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Diagnostic Evidence Admissibility and the Multiple Personality Disorder Defense

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DIAGNOSTIC EVIDENCE ADMISSIBILITY AND THE MULTIPLE PERSONALITY DISORDER DEFENSE

I. INTRODUCTION

> Archbishop Littmann felt a tap on his shoulder. Startled, he turned. He began to smile, then saw the knife. Confusion turned to fear as he attempted to shield himself from the slashes. Nineteen-year-old Jared, the Bishop's favorite altar boy, found himself huddled in a confessional. He was covered with blood and holding a knife. Panic-stricken, Jared didn't know what happened; he didn't know what happened because someone else killed the Bishop, not another person - but another personality.[1]

The growing recognition of psychiatric conditions resulting from childhood trauma[2] has become a significant mental health issue of the 1990s.[3] One such condition that has become significant in a legal context is Dissociative Identity Disorder (DID), better known as Multiple Personality Disorder. Over the last few decades, criminal defendants have increasingly raised insanity defenses based on DID in cases ranging from drunk driving to murder.[4]

Although insanity defenses based on mental illness are common, defenses based on DID are unique. Defendants in DID cases allege that more than one personality inhabits their body, and thus, they

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1. This illustrative scenario is an adaptation of the book *Primal Fear*, written by William Diehl. WILLIAM DIEHL, PRIMAL FEAR (1993).

2. "Psychological trauma" is an event that is outside the range of usual human experience and which is so seriously distressing as to overwhelm the mind's defenses and cause lasting emotional harm. THE SIDRAN FOUNDATION, PSYCTRAUMA GLOSSARY, 20 (1995) [hereinafter PSYCTRAUMA GLOSSARY].

3. *See* THE SIDRAN FOUNDATION, DISSOCIATIVE IDENTITY DISORDER (MULTIPLE PERSONALITY DISORDER) (1994).

4. *See* Sabra M. Owens, *Criminal Responsibility and Multiple Personality Defendants*, MENTAL & PHYSICAL DISABILITY L. REP. 133, 140-143 (1997) (calculating percentage of insanity pleas based on a comprehensive analysis of DID criminal cases). Insanity test application is particularly important in a DID context because 55% of DID defendants enter an insanity plea. *See id.* Criminal courts hearing DID cases have overwhelmingly agreed that a diagnosis of DID alone is insufficient to support a not guilty by reason of insanity (NGRI) plea. *See id.* at 134-35. Thus, without a corresponding lack of mens rea, a DID diagnosis is insufficient for exculpation. *See id.* While determining mens rea for most defendants is complex, in DID cases, it is particularly difficult. *See id; see also* Dorothy Otnow Lewis & Jennifer S. Bard, *Multiple Personality and Forensic Issues*, 14 PSYCHIATRIC CLINICS NORTH AM. No. 3, 741, 741 (1991). In civil cases, DID arises in a wide variety of situations such as parental termination, sexual assault, medical malpractice, and disability benefit application.

should not be held responsible for the actions of an alternate personality.[5] Essentially, DID defendants argue that their various personalities should be granted separate legal status. Because DID as a diagnosis and as a defense is controversial,[6] evaluating a defendant's criminal culpability is an exceptionally complex task.[7] As recently as 1993, the Supreme Court of Washington, in *State v. Wheaton*,[8] held a special evidentiary hearing to determine whether DID was sufficiently accepted in the psychiatric community so as to be legally admissible.[9]

Expert testimony is given to support or deny a diagnosis of DID, as well as to identify the disorder's effect on a person's behavior and state of mind.[10] A wide variety of diagnostic evidence is presented in DID cases. This evidence, often controversial, includes clinical interviews —structured and unstructured, as well as hypnotic and sodium amytal induced[11]— psychological test results, psychotherapy records and reports, physiological test results and observations, social service,

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5. For example, in *Ohio v. Grimsley*, Robin Grimsley was convicted of driving while under the influence of alcohol. 444 N.E.2d 1071, 1072 (Ohio Ct. App. 1982). She had been diagnosed with DID and claimed that she should not be held responsible for the offense because, at the time of the crime, she was dissociated from her primary personality and was in the state of consciousness of a secondary personality named Jennifer. *See id.* She contended that she was not acting consciously or voluntarily. *See id.* The court decided that Grimsley was culpable because it was immaterial what state of consciousness or personality she was in as long as the personality controlling her behavior was conscious and aware of her actions. *See id*; *see also* Felicia G. Rubenstein, *Committing Crimes While Experiencing a True Dissociative State: The Multiple Personality Defense and Appropriate Criminal Responsibility*, 38 WAYNE L. REV. 353, 355 (1992).

