their alternate personalities? Future control groups should include subjects who alter their state of consciousness in other fashions, perhaps through hypnosis or medication.²⁷

In his attempt to distinguish between alters and actors, Putnam used university students, none of whom were professional actors, as control subjects. Putnam agrees with Ross that MPD/DID starts in early childhood with playacting that transforms into involuntary switching over many (tens of) years. Because of this, Putnam acknowledges his findings may not hold true if alters were instead compared to professional actors or to roles performed long-term by normal subjects.

Although Ross uses Putnam's research as support for the validity of the alter-actor distinction, Putnam himself admits that the research may show false significance. Putnam is concerned that anyone, not just MPD/DID clients, who act the same roles for a long time or who are practiced at switching roles, may exhibit the same symptomatology. This would mean that non-MPD/DID persons could experience the symptomatology normally attributed only to MPD/DID clients. This would lead one to suspect that multiple

personality/dissociated identity is not a disorder, and that the alter-actor distinction is not valid. Ross does not address this challenge, and seems to ignore Putnam's concern over the matter of "rehearsal" longevity. This seems surprising on Ross's part, since longevity of client acting may play a role in the occurrence of unwanted symptomatology. And it is MPD/DID symptomatology that is being compared to actors' experiences. Rehearsal longevity is an aspect of the alter-actor distinction. If actors suffer negative effects of playing a part many times, or of getting into a role too deeply, this will impact the alter-actor distinction. To investigate the possibility that long-term role enactment, or deeply enacted role enacted, may affect the validity of the alter-actor distinction, we need to know more about the psychology of acting.

The Psychology of Acting

Ross, without being aware of doing so, compared alter-making to only one type of acting—that of acting without *real* feeling, i.e. mimicking. He equates Hollywood acting, i.e., all types of acting, to mimicry. This will be shown to be a narrow view of acting. It is Ross's view of acting as mimicry that lends support to the alter-actor distinction. Without a narrow view of acting as mimicry, the alter-actor distinction is compromised.

It is a misrepresentation that *all* actors pretend or fake their character role during performance. Some actors do use mimicked or memorized performance, but not all the time. Other actors do not use mimicry, but instead rely on real feelings to portray a

character. Ross's view of acting is representative of a particular acting style, but it does not reflect all actor's acting experiences.

Literature on acting informs us that *at least two styles* exist: commonly (though problematically) referred to as English acting and Method acting. English acting, according to by Brian Bates, a theater psychologist, is an outside-in approach, while Method acting is an inside-out approach. Though these two style names are familiar to many, they have become characterizations of English actors and American actors that no longer hold true. In addition, a plethora of interpretations and mis-interpretations have arisen around the Method, making it a confusing term to use here. Put another way, the clash between these two acting styles is indicative of the debate between the Anti-Emotionalists (acting should not involve real emotion) and the Emotionalists (acting should involve real feeling), respectively.²⁸ But, the word Anti-Emotionalist is also problematic. The word "anti-emotion" leads one to believe no emotion is experienced. It would be extreme to think that some actors feel nothing, therefore, the word "Technical" will be used instead of Anti-Emotionalist. Emotionalist and Technical styles of acting are initially presented as contraries but investigations into acting will show them to sometimes overlap substantially during actors' performances.

Ross, unaware of the existence of two or more acting styles, is likewise unaware that even within the Technical conception (which parallels his view) there are experiences in acting that prove important to the alter-actor debate. According to Diderot, a proponent of the Technical style of acting, there are three qualities of acting—genius, bad

and fair acting. The differences that exist, between these three qualities of Technical acting, each have a different impact on the alter-actor distinction.

The qualities of Technical acting are as follows. Genius acting is considered by Diderot to be artistic. He says it requires planning and composition. It requires a lot of practice and is built up by degrees, over time, which contributes to its being able to last through many performances. It can be repeated exactly the same each time. When Technical acting—mimicry—is adhered to, it results in “consistently good acting.”²⁹ And, being consistent in good performance is a sign of genius acting. Genius acting is a result of the actor maintaining strict, trained, and skilled self-control.³⁰ Genius acting involves no felt sensibility and is indicative of the mimicry Ross expects of professional acting. This means that genius acting should involve no real feeling. Genius acting should, rather, mimic feeling. This seems to be that case. Diderot says the actor’s, “talent depends not, as you think, upon feeling, but upon rendering so exactly the outward signs of feeling, that you fall into the trap.”³¹ Genius acting, according to Diderot, is indicative of imitation—faking or pretending.

When Ross speaks of acting it is this sense of genius or professional acting as indicative of mimicked feeling that he contrasts with alter-making. Genius acting has what, for Ross, MPD/DID clients do not have, i.e., self-control over switching characters, and that which Ross believes actors do have. And so, it is the Technical genius acting that strongly supports the alter-actor distinction.

But, genius acting is only one of three qualities of Technical acting. The other two still need to be considered. In Diderot’s view, bad acting is not the opposite of genius

acting, as one might anticipate. One might think that if genius acting involves mimicry and no feeling then bad acting would involve the opposite, i.e. deeply felt sensibility and character role absorption (extreme dissociation). According to Diderot's view, this would be a mistaken assumption. Instead, bad acting is the result of "middling sensibility." Bad acting is missing the benefits of repeatability that come with mimicked and perfected behavior of a performance and is also devoid of real and full feeling of performance—it has neither totally real nor totally practiced (mimicked) feeling. Bad acting results in a bad performance wherein the observer (and the actor) is not fooled into believing the actor is someone else. [Bad acting may be indicative of the performances of the college students used by Putnam in his comparison of student acting to MPD/DID alter-making.

Remember, Putnam pointed out that unpracticed or short-term enacted roles (i.e., by student actors) may not be a fair comparison to MPD/DID alter-identities.] Bad acting is devoid of character role absorption, but it also is unprofessional, unpracticed acting, and therefore not a fair comparison for the alter-actor distinction, since therapists would quickly detect this fakery. Fair acting remains to be considered.

Contrary to genius and bad acting, it is fair acting (thus far) that challenges the alter-actor distinction because, as Diderot puts it, it involves "extreme sensibility." It is Diderot's conception of fair acting that seems most similar to the experience of the MPD/DID client changing identities. The extreme sensibility involved in fair acting is based on real, not imitated, feeling and is therefore like a "passing moment in Nature."³² When Ross proclaims that MPD/DID clients act (but not like professional acting) and that

client acting is “real,” not pretended, he may unintentionally be referring to, and equating client acting to, fair acting, i.e., as real, emotionally laden and felt, alternation of self.

If Ross is correct that MPD/DID clients really feel their roles, then a problem arises for the alter-actor distinction. Diderot’s conception of fair acting is not about MPD/DID clients, though it may be applicable to them—it is about actors in general. Diderot’s conception of fair acting narrows the division between MPD/DID alter-making and acting because alters and actors (at least some times) use real feelings to accomplish a change in identity/character.

Of course, other actors and directors may disagree with Diderot’s schema of qualities of acting. I have chosen to use Diderot because he is a prominent figure in literature on acting whose view remains provocative today. The objective here is not to give a full accounting of literature on acting, but rather to present enough basic information on acting to at least put into question the validity of the alter-actor distinction. But, it should be noted that although Diderot’s schema helps give rise to challenging the validity of the alter-actor distinction, some other acting theory may not. Regardless of whatever contrary views on acting may exist, Diderot’s schema and its impact on the alter-actor distinction warrants investigation.

To continue, like during MPD/DID alter-making, the real feelings accessed during fair acting, according to Diderot, involve the actor’s loss of self-control of his acting and results in “sporadically good acting.” It is sporadically good, according to Diderot, because it lacks the memorized repeatability of a mimicked feeling.³³ Fair acting, on its best days, is as convincing to the observer as genius acting—it is just not as reliably and

consistently good. But, Diderot's conception of fair acting suggests that when real feelings are used to enact a role, the actor is subject to losing control of the act, just as a MPD/DID client does during switching. This is what needs to be substantiated.

Of the three acting qualities reviewed only Diderotian Fair acting produces sporadic results, i.e., sometimes involves feeling and other times involves mimicked feeling, sometimes involves control, at other times exhibits lack of control of the role. It could be contended that, contrary to Fair acting, MPD/DID acting is consistent in both its feeling and lack of control and its ability to convince therapists of its realness. This suggests Diderot's fair acting may not be the type of acting similar to MPD/DID acting—leaving us to wonder what type is.

To challenge the alter-actor distinction a type of acting must be found that is most similar to MPD/DID alter-making. But, remember that Diderot's Technical view is classically only one side of the acting-style debate, the Technical side. And, of Diderot's three acting styles only one, Fair acting, came close to alter-making, but still remained problematic due to issues of sporadic feelings and sporadic control. There is still the Emotionalist's view to consider.

The Emotionalist's view brings to the foreground two questions, "do actors feel, and ought they to feel?"³⁴ The first question of "do actors feel" is the one that will be focused on next. The latter question of "ought" has two interpretations. The question of whether one should feel the role they perform normally has to do with whether feeling a role results in aesthetically pleasing acting, i.e. results in art. But, it also has to do with whether Emotionalist acting can be *psychologically dangerous*; it is this sense that matters

to therapy. This will be debated in chapter six, the chapter on therapy, rather than here because the answer is protracted and better suited to the purpose of that chapter. The question that needs investigated for this chapter is; “do actors feel.”

William Archer, journalist, actor, and director explains that, counter to the Technical view of feelings (sensibilities) being an interference in good or genius acting, Emotionalist actors believe that natural feeling is essential and is what lends the, “clear ring of truth,” to the role. Some actors, at least some of the time, use real feelings to breathe life into a character.

So, when the psychology of acting is considered, Ross’s conception of acting is shown to be naïve, i.e. too limited. Certain styles or techniques of acting exist, such as Diderotian Fair Acting and Emotionalist acting, wherein actors do more than mimic a role—they deeply feel the part they play. What is meant by deep feeling needs to be investigated. And whether Emotionalist actors feel and whether these feelings are indicative of MPD/DID suffering is still at issue and needs to be considered.

Feelings and Control: Similarities of Emotionalist Acting and MPD/DID Alter-making

Bates informs us that, “The principal focus of the Method approach” (i.e., Emotionalist acting) is called “Emotional Memory” or sometimes “affective memory.”³⁵

The idea of this technique is for the actor to decide the emotion appropriate for a particular part of his role. The actor then attempts to discover in his ‘affective memory’ a recollection similar to that particular emotion. Thus, by a

series of exercises using this *memory and imagination*, the actor prepares himself *to arouse that emotion* when he needs it in the performance.³⁶

Two points need made here, one about control, the other about feeling. First, about control—the actor can arouse emotion “when he needs it in the performance.” In comparison, the MPD/DID client supposedly cannot control his or her switching roles. Two possibilities come to mind. First, it may be that a client exhibits habituated acting behavior that at one time was based on a willful act, but now appears as uncontrolled. I refer the reader to both chapter five, the section on the problem of switching, and chapter three, the part on Bliss’s conception of self-hypnosis as narrowly focused attention—an intentional act, performed for many years, since childhood, transformed into a habituated coping behavior by adulthood. Behavior that is automatic appears fluid and without forethought, but does not preclude willfulness. Secondly, alter-identities are often called out for the first time (since childhood) during MPD/DID therapy. This being the case, the client must be in control and “intentionally” arouse the emotion when he or she is directed to do so by the therapist. For example, the client may be directed to remember being abused at six years old; so the client intentionally delves into his or her memory and subsequently intentionally performs the role of victim of that particular past story. Using affective memory may be emotionally painful. The pain and suffering that accompanies memory re-enactments are referred to as abreactions. Ross says,

Observing and guiding the abreactions is emotionally intense, technically delicate work for the therapist. The therapist must “be on his toes.” To do the work, it is essential not to be too involved and not to take the abreactions too literally. The patient will experience an abreaction as an exact copy of the original experience, which it isn’t. An abreaction is a highly stylized enactment of the

memory of a real trauma. It is not a video playback of reality. The therapist is not really watching a rape, and the abreacting patient is not really a child.

Abreactions, though, are sincere, genuine experiences for patients. They are very dramatic and [...] convince the therapist of the reality of the childhood abuse. There is just no way that clinical abreactions by multiples are faked. They are dissociative recreations of the original trauma and are important healing rituals.³⁷

The alter-actor distinction appears again here when Ross says, "An abreaction is a highly stylized enactment" followed by the statement, "There is just no way that clinical abreactions by multiples are faked." Clearly, the abreaction is some kind of acting and the therapist some kind of guide or director. The performance is a recreation of a supposed real event. It has a story line and a main character, i.e., the victim/client as a child, in this case. The "client" is in control and arouses the emotion from his or her memory and imagination for the performance, when directed by the therapist to do so, in the name of a "healing ritual."

Because abreacting requires guiding/directing by a therapist, some opponents of MPD/DID (including some therapists) contend that the abreactions, no matter how genuinely felt, may be a result of imagination rather than memory, i.e., may be false memories or therapist implanted (iatrogenic) memories. The false memory debate, will not be further addressed here as it is lengthy and well documented.

During abreaction both the therapist and the client are completely focused on the client's past (keeping in mind what was just said about the false memory debate). What may be different about abreacting and acting is that abreacting may involve one take of each memory or story; acting may involve needing to remember and repeat lines, and make appropriate exits. The setting, too, may be different for the client, i.e., the

therapist's office rather than a stage. And, the client's range of story lines may be restricted—they may usually, if not always, involve memories of abuse/neglect and therefore have limited comparison to the range of stories actors perform. Differences between alter-making and acting exist, but these differences (number of takes, varied setting, range of characters, range of story lines) are incidental to acting. They do not have to do with an essential component of acting, i.e., technique. And the validity of the alter-actor distinction hinges on difference of technique. The point is that acting can take place with an audience of at least one, anywhere, anytime, for fee or for free, and abreacting, like acting, can involve real feeling, and control.

Now, there is an experience Ross refers to as 'malignant abreaction' that involves loss of control, and that can be "countertherapeutic and destructive if not handled properly."³⁸ He says, "malignant abreaction consists of chaotic uncontrolled runs of screaming, self-abusive, or regressed behavior during which the patient may switch repeatedly."³⁹ Malignant abreaction demonstrates lack of control while abreaction demonstrates control.

Therapists direct abreactions. Abreactions sometimes first occur after desensitization of the client to the past experience. To desensitize the client, i.e., the host, he or she must be made aware he or she has alter-identities that house or carry the client's unwanted memories for him or her. Since most alter-identities are covert, the assistance of a therapist is needed to expose the alters and the memories they contain.

The first step is to tell the host about the alter and establish neutral communication as described previously. The host is told that the child alter was created at the age of 6 to be the victim of sexual assault by her father. A contract

is made for the child to abreact an assault with the hose coconscious in the background, then the child alter is called out. The child is asked to begin describing the scene just prior to the assault, and usually an abreaction will begin spontaneously. If it doesn't, hypnotic suggestion that the abuse will be relived can be made.⁴⁰

The client is given the basic story line, and his or her character age and type, and then improvises the description of a scene and then acts it out, under the guidance/direction of the therapist. Ross says, "Successful abreactions often involve cueing by the therapist, with inquiries like, "What happened next?" or "And then what?"⁴¹ The therapist is like an acting director, directing the client to abreact.

Abreaction may be more akin to improvisation than some kinds of acting. If the client is not good at improvising the therapist must put more energy into directing the abreaction or act. Abreaction involves control of the use of emotion within the confines of the contract as to which alter/memory will be called out. Abreaction involves the creation of a scene by therapist and/or client, a contract of 'who' the character to be performed is, and prompting/directing by the therapist. Abreacting may involve improvisation more often than repeating performance as in Emotionalist acting. The importance of this difference is unknown and will remain unexplored since the issues being dealt with herein are control (not memorization of lines) and feeling. For further considerations of the issue of control in alter-making and acting, see section below on *Possession versus Control*.

Next to be considered is the issue of similarity of feelings between client acting and Emotionalist acting. Emotionalist actors rely on the use of personal memories of felt experience, as indicative of MPD/DID clients. Emotionalist actors search their memories

for personal experiences that match or are similar to the experiences of the character to be performed. If a needed previously felt experience can not be found, Emotionalist actors still use their affective memory, but use a dissimilar experience to produce a like feeling—one that results in the necessary emotion for the part to be played.⁴² Either way, contrary to Ross's conception of acting, the Emotionalist actor can use *real* emotions from his or her own experience, i.e., can deeply emote during a performance. Emotionalist acting and MPD/DID alter-making appear to be based on the same thing—affective memory.

Another question may arise at this point. Does Emotionalist acting, i.e., the use of real emotions, result in loss of the paradox—loss of the 'real' self as observer of the act? The answer is sometimes (see the section on Living Near the Edge in this chapter). In other words, do Emotionalist actors, by feeling their role, suffer dissociative delusions about who they are, as MPD/DID clients do? The answer is sometimes (see the Bogarde example on page 143.) Answers to these questions will become clearer as we proceed.

If both alter and actor use affective memory, then they both feel the roles they play. But, it could be contended that actors are only acting the emotion. Bates denies this saying,

But while it is possible to conceive of the actor's own emotion becoming fused with that of the character, we are still left with an unclear picture of where the character's emotion comes from. For although actors might *act* emotion, we have all witnessed performances in which the quality of that emotion was undeniably real.⁴³

If enacted feelings come from affective memory then both alter and actor must relive past experiences when they are in character. To merely think about a memory may, or may

not, have the same effect as actually using the memory to enact a role. To draw from memory those feelings needed for acting a character role may (but not necessarily) require acting out the past in such a way that the same associations and feelings are evoked now as they were then, for anyone doing so, including the MPD/DID client and actor.

The ability to connect with affective memory is one reason clinicians believe that exposing alter-identities, i.e., uncovering hidden memories that alter-identities have, is so effective—it results in the present cathecting of the suffering that occurred in the past. Ross says, “Alter personalities are highly stylized enactments of inner conflicts, drives, memories, and feelings,”⁴⁴ what clinicians refer to as psychic material, particularly of a negative or problematic quality. Contrary to Ross’s understanding of acting, Bates explains that, “the actor purposely enters the ‘deepest levels of the psyche’, and encourages past experiences and emotions into consciousness for performance.”⁴⁵ Contrary to Ross’s contention, the actor’s memories may involve the same types of psychic content as that of the MPD/DID client such as childhood abuses, neglect, and the like, as Bates explains.

The psychic material which most of us would not care to recall, let alone confront and express in public performance, is the material from which actors fashion their character. Whether it is done in a conscious way as in Method acting, or less directly in other approaches, it is a confrontation with parts of the self that we might consider ‘problems’.⁴⁶

It is this sense of deep emoting of emotional-affective memory that forms the basis of Emotionalist acting. For example, “The ten weeks of filming for *Last Tango in Paris* required Marlon Brando to draw from himself memories and emotions which had been

forgotten, rejected, even *repressed*.”⁴⁷ Since most people do not need to reject or repress happy memories, those memories that have been rejected or repressed must be of a negative or problematic quality. A similarity seems to exist between actors’ use of emotional or affective memory to enact characters and MPD/DID clients’ use of past experiences and emotions to form alter-personalities. Emotionalist actors, if the role calls for it, must also dredge up psychic material of a negative or problematic quality. Therefore, both MPD/DID client and actor must rely, at least sometimes, on phobias/abuses/neglect, i.e., and negative experiences to perform as either alters or characters.

The question may arise as to whether this means that Emotionalist actors are, as Ross claims MPD clients are, i.e., stylized enactments of inner conflicts, rather than as actors enacting character roles. This may just be a difference in nomenclature. As indicated, actors using Emotionalist acting find it occasionally necessary to remember abuses and traumas in order to perform the character’s personality. “Acting is not imitation, it is revelation.[. . .] Actors in performance reveal their inner selves;”⁴⁸ and must draw from themselves (as Brando did), even repressed emotions and memories. Whether actors also reveal their roles, i.e., whether actor, act, and role, are separate, is a point of contention in the acting industry that is dealt with briefly, later in this chapter. Both Emotionalist acting and MPD/DID clients reveal “inner selves,” though the clinical way of talking about this experience as the presence of “stylized enactments of inner conflicts” may not agree with the nomenclature of the theater.

Yet, a clinical/theatrical difference regarding inner selves is reported by at least one actor—though it does not support the alter-actor distinction. William Hurt “blames the Emotionalist school of acting for encouraging actors to exhibit their neuroses.” This complaint does two things. It supports the idea that actors using Emotionalist acting and MPD/DID clients have something important in common—catharsis of inner selves and inner emotions. Secondly, it supports the idea that other types of acting may not be like MPD/DID alter-making. In the following quote he seems to equate the emotion and deep feeling used in Emotionalist acting with psychopathological emoting.

There is a big difference between acting and acting out. One’s crazy and the other isn’t. We’re not schizophrenics. You are not there to cathart your personal angst in front of somebody else. It’s not a therapy session for you.⁴⁹

Schizophrenia was the old term for split personality—a mental illness thought to involve two personalities/selves. As far as Hurt is concerned, therapy and Emotionalist acting both result in a person *acting out* gloomy, neurotic feelings of anxiety and depression. For Hurt, therapy as the cathecting of personal emotions/feelings and Emotionalist acting are not acting. But as regards the alter-actor distinction, in a backwards way, Hurt’s view substantiates that a certain type of acting, i.e., Emotionalist acting, uses very much the same techniques as is required of clients during the MPD/DID therapeutic ‘discovery’ or calling “out” of alter-identities.

But then, a second question arises for Emotionalist actors if it is the case that the Emotionalist style and MPD/DID therapy result in catharsis of inner selves/inner phobias. Are Emotionalist actors’ roles and MPD/DID client alter-identities indicative of inner

phobias/affective memory or character roles? As regards MPD/DID, Ross, Bliss, and others want to claim that inner phobias amount to MPD/DID self-created characters (alter-identities), i.e. that you are the sum total of your memories and phobias. Clinically speaking, since alter-identities are separated by mental barriers, which makes them autonomous, and since each alter-identity is said to house a particular set of hidden memories/phobias, this suggests that exposing a particular set of memories/phobias equates to exposing the alter-identity that houses, or 'is,' those particular memories/phobias. Likewise, but put in terms actors are familiar with, these memories/phobias encompass "a wide variety of subselves, aspects of ourselves that normally remain hidden, locked away, even repressed."⁵⁰ Does this mean, as it suggests, that actors' subselves, MPD/DID alter-identities, and inner phobias/affective memory are all parts, normal healthy parts, of the same thing, i.e. the human being—the actor? This would be a big claim and cannot be completely investigated herein, but can be given the beginnings of a foundational support if the findings of all chapters are considered together.

As with observation of MPD/DID client behavior, Bates knows that some professional acting, i.e., feeling, deeply emoting, exposing memories/phobias, can appear as multiplicity/dissociated identity. He explains that having many subselves, in addition to "a personal essence, an essential self," is not an expression of mental illness.⁵¹ He says, "the notion that we have a single 'personality', coherent, integrated and stable, is one of the most limiting myths of everyday life."⁵² Bates takes this view from actors like Shirley MacLaine, Sybil Thorndike and Edith Evans. MPD/DID clients are not the only people that see themselves as comprised of multiple identities. MacLaine says, "It intrigued me

that there might be more to me than what I was aware of in my conscious mind. Perhaps there were other identities buried deep in my subconscious that I only needed to search for and find.” And Thorndike agrees saying, “When you’re an actor [. . .] you’re a person with all the other persons inside you.” And Edith Evans agrees with them both saying, “I seem to have an awful lot of people inside me.” This way of talking—about having other persons, identities, or selves inside, or buried deep in one’s subconscious, can be said of both MPD/DID clients and actors. What should be noted is that a person is not necessarily aware of these inner selves or subselves until searching for them. MPD/DID clients and actors are two groups that are in a regular practice of searching for them. This suggests that multiple identities inside a person is not a phenomenon limited to abused child-adult MPD/DID diagnosable persons, but instead, could be a natural phenomenon of anyone who searches their inner self. But, it seems plausible that the only people needing to overtly search for alter-identities would be either MPD/DID clients or actors. Some Emotionalist actors and MPD/DID clients each have reasons to expose hidden memories/phobias, i.e., clients and actors each have motivating factors for appearing behaviorally as different selves, or diverse characters.

But, according to the DSM, the presence of alter-identities is indicative of psychopathology. And, even though acting is not considered a mental illness, the language of actors like MacLaine, Thorndike, and Evans, supports the idea that acting is multiplicity. If multiple identity is not limited to psychopathology then multiple identity is not a mental illness.

Professional actors' characters may come about in a couple of ways, and these methods may give us insight into MPD/DID alter-making. Disbelievers of the alter-actor similarity may contend that clients extremely dissociate when an alter-identity comes out—that the client enters a trance or hypnosis whereas actors just access their affective memory to switch into character. Bates explains that in creating a new character an actor

calls upon the depths of his experience in new ways. Whether the actor tries to work from within that experience to build a character, or creates first an idea of the character and allows his emotional resources to respond to it, either way the actor is activating his inner experience around a new focus.⁵³

It seems to me, (admittedly, after reading only a limited sample of the literature on acting), that "calls upon" could be, simply, another way of saying that the actor narrowly focuses his or her attention on his or her experiences. This is what the MPD/DID client as child had to do and this is what the adult client has to do in therapy. Both the actor and MPD/DID client use their affective memories to get into the character. But, when using one's inner resources, feelings, memories, phobias, etc., while acting (or alter-making), the actor can either first create a character and then 'breathe life' into it with those feelings, or a character can be developed around those feelings.

This suggests three possibilities as regards MPD/DID. During therapy clients can either be revealing a previously created character, or can be creating a character during therapy and cathecting emotions into it, or a character will seem to develop while the client is exposing his or her hidden emotions/traumas/phobias to the therapist. It should be noted that the outcome of these three would be seemingly the same, i.e., the client would exhibit an alter-identity or subself. It should also be noted that the therapist would

be hard pressed to distinguish which protocol was used in the character development since the therapist only observes the outcome and not what goes on inside the client.

This explanation of the actors' development of character roles, in three ways, brings up several points regarding MPD/DID. Since it is one of the three possibilities mentioned earlier that hidden memories are revealed while acting, it must be the case that catharsis of hidden memories can be indicative of a normal process of acting rather than being solely indicative of the clinical existence/presence of alter-identities. Secondly, the various ways to develop characters suggests that alter-identities can merely be fantasized, self-created, enacted character roles, i.e., exercises of the imagination, without representing anything "clinical" at all. And thirdly, it suggests that when a MPD/DID client cathects inner phobias or imaginary characters, he or she could be acting using the same techniques as professional Emotionalist actors with feelings being put into a character role or with a character seeming to appear with the catharsis of emotion.

These similarities of use of feelings, affective memory, etc. between alter and actor indicate that we need to reflect on a point made earlier as to Putnam's suspicion that longevity of role enactment may challenge the significant findings in his psychophysiological research. Emotionalist acting indirectly supports his concern in its use of real feelings. Longevity of acting plays a role in the ability to access emotional-affective memory and do so quickly and easily. Use of emotional memory may sound easy to learn, but it is not. It takes years of practice. [Remember, alter-making has taken years of practice.] Actor Bruce Dern, on Emotionalist acting, says "it takes about five years of total concentration to learn how to do it."⁵⁴ And, actress Geraldine Page adds, "the

Emotionalist actor, who has acquired skills and knowledge of what is in his unconscious, can consciously bring material from within the self.”⁵⁵ That it takes many years of practice to be able to quickly switch character roles based on emotional-affective memories again suggests a similarity between Emotionalist acting and alter-making.

So some actors, those using affective memory techniques, (Emotionalist and possibly Diderotian fair acting), and MPD/DID clients, can feel the roles they play. But do actors suffer psychologically when they feel their roles? This remains to be considered.

The Dangers of Acting and MPD/DID Alter-Making

Emotionalist acting, in its use of affective or emotive memory, challenges Ross's assumption that MPD/DID clients are the only actors who suffer negative symptoms of really feeling their character roles (as will be shown). The psychological experiences of the MPD/DID client, including those that clinicians claim are problematic, are importantly similar to experiences talked about in certain types of professional acting. These experiences include, (1) self- or autohypnosis, (2) feeling the pain/life of the character, i.e., character role absorption, (3) dissociative delusions, i.e., believing one is the character played, (4) difficulty coming out of character, and (5) difficulty returning to one's self. Ross stated that if actors did feel their roles, like MPD clients do, actors too would have negative ramifications of doing so. Ross said this tongue in cheek, not really believing that actors (mimics) would ever experience the negative symptoms of MPD/DID. But, Emotionalist acting, or the use of affective memory techniques, challenges Ross's claim

that extreme dissociation and its accompanying negative psychological effects are restricted to psychopathologies.

The following, is the first of several examples that will challenge the contention that actors do not suffer negative MPD/DID symptoms while acting. Dirk Bogarde suffered some negative effects during his experience as an actor, while preparing to get into character for the film *Death in Venice*, and afterward, while returning to himself. Bates quotes Bogarde as saying,

"I started to walk slowly round and round the room emptying myself of myself, thinking pain and loneliness, bewilderment and age, fear and the terror of dying in solitude. Willing von Aschenbach himself to come towards me and slip into the vacuum which I was creating for his reception."⁵⁶

Bates goes on to say,

Dirk Bogarde was being possessed by the character of von Aschenbach, his acclaimed role in Visconti's film *Death in Venice*. The takeover of Bogarde by his fictional character sounds almost sinister.

Bogarde had become a receptacle, a shell, for a presence he had trained his mind and body to accept.⁵⁷

Bates takes note of Bogarde's explanation of his transformation into von Aschenbach.

"...He came, not all at once, but in little whispers...bringing with him the weight of his years, the irritability of his loneliness, the tiredness of his sick body...Arrogance slid in like a vapour. [...] I had absolutely no doubt that I was him, and the exterior shell of my normal body was only the vessel which contained his spirit."⁵⁸

The question is, did Bogarde suffer the five symptoms of MPD/DID switching (refer back to page 120)? (1) Bogarde extremely dissociated. We know this because (2) the character role, von Aschenbach, absorbed Bogarde (or Bogarde's attention, thoroughly). For Bogarde to have difficulty letting go of the character von Aschenbach, it must be the

case that Bogarde, like MPD/DID clients, became deeply absorbed by or in another character/identity. Deep absorption is a result of extreme dissociation; therefore, Bogarde must have dissociated to an extreme degree. Extreme dissociation requires the use of one of the three types of hypnosis. Bogarde must have self-hypnotized just as MPD/DID clients have done since childhood. Bliss's comment about hypnosis contributing to the disappearance of world and body lends credence to the Bogarde example being one of hypnosis. In his account, Bogarde goes from a point of what clinicians would deem the beginning of dissociation (depersonalization) to (DC-A) a complete split in personality (the result of extreme dissociation). Bogarde brought this on by, in his words, "emptying myself of myself," and then thinking of "pain" and "loneliness," "bewilderment," "fear." These seem to be an attempt on his part to focus on simple, basic feelings. According to Bliss, "concentration on a single idea", is what the MPD/DID client does to change identities.⁵⁹ Bogarde moves from a depersonalized state into the trance state of feeling "the vacuum," i.e., the nothingness that hypnosis can bring prior to the experience of the alter-self (DC-B; i.e., he switches). As noted above, Bogarde states that the character "came not all at once, but in little whispers." Bliss explains that hypnosis can come in stages from "superficial to deep."⁶⁰ Bliss tells us that with hypnotic subjects "[. . .] the dimension of depth for subjects primarily involves the degree of their inner absorption, the extent to which they relinquish the external world and the body until finally they seem to disappear altogether."⁶¹ It appears that Bogarde accomplished this achievement and that any of us, with practice of focusing attention, could do the same. Bogarde's dissociation was extreme.

And also, we know Bogarde must have extremely dissociated because (3) Bogarde suffered dissociative delusions. Bogarde saying, "I had absolutely no doubt that I was him," exemplifies the fantasy-reality blending that Bliss speaks of, and the dissociative delusions Ross claims MPD/DID clients experience.

(4) MPD/DID clients do not control their switching—the alter-identity takes over control of the client's behavior. One might contest that Bogarde had control over letting von Aschenbach enter him—after all Bogarde *intentionally* entered a type of hypnosis. But, a different interpretation, one like that applied to MPD/DID client switching, suggests that Bogarde had no control of von Aschenbach coming out once Bogarde entered a type of hypnosis and emptied himself of his self—at that point he became possessed or taken over by the character. Therapists direct clients to initiate hypnosis or trance or focused attention on their inner selves; this takes control on the client's part. But, once a client empties herself of herself while looking for that part of herself that is an alter-self (i.e., the little child, or the protector personality, or the prostitute, etc.), it appears to the onlooker (the therapist, in this case) that the alter-identity is in control. In the same way, it could be said that Bogarde has extremely dissociated, and that von Aschenbach has taken control of Bogarde's behavior for that period of time that von Aschenbach is "out." After all, Bogarde describes von Aschenbach as doing the entering (in little whispers).

