Multiple Personality Disorder: Scientific and Medicolegal Issues

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Despite the intense study it has received since its inclusion in *DSM-III*, multiple personality disorder (MPD) largely remains an unvalidated construct. Definitional problems remain (there is not even agreement in the field as to whether a diagnosis of MPD truly means the existence of more than one personality), while the vagueness and liberality of existing criteria give the clinician little guidance in diagnosis. In forensic settings, diagnosis of MPD is even more problematic, since there is substantial evidence that the disorder cannot currently be phenomenologically distinguished from malingering. It also remains to be demonstrated that evaluators can determine whether alter personalities, if they exist, are truly unaware of each other, lack control over other alters' behavior, or are unable to know right from wrong.

Perhaps no other psychiatric construct has attracted as much attention in recent years as multiple personality disorder (MPD), both within psychiatry and in the lay press. Since MPD gained inclusion in the *DSM-III*[1] in 1980, a veritable epidemic of MPD has followed[2]—at least in the U.S., though the diagnosis is less popular elsewhere:

> In the UK, we react to any suggestion by patients or relatives that there are two or more personalities by immediately saying that there are two or more aspects to one personality, and asserting that the individual must take responsibility for both of these aspects. It works.[3]

Even within the U.S., however, on a variety of grounds many doubt the validity of the diagnosis; as a result, its employment in legal settings, criminal actions in particular, is especially precarious. In this article, we shall first discuss the nosological status and phenomenology of the syndrome of multiple personality and the current status of efforts aimed at its validation. Next, we will examine clinical ability to distinguish MPD from malingering. Finally, the potential impact of MPD on the issues of competency to stand trial, criminal responsibility, and diminished capacity will be reviewed.

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Nosology and Phenomonology of MPD

The unclear nosological status of MPD is well illustrated by the diagnostic standards set forth in *DSM-III-R*.[4] There are only two diagnostic criteria: first, that "two or more distinct personalities or personality states" exist within the person, and second, that "at least two of these personalities or personality states recurrently take full control of the person's behavior." Personality—a notoriously difficult concept to define—is there defined as ". . .a relatively enduring pattern of perceiving, relating to, and thinking about the environment and one's self that is exhibited in a wide range of important social and personal contexts."* Personality states, explicitly differentiated from personality in the diagnostic criteria, are said to differ from personality ". . .only in that the pattern is not exhibited in as wide a range of contexts. . .."[4] The clinician is given no guidance as to how significant the change must be to qualify as a personality or personality state, how distinctive the behavioral pattern must be, or how wide a "range of contexts" is necessary to qualify.

Furthermore, there are no exclusion criteria, so it is conceptually possible for MPD and any other psychiatric disorder to coexist. Indeed, according to *DSM-III-R*, "Frequently, one or more of the personalities exhibits symptoms suggesting a coexisting mental disorder. . .It is often unclear whether these represent coexisting disorders or merely associated features of multiple personality disorder."[4] It seems possible, in other words, for one personality to show evidence of mental illness, while others may not—except for the fact of their existence. How this observation may be reconciled with biological theories of the etiology of mental disorders is not clear, nor, if one or several other disorders coexist with MPD, is the issue of which disorder should be considered primary.

What is considered to be specific evidence of multiplicity has changed substantially between the publication of *DSM-III*[1] and *DSM-III-R*.[4] When MPD was proposed in *DSM-III*, it was thought that "usually the original personality has no knowledge or awareness of the existence of any of the other personalities"; now it is believed that "often other personalities are aware of some or all of the others to varying degrees." Moreover, while differing personalities "may be quite discrepant in attitude, behavior, and self-image. . .they may also differ only in alternating approaches to a major problem area."[4]

Further changes may occur with the publication of *DSM-IV*. According to the *DSM-IV Options Book*,[6] it may not be required that alters take "full" control of the person's behavior. It has also been suggested that "Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness" be added to the diagnostic

* Ross[5] goes so far as to explicitly deny the existence of truly multiplex personalities, considering "personality" in this context to be simply "a convenient, historically sanctioned label for the dissociated states characteristic of the disorder. Alter personalities are dissociated components of a single personality. . .The patient's mind is no more host to numerous distinct personalities, than his or her body is to different people."

criteria, and that the diagnosis be excluded if the disturbance is found to be due to a substance-induced disorder such as alcoholic blackouts or intoxication.