6. *See* H. Merskey, *The Manufacture of Personalities*, 160 BRIT. J. PSYCHIATRY 327, 328 (1992); *see generally* Jacqueline R. Kanovitz et al., *Witnesses with Multiple Personality Disorder*, 23 PEPP. L. REV. 387 (1996); Elyn Saks, *Multiple Personality Disorder and Criminal Culpability*, 25 U.C. DAVIS L. REV. 383 (1992).

7. In civil cases, DID has perplexed the legal system as well. At least one civil party has even claimed DID as an affirmative defense to adultery. *See* Rutherford v. Rutherford, 401 S.E.2d 177, 179 (S.C. Ct. App. 1990) (claiming that because the alternate personality committed adultery while the host was unaware, the host should not be held responsible).

8. 850 P.2d 507 (Wash. 1993).

9. *Id.* at 508. In 1993 the Diagnostic and Statistical Manual for Mental Disorders (DSM-III) still referred to DID as Multiple Personality Disorder. *See infra* note 17.

10. *See* David B. Savitz, *The Legal Defense of Persons with the Diagnosis of Multiple Personality Disorder*, 3 DISSOCIATION 195, 201 (1990) (explaining the primary testimonial responsibilities of mental health experts).

11. "Sodium amytal" is a barbiturate used extensively as a sedative and hypnotic. It is sometimes called truth serum because under its influence inhibitions may be lowered with the result that individuals discuss problems more freely. J. P. CHAPLIN, DICTIONARY OF PSYCHOLOGY 23 (1985). Sodium amytal is occasionally used in psychotherapy with trauma clients to access repressed or unconscious feelings and memories. PSYCTRAUMA GLOSSARY, *supra* note 2, at 18. An intravenous drip infused with sodium amytal, is usually done on an inpatient basis due to the slight risk of medical complications. *See id.*

medical and school records, family interviews, and to a lesser extent, polygraphy, artwork interpretation and writing analysis.[12]

Part II of this article defines DID and the other Dissociative Disorders,[13] and explains potential effects on behavior and mental state. Part III examines expert testimony and evidentiary admissibility standards. Part IV examines various types of forensic evidence presented in DID cases. Part V examines common areas of diagnostic controversy: malingering,[14] misdiagnosis and iatrogenesis.[15] And, part VI concludes that a wider variety of evidence should be admissible in DID cases because DID frequently results from severe and recurrent childhood abuse[16] and there is usually very little physical proof of that abuse. In addition, there should be a rebuttable presumption of insanity for every identified and confirmed criminal defendant with DID; resulting in acquittal and mandatory treatment until recovery occurs. This article focuses primarily on DID in the criminal context, however, there are examples and commentary of civil cases provided in the footnotes.

II. THE DISSOCIATIVE DISORDERS[17]

DID, originally called Multiple Personality Disorder, became an official psychiatric diagnosis in 1980 when it was included in the *Diag-*

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12. *See infra* notes 116-172 and accompanying text (for a further discussion of evidence used in DID cases).

13. The Dissociative Disorders are a group of psychiatric conditions characterized by disruption in consciousness, memory identity or perception. *See* THE SIDRAN FOUNDATION, *supra* note 3, at 8; *see also infra* note 17.

14. *See infra*, notes 176-88 and accompanying text (for further discussion of malingering); *see also* ROBERT L. BARKER, THE SOCIAL WORK DICTIONARY 222 (1995); AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS 477-91 (4th ed. 1996) [hereinafter DSM-IV].

15. However, there is no scientific research to support the idea that DID is an iatrogenic illness. *See* PSYCTRAUMA GLOSSARY, *supra* note 2, at 11 (for a definition of iatrogenesis); *see also infra* notes 209-20 and accompanying text (for a further discussion of iatrogenesis).

16. *See* JOAN A. TURKUS, AN OVERVIEW OF DIAGNOSIS AND TREATMENT (visited July 4, 1997) <http://www.voiceofwomen.com/centerarticle.html>.

17. The Dissociative Disorders include:

Dissociative Amnesia (formerly Psychogenic Amnesia) - the sudden inability to recall important personal information too extensive to be explained by ordinary forgetfulness.

Dissociative Fugue (formerly Psychogenic Fugue) - sudden unexpected travel away from one's home or place of work, with the assumption of a new identity and the inability to remember one's past.

Depersonalization Disorder - persistent or recurrent episodes of depersonalization (in which the usual sense of one's own reality is lost or changed) sufficiently severe to cause marked distress.

nostic and Statistical Manual for Mental Disorders (DSM-III).[18] The general public has become familiar with DID through biographies, fictional books, such as *Primal Fear*,[19] and movies[20] characterizing people with multiple personalities (multiples).[21]

DID generally begins in childhood and is caused by severe and repeated physical abuse, sexual abuse or both.[22] Additionally, many survivors have reported being ritually abused.[23] As many as 98-99% of

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Dissociative Identity Disorder (DID) - the existence of two or more distinct personalities, each of which is dominant at a given time. The dominant personality determines the individual's behavior. Each personality has a consistent pattern of perceiving the environment and self.