The fact that Bogarde "trained his mind and body to accept" the character of von Aschenbach makes it seem like Bogarde's acting is a willful process, unlike that of the MPD/DID client. But remember that the MPD/DID client's switching started out as

willful playacting and at some point transformed into uncontrollable switching. This could be viewed in two ways. Hypothetically speaking, the MPD/DID client's switching could have become habituated to the point of not being able to control when and which alter-identity pops out. Or, it could be the case that switching could have become so habituated that switching to another identity, i.e., that emptying oneself of him or herself, is intentional but the technique to do so is automatic, making it seem unintentional. Bogarde's intention to empty himself of himself is similar/same to a MPD/DID client's intention to leave a situation and go 'inside.' Likewise, Bogarde's character entering the vacuum he'd created, is like a client's alter-identity entering the vacuum he or she creates by dissociating, i.e., going 'inside.' von Aschenbach took control of Bogarde's behavior.

What is not known is whether Bogarde (5) suffered dissociative amnesia for the time he was von Aschenbach, but remember this point is being put on hold until the problems of dissociative amnesia can be talked about in chapter five. With the exception of number five (which is problematic) Bogarde suffered the undesirable symptoms of MPD/DID that Ross denies are present in acting.

Though it is not part of the list of five criteria just covered, a question of the actor's paradox, and the presence of a hidden observer, remains, unconnected with Bogarde's experiences. His portrayal of von Aschenbach (or his experience as von Aschenbach), if I remember correctly from watching it years ago, was notable if not genius. This puts into question whether a genius performance requires the maintenance of a hidden observer, as the actor's paradox suggests. It is not until Bogarde's transitional phase back to his 'normal' self that it becomes obvious he is aware he both is and is not

his usual self. In fact, it appears that Bogarde had difficulty coming back to his 'normal' self, just as MPD/DID clients sometimes do during therapy sessions. After Bogarde came out of character, he says of his enacted role von Aschenbach, "I still retained his walk and mannerisms...as a man possessed without consciousness of the present world."⁶² Bogarde has difficulty ceasing 'being' von Aschenbach. This happens sometimes with MPD/DID switching, and according to Bliss the person must *reverse* his or her initial trance back to the depersonalization stage, i.e., the person must leave a character role as it was entered. Bliss says, whatever psychic content (for example, memories or, in this case, von Aschenbach) has been "spontaneously sequestered by hypnosis, [...] can only be retrieved by hypnosis."⁶³ Bogarde, like many MPD/DID clients, had difficulty returning to his 'normal' self—having temporarily lost the sense of himself as hidden observer. It appears that he did not maintain the actor's paradox during performance and suffered repercussions similar to, or the same as, MPD/DID without being abnormal.

Jack Watson, theater professor, says he is "not sure most theatre people would consider Bogarde's" behavior to be 'normal.'⁶⁴ This suggests that the negative effects Bogarde suffered are not typical in acting, though, obviously they do occur. These side effects probably happen rarely because most actors psychologically protect themselves from such occurrences. The point is, Bogarde is not MPD/DID, is probably not diagnosable MPD/DID, yet suffered symptoms that are typical of extreme dissociation and psychopathology—experiences clinically considered indicative only of mental illness. This means that non-MPD/DID persons can experience extreme dissociation and its repercussions. As explained earlier, if extreme dissociation is not solely a

psychopathology, the alter-actor distinction is compromised and the validity of multiple personality/dissociated identity is put into question.

Identifying With the Mask

Both clients and actors are “working on other than normal lines” since each are concentrating “on another situation than reality;” each is “concentrating on a fiction.” Bates quotes Richard Southern, theatre historian, as saying the actor, “is not unlike a mad person; he is abnormal; he is a mask; the man himself can no longer be seen.”⁶⁵

But, MPD/DID clients, according to Ross, experience dissociative delusions. Another way of putting this, in the client-actor model, is to say that the MPD/DID client identifies with the masks he or she performs, just as Bogarde did. And although Bogarde’s extreme symptomatology may be unusual among actors, his identifying with his role is not so rare. One assessment that can be made, to see if actors other than Bogarde suffer MPD/DID symptomatology, is to see whether other actors suffer from dissociative delusions, which may, but do not have to necessarily, accompany dysfunctional behavior. As mentioned earlier, Ross contends that actors who identify with their role, i.e., actors who really felt like their role, would become dysfunctional. Some actors’ experiences defy this claim.

Just as Bogarde suffered dissociative delusions so has Mike Judge, creator and portrayal of Beavis and Butthead. He talks about his brainchildren as if they are real.

I was improvising when I had Butt-head call Beavis a "butt knocker." I didn't mean anything homosexual by it, but Beavis got mad. "Don't call me that. I'm serious," he said. Butt-head is still dominant, but Beavis has been talking back more lately. He's evolving, becoming less dependent, maybe more of a spastic savant..."⁶⁶

Notice how Judge, in the first sentence, talks as though he is the creator of the characters. Yet immediately following this, in sentence two, he lapses into talking about Beavis responding on his own. He says, 'Beavis got mad,' instead of "I had Beavis get mad" (i.e., the protocol he used for Butt-head in the first sentence). Then Judge talks about the two boys as real selves, one being "still dominant" while the other is "becoming less dependent." He admits that he personalizes Beavis and Butt-head and that this personalization has had its effect on him. He says, "Once, I had a scary feeling, thinking, God, these guys are a bigger part of my mind than I am." After all, Judge has played these roles sixteen hours a day for more than five years. After this long, his ability to keep straight that they are his creations rather than real persons has waned. In terms of MPD/DID he is beginning to have dissociative delusions about 'who' he is.

Bates gives other examples of the negative symptom of identifying with the mask occurring or nearly occurring to actors. From several examples it seems not uncommon that actors suffer dissociative delusions, i.e., confuse their own feelings with that of the character, and come to think of the character as being a person or a real identity.

In the film *Face to Face* Liv Ullmann depicts a psychiatrist breaking down. In one six-minute scene the character loses and gains and loses control of her emotions. Of her control, as the actress, over the emotional energy of this long demanding and extremely intense scene, Liv Ullmann says, 'I like to think I'm in control all the time, that it's not the character doing it. But it's a mixture.'

[. . .] This view sounds like that of Charlton Heston: the actor is in control of the character's emotions, though occasionally the actor's own emotion becomes involved with the character's and a fusion, or possession, takes place.⁶⁷

The 'fusion' to which Heston refers suggests that Ross may have been wrong about his notion that actors identifying with their mask would result in dysfunctional behavior. And it appears that identifying with the mask occurs for both MPD/DID client and for some actors. If actors can identify with their mask (their role) and not become dysfunctional, it could be the case the MPD/DID clients do not suffer dysfunction from their dissociative delusions either. This would mean that MPD/DID client dysfunctional behavior is due to something other than multiplicity/dissociated identity.

In addition, contrary to what Ross suggests, and even contrary to common sense, the actor's losing control by identifying with the mask, i.e., by feeling the enacted character's feelings, does not necessarily result in a poorly performed act. According to Dustin Hoffman, maintaining control of a character role is not necessary. In fact, some of his best performances occurred when he let the character take control of him. He says,

So when I hear someone say my character there's like two characters in a way. There's the same character which is whoever that person is that's supposed to be myself; and that gets depressed and cries and laughs and angry and jealous and scared [. . .] And it's that person who is the same person no matter if it's Ratso or Raymond or whoever is on the outside.

Nevertheless something happens which I can't explain. [. . .] And that is... something takes place if you're lucky and you take off. *And the game starts to play you.* And as they say in tennis you are in the zone. You can't do anything wrong. [. . .] And it just keeps doing what you want it to do. Dorothy in *Tootsie* that I played, and Ratso, and a couple of others that something happens—and that is that you are moved by this *person* in a way you can't explain.⁶⁸

Good/genius acting can occur even if the actor lets the character/person do the controlling. The game—the act of pretending to be someone else—starts to play the actor. The actor relinquishes control to the alter-identity, and the actor ‘becomes’ the other identity. Hoffman believes Ratso, Raymond, Dorothy, are persons, while at the same time believing he, Dustin, maintains his sameness, regardless of “whoever is on the outside,”—regardless of ‘who’ comes “out.” This, technically, is a dissociative delusion, though to call it that seems odd because it is Dustin Hoffman that is being referred to and not some MPD/DID client.

Of course, one could claim that each of us put on and identify with many masks or roles everyday; but that this, surely, is not what Ross refers to—MPD/DID clients are not just putting on a mask. No, the difference between professionally getting into character or MPD/DID switching phenomenon and daily mask identification has to do with level or degree of dissociation involved and whether one maintains the actor’s paradox. For example, a man may reluctantly identify with the mask of a car salesman during the day, later taking off that mask to become loving husband, and funny dad. This may require a superficial level of dissociation. He may identify at different times with each role (salesman, husband, dad), while avoiding dis-identifying himself as the other masks. He may do so without coming to believe that one or more of the masks are other autonomous, distinct identities inside him, in which case has not extremely dissociated and is not experiencing dissociative delusions. He accepts that he plays many roles, knows what each of those roles entails, and uses them socially appropriately most, if not all, of

the time, and does so without much fore thought, (i.e., habitually) having done so for so long. This is not what a MPD/DID client changing identities involves.

Contrary to role theory, the actor or MPD/DID client, may use habituated techniques to enter a particular role at a particular time, and by doing so become extremely dissociated and deeply absorbed into character, at least for that time period, and thereby dis-identify him or herself from his or her other masks, though he or she may or may not maintain a hidden observer. To learn to do this takes practice. Mike Judge used to have to put pictures of Beavis and Butthead in the studio and stare at them when he did their voices. Having practiced their roles for years, he says “now I just shut my eyes and go to their world.”⁶⁹ Judge’s ability to become absorbed by Beavis or Butthead has become habituated to the point he lapses into either of them mid-sentence, personalizes them, thinks of them as developing and evolving, and as a bigger part of his mind than even he is. Judge suffers from symptoms of multiplicity yet he is not mentally disordered.

Possession versus Control

Common sense suggests that if someone is possessed by an alter-identity or character he or she is no longer in control. This is not necessarily the case when it comes to acting and even when it comes to MPD/DID alter-making.

Issues of loss of control when it comes to acting and alter-making were talked about much earlier. But, actors used to talk about this phenomenon in terms of ‘possession.’ Bates informs us that,

[. . .]to encourage the domination of the whole personality by one part is to invite possession. This is why in amateur acting we are often stunned by the transformation of a person in performance: the 'tough guy' who reveals surprisingly vulnerable aspects; the shy girl who is totally convincing as a whore. The role provides opportunities for repressed aspects of the personality to burst free of their bonds. We all have 'parts' of ourselves which we repress, or at least neglect, and which do not find expression in our daily lives. But the way of the actor releases these elements.⁷⁰

Possession is another way of saying that the actor loses control during his or her performance just like MPD/DID clients lose control during switching. An actor losing control of his or her performance may or may not result in a bad performance. To compare the two, for example, an MPD/DID therapist may call out a particular alter-identity such as 'the shy one,' the client then extremely dissociates with 'the shy one' taking control of behavior, yet the 'performance' of 'the shy one' remains in character while 'the shy one' is "out." Likewise, if an actor extremely dissociates, i.e., becomes 'possessed' by a character, once absorbed into or by that role, the actor can relinquish control of the performance to that character. The Hoffman quote earlier explains an example of this—of the game of acting taking control of the actor, without the performance or script suffering.

Typically, neither a MPD/DID client's, nor an actor's performance results in a script that is not being followed properly, but it can sometimes. Earlier in this chapter I mentioned about malignant abreactions—i.e., uncontrolled acting out of a client's personal emotions. And, examples have been given about actors feeling their own emotions instead of their character's emotions, or instead of letting their character do the emoting. A poorly followed script, seems to be the result of either of these, i.e., of an actor getting in

touch with his or her affective memory, and cathecting it on stage rather than using it to form a particular character—the actor exhibits his or her private angst. The possession of an actor by a character is explained in the following quote.

Liv Ullmann explains that, “the character can come through you. And if the character needs to cry, it’s the character and not you feeling all over the place. It’s a kind of openness that allows you to stand beside and watch, like having an instrument so tuned that whatever you choose to play on it will come out right. The moment you feel too much private anger or private anguish you aren’t in tune any more.”

So how can we understand this process of containing a character’s emotions? It sounds as if an ‘alien being’, in the form of a dramatic character, is literally using the body and mind of the actor in order to exist.⁷¹

Although Ullmann’s feelings were not monitored (directed, observed, analyzed) as they would have been during a therapy session, her experiencing the feelings of the character, is precisely the type of feeling that clinicians would claim would be indicative of MPD/DID clients switching alter-identities. This is because, for example, the client can claim later on that he or she did not feel the abuse—the alter-identity did the feeling, experiencing, and living of the horror. Losing control of a character, or becoming possessed by a character does not have to result in loss of maintenance of a script (as the Bogarde and other examples attest). Both actors and MPD/DID clients can lose control of, or let go control of, an identity/character to the point that it seems like the character is taking control of the actor or MPD/DID client; but it may be that the actor and client have intentionally relinquished control to the alter-identity or character.

Becoming ‘possessed’ and having dissociative delusions can occur whether the actor’s paradox is maintained or not during performance. Two possibilities exist. Either one can identify with the character, in which case the actor’s paradox has not been

adhered to. Or, one can believe him or herself to be comprised of many identities, in which case the actor's paradox was probably maintained. Bogarde's performance of von Aschenbach led him to believe he was that person (character). This seems an example of possession and dissociative delusion by loss of the actor's paradox and believing one is the character performed. Yet, Ullmann reports maintaining a separation between herself and the possession of her by an " 'alien being' " that "is literally using" her "body and mind [...] in order to exist." This seems an example of possession and dissociative delusion by maintaining the actor's paradox and believing one's self to be more than one person. Likewise, the MPD/DID client either believes him or herself to be many people in one body, or does not identify with any one of them while 'being' another of them. This means that contrary to Ross's contention, either the actor or the MPD/DID client is prompted by 'possession' to believe he or she either is someone else (if the actor's paradox has not been adhered to) or he or she believes that he or she has another identity inside him or her (if the actor's paradox is maintained). Both MPD/DID client and actor can appear 'possessed' by an alter-identity, and as clinically interpreted, have dissociative delusions as a result of switching or 'possession.'

The idea of possession normally conjures up the picture of "a person totally out of control, dominated by some psychic force more powerful than himself."⁷² Neither clinician nor director/actor would want to portray switching or acting, respectively, as "a zombie-like body, inhabited and controlled by an external agency."⁷³ Bates explains that this different state that Liv Ullmann refers to is no longer talked about in terms of possession.

(It) would traditionally have been part of the possession experience but today actors rarely talk about 'possession' experiences. More often they think in terms of 'getting into' the character; stepping into an imagined external person, rather than letting the character into them.⁷⁴

Experiencing the feelings of a character role is no longer referred to as 'possession' by the acting community (possession is today most often of religious nomenclature not clinical/scientific verbiage). And, although the nomenclature has changed, this sense of *stepping into an imagined external person*, is the same sense of what the MPD/DID client does in trying to avoid dealing with life directly. It is this experience of 'possession', i.e., of 'getting into' the character, that promotes the feeling one really "is" that person.

As it is misleading to equate a MPD/DID client (DC-B) or actor to a possessed zombie-like body, it is also misleading to think that 'possession' implies a loss of consciousness or will. Bates explains this.

While we often assume that the possessing force completely obliterates consciousness and will, even in traditional societies when actors 'become' the spirits and are 'possessed' by them, they do not lose contact with the requirements of the performance they are giving.⁷⁵

Both actor and MPD/DID client can be in control while acting as if they are another person.

Becoming absorbed in a character also has to do with what is going on 'inside' a person. Remember Putnam's psychophysiological testing was a way to determine if there was a significant difference between the physiological responses of MPD/DID clients switching alter-identities and students switching characters—the idea being that alter-

identities exhibit changes in physiology that character enactments would not. According to Bates, actors can emote so deeply they, too, experience physiological changes.

An actor can *look* different from his usual self because he is different 'inside.' Entering into the psychological, mental, emotional world of a character can result in quite startling physical changes. Sometimes a physical transformation can be literally 'coloured' by inner concentration.⁷⁶

This notion of "inner concentration" is what is required for self-, auto-, and heterohypnosis, i.e., for the switching of alter-identities. "This ability to apparently alter physical appearance without the intervention of make-up and other aids is noted in a number of actors."⁷⁷ So, MPD/DID clients are not the only ones that can report psychophysiological anecdotes. Bates mentions several actors who have experienced such physical transformations. For examples, Ben Kingsley in *Gandhi*, and *Melons* appeared "frail as a leaf and immovable as a rock." Meryl Streep's eye color, normally blue-gray, turned green during her part in *The French Lieutenant's Woman*,⁷⁸ without use of contacts. Inner concentration of an actor, not a metaphysically autonomous distinct alter-identity, is what brings about the transformation from one persona to another.

To 'be' in character, actors use what Bates refers to as "emotional streams" to portray various characters. These emotional streams are equivalent to the clinician's conception of alter-identities or streams of consciousness, or co-consciousnesses. Despite this difference in nomenclature, the sense of what is going on with the actor is very much the expression given to MPD/DID switching.

The opening and maintenance of these emotional 'streams' are like an exercising of one's psychic being. But although Liv Ullmann describes herself as a kind of empty vessel through which the emotions flow, she nevertheless recognizes something

crucially important for our understanding of the way in which 'possession' works, namely that the character and herself are one and the same person. The emotions of the character, contained within her, keep Liv Ullmann open to depths of her own emotion, 'What happens to a role is a kind of life, and now as I sit talking with my colleagues, *Jenny is living inside me*. So that in a way I am she; and what are her tears and fear and anger keep open in me that which I shall use to portray her.'

The character within Liv Ullmann is experiencing its own emotions, but they are derived from Liv's own emotional 'reservoir'. [...]

The possessing character, personality, being, is allowed a stream or channel of space into the 'backlog' of the actor's experience, *going right through the layers from deep unconscious to surface persona*. Sometimes, Liv does not know where the emotions come from; sometimes, the possessing character surprises her.

But the observations of Liv Ullmann and other actors make clear that when the possessing character becomes too powerful, it dips into other areas of the actor's psyche, and *begins to take over control*.⁷⁹

Ms. Ullman even talks like an MPD/DID client here when she says, "Jenny is living inside me," claiming that what happens to a role, "is a kind of life." Adding to the similarity between alter and actor is the emotional streams "going right through the layers of deep unconscious to surface persona." This way of explaining what is going on while enacting a role seems indicative of both Bliss's conception of alter-identities in the unconscious (as consciousness split horizontally) and Ross's conception of alter-identities readily available in consciousness (as consciousness split vertically) as mentioned in chapter three.

To review, it appears then, that acting and MPD/DID switching behavior may use the same techniques and styles with the same potential psychological dangers of character role absorption (possession), and dissociative delusions. Both Diderot's concept of fair acting and Emotionalist style acting satisfy the criteria of extreme dissociation, character role absorption, i.e., deeply emoted role enactment, and even sometimes dissociative delusions. These delusions may take the form of the actor/client believing he or she is

another person, or they may take the form of the actor/client believing he or she has one or more identities inside him or her, i.e., that he or she is 'possessed' by other identities/characters. The nomenclature of these experiences may vary between therapy and theater. The use of one's affective memory may facilitate becoming deeply absorbed into a character role, and this may result in dissociative delusions for either the MPD/DID client or actor. But deep absorption and dissociative delusions do not necessitate an actor, or a client, stepping out of script or character. An actor, or a client, may cathect inner emotions in a personal way on stage or during therapy, but this is not what is meant by 'becoming' another identity/character. The notion of dissociative amnesia was ignored, referring the reader to chapter five, because the conception of dissociative amnesia is logically flawed and may not apply to either MPD/DID clients or actors. The point is that the experience of extreme dissociation, i.e., of being focused on feeling the feelings of a particular self-created character based on and wrapped up in one's own psyche, emotion, memories, etc. can be said of either MPD/DID clients, Diderotian fair actors, or Emotionalist style actors.

The Lack of Adherence to a Particular Acting Style

It could be argued that MPD/DID clients are different from professional actors because clients do not use a particular acting "style" since they have never been educated in either Technical or Emotionalist acting styles, and actors have. But then, upon more

careful consideration, it may be that professional actors do not adhere to a particular style either, though they may use a varying combination of techniques.

Brian Bates, acting psychologist, concludes that Technical acting, though touted as Technical, may not be as free of feeling as believed. It is questionable whether actors adhere to one particular style of acting from character role to character role, from performance to performance, or even from within a given performance.

When we look at the experiences of actors, it perhaps becomes clear that there is no uniform, homogenous 'English' approach to a role. Many actors tend to approach different parts in different ways.

It seems very difficult to identify with any precision what, exactly, 'English' acting is because, in contrast with 'Method', it is not a consciously constructed system. Instead, we are left with the conclusion that non-Method actors are just that. They do not adhere to *any* rigid technique.⁸⁰

Of course, Method or Emotionalist actors do not adhere to any rigid technique either. If Emotionalist acting requires reality of feeling and Technical acting requires no adherence to "any rigid technique," and if actors use either of the acting styles at any given moment or for any given production or scene change, these acting techniques are not pure. This does not mean that no technique is used, but rather, more likely that a combination of techniques is used. This suggests that real feelings do creep in or are intentionally or unintentionally used by actors, regardless of which acting style is being used. Neither professional actors or MPD/DID clients have to adhere to a particular acting style to have *real* feelings creep into role enactments.

The notion that any one actor uses or adheres to any one acting style, such as Technical genius acting, i.e., mimicry, may be a misnomer—as such acting and MPD/DID

switching may be even less different than clinicians suppose. Bates comes to the conclusion that real feelings are present in most performances and therefore the identification of, or the consistency of acting style may be unimportant. For example, Charlton Heston, when interviewed by Bates, explains that it does not matter to him in his acting whether he uses sense memory to evoke a specific feeling or whether he comes to it by some other immediate technique. (Bates; pgs. 37-38)

Coming to the realization that acting style is often varied, Bates questions the importance of talking about style at all. Using techniques may be useful for actors, but if no particular style is required for a given performance or character role then, it is more difficult to contrast acting with alter-making as some kind of opposites or separate categories. This point further blurs the alter-actor distinction.

Since actors use many styles, and since a particular style may not be important, if there is any one thing that is used by all professional actors it would have to do with the technique of concentration which implies control over behavioral changes. Some level of concentration must be involved in making an identity/character *present* to the observer, be it therapist or audience. When diagnostic criterion A speaks of "the presence of two or more distinct identities" etc., it is the ability to make an identity present that comes into question with the alter-actor distinction. But, the characters played by actors are also made present. "We speak of an actor having "presence," and it means exactly that."⁸¹

MPD/DID clients supposedly have no control over the presence of their alter-identities appearing and actors supposedly do have control over entering a role. Yet, as explained earlier, becoming a professional actor takes years of practice just as does

becoming MPD/DID. The ability to extremely dissociate and to “switch” personalities quickly, is an experience that takes years of practice. It is the quickness and depth of stepping into another character that makes MPD/DID seem uncontrolled—almost like an *instinct* that is needed toward self-preservation during a crisis. To designate MPD/DID switching as uncontrolled is to make a false dichotomy of switching and acting. Control is necessary for both alter-making and professional acting.

Control of acting requires years of practice, whether the actor is a professional or an MPD/DID diagnosed person. When some things are practiced they become habit and habit appears automatic, as if uncontrolled. Playacting, as a natural phenomenon of childhood, *seems* almost instinctual for many children. Some adult actors’ performances appear so smooth and unmanipulated they, too, *seem* to be working by instinct. But, Bates explains that “‘working by instinct’ is a highly disciplined process.[. . .] It takes supreme concentration,” i.e., concentration of a particular *kind*.⁸² Behind a “compelling presence [. . .] is more than conscientious attention to the business of [an actor’s] working day.”⁸³ The kind of concentration to which Bates refers is the ability of all good actors, “to focus all their attention intellectually and emotionally, into the character and scene.”⁸⁴ If you will remember, in chapter three, technique of extreme dissociation was clinically reported to require an extremely narrowed focus of attention. It is this total *absorption* of one’s concentration into a particular role that “generates a presence that people can *see*.”⁸⁵ Whether the person is an MPD/DID client or a professional actor, his or her years of practice of this particular kind of deeply absorbing concentration lends itself to the ease of switching character roles, of making alternative identities or characters appear to therapist

or audience alike. Being present as a MPD/DID alter or actor's character to a therapist or audience, respectively, requires deep focused concentration. And, although this concentration may not appear obvious—it may appear quick, instinctual, uncalculated, and unmanipulated, i.e., uncontrolled, both MPD/DID clients when switching alter-identities and actors when changing characters are intentionally implementing techniques of concentration.

Imagination as Mental Illness: Separating Actor and Act

According to the clinical conception of MPD/DID, the client is separate from his or her alter-identities, just as the actor is presumed separate from his or her acting. This notion falsely supports the alter-actor distinction. Bates's more thorough understanding of acting defies the clinical notion of separateness of actor and act. Bates says, "there seems no point in separating *acting* from the actor."⁸⁶ [And, I would add there is no sense in separating acting or alter-identities/characters from the MPD/DID client.] Having consulted actor Sam Waterston, Bates agrees with him that, "*You can't really talk about acting because acting is a person*. There is no such thing, maybe, as acting, there are only actors."⁸⁷ If this is the case, the difference between some of the five clinical views may dissolve.

If MPD/DID clients are actors and if acting is a person then it could be said that client alter-identities are persons, in the same sense that characters enacted by professional actors are persons. The character/identity that the client/actor portrays at any one time is

done by a person, i.e., is a person, acting either this way or that way, either during therapy or outside of therapy, either on stage or off stage, at any particular time. We normally do not speak of alter-identities or enacted roles as persons, probably because this would contribute to confusion of 'who' is being talked to or about. The point is that both alter-identities and enacted roles are made to appear as living persons, because they are performed by living persons—the act is the actor and the actor is the act.

But, the clinical way of describing MPD/DID client behavior has led people to believe that alter-identities are rare and abnormal. The psychology of acting indicates alter-identities are a common phenomenon of acting. This suggests that there may be a better way of describing MPD/DID client experience than to say he or she is or has many persons, personalities, or identities. Instead, it means that, like any actor, an MPD/DID client is a person who can become transformed—moving from one way of being in the world into another way of being in the world. If there is no sense in separating the actor from the acting, and if MPD/DID clients are actors (as Ross says), it seems unnecessary and problematic to separate the MPD/DID client-proper from each of his or her alter-identities.

Separating the actor or client from his or her acting is like trying to separate him or her from his or her imagination. And, unfortunately, it is the imagination that gets blamed for mental disorder when it comes to MPD/DID. Even though Ross admits that MPD/DID clients are a "fascinating theater of personalities," all based on "an elaborate pretending," that started with the child getting the "idea of creating someone else

inside,"⁸⁸ he highlights the importance of therapeutically treating, i.e., correcting the imagination.

MPD is a little girl *imagining* that the abuse is happening to someone else. This is the core of the disorder, to which all other features are secondary. The imagining is so intense, subjectively compelling, and adaptive, that the abused child experiences dissociated aspects of herself as other people. It is this core characteristic of MPD that makes it *a treatable disorder, because the imagining can be unlearned*, and the past confronted and mastered."⁸⁹

The way Ross sees to take the acting out of the MPD/DID client-actor is to get him or her to cease or curb his or her imagination.

It is the imagination that is blamed for interfering with acceptance of past realities/traumas. There seems to be an assumption that if one's imagination controls them they are mentally ill. While interviewing Rip Torn, Bates notes that,

Rip Torn puts it more directly, when asked his view concerning the fact that actors are often seen as being unstable, 'Adults are supposed to be controlled; they're supposed to repress their emotions: that's our Puritanical background. But an actor must go through the emotions in a night that some people only go through two or three times in their life—at weddings, funerals, and by the side of death beds.'⁹⁰

Both the MPD/DID client and the actor are on emotional roller coaster rides. The actor does not attempt to cure imagination by controlling it because it is essential for acting. But, the MPD/DID client's imagination is clinically found at fault.

It may (or may not) be the case that learning to curb one's imagination is sound advice for anyone whose imagination is resulting in dysfunction. If imagination were the cause of dysfunction, therapy would look different. The therapist would help the client confront his or her trauma, hidden past, in a different, a more integrated way, such as by

helping the client to implement the psychological safeguards actors use. These include such things as maintenance of the hidden observer, a change in nomenclature, and the presumption that the client is a single person acting various roles.

By the APA categorizing multiple personalities/dissociated identities as a mental illness, the APA board members are, in essence, categorizing a particular use of the imagination (for the creation of alter-identities) as a mental illness. Finding a problem with split-consciousness, i.e., with the 'being' of various identities, is to find fault with the process of extreme dissociation as a tool to enact or 'be' various people. It takes deep concentration to split attention and it takes much imagination to create a role, and it takes affective memory to breathe life into that role whether MPD/DID client or actor is doing these.

It is the conception of a particular use of the imagination (for alter-identity creation) as mental illness that both supports and problematizes the validity of the alter-actor distinction. Imagination plays a primary role in the extreme dissociation (used to create alter-identities) that is clinically interpreted negatively as deep absorption into a character role, i.e., as dissociative delusions. It is being deeply absorbed that breathes life into the act so that the therapist and client are convinced that the client is, or really believes him or herself to be, another identity. This, in turn, (problematically) supports the therapist's belief in the diagnosis of MPD/DID, and reinvigorates MPD/DID therapists' belief in the validity of multiple personality/dissociated identities as a Disorder. This is an example of a false positive, of sorts.

Clinicians sometimes forget that part of a person's becoming absorbed in a role he or she plays involves others *treating* him or her like a different person (and not just feeling 'inside' like someone else).

Being 'out in the world' in character, rather than safely cocooned in rehearsal rooms or film studios, means that the actor is perceived, approached, dealt with as if he were someone other than himself. The 'character' becomes the person. It is both shocking and exhilarating. And therein lies an important lesson in being ourselves.

Simply walking as someone else makes the world look and feel different. But to interact with others as a changed person—a character transformed—is an enlightening experience. It subtly but dramatically alters the thousands of ways the environment feeds back, supports, shapes and channels the signals we send out. How those signals are returned shapes our view of ourselves. A change in persona can change your life.⁹¹

When therapists treat MPD/DID clients as multiple, or even when they confirm the clients' Disorder with metaphorical language of multiplicity (whether the client or the therapist imposes these metaphors), these attitudes and behaviors play a role in treating the client as a different person, or as many different people—in the context of multiplicity as a disorder. The making of a diagnosis of multiple personality/dissociated identity is the same as a therapist's agreement to be a participant (an audience) in the beginning of a drama of multiple role-playing. If the MPD/DID client does not want to be him or herself, being able to act as another person is aided by the therapist as audience to accept and respond to the difference in identity, with both therapist and client believing to do so is indicative of the client's psychopathology.

Imagination is necessary for playacting, MPD/DID alter-making, and professional acting. Both alter-making and some styles of acting depend on extreme dissociation

(intense or narrowed focus of deep feelings from inner phobias/affective memory) to pretend to be someone else. That both MPD/DID clients and actors can use feelings/emotions and a narrowed attention to accomplish extreme dissociation invalidates the clinically constructed alter-actor distinction. The use of extreme dissociation for pleasure or avoidance of pain, or for the creation of and performance of alternative ways of being is a developed skill of normal people. Some people like using extreme dissociation—they like ‘living near the edge’ of psychological safety.

‘Living Near the Edge’ of Psychological Danger

The negative symptoms associated with MPD/DID, i.e., switching, difficulty switching back, dissociative amnesia, character role absorption, dissociative delusions, are referred to in the acting trade as ‘*living near the edge*’.⁹² Actors who love challenge, or danger, or the experience of stretching their capabilities, are willing to ‘live near the edge’ psychologically.