With such a range in the diagnostic threshold for MPD, it is not surprising that the literature is replete with references to the various forms MPD can take and to the difficulty of making the diagnosis. Kluft[7] has asserted that only 20 percent of MPD patients spend a majority of their lives in "an overtly MPD adaptation," believing that another 40 percent may present with signs suggestive of MPD to the alert clinician, but that the remaining 40 percent "...are usually found only if efforts are made to explore for MPD even in a patient who offers no strong suggestive signs...." In Kluft's view, the subtlety and complexity of the syndrome is such that many cases may be diagnosable only intermittently.

Efforts Toward Validation

As a means of validating psychiatric disorders, Robins and Guze[8] proposed a five-step process consisting of clinical description of the syndrome, delineation from other psychiatric disorders, family studies, follow-up studies to ascertain stability of diagnosis over time, and laboratory studies to define the unique characteristics of the syndrome. Using this process, how well validated is MPD as a clinical syndrome?

The first step, clinical description of the syndrome, has been carried out by a number of researchers.[7, 9, 10, 11] Indeed, one might say that such descriptions have uncovered an embarassment of riches. Symptoms other than dissociative phenomena said to be associated with MPD are extraordinarily nonspecific, ranging from features of anxiety, depressed or labile mood, and conversion symptoms to thought disorder, amnesia, auditory and visual hallucinations, and other psychotic phenomena.[7, 9, 12, 13]

Unsurprisingly, therefore, comorbid conditions are very frequently diagnosed in MPD subjects, so much so that Robins and Guze's second step, delineation from other psychiatric illnesses, cannot be said to have been accomplished. Coons *et al.*,[12] for example, reported that 84 percent of their subjects qualified for at least one personality disorder diagnosis. In particular, it has been estimated that 20 to 45 percent of MPD cases may also be diagnosed as antisocial personality disorder.[2, 14–18] Similarly, one large series reported that 91 percent of 102 MPD subjects had a concurrent diagnosis of major depression and 64 percent had borderline personality disorder.[19]

The relationship of MPD to somatization disorder (SD) appears to be particularly close. Coons[10] reported an 80 percent rate of Briquet's syndrome in a small series of MPD subjects, similar to findings by Bliss.[20] Ross *et al.*[19] found that their MPD subjects on average reported 15.2 somatic symptoms; overall, 61 percent met criteria for SD. Another finding consistent with SD is the high rate (68–90%) of a sexual or other abuse history among MPD subjects, comparable to the rate of 55 percent of women with SD who report "sexual mo-

lestation."[21] Finally, as in SD, the vast majority of patients diagnosed with MPD are female, typically in a ratio of about 9:1.[9, 11]

Thus, coexisting psychiatric illness is the rule rather than the exception in MPD as currently defined. The remaining steps toward validation recommended by Robins and Guze[8] (family studies, laboratory findings, and follow-up studies) remain undone, as well. We are aware of no adequate family studies of MPD nor of studies addressing stability of diagnosis that support its distinctness. Neurophysiologic and other laboratory studies as well have not consistently confirmed specific changes associated with emergence of alternate personalities.[13, 14, 22–25] Of course, this latter criticism may be leveled at many other psychiatric disorders as well.[25] Nonetheless, as a distinct entity, MPD largely remains an unvalidated construct, and its very substantial overlap with other disorders has led to the suggestion that MPD might better be considered a nonspecific psychiatric symptom rather than a distinct disorder.[26]

The task of validating MPD has been further hampered by difficulties in reliably diagnosing it. In addition to problems posed by overlap with other psychiatric disorders, some lack of interrater reliability perhaps stems from clinicians overlooking (or refusing to consider) the diagnosis; as noted by Dell,[27] "that which is unsought is certainly not likely to be found." But falsely believing the disorder to be present occurs as well,[28] and claims of researchers who find high rates of the disorder are vitiated when lengthy lists of questions designed to elicit symptoms are used without revealing how many positive responses are needed to meet diagnostic thresholds.[29] Asking more questions may increase the likelihood of turning up cases, but will also increase the number of "false positives." One must be sympathetic to the problem of interrater reliability, given that ideological differences on either side might affect rates of agreement; nonetheless, the lack of a diagnostic "gold standard" and the liberality of current diagnostic criteria produce a situation that is unsatisfactory from the standpoint of both research and clinical practice.