Dissociative Identity Disorder Not Otherwise Specified - the prominent feature is a dissociative symptom, but it does not meet the criteria for any specific Dissociative Disorder.

DSM-IV, *supra* note 14, at 477. Although DID is the most severe form of the five Dissociative Disorders, they all have overlapping symptoms. *See* Diane Swirsky & Valory Mitchell, *The Binge-Purge Cycle as a Means of Dissociation: Somatic Trauma and Somatic Defense in Sexual Abuse and Bulimia*, DISSOCIATION 18, 19 (1996); *see also* JAMES L. SPIRA, TREATING DISSOCIATIVE IDENTITY DISORDER at xvii (1996); Kirkland v. Georgia, 304 S.E.2d 561, 563 (Ga. Ct. App. 1983) (the defendant was diagnosed with Psychogenic (Dissociative) Fugue, which the court found indistinguishable from DID for culpability purposes). Though a person with Dissociative Fugue experiences personality differentiation on a more temporary or sporadic basis than DID, many of the experiences and perceptions are the same. *See* DSM-IV, *supra* note 14, at 481-83.

18. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS (3d. ed. 1987). The *Diagnostic and Statistical Manual for Mental Disorders* is the official manual used in the United States to classify and diagnose mental disorders. *See* CHAPLIN, *supra* note 11, at 127. DSM I was created after WWI to provide a framework for labeling post-war psychiatric casualties; DSM II was written after WWII for the same purpose; DSM III was the first version to officially recognize Multiple Personality Disorder (MPD); DSM IV changed the name MPD to DID and grouped it with four other Dissociative Disorders. *See* RALPH B. ALLISON, DUAL PERSONALITY, MULTIPLE PERSONALITY, DISSOCIATIVE IDENTITY DISORDER - WHAT'S IN A NAME? (visited September 6, 1997) <http://www.dissociation.com/index/definition>; *see also* DSM-IV, *supra* note 14, at 477-91.

19. DIEHL, *supra* note 1. In the book and movie *Primal Fear*, an altar boy, later diagnosed with DID, repeatedly stabs and mutilates a Catholic Bishop. His development of DID occurred because the Bishop forced him and other teenagers to engage in sexual acts for the Bishop's voyeuristic gratification. Ultimately, however, *Primal Fear* portrays a case of malingering as opposed to genuine DID. *See also infra* notes 176-88 and accompanying text (for further discussion of malingering).

20. *See* Merskey, *supra* note 6, at 327-28, 335.

21. Multiples is a term commonly used by clinicians and individuals diagnosed with DID.

22. *See* SANDRA J. HOCKING, SOMEONE I KNOW HAS MULTIPLE PERSONALITIES 7 (1994).

23. Ritual abuse consists of physical, sexual and psychological abuse involving the use of rituals. *See* THE SIDRAN FOUNDATION, *supra* note 3, at 17. "Ritual," a system of rites or ceremonies, does not necessarily mean satanic. J.P. CHAPLIN, *supra* note 11, at 402; *see also* THE SIDRAN FOUNDATION, *supra* note 3, at 17. However, most survivors state that they were ritually abused as part of satanic worship for the purpose of indoctrinating them into satanic beliefs and practices. *See* THE SIDRAN FOUNDATION, *supra* note 3, at 17. Ritual abuse rarely consists of a single episode. *See id.* It usually involves repeated abuse over an ex-

people diagnosed with DID have histories of repetitive, overwhelming, and often life-threatening trauma first occurring before the age of nine.[24] In fact, DID is the psychiatric disorder most strongly associated with childhood sexual abuse.[25] Children who develop DID are highly hypnotizable.[26] Essentially, they unconsciously hypnotize themselves in order to escape unbearable trauma.[27]

> If a child is being hurt outside the home, he or she can turn towards parents for comfort and safety. Even if the child is not able to voice concern (because of age or out of fear of reprisal, confusion, or guilt), the comfort of the family can be a place of retreat from the pain. In addition, the child can count on parents to be vigilant of and protective from harmful events. When the family is not a place of comfort, however, either because of family difficulties or because the family is the source of the abuse, then the child may have no external resources to rely on. When a child's faith and trust in parental safety and protection and comfort are lacking, all that remains is to make sense of the world through what internal devices the child has developed from observing the world around him or her.[28]