Some actors, like Hoffman, mentioned above, maintain a strong hidden observer; but others, like Bogarde as von Aschenbach, ignore the warnings of becoming absorbed in a character through loss of the hidden observer. Bates cautions about deeply felt acting. He says that it can sometimes be dangerous—when the actor identifies him or herself as the character. Bates says,

But the *crucial danger* of the persona is that of identifying oneself with the mask, the role. Our whole, true self is not the same as the self that fits a particular role. If this happens, the person loses contact with the deeper sources of their own being. Life itself becomes one continuing series of role-plays, behind which the person's true self is denied.⁹³

Bates seems to be saying that the actor can become so busy playing a multiple of roles, he or she loses something genuine about who he or she is.⁹⁴ Bates does not talk about it in terms of fragmentation, split personality, multiple personality, dissociated identities, or as a disorder, but rather as a loss of "contact with the deeper sources" of one's being, in other words, as a deep dissociation. The person may or may not think of his or herself as playing roles instead of being genuine, but in some sense he or she may lose touch with his or her real feelings about situations and events. This identification of oneself with the many masks one puts on is the sense of dissociative delusion that Ross speaks of as occurring with MPD/DID, but with a qualifier. The actor may not think of him or herself as multiple identities or persons when identifying with each mask (and the MPD/DID client may not either), until someone else (a director, therapist, loved one) points it out. Bates's quote above serves to indicate that both alter and actor can experience negative psychological effects of identifying with his or her masks. Actors are usually taught to guard against it by maintaining a hidden observer, as Hoffman admits to. But, when actors lose their hidden observer, as Bogarde did as von Aschenbach, actors' too experience dissociative delusions about who they are.

In spite of the psychological dangers involved, some actors believe that "Living 'near the edge' keeps a person sharp, aware, creative, ready to respond to life's

surprises.[. . .] And the way of the actor is to live with challenge."⁹⁵ Bates explains of actors (shamans of old) that,

Actors in traditional societies were expected to transcend physical and psychological death. In a sense, the two were seen as one and the same experience. [. . .]

Today, of course, it is very rare for people to undergo such demanding and personally transforming experiences. But the principal is provocative: That to live 'near the edge,' to be aware of boundaries of experience, encourages the individual to live to the full. We do not need to go beyond the boundaries necessarily, but to test them was, and is, a test of one's commitment to life. People who have been very near to the edge, surviving a serious accident or illness, for example, tend as a result to live more fully. Awareness of death (of self) introduces one to the fullness of life.⁹⁶

Actors like, Heston, Streep, Hoffman, Brando, Redgrave, etc. live to test their psychological boundaries.⁹⁷ Acting is what offers them the opportunity to do so. Becoming absorbed in a role, experiencing dissociative delusions—either believing they are the character portrayed or that they are being 'possessed' by another character, are some of the psychological risks involved in extreme dissociation, i.e., in acting as well as in alter-making.

The accusation may arise that if MPD/DID clients are acting, maybe actors are mentally ill. Just as Ross feels a necessity to distinguish between alter-identity as treatable mental illness and actor as professional mimic, Bates, too, feels prompted to distinguish between acting as sanity or insanity.

As a psychologist, Bates is aware that actors and acting are associated with madness, neurosis, schizophrenia, possession, etc. because of the *clinical* interpretation of imagination and dissociation. As such Bates knows he needs to distinguish between acting as pathological and acting as theatrical.

Psychiatrists, dealing today with people distressed by involuntary possession (now called hysteria or dissociation), and seeing possession in an exclusively clinical environment, have reinforced the taboo nature of the state in Western societies. And psychiatric jargon, supposedly providing an objective, scientific language for discussing mental states, represents the behaviour of a possessed person as, ... gross non-reality ideation, abnormal perceptual experiences, (and) profound emotional upheaval's which constitute a 'schizoid' state—regarded as a serious pathological condition. Stripped of its unscientific bias, this is saying that possession is a mental state involving highly imaginative ideas, unusual perceptual experiences and strong emotion—which is what actors experience in almost every performance.⁹⁸

Bates believes that deep emotion into a character role can lead to a state of split personality (i.e., a 'schizoid' state). But he does not mean this in a clinical or psychologically negative way. Bates contends that a state of split or multiple personality is not a mental illness.

If extreme dissociation is not an experience relegated only to psychopathologies, then why is the same behavior perceived differently by clinician and actor? Differences in nomenclature, i.e., clinical versus theatrical, were mentioned earlier. But does the difference between alter-making and acting amount to nomenclature alone?

The Alter-Actor Distinction: Nomenclature

Bates seems disgruntled at psychiatric jargon, and the psychiatric industry's belief that they are furnishing the truth (objects of knowledge, i.e., scientific facts) about mental states. Bates seems distressed that deep emotion, i.e., absorption into a role, gets relegated to the "pathological" when it is a common, everyday experience and a necessity

for the professional actor. Normally, what is common and everyday behavior does not get categorized as a mental illness. It seems odd then that the imagination, extreme dissociation, deep absorption, and dissociative delusions, that are negative symptoms of, and used as support for, the mental illness category of MPD/DID are the same skills and techniques used by actors to become good at their profession. These symptoms, interpreted as *negative* by clinicians, are used to support the alter-actor distinction. But, when these same symptoms are interpreted *positively* by acting psychology, they challenge the validity of the alter-actor distinction. The distinction's validity seems to rest precariously on nomenclature.

Why do clinicians trade theater language for scientific language when it comes to the adult MPD/DID client? Both MPD/DID acting and professional acting abilities started out as early childhood playacting. But when the MPD/DID adult-child's playacting is misinterpreted as turning into an uncontrolled behavior as an adult, the language of the theater (i.e., acting, pretending, imagining), is traded in for scientific explanation (i.e., MPD/DID). Bates gives us an explanation of this phenomenon. He says, it is the ability of "being childlike" while acting that can lend understanding to why clinicians do this.

And when people have entered the world of imagination they are, according to Hurt, in a mental environment in which they can create communal events with their shared imaginations, '... The mask comes to life. And what do people believe? They believe their imagination. The life that is happening is the life of the imagination. That is the mind of the actor.'

Children enter this world frequently. In fact, we often associate 'make-believe' with children, forgetting that as adults we make-believe all the time in our minds. We carefully avoid expressing this fantasy life externally, afraid we might be thought 'childish'... Bates, 130-31.

MPD/DID clients are told that it is essential to identify and call out the alter-identities so healing can begin. Both MPD/DID therapists and acting directors each encourage this aspect of make-believe in their patrons. I have to surmise that to equate adult MPD/DID behavior with make-believe, or pretend, or fantasy is equivalent to equating adult behavior with childish behavior rather than with serious scientific study.

And, just as clinicians trade the language of acting in for the language of science, the normal behavior of the child is re-couched in the adult terminology of disorder. For clinician and client, when children become adults, make-believe is renamed dissociated delusions, actors become alters, character roles and possession states become disordered personalities and fragmented identities, and multiple personalities become a psychopathology while acting becomes art.

It could be otherwise.⁹⁹ Acting the role of a person, i.e., a self or character, does not have to lead us to the clinical-scientific view of MPD/DID as split or fractured incarnate consciousnesses. A theatrical explanation could be given instead.

A Second Look at Putnam's Alter-Actor Test in Light of Acting Psychology

Putnam, though aware of potential problems of testing professional actors against alters, anticipates there will be psychophysiological differences. Many clinicians have ignored Putnam's cautions that college students faking MPD/DID switching of alter-identities may not have performed their roles over a long enough period of time to be

fairly compared to MPD/DID alter-identities. Putnam acknowledges that if test subjects are too dissimilar, test results can be misleading. In spite of Putnam's cautions some clinicians have used Putnam's findings as scientific support for proof of the existence of multiple identities in clients diagnosed as MPD/DID. For example, Dr. Robert A. Phillips, Jr., the therapist for MPD/DID Truddi Chase and her Troops (her alter-identities) says,

Since each personality is significantly different from the others (and Dr. Putnam has demonstrated that the differences are measurable), what we see are the reactions and actions of different people. [. . .] Professional actors have been asked to express these differences under controlled clinical conditions. The results of such tests indicate that one person cannot simulate these differences in as distinct a manner as can the multiple. As incredible as these findings may seem, they indicate that many persons can exist in one body.¹⁰⁰

In spite of these kinds of misrepresentations, Putnam is very careful to not overstate his work.

People who misrepresent his work, and Putnam himself, when he does more alter-actor test construction and interpretation, need to consider the following. Only some professional actors choose to 'live near the edge' of psychological danger (indicative of MPD/DID diagnostic criteria symptomatology) when they act. Other actors do not. If professional actors guard against becoming too absorbed in their character roles, because of absorption's inherent dangers to the psyche, a testing problem arises. Putnam anticipates that scientifically comparing the physiological responses of alter-making to professional acting may result in a similarity between the two. This result may not hold if professional actors guard against character role absorption during the testing procedure. Putnam's findings will likely be the same as when he used student actors, provided he will

again use a certain kind of professional actor (those that do not like to 'live on the edge' and risking the psychological dangers of acting). If, during testing, MPD/DID clients intentionally become absorbed in their roles, while certain professional actors intentionally avoid doing so, a false negative would result. Putnam would get the results he expects, i.e., a significant difference between alters and professional actors, but this difference would have a valid explanation and defy Putnam's explanation of significance. In other words, alters and actors would very likely appear significantly different psychophysiologically, but not because alters are real and actors are mimics. Instead, alters and actors would appear different most of the time because actors, having been made aware of the psychological dangers of acting, have guarded against becoming too absorbed in a character role during testing, and MPD/DID clients have not.

Only if a professional actor subjected her or himself to 'living near the edge' of psychological danger by using certain techniques, then that particular actor during that particular performance may have a similar psychophysiological response to an MPD/DID client switching identities. Remember Ross's statement that "(t)he actor who became too absorbed in his role would be disoriented and dysfunctional, like the MPD personality who comes out of a blank spell in a bar, surrounded by strangers."¹⁰¹ Whether actors acting a role appear psychophysiologically equivalent to MPD/DID clients switching depends on what acting techniques the actor is incorporating at the time of the psychophysiological testing. Contrary to Putnam's research method, psychophysiological tests would be testing subjects' acting techniques, not the realness or imitation of an alter-self.

Summary

Once MPD/DID dissociative behavior is talked about in terms of a continuum—of being an extreme degree of a normal, common experience (trait or skill)—clinicians are faced with demarcating normal dissociation from the psychopathological varieties. Because childhood playacting can be used for pleasure or to avoid pain, and as adults those dissociative skills learned and practiced as a child can be used to continue to enact roles on stage or off, clinicians are faced with explaining how professional acting is different from MPD/DID alter-making. The determining difference, as reported by Ross, is extreme dissociation. Extreme dissociation involves real suffering, real feelings, character absorption, and dissociative delusions. The Rossian claim is that professional acting is mimicry, does not involve real feeling/suffering, and hence does not require the use of extreme dissociation like alter-making and switching do. Therefore, extreme dissociation is relegated to the extreme end of the dissociative continuum, i.e., to the realm of psychopathology, and acting is normal dissociation and somewhere to the left of abnormality on the continuum of dissociative experience.

But, the Rossian view of acting as mimicry proved to only superficially support the alter-actor distinction. When a well-rounded (non-naïve) view of acting is considered, by consulting a psychologist of acting, actors' self-reports, and directors' observations and experiences, the alter-actor distinction was shown to be invalid. Actors use extreme dissociation but try to protect themselves against the psychological dangers that clinicians and actors agree come with such experience. Some actors like 'living near the edge' of

psychological danger and therefore, intentionally subject themselves to those styles of acting that involve extreme dissociation, loss of control of the act/character, character role absorption, and dissociative delusions. Counter to clinical contention, some people can learn to extremely dissociate, and many intentionally do so, not just MPD/DID clients.

The invalidation of the alter-actor distinction leaves us with the possibility that MPD/DID is not significantly different from professional acting, i.e., MPD/DID clients are actors (i.e., the MPD/DID client-actor model). The differences between alters and actors is not that of extreme dissociation, i.e., the alter-actor distinction. Instead, the contrast seems to be based on at least two things; for one, nomenclature—a difference between clinical-scientific language and the language of the theater when each is referring to the same behavior, that of acting. Secondly, professional actors are taught to guard against the potential psychological dangers of extreme dissociation while MPD/DID clients are encouraged to subject themselves to those same dangers in the name of catharsis of hidden traumas. Some differences exist between alters and actors but they are not clinical differences.

The invalidation of the alter-actor distinction makes MPD/DID vulnerable to the accusation that multiple personality/dissociated identity is not a disorder. If it is not a disorder its inclusion in the DSM should cease. Of course, this brings up a question of what should be done to help those already diagnosed as MPD/DID and treated by encouraging clients to use what acting psychology would consider dangerous acting techniques. This situation is dealt with in chapter six.

But, before we turn to treatment considerations, I want to explore the metaphysical-logical problems of MPD/DID in the next chapter. If the MPD/DID client-actor model is not accepted, we are left to return to the current clinical/diagnostic model of MPD/DID with what will be shown to be its inherent logical fallacies and its bizarre conception of distinct, autonomous, alter-identities taking control of client behavior. The metaphysical confusion and illogicality of the clinical/diagnostic model will reinforce and substantiate the soundness of, and preference for, the MPD/DID client-actor model and lead us to question the benefits, methods, and goal of MPD/DID therapy.

Notes

¹ Lysaker, John. Dissertation comment to the author. 26 Oct. 1999.

² Though it may be the case that dissociative delusions stretch the meaning of Diagnostic Criteria A, Ross's view will be accepted as indicative of DC-A and not challenged herein as to this point. The claim that MPD/DID clients are not acting is so pervasive, while being based on a naïve view of acting, that it mandates investigation.

³ Bliss 122.

⁴ Bliss 122.

⁵ Ross 110.

⁶ Ross 2.

⁷ Ross 61.

⁸ Ross 12.

⁹ Ross 2.

¹⁰ Ross 109-10.

¹¹ Ross 110; emphasis added.

¹² Watson, Jack. Dissertation comment to the author. 26 Oct. 1999.

¹³ Ross 110, emphasis added.

¹⁴ Ross 110.

¹⁵ Ross 110.

¹⁶ Diderot 161.

¹⁷ Ross 29.

¹⁸ Ross 29; on Binet (1890) page 10; emphasis added.

¹⁹ Ross 29.

²⁰ Ross 33; from Breuer & Freud's *Studies on Hysteria*, 1895/1986; 101). (emphasis added.)

²¹ Ross 114.

²² Ross 110.

²³ Ross 47.

²⁴ Ross 110; emphasis added.

²⁵ Putnam, *Scientific Investigation* 114.

²⁶ Putnam, *Scientific Investigation* 114-15.

²⁷ Putnam, *Scientific Investigation* 116.

²⁸ Archer 366.

²⁹ Diderot 164.

³⁰ Diderot 161-169.

³¹ Diderot 164.

³² Diderot 161-69.

³³ Diderot 161-169.

³⁴ Archer 366.

³⁵ Bates 32. Emotional or affective memory is a term and technique developed in 1923 by "Richard Boleslavsky, an early member of the Moscow Arts" who came, "to America and founded the American Lab Theatre."

³⁶ Bates 32; emphasis added.

³⁷ Ross 248.

³⁸ Ross 248.

³⁹ Ross 248.

⁴⁰ Ross 248-249.

⁴¹ Ross 249.

⁴² i.e., an actor playing the role of an MPD/DID person uses her memory of being sexually abused by her father to portray that phobia in the role.

⁴³ Bates 76.

⁴⁴ Ross 109.

⁴⁵ Bates 65.

⁴⁶ Bates 65.

⁴⁷ Bates 63; emphasis added.

⁴⁸ Bates 62. A quote from the Director of the National Theatre, Sir Peter Hall.

⁴⁹ Bates 61.

⁵⁰ Bates 80.

⁵¹ Bates 71, 80.

⁵² Bates 80.

⁵³ Bates 81.

⁵⁴ Bates 33.

⁵⁵ Bates 33.

⁵⁶ Bates 69.

⁵⁷ Bates 69.

⁵⁸ Bates 69.

⁵⁹ Bliss 102.

⁶⁰ Bliss 67.

⁶¹ Bliss 67.

⁶² Bates 70.

⁶³ Bliss 112.

⁶⁴ Watson, Jack. Dissertation comment to the author. 26 Oct. 1999.

⁶⁵ Bates 87.

⁶⁶ Judge, Playboy interview, January 1997; 169-170.

⁶⁷ Bates 76-7, 81.

⁶⁸ Hoffman, Dustin. Interview. *Time and Again*; J. Pauley, 11/9/97; review: *Today Show* taped interview of 12/16/88, emphasis added.

⁶⁹ Judge, Mike. Interview. *Playboy*. January 1997; 169-170.

⁷⁰ Bates 81.

⁷¹ Bates 77-8.

⁷² Bates 71.

⁷³ Bates 71.

⁷⁴ Bates 72.

⁷⁵ Bates 71.

⁷⁶ Bates 94-5.

⁷⁷ Bates 95.

⁷⁸ Bates 94-5.

⁷⁹ Bates 78; emphasis added.

⁸⁰ Bates 36-7.

⁸¹ Bates 163.

⁸² Bates 162.

⁸³ Bates 162

⁸⁴ Bates 163.

⁸⁵ Bates 163.

⁸⁶ Bates 38.

⁸⁷ Bates 38; emphasis added.

⁸⁸ Ross 109, 12; respectively.

⁸⁹ Ross 55-56; emphasis added.

⁹⁰ Bates 64.

⁹¹ Bates 93-4.

⁹² Bates 147-50.

⁹³ Bates 96-7; emphasis added.

⁹⁴ As an aside, there may or may not be an essential self. Life may simply be a series of role-plays. Whether or not this is the case is a metaphysical dilemma that will not be dealt with. Actors and clinicians views are being compared here. The point is that the professional actors' world, according to Bates, seems to be based on the notion of an essential self, and it is that self that becomes the hidden observer when roles are enacted. Though the language of the actor varies from the clinician's, acting psychology seems to agree with clinical psychology. The acting world's contention is that without a hidden observer, one becomes a series of masks that one identities with. Without a hidden

observer, one becomes many masks, selves, identities—a dissociative delusion, in clinical terms.

⁹⁵ Bates 148.

⁹⁶ Bates 148-49, my parenthesis.

⁹⁷ Bates 141-150.

⁹⁸ Bates 71; Bates, in this reference to a 'schizoid' state refers the reader to a bibliographical reference, Lewis, I. M., *Ecstatic Religion: An anthropological Study of Spirit Possession and Shamanism* (Baltimore: penguin 1971)

⁹⁹ As Hacking contends is the case with any object of knowledge.

¹⁰⁰ Chase x.

¹⁰¹ Ross 110.

CHAPTER V

THE FOUR METAPHYSICAL-LOGICAL PROBLEMS OF MPD/DID

In the last chapter, I presented a new model of MPD/DID—the client as actor model. With this model arises the question, “why should the client as actor model be preferred over the diagnostic description of MPD/DID?” Herein are two answers to this question.

First, the client as actor model should be preferred because, as will be shown, the diagnostic criteria of MPD/DID are riddled with irresolvable contradictions—they are illogical and metaphysically problematic. By illogical I mean contradictory. By metaphysical I mean ontological—that which has to do with the nature and reality of being, self, personality, identity, and persons. The metaphysics in psychology/psychiatry involves use of a dualistic system of ideas, and an empirical parallelistic method of grasping those ideas, which come together to produce the metaphysical foundation for the clinical model of MPD/DID. I am using dualistic system of idea's in the Jamesian sense of mind (psyche) and body (soma) wherein “Psychology is the Science of Mental Life, both of its phenomena and their conditions...such things as we call feelings, desires, cognitions, reasonings, decisions, and the like [. . .].”¹ By empirical parallelistic method I mean the

assumption of the existence of a correspondence between mind and body (as two existent parallels of experience that interact, we know not how). Or it could be phrased as a “psycho-physic formula” wherein an “ascertainment of a blank unmediated correspondence, term for term, of the succession of states of consciousness with the succession of total brain-processes” is assumed, by psychologists/psychiatrists to take place.² Dualism or the empirical parallelistic method is the “provisional halting-place” within metaphysics, from whence psychology/psychiatry can begin doing what they do while not having to wrestle with the mind/body problem.³

Clinical judgments are suspect when it comes to analysis of, and decisions about, diagnosis, and treatment of multiple personalities/dissociated identities in one body. The clinical judgments in question are (1) the nature of the reality of the existence/presence of multiple personalities/dissociated identities, and (2) the reality of multiple personalities/dissociated identities as representative of mental disorder. Dualism is used to support the existence/presence of multiple personalities/dissociated identities and to diagnose it as a disorder. The MPD/DID model will be criticized both as a means to explaining client behavior and for treating it as a mental disorder.

There are four problems tied inseparably and directly to the label and diagnostic criteria of MPD/DID. The four problems are, (1) the problem of “who,” (2) the problem of co-consciousness, (3) the problem of switching, and (4) the problem of dissociative amnesia. These are problems that arise from a psychiatric dualistic conception of the MPD/DID client. These problems are irresolvable. Talk of mental life, even outside of the therapeutic industry, may contain these problems. But, we seem to get along in our

daily living, and are able to communicate fairly clearly with each other about mental life, in spite of these metaphysical problems. But, in the therapeutic industry, definition of a Disorder, and diagnostic criteria for a Disorder and their interpretation, directly affect therapeutic methodology. Therefore, any problems inherent in the diagnostic criteria of MPD/DID will directly affect the goals and methods used to “correct” the client’s mental problem. The client as actor model should be preferred because it avoids these problems.

The purpose of this chapter is to explain the role that dualism plays in the diagnostic criteria of MPD/DID and how this dualism both supports the clinical conception of MPD/DID and, at the same time, gives rise to the irresolvable four logical problems mentioned.

To present these findings, I will need to explain: why I focus on the diagnostic criteria, the importance of dualism to the diagnostic conception of MPD/DID, and how the diagnostic criteria are interdependent. This is followed by an analysis of each of the four problems of multiple personality/dissociated identity disorder to reveal both their direct-connection to the diagnostic criteria, and their inherent logical fallacies.

Before I begin, I want to put on hold any assumption that clinicians know what they are doing, not in general (for they help many people), but specifically when they diagnose and treat MPD/DID. There is an early example of MPD diagnosis and treatment that will make clear why I hope to arrive at a new understanding of MPD/DID through philosophical analysis. It involves reviewing Dr. Morton Prince’s first case study of MPD—the Miss Beauchamp story (pronounced Beecham).⁴ Not only will this account prepare you for the first of the four problems, i.e., the problem of who, it will also show

the metaphysical complexities that philosophically/metaphysically untrained therapists face when diagnosing and treating persons as having or being multiple personalities/dissociated identities in one body.

The Case Study—Dr. Prince and the “Real” Miss Beauchamp

The Miss Beauchamp story, the earliest recorded case study of MPD in America (if not the world), is an example of the therapeutic endeavors of Morton Prince. Prince’s work, even though it was done in 1898-1905, is based on hypnotherapy, and still serves as a clinical model for both understanding MPD and treating it.

Morton Prince’s client, Miss Beauchamp, had many personalities or selves. He had difficulty determining which of them was the real self. Prince divulges which personality she is in his final chapter (some five-hundred pages and six years later) entitled, ‘The Real Miss Beauchamp At Last, and How She Was Found.’⁵ Once found, the supposed real Miss Beauchamp keeps going back inside. She can not perform the duties of the real self, such as maintaining continual outward presence, and so Prince attempts to hypnotize her into staying out. Unfortunately, as you will see, the hypnosis was not totally successful.

Morton Prince was fooled, like any of us could be, into thinking that the real Miss Beauchamp was the initially presenting client.⁶ After many selves appear he refers to them as the “family” of Beauchamps—unsure as he is as to which of the alters is the “real” Miss Beauchamp. After thinking the client-proper’s real self to be the initially presenting client,

he changes his mind to believing the client-proper is really a hypnotic state of the initially presenting client. The hypnotic state (and other client-alter) came to be referred to in numerical form—B for Beauchamp followed by a Roman numeral in order of appearance. The hypnotic-state in question came to be referred to as B I. The real self was believed to be B I until B II appeared as a second hypnotic state with a more full fledged personality, and so Prince assumed B II must be the real self.⁷

After several other personalities appear, Prince, in clinical fashion, still assumes a real single self exists and so tries to bring out the Real Miss Beauchamp during therapy with problematic results. He did not expect the outcome, as he explains. "The new Miss Beauchamp readily consented to be hypnotized, becoming first B IVa, and then B II," who Prince refers to at one time as a "less perfect amalgamation."⁸ Having witnessed Prince's frustration, B III tells Prince that B II is the real self and so Prince comes to believe that it must be the case that B II is "the Real Miss Beauchamp with her eyes closed," meaning B II in a hypnotic state.⁹

Prince believes his therapeutic task is to get B II to come out of her hypnotic state and stay out. To avoid the previous problems of amalgamation in bringing the real self to the surface, Prince decides to solidify the real self, B II, and so he "changed Miss Beauchamp to B II" by hypnotizing her and commanding that she open her eyes and stay herself, i.e. her "real self."¹⁰

Prince admits that "The Real Miss Beauchamp, however, is not permanent . . . She has intermittent existence."¹¹ And, "although such a person was obtained, her appearance was infrequent, capricious, and uncertain."¹² Note that Prince does refer to this

hypnotized-into-being B II as a person even though she is sometimes an “amalgamation,” “a hypnotic state,” “a personality.” He became unsure she “could be maintained as her real self, stable and permanent.”¹³

Even though she has intermittent existence/presence Prince considers her as a real self, i.e., a person. He explains that “the Real Miss Beauchamp “persisted unchanged for about two months” then broke down and became again just one of the many personalities and although being the most frequent in appearance was “little better than a dement.”¹⁴ Subsequently, in the first 7 months of one year she experienced “continuous existence, with the exception of a slight lapse on one occasion following a physical illness and other strains.”¹⁵ It is unknown if the *real* Miss Beauchamp ever attained permanent integration.

The case of Miss Beauchamp shows what kind of questions therapists, or any of us, are faced with once someone is diagnosed as being or having MPD/DID. Once the description of client behavior is put forth as the existence/presence of distinct identities in a client, all those concerned are faced with many questions.¹⁶ What is a “real” person, self, or identity? Which of the many identities in one body is the real person? Is there a real person? What is the relation between the person and his or her identity? What is the relation between one’s body and one’s mind or psyche? Can alter-identities be events of the client’s mind and if so can they really be separate, distinct, and autonomous? Are hypnotic states separate selves? What is the relation between the individuality of hypnotic states and their autonomy as distinct identities? These are (or should be) questions faced in diagnosing and treating MPD/DID.

Diagnostic Criteria as Focus of Analysis

My accusation of illogicality or contrariness is directed at the diagnostic criteria and label of multiple personality/dissociated identity disorder, rather than at the variety of interpretations given them by therapists (those mentioned in chapter two). "The function of diagnostic criteria is to define illnesses in a valid and reliable way, in order to guide treatment and provide a prognosis."¹⁷ If the diagnostic criteria can be shown to be illogical it follows that subsequent clinical endeavors involving the criteria such as interpretation, the characterization of MPD/DID as a disorder, and the treatment method also contain these contradictions. Disorders that are shown to be invalid are subject to suspension from the DSM, or are subject to reclassification under a different superordinate classification with different diagnostic criteria, or are demoted to ordinate status, or put in a section pending further investigation and consideration. Invalid diagnostic criteria are grounds for declassification of MPD/DID.

But, to understand whether MPD/DID is metaphysically disordered we need to assess the psychiatric metaphysical system and method underlying the disorder. The next section will explain the radical dualism involved in the explanation of MPD/DID.

Dualism, Disorders, and MPD/DID as a Problem of Mind

MPD/DID is about the psyche. MPD/DID is based on a dualistic psychiatric model. Alter-identities are events of the mind not the brain. This distinction is important for understanding the metaphysical disorder of MPD/DID.

To understand dualism's role in the clinical conception of MPD/DID we'll look briefly at how psychiatry has strayed from its traditional empirical parallelistic method and why. Two mental illnesses, schizophrenia and manic-depression, will be compared to MPD/DID to make this point. In the process, it will become intelligible why MPD/DID is a psyche-only (mind-only) event. This will make way for understanding the fundamental basis of the four metaphysical-logical problems of MPD/DID.

Psychiatry, according to one psychiatrist, is based on mind-body dualism—on psyche and soma. Dr. Colin Ross freely points out that “Our psychiatry is dualistic [...]”¹⁸ Not all therapists/clinicians are psychiatrists and so not all therapy is based on mind-body dualism. But, the American Psychiatric Association is the one that publishes the Diagnostic and Statistical Manual of Mental Disorders and is the organization that determines which problems will be included in that manual. Any therapist diagnosing MPD/DID is faced with either following its diagnostic criteria as expected, or using the diagnostic classification and making up their own criteria. Assuming the liberty involved in the latter is not generally adhered to, whatever problems are inherent in the diagnostic criteria, even of a dualistic basis, will most likely appear in diagnostic criteria interpretation, and treatment methodology and prognosis.

More specifically as regards mental illness, in the late 1800's when psychiatry/psychology broke away from philosophy, an empirical parallelistic system and method were chosen as the metaphysical starting point for diagnosis and treatment. William James (1890) theoretically supported and recommended the intentional overt use of dualism, particularly empirical parallelism, when doing psychology, and at the same time, because of his literary work on secondary selves he became known as the American father of dissociation. MPD/DID has its roots in dualism, empirical parallelism. This system and method define dissociation, the foundation of MPD/DID and its diagnostic criteria. But, as will be shown, the empirical parallelistic method has become problematic for interpreting MPD/DID behavior.

But before I explain why, let me make an important point: just because dualism/empirical parallelism will be shown to be a problematic starting point for MPD/DID does not mean that it is a problem for other mental illnesses or for situations outside of psychiatry/psychology. I am not trying to undermine dualism or say that dualism itself is disordered or problematic in general.¹⁹ I am contesting its use as the basis of multiple personality/dissociated identity *as a disorder*. This does not mean that I am claiming dualism is disordered. It means that I am claiming that when dualism is used for a specific purpose, i.e., to support a diagnostic understanding of client divergent behavior as MPD/DID, then it becomes problematic in that context. Dualism can wisely be put to use in philosophy as a particular way of looking at things. Or, when dualism is used in everyday speech it is not problematic. For example, I can say things like, 'my brain hurts' or 'my mind is slipping' or 'I don't know whether my forgetting things is because my mind

is wandering or because I might have something wrong with my brain.' Talk of mental events or somatic events is not usually problematic for daily life. Dualism is not a problem in itself.

Dualism/empirical parallelism becomes a problem depending on how it is used or depending on what it is used for. When dualism/empirical parallelism is the basis for understanding a mental disorder, which will then indicate the need for and subsequently dictate the possibilities of treatment, then whether that clinical understanding is sensible is important. If the conception of a mental disorder is illogical, it is invalid. More importantly, since theory precedes and affects treatment, if a mental disorder is illogical, the treatment will contain this fallacious reasoning—treatment would be misguided or ineffective. It does not make sense to believe that unsound tenets could contribute to the re-attainment, or attainment, of sound mental health in a client.

To return to the chapter's focus, psychiatry is about *mental* illness. But the word "mental" has taken on dual meaning with the advent of science. When psychiatry first started over a hundred years ago, "mental" referred to mind (psyche) events, i.e., "feelings, desires, cognitions, reasonings, decisions, and the like."²⁰ Today, through scientific findings about brain disorders, mental refers to both mind and brain events. Scientific findings about brain disorders have resulted in a parceling up of mental illnesses into three categories: brain-only disorders, combination mind and brain disorders, and mind-only disorders. The division of mental illness into these categories has altered the traditional psychiatric method. And now, empirical parallelism no longer extends throughout the therapeutic industry. Brain-only disorders seem more aligned with a

materialist ontology. Psychiatric dualism seems to apply to mind-only disorders. And empirical parallelism applies to the combination mind-brain disorders. Technically speaking, if psychiatry's empirical method were to be adhered to, there would be no brain-only, mind-only disorders, there would only be the combination mind-brain disorders. Examples of each of these will be given shortly.

The use of dualism without the empirical parallelistic method has created metaphysical-logical problems for understanding the mind-only disorder of MPD/DID. Mind-only metaphysics has been retained for those disorders that have specifically to do with the psyche, such as the dissociative disorders—MPD/DID being the prime example.

The DSM-III-R is organized in a number of major sections that bear no stated logical relation to each other. These include organic mental disorders, schizophrenic disorders, affective disorders, anxiety disorders, and personality disorders. The dissociative disorders have a section of their own. Within each of these sections there are a number of diagnoses that may or may not have a specified relationship to each other.²¹

Contrary to dissociative disorders, and generally speaking, organic mental disorders and schizophrenic disorders are disorders of the brain-only. Affective disorders, anxiety disorders, and personality disorders are combination mind-brain disorders best suited to the empirical method. Dissociative disorders are mind-only disorders and appear in the DSM in a separate section. It will help to understand why empirical parallelism applies to some but not all psychiatric disorders by comparing three different disorders: (1) schizophrenia, (2) manic-depressive illness, and (3) MPD/DID.