One means of improving and standardizing diagnosis has been to use rating scales and structured interviews. The first is exemplified by the Dissociative Experiences Scale (DES), a 28-item self-report inventory that has been reported to have good test-retest reliability and to differentiate between normal controls and subjects diagnosed with MPD, alcoholism, schizophrenia, post-traumatic stress disorder, phobia-anxiety, or agoraphobia.[30, 31]

The second is the Dissociative Disorders Interview Schedule (DDIS), a 131-item structured interview that is reportedly able to diagnose somatization disorder, borderline personality disorder, and major depression in addition to dissociative disorders.[32, 33] The authors of the DDIS report very high sensitivity and essentially 100 percent specificity of diagnosis when tested on subjects with eating disorders, panic disorder, schizophrenia, or MPD. However, while these

instruments are promising, further research is needed before they can be considered validated. In particular, information regarding interrater reliability (including correction for chance agreement), thresholds for diagnosis, and especially data on performance of the instruments with more challenging mixes of diagnoses, particularly cases of somatization disorder and borderline personality disorder, remains to be presented.

Basic reservations persist despite these efforts. As noted above, the meaning of "personality" in the context of MPD has yet to be settled. It is difficult to know how to test or prove an assertion that an individual has more than one personality, or how to clinically distinguish between personalities and personality states when there is no general agreement about what any of these terms mean in practice. If disagreement between clinicians is to be avoided, we can only observe behaviors (including speech production), and from such observation form conjectures about underlying processes. If, as Kluft[7] suggests, "the irreducible core of MPD is a persistent form of intrapsychic structure rather than overt behavioral manifestations," we are left with a syndrome that clinicians ultimately diagnose based on their beliefs about an underlying "intrapsychic structure" rather than observable, overt phenomena—an approach that historically has hardly lent itself either to rigorous investigation or high rates of agreement between clinicians. One must wonder to what degree this approach has led to the problems of reliability of diagnosis noted above.

Even if it is ultimately shown that the construct of "multiple personalities" is literally correct, we are left with a number of troubling social and legal conundrums. As Halleck[34] points out, ". . To the extent that we accept the separateness or autonomy of differing personalities, we cease to describe a morally or legally recognizable person. . .We would also be dealing with a potentially dangerous entity, which (or who) has limited capacity to control undesirable conduct." Moreover, it has been pointed out that truly distinct personalities might merit separate legal representation. While perhaps logical, from the viewpoint of social policy such an approach would be disastrous: "One considers with amusement and distress the chaotic spectacle that would occur as a succession of attorneys, each presenting himself and his new client to the court, demands recognition."[35]

Perhaps the best solution to this problem is to follow the reasoning of Ross,[5] that "multiple personality" is no more than a historically sanctioned and convenient label for "embodiments of conflicted memories, feelings, thoughts, and drives." In his view, the disavowal of responsibility for one's actions seen in MPD is in fact a symptom of the disorder, while taking responsibility for all of one's behaviors is a goal of treatment. Many difficulties are thereby avoided, since it is accepted that there is only one persona involved, albeit one that may exhibit a great deal of memory impairment and denial of responsibility. While

it may merely be a matter of convenience, insofar as workers in the field refer to "the MPD patient," there appears to be a tacit acceptance of this view.

MPD and Malingering

MPD presents additional difficulties in forensic settings. To the degree that a diagnosis of MPD allows one to disown responsibility for socially disapproved or illegal behavior, there is tremendous incentive for dissociative symptoms to arise, especially in highly suggestible individuals. It has been suggested that intimation by the interviewer that MPD might exist may be enough to provoke appearance of its symptoms,[36, 37] while outright malingering of the syndrome has been repeatedly described.[38, 39]

Detection of malingering is a demanding task at best[40] and in the case of MPD the problems are further magnified. After reviewing over 200 clinical cases, Kluft[41] found numerous areas in which MPD patients demonstrated behaviors classically associated with malingering. While he did not on this basis believe that the two syndromes were identical, he concluded that "Reliable procedures for the differential diagnosis of MPD in the forensic context remain to be developed, and extrapolations from other bodies of knowledge or from theoretical assumptions are fragile vessels at best." Similarly, discussing the notorious Binachi case, Allison stated that ". . .it is extremely difficult—if not impossible—to be sure that a defendant who has not been in psychotherapy for the disorder really has the multiple personality syndrome, since we have no firm criteria against which to measure him."[42]