Each person with DID has a unique and complex internal system.[29] The variety of personalities and the manner in which they interact characterize each person's system. Every system is composed of one host, who is in control most of the time, and at least one alternate personality.[30] The average DID system is composed of ten personalities, but some have hundreds.[31] For example, a young woman with DID might have six personalities including a 4-year-old girl, a 90-year-

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tended period of time. *See id.* At the present time there is tremendous controversy about the objective reality of ritual abuse. *See id.* While some clinicians, researchers, and police believe that ritual abuse occurs, others do not. *See id.* They believe that reports of ritual abuse are part of a mass hysteria fed by media accounts and talk show programs. *See id.*

24. *See* BARRY M. COHEN ET AL., MULTIPLE PERSONALITY DISORDER FROM THE INSIDE OUT at xx (1991).

25. *See* C.A. Ross et al., *Dissociation and Abuse Among Multiple Personality Patients, Prostitutes, and Exotic Dancers*, 41 HOSP. COMMUNITY PSYCHIATRY 328, 328 (1990).

26. *See* ALLISON, *supra* note 18.

27. *See id.*

28. SPIRA, *supra* note 17, at xxvii.

29. A DID system is composed of all of the aspects or parts of the mind. *See* THE SIDRAN FOUNDATION, *supra* note 3, at 19. This includes personality states, memories, feelings, ego states, and entities. *See id.*

30. *See* Kanovitz et al., *supra* note 6, at 387; *see also* SPIRA, *supra* note 17, at xx.

31. *See* Merskey, *supra* note 6, at 328.

old man, a secretive intellectual, a promiscuous young lady, a studious introvert, and an impulsive, teenage girl.[32]

The initial separation of personalities (splitting)[33] is induced by a traumatic event.[34] Subsequently, a person with DID finds identity creation easier and new identities might be added to cope with various types of trauma.[35] Each alternate personality performs a defined set of psychological tasks.[36] The alters created and the tasks they are assigned are unique to each personality system.[37] For example, a sexually abused child might find it necessary to create several identities to cope with the psychological effects of his or her abuse.[38] One identity might be needed to house the terrifying memories, another to protect bodily integrity, a third to discharge rage, a fourth to contain sexual urges, a fifth to inflict self-punishment, and a sixth to be anesthetic to pain.[39]

Contrary to popular stereotypes, personality changes may be subtle, such as an abrupt change of mood.[40] For example, a person may be happy and enthusiastic one moment, then for no apparent reason, suddenly become withdrawn or hostile.[41] In other cases, personality changes are more dramatic.[42] For example, Annette and Ann are two personalities residing in a 22-year-old female.[43] Annette is right-handed while Ann is left-handed.[44] The sound of their voices and their pronunciation of words are very different.[45] Annette wears her clothing conservatively, whereas Ann loosens the same clothes to cre-

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32. *See* George E. Atwood, *The Impact of Sybil on a Patient with Multiple Personality*, 38 AM. J. PSYCHOANALYSIS 277, 277 (1978).

33. Splitting is a defensive process in which the individual represses, dissociates, or disconnects important feelings that have become dangerous to his or her psychic well-being. BARKER, *supra* note 14, at 363.

34. *See* COHEN ET AL., *supra* note 24, at 228.

35. *See* Kanovitz et al., *supra* note 6, at 406 (citing CORNELIA B. WILBUR, THE EFFECT OF CHILD ABUSE ON THE PSYCHE IN CHILDHOOD ANTECEDENTS OF MULTIPLE PERSONALITY DISORDER 21 (1985)).

36. *See* Kanovitz et al., *supra* note 6, at 406.

37. *See id.*

38. *See id.* at 407.

39. *See id.*

40. The personality observation is based on the author's personal experience working with DID patients at the Sheppard and Enoch Pratt Hospital in Towson, Maryland.

41. *See id.*

42. *See* M.T. Orne et al., *On the Differential Diagnosis of Multiple Personality in the Forensic Context*, 32 INT'L. J. CLINICAL & EXPERIMENTAL HYPNOSIS 118, 120 (1984).

43. *See* Allen Battle, *Rorschach Evaluations of Two Personalities in a Patient*, 30 BRIT. J. PROJECTIVE PSYCHOL. PERSONALITY STUDY 11, 12 (1985).