Some disorders, like schizophrenia, are physical disorders of the brain, not of the psyche or mind. Schizophrenia is a typical brain disorder. Treatment for schizophrenic

disorders, prior to scientific discoveries, used to involve empirical study of a patient's mind. Now, due to advances in science, schizophrenic disorders are considered to be biomedical in nature, and have been discarded from psychiatric "mind" investigations.

The medical treatment of schizophrenia isn't really psychiatric these days, although the physicians who provide it are called psychiatrists. [...]

Schizophrenia is an organic disease of the brain and [...] its primary treatment is physical. It is a medical illness in the strictest biomedical sense of the term.

Globally in psychiatry, I think, we have become sloppy clinicians in our study of schizophrenia because of the biological model of the illness. The tendency now is away from spending any amount of time talking with the schizophrenic patient in an attempt to understand his or her mind. Once we check off a few symptoms, make the diagnosis, and start medication, detailed study of the psychosis becomes clinically irrelevant, in much of daily practice. [...] There is no reason to try to understand the patient's mind in detail, as there is in a long-term psychotherapy case, because the symptoms are just biologically driven craziness that needs to be suppressed with medication.²²

It is important to note that because psychiatry classically refers to disorders "of the mind," and because schizophrenia is considered a "medical illness", i.e., a disease of the brain (a part of the body), it is "globally" eliminated from consideration as a disorder of mind. By "globally in psychiatry" Ross seems to mean that psychiatrists around the world have given up mind therapies as treatment for schizophrenia. Schizophrenia used to be thought treatable using mind-therapies. But, schizophrenia no longer requires "long-term" mind therapy—there is no need to investigate or understand the patient's mind. Schizophrenia is now treated by medication. Yet, it requires diagnosis by a psychiatrist and so is tolerated by psychiatrists who would rather concern themselves with purely mental events rather than brain events.

Unlike schizophrenia, *MPD/DID is all about the mind*. This is because medical treatment and psychiatric treatment are thought of as separate entities. Medicine concerns itself with soma while psychiatry concerns itself with psyche. Psychiatric dualism functions to distinguish purely medical from purely psychiatric disorders.

The importance of the psychiatric distinction comes into play, for example, when considering the different characterizations of schizophrenia and MPD/DID. Both schizophrenic patients and MPD/DID clients hear voices. But, because a causal distinction is made between brain and mind, schizophrenic voices are considered brain derived and MPD/DID voices are considered psyche or mind derived. Schizophrenic voices are treated with drugs. Contrary to this, MPD/DID voices are treated with mind therapies. Schizophrenic voices are considered to be hallucinations—crazy ramblings of a biologically disturbed brain. MPD/DID voices are considered rational—the expressions of distinct alter identities present in the client's mind.

The first steps in the clinical examination of auditory hallucinations are those of classical psychiatry. One must find out if there are voices, the number of different voices, what they say, the tone or mood of their speech, their association with other symptoms, and the patient's understanding of them and response to them. The voices may talk directly to the patient; if they order her to do things, that is called a command hallucination. Or the voices may talk to each other, in a cooperative, argumentative, or other fashion. The voices may comment on the patient and her thoughts, feelings, and actions in the third person.

[. . .] It is important for the examiner to think about the voices *as if* they are actual people and try to find out what they are like, what they are doing, and what their motivation seems to be. In other words, one should examine *all* auditory hallucinations as if they come from alter personalities, in order to positively rule dissociation in or out. This applies no matter what the clinical diagnosis.

In severe acute schizophrenia the voices are often bizarre and irrational. [. . .] Such voices tend to be psychotic, rather than dissociative.²³

In order to determine which kind of voices a client is experiencing, the clinician must make the recommended inquiries. Regarding a schizophrenic patient that had two alter-identities Ross says,

I was unable to induce a switch, but I had a long rational conversation with the two voices. They both gave their points of view on the patient and each other, spoke politely, and would be described as “cooperative to examination” in a classical mental status examination report. The voices in this patient were more than chaotic symptoms of insanity. They were in fact sane. Schizophrenic voices tend to be crazy.”²⁴

In this quote it is quite plain that, clinically speaking, dissociative voices are considered sane and “cooperative to examination” while schizophrenic voices are considered symptoms of insanity. Psychiatric dualism allows for the distinction between problems of the psyche and problems of the brain.

But, can MPD/DID be both medical (brain-related) and psychological (mind-related)? The answer is, no. [The answer no applies to the psychiatric category and diagnostic criteria, and may or may not apply to the actual phenomenon.] By giving dissociative disorders a section of their own in the DSM, as mentioned earlier, they are separated off from disorders that could be purely medical or both medical and psychological in nature. Dissociative disorders refer to dissociated portions of mind. MPD/DID, being the most extreme form of dissociation, is the epitome of dissociated psychic (mind) states.

For example, compare MPD/DID to its close cousin—manic depressive disorder. A look at manic depressive illness can tell us a lot about the radical role of dualism when it comes to understanding MPD/DID. This is because manic depressive illness also involves

dissociated states, though importantly to a lesser degree. Understanding the difference between MPD/DID and manic-depressive illness will help in understanding the role of the mind in both psychiatry and MPD/DID.

Manic-depression is an affective disorder. It is treated both as a brain malfunction and a problem of the mind—a combination disorder. It is treated with both drugs and mind therapy.

Manic depressive illness is called bipolar affective disorder in DSM-III and DSM-III-R. I believe that, like schizophrenia, it is a biological brain illness, that the primary treatment is medical, and that psychosocial interventions are required. Manic-depressive illness is a disorder of switching. Patients with the disorder switch states in a pathological manner. Their problem is several-fold: they switch into states, switch out of states, and get stuck in states in an abnormal manner.

There is a severe discontinuity of mood, speech, thought, and behavior across states. What about identity? And memory? [...] Little attention is paid to the discontinuity of identity that must occur across states, as patients switch from depression to mania. This is an interesting area for research in itself.²⁵

It is pertinent to note that here we have a disorder, an affective disorder, that is biological in nature with a concurrent psychological impetus. This is important when it comes to understanding the difference between manic-depressive illness and MPD/DID. Manic-depressive illness and MPD/DID each involve both switching and discontinuity of affect, yet they are classified differently. Why?

Dissociative states lead to switching phenomena. Depending on whether mind, or mind and brain are involved, switching can result in either of two situations. Switching occurs, for example, in both manic-depressive illness and MPD/DID. Switching is noted by discontinuity of affect, i.e., changes in mood, speech, thought, and behavior. Manic depressive illness has different symptoms than MPD/DID even though both Disorders

involve the phenomenon of switching. But, because manic depressive illness is, in part, based on brain chemistry, its switching phenomenon is talked about in the restricted terms of a client getting “stuck in states in an abnormal manner.” Because switching behavior is tied to the body/brain, and since there is only one body/brain, the number of identities of the manic-depressive client remains constant—at one. The client is assumed to be a unified single identity before, during, and after discontinuity of affect.

Contrary to this, MPD/DID is a dissociative disorder that has to do with the mind alone. Because of psychiatry’s focus on mind, and because mind is interpreted as consciousness that can split, i.e., multiply or fracture, discontinuity of affect gets attributed to multiple alter-identities. These identities, being representative of a dissociated mind, must be distinct and separate from each other (DC-A). The difference between manic-depressive switching and MPD/DID switching phenomenon is substantial, for it is the interpretation that MPD/DID is an event of the mind that results in the attribution of identities (rather than states) to divergent client behavior.

[As an aside, the difference is not simply in the explanations. Manic-depressive client behavior is different than MPD/DID client behavior. But, therapeutic explanation affects therapeutic methodology that in turn affects therapist/client interaction, attitude, behavior, etc. The therapist, in believing separate selves exist or are present in the client, is therapeutically prompted to correct that disorder of multiplicity/fractured identity. The methods used to correct the client’s multiplicity/dissociated identity may contribute to that behavior. This is not the chapter for further exegesis on this. This possibility is talked about at length in chapter six.]

So, within those branches of psychiatry that remain based on dualism, there are, technically speaking, three metaphysical qualities of disorders. This fact directly affects the conception of MPD/DID. There are disorders of the brain such as schizophrenia; disorders of the brain and mind such as manic-depressive illness; and disorders of the mind alone such as MPD/DID (without ordinate disorders).

When it comes to MPD/DID, the traditional psychiatric empirical method of analysis no longer applies. The notion that mind and body/brain interact is forgotten when it comes to the Dissociative Disorders. MPD/DID is a mind-only disorder and as such defies the empirical parallelistic assumption of mind/body interaction. This effects decisions as to all aspects of the Disorder—cause, definition, treatment methodology, and prognosis. For example, voices heard by an MPD/DID client are interpreted as caused by the mind alone (DC-D). The definition of these inner voices is proof of the existence/presence of alter-identities (DC-A). The treatment methodology involves getting in touch with the alter-identities, and calling them “out”, using mind-therapies (DC-B). It is not until the prognosis stage of fusion/integration of these identities into one functional whole self that the empirical method re-applies—the client no longer has mind-only symptoms.

This approach of having mind-only Disorders results in a radical dualistic conception of MPD/DID alter-identities. It may seem bizarre to think about it this way, but due to DC-D, it must be the case that mind-only identities are body-less/brainless identities—they are discarnate entities separate from the brain activity of the client.

Because MPD/DID falls into the realm of mind-only, voices are attributed to alter-selves, instead of schizophrenic brain hallucinations, and MPD/DID divergent affect and behavior are attributed to the presence of distinct alter-identities instead of to manic-depressive mood swings. Psychiatric dualism dictates that MPD/DID alter-identities are distinct identities of the mind alone.

This clinical account of alter-identities is important to the understanding of the metaphysical disorder of MPD/DID—to understanding why alter-identities cannot be both distinct from each other and from the client, while at the same time being part of the client. The use of dualism/empirical parallelism in psychiatry has resulted in a metaphysically disordered conception of MPD/DID, as will be explained in the next section.

The Interdependence of the Four Problems

As indicated at the beginning of this chapter, the four metaphysical-logical problems of MPD/DID are each inseparably tied to the diagnostic label and criteria. What also needs to be made clear, before each problem is analyzed, is that each of the diagnostic criteria (and hence, also the four problems) depend on each other for explanation. The concept of dissociative-amnesia (DC-C) is dependent on the existence/presence of distinct autonomous identities (DC-A) having switched (DC-B); none of which can be the result of material, physical, physiological conditions by soma (organic) or ingested substance (DC-D). Switching (DC-B) makes no sense if there are not two or more identities to do the switching. Dissociative amnesia (DC-C) does not make sense if there are not distinct

alter-selves to hide memories from the client. And the existence/presence of distinct alter-identities does not make sense if they are the result of a medical condition (DC-D).

Because the DC are so interconnected, if one criterion is false or illogical then all suffer. Each contradictory criterion depends on and would, therefore, lend false credence to the others. The primary contradiction stems from the APA wanting alter-identities to be distinct and autonomous but still part of the client-proper. This will become evident throughout the following analyses of the four problems of MPD/DID.

The Problem of Who

The first problem, the problem of who, has to do with the diagnostic label. The Disorder of multiple personalities/dissociated identities entices one to conjure up the vision of multiple selves in one body. This conception prompts the question, "which self is the 'real' original person?" This is the problem that Morton Prince faced in the case of Miss Beauchamp. Determining which who is the real one is no easy task. Neither the MPD/DID label nor the diagnostic criteria give a method for such an endeavor.

In light of this problem of "who", and because alter-identities and the patient are treated as clients, I will refer to each respectively as client-alter(s) and client-proper. The diagnostic label indicates that a client-proper "has" or "is" multiple personalities or dissociated identities. Each of the client-alters, in one sense, appears the same because he or she shares the same body. Each presents itself in animated human form as an autonomous conscious self, identity, personality, i.e. as a "person" to be observed, and

interacted with. The difference between them is expressed by changes in behavior, haircut or style, dress, etc. Anyone can make these types of changes. It is not the affective or behavioral changes that give substantive meaning to the idea that someone either, "is," or "has" multiple identities. [Remember, manic-depressive clients exhibit affective and behavioral changes as do actors, dancers, etc. These changes are not what distinguish manic-depressive clients from MPD/DID clients.] It is the metaphysical concept that one is/has real identities inside them that gives import to the label of MPD/DID.

With the substantial sameness of client-alternates and client-proper in mind, how can therapists, or the best of us, know which identity or self is truly the client-proper? Is it the one who appears most often, or the one that is so emotionally scared he or she is too afraid to come out? Is it the one with the most rounded personality or the one most fractured and so most devoid of personality? Is it the strongest personality, i.e. the one with the fortitude to have survived long term abuse, or is it the shy one that is so broken his or her character is recessive? Is it the one that the therapist believes has the best chance of mental health? [This has ethical implications.] Maybe there isn't a real self. How are we to know? How is any therapist to know? Use of the diagnosis of MPD/DID forces therapists to pick the correct identity to fuse or integrate the client-alternates to. So, when it comes to MPD/DID, therapists must answer the question, "Who is the real, i.e., original, self?" Some therapists may, instead, choose to determine which is the best or mentally healthiest self. The real self and the healthiest self may not be the same. A real self that is eccentric may be angry that a therapist believes a different self—a less eccentric healthier (normal) self—is the one that should be out all the time. These questions present

both ethical and methodological dilemmas. It is problematic that therapists claim to “just know” intuitively and professionally which of the “who’s” is the real one.

With multiple personality/dissociated identity disorder one’s self becomes a metaphysical contradiction—parts of one’s self exist as parts of, yet are distinct from, one’s self. Out of this contradiction of parts as parts of something yet distinct from their own intervening agency, arises the problem of who. The story of the Miss Beauchamp “family” is a prime example of the problem of who. Miss Beauchamp, for example, was supposedly herself but also not herself—she was also B I, B II, B III, B IV, B IVa, etc. Alter-identities exist as separate, distinct selves at the same time they are considered as part of some real self, in this case Miss B.

The problem of “who” arises because therapists believe that singletonism represents mental health and multiplicity/dissociated identity represents mental illness. [Singletonism, a word I periodically use, was coined by some MPD/DID clients in retaliation to therapists wanting to fuse or integrate them into a single self. “Some of the more militant functional multiples maintain (quite vigorously) that it is better to be a ‘multiple’ and they might disdainfully refer to non-multiples as people suffering from ‘single personality disorder’.”²⁶] Because therapists are faced with the task of treating mental illnesses and MPD/DID as, clinically speaking, a mental illness, it is a therapist’s job to try to correct or alleviate the disorder. In doing so he or she has to follow the dictates of the diagnostic criteria. Declaring multiple personalities/dissociated identities a disorder predisposes the therapist to correct the “metaphysical problem” of multiple selves in one body by unifying them into one self. Multiplicity/dissociated identity is the

problem. Unification is the correction to the problem. The original person's mind became fragmented or dissociated into a multiple of distinct identities. The therapist must pick a who, to fuse or integrate the parts (alter-identities) to in order to recreate the whole original self.

As an aside, which who the therapist picks, or rather how the therapist goes about determining which who should be picked for fusing alter-identities to has ethical/moral ramifications. Should the therapist pick the most functional alter-identity to become the post MPD/DID self? Or, should the therapist try to determine which who is the original who and get the alter-identities to fuse to the original? Or, should the therapist pick the who that is the most fun, or most social, or most productive, or least obnoxious, or . . .? Do the alter-identities and client-proper have any say in the choice? If the client-proper has not "come out" yet, can an alter-identity claim to be the original self? What if the original self died, never to be seen again? Should the alter-identities get to decide who will be the one to fuse to, or should the therapist decide, or should the APA or the courts decide? These problems exist because the clinical view of MPD/DID is of separate, distinct, autonomous, identities, each with their own memories and view of self. The client-actor model resolves this dilemma.

The problem of who arises because, as explained in the previous section, multiple identities are mind-only events. This enables the conception of multiple, dissociated mental identities to come about. As explained earlier, for the purpose of understanding MPD/DID, psyche is clinically interpreted as mind, and psyche/mind is re-interpreted as self (see DC-A), consciousness (Bliss, Ross, and others), identity (see DID—DC-A),

personality (see MPD—DC-A), or person (some clinicians such as Phillips, Prince and others). The assumption of mind and body as separate entities, and the assumption of mind as equivalent to self, identity, etc., dissolves the necessity for a one mind or consciousness to one body relation between the two. This assumption opens up the possibility of a person having many dissociated psychic states, or several separate, distinct consciousnesses or identities in one body. From these metaphysical assumptions and inferences about identity (personality, self) and about how many selves can be contained in one psyche, arises a dilemma or contradiction about *who* the client-proper is.

The Problem of Co-Consciousness and Its Two Manifestations—An Overview

When I explain and discuss the problem of co-consciousness, I will make the assumption that we all know what we mean when we say consciousness—referring to something like a state of awareness. [Although a state of awareness is probably the most common among conscious folks, it is not a necessity that someone be aware if conscious. Awareness is not restricted to self-awareness, but includes the ability to interact with world and other, whether self-aware or not.] Since this is not a dissertation about consciousness, and since the topic of consciousness could fill volumes, I will not debate it here. The fact that the topic of consciousness is so complex and unsettled only adds weight to my accusation that therapists are being careless in their lack of logical and metaphysical analysis of MPD/DID. And, although this assumption of knowledge about

the topic of consciousness takes a lot for granted, it will furnish an easier start for explicating the problems inherent in the diagnostic conception of co-consciousness.

The explanation of what it clinically means to be co-conscious will turn out to be problematic. First, a diagnostic explanation of co-consciousness and its general problems will be outlined. This explanation will include an analogy to express what is clinically meant by co-consciousness. Next, the problem of co-consciousness will involve exposing the logical problem of its two manifestations: (1) interpersonality communication, and (2) the generation of inner voices. Each of these will be explained and debated in turn.

The General Problem of Co-Consciousness

Co-consciousness is a contradiction in terms. Co-consciousness means shared consciousness. It does not mean merely the experience of separate individuals being conscious at the same time as you and I. Clinically speaking, co-consciousness refers to a situation where each alter-identity has his or her own consciousness while at the same time sharing, i.e. being part of, the consciousness of the client-proper. The client-proper's mind, i.e., consciousness, is severely dissociated. It is fractured or split into two or more separate, distinct consciousnesses referred to as alter-identities. These consciousnesses are separate and distinct from the client-proper with the help of some kind of barriers, yet at the same time are part of the client's mind. This amounts to the contradiction that alter-identities both have and do not have their own consciousness.

To understand this provocative conception of MPD/DID and to aid in explaining this contradiction, it may help to consider the following analogy of co-consciousness. Pretend that co-consciousness is akin to many separate people (each with a private autonomous consciousness) standing together inside a pool (a head) that contains the consciousness of a "deity." Now, since alter-identities do not have bodies while co-conscious, remove the bodies of the people so that only their consciousnesses remain. The removal of these bodies is analogous to the removal of physical barriers between individuals—leaving only a mass of consciousness.

But alter-identities have distinctness. Their distinctness is acquired via mental barriers. Because of this the deity must construct invisible barriers in order to insure that there are many who's, that none of them is the deity, and to keep straight who is who. Without the barriers, there is only one consciousness. Without the barriers, the people lose their distinctness and the many consciousnesses flow together into one consciousness, i.e., the people "are" one big mass of consciousness, that of the consciousness of the deity. Paradoxically, with barriers the people are each, clinically speaking, "part of" the deity's pool-of-consciousness, yet, at the same time, are not the deity itself.

Let me extend the analogy. When we think of separate people swimming in the deity's pool it is easy to picture client-alter in the mind of the client-proper. But when we think of the people stripped of their bodies the picture, at least for me, starts to fade. It is harder to imagine people as mere consciousnesses, maintaining their distinctness and autonomy while floating in the deity's pool of consciousness, separated only by something invisible. Are the people still distinct and present once stripped of their physical

individuality? Are the invisible barriers really any kind of barrier at all? In being hesitant to give up all sense of thinking of these people as autonomous, one may be tempted to give a reluctant 'yes' to these questions—believing that any form of autonomy, even by way of an invisible mental barrier, may be better than total loss of autonomy.

But, the deity example is very different from the MPD/DID example. The deity example started out with many separate people. By contrast, the MPD/DID example starts out, not with real people, but with a client creating in her imagination, childhood playmates that become alter-identities that subsequently take over the client-proper's behavior and develop lived histories for themselves. These alter-identities did not start out with their own body and own consciousness.

Now let's look again at the deity example. Suppose people do not jump in to the deity's pool of consciousness. Instead, the deity, in his or her loneliness (or for some reason), starts to imagine he or she has playmates. The deity pretends to be these playmates. He or she pretends so often and for so many years that the playmates become real. The questions are as follows. (1) Are the barriers real or imagined? (2) Are the playmates now real, distinct identities? (3) Are the playmates autonomous—are "they" the ones thinking about self and environment? (4) When a playmate comes out, has a "who" come out? (5) When a playmate comes out "who" has come out? (6) And, when a playmate comes out where has the deity gone? (7) Do the playmates have their own consciousness? (8) Are the playmate's consciousnesses really the client's consciousness or instead part of the client's consciousness? (9) Are these the right questions to ask? (10) Or are these questions metaphysically presumptive? If the deity created these

identities in its imagination, then why do we refer to them as distinct identities or co-consciousnesses instead of, for example, either imaginary characters or enacted roles?

These questions will be answered more fully by proceeding with the analysis of the problems of MPD/DID co-consciousness. Co-consciousness is predominantly associated with diagnostic criterion A (DC-A). Each of the diagnostic criteria are indicative of what is going on in the client-proper's psyche. So, when primary criterion (DC-A) explains client-alter selves as, "The presence of two or more distinct identities or personality states" it means that these identities are in the client-proper's psyche.²⁷ [I say "in" his or her psyche because they "emerge" from the client's mind during hypnotherapy.²⁸ During a switch they "come out." And, I say "in" because MPD/DID voices, as proof of co-consciousness, are "inner voices"—they originate inside the mind not outside like with schizophrenia. (This point is explained more fully later.)] Client alter-identities are considered to have presence and identity because each has, "its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self."²⁹ DC-A does not say the client-proper has various ways of perceiving, relating to, and thinking about the environment and self. It says client-alters do these things. It is because separate identities are thought to exist, and to exist in the psyche, i.e., the consciousness of the client-proper, that the idea of co-consciousness is promulgated.

To think about the self and the environment, each client-alter must be present, distinct, and have consciousness. For lack of a better word, each client-alter must be autonomous. Autonomy includes the capacity to function independently from other identities, including functioning independently from the client-proper, who also is an

identity. [Again, an assumption is made that we all know what is meant by autonomy.] Acknowledgment of one's autonomy, I assume, occurs when one is able to think about and distinguish the "me" from the "not me" (as most of us are reported as capable of doing). As a reminder, DC-A says, "the presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)." It appears then, that according to DC-A, the attainment of autonomy for an alter-identity occurs with his or her ability to become conscious of his or her self as a self. Once this form of individuality/autonomy takes place in the development of the alter-identity, he or she can then function independently. He or she can acquire memories of self, communicate with other alter-personalities as a separate, distinct, identity, have a social life both inside and outside the client-proper, comment on other alter-identities or on the client-proper, exercise his or her desire/will to "come out," i.e., have self-government. And, the alter-identity can be acknowledged as an autonomous person in the public realm while "out. Others would not be aware whether they were interacting with a client-proper or a client-alter—to them he or she would just be a person, acting various ways at various times, given various situations. If client-alters have acquired a history, because of having spent time out (time in the body), then a client-alter's coming to see him or herself as a self, would include observation of him or herself, not just as a distinct, separate consciousness, but as a distinct and separate person—an autonomous person.

Yet, according to the MPD/DID diagnostic label and DC-A, client-alters are considered separate at the same time they are reported as "sharing" the consciousness of

the client-proper—the client has multiple personalities or dissociated identities in her mind. Client-alters both are and are not the client-proper. This contradiction, i.e., the problem of co-consciousness, puts diagnostic criterion A's validity into question. Co-consciousness, i.e., one consciousness shared by many identities, interferes with the conception of alters as distinct, separate, present, and autonomous.

Therapists would retort that what makes identities distinct are “transient” barriers of some sort, that exist or are present (i.e., are real) between each of the client-alters. These barriers distinguish and separate one set of hidden memories from another. Each set of hidden memories that belong to a client-alter. In this way the client-alter can hide horrifying traumas from the client-proper until he or she is ready to cathart—to relive and accept them as his or her own experiences. Until then, these barriers furnish “temporary” autonomy that enables the distinctness of identity that allows for the self-referential ability of each client-alter.

The word “barrier” then is meant to represent something real—“real” phobias as housed and contained by “real” identities—in the client-proper's psyche. The diagnostic description of MPD/DID needs the existence/presence of mental barriers to make sense of client-alters as distinct, present, and autonomous. But, mental barriers either exist or they do not exist.

The problem is, if mental barriers are real and create the autonomy between each alter-identity and between the alter-identities and the client-proper, the notion of transient barriers becomes a problem. As the barriers come down “temporarily” to allow for co-consciousness, their removal prompts loss of autonomy and distinctness of the alter-

identities. The temporary loss of mental barriers with their temporary loss of distinct alter-selves results in the retention of only one consciousness, i.e. the consciousness of the client proper, rather than resulting in shared or co-consciousness. [As explained much earlier in the section on dualism, without mental barriers to form alter-identities, inner voices would be considered indicative of schizophrenic hallucinations and changes in affect and behavior would be construed as manic-depressive illness, for example.] Mental barriers allow for the possibility of separate identities but, at the same time, barriers prohibit the sharing of consciousness—they prohibit co-consciousness.

So the question is, since mental barriers are needed to preserve both the autonomy of alter-identities and the sense of multiple personalities/dissociated identities, when, if ever, does co-consciousness make logical sense? ³⁰ There are four possibilities: (1) before hypnotherapy, (2) during hypnotherapy, (3) after hypnotherapy, and (4) post therapeutic fusion or integration. We'll consider each of these in turn. It will be shown that none of these four support a logical conception of co-consciousness.

(1) Pre-hypnotherapeutic co-consciousness is illogical. The client may or may not be aware of the existence/presence of alter-identities. If she or he is aware of them it is via inner voices—each inner voice representing a client-alter. But, if inner voices are to maintain their representation as distinct, autonomous identities, then interpersonality communication cannot occur because the mental barriers that create the autonomy are also the same mental barriers that prohibit communication. Alternatively, if barriers did not exist, distinct identities would not exist to perform inner voices. So, mental barriers

enable alter-identity autonomy, but negate the possibility of co-consciousness. Pre-hypnotherapeutic MPD/DID co-consciousness is illogical.

(2) Co-consciousness does not make sense as a hypnotherapeutic experience either. During hypnotherapy the therapist calls forth a client-alter. The therapist talks with the alter-identity's voice in order to find out what its function is (i.e., protector, mother, shy-one, student, employee, etc.) and in order to paste together the client-proper's missing memories. The question is, does alter-to-therapist conversation count as an alter-identity being conscious at the same time the client-proper is conscious? Not if alters are distinct identities and only one identity can be "out" at a time. Hypnotherapeutic co-consciousness does not make logical sense.

Let me elaborate on this issue. During hypnotherapy there is only one consciousness being communicated with at a time by the therapist. Each time the therapist says, "now let me talk to" (then fill in a name of an alter-identity), the therapist is calling forth a different distinct, autonomous, identity. The previous alter-identity or client-alter being spoken to must recede inside behind mental barriers while the one comes out to visit with the therapist. The mental barriers forming the me and the not-me for client-alter and the client-proper must logically still be in effect during therapy otherwise the therapist would always be talking to the "real" client-proper and MPD/DID would not make sense. During hypnotherapy the identities involved are still distinct, present, and autonomous and not co-conscious in the clinical sense of shared consciousness. This means that hypnotherapeutic co-consciousness is a contradiction.

The clinician would retort that while he or she taps into the consciousness of the alter-identity, he or she (the therapist) is, in essence, tapping into the consciousness of the client-proper and therefore the client-proper is co-conscious with the client-alter. This results in a contradiction—that of saying that the client-alter's identity as a distinct, autonomous consciousness is, at the same time, not distinct because it is the same as the consciousness and identity of that of the client-proper. Co-consciousness during hypnotherapy is illogical.

(3) Post-hypnotherapy co-consciousness does not make sense either. While hypnotized, the client-proper is instructed to remember the therapist-to-alter conversation. The problem is that the client-proper will remember the session as instructed—as the therapist talking to “part of” the client-proper, i.e. as the therapist talking to an alter-identity—a “not me.” The reason the client-proper will remember the presence of an alter-identity is for the same reason given in connection with hypnotherapy co-consciousness. The therapist, in communicating with “a part” of the client-proper is actually communicating directly with the client-proper and therefore, no mental barriers exist to form the autonomy of the alter-identity during hypnotherapy. Once the hypnotherapy session is over and the client-alter has supposedly gone back inside the mind of the host, the client-alter once again takes on the barriers that enable it to be a distinct identity—not part of the consciousness of the client-proper. Post-hypnotherapeutic co-consciousness is not possible if the autonomy of client-alter is to be maintained.

The therapist may retort that the client may start hearing inner voices now that he or she has become aware of his or her alter-selves. The logical response to this claim is

dealt with under the problem of interpersonality communication as well as under the problem of the generation of inner voices.

(4) The last possible explanation of co-consciousness has to do with the time period after therapy, i.e., when therapy has attained its goal of a unified, single self. Post-therapeutic co-consciousness is also senseless. Once the client-proper has been fused or integrated into a singleton, there are two ways to look at the concept of co-consciousness. First, it could be said that due to singletonism no more alter-identities exist. In this case co-consciousness can not occur because there are no client-alters for the client proper to be co-conscious with.

Alternatively, it could be contended that post-integration/post-fusion co-consciousness makes the most sense because no barriers exist to prevent the parts of the self from sharing and communicating consciousness. Unfortunately, this latter conception falls apart for two reasons. (A) If no mental barriers exist, no client-alters can exist. Due to integration or fusion, a singleton's hearing of inner voices can not be representative of co-consciousness but must, instead, be indicative of another disorder such as schizophrenia or epileptic seizures. (B) If no mental barriers exist then inner voices could be indicative of one's talking to him or herself. So, post-therapeutic co-consciousness does not make sense whether it is considered as being due to inner voices or singletonism, because of the lack of mental barriers.

To review, the possible explanations of co-consciousness do not make sense at any time in the life of the MPD/DID client. Whether we consider it plausible before, during, or after hypnotherapy, or post-therapeutically, the result is that co-consciousness is

illogical because it requires that alter-identities be present, conscious, distinct, and autonomous. If client-alter consciousnesses are distinct and autonomous from the client-proper they cannot logically also share the consciousness of the client-proper.

As the concept of distinct identities logically dissolves the meaning of shared consciousness, therapy loses its goal, i.e., to fuse or integrate the separate identities. If client-alter can not share consciousness with the client-proper or each other, they can not reveal their hidden memories to the client-proper. The client-proper could never come to know those hidden memories as his or her own.

So, the very description of presence, distinctness, and autonomy that enables the conception of multiple identities in one client, is the same conception that, logically speaking, does not permit for the integration or fusion of those identities into a single individual identity via the necessary co-conscious awareness of each identity prior to their integration or fusion.

The questions that will most likely arise with this analysis are, “if there is no co-consciousness, then what are inner voices? How is it that inner voices can communicate with each other and the therapist? And how are these voices generated, if not by alter-identities? This brings us to the problem of interpersonality communication.

The Problem of Interpersonality Communication

The first manifestation of co-consciousness—the problem of interpersonality communication—stems from the MPD/DID client hearing voices reported as coming from

inside the head. These are often referred to as “inner voices.” [The inner voices, though not mentioned in DC-A, are explained in the DSMC³¹ and in most, if not all, MPD/DID treatment education manuals.] Inner voices are clinically considered as one of the “proofs” of the presence of alter-identities. The problem of interpersonality communication results from the interpretation of inner voices as separate, distinct consciousnesses (alter-identities) that speak to each other, to the client-proper, and speak during hypnotherapy to the clinician.

The problem of interpersonality communication is also part of the problem of co-consciousness. To make sense of interpersonality communication, two things are essential, i.e., the existence/presence of distinct identities to do the communicating, and a medium by which to communicate, i.e., a single consciousness—that of the client-proper.