In addition, the clinical literature points out that MPD symptoms may be of an evanescent and subtle nature, so much so that in some cases years of intensive treatment by the same therapist may go by before the disorder is recognized.[43] Thus, it should not be surprising to find honest diagnostic disagreements between clinicians even in a treatment setting, which has an emphasis on supportive, nonjudgmental interaction. In the setting of a forensic evaluation, where no physician-patient relationship can be established, where less reliance can be placed in the truth (historical or narrative) of the subject's report, and where less time may be spent with the defendant, a great degree of diagnostic disagreement might well be expected, especially in cases where symptoms are less overt. If scientific and philosophical differences about MPD exist between evaluators, such disagreement can only become more pronounced. Since no scientific grounds or well-validated clinical indicators currently exist on which one can make the distinction between MPD and deception, the evaluator is left to rely solely on clinical judgment, without any possibility of external validation. Clinical assessment of malingering is a challenging enterprise whatever the diagnosis, but in the case of MPD, these factors combine to make such a determination even more debatable.

One potential solution to this dilemma, as with clinical determination of malingering in the case of other disor-

ders, might be to more carefully evaluate accounts of the defendant's behavior substantially before the occurrence of the unlawful act in question. But while potentially useful, once again, such an approach may lead only to differences in psychiatric opinion as to what sorts of behaviors might be considered sufficient evidence of the presence of MPD (or malingering), while the absence of such historical evidence would not necessarily disprove the existence of the condition.

A related problem is that, even if multiple personality could be demonstrated, there is no source of information other than the defendant himself as to the degree of communication between alters or the degree of control over alters by the primary personality. Determination of responsibility in a setting where there is great motivation to deny responsibility, dealing with a disorder that is known for just such denial, and where the defendant is the only source of information for the determination, would indeed be a hazardous exercise.

MPD and Criminal Issues

In criminal settings, psychiatric illness may potentially may affect determinations both of competency to stand trial and degree of criminal responsibility. To date, MPD has been proffered as a defense against charges as various as drunk driving, forgery, robbery, rape, and murder,[39, 44, 45] and recent legal decisions have been extensively reviewed by Perr[44] and Lewis and Bard.[46] As attention continues to be focused on MPD, it seems inevitable that more defendants will raise it as a possible reason to delay trial or extenuate their responsibility.

Lewis and Bard[46] have suggested four ways in which it might negate either responsibility or competency: (1) that by virtue of being amnestic for the actions of secondary personalities, the defendant cannot assist in his/her defense; (2) that the defendant, having no control over alter personalities, cannot be held responsible for their actions; (3) that while an alter personality controlled the defendant's behavior, the defendant was unconscious and that, like a sleepwalker, should not be held accountable for his/her actions; and (4) that MPD inherently negates ability to refrain from wrongful acts or to distinguish between right and wrong.

Of these arguments, only the first directly addresses competency to stand trial. If accepted, this reasoning would treat MPD-induced amnesia differently from other causes of amnesia such as alcoholic blackouts, since defendants amnestic for any other reason, barring the presence of other active mental disorder, are generally held to be able to assist in their defenses. The practical justification for this stance is readily apparent, since otherwise the advantage to the defendant of feigning amnesia is obvious.[47] A barrier to competence unique to MPD, of course, might be the appearance at trial of other personalities without memory for the court proceedings; one court at least has held that "this problem. . .can be overcome by having defendant's attorney explain to him what has occurred just prior to the personality change."[48]

Lewis and Bard's second and third arguments are more relevant to criminal responsibility than competency to stand trial. If Ross'[5] view is accepted, the defendant truly has only one persona; if so, who (other than the defendant) should be held accountable? In this case, the issue then reduces to amnesia for the act, which is not equivalent to nonresponsibility, for the reasons given above. Conversely, if alter personalities are accepted as distinct, it must be shown that an alter rather than the primary personality committed the act, or the issue of MPD becomes irrelevant for the purpose of assigning criminal responsibility. It does not need to be pointed out that ascertaining which personality was truly in control at the time of the crime would appear to be a daunting task for the same reasons as determination of malingering.