44. *See id.*

45. *See id.*

ate a seductive look.[46] Annette is very reserved whereas Ann is boisterous.[47] Annette wears her hair flat and tied in a bun whereas Ann wears hers loose and curly.[48]

Alternate personalities exist to keep stressful memories and emotions out of the host's awareness.[49] An identity switch[50] frequently occurs when the host experiences fear, anger, or sexuality.[51] When the host feels overwhelmed, the appropriate alternate automatically emerges.[52]

Children employ dissociative behavior[53] to effectively defend themselves against an adult aggressor.[54] However, in adulthood, personality fragmentation often results in reduced behavioral control leading to conflict with society or the criminal justice system.[55] For instance, multiples frequently have personalities which attempt to make life difficult for the host personality —these personalities are known as destructive alters.[56] DID crosses gender and socioeconomic boundaries, though many multiples in treatment are well-educated

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46. *See id.*

47. *See* Battle, *supra* note 43, at 12.

48. *See id.*

49. *See* Mark E. Hindley, *United States v. Denny-Shaffer and Multiple Personality Disorder: Who Stole the Cookie from the Cookie Jar?*, 1994 UTAH L. REV. 961, 964 (1994).

50. "Identity switching" is the process of changing from one personality to another. COHEN ET AL., *supra* note 24, at 227-28. Switching may be stimulated by an internal perception of the need for a particular alter or by an external, environmental trigger. *See id.* Individuals with DID have varying degrees of control over the process, gaining more control as treatment progresses. *See id.* Switches may be accompanied by physiological changes (such as posture, facial expressions, and voice or speech patterns) and by psychological changes (such as mood, behavioral age, and level of intelligence). *See id.* There are three signals that indicate a possible switch: physical manifestations, changes in demeanor and carriage, and amnesia. *See* Kanovitz et al., *supra* note 6. Common physical manifestations include eyelid flutters, eyeball rolls, rapid blinking, twitching, startle responses, shudders, and facial grimaces. *See id.* In addition, switches are often accompanied by subtle changes in carriage and demeanor, such as a transition from responsible to guarded or from age-appropriate to infantile. *See id.*

51. *See* COHEN ET AL., *supra* note 24, at 227-28; *see also* HOCKING, *supra* note 22, at 26-27.

52. *See* COHEN ET AL., *supra* note 24, at 227-28.

53. Dissociation is a complex process of changes in a person's consciousness that causes a disturbance or alteration in the normally integrative functions of identity, memory, thoughts, feelings, and experiences. *See* COHEN ET AL., *supra* note 24, at 226. Dissociative processes exist on a continuum. *See id.* At one end are mild dissociative experiences common to most people (such as day dreaming) to the other extreme of severe, chronic dissociation (such as in DID and the other Dissociative Disorders) which may result in an inability to function. *See id.* Dissociation is normal in children and may be the only effective defense available to them against extreme anxiety caused by highly traumatic situations and acute physical and emotional pain (most commonly sexual abuse). *See id.*

54. *See generally* Kanovitz et al., *supra* note 6 (discussing advantages of dissociation for children); *see also* SPIRA, *supra* note 17, at xviii.

55. *See* SPIRA, *supra* note 17, at xvii (citing JAMES P. BLOCH, ASSESSMENT AND TREATMENT OF MULTIPLE PERSONALITY DISORDER AND DISSOCIATIVE DISORDERS 8-9 (1991)).

56. *See* Kanovitz et al., *supra* note 6, at 424-25.

Caucasian women.[57] Defendants with Dissociative Disorders frequently behave like their mentally healthy counterparts.[58] Many are high-achievers, hold responsible jobs, and function well socially until they begin to recover traumatic memories.[59]

Integration therapy is frequently used to treat a DID patient's various personalities.[60] Individual psychotherapy facilitated by hypnosis is the most common method of treatment.[61] The average DID patient engages in therapy twice a week and takes an antidepressant or anti-anxiety medication as an adjunctive treatment.[62] Approximately 75% of DID patients treated in this manner experience favorable outcomes.[63] Treatments that fail to address the uniqueness of the disorder are unsuccessful.[64] Unfortunately, mental health care received in prison is frequently unsatisfactory because specialized care oriented towards treatment of DID is virtually non-existent.[65] Because DID is treatable,[66] a rehabilitation focus as opposed to a retribution focus, would ultimately be more beneficial.

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57. *See* Savitz, *supra* note 10, at 200; *see also* Rubenstein, *supra* note 5, at 357. Interestingly, most multiples in treatment are females, but most multiples accused of criminal conduct are males. *See* RALPH B. ALLISON, MULTIPLE PERSONALITY AND CRIMINAL BEHAVIOR (visited September 6, 1997) <http://www.dissociation.com/index/published/MPD&CR.TXT>. Dr. Ralph Allison, a forensic psychiatrist who has worked extensively with DID patients, found that the majority of the multiples he diagnosed were women. *See id.* However, among those he evaluated in the criminal justice system, the proportion was almost reversed. *See id.*

58. Based on the author's observations while working with DID patients at the Sheppard and Enoch Pratt Hospital in Towson, Maryland.