The problem of interpersonality communication stems from the general problem of co-consciousness. If client-alterers are distinct identities and not able to be co-conscious because of their autonomy, then there is no medium (consciousness) for the interpersonality communication to take place in. Alternatively, if co-consciousness can exist, then autonomy of alter-selves is compromised, leaving no distinct identities to do the communicating. *The necessary separateness of identities that makes MPD/DID plausible, is the same separateness that makes interpersonality communication illogical.*

To review, the result of this conundrum is that if there are distinct identities, there cannot be co-consciousness, nor can there be interpersonality communication. Because alter-identities need distinctness in the clients mind, they need to exist as separate consciousnesses. But, each consciousness cannot be aware of, nor speak to, the other

consciousnesses because barriers must exist to manifest the separateness and distinctness of each identity. The therapist, logically speaking, cannot come to know the client-alter because removal of the barriers during hypnotherapy amounts to the removal of the autonomy and distinctness of the identities. Co-consciousness does not make sense if client-alter are really distinct. Nor does co-consciousness make sense if client-alter have integrated with the client-proper. Co-consciousness has been shown to be illogical in all possible instances. Without co-consciousness, interpersonality communication is an illogical explanation of the presence of inner voices. Regardless of these findings, inner voices still exist. The problem of their generation remains to be investigated.

The Problem of the Generation of Inner Voices

The second manifestation of co-consciousness presents us with the problem of accounting for how inner voices come about. I refer to this as the problem of the generation of inner voices.

The generation of inner voices also presents a problem for DC-A (distinctness of identities). Inner voices exist and must be explained. But, considering the problems shown to exist with the concept of inner voices, if inner voices are not generated by distinct, autonomous client-alter-selves then who or what generates them? If separateness of identities does not exist by which to explain inner voices then the generation of inner voices would have to be accounted for in at least one of two ways—either as hallucinations or possibly as the experience of talking-to-oneself. If inner voices are

hallucinations then their generation is due to a medical or brain chemistry problem (DC-D), which is not a problem of the mind or psyche. Or, if inner voices are just the client-proper talking to him or herself, this suggests he or she is not MPD/DID, but rather suffers from some other diagnosis, or possibly is not mentally ill at all. Either of these explanations presents a challenge to the diagnosis of MPD/DID. These alternative explanations, of inner voices as due to hallucinations or as talking-to-one's self, will be considered in turn.

Clinicians avoid explaining co-consciousness voices as hallucinations for three reasons—DC-B, DC-C, and DC-D. The first is due to MPD/DID diagnostic criterion B—the view that client-alters takeover client-proper behavior. It goes against reason to claim that a hallucinatory experience switched places with the client-proper. Without co-consciousnesses as autonomous, distinct, self-reflecting, identities (diagnostic criterion A), problems arise for switching (DC-B). If co-consciousness is a misnomer, the idea of switching (diagnostic criterion B) can not make sense without the presence of separate selves to do the switching.

Secondly, without (DC-A) alter-identities sharing the mind of the client-proper, loss of memory/time gaps (DC-C) would be left to be attributed to hallucinatory or epileptic experiences instead of being accounted for by alter-identities hiding memories from the client-proper. Both DC-B and DC-C are interdependent on the clinical conception of shared or co-consciousness.

Thirdly, if co-consciousnesses are hallucinations, according to DC-D schizophrenia, or epileptic seizures, or drug or alcohol inducement must generate them.

This being the case, according to DC-D, inner voices would be considered as body/brain related and therefore due to “a general medical condition,” not a psychological one.³² If inner voices are a medical condition then the client cannot be diagnosed as having MPD/DID. Client-proper inner voices would no longer represent “proof” of client-alters. Without alter-selves there is no need for a conception of shared consciousness. Co-consciousnesses as the generation of “hallucinations” defy a diagnosis of MPD/DID. The explanation of inner voices as some kind of hallucinatory experience places the explanation of the generation of inner voices under the heading of somatic cause, and this is incompatible with the explanation of MPD/DID as a psychological phenomenon.

Problems also occur for MPD/DID with the explanation of inner voices as the act of talking to one’s self, because inner voices would be generated by the client-proper and not by alter-identities. This suggests one of several possibilities. It might be the case that the client-proper is imagining, fantasizing, or pretending his or her character roles, i.e., as alter-selves (this was dealt with in chapter four). Or, he or she has some kind of medical condition such as dementia (i.e., disqualifying MPD/DID by DC-D). Or thirdly, he or she is possibly listening to his or her voices of reason (disqualified from being a disorder by commonality of experience). None of these types of inner voices are accounted for as being generated by distinct and present identities and cannot be indicative of MPD/DID.

To review co-consciousness and its two manifestations, because DC-A requires the presence of distinct identities when it comes to MPD/DID co-consciousness is illogical. Without the notion of co-consciousness, inner voices (interpersonality communication) and the generation of inner voices must be explained another way. But,

inner voices as hallucinations/schizophrenia, or inner voices as the act of one talking-to-one's self, each disqualifies the client from being considered MPD/DID. Alter-identity distinctness, consciousness, autonomy, and presence run contrary to the concept of co-consciousness and interpersonality communication, which are illogical explanations for the generation of inner voices.

The clinical meaning of MPD/DID and the purpose of therapy depend on alter-identities being distinct and present. Yet, this dependency results in the problem of co-consciousness and its two manifestations, the problem of interpersonality communication and the problem of the generation of inner voices—all of which point out irresolvable logical contradictions to the clinical conception of multiple personalities/dissociated identities as a disorder.

The Problem of Switching

The third problem stems from Diagnostic criterion B. DC-B states that “at least two of these identities or personality states recurrently take control of the person's behavior.”³³ This is referred to as “switching,” i.e. switching places. DC-B is also indirectly involved with DC-A because switching alter-identities presumes at least two separate entities exist. These identities are said to change places, one receding inside to the mind and the other coming “out” into the body. The question and the problem is, how can a mere consciousness, a small part of the whole client-proper, take control, i.e.,

“switch,” with the client-proper of which it is a part? How can a co-consciousness switch with its intervening agency? This is referred to as the problem of switching.

In addition, because switching involves an executive decision in order to perform a situationally appropriate exchange, the problem is sometimes erroneously referred to as the executive controller problem.³⁴ [I say ‘erroneously’ because they are actually different problems.] The executive controller problem got its name because someone (some “Who”) has to execute, make the decisions about, and orchestrate who is to come out and when, given a particular situation. The two problems are a bit different. The problem of switching is mechanistic. The problem of the executive controller is a problem of decision-maker. These two problems are different but inter-related, and will be considered in turn.

The problem of switching is a mechanistic metaphysical problem. How can a part of the whole person take control of the whole person of which it is a part? To think this could occur is illogical. Alter-identities are supposed to be part of the client-proper. To say that an identity takes control of the person’s behavior is to say that a part of the client-proper takes over the client-proper. This is a senseless redundancy.

Consider the following analogies. To say that a person’s conscious mental state took control of the person’s behavior would be like saying a person’s blood stream took over a person’s behavior. Examples like “her fever took control of her” or “his gonads took control of his behavior,” are plausible but meant only metaphorically (in the as-if sense). Yet, given mind/body dualism implied in MPD/DID, some may claim that the fever example and gonad example are brain/soma related and therefore unlike the clinical

example of a mental event taking control of a client. Examples involving mental states such as, being overcome with rage or transformation of a person because of grief over loss of one's spouse, may seem more similar to MPD/DID alter-identity transformation.

But, mental states such as rage and grief are not attributed distinct autonomy as MPD/DID alter-identities are. In other words, MPD/DID alter-identities, as mental states, are treated differently than other types of mental states. In the rage and grief examples we remain clear about who is angry or grieving. In the MPD/DID example, it is unclear who is the 'real' person, or 'original' person, i.e., client-proper, because mental states are given the status of autonomous identity. The alters are named, interacted with as separate and distinct, are said to interpersonally communicate with each other, build a life history, etc.

To say rage or grief takes over someone's behavior is not metaphysically-logically problematic (though it may be phenomenologically challenging to explain). When someone is grieving, we do not say, "can I speak to Grief now." Or when someone is angry, we do not say, "can I speak to Anger now," as if Anger is a separate, distinct identity. Admittedly, a counselor may say, "let me talk to *your* anger," but this statement presupposes the presence of one identity, not two or more. MPD/DID, on the other hand, being of multiple identities in one body, presents us with the problem of switching. It gives rise to the question of how an alter-identity, i.e., a mental state of the client-proper's imagination, created by him or her during childhood pretending, becomes a real, separate, identity that can willfully take over the client's behavior while the client him or herself goes we know not where. How can an alter-identity become a separate and distinct mental state, separate from other mental states, as well as a separate identity from the

client-proper's identity, while at the same time being a part of the client-proper's mental states? And, once a mental state (of the client-proper), how can it become a living, breathing, socializing, flesh and blood, person while it is "out," (with the client-proper now a mental state of the alter-identity)? Once the alter-identity is out for a while (as a person), how can he or she once again become a mere mental state, when a different alter-identity or the client-proper supercedes him or her? Other mental states, such as anger and grief, do not present us with these particular metaphysical dilemmas.

It could be argued that alter-identities taking control of the client-proper of which they are a part is not meant to be taken literally. But, the intention of DC-B is literal—a real distinct identity takes over and changes the client-proper's behavior—at which time the client-proper becomes a different identity...literally. The analogies make switching phenomenon seem silly, yet DC-B seems to be meant literally.

Switching is not meant as an "as-if" type metaphor. The diagnostic criteria say nothing about identities or switching being metaphors. The DC do not say, "'as-if' alter-identities are present,' or 'feels "as-if" an alter-identity is taking control.' But, if switching was meant metaphorically the identities that do the switching would have to be metaphors also, and this is not the intent of the diagnostic criteria. If identities were metaphoric, then dissociative amnesia, memory loss/time loss would have to be metaphoric also, and this goes against the seriousness of the criterion. Among a host of theoretical perspectives ranging "from psychodynamic and object-relations approaches on the one hand to physiological accounts on the other" what is common to them is "an implicit acknowledgment that multiple personality is somehow a "real" phenomenon with

a discrete and distinctive existence.”³⁵ Since the diagnostic criterion is inter-related, switching cannot be meant metaphorically.

When it comes to the executive controller problem, switches take place for a reason—to avoid a psychological or physical threat. The alter-identity coming out is meant to be a situationally appropriate alternative for the identity who has gone inside to escape the unwanted situation. Each client-alter is meant as a “function” of the client-proper, i.e. the protector personality, the shy one, the boy next door, the sexy one, etc. Client-alters take turns “coming out” to protect the client-proper from environmental-social triggers, i.e. abuse, the odor of a perpetrator’s aftershave, an abuser’s voice, etc.

For example, Charlie’s function is that of protector. If the client-proper is being abused and can not deal with the immediate abuse, nor the memories of abuse that the immediate abuse is triggering, the client-proper needs his or her “protector” personality, i.e., Charlie, to come out. As a distinct identity somewhere inside the client-proper’s mind, Charlie comes out to take over the client-proper’s behavior, thereby relieving the client-proper from unwanted experiences. This situationally appropriate switch requires Charlie to relocate, presumably from a state of consciousness to a state of embodiment, i.e., from the mind to the body—the position of therapeutically observable behavior. When out, these identities (these functions) protect the client-proper from situational associations or from experiencing unwanted abuses. The switching of client-alters occurs purposefully for functional reasons.

This situational (functional) appropriateness proves problematic for alter-identities and MPD/DID for two reasons. The requirement of situational appropriateness dictates

that not just any client-alter can come out to take the client-proper's place. A particular client-alter must come out for a particular situation. Secondly, the idea of situational appropriateness demands an executive controller be present to make the executive decision about which client-alter is the situation-appropriate one to take control of the client-proper's behavior. The problem for the idea of situation appropriateness is twofold—it is unknown "who" the executive controller is and it is unknown "who" decides who the executive controller will be.

The identity who is "out" cannot be the one who decides who will take his or her place. According to DC-B, it is a client-alter, one inside the mind that takes control of behavior. Whether it is one or many alter-selves that make the decision about who will come out next, problems ensue. With one decision-maker problems of co-awareness and altruism arise. If many or all alter-identities are involved, problems over political structure for decision making occur, as well as problems of selfishness. These possibilities will each be considered.

For a situationally appropriate replacement to happen, all of the client-alters would have to be aware of each other, i.e. would have to be co-conscious of each others' functions in order to make an informed decision as to which of them should be the one to come out. If client-alters have consciousness, but are not incarnate (as the diagnostic criterion D insinuates) they have no felt/bodily perception of the experience of the environment and situation to know the most appropriate replacement. Client-alters, while present inside the client-proper's head, are present in psyche only and therefore lack sensorial awareness of the situation by which to make an informed decision. Even the

executive controller must be inside, so even the executive controller, if one could be determined, would not have sensual, environmental, situational, knowledge by which to make an informed decision. Switching phenomena involving functional identities makes no sense without a situationally "informed" executive controller to facilitate proper functioning in the client-proper.

Without an executive controller there is also no one to keep the body animated with personality. "Someone" needs to control unruly client-alterers. Some less ethical client-alterers may want to take advantage of the client-proper receding into consciousness. They may want to come-out at inappropriate times. They may resent only being able to come out to fulfill the client-proper's functions. As autonomous identities they may want to come out just for the fun of it, as some reports suggest. It is also clinically reported that clients complain of their client-alterers arguing over such things as what should be done next (i.e., housecleaning, shopping, or joy riding), or as to who should get to come out next—some claiming they have not been out for a long time, etc. [This arguing comes in the form of head noise, i.e. inner voices.] If disagreements occur over who is to come out, by the time the argument is resolved the client-proper would have dissociated and the body would be left vacant and unanimated, or at least this is a possibility. We don't hear of lack of animation occurring, unless that is what being in a coma is. Even so, there is need for a decision-maker to keep situationally appropriate behavior intact and to keep the body animated (not catatonic, or in limbo such as in a pro-longed unanimated trance).

In addition, being a mental executive controller would be difficult—it would require altruism on the part of the decision-maker. If alter-selves are separate autonomous

personalities/identities, all wanting to come out given the chance, none of them should want the ethical responsibility of being executive controller. It would look suspicious if, as executive controller, one of the client-alters always chose him or herself to take over behavior. The idea of an executive controller presumes an ethics of care that would not make sense of autonomous distinct identities.

If an executive controller does not exist, there must be a political structure in place for some or all of the alter-identities to make the situationally appropriate executive decision of who will come out next. Some therapists recommend clients use a democratic process for this purpose, with some particular client-alter designated the president. Other therapists recommend the client-proper designate someone akin to an orchestra leader for decision making. If no executive controller exists, but a democratic process is used when a client-proper dissociates, his or her democratic party, i.e. all or at least some of the alter-identities, would have to convene on the spur of the moment and decide "who" is to come out.

But, what democratic decision happens that fast? Due to the immediacy of the switching phenomenon, i.e., literally one or two seconds, if a democratic decision had to be made to facilitate the switch it would never happen. Or, imagine an orchestra leader type trying to keep an alter-identity like the prostitute, or the rebel, in line. Either way, a political structure with an executive controller is needed to preserve the sense of and use of functionality of client-alters.

"Who," then, is the executive controller? This question has not yet been answered by the mental health industry. As separate autonomous identities, each alter has self-

interest, each wants his or her turn out as each wants to be freed from the confines of the mental realm to experience life in the full sense (experiencing sensations, the social realm, making things, doing things, etc.). Because of this, there is no disinterested "observer" to act as executive controller of the switching.

DC-B proves problematic because it is illogical. It indicates switching behavior without the benefit of an executive controller. The switch occurs as behavior. If the client-proper dissociates, and there is no situationally appropriate controller, either the body would be left unanimated or a situationally inappropriate client-alter would come out. Can you imagine the scene of the child personality coming out to deal with the chemistry class that the studious identity is taking? Or imagine the chemistry student coming out to take money from and perform services for the clients of the prostitute identity? The APA wants the alter-identities to be functional and situationally appropriate to give explanation and purpose to their creation and presence. But, this requires the executive controller: (1) to not be the client-proper due to DC-B, and (2) to not be one of the alter-identities due to (a) their lack of altruism, and (b) lack of awareness of each others' functions, and (c) lack of sensorial experience by which to perceive the actual situation in question (with its sights, smells, tastes, tactile sensations, social interactions, etc.), (d) and sometimes to their lack of consciousness. This leaves MPD/DID with switching phenomenon and no executive controller to perform the situationally appropriate switch. Switching (DC-B) with no controller is illogical.

The Problem of Dissociative Amnesia

The fourth problem stems from DC-C that indicates that clients have an "Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness." The third criterion, DC-C, has to do with memory problems, but with a qualifier—DC-D, indicates that this forgetfulness cannot be due to a medical condition or substance abuse, i.e., physiologically oriented. This turns out to be a crucial point when it comes to understanding what is metaphysically at stake for MPD/DID. MPD/DID memory loss is psychologically derived, not medically caused. The memory problems of the MPD/DID client represent gaps in memory or time loss for a given period during which the child dissociated and went into the unconscious. This prompts the question, how can a client experience time loss/memory loss if the client and alter-selves are really distinct (separate), autonomous, self-referential identities? I call this the problem of dissociative amnesia.

To understand the problem of dissociative amnesia we'll take a closer look at what is at stake in distinguishing between common amnesia and dissociative amnesia. One of the main differences is that in dissociative amnesia memory loss gets equated with time loss—what I call the memory loss, time loss equation. By use of an example this equation will be shown to be a contradiction. If memory loss does not equal time loss then dissociative amnesia is a misconception. Without diagnostic criterion C, i.e. without dissociative amnesia, MPD/DID has to be attributed to a medical condition, i.e. common amnesia, which violates criterion D.

We need to be clear on what MPD/DID dissociative amnesia is. Dissociative-amnesia and amnesia are not the same. The difference is again (not surprisingly) clinically based on a dualism between psyche (mind) and soma (body-brain). Dissociative amnesia is a mind-only event. Other amnesias are soma related.

Common (non-dissociative) amnesia is a medical condition. Amnesia is a total or partial loss of memory. There are different kinds of mental amnesia. Mental amnesia is of the mind and is more often referred to, and better known as, dissociative amnesia. There are also physiological or somatic reasons for amnesia. The DSM distinguishes between these two types. Non-dissociative amnesia does not result in MPD/DID. Because non-dissociative amnesia has a physiological or organic basis, DC-D disqualifies the client as MPD/DID.

Somatic-based memory loss is considered to be due to a loss of brain activity, as demonstrated by brain damaged individuals whose memory is destroyed when certain parts of the brain are destroyed. It can be said that brain-damaged individuals experience a loss of memory and even a lapse of time from this damage. If clinicians suspect that a presenting client has common amnesia, then it would make sense to look for a brain malfunction of some kind, or find out if the client is alcoholic, or epileptic. Clinicians must rule somatic possibilities out before considering a client as having psychological, dissociative amnesia. If an intoxicant or something neurological is found to account for memory loss, the client-proper must not be diagnosed as MPD/DID. According to DC-D this type of amnesia is medically related and cannot be the cause of an MPD/DID client's inability to remember.

Dissociative-amnesia, on the other hand, is a special type of amnesia. It is specifically the type that persons with MPD/DID suffer from. Because of the APA and therapist followers' dualistic perspective of psyche and soma, it is the MPD/DID client-proper's mind, not his or her brain, which has amnesia. Dissociative-amnesia is a type of psychological amnesia.

To understand the clinical conception of dissociative amnesia as a psychological event, one has to perceive of the existence/presence of alter-selves as switching places with the client-proper. To visualize this, imagine alter-identities as discarnate (disembodied) consciousnesses. Then, imagine the client-proper as being able to detach from his or her body, and go into his or her mind (psyche) where he or she becomes a mental state (conscious or unconscious), while unbeknownst to the client-proper, a separate, distinct alter-self comes out to deal with the client-proper's situation. Prior to switching, the client-proper is the embodied identity, the "who" whose behavior is being observed by others. After the switch, a client-alter controls behavior.

While a client-alter is exhibiting control of behavior, the client-proper is absent from immediate behavioral experience and so has amnesia of corresponding events. The client-proper cannot remember what she did (or what was done by the alter-identity) during the time the client-alter had control of behavior, because the client-proper was psychologically absent from those bodily events. This period of absence from the body (while the alter-self is out) results in client-proper dissociative amnesia.

The problem arises when anyone (including and especially therapists) referring to dissociative-amnesia, synonymously equates a lapse in memory with a lapse in time. This

equation is metaphysically problematic but is relied on to explain gaps in memory and memory loss in MPD/DID clientele.

Consider the following example. Clint, an MPD/DID client-proper, goes to a party. After the party he dissociates. Let us assume for the moment that unconscious client-alter Alder takes "post-party control" of the body for three days, at which time he, too, dissociates. Client-proper Clint then takes back control of behavior from Alder. Does Clint's three-day time loss equate to memory loss, i.e. dissociative amnesia, as is clinically reported to be the case?

If we are to remain logical and consistent with the diagnostic criteria's insistence on distinctness of identities we can now say which "who" did and did not attend the party. The separate, autonomous client-alter Alder did not attend the party—he was "inside" at that time. Only client-proper Clint was "present"—only he could experience the party. Client-proper Clint has supposedly, for some reason, erected an amnesia barrier of the post-party time period. He needs interpersonality communication with client-alter Alder to find out what he, Clint, did during those three lost days.

Client-alter Alder, as post-party experiencer, leads therapists to problematically claim that Alder is housing memories for Clint of the post-party three day period, since client-proper Clint was dissociated for that time-period. This can not be the case if distinctness of identity is to hold. Client-alter Alder cannot house Clint's memories of the post-party period because distinct, autonomous Alder was the post-party experiencer, not Clint. If autonomy is to be maintained, client-alter Alder can house his own experiences of the post-party period while client-proper Clint houses his memories of being at the party.

For therapists to claim that client-alter Alder houses client-proper Clint's memories of the post-party period involves a contradiction, i.e., that client-alter Alder is a distinct, autonomous, identity but that Alder's memories are really Clint's memories and not his (Alder's) own.

To explain further, amnesia of all kinds requires the capacity of "forgetting" memories, in this case, memories of the party. Client-alter Alder, if the diagnostic criteria are to avoid contradiction, cannot have dissociative amnesia of a party he did not attend. And client-proper Clint cannot have dissociative amnesia of the post-party time-period he did not experience. One cannot forget what one never experienced.

Time loss and memory loss, are not equivalent as regards dissociative amnesia. Alder a separate, distinct, autonomous identity, can only claim he has lost some time—that of the time while Clint was "out" attending the party. Likewise, Clint can claim three days time-loss. But, this time-loss is not synonymous with amnesia or dissociative-amnesia as therapists contend. [Actually, Clint, the party-goer, could claim amnesia of the party, if for some reason, he did not remember going, i.e., maybe he got too drunk or fell and hit his head. But then, these examples are of medical amnesia; not dissociative-amnesia and so are not MPD/DID related.] Time loss and dissociative amnesia are not synonymous.

Alder, as a part of Clint's mind, is a part of the whole of Clint. If Alder hides memories from Clint, this is the same as saying that Clint hides memories from himself.

Therapists would retort that what is meant by dissociative amnesia is that Alder's time out is insulated from Clint's mind via mental barriers. Therapists want us to believe that once Clint becomes aware of Alder and Alder's time out and corresponding

memories, Clint can begin to slowly accept Alder as part of Clint's self—part of Clint's history. At some point, Clint will want Alder to fuse with him so the two can become a unity and live as one person again.³⁶

But, what this amounts to for MPD/DID diagnostic criteria is that if separate selves really exist, then dissociative amnesia is a misnomer. If the diagnostic criteria are interpreted as implying that dissociated identities really are "distinct identities" that are autonomous, etc., then it would be illogical for the diagnostic criteria to also be interpreted in a contrary way, i.e., that dissociated identities are not distinct, not autonomous, etc. Clint and Alder must either be separate and autonomous identities, selves, etc., *or* Alder is part of Clint.

If what is meant by psychological dissociation is that Clint merely experiences Alder as separate then this separateness is not real but rather imagined. The problem this creates for MPD/DID is that if alter-identities are not real but are imagined then MPD/DID is make-believe—a feeling or acting "as if," or wrongly believing one's self to be more than one person. Or it means that an MPD/DID client is having an organic experience, i.e., epilepsy or hallucinations. None of these, i.e., pretending, acting "as-if," wrongly believing, or organic experiences, are acceptable as explanation of dissociative amnesia, if we are to follow the intent of the diagnostic criteria. This being the case the DC result in a conceptual fallacy of claiming that Alder both is and is not Clint.

To review, dissociative amnesia is a psychological amnesia not a medical amnesia. This clinically means that memory loss is due to alter-identities housing some of the client-proper's memories. Alter-identities attain these memory experiences while "out." This is

supposed to mean that the client-proper "lost time" while the alter-identities are out. This is clinically how the lost time-lost memory equation came about. But dissociative amnesia only holds up if alter-identities are present and distinct in the mind of the client-proper and not the result of a false-belief, a pretense, a fantasy, or an organic condition.

Contrary to DC-C, if alter-identities are present and distinct, they are experiencing their own memories and not the memories of the client-proper. This results in a false equation about time-loss/memory-loss. The concept of dissociative amnesia contains this irresolvable contradiction and with it the validity of MPD/DID is again put into question.

Summary

According to at least one psychiatrist, Ross, psychiatry is based on dualism. In one sense dualism can not be anything but metaphysics. But, in another sense, whether an organization pays attention to the metaphysics inherent in its efforts and how a metaphysical view is used can have an impact on some peoples' lives. In this case, psychiatry is a discipline that decides which human experiences should be included in a manual on mental disorders. It is a discipline that makes decisions on how those experiences should be classified and articulated for the specific purpose of subsequent diagnosis and treatment of human lives. It is, therefore, accountable for whether mental illness classifications are valid.

The presumption, on the APA's part, that metaphysical analysis is unnecessary when establishing Disorders, at least when it comes to the classification of multiple

personality/dissociated identity, has proved highly problematic. Unlike some Disorders, MPD/DID is a topic that is embarrassingly and directly focused on metaphysics—multiple personalities/dissociated identities in one body. Yet, metaphysical problems associated with the conception of client behavior as indicative of multiple or dissociated identities have been ignored. The result of the dualistic underpinnings of the diagnostic criteria for MPD/DID is either a bizarre conception of multiple selves in one body, or the lesser conception of clients having dissociative delusions based on inner voices as “proof” of the existence/presence of multiple, distinct, separate, autonomous alter-identities. The psychiatric dualistic conception of mind/psyche-only mental disorders, from which the diagnostic conception of multiple selves/dissociated identities arises, is the same dualism that prompts the four metaphysical-logical problems discussed.

The fallacious reasoning inherent in MPD/DID diagnostic criteria is passed along to the client in the form of diagnosis and treatment. Clinicians proceed unawares that the senselessness and confusion (illogicality) inherent in the classification and diagnostic criteria of MPD/DID, are used by them to try to promote mental health. MPD/DID is illogical and therefore, invalid. MPD/DID should be discontinued as a mental illness classification because of its lack of validity and its contradiction in promoting mental health.

An alternative, less problematic, conception of MPD/DID client behavior is available. The most plausible explanation of MPD/DID behavior is that which would normally arise from the cause of the disorder— that of acting, (i.e., childhood pretending). Had clinicians chosen to carry forward the use of the theater model of childhood

playacting that they started with, explanation of adult-client divergent behavior would have held a different meaning and the label and diagnostic criteria of MPD/DID would have appeared very differently—if at all. The theater model is less problematic than the clinical adult-MPD/DID model. It avoids the metaphysical-logical pitfalls of MPD/DID and is congruent with normal experience. The client as actor model should be preferred over the clinical model of MPD/DID.

Of course, this means that multiple personality/dissociated identity is not a disorder. The question of what to do with all of the people who have been and are currently diagnosed and being treated as MPD/DID is the focus of the next chapter.

Notes

¹ James, Volume I, 1. James is the American Father of Dissociation and of the philosophy of psychology. Since his work was and is prominent I assume that at least traces of his philosophical position as to the explanation of psychology and methods to be used by clinicians exist in today's psychology/psychiatry. The empirical method of observation and interpretation of client behavior is still widely practiced, although supplemented by scientific tests and findings.

² James, Volume I, 182.

³ James, Volume I, 182. The empirical parallelistic method is "the simplest psycho-physic formula, and the last word of a psychology which contents itself with verifiable laws, and seeks only to be clear, and to avoid unsafe hypotheses. Such a mere admission of empirical parallelism will there appear the wisest course. By keeping to it, our psychology will remain positivistic and non-metaphysical."

⁴ Prince 1-575.

⁵ Prince 514-25.

⁶ Prince 1-575.

⁷ Prince 24-5.

⁸ Prince 518, 515.

⁹ Prince 24-5; 514-19.

¹⁰ Prince 519.

¹¹ Prince 521.

¹² Prince 515.

¹³ Prince 521.

¹⁴ Prince 521-22.

¹⁵ Prince 524.

¹⁶ To make the leap as Prince did with Miss B—that many selves exist, i.e., that she is MPD because alter-identities exist in her unconscious mind—is to fall prey to what Mead calls the Real Psychologist's Fallacy. This will not be explained due to time constraints and dissertation focus but I refer the reader to Mead's work for explanation.

¹⁷ Ross 78.

¹⁸ Ross 180.

¹⁹ Johnson, Mark. Clarification prompted by Dissertation note to author. 26 Oct. 1999.

²⁰ James, Vol. I, 1.

²¹ Ross 78.

²² Ross 159-61.

²³ Ross 162.

²⁴ Ross 163.

²⁵ Ross 173.

²⁶ Braude 45.

²⁷ DSM-IV 487.

²⁸ DSM-IV Casebook, 56-8. Or, see my chapter two, items 16 and 18, for examples.

²⁹ DSM-IV 487.

³⁰ Ross 242-246. To paraphrase: acknowledgment of co-consciousness is not necessarily something the client-proper comes to therapy complaining about. In fact, it is rare that a client-proper is aware of client-alter prior to therapeutic intervention. Still, co-consciousness is said to occur pre-therapeutically or during therapy. Co-consciousness can supposedly be acknowledged via inner voices or by hypnosis with subsequent therapeutic instruction to remember them, or co-consciousness can occur by the client-proper in a co-conscious state during a switch with an alter-self who comes out and takes control of the client-proper's behavior.

³¹ DSM-IV Casebook 56-8.

³² DSM-IV 487; diagnostic criterion D.

³³ DSM-IV 487.

³⁴ Aldridge-Morris, 72-4. "However, who (or what) is it that is responsible for the coordination of all these aspects of what we call "personality"? What is the source of decision making, of behavioural selection, of that part of us that is so readily able to detach itself from all else and look on, like a spectator at a play? [. . .] in the quest for the *physiological identity* of the "executor" or "supreme knower", its location in the cortex or the pineal gland is of questionable value to the *psychological investigator*. [. . .] In both hypnosis and multiple personality, the "Knower" seems, at various times, to exert and relinquish control over the rest of the personality. [. . .] It is the "Knower" which can decide to call a halt to proceedings..." (emphasis added). The term "Knower" is an Allportian term. The executive controller is also referred to as the "hidden observer" by numerous sources such as Ross (1989) or Hilgard (1977).

³⁵ Aldridge-Morris 83.

³⁶ Ross 192: "The MPD patient also needs to learn how to be a single person."

CHAPTER VI

MPD/DID THERAPY—THE INTERIM: A CAUTIONARY AND TRANSITIONAL GUIDE TO AVOIDING THE PSYCHOLOGICAL DANGERS OF ACTING

Diagnosis and treatment are intertwined. The problems shown in previous chapters to be associated with MPD/DID indicate a need to reconsider MPD/DID treatment procedures and goals. The MPD/DID client-as-actor model prompts a closer look at MPD/DID therapy. The therapeutic method of identifying and calling 'out' alter-identities is put into question by the client-as-actor model.

Acting, like MPD/DID alter-making, "completely engages attention in a manner that renders it impossible to keep all defenses intact."¹ Whether acting or alter-making, one's defenses, i.e., one's self-imposed protection against remembering, gets destroyed. Alter and actor are subjected to re-experiencing the pain, and the joy (if directed to do so), that particular memories bring. However, unlike with acting, MPD/DID therapists tend to encourage the client to focus on memories of pain, to the exclusion of memories of joy. [This, in itself, may be a false move.]

Any of us can "give expression to the variety of inner personalities that we so often ignore or repress."² The 'therapy' that MPD/DID clients go through in an attempt to

regain normalcy, i.e., a single identity, involves acting those various inner personalities that we all have. They just need to learn to do it in a psychologically safe way—instead of through MPD/DID alter-identity exposure and abreaction.