Moreover, there is no logical basis to conclude that MPD *per se* should affect ability to refrain from wrongful behavior. As Halleck[34] notes, the point of therapy for MPD is to promote fusion of the personalities, which means that the patient has the capacity, even if unexercised, to create this fusion. This argument is further strengthened by assertions that many patients can hide the existence of their MPD,[7, 41] implying as it does some degree of control over the alters. Growing numbers of reports attesting to variable degrees of shared memory and communication between alters would also support this view. Thus, at most only a subgroup of MPD defendants could reasonably be thought not to have control over their alters' behaviors; in such cases, judgments as to the alter's ability to refrain would be in theory no different from any other determination of ability to refrain from wrongful conduct, though more difficult as a practical matter.

Finally, Lewis and Bard's last argument, the assertion that MPD inherently negates ability to refrain or ability to know right from wrong, would if accepted make the disorder unique in forensic psychiatry. A more realistic approach, in keeping with any other determination of responsibility, would involve first establishing the existence of a mental illness and then investigating its impact, if any, on the behavior in question. In the case of MPD, assuming an alter could be shown to a reasonable degree of certainty to have been in control, the first task of the interviewer would be to determine whether or not that alter knew right from wrong or could refrain from wrongful behavior, just as would be done in any other evaluation.

If, based on the foregoing arguments, exculpation based on MPD is unlikely, could the disorder be used as the basis for a defense of diminished capacity? This defense rests on the negation by a mental illness of the mental state required for a particular crime. For the issue to be relevant to MPD at all, it requires, like the insanity defense, accepting alters as separate individuals for the purpose of determining accountability, and requires a determination of which alter was in control at the time of the crime. If that judgment can be made with a reasonable degree of medical certainty (given the difficulties noted

above), the way in which the disorder negated the specific mental state must be demonstrated in a manner identical to any other evaluation of diminished capacity.

Alternatively, if Ross'[5] view is accepted, it must still be demonstrated that the psychopathology referred to as MPD could negate a given mental state. But, as noted above, there is no logical reason to assume that the presence of MPD in and of itself is sufficient to do so; it must also be shown that the disorder precluded forming the culpable state of mind.

One area of concern related to both the insanity defense and the diminished capacity defense is that psychodynamic interpretations might be introduced into forensic settings as a way of "explaining" wrongful behavior. For example, given the extremely high rate of physical and/or sexual abuse in the childhoods of MPD subjects, plausible (but untestable) hypotheses might be offered as partial or complete extenuation of the defendant's behavior, e.g., that ". . .alternates frequently misconstrue situations and lash out whenever they perceive or misperceive that they or the child are threatened" or that their "primitive retaliatory violence reflects the thoughts, feelings, and attitudes of the immature mind that created them."[46] However, the purposes of psychodynamically oriented therapy and forensic evaluations are quite different, and without scientific evidence such as studies reporting how many children with similar childhoods grow up *without* committing such acts or otherwise rigorously establishing a causal link between the prior trauma and current wrongful behavior, use of such hypotheses in the courtroom reflects nothing more than a theoretical stance, which should not be related to the court as psychiatric fact.[49]

Summary

Over the last decade, clinical interest in and recognition of MPD has grown tremendously. While professional acceptance of MPD has been broad enough to merit its exclusion in *DSM-III*,[1] *DSM-III-R*,[4] and soon in *DSM-IV*, it has yet to be conclusively demonstrated that MPD is a distinct psychiatric disorder. Consideration of efforts along these lines illustrates the need to obtain agreement on a definition of multiple personality and to identify the core features of the syndrome and formulate objective, observable criteria by which to establish their presence. Further work is needed to delimit this syndrome from other distinct disorders—somatization disorder in particular—and to better validate the condition via family and follow-up studies.

The use of MPD in forensic settings is particularly perilous. The little knowledge that exists on the subject suggests a high degree of phenomenological overlap with malingering, with substantial evidence indicating that the distinction between MPD and malingering may be even more difficult to make than in other psychiatric illnesses—so much so that there is as yet little reason to believe that it can be done with an acceptable degree of accuracy.

Thus, the expert faced with medico-

legal questions about MPD is asked to base opinion about mental state on a most unsteady foundation. Diagnostic clues to the condition may be subtle and debatable, and evaluators may vary tremendously in their willingness to entertain the diagnosis both on philosophical grounds and on how much clinical substantiation they require. The effect of MPD on mental state is likewise problematic, and with no independent verification of clinical impression possible, such disagreements cannot be easily resolved. When so many critical scientific and clinical issues remain undecided, the forensic clinician must tread warily indeed.

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