59. *See* M. Laurita Fike, *Considerations and Techniques in the Treatment of Persons with Multiple Personality Disorder*, 44 AM. J. OCCUPATIONAL THERAPY 999, 1004 (1990); *see also* United States v. Denny-Shaffer, 2 F.3d 999, 1002 (10th Cir. 1993) (the defendant, convicted of kidnapping an infant, was a labor and delivery nurse); In re the Marriage of Joan C. Chatterton and William E. Zimkouski, 1996 Del. Fam. Ct. LEXIS 92 *1, *4 (both parties to a divorce were diagnosed with DID; the husband was a Lab Technician for DuPont Company and the wife was the Executive Director of a psychological and counseling services agency); Louisiana State Bar Association v. Stevenson, 356 So.2d 408, 409 (La. 1978) (the defendant was an attorney, ultimately convicted of credit card fraud and disbarred).

60. *See* Rubenstein, *supra* note 5, at 357; *see also* INTERNATIONAL SOCIETY FOR THE STUDY OF DISSOCIATION, GUIDELINES FOR TREATING DISSOCIATIVE IDENTITY DISORDER (MULTIPLE PERSONALITY DISORDER) IN ADULTS (visited September 6, 1997) <http://www.issd.org/isdguide.htm> [hereinafter ISSD GUIDELINES].

61. *See* Frank W. Putnam, & Richard J. Loewenstein, *Treatment of Multiple Personality Disorder: A Survey of Current Practices*, 150 AM. J. PSYCHIATRY 1048, 1048 (1993).

62. *See id.*

63. *See id.*

64. *See* Elyn R. Saks, *Does Multiple Personality Disorder Exist?*, 17 INT'L. J. L. & PSYCHIATRY 43, 55-56 (1994).

65. *See* T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 299 (1997).

66. *See* NORTH ET. AL., MULTIPLE PERSONALITIES, MULTIPLE DISORDERS 66 (1993).

III. EXPERT TESTIMONY AND EVIDENTIARY ADMISSIBILITY STANDARDS

In criminal cases, experts frequently testify about the defendant's state of mind at the time of the crime (retrospective capacity); the defendant's capacity to perform the various mental and behavioral tasks required in the various phases of the criminal justice process (contemporaneous and future capacity); and the defendant's capacity to deal with the various future environmental stressors without committing disruptive or harmful acts (prospective capacity).[67]

A defendant with DID raises difficult legal questions about how evidence relating to the disorder should be assessed in the courtroom.[68] Should a person with Dissociative Identity Disorder be considered one person or more? Which personality should be held responsible for the criminal act? Which will suffer the consequences? If one personality commits a crime about which another is unaware, how should mens rea be assessed? Similarly, how should responsibility be assessed when one personality is aware of another's criminal act, but is unable to intervene?

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67. *See* Seymour L. Halleck et al., *Psychiatric Diagnoses in the Legal Process*, 20 BULL. AM. ACAD. PSYCHIATRY & L. 483, 483 (1992). In civil cases, experts frequently testify about a person's capacity to work or parent, or to perform other necessary life skills. Expert testimony can establish the fitness of a person to maintain parental responsibilities. *See* In re the Welfare of B.R., 1996 Wash. App. LEXIS 739 at *7 (a mother with DID, whose parental rights were terminated, attempted to refute allegations of parental unfitness; an evaluating clinician testified that the mother had required respite care because of fear of self harm; that the mother found herself in a car many miles from home without knowing how she arrived; and the mother had overwhelming urges to run or commit suicide).

68. *See* State v. Wheaton, 850 P.2d 507 (Wash. 1993) (finding that the Multiple Personality Disorder (MPD) defense is new to the law and a thorough analysis of how medical opinions fit relevant legal concepts was necessary but currently unavailable); *see also* State v. Jones, 920 P.2d 225, 227 (Wash. Ct. App. 1996) (affirming the reasoning in *Wheaton* and reiterating that again the trial court simply did not provide enough information in the record about DID and its ramifications to make a determination about how to apply the insanity defense to this disorder). Six dissociative disorder cases have been overturned on appeal at least in part because of some confusion at the trial level about DID and associated legal ramifications. *See* United States v. Howard, 26 F.3d 134 (9th Cir. 1994) (vacated and remanded due to confusion over admissibility of MPD diagnosis); Parker v. State, 606 S.W.2d 746 (Ark. 1980) (reversed and remanded due to confusion over admissibility of sodium amytal interview); State v. Rodrigues, 679 P.2d 615 (Haw. 1984) (vacated and remanded due to confusion over whether or not the defendant's sanity was a question for the jury where he was diagnosed with MPD); Tanner v. State, 265 A.2d 573 (Md. Ct. Spec. App. 1970) (remanded due to confusion over whether the issue of defendant's sanity should have been submitted to the jury where he had been diagnosed with having a dissociated reaction); State v. Moore, 550 A.2d 117 (N.J. 1988) (reversed and remanded due to confusion over whether defendant, diagnosed with DID, committed homicide by her own conduct); Frederick v. State, 902 P.2d 1092 (Okla. Crim. App. 1995) (reversed and remanded due to confusion over defendant's right to a competent psychiatric exam where he had been diagnosed with possible MPD).