The psychology of acting suggests that acting can be psychologically dangerous if certain precautions are not taken. Actors have gotten themselves into psychological/behavioral problems, like those suffered by MPD/DID clients, by not adhering to certain acting safeguards. The MPD/DID client protocol of getting in touch with the hidden secrets of one's psyche and acting out deeply felt, self-created or therapist-directed roles during therapy needs assessed in light of the potential psychological dangers of acting.

Most (but not all) actors guard against what they call 'living near the edge' of psychological danger. Therapists, without realizing it, encourage MPD/DID clients to do what actors guard against. Certain techniques subject actor or MPD/DID client to MPD/DID symptomatology, i.e. character role absorption, dissociative delusions, switching roles uncontrollably, and difficulty coming out of a role. Suggestions will be made as to problematic methodology of diagnosis and treatment of MPD/DID.

Why A Chapter on Therapy Is Needed

Still, one might wonder why a chapter on therapy is needed here. Considering the myriad problems associated with the clinical view of MPD/DID, and given the plausibility

of the client-actor model and its claim that multiplicity/dissociated identity is not a disorder, one might wonder why bother spelling out warnings about MPD/DID therapy.

In spite of problems with the conception of MPD/DID, the claim of therapeutic value could still stand in modified form. The possibility stands that any of us might get caught up in the overuse of, socially inappropriate use of, or addictive use of the extreme dissociative techniques that contribute to psychological suffering. It could be contended that MPD/DID therapy is still needed to remedy the resulting multiplicity (character role absorption and dissociative delusions) and rejuvenate healthy singletonism in those that engage in unhealthy acting practices.³

Therefore, if it is to be argued that the client-as-actor model be preferred, this chapter on therapy is necessary for three reasons. First, because when considering acting psychology, the techniques used in MPD/DID therapy to promote singletonism are psychologically unhealthy—they are the very techniques actors are taught to guard against from becoming multiple/dissociated (too absorbed in character roles). Second, until DID is deleted from the DSM, therapists can and will continue to diagnose and treat MPD, and these therapists need to understand the therapist-client interactions that tend to contribute to MPD/DID symptomatology. Third, if DID is declassified, certain things need to happen. Those individuals already diagnosed and being treated with MPD/DID will need assistance for several reasons. First, in coming to understand the industry's declassification of their disorder, they will need help accepting and adjusting to a different diagnosis or to no diagnosis. Secondly, they may need help learning a new way to think about their ill-defined, problematic behavior. Thirdly, clients may need guidance in either

recovering from those psychologically dangerous acting techniques that have been encouraged in therapy in the name of catharsis, or in learning how to stop extremely dissociating if they (the clients, not the therapists) do not like the multiplicity that ensues. This chapter on MPD/DID therapy (in light of the client-actor model) is needed whether the diagnosis of DID is declassified or remains in effect.

Chapter Tasks and Protocol

The primary task of this chapter is to point out which therapeutic techniques psychologists of acting would deem as psychologically dangerous. Clinical attitudes about MPD/DID and therapy's task of integration of alter-selves, play a role in MPD/DID therapists not perceiving their actions as that of a director, nor of perceiving their directing as dangerous. But, the client-actor model carries with it the claim that *MPD/DID therapists are acting directors*, and not good ones at that. These attitudes will also be explained and sometimes contrasted with the nomenclature and interpretation of the acting world.

The accusation that MPD/DID therapists are like poor-acting directors will prompt at least four counter-claims, which will then be discussed. These are as follows. First, there will be the accusation that the client-actor model of MPD/DID is a version of the claim that MPD/DID is iatrogenic. Second, some readers may think the client-actor model is just another role-theory model of behavior. Third, therapists (one in particular) may claim they are more like architects than directors. And fourth, the client-actor model

is nothing more than a claim of difference in nomenclature—the clinical/scientific versus the theatrical. Each of these anticipated accusations against the client-actor model will be presented and rebutted in brief as they are not the primary purpose of this chapter. However, addressing them will help to alleviate misunderstandings about both the client-actor model and the problems of MPD/DID therapy, which is the goal of this chapter.

Acting—A “Healing Madness”

Actors can heal with each performance. MPD/DID clients often times never heal, but the ones who do, on the average, do so in about three years. Even afterwards, old or new “alters” may pop out post-therapeutically, when the client is under stress. Both acting and MPD/DID therapy require exposing/cathecting hidden or repressed emotions. Brian Bates refers to acting as a “healing madness.”⁴ He contrasts acting with psychotherapy. Of acting he says,

When a dramatic role demands that a highly charged aspect of oneself, an aspect hidden or even repressed, needs to be released, then the result can be very powerful. [...] Marlon Brando has talked of the emotional turmoil which powers his performances, and his accounts match those of ‘primitive’ actors who enter states of mind we would label *pathological*, but yet they emerge *unscathed and with lessons for life in the world of the sane*.⁵

The fact that trained actors can expose hidden emotions and do so “unscathed” and MPD/DID clients can not, is a not-so-praise-worthy commentary on MPD/DID therapy.

Of course, it could be contended that actors and MPD/DID clients are not dealing with the same issues—clients are dealing with issues of abandonment and abuse, actors are

dealing with a broad range of issues or memories. Only some actors have memories of abuse, and even those actors only sometimes draw from those abuse and abandonment issues. MPD/DID clients are encouraged to reveal hidden traumas constantly in therapy. But, it is not the content of the memory alone that creates the behavior of multiplicity. It is the unguarded practice of identifying with any particular content as a separately created self that results in dissociated identity and MPD/DID symptomatology.

Reassessing MPD/DID Therapeutic Value/Usefulness

The general purpose of any diagnosis and corresponding treatment methodologies is an attempt to help the client become functional again, to alleviate as much suffering as possible, or to protect the client from him or herself, or protect others from the client. MPD/DID diagnosis and treatment is thought valuable for these purposes. But in particular, at the foundation of the claim that MPD/DID therapy is of value or use, is a fundamental question. A 1980's physician, John O. Beahrs, concerned about the effect of the clinical conception of multiplicity on clients, asked what the appropriate/helpful method of therapy should be.

The first dilemma posed by dissociative disorder to the clinician is the question of whether it is meaningful and useful for him to perceive alter-personalities and their ego state equivalents within a given patient as having a unique sense of identity of their own. Should he seek out, find and communicate with many different parts of that patient toward the end of helping him integrate these creatively into a Cohesive Self? Or would treating him as a unified whole to begin with prove more efficacious? Since every individual is actually both a whole as well as composed of many parts, like any complex organization, the issue becomes the question of which conceptualization is the more useful.⁶

Unfortunately, in the case of MPD/DID, Beahrs's common sense question of usefulness got pushed aside because theory precedes and dictates therapeutic methodology possibilities. The clinical conception of multiple personalities as distinct, separate, autonomous selves dictates that therapists "communicate with many different parts of that patient" toward the goal of integration, i.e., singletonism.

Given that we now have the client-actor model, and the view that acting can be a "healing madness" (given certain precautions), Beahrs's concern must be re-interpreted, placing emphasis on treating the client (as mentioned above) "as a unified whole to begin with." In light of the client-actor model, MPD/DID therapy should start with client as singleton and therapists should redirect their focus onto healthy acting techniques and away from bizarre and counter-cultural metaphysical conceptions of selfhood.

MPD/DID Therapy versus Acting Psychology—A Point of Clarification

This chapter is mostly about the similarities between the therapist's directing of the client's alter-making (i.e., directing of the exposure of alter-identities) and the directing of acting. In spite of this, a fundamental difference exists between MPD/DID therapy and acting directing. The one (therapy) subjects the MPD/DID client to the psychological dangers of prolonged and deeply emoted character roles, and the latter (theater directing) results in a move toward wellness. This will be explained.

Before doing so, let us consider how Bates, the actor's psychologist, compares therapy to acting differently than I do, in order to clarify my own view.

But the work of the actor is unlike most systems of psychotherapy, in which energy is directed inwards to focus on past experiences, bring them into the consciousness and subject them to detailed analysis. The actor connects with, and apprehends past experiences in an intuitive way, but the inner material is employed in breathing life into a character role. Inner emotion remains inner emotion, but expressed through a different form—that of the character. Strong emotional forces within the actor are reintegrated creatively, *without the loss of power that sometimes accompanies the conscious, rational analysis of inner experience.*⁷

I wish to reinterpret or make a modification to Bates's analysis of the difference between therapy and acting, in light of MPD/DID.

Bates's therapy-actor contrast is based on psychotherapy in general and not on MPD/DID specifically. General psychotherapy treatment methodology is different from MPD/DID methodology and goals. So, I would agree with Bates up to a point. I would agree with the part of his statement, as applied to MPD/DID, where he says that in "most systems of psychotherapy . . . energy is directed inwards to focus on past experiences, (and) bring them into the consciousness," but would disagree that these experiences are subjected to "detailed analysis." The MPD/DID client is not a passive agent whose consciousness is merely analyzed. He or she is an active participant—an actor. The MPD/DID client, like the actor, "connects with, and apprehends past experiences in an intuitive way," and "the inner material is employed in breathing life into a character role." The "intuitive way" for the MPD/DID client may have to be learned in therapy, or remembered from childhood playacting. But, MPD/DID clients act during therapy, they

do not just sit back and do “detailed analysis,” while bringing the alter-identities into consciousness.

The “loss of power” that Bates says accompanies detailed analysis, I would contend, still exists for the MPD/DID client in therapy, but not due to the analysis work. The loss of power occurs because of the clinical/scientific interpretation of MPD/DID as the presence of distinct, separate, autonomous identities inside the client. It is the normal experience of acting, when reinterpreted as the presence of alter-identities that house hidden memories, i.e., as some thing abnormal and mentally ill, that results in a loss of power. People diagnosed with mental illnesses feel socially outcast, i.e., marginalized by society. They hesitate to tell others of their diagnosis out of fear of rejection, such as loss of job, or a turning away by friends, and such, i.e., as a form of alienation. [Alienation and marginalization will not be further defined or analyzed due to time and focal constraints.] Both marginalization and alienation are disempowering. For Bates then, “detailed analysis” sometimes accompanies loss of power, but for the MPD/DID client-actor it is the clinical description of client dissociated behavior as a mental illness (and not an act) that results in loss of power for the client.

Dangers of MPD/DID Therapy

Multiple personality/dissociated identity is not a disorder. It is the result of both (1) the directing of *and* client use of, what acting psychology refers to as, psychologically dangerous acting techniques, and (2) the clinical interpretation of client experience as

multiple/dissociated identities—an interpretation the client must accept in order to participate in therapy. By therapists denying that MPD/DID involves certain acting techniques, they are unaware of the dangers that MPD/DID therapy holds. The dangers that directors and theater instructors teach actors to guard against seem to be the very psychological problems that MPD/DID clients suffer from—ones brought about by ‘therapeutic’ interpretation, directing, and methodology.

By psychological dangers I mean whatever acting techniques, attitudes, and behaviors most actors avoid or guard against experiencing. As listed in chapter four psychological dangers consist in: (1) emoting too deeply; (2) becoming too absorbed by a character role; (3) dissociating to the point of delusions about “who” one is; (4) difficulty coming out of character; (5) preferring a character to one’s ‘normal’ self; and (6) lapsing (i.e., switching) into character unintentionally (interpreted as the character is in control). Most actors guard against all of these whereas MPD/DID clients exhibit them during therapy.

As a point of clarification, I want to insert a qualifier concerning the term ‘psychological danger’. For example, dissociative delusions (the belief one is more than one person) are not *necessarily* dangerous in themselves, but become psychologically dangerous in the context of a given time and culture. American culture today still values a conception of a person as a single self or identity, i.e., one personality to a customer. As this is not a chapter or dissertation on concepts of selfhood, this is not the time or place to discuss whether Romantic, Modern, or other conceptions of self, or Post-Modern denial

of self, are indicative of today's American culture. MPD/DID could be, and has been, challenged on these grounds (i.e., Post-Modernism) by feminists and social psychologists.

American culture's preference for a single conception of self is questionable, but is, nevertheless, clinically accepted as indicative of normalcy. Psychological danger is, therefore, meant as a danger to singletonism since both the clinical version of unified, cohesive self and the theatrical version of essential self have a singleton component to them. Hence, singletonism is considered the norm.

MPD/DID, as presumed to stem from techniques developed during childhood pretending, sets the stage for therapist as director. When therapists believe that they need to expose *hidden* personalities during therapy, alter-identity identification and revelation are like what theater directors do when they attend to character role development and portrayal. This was partially noted in 1983 by Confer and Ables who cautioned MPD/DID therapists that, "too much interest in the dissociated personality or participation in their fantasy may subtly reinforce the *dramatic* aspects of the disorder."⁸ Here, Confer and Ables only hint at the theater model of MPD/DID,⁹ suggesting that MPD/DID therapists may be like theater directors.

A more than subtle interest *must* be given to alter-identities (character-roles) during MPD/DID therapy due to the theory of multiple personalities and the goal of singletonism. I say more than subtle interest, because MPD/DID is a DSM classification, it is always a looming possibility during a diagnostic session. Therefore, the therapist is placed in a situation where he or she must look for any overt or covert signs and symptoms that may suggest the possibility of any particular disorder, including MPD/DID.

The therapist, before any particular diagnosis of MPD/DID occurs, is placed in a position where he or she must become a director of an unfolding drama of character roles, if a diagnosis of MPD/DID is considered a possibility.

For therapy in general, a therapist often directs a client to focus on his or her mental life (i.e., their memories, thoughts, feeling, decisions, desires, etc.). The *attention* to one's mental life can bring up long-forgotten memories of situations and experiences which, when focused on, result in an alteration of mood, behavior, and personality.

But, during MPD/DID therapy, the encouragement of the client's *use* of emotional responses to memories (affective memory) during hypnotherapy, trance-state, or meditative couch sessions can result in what some actors deem as "acting out," i.e., poor acting. With ongoing therapy the quality of acting may improve with practice. Either way MPD/DID therapy results in acting.

Acting can be done safely or dangerously. Safe acting must be learned and not *misdirected*. Bates cautions that, "Good actors are aware of the pitfalls of an approach charged with immediate and personal emotion."¹⁰ For "bad actors," i.e., for people who do not yet know how to act safely (or for people like MPD/DID clients) who have been encouraged or hypnotized into emoting too deeply into hidden phobias, "Method can be dangerous, because they don't know what to take and what to leave."¹¹ Therapists, unaware of the psychological dangers connected with Method acting and disbelieving of clients as actors, would not know to take the time to teach clients how to protect themselves against those dangers.

So, what is it that MPD/DID therapists do, exactly, that contributes to some clients' experience of the dangers of acting? Answers to this question are presented in the next section.

The MPD/DID Therapist-Director: Eight *Mis*-Directions

Therapists, in being expected to facilitate integration or fusion of alter-identities and client-proper, must use a treatment methodology wherein they must direct the client to act or perform. The performance of the client, which incorporates psychologically dangerous acting techniques, is then interpreted as indicative of MPD/DID behavior. But, the therapist may also treat other non-MPD/DID symptomatology such as post-traumatic stress, dysfunctional communication, compulsive behavior, etc. Because other symptoms or behavioral problems may be a part of MPD/DID-client therapy, it is therefore important to be specific about which therapeutic endeavors result in mis-directions toward correction of extremely dissociated behavior. The following is not meant as a complete list of treatment strategies that result in extremely dissociated acting. Eight examples of therapeutic mis-directions will be given as a starting point for understanding the situation that both the therapist and MPD/DID client are placed in, given a diagnosis of MPD/DID.

(1) *Therapists direct and encourage clients to emote too deeply in the name of catharsis* because they believe that exposure of hidden traumas will help the client to heal.

Most people do not normally attempt to get so deeply in touch with their memory to the point they extremely dissociate and change character. It usually takes a motivation

(fun, artistic enjoyment, or abuse-avoidance) or a *director* to prompt one to do so. Ross, not thinking of himself as a director, nor of the client as someone practiced in acting (and so he calls it switching) explains.

As in much of the therapy, one good way to proceed is to ask the patient how her switching works. Some patients already know how to induce a switch, and can do so on request. In such cases, the therapist just asks to talk to a certain personality and the switch occurs readily. Virtually all patients learn how to switch on demand during therapy. When switching is well practiced, I just say, "Okay, could I talk to Mary now? Mary." This is followed immediately by a brief head nod, eye closing, and emergence of Mary.¹²

[Note that the client enters either a self or auto-hypnotic state to perform the change in character.] As can be seen from this quote, the therapy session and the therapist offer the motivation for the client's acting. Either, clients come to therapy knowing how to extremely dissociate and do so upon request from the therapist, or they "learn how to switch on demand" because they have been taught and directed to do so by the therapist.

The treatment methods that encourage clients to cathect hidden memories require them to either create or re-create characters, i.e., MPD/DID alter-identities. The cathecting of hidden memories is equivalent, in MPD/DID therapy, to the "letting out" of alternate ways of acting or being in the world. Therapists encourage and condone these acts, as indicative of the verification of the diagnosis of MPD/DID, and of the need for integration or fusion. This treatment method results in clients' becoming too absorbed in various character roles to the point of attaining dissociative delusions about their own identity. MPD/DID therapists, in believing they are discovering real separate, distinct, autonomous identities, promote and direct these dangerous-acting techniques.

The catharsis of alter-identities encourages and directs the client's use of his or her mental life in an affected way, i.e., the client uses his or her affective memory, which then appears as if the client has changed moods, personality, character, or identity. Affective memory is used in both Method acting and MPD/DID therapy to facilitate the switch to a different character/identity.

It is important to note that the use of affective memory techniques by non-professional actors places them at risk for experiencing the same undesirable symptoms that person's diagnosed as having MPD//DID experience when dissociating extremely. According to Bates's research, Liv Ullmann scorns the Method (use of affective memory) saying, "I've worked with some Method actors, and they're very difficult to work with because you never know who's coming in on the stage.[. . .] (e)very day somebody new comes in."¹³ [Bates contends that, "this is probably more a criticism of bad Method acting than the Method itself."¹⁴] The use of affective memory techniques, or Method acting techniques, results in the appearance of unexpected character roles for either the actor or the MPD/DID client.

Theater director and clinical director have different sentiments about the appearance of unexpected characters. Theater directors may become frustrated or short-tempered—during a rehearsal or performance the appearance of the unexpected character role can create problems for the story line. But for the MPD/DID therapist, the presentation of unexpected characters acts as confirmation of both the clinical belief in hidden selves and the therapeutic belief in the need for MPD/DID therapy. The therapist then continues to direct clients to cathect hidden selves.

The therapist's belief in alter-identities prompts him or her to direct the client to encourage alter-identities to come to the surface by using various techniques, since the client may not know how to do this. [Note that the counter to this is that the client just may have forgotten, since childhood, how to extremely dissociate, i.e., how to pretend using narrowed focus of attention and his or her imagination to become someone else.]

According to Ross,

[...]there are alters who are reluctant to enter therapy. Depending on the degree of certainty as to whether alters are present, I will personify the absent part of the mind in my requests. If I am virtually certain that there is an unidentified alter, I will ask to speak to "someone I haven't talked to yet." If it appears to be a case of psychogenic amnesia, I will use generic referents like "the part of the mind that remembers," or "the part of Susan's mind that holds the memories." This is done to avoid suggesting multiplicity when it is not present.

If an alter or alters will not come out, indirect conversation, ideomotor signals, inner conferences, automatic writing, and other techniques can be used.¹⁵

This quote indicates that, if a client is having difficulty acting, the therapist encourages the client to focus on the mind, i.e. memories. If alter-identities (characters) are not forthcoming, the therapist uses various techniques to get the client to act—just as a director would use whatever techniques he or she thought would help a theater student or actor get into character.

To review, whether a person is MPD/DID or not, the use of affective memory or Method acting techniques can provoke the appearance of unexpected personage. So, when Ross contends that, "(t)he first attempt at contacting alters is always based on some reason for suspecting their existence,"¹⁶ it is more likely than not, that anyone with an abusive history, or a dramatic personality, or alternating moods, or a vivid imagination, or

who is good at extremely dissociating, will confirm the therapeutic suspicion of MPD/DID. This is because all of us can act.

(2) *The therapist directs and encourages the client to get in touch with his or her affective memory in the hopes of removing the client's mental barriers.* Remember that mental barriers supposedly create alter-identity autonomy and facilitate the protective but unhealthy division between one alter-identity and another. Clinicians contend that these barriers are developed by MPD/DID clients during childhood abuse to barricade themselves from unwanted memories. Acting psychology would perceive the removal of mental barriers as a dangerous protocol, and would accept dissociative barriers as common and healthy. According to the client-actor model, MPD/DID therapy requires the client to go *against* his or her inclination to retain dissociative barriers between enacted roles. Dissociative barriers help protect the client from confusion about "who" he or she is (i.e., based on Bates's notion of the existence of an essential self).

Could it really be the case that MPD/DID therapists encourage the breakdown of healthy mental barriers during therapy? There *is* therapist-reported insensitivity to client reaction to MPD/DID therapy. Client distress over MPD/DID therapy is freely admitted because it is given clinical justification. This type of client distress needs to be reconsidered in light of the client-actor model. Colin Ross, who believes that mental barriers are a bad thing, admits that

The patient will often experience more distress as her dissociative defenses are being dismantled. Numerous symptoms of a posttraumatic stress nature will occur and the ability to cope on a day-to-day basis may deteriorate. Fortunately this

does not last forever, and eventually the patient moves into the less volatile, later stages of treatment.¹⁷

The psychology of acting suggests that the *dismantling of dissociative defenses* is actually an example of the therapist's poor directing ability—encouraging the client to use psychologically dangerous acting techniques. The acting psychologist would claim that the client's *defenses* are there for a reason and, that the MPD/DID therapist should not be dismantling them.

Counter to this, the clinician believes that the defenses are equivalent to the “mental barriers” that represent the supposed boundaries between alter-identities. These are the same boundaries that are mandated for removal before “integration” can begin.

But, the point of view presented by acting psychology is strongly supported by the fact of the client's resistance to the dismantling process. When the therapist-director encourages and directs the client to remove his or her defenses, the client resists and struggles to maintain his or her singletonism—reluctant to identify the “parts” of him or herself as separate identities, as can be seen in this quote.

The host personality often experiences voices as frightening signs of insanity at the beginning of treatment. Personalities in the background will simultaneously view them as conversations in a matter-of-fact way. [. . .]¹⁸

Note that some part of the client views these voices as normal conversations—like when any of us talk to ourselves—yet the clinician interprets these voices as indicative of alter-identities, an interpretation which frightens the client into thinking he or she is insane. The acting psychologist would just interpret these voices as normal expressions of the possible

ways of being that comprise the whole self—rather than separate identities. The fact that the client does not initially perceive these voices as representative of alter-identities, but instead as the normal process of talking to one's self, suggests that the client has a unified conception of self in place, prior to therapeutic intervention.

Besides, if Ross is correct that MPD/DID alter-identities are dissociative delusions, then inner voices of alter-identities amount to auditory hallucinations. As such, auditory hallucinations are normally *discouraged* or thought to interfere with therapy, according to the following quote. "MPD therapy is the only form of psychiatric treatment in which auditory hallucinations are deliberately amplified."¹⁹ But in the case of MPD, inner voices are used to accomplish the therapeutic goal of integration. So, a procedure that is normally thought unwise and hence avoided—the amplification of inner voices—is used only in the case of MPD/DID, solely because therapists interpret the voices as hidden selves that need to be exposed and integrated.

The MPD/DID therapist amplifies the attention to voices by directing the client to seek them out and attend to them. The therapist then gives a clinical account of these voices as being alter-identities. The fact that the client fears she is going insane once she hears these voices should not be surprising—he or she had no idea that these voices meant he or she had alter-identities inside him or her—the client probably thought of him or herself as a normal singleton. This suggests that breaking down the client's unified conception of self by encouraging the client to amplify his or her inner voices, requires the client to deeply emote into a character role corresponding to each inner voice. These character-roles are then redescribed as alter-identities of the client, by the therapist. The

narrow focus of attention needed to perform this therapeutically directed task, subjects the client to the psychological dangers of acting. The client's normal, healthy dissociative defenses should be left alone.

To review, two models of multiple personality, dissociated behavior can be used to describe the client's experience—the clinical model or the acting model. The model that is assumed dictates what kinds of therapeutic endeavors are valuable or useful. Dismantling dissociative barriers is clinically interpreted as a good thing. According to the psychology of acting, dissociative barriers should remain in place. MPD/DID therapy tries to remove the dissociative barriers by directing the client to use affective memory or Method acting techniques. When these techniques are used, actor or MPD/DID client alike will produce characters he or she did not know were present (i.e., that he or she did not know he or she could perform). But, the clinical model is then used to convince the client to conceive of his or her inner voices as representative of the presence of alter-identities (a counter-cultural conception of self). Counter to this, the theater model could be used to reveal to the client their ability to act various ways using their affective memory. According to the psychology of acting, breaking down dissociative barriers (between the characters we can become), using our focused attention and imagination, is equivalent to breaking down the normal, healthy separation we each construct between the essential self and our alternate possible characters (ways of being). Mental barriers between alternative characters should be maintained, not destroyed.

(3) *Bad acting techniques continue in MPD/DID therapy in part because acting is thought of as overt and short term, while real alter-identities are perceived of as covert and long-term.* Ross admits, "MPD patients rarely come for treatment with obvious or overt multiplicity."²⁰

Usually MPD does not present in an obvious overt fashion. [...] Patients will not walk into the office announcing that they have MPD and spontaneously exhibit named alters."²¹

It seems that some therapists only believe the client is really MPD/DID if hidden memories have to be coaxed or dragged from the client during therapy. The client's reluctance plays a role in the believability of MPD—that the client is not "putting on" an act. But the notion of hidden memories (and selves) places the therapist into the role of director of exposure of these alter-identities, i.e., character roles.

Do therapists always direct clients or do clients sometimes act without the encouragement or directorship of the therapist? This is a complex issue. A general explanation will be given here and a more complete one given in the paragraphs to come on hypnotherapy. Roughly five percent of clients *overtly* exhibit MPD/DID behavior. These clients could be said to be acting without direction. Unfortunately, these same clients, according to Ross's review of Kluft's work (1985), were self-diagnosed and were not believed by their psychiatrists.²² In other words, clients overtly expressing multiple characters were perceived as faking the disorder and were therefore, not usually diagnosed as MPD/DID. [Remember, Ross's conception of acting is that acting is mimicry (i.e., faking) and not based on real feelings—see chapter four for further explanation.]

It is the extreme percentage of *covert* MPD/DID—the remaining ninety-five percent—which warrants consideration of a connection between the promotion of psychologically dangerous acting techniques and MPD/DID symptomatology. All ninety-five percent of Kluft's case study supports the notion of covert behavior, as Ross contends. Out of these cases, "fifteen percent openly dissociated" and did so "during assessment and treatment,"²³ supporting the notion of the need for the therapist's request to have the covert 'alters' come out. [This is one reason why accusations of iatrogenesis continue.] Of the remaining eighty percent—half of these "presented with signs that could alert a clinician with a high index of suspicion for MPD," and of course alter-identities would have to be searched for during therapy to determine if they were present in the client. And, the remaining forty percent "were highly disguised and were discovered while [. . .] testing a special diagnostic protocol."²⁴ In other words, the five percent of clients that presented with overt behavior were thought of as acting/faking, while ninety-five percent were perceived as "unknowingly" harboring real alter-identities. This suggests that therapeutic suspicions of MPD/DID were confirmed by covert behavior but not by overt behavior. Therapists support the idea of covert MPD/DID because they believe in having to 'discover' the 'hidden' (covert) alter-identities in the client. The psychology of acting suggests alter-identities can be discovered, i.e., encouraged to 'come out,' of anyone, because we can all act, and because anyone who acts and uses psychologically dangerous acting techniques will be surprised at 'who' appears.

This five to ninety-five percent ratio matters to whether MPD/DID diagnosis is valid and treatment is valuable. That nearly all clinically *believable* MPD clients appeared

covertly in therapy means that the therapist had to participate in the discovery of the alter-identities in some way. Since the therapist directs the therapy session and the dismantling of dissociative barriers, the therapist must direct some clients, and as much as teach other clients the techniques involved in acting (without advantage of psychological safeguards). The therapist must direct the MPD/DID client in several ways. The therapist must direct the client as to how to narrowly focus his or her attention on his or her mental life. The therapist must also get the client to identify inner voices as alter-identities. And, the therapist must direct the use of the various techniques mentioned earlier, even going so far as to “model” interpersonality “communication for the patient,”²⁵ in order to direct the client to expose his or her hidden identities. This suggests some connection exists between therapy “alter-identity” presence, and the *misdirecting* of enacted character roles—without the safeguards professional actors are provided for avoiding becoming too absorbed in character roles with the accompanying dissociative delusions. MPD/DID therapy puts the therapist in the position of directing the client toward, what amounts to psychological danger. This puts into question whether MPD/DID therapy is valuable or useful.

It could be contended that clients can act and use either healthy or harmful acting techniques *without* the directorship of a therapist. So, the criticism—that MPD/DID therapists are like poor-acting directors—needs to be qualified.

(4) *MPD/DID therapy usually involves therapist-directed hypnosis or therapist-directed meditation/trance.* MPD/DID therapists can trigger or direct MPD/DID behavior in one of three ways—by directing the client to do so during hetero-hypnosis, or

by sanctioning and encouraging autohypnosis, by acknowledging and sanctioning self-hypnosis.

(4a) Hetero-hypnosis is hypnosis induced by another person, usually a hypnotist or counselor. Hetero-hypnosis supposedly helps a client draw from his or her deeply buried memories and feelings. This is like Method acting. Since alter-identities (characters) can be “pulled” out of one’s pool of lived experiences, alter-identities could be fabricated and enacted on the spur of the moment via the director’s cues during hetero-hypnosis. That alter-identities can be originated in this way, i.e., as enacted character roles, is evidence that MPD/DID is an iatrogenic Disorder (although the next two types of hypnosis do not support this claim).

(4b) Autohypnosis is hypnosis learned as an adult after being exposed to hetero-hypnosis. Alter-identities can be created by autohypnosis. Technically, these would not qualify as MPD/DID because of their lack of longevity (i.e., they were not created during childhood, nor was the learning of how to create them acquired during childhood.) The experience of autohypnosis affects the validity of MPD/DID in two ways. First, it means that the ability to become deeply absorbed by characters that are sketched/created from ones’ memories could have occurred either of two ways. Character role absorption could have been learned in therapy and subsequently repeated, or the heterohypnosis could have triggered the client’s ability to extremely dissociate, i.e., to dissociate to the degree some of us learn how to do as children while pretending to be various imaginary characters. These two possibilities suggest that the clinician is encouraging or witnessing spur of the moment *post-heterohypnotic identity-creations* rather than long-term enacted roles.

The validity of MPD/DID is affected in a second way given the possibility of client behavior triggered auto-hypnotically. Clients could be mis-diagnosed as MPD/DID. Misdiagnosis can occur because clients could have been abused as children, even severely so, yet not developed alter-identities nor the current “coming out” behavior until after hetero-hypnosis exposure. In other words, a client with abuse history would not exhibit dissociated identities until after his or her first therapy session because it is the therapy session that triggers and encourages “acting out” of forgotten memories/feelings. The alter-identities presenting in therapy would not have been the ones created during childhood playacting. But therapists seeing these characters would take them (or the client’s behavior) as “verification” of the diagnosis of MPD/DID, claiming that, as expected and as is often the case, the alter-identities were *covert*.

But, if alter-identities (characters) were newly formed out of a client’s first hetero-hypnotic session, the client’s memory of how to “playact” roles also gets triggered. Subsequently, this refresher course on how to playact, in addition to the therapeutic encouragement to cathect “hidden” selves, could prompt the client to continue creating spur of the moment characters in the name of “wellness”. The heterohypnotic reminder of how to playact, gets auto-hypnotically carried forward. This technically means that the client did not exhibit multiplicity until after the first therapy session, and now continues “switching” characters. In this case, his or her alter-identities would not represent repressed memories, but instead would represent auto-hypnotically-created characters. This client would not satisfy the requirement of longevity of enacted roles since childhood, and for that reason has been wrongly diagnosed and treated as if MPD/DID.

What this means is that a history of early childhood abuse/trauma, and the ability to extremely dissociate, are not necessary subsets of MPD/DID behavior. Abuse/trauma and extreme dissociation do not necessarily result in MPD/DID in the classic sense of the word.