DID is almost as controversial a medical diagnosis as it is a defense.[69] Opponents either (1) do not believe that the disorder exists, (2) do not believe that the defendant has the disorder, or (3) do not believe that a defendant with the disorder should have reduced criminal responsibility.[70] Nonetheless, DID's inclusion in DSM-IV indicates general scientific acceptance.[71] Additionally, the majority of scientific literature accepts the existence of DID.[72] Many courts have recognized DID as an abuse excuse, and legal treatment has varied greatly.[73] Because DID is becoming increasingly common in legal contexts, the legal community should carefully consider evidentiary questions.

Determining whether a DID defendant committed the criminal act in question, can be resolved using traditional rules of evidence and burden allocation. The second task, determining whether a DID defendant who committed a crime is criminally culpable, is more complex. Diagnosing DID is only the first step toward evaluating culpability. A more in depth assessment might involve: (1) identifying the personality or personalities involved in the criminal activity (2) assessing each personality's ability to exert control over the defendant's overall behavior and (3) evaluating each personality's capacity to appreciate the wrongfulness of the conduct at issue. Courts are con-

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69. *See generally* Eugene L. Bliss, *Professional Skepticism about Multiple Personality*, 176 J. NERVOUS & MENTAL DISEASE 533-34 (1988); *see also* Phillip M. Coons, *Confirmation of Childhood Abuse in Child and Adolescent Cases of Multiple Personality Disorder and Dissociative Disorder Not Otherwise Specified*, 182 J. NERVOUS & MENTAL DISEASE 461, 461 (1994).

70. *See* Ralph B. Allison, *The Multiple Personality Defendant in Court*, 3 AM. J. FORENSIC PSYCHIATRY 181, 182 (1983). Perhaps partially as a result of skepticism about the disorder, acquittals are rare. *See* Merskey, *supra* note 6, at 336. There is only one on record. *See id.* In 1978, Billy Milligan, the campus rapist, was acquitted on charges of rape based on his claim of DID (MPD). *See id.* Although Milligan was not incarcerated, he spent twelve years in various mental institutions before being released. *See* Nancy McVicar, *A Tale of a Man's Many Minds*, SUN-SENTINEL (Fort Lauderdale), February 16, 1995, at 1E. A second DID defendant, Rodrigo Rodrigues, initially received an acquittal based on his DID defense, but the ruling was reversed and he was convicted. *See Rodrigues*, 679 P.2d at 617. He was charged with first-degree rape and sodomy after he lured young girls into secluded areas and sexually assaulted them. *See id.* He was acquitted because he was diagnosed with DID. *See id.* at 620. Subsequently, the Hawaii Supreme Court held that an insanity defense based on DID did not per se require a finding of acquittal and that the lower court had erred in not allowing a jury to determine the defendant's sanity. *See id.* at 617. The court reasoned that, [w]hat psychiatrists may consider a mental disease or defect for medical purposes where clinical treatment is the main concern may not be the same as mental disease or defect for the jury's purpose where an accused's criminal responsibility is at issue. *See id.* at 620 (quoting State v. Nuetzal, 606 P.2d 920, 928 (Haw. 1980)).

71. *See* Saks, *supra* note 64, at 76; *see also supra* note 18 and accompanying text.

72. *See* Saks, *supra* note 64, at 77.

73. *See* AMERICAN BAR ASSOCIATION, *Can Psychiatrists Give Reliable Testimony in Criminal Trials?*, 83 ABA J. 77, 77 (1997).

cerned not only about a legitimate DID diagnosis, but with the functional limitations resulting from medical and psychological disorders.[74] Consequently, expert witnesses must testify whether a person has DID and, if so, what effect the disorder had on their psyche at the time of the criminal conduct.[75]

Obviously, evidence, no matter how convincing, is of little use if inadmissible. *Daubert*[76] and *Frye*[77] have set the standard for admissibility of scientific evidence in both criminal and civil cases. In 1993, the Supreme Court broadened the federal admissibility standard in *Daubert v. Merrell Dow Pharmaceuticals*[78] when it held that the Federal Rules of Evidence should be used for admitting scientific testimony in federal trials.[79] *Daubert* provides that, if scientific, technical, or other specialized knowledge will assist a trier of fact to understand the evidence or to determine a fact or issue, an expert may testify thereto in the form of an opinion or otherwise.[80] Under *Frye*, evidence had to be generally accepted in the scientific community before it was considered admissible.[81] General acceptance is still relevant to evidentiary decision making, but it is now just one of the four *Daubert* prongs.[82] The additional three are testing, peer review, and known rate of error.[83]

States use *Daubert*, *Frye*, or a hybrid of the two to determine admissibility. Because *Daubert* is not as restrictive as the former *Frye* standard, DID defendants may benefit from an increased range of admissible forensic evidence.[84] Although evidence still must be relevant and reliable, general scientific acceptance is not absolutely necessary. Some diagnostic methodologies, such as hypnotic and sodium amytal induced interviews, are still not generally accepted in the scientific community because they are controversial, and thus, may not be admissible, even in a *Daubert* jurisdiction.[85] In jurisdictions still following *Frye*, it may be much easier to argue that controversial DID evalua-

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74. *See generally* Halleck, *supra* note 67.

75. *See id.* at 490.

76. Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993).

77. Frye v. United States, 293 F. 1013 (1923).

78. 509 U.S. at 591; *see generally* Joseph T. Walsh, *The Evolving Standards of Admissibility of Scientific Evidence*, 36 JUDGES' J. 33, 33-36 (1997) (commenting on *Daubert's* effect on the judiciary).

79. *Daubert*, 509 U.S. at 589.

80. *Id.* at 588 (quoting FED. R. EVID. 702).

81. *Id.* at 586 (quoting *Frye*, 293 F. at 1014).

82. *Id.* at 594.

83. *See id.* at 593-94.

84. *See* Richard C. Reuben, *Completing the Admissibility Equation*, A.B.A. J. 44, 44 (1997).

85. *See supra* note 11 and accompanying text.

tion methods should not be admissible because they are not generally accepted in the scientific community.

IV. EVIDENTIARY BASES FOR DIAGNOSING DID

Some of the common types of evidence introduced to establish a defendant's diagnosis of DID create admissibility problems. Common types of evidence include (1) clinical interviews, (2) psychological testing, (3) psychotherapy, (4) physiological testing, (5) social service, medical and school records, (6) and family interviews. Polygraphy, artwork interpretation and writing analysis are less frequently used.

A. Clinical Interviews

Clinical interviews can consist of an informal dialogue or they can be highly structured. In either case, the person being evaluated is questioned about various occurrences including amnesia,[86] fugue states,[87] derealization,[88] depersonalization,[89] age regression,[90] and autohypnosis.[91] DID defendants are also asked about childhood trauma because Dissociative Disorders most frequently result from child abuse.[92]

A number of standardized diagnostic interview protocols exist for assessing dissociation.[93] The Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) was the first diagnostic instrument developed to comprehensively evaluate dissociative symptoms and dis-

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86. Amnesia is characterized by the inability to recall some or all past experience as a result of trauma or organic factors, or combinations of both. *See* BARKER, *supra* note 14, at 19.

87. A fugue state is a psychogenic condition in which individuals, usually after experiencing intolerable internal or external stress, develop amnesia and abandon their homes, jobs, or familiar environments. *Id.* at 143.

88. Derealization is a dissociative symptom in which one experiences the external world as strange or unreal. *Id.* at 97-98. Individuals may see others as being unfamiliar or robot-like and perceive alterations in the size or shape of viewed objects. *Id.*

89. Depersonalization is a feeling of being in an unreal situation or a sense that one's self or body is detached from the immediate environment. *Id.* at 97. This experience is often found in individuals who are subjected to inordinate stress or are in crisis. *Id.*

90. Behaviors and thought patterns that indicate a return to earlier or more-primitive levels of development characterize age regression. *Id.* at 319. This phenomenon is often seen in people who are exposed to severe stress, trauma, or unresolved conflicts. *Id.*

91. Autohypnosis is a spontaneous or purposeful hypnotic trance state produced by a person within his or her own psyche. THE INTERNATIONAL SOCIETY FOR THE STUDY OF DISSOCIATION, GUIDELINES FOR TREATING DISSOCIATIVE IDENTITY DISORDER IN ADULTS 11 (1994). These states may include any or all of the full range of hypnotic phenomena, such as sensory alterations, anesthesia, time distortion, relaxation, age regression, and alterations in physiological functioning. *See id.*; *see also* TURKUS, *supra* note 16, at 2.

92. *See* TURKUS, *supra* note 16, at 3.

93. *See generally* NORTH ET. AL., *supra* note 66, at 100-05.

orders.[94] The SCID