(4c) That leaves us with the third kind of hypnosis, i.e., spontaneous self-hypnosis, as regards the creation of character roles and as to the validity of MPD/DID and the value of MPD/DID therapy. The terms spontaneous self-hypnosis (usually referred to as simply self-hypnosis) and autohypnosis are sometimes used synonymously. [See chapter four for a more detailed explanation.] According to Eugene Bliss, this is a mistake. The difference between these two matters as each affects the validity of MPD/DID and the value of MPD/DID therapy in a different way.

Self-hypnosis is learned in childhood whereas autohypnosis is the implementation of techniques to dissociate that are learned during a heterohypnotic experience.²⁶ Self-hypnotically created character-roles are created and carried forth since childhood. The ability to self-hypnotize is learned via childhood playacting. According to the psychology of acting, "Games of make-believe, the hallmark of childhood, are also the central aspect of the actor's world."²⁷ This is the usual case presumed to exist with MPD/DID—that alter-identities are created during childhood abuse/neglect.

But, as regards MPD/DID therapy, a problem arises with the possibility of self-hypnotically created childhood character-roles. It is self-hypnotically created characters that best satisfy the meaning of MPD/DID as stemming from childhood playacting as a dissociative technique to avoid the pain of abuse. But, as indicated earlier, self-

hypnotically created identities can be derived for direct pleasure as well as for pain-avoidance. This creates a problem for the distinction between fake and real alter-identities. Self-hypnotically created character roles can be created at any stage, prior to diagnosis, i.e., from early childhood until minutes before the therapist sees the client for the first time. The ability to self-hypnotically-create alter-identities could have been retained since childhood without particular identities having been retained. There would be no way to tell, from a therapist or observer perspective, those character roles created in childhood from those created just prior to therapy, if they were created by a self-hypnotically trained person. It would be difficult, if not impossible, to distinguish between the creation of childhood alter-identities and immediately created identities, for the purpose of diagnosis of MPD/DID as a response to childhood abuse.

In addition, spontaneous self-hypnosis lends itself to overt symptomatology. As explained earlier only about five percent of presenting clients present overtly. Yet, it is the clients who have retained their ability to spontaneously self-hypnotize that have the ability to present alter-identities without the directorship of the MPD/DID therapist. This means that, the very kind of dissociative technique, e.g., spontaneous self-hypnosis, that is most indicative of the meaning of MPD/DID, is also the type of client-experience that is most likely to be discounted as authentic MPD/DID as the result of childhood abuse, because of its overt quality.

Self-hypnotically created alter-identities may not subject the therapist or MPD/DID to accusations of iatrogenesis, but this does not relieve the therapist of the accusation of poor-acting director. Whether the client already knew how to emote too

deeply or not, the therapist's directing the client to do so sanctions that behavior. If the therapist is directing the client to emote too deeply, rather than helping the client to unlearn this psychologically dangerous technique, then the therapy is contributing to exacerbating the behavior indicative of MPD/DID symptomatology—not a useful methodology. By encouraging clients to emote deeply and call forth alter-identities, therapists prompt poor-acting behavior either for the first time or they prompt the client to reinvigorate previous poor-acting techniques, thereby sanctioning the behavior of self-hypnotizing clients.

The three types of hypnosis affect what we go on to say about the validity and value of MPD/DID diagnosis and treatment. Heterohypnosis and autohypnosis subject MPD/DID to the accusation of iatrogenesis, subject MPD/DID therapists to the criticism of being poor-acting directors, and subjects MPD/DID therapy to the accusation of being without merit or value. Spontaneous self-hypnosis, on the other hand, subjects the authentic presenting client to the accusation of fakery, since his or her alter-identities (various characters) are produced without the direction of a therapist. If MPD/DID diagnosis does occur, spontaneous self-hypnosis produces alter-identities (enacted roles) that the therapist can not determine when they first appeared nor whether they appeared as a response to abuse or as an invention for fun or foolery. There is no way to determine for sure when the multiple role enactment started and why.

(5) *Therapist's misdirection of client-actors results in the client's difficulty or inability to 'switch' back to his or her 'normal' self.* Clients become so deeply absorbed in a character role, as guided by the poor-directing techniques of the therapist, that

subsequently, the clients have difficulty "switching" back to their usual self, just as actors do that emote too deeply. Without realizing it, Ross's observations support this contention.

Another problem is patients for whom the return of the host personality seems to be psychophysiologically difficult. Some host personalities just seem to have a harder time coming back. In such cases the difficulty in switching seems to be a property of the system and isn't linked to any particular alter, resistance, or dynamic. In such cases one just has to work at it longer. Lengthy monologues by the therapist can help, as can physical touch or the holding of a special object like a teddy bear, amulet, or diary.

With such patients I give suggestions that the therapist's voice will pull the patient back. We give repeated instructions to focus on physical reality and orient the host personality to where she is and who the therapist is. This can sometimes take 10-20 minutes. The worst that can happen, in our experience, is a longer delay than planned for." (Ross 234.)

The therapist-director must intervene in such cases of deep character role absorption, a negative symptom that is avoided if the client-actor model were to be adhered to.

(6) A clinician giving directives for the client to attend to, and accept, "inner voices," as alter-identities of him or herself (i.e., during and after role enactment), forces the client to choose between the clinical interpretation of his or her experience and no help.

One of the duties of the clinician, as director of the therapy session, is to help the MPD/DID client establish interpersonality communication. Interpersonality communication is rarely present prior to diagnosis. Ross says, communication among alter-identities and host "is an essential interim goal of therapy and a step toward integration."²⁸ MPD/DID clients are clinically thought of as needing someone, i.e., a

director-type, to help them get in touch with their hidden traumas, i.e., and their hidden alter-identities.

MPD/DID therapy often requires the client to accept the clinical model of him or herself as comprised of alter-identities and to accept that inner voices are representative of those alter-identities before therapy can proceed. Just as an acting director needs an actor's cooperation in the performance of character roles, so a MPD/DID therapist needs a client's cooperation and participation in the acting out of alter-identities. Just as the actor must follow the dictates of the director so that the director can produce the kind of scene he or she has in mind, so the MPD/DID client must follow the dictates of the therapist-director so that the playing out of alter-identities and subsequent fusion/integration can occur. This protocol involves the therapist's instructions for the client to attend to his or her inner voices as separate, autonomous, alter-identities. Insisting on this protocol is like saying to the client, 'As therapist, I can only help you when you accept your diagnosis, i.e., when you accept my (the clinical) interpretation of your experience.' Or, it is like saying, 'You have MPD/DID: before healing can begin, you must accept that you have multiple personality/dissociated identity disorder—you have to allow me to help you get in touch with your whomever those inner voices are in order to help you integrate those identities so that you can become a functional and whole person again.' This insistence on client-acceptance of the clinical model of his or her inner voices as indicative of alter-identities before healing can begin, is the initial phase to breaking down the client's amnesia barriers, which will be discussed next.

(7) *Poor directing of the client-actor is most strongly seen in the clinical destruction of amnesia barriers which results in dissociative delusions and requires subsequent intervention.*

The interim goal of interpersonality communication is mandated even when clients are reluctant or reticent to comply. The therapist directs the client to act in spite of this reluctance, claiming it is in the client's best interest in a move toward mental health.

The host personality often experiences voices as frightening signs of insanity at the beginning of treatment. Personalities in the background will simultaneously view them as conversations in a matter-of-fact way. [. . .] Once a treatment alliance has been formed with the host and another alter, the next step is to begin working toward open communication between them.²⁹

Fighting acknowledging the existence/presence of alter-identities can be so great that the MPD/DID therapist has to "desensitize" the client to the whole process of interpersonality communication.

This process of desensitization involves *breaking down amnesia barriers*.

Amnesia barriers are equivalent to an actor's not knowing what a character will look like newly formed from the actor's affective memory. The clinical destruction of amnesia barriers requires intervention. The therapist directs the client to get in touch with her "alter-selves" using various techniques including prompting visual images.

If the host is completely unaware of the other personality, one can begin breaking down the amnesia barrier using neutral, nonthreatening material. This could begin with writing exercises [. . .], whispering, or transmission of visual images to the host. The idea is to desensitize the host personality to the process of communication, in order that she can eventually receive the difficult content. This can be conceptualized in behavioral terms as the construction of a hierarchy for systematic desensitization.

The therapist directs the client both conceptually and technically. The clinician guides the client to conceive of these inner voices as distinct, autonomous alter-identities as well as directing him or her to use techniques such as visualization—encouraging the client to channel inward and focus on his or her mental contents.

After one, or, sometimes, many attempts, Ross gets the client to catch on to the drama that is to unfold. Talking first to one identity and then another, Ross tries to direct them, yet again, to talk to each other. This is no easy task. He must first act as mediator, communicating to each what the other has said in hopes of the client objectifying that part of him or herself as another autonomous identity. Eventually a direct conversation is established between identities and host.

I might get an agreement from the host that the alter will try to send her messages. I then ask the alter, who is conscious behind a one-way amnesia barrier and with whom I have previously discussed the exercise, to say a number or to say, "Hello." The host listens and writes down the message. I then switch to the alter and check as to whether the message has been received correctly. Step by step I then have the alter transmit more complex neutral messages, until a conversation is established. Because the background alter is co-conscious and can hear the host easily, the desensitization is unidirectional: where there is two-way amnesia, the desensitization must be done in both directions at once.

Unwillingness or reticence toward interpersonality communication on the part of the client is clinically viewed as a reluctance to get in touch with alter-identities—the same alter-identities that are the cause of the client's dissociative amnesia. To alleviate the client amnesia, the therapist sees his or her role as director as essential to the uncovering of the hidden traumas, i.e., and alter-identities.

Sometimes suggestions by the therapist are not enough to get the client to emote deeply and hypnosis is employed to bring about the desired result. The clinician sees hypnosis as a form of prompting rather than directing. As Ross puts it,

If the patient has trouble opening up the communication channel, formal hypnotic suggestions can be given to help. [. . .]

Once the host can hear the alter's voice, I might ask the alter, with the host in executive control, if there is anything she wants to say to the host. The therapist can prompt therapeutic conversation, knowing the fears and concerns of the alters. For instance the alters are often afraid that other alters won't like them, will be mad at them, will blame them, or will not be satisfied with their performance. A direct simple statement by the host that she likes the hidden child and wants to talk with her can ease the child's fears. It also makes the host feel better.

Once the client attains the technique of switching from one character to another, i.e. of acting various roles, he or she can be one identity talking and subsequently be another identity responding to the first enactment. At this point the clinician interprets that the knowledge of how to get in touch with alter-identities (interpersonality communicate) is in place and that alter-identities will begin revealing the clients hidden secrets which will, in turn, relieve the client of the dissociative amnesia that accompanies switching.

Sometimes hypnosis is not enough to accomplish alter-identity identification and a stronger director's role is required of the therapist.

If there seems to be excessive trouble establishing communication between two personalities, there is a good chance that someone else is blocking it. In this situation it is necessary to explore further and try to deal directly with the blocking alter, who will have a rationale for what she is doing. I might say:

I have a feeling that there's someone else there who's blocking the conversation between Susan and Susie. If there is, there's probably a good reason for the blocking. I'd like to find out what it is so I'd know what to do. Is there anybody there who knows about that who could talk to me?

If an alter comes forward, I ask for as much information as possible, then work to solve whatever problem is motivating the blocking. [. . .]

Once two personalities are able to talk freely, communication will continue outside therapy. [. . .]

I get permission from both alters for a trial of coconsciousness, then switch to Susie. Prior to the switch I may do a formal hypnotic induction with suggestions for removal of the amnesia barrier. [. . .]

During the early phases of establishing coconsciousness, it is helpful to ask Susie to talk to Susan while Susie is out. Susie can then report to the therapist on Susan's responses. This gives Susan experience at being a background alter, and seems to help free up the communication channel. The same procedures can be used for all forms of communication between all combinations of personalities.³⁰

In the hard cases of revelation of alter-identities, the directing by the therapist is not yet complete.

The character sketch of each alter-identity must be detailed, and must be furnished by the therapist-director. If the client can not quite get the hang of bringing out the various characters, Ross suggests the therapist "model communication" for the client, until the client becomes "desensitized" to the process to the process of fragmentation/multiplicity and the acknowledging that one is or has multiple identities inside him or her.

Positive feedback (kudos from the director) is supplied to counteract the client's strong resistance to the process of deep emotive, alter-absorbing therapy.

Before exercises with Susie and Susan can begin, Susan will have been filled in on Susie's name, age, function, character, and concerns. This is the first step in desensitization. [. . .]

Interpersonality communication is reinforced by the therapist in a number of ways. One is by modeling communication for the patient, which occurs when the therapist requests switches and debriefs alters on conversations held behind amnesia barriers. I give lots of "strokes" for progress in therapy and lots of reassurance. [. . .]

The patient will stall and resist the work toward interpersonality integration in countless ways. This is as it should be for someone who has survived extreme trauma thanks to dissociation.

The preceding sections describe the principal techniques used in the initial phase of therapy. If a new layer of alter personalities is discovered late in therapy, these techniques may be used again at that stage.³¹

Once the client has been directed and coached toward a multiple conception of self—toward exposure of the alter-identities that cause dissociative amnesia—the client may proliferate character roles later in therapy.

(8) Due to poor directorship of the client-actor, the psychological dangers of acting may continue outside of MPD/DID therapy, a therapy that may cause post-traumatic stress.

The negative effects of the initial phase of MPD/DID treatment are discounted as expected of someone learning of their hidden memories and is qualified as lessening over time.

The middle and late phases of therapy are long and involve most of the work. During this part of the treatment many patients will feel, at times, that the effort is not worth it. Within a short-term perspective, this may be an accurate assessment. The patient will often experience more distress as her dissociative defenses are being dismantled. Numerous symptoms of a posttraumatic stress nature will occur and the ability to cope on a day-to-day basis may deteriorate. Fortunately this does not last forever, and eventually the patient moves into the less volatile, later stages of treatment.³²

If acting psychology is correct, these posttraumatic stress symptoms occur not because of a move toward wellness, but because anyone spending time becoming absorbed in character roles will suffer loss of cohesiveness of self-concept. This being the case, it should be no surprise, that in having been taught, directed, and encouraged to do so by

therapists who search for *covert* multiplicity, MPD patients “also enter trance states spontaneously more often than patients from other diagnostic groups,”³³ Dissociative defenses should be left in place—they are necessary to maintain psychological wellness.

To review, the therapist will take the directorship as far as necessary, even to the point of modeling the interpersonality communication and if that does not work will fill out the character sketches and names of the alter-identities. In the process the amnesia barriers, i.e., the natural tendency to protect oneself from emoting too deeply and becoming absorbed in a character, are destroyed under the direction of the therapist. For the purpose of curing dissociative amnesia (a metaphysically illogical conception as explained in chapter five), the client becomes desensitized to his or her own self-protective measures of character role absorption, and succumbs to the psychological dangers inherent in the use of poor-acting techniques. From that point on it is no surprise that “communication will continue outside therapy” between the “alter-selves,” with therapy continuing for an average of three years.

These eight mis-directions of MPD/DID therapy have been offered as a cautionary for therapists as to what therapeutic methods may contribute to the suffering of the MPD/DID client. Until the diagnosis is reassessed or discontinued, a new protocol for treatment needs to be implemented in light of the client-actor model. The hope is that cessation of problematic methodology will shorten recovery, make treatment easier for both therapist and client, and provide a safe transition until re-diagnosis can occur, if symptomatology warrants such re-diagnosis.

Four Anticipated Counter-Claims of the
Client-Actor/Therapist-Director Model

The client-actor model of MPD/DID is just another iatrogenic claim. Because of the client-actor model and concerns over misdirection of MPD/DID clientele, one might too quickly assume that the client-actor model is just another iatrogenic claim against MPD/DID—that the therapist “creates” characters in the client. To think so is to misunderstand what is at stake for MPD/DID clients during therapy.

The difference between the iatrogenic claim and what I am claiming is twofold. First, the typical claim of iatrogenesis involves the belief that therapists “create” alter-identities rather than “discovering” them. Second, the iatrogenic model accuses therapists of creating alter-identities through mere hypnotic suggestion, as if the client is a *passive* robot that responds to the dictates of the therapist. This is based on a horizontal-split consciousness model as opposed to the vertical-split model of consciousness explained in chapter four. The model of split-consciousness used results in different claims of iatrogenesis, either the hypnotherapeutic iatrogenic claim (which I’ll call hypnotic-iatrogenesis) or the role theory iatrogenic claim (which I will refer to as role-iatrogenesis). The hypnotherapeutic claim will be dealt with in this section and the role theory claim in the next.

Does the therapist-director’s use of hypnotherapy to get the client to enact characters means that these client characters (alter-identities) are created by the therapist? Only, and possibly, in a qualified case. It is dependent on one’s conception of hypnosis.

Remember, the client-actor model of MPD/DID therapy involves three types of hypnosis—not just one (see chapter four). Iatrogenesis can only be a possibility in a particular type of hypnosis.

Spontaneously created characters do not involve a therapist and so defy the iatrogenic claim. Characters created prior to or without the directorship of the therapist do not qualify as iatrogenically created alter-identities. Only those that the therapist has directed the client into bringing to life initially represent the meaning of iatrogenesis. But this meaning of iatrogenesis can not be substantiated as 'therapeutic' for the following reason. Bliss believes that heterohypnotically created identities can only be recalled by the person who created them. Heterohypnotically created characters are based on a horizontal-split view of consciousness wherein the client's unconscious is tapped into by the therapist—the client is not consciously aware of what he or she is doing or saying—neither does he or she remember what went on during that time. This would mean that heterohypnotically created characters may not subsequently be re-enacted autohypnotically—they can only be called out by the therapist. This means that even though characters enacted during heterohypnosis satisfy the iatrogenic claim, they do not satisfy the diagnostic description of MPD, since no switching can occur outside of therapeutic control.

Autohypnotically created characters, can be either created or re-enacted outside of therapy. First, if created outside of therapy they did not involve a therapist and so do not satisfy the iatrogenic model. Second, there is still the autohypnotically created character that was initially developed during MPD/DID therapy to consider. If an alter-character

was created during therapy and subsequently reenacted post-therapeutically, this would mean that the therapy involved tapping into the client's vertically-split consciousness (as opposed to unconsciousness or subconsciousness). According to the vertical-split view of consciousness, the client can actively participate in the creation of alter-identities during therapy while being given directions on how to do so by the therapist. But, these *consciously* created characters were created without psychological safeguards, due to the client being poorly-directed in acting techniques by the therapist, and so the client may lapse into various character roles she, herself, consciously participated in creating.

This does not mean that the therapist iatrogenically created the characters in the client—as if the client were a passive puppet. It means that the client has learned poor acting techniques and needs to be re-trained to implement psychological safeguards while extremely dissociating or the client may choose to stop extremely dissociating altogether.

To review, traditional iatrogenic claims portray the hypnotized client as a passive puppet and the therapist-hypnotizer as a puppeteer. Spontaneous hypnosis does not involve a therapist and so is not subject to iatrogenic claims. The puppet analogy only works with heterohypnosis as it may result in iatrogenically created characters, but these characters would not be indicative of MPD because they defy DC-B. And hence, the therapist could iatrogenically cause multiplicity but could not cause MPD/DID proper. The autohypnotically created characters involve a conscious, willing, and in control subject and so furnishes no basis for hypnotic-iatrogenesis. Counter to hypnotic-iatrogenesis, the therapist-director model involves a pro-active client (an actor), and not a passive client (a receiver of therapist-created alter-identities). It appears that no real case

exists wherein MPD/DID proper could be iatrogenically created; but this is because MPD/DID involves a conscious actor (a singleton) and not multiple autonomous distinct mind-only identities.

(2) *The client-actor model is just another role theory or social learning model of MPD/DID.* Ross explains the role theory model of MPD as another iatrogenic model—unlike the hypnotic-iatrogenic model. But, there is a complication with the conception of iatrogenesis when it comes to role theory. It contains within it the alter-actor distinction, i.e., roles do not reflect real suffering, whereas MPD does. Role-iatrogenesis results in a type of “as-if” personality without the intention to deceive. First, the less complicated version of role theory iatrogenesis.

Ross describes the role theory/social learning model as

The idea that MPD is an artifact of the doctor-patient relationship, based on role demands, cues by the doctor, mutual reinforcement of role performance by doctor and patient, and similar mechanisms...³⁴

He goes on to say that this model is applicable especially when professors who have never seen MPD base their findings on experiments involving normal college students. By this he seems to mean that professors, untrained in the subtleties of MPD therapy, can for testing purposes, pretend to be MPD/DID therapists who “create” MPD behavior in normal college student subjects—what Ross believes is a misinterpretation of experimental subjects behaviors.

It could be contested that the client-actor model, in construing the MPD/DID therapist as a director, is accusing MPD/DID therapists of perpetrating or contributing to the creation of client roles. The problem with role theory models in general is that they do

not take account of extreme dissociation and its possible psychological dangers. It portrays the therapist-client relationship as similar to that of any normal everyday role-playing, i.e., of a boss-employee, or a mother-daughter, etc. This leaves role theory models open to the accusation that, as in the case of the experimental subjects, clients are playing roles, but they are not really suffering like MPD/DID clients do, because they do not have the abusive histories that clients do.

But, the conception of iatrogenesis itself is skewed when it comes to role theory because of the alter-actor distinction. MPD/DID proponents deny that MPD/DID therapy is iatrogenic because they believe alter-identities are "real" whereas iatrogenic alters would be equivalent to mimicked or faked alters.

The initial questions after calling out an alter are the point in therapy at which iatrogenic creation of MPD is most likely to occur, if it ever occurs. Therefore one must take great care in a forensic assessment not to ask leading questions, suggest multiplicity, or create artifacts. The way of proceeding just outlined might have to be modified for *forensic* work. Once I am clear enough that I am talking to an alter, I make no further effort to phrase every question meticulously in such a way as to avoid iatrogenesis, because I don't believe that de novo creation of alters occurs in this stage of clinical work. It can occur later in therapy, however." Ross 236; emphasis added.

Forensic MPD/DID is also referred to as "as-if" personality, meaning that the client is pretending to be MPD/DID in order to escape a guilty verdict. In other words, artifactual or imitation MPD can be induced, or at least contributed to, in clients by therapists. But, the reason that Ross does not believe in de novo creation of alters (meaning real alters) is because he believes he can tell the difference between real and acted MPD/DID. Because of his sureness of his view of acting as mimicry, Ross proceeds to "discover" (or direct,

depending on your view) the name, age of each alter, chronological body age, why the alter came about, and the history of each alter-identity. In essence, he helps *direct* the client in the articulation of a character sketch—one either developed in childhood by the client-proper and re-enacted for Ross, or one being developed during therapy with Ross's direction. Remember he mentioned that child alters "may evolve during therapy."³⁵ When we take into account that 80% of Kluft's research group had covert alters this suggests that most alters do not appear until therapeutic intervention, i.e., by acting-director guidance.

So, does this mean therapist's cause clients to enact roles merely by interacting with them? No. Unlike role theory models of MPD/DID, the client-actor model takes account of extreme dissociation as a normal capability, one misdirected by well-meaning therapists. MPD/DID therapists are not just participants in a role-play—they are poor-directors of extreme dissociation. And MPD/DID clients are not just responding to expected roles outlined and prompted by the therapist. Doing so would not take concerted effort, nor result in the negative symptoms of dangerous acting, since it is similar to what people are doing everyday while performing various roles to fit changing situations (i.e., social role theory). Instead, the client must actively and intentionally use specific techniques to accomplish the narrowed focus of attention into his or her imagination or memory in order to facilitate a 'switch' to a different character. This does require direction from the therapist, but because it also requires the client's intention/habit to extremely dissociate, it cannot be equivalent to a social role model of behavior as some may think. Social role theory does not involve use of extreme dissociation.

(3) *MPD/DID therapists are not directors, they are more akin to "architects of whole selves."* Contrary to my claim that MPD/DID therapists are like directors, at least one therapist, Colin Ross, has compared his work as therapist to that of an architect of "whole selves," as a way of defending his treatment strategy. Because architects and directors are quite different I want to consider the accuracy of Ross's claim. As regards his work with MPD/DID clients in therapy, Ross says

The frame should be more like the consultation with an architect on house plans. It is the client's house and life; the architect has special skills; and the client can't design a house alone. In my architectural practice I build whole selves [...] ³⁶

I find this analogy troublesome. An architect making decisions about "structural" details of a house and a clinician making decisions about the "structural" details of a person's metaphysical status are far from equal. An architect studies engineering, i.e., stress loads, wind factors, snow loads, ground compaction ratios, etc. for the various components of a building. The architect can learn the necessary finite structural details of house building through physics, math, and geology. The MPD/DID clinician, on the other hand, is untrained in those areas about the structure or nature of reality, identity, self, personality, and persons. That is to say, psychology/psychiatry are disciplines overtly self-stripped of metaphysical concerns. This is analogous to an untrained counselor/architect—one who lacks the tools to help a client construct or re-construct a whole being from many identities. The MPD/DID counselor of whole selves is equivalent to an untrained architect trying to design and construct a complex multistory building.

(4) *If MPD alter-making and a certain style of acting amount to the same thing, then the only difference between MPD/DID and acting is nomenclature, i.e., MPD/DID is the result of nomenclature.* By nomenclature I mean the system of names and words used by particular branches of learning, in this case therapists and actors, i.e., clinical/scientific nomenclature and theater nomenclature.

For nomenclature to be a possibility, words used by the clinician and MPD client must also be used by actors, while at the same time meaning something different. This presents two possibilities. Either, (1) clinician/client and actor use the same word but with different interpretations, or (2) the difference in nomenclature must point to the same experience while being called something different—same experience, different word.

Shared nomenclature is evident in the fact that both MPD/DID and acting have historical ties to spirits, demons, possession, and shamanism. Both have connections to split or dual personalities, internal phobic stimulus, self-hypnosis, repressed memories, liberation from personal feelings, depersonalization, strategies for evading and reliving traumas, strategies for healing, dissociation, extreme dissociation, switching roles/identities, trance states, absorption into a character/personality, dissociative delusions, difficulty coming out of character, and accusations that this behavior is indicative of madness and neurosis. Both involve techniques of narrowing one's attention, and both involve use of the imagination. The skills for both acting and alter-making begin in the early stages of development as childhood playacting. Alter-making and acting have all these major features/techniques/styles in common.³⁷

The difference in nomenclature affects what clinicians/clients and actors go on to do, or affects the way they perceive themselves. Actors multiply themselves into many characters, just as MPD/DID clients manufacture alters. Psychological content is perceived differently by MPD/DID therapist and actor. What the therapist tries to expunge from the MPD/DID client, i.e., traumatic memories, feelings, emotions, etc., are perceived as negative and in need of removal. Those same experiences are perceived positively by actors, i.e., are the actor's acting palette, one the actor does not want fixed, resolved, or altered. For therapists, phobias and hidden memories represent a psychological mess (of alter-identities) that needs sorted out in psychotherapy. But for actors, those same psychological problems present an *opportunity* (to enact various characters) for a transcendent "*way of living*."³⁸ For actors, psychological content, even of a traumatic nature, is perceived as an "inner resource"—a pool of experience from which to draw and express. In this way, acting offers "a way of apprehending, getting in touch with, and using [. . .] inner resources[. . .]."³⁹ Psychological content, even of abuses and traumas is clinically interpreted as dysfunction but valued theatrically as function. Likewise, the psyche represents opposite ends of the spectrum of human experience for acting and for MPD/DID alter-making. The acting community appreciates "psyche" as "a rich world of intuitive knowledge and human insights."⁴⁰ At the same time, the psyche is perceived by MPD/DID therapists as an unconscious, subconscious, or split-conscious conundrum of deep, dark, harmful secrets that if not released slowly, under the watchful eye of a trained counselor, may result in suicidal or homicidal tendencies.

Acting involves “responsivity, imagination, psychological and physical resources, and means of expression,”⁴¹ as does MPD/DID behavior. Yet clinically speaking, theater acting is considered healthy and MPD/DID client acting is indicative of mental illness. Both the actor and theater director see “actor performance, rehearsal, training, and life experience” as the instrument for expression, revelation, self-knowledge, and insight. On the other hand, MPD/DID therapists see client performance of alter-identities as representative of dissociative amnesia and uncontrolled switching. While “the way of the actor” is seen as an achieved “state of advanced responsivity, and awareness of personal powers,”⁴² MPD/DID client acting is proclaimed as dysfunction, loss of memory, and lack of control,⁴³ i.e., loss of personal power.

These differences may lend themselves to the accusation that the client-actor model of MPD/DID is *solely* a nomenclature-claim. But, therapy is not just words—it involves the directing of clients to act without psychological safeguards. For example, professional actors employ psychological protection against becoming too absorbed in the character roles performed and MPD/DID clients are encouraged to remove those “barriers.” Professional acting is not about the actors’ psyche. It is about the character performed—not as a distinct, autonomous being inside the artist waiting to be released to reveal hidden secrets and past traumas and lives—but as a character that the artist breathes life into based on past experiences.

It may be the case that, had clinicians maintained the theater model (i.e., childhood playacting) to explain adult MPD/DID, then the clinical/scientific nomenclature would not have arisen. Once the therapists switched to the clinical/scientific nomenclature a rift

between actor as mimic and MPD/DID client as alter-maker ensued. Without the clinical/scientific nomenclature, multiple personalities/dissociated identities would not have become associated with mental illness.

But, to think that the client-actor model amounts to nothing more than a difference in nomenclature would be wrong. Nomenclature plays a role in the client's conception of him or herself because of the therapist-director's interpretation of client behavior⁴⁴, but nomenclature does not involve the use of the extreme dissociation that is necessary for character role absorption and its ramifications.

To review, the client-actor model does not imply that MPD/DID is iatrogenic. If iatrogenesis could occur, it would not result in MPD, and would not involve a consciously active actor, nor would it involve spontaneous 'switching' amongst characters. The client-actor model involves the client's use of extreme dissociation and so is not another role theory model of MPD. And, if the therapist is an architect of whole selves, he or she is untrained to practice such architecture, in not being trained in metaphysics. Instead the therapist is more like a poor-acting director, directing MPD/DID clients to cathect using extreme dissociation without psychological safeguards. And, the client-actor model says far more than that the difference between alter-making and acting is nomenclature. The client-actor model says that therapeutic acts (including a therapist's behavior, attitudes, poor-acting teaching and directing without revealing psychological safeguards, modeling of interpersonal communication, etc.), not just therapeutic words, contribute to the client's implementation of extreme dissociation.

Summary

The therapeutic focus on client as distinct identities occurs, in part, because all interpretations of MPD/DID are (as indicated in chapter two) variations on a theme, i.e., they are variations on the diagnostic criteria of MPD/DID. The theme then gets reinforced because of the alter-actor distinction—that clients are not acting, which in turn depends on two points, (1) a naïve view of acting, and (2) clinical/scientific nomenclature.

But, a narrow view of acting and scientific language alone is not enough to prompt client dysfunctional behavior. The naïve view of acting and nomenclature in turn prompt the therapist and client toward the treatment goal of integration. This goal presumes the presence of distinct, separate, autonomous, identities as representative of dysfunction, unwanted symptomatology, and mental disorder. Clinically speaking, mental disorders are presumed to be in need of correction or alleviation. In the case of MPD/DID the alter-identities need to be alleviated by integration or fusion. It is the goal of integration that puts the therapist in the position of a director. It is the therapist's belief that clients are not acting that contributes to directing clients to emote without psychological safeguards. But, without psychological safeguards (preservation of dissociative barriers) the client becomes extremely dissociated, disoriented, dysfunctional, deluded, and too absorbed into character to come out of the act without clinical intervention. This dissociated behavior only serves to reaffirm the clinician's conviction that his or her therapeutic efforts have resulted in "proof" of the existence/presence of covert alter-identities and "proof" of the client's mental status of MPD/DID, and proof of the need for integration therapy.

According to acting psychology, acting in a safe manner results in a type of healing. This suggests that the MPD/DID therapists' poor directing of clients presents an *unnecessary* and *avoidable* danger. By contrast, acting psychology suggests that deep character role absorption, dissociative delusions, spontaneous inappropriate stepping into character, and trouble coming out of character do not have to occur for healing from trauma and abuse to take place. If taught the psychological safeguards of acting, MPD/DID clients would not have to experience the psychological "distress" and resulting "post-traumatic stress"⁴⁵ of MPD/DID therapy.

Most of the support for continuation of the classification and treatment of MPD/DID has been the belief that therapy is helpful. In light of the client-actor model, therapeutic claims are strongly denied any validity and in fact point to MPD/DID therapy as counter-productive to the *clinical goal* of attainment of single personality or unified identity.

Notes

¹ Bates 202.

² Bates 202.

³ Whether singletonism (as opposed to multiplicity) is more indicative of mental health and improved daily functioning, I will leave for acting psychologists and MPD/DID clinicians to debate.

⁴ Bates 5.

⁵ Bates 4-5. (emphasis added.)

⁶ Beahrs 111.

⁷ Bates 4-5, emphasis added.

⁸ Confer and Ables 114. emphasis added.

⁹ Confer and Ables never take the theater model up directly because they buy into the metaphysically challenged view of identities as distinct and autonomous.

¹⁰ Bates 34.

¹¹ Bates 35.

¹² Ross 229.

¹³ Bates 34.

¹⁴ Bates 34.

¹⁵ Ross 231.

¹⁶ Ross 230.

¹⁷ Ross 247.

¹⁸ Ross 243.

¹⁹ Ross 243.

²⁰ Ross 93.

²¹ Ross 84.

²² Ross 84.

²³ Ross 84.

²⁴ Ross 84.

²⁵ Ross 246.

²⁶ Bliss 70.

²⁷ Bates 130.

²⁸ Ross 242.

²⁹ Ross 243.

³⁰ Ross 242-46.

³¹ Ross 242-46.

³² Ross 247.

³³ Ross 107.

³⁴ Ross 66.

³⁵ Ross 111.

³⁶ Ross 226.

³⁷ Ross 12-27, 65, 73, 101, 231-232; and Bates 2, 21, 27, 32, 48-66, 72, 74, 85, 171, 174.

³⁸ Bates 8.

³⁹ Bates 8.

⁴⁰ Bates 8.

⁴¹ Bates 8.

⁴² Bliss 8.

⁴³ DSM-IV, DID diagnostic criteria and Casebook example.

⁴⁴ The intent of this is similar to Hacking's claim of retroactive redescrptions and the looping effect of human kinds.

⁴⁵ Ross 247.

CHAPTER VII

CONCLUSION

This conclusion, in addition to being a review of the main dilemma addressed in this dissertation, will also furnish an additional explanation, in light of the psychology of acting, as to why multiplicity would be interpreted as a disorder. This chapter will also point out several additional benefits of the Client as Actor Model, supply a short list of new issues for therapy that arise from the Client as Actor Model, and furnish suggestions for future research that could be developed from the findings in this dissertation.

Review

The difficulty and complexity surrounding MPD/DID makes it understandable why debates continue about diagnostic interpretation, iatrogenesis, and painful, long-term therapy. The complexities and contradictions inherent in MPD/DID diagnostic criteria explain why therapists, clients and client loved ones have difficulty understanding what it means to say, or hear someone say, "I have many people inside me."

MPD/DID is about dissociation and metaphysics. But, the current day explanation of dissociation as a trait that gets developed during childhood playacting both supports

and undermines the characterization of multiple personalities/dissociated identities as a disorder. On the one hand, the current conception of dissociation enables clinicians to support the idea that given motivation, such as abuse, trauma, or neglect, dissociation can be taken to an extreme. Dissociation became conceived of in terms of a continuum of experience from normal to extreme. It was shown above that dissociation alone is not scalar but becomes scalar when clinical judgements such as of normal/abnormal are placed on it. An extreme level of dissociation is believed to result in the fracturing of the client's mind into separate, distinct autonomous identities; so extreme dissociation results in MPD/DID, a psychopathology. At the same time, because dissociation starts as childhood playacting, a distinction needed to be made between the acting of various roles as a normal phenomenon and the psychopathological existence/presence of alter-identities in a client's mind. This was referred to as the alter-actor distinction. So, the conception of dissociation as a continuum that is used to support the development of MPD/DID in the adult-child, is then the same conception that can also explain people's ability to act on stage or in the movies. The clinical distinction between alter-making and acting is that MPD/DID clients suffer psychological ramifications of extreme dissociation, they really feel they are many different identities, and really feel the pain of abreacted memories, whereas actors do not. In other words, MPD/DID clients suffer the symptoms of the MPD/DID diagnostic criteria, and actors do not.

But the alter-actor distinction turned out to be based on a naïve, narrow view of acting as mimicry. Given a more comprehensive view of acting as reported by psychologists of acting, acting theorists, actors, and directors, the alter-actor distinction

proved invalid. Literature on acting indicated that actors, too, can experience extreme dissociation and suffer negative side effects of doing so, just as MPD/DID clients can. Actors, however, tend to protect themselves from the destructive effects of extreme dissociation by using psychological safeguards taught to them in acting school.

The invalidation of the alter-actor distinction put into question the validity of multiple personalities/dissociated identities as a disorder. If no significant distinction remains between the level of dissociation involved in alter-making and that which is involved in some types of acting, the basis of multiple personalities/dissociated identities as a psychopathology is eliminated. What this amounts to is that the conception of dissociation as a continuum that enables multiple personalities/dissociated identities to be set apart as a mental illness, is the same conception of dissociation that challenges its validity. Both clients and actors can experience the benefits of, as well as suffer the negative effects of, extreme dissociation and living life as if they are multiple people. These findings supported my claim that if actors can extremely dissociate, then multiple personalities/dissociated identities is not a disorder at all. The findings in this dissertation indicate that MPD/DID should be de-classified, and particular cautions against the dangers of acting should be given in therapy for those already diagnosed and treated (or in treatment) for MPD/DID.

It is from the similarity between alter-making and acting that the Client as Actor model arose. The reason it should be preferred over the clinical alter model is that the alter model has been shown to be a metaphysically-logically flawed conception of client behavior. The diagnostic criteria of MPD/DID were shown to be riddled with irresolvable

flaws. The diagnostic criteria contain such problems as the problem of who, the problem of co-consciousness and its two manifestations, the problem of switching, and the problem of dissociative amnesia. The Client as Actor model avoids these problems and gives new insight into healthier therapeutic methods for dealing with the negative side effects of extreme dissociation.

But, a question remains as to why clinicians would have entertained the notion of multiplicity/dissociated identity as abnormal and single identity as normal. Dissociation defined initially as split or fractured streams of consciousness did originate from investigations into psychic phenomena. This may have given reason to suspect multiplicity as something unusual or bizarre, but why categorize it as abnormal? The psychology of acting can furnish one possible explanation.

The Fear of Extreme Changes in Identity

The Client as Actor Model does not tell against, and in fact supports, the alter model's conception that early childhood abuse can be so painful and intolerable that the child, who can not escape his or her abuser, is left no alternative but to fantasize and imagine being somewhere and *someone* else. But, if early childhood trauma is the adult MPD/DID client's problem, why did therapists focus on client changes in identity rather than on the trauma itself?¹ The psychology of acting can suggest an answer to this question, an answer that is different from the standard psychiatric explanation of regressed memories showing up as psychosomatic illness.

According to acting psychology, behavioral deviations (to any extreme) are not usually tolerated in society. However, on stage or in the movies, acting obviously is tolerated. Because it is tolerated, acting is praised or characterized in terms of strength and benefit. Yet, outside of theatrical settings, including such places as a hospital or a therapist's office, multiplicity is perceived of as an abnormality.

The cultural acceptance of multiplicity only under certain conditions suggests why single personality is clinically considered indicative of mental health, and multiple personality/dissociated identity is considered a mental illness. Acting psychology explains that "a relatively stable appearance renders a person predictable, identifiable, 'safe'" while at the same time, "a person who is a chameleon, totally different on separate occasions, is considered 'shallow', weak, lacking a strong centre."² Just as therapists monitor client behavior during therapy, people in general monitor each other's "appearance and take note of changes." Strong reactions from people as to another's altered appearance suggests that too radical an alteration or a too sudden alteration is "threatening in some way."³ Bates explains that,

It appears to indicate to others that we have somehow changed as a person, since physical appearance expresses psychological states.[. . .]We have become an unknown quantity, a transformed individual, a 'new person.'⁴

The therapist's tendency to interpret radical or sudden alterations in appearance or behavior as indicators of mental illness supports this contention. Having observed client behavior as a radical or sudden alteration in identity, outside of a theatrical setting, therapists respond by diagnosing the behavior as uncommon/abnormal and pathological, instead of normal. The multiple/dissociated client is thereby not classified as an actor and

instead is diagnosed as mentally ill and in need of integration or fusion therapy in order to become a single, unified whole person again. By contrast, the Actor model offers a sensible and less problematic conception of client behavior.

Benefits of the Client as Actor Model

Several benefits arise from the invalidation of the alter-actor distinction and from the development of the Client as Actor Model. Because of the problems inherent in MPD/DID, the time is right for the presentation of a new theory. The Client as Actor Model acts as a bridge of thought between opposing views of MPD/DID as real (in its various interpretations) and MPD/DID as iatrogenic. And, the Actor Model gives an explanation as to why a surgical analogy of cutting out painful repressed memories is misguided.

A New Theory Welcomed

One of the benefits of the Client as Actor Model is, simply, that it is being presented at a time in the history of MPD/DID when new ideas are needed, but are in short supply. Ross, himself, proclaims that "If someone could develop a method for treating multiple personality disorder that circumvented the abreactions, it would be wonderful."⁵ This is because MPD/DID therapy is traumatic for both client and therapist.

Disclosing abuse memories at an informational level is the first step towards abreaction. Abreaction is not an end in itself and is extremely painful for the patient. It is also stressful for the therapist, and in fact some therapists develop full DSM-III-R posttraumatic stress disorder from working with severely abused multiples.⁶

The radical qualities of the Client as Actor Model may be disconcerting to some clinicians that have a lot invested in current treatment regimens. But, my approach offers new understanding for both client behavior and client treatment, and it offers hope for the cessation of therapy-based PTSD (Post Traumatic Stress Disorder) in both the MPD/DID therapist and the client. Although this dissertation directly and specifically challenges Ross's alter-actor distinction, it is his work and his acceptance of the possibility of the MPD/DID client as some kind of actor that encourages me to offer the Client As Actor Model as a fresh approach to understanding client divergent behavior.

The Client as Actor Model—Between Extremes

The Client as Actor Model offers a resolution to the long-standing debates between standard opposing interpretations of MPD/DID as real versus MPD/DID as iatrogenic. For years opponents and proponents of MPD/DID have not been able to reach a compromise position about multiplicity/dissociated identity as a disorder. Opponents claim either that MPD/DID is iatrogenic, faked, or a mis-classification of client behavior, while MPD/DID proponents wrestle and argue with each other about how to understand multiple identities in one person—as to whether they are persons, personality states, co-

consciousnesses, metaphors, or dissociative delusions. The client actor model offers a bridge between these claims.

The Client as Actor Model offers a compromise between opponents and proponents of MPD/DID. The Client as Actor Model does not deny client suffering, nor does it refuse to acknowledge the experience of multiple identity, but it supports a belief in multiplicity/dissociated identity while rejecting the idea that it is a disorder. It gives therapists a way to conceive of multiplicity while giving up the drawbacks of MPD/DID theory, diagnosis, and treatment. The Client-Actor model allows proponents of MPD/DID to maintain that multiplicity is real with certain qualifications. At the same time, it enables opponents to maintain that at least some cases of MPD/DID are iatrogenic, i.e., in this case, that therapists are poor-acting directors who, in certain (but not all) instances, contribute to extremely dissociative client behavior and its negative symptomatology. Multiple identities created via spontaneous self-hypnosis may not be iatrogenic, but heterohypnotically created alters may be considered to be iatrogenic. Opponents of MPD/DID may be partially correct that ignoring client behavior makes alters disappear (since all actors need an audience). But, opponents' belief in the therapeutic technique of ignoring the client's behavior may not be as good a methodology as that of instructing clients about safer acting techniques. Proponents can maintain that MPD/DID "is not a sick role," because clients, like some actors, do not pretend to be 'absorbed' by a character role when transformation of identity happens—both client and actor really are absorbed by that role. But, by proponents acknowledging that multiplicity is acting, they must give up the idea that it is a mental disorder. Proponents can also

maintain that MPD is, "a complex, childhood-onset, posttraumatic dissociative," experience, but, again, they have to give up the idea that the dissociation involved in multiplicity is anything different from that involved in deeply emotive acting. And, the client-actor model allows therapists to maintain that the client can extremely dissociate to the point of having dissociative delusions but therapists must give up the idea that these delusions are a necessary part of the client's pathology (ability to extremely dissociate). This is because if psychological safeguards are implemented, then multiple identity can continue without the negative side effects.

In addition, the client-actor model dispels the metaphysical illogicality of dissociative amnesia (DC-C) by avoiding talk of multiple consciousness, yet maintains the concept of multiplicity by referring to it in terms of multiple enacted roles. The client actor model eliminates the contradiction of separate, distinct, autonomous identities of the mind (DC-A) taking control of a client's behavior (DC-B). The client-actor model maintains the notion of switching but explains it as switching character roles. The client's reported lack of control is re-explained as a habitualized spontaneous hypnosis, or as auto-hypnosis, i.e., a habitualized narrow focusing within one's attentional landscape. The client-actor model retains the notion of repressed and then recovered memories but opposes the metaphysically problematic version of recovered memories as those housed and exposed by the client's acknowledgement and acceptance of his or her alter-selves.

A Safer Alternative to the Surgical Analogy of MPD/DID Therapy

The Client as Actor Model offers a safer therapy for reliving trauma, while still offering the healing qualities of acting. Contrary to this, a surgical analogy for MPD/DID therapy has contributed to excusing the longevity of and pain of current MPD/DID therapeutic methods. Ross, and other clinicians, arrive at the wrong conclusion about therapeutic suffering because they believe that alters and actors are different. They believe that suffering may be a necessary part of MPD/DID therapy (but not of acting). Ross says,

The problem is that intense reliving of abuse in the presence of a therapist seems to be part of getting better, much like inflammation is part of the natural healing process.

In a surgical analogy, the abuse memories are like foreign bodies. Unless they are removed, the abscess cannot be definitively treated. This does not mean that every single abuse incident requires full abreaction. Such work would take far too long. Generalization occurs in abreactive work, as in other aspects of the therapy, so that reliving key representative traumas cleanses the entire system.⁷

By maintaining the alter-actor distinction in order to clarify the seriousness of client suffering, Ross and others have unintentionally prolonged the establishment of a theory of client as actor—a theory whose corresponding treatment may help suffering for both clients and therapists.

New Issues for Therapy

With the adoption of the Client As Actor Model two new problems arise: one for therapy in general, and one for MPD/DID therapy specifically. The problem that arises for therapists/therapy in general has to do with the possible value of maintaining psychic 'garbage,' rather than therapeutically ridding one's self of negative psychic content. The new dilemma for MPD/DID therapy specifically has to do with the possibility that multiplicity should not only be allowed to exist (if a client desires to be multiple) but it should also be encouraged to thrive. Bates contends that multiplicity is a valuable resource. These two dilemmas will be briefly presented in turn.

Multiplicity—The Client's Avenue to Mental Health

Should painful memories be rooted out as psychiatry contends or should they be left alone? The Client as Actor Model proposes this problem for therapy in general. In helping the MPD/DID client to arrive at a decision about whether to squelch his or her multiplicity, the therapist should consider the following. Multiplicity, the very phenomenon that clinicians are trying to rid the client of, could be the very behavior that if cultivated properly, could help the client to heal.

Bates explains that "it is often assumed that actors are people who like to 'escape' from themselves into being 'other people.'⁸ Escapism sounds like something psychologically negative. Therapists interpret MPD/DID behavior in this same way. But,

Bates suggests that there is a benefit in pretending to be other people—it gives us “a very strong orientation towards ‘other people’, or characters.” Bates explains this in Lawrence Luckinbill’s terms of “the paradox of the actor as wanting to be someone else—but as a way of expressing himself.”⁹ It is this paradox that presents a dilemma for MPD/DID therapists. Acting, i.e., being other people, even if only for a brief time, furnishes actors with an empathetic capacity to understand themselves and others. Luckinbill’s insight is that “There is a suggestion here that we share with other people hidden identities, such that if circumstances had been different we could have ‘been them’, and they us.”¹⁰ The paradox for MPD/DID therapy is that by interpreting multiple personalities as pathogenic and in trying to “root out” the client’s multiplicity, therapists may be inhibiting the client’s empathetic capacity to understand him or herself as well as others through the client’s artistic implementation of his or her imagination. By attempting to cleanse the MPD/DID client’s system of multiple/dissociated identities and the painful memories they house, the therapist may be ridding the client of the palette of experience her or she needs to heal herself through understanding other people.

By way of contrast, in the world of the actor, some actors do not want to cleanse their entire system of key representative traumas. They acknowledge that cathecting memories can cleanse them of the pain of those memories but choose not to do so because their memories, good and bad, are their palette from which multiple identities are created and enacted.

The ghosts of our life experiences lead us this way and that without our conscious knowledge. For most of us, who do not enter into depth psychotherapy, the deep waters of our unconscious run undisturbed by even a dipping toe

of consciousness. Our only clues to the hidden parts of ourselves are the fragmented images of dreams, and the frequently inexplicable nature of the strength of our emotional responses to everyday events.

For the actor it is different. The actor seeks to 'encourage those of his inner impulses which are relevant to the role to emerge as dominant' and to encourage the domination of the whole personality by one part is to invite possession.'¹¹

In other words, by cleaning the actor's psychological framework up too much, his or her range of characters and depth of feeling of character roles, and capacity for empathetic response may suffer.

The client as actor model presents a new dilemma for therapeutic ethics as to whether keeping and using painful memories to enact character roles is healthier than cathecting them (cleansing the mind of the pain of them) by traditional mind-therapy methods. The contrast between the post-therapeutic cleansed system or psyche of the MPD/DID client and the uncleansed system/psyche of the actor brings up a question, for further research, as to what mental health is. Is it healthy to prefer to keep, adjust to, and use the pains and joys of life in order to empathize with others and act as if one is other people? Or, as therapists contend, is mental health more a matter of memories devoid of their original pain? This is a matter for therapeutic ethics.

Multiplicity—A Precious Commodity

According to Bates, multiplicity is a precious commodity that should be preserved. Those who can act, those who have learned the technique of extreme dissociation and of

narrowly focusing their attentional landscape, should not be categorized as mentally ill, but should be encouraged to express their skill in a healthy way, inclusive of psychological safeguards.

with the scientific toys of our much-vaunted rationality, [...] we cannot afford to reject any possible sources of insight into human nature.

I am trained as a scientist and I value the benefits of the scientific approach to knowledge. But scientists themselves are now beginning to realize that our rational world is, in reality, deeply irrational and that science has its limitations. Actors are more than just cultural luxuries, aesthetic appendages or up-market entertainers. On the contrary, actors are essential for maintaining our vital links with the imaginal world, our universal self, the part of us that unites with the rest of humankind. In our efforts to create harmony and reclaim individual and mass sanity, I believe actors should be classified as a precious resource, and protected as an endangered species. (Bates 204-205)

This suggests that therapists should not be rooting out multiplicity/dissociated identity from clients's 'psyches,' and attempting to make clients into single personalities because by doing so, therapists may be divesting clients and society of "a precious resource," i.e., imagination.

It is the ability to extremely dissociate that contributes to some of society's most productive individuals. For example, Trevanian (one of several pseudonyms of the author of such thrillers as The Eiger Sanction and Shimbumi) utilizes an "unusual method of writing." Trevanian's ability to write such different kinds of books stems from his being able to extremely dissociate from his 'normal' self and become different characters for long periods of time while 'they' do the writing he can not do as Rodney Whitaker. Trevanian's use of a multiple identity to produce a number of, and diversity of, books illustrates Bates's contention that imagination and multiplicity is a valuable commodity.

Another example is that of Garth Brooks. Imagine making an album such as "No Fences" which sells 13 million copies, or having three top twenty albums, at the same time. According to Karen Schoemer¹², Garth is able to be so productive because he is a commodity. Garth Brooks the man has been separated from Garth Brooks the product. Sometime during his career of selling 67 million records, 'Garth' became "a brand," like "Campbell's soup or Budweiser beer," says his comanager, Doyle. Somewhere along the way Brooks had to separate himself from the product 'Garth,' in order to maintain his sense of self and his sense of sanity. He steps into the person 'Garth' only when needed, such as on stage or during public appearances. He talks about 'Garth' in the third person and does not believe he, the man, is the "biggest-selling solo act in the United States" even though he admits 'Garth' is. He says, "Garth is what you see on stage. Garth is the lighting rig, he's the band and most of all Garth Brooks is the *people* out there." The interviewer's final comment is apropos. "Imagine that: feeling so invisible that you only exist as a reflection of others... You'd better have two personalities... Otherwise, you'd have none." We are able to have Garth Brooks and all that entails because he was able to extremely dissociate from the person turned product. As Ross contends, Brooks's ability to dissociate has contributed to the enrichment of our lives in the form of the music that Brooks's multiplicity facilitates.

These examples of Trevanian and Brooks (and others mentioned in earlier chapters) suggest that multiplicity/dissociated identity can be a positive force. The concept of multiple identities as something positive to be maintained and encouraged presents a new dilemma for therapists, in at least two ways. First, Bates's view runs

counter to Janet and others' contention that we should ignore multiple behavior in order to make it disappear. Secondly, Bates's claim suggests that multiple behavior should be applauded, encouraged, and revered, not diagnosed, integrated, and fused.

Considerations for Future Research

Findings from the investigations into dissociation and acting in this dissertation could form the bases of research for at least four topics: panic disorder, alcohol and drug rehabilitation, phenomenology and therapeutic ethics. These will each be briefly explained.

Panic Disorder

People with anxiety and panic disorder have difficulty controlling their thoughts. For example, Sandra Kimberley Hall, a writer and anxiety/panic sufferer says of her problem, "My neurosis escalated to the point that I was uncomfortable leaving the house," and "I'd panic when driving, standing in line at the bank or buying groceries."¹³ She wanted desperately to travel as her friends were doing. Her drive to stop being an "armchair traveler reading National Geographic," is what prompted her to face her fears. As regards her method for doing so she says, "I discovered that my imagination was responsible for many of my anxieties." She had to learn to control her imagination to not

allow herself to consider all the possible horrible things that could happen if she left her house or traveled.

But curbing her imagination was not enough. She had to learn to “reinvent” herself. By reinventing herself she was able to shed many of the fears contributing to her incapacity. This suggests that she had to dissociate from herself as a debilitated, panic disordered person, and create and act the role of a new self as an “adventure traveler,” trekking and hiking around the world. Perhaps, Sandra’s ability to narrowly focus her attention on her fears (seen as a mental illness) is the same technique that enabled her to attend to the dictates of a new character role as traveler, and to conquer her fears.

Alcohol and Drug Rehabilitation

The research on dissociation and acting done for this dissertation may also lay the foundational work necessary for a new theory about alcohol and drug addiction (A/D) recovery. The clinical division between mind-based dissociations (such as MPD/DID) and brain based dissociations (such as dissociation due to intoxication), is a division of convenience established for diagnosis and treatment. But, if this division can be put aside temporarily, a new possibility for treatment of A/D recovery can be considered. Drug/alcohol use may be looked at as either an attempt to dissociate either for fun or to curb the pain, suffering, boredom, frustration, or exasperation of daily life and problems.

Because some drug-use results in emotional and/or physical addiction, emotional addition to drugs can be conceived of as a dissociative coping mechanism. It could be the

case the those people who use drugs/alcohol for coping do so because they cannot, or rather have not learned to, dissociate some other way. The findings of this dissertation, in deconstructing the alter-actor distinction, and clarifying that anyone using certain techniques can extremely dissociate and do so with or without psychological safeguards, opens an avenue of investigation into the possibilities of extreme dissociation.

For example, acting (dissociation with safeguards) may offer people wishing to cease drug/alcohol addiction, an alternative form of dissociation—a safer dissociation than the drugs/alcohol offer. One reason why recovery fails is that either no substitutes are offered for ridding the person of life's pains/sufferings, or the substitutes offered (methadone, etc.) address only the physiological addiction and not the social/emotional/psychological addiction to the drug. Recovery from a lifestyle of addiction involves changing friends, daily routine, learning new coping skills, new social skills, and a host of other transitions, including coming to view one's self in a new way as a normal (non-addicted) person. Imagining and acting as a different person may help in this regards by allowing the addict to dissociate from his addicted self and lifestyle. Especially during the drug withdrawal period, the tendency to return to old coping habits is the greatest. Learning to psychologically extremely dissociate in a safe way may offer an alternative to returning to chemical dissociation, especially if it is true that extreme dissociation can alter one's physiology.

Phenomenological Research

MPD/DID and acting suggest that identity changes can affect physiological changes. If deep character role absorption can result in physiological changes in the person then metaphysics/phenomenology has a whole new avenue of investigation to explore. The statement that deep character role absorption can change one's physiology is not a light claim. This would mean that spontaneous or autohypnosis (i.e. narrowly focused attention on ones inner self, ones imaginings and fantasy's), when acted out, can actually change one's physiology. In other words, people may be able to change their eye color, their diabetes, their eyesight, their allergy status, (or as in the example above, their cravings for street drugs), etc. merely by transforming themselves into another character devoid of these. In light of these potential pluses of possibility, it may be time to test this theory, using actors trained in acting techniques of 'living near the edge' of psychological danger.

These three examples, of panic disorder, drug and alcohol rehab, and phenomenological investigation, are just some of the possibilities for future research that could be developed from the findings provided in this dissertation. Alter-making and acting offer new insight into the drawbacks and benefits of dissociation and multiplicity and likewise into what it means to be human.

Notes

¹ After all, clinicians could have named client behavior as ECAS (Early Childhood Abuse Syndrome), or ECTD (Early Childhood Trauma Disorder), or CVD (Child Victimization Disorder), to suggest a few possibilities. Or they could have referred to the clients problems as simply PTSD (Post Traumatic Stress Disorder).

² Bates 90.

³ Bates 91.

⁴ Bates 91.

⁵ Ross 247-48.

⁶ Ross 247-48.

⁷ Ross 248.

⁸ Bates 83.

⁹ Bates 83.

¹⁰ Bates 83.

¹¹ Bates 81.

¹² Newsweek, The World According to Garth, by Karen Schoemer, 16 March, 1998. 66-70.

¹³ Newsweek, I Know That Only Cowards Can Be Brave, by Sandra Kimberley Hall, 6 Sept., 1999. 14.

SELECTED BIBLIOGRAPHY

- Aldridge-Morris, Ray. Multiple Personality, An Exercise In Deception. Hove, East Sussex, U.K.: Erlbaum, 1989.
- Archer, William. "William Archer (1856-1924)." Actors On Acting: The Theories, Techniques, and Practices of the World's Great Actors, told in Their Own Words. Eds. Toby Cole and Helen Krich Chinoy. New York: Crown, 1970. 363-370.
- Bates, Brian. The Way of the Actor, A Path to Knowledge & Power. Boston: Shambhala, 1987.
- Beahrs, John O. Unity and Multiplicity, Multilevel Consciousness of Self in Hypnosis, Psychiatric Disorder and Mental Health. New York: Brunner/Mazel, 1982.
- Bliss, Eugene L. Multiple Personality, Allied Disorders, and Hypnosis. New York: Oxford UP, 1986.
- Braude, Stephen E. First Person Plural, Multiple Personality and the Philosophy of Mind. Lanham, Maryland: Rowman & Littlefield, 1991, rev. 1995.
- Braun, B. G. "Issues in the Psychotherapy of Multiple Personality Disorder." Treatment of Multiple Personality Disorder. Ed. B. G. Braun. Washington, DC: American Psychiatric P., 1986. 1-28.
- Brown, Laura S. Subversive Dialogues, Theory in Feminist Therapy. New York: Basic Books. 1994.
- Burnham, John C. "The Fragmenting of the Soul." Split Minds/Split Brains, Historical and Current Perspectives. Ed. Jacques M. Quen. New York: New York UP, 1986. 63-83.
- Chase, Truddi. When Rabbit Howls, The Troops for Truddi Chase. Intro. Robert A. Phillips, Jr. New York: Jove, 1987.
- Confer, William N., and Ables, Billie S. Multiple Personality, Etiology, Diagnosis, and Treatment. New York: Human Sciences P., 1983.

- Coons, P. M. "The Differential Diagnosis of Multiple Personality: A Comprehensive Review." Psychiatric Clinics of North America. (1984) 7:53
- Crabtree, Adam. "Explanations of Dissociation in the First half of the Twentieth Century." Split Minds/Split Brains, Historical and Current Perspectives. Ed. Jacques M. Quen. New York: New York UP, 1986. 85-107.
- Decker, Hannah S. "The Lure of Nonmaterialism in Materialist Europe: Investigations of Dissociative Phenomena, 1880-1915." Split Minds/Split Brains, Historical and Current Perspectives. Ed. Jacques M. Quen. New York: New York UP, 1986. 31-62.
- Descartes, Rene. Descartes, Selected Philosophical Writings. Trans. John Cottingham, Robert Stoothoof, and Dugald Murdoch. Cambridge: Cambridge UP, 1989.
- Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III and DSM-III R). Washington, D.C.: American Psychiatric Association, 1980.
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Washington, D.C.: American Psychiatric Association, 1994.
- Diderot, Denis. "The Paradox of Acting (1713-1784)." Actors On Acting: The Theories, Techniques, and Practices of the World's Great Actors, told in Their Own Words. Eds. Toby Cole and Helen Krich Chinoy. New York: Crown. 1970. 161-170.
- DSM-IV Casebook, A Learning Companion to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, D.C.: American Psychiatric Association, 1994.
- Flanagan, Owen. "Multiple Identity, Character Transformation, and Self-Reclamation." Philosophical Psychopathology. Eds. George Graham and G. Lynn Stephens. Cambridge, Massachusetts: MIT Press, 1994.
- Frischholz, Edward J. "The Relationship Among Dissociation, Hypnosis, and Child Abuse in the Development of Multiple Personality Disorder." Childhood Antecedents of Multiple Personality. Ed. Richard P. Kluft. Washington, D.C.: American Psychiatric P., 1985. 99-126.
- Graham, George and G. Lynn Stephens, Eds. Philosophical Psychopathology. Cambridge, Massachusetts: MIT Press, 1994.
- Hacking, Ian. Rewriting the Soul, Multiple Personality and the Sciences of Memory. Princeton, New Jersey: Princeton UP, 1995.

- Hart, Bernard. "The Conception of Dissociation." British Journal of Medical Psychology 6. 1926.
- Humphrey, Nicholas; Dennett, Daniel C. "Speaking For Ourselves: An Assessment of Multiple Personality Disorder." Raritan: A Quarterly Review, IX, Summer, (1989): 68-98.
- James, William. The Principles of Psychology. 2 vols. New York: Dover, 1890, 1918, 1950.
- Janet, Pierre. "A Symposium on the Subconscious." Journal of Abnormal Psychology 2. 1907.
- Leder, Drew. The Absent Body. Chicago: University of Chicago P., 1990.
- Mead, George Herbert. Selected Writings. Ed. Andrew J. Reck. Chicago: University of Chicago Press, 1964.
- McHugh, Paul R. Journal of the American Academy of Child and Adolescent Psychiatry, 34.7 July (1995): 957-63.
- The Original Roget's Thesaurus of English Words and Phrases (Americanized Version). Licensed Longman Group UK Ltd., 1994.
- Philosophical Psychopathology. Eds. George Graham and G. Lynn Stephens. Cambridge, Massachusetts: MIT Press, 1994.
- Prince, Morton. The Dissociation of a Personality, A Biographical Study in Abnormal Psychology. New York: Longmans, Green, and Co., 1910.
- Putnam, Frank W. Diagnosis and Treatment of Multiple Personality Disorder. New York: Guilford Press. 1989.
- - -. "Dissociation as a Response to Extreme Trauma." Childhood Antecedents of Multiple Personality. Ed. Richard P. Kluft. Washington, D.C.: American Psychiatric P., 1985. 65-97.
- - -. "The Scientific Investigation of Multiple Personality Disorder." Split Minds/Split Brains, Historical and Current Perspectives. Ed. Jacques M. Quen. New York: New York UP, 1986.

- - -, "Debate Forum: Negative: Frank W. Putnam, M.D.". Journal of the American Academy of Child and Adolescent Psychiatry. 34: 7, July (1995): 957-963.
- Ross, Colin. Multiple Personality Disorder, Diagnosis, Clinical Features, and Treatment. New York: John Wiley & Sons, 1989.
- Siegelman, Ellen Y. Metaphor and Meaning in Psychotherapy. New York: Guilford P., 1990.
- Webster's New Twentieth Century Unabridged Dictionary, Second Edition, 1983.
- Wilkes, Kathleen V. Real People, Personal Identity without Thought Experiments. Oxford: Clarendon P., 1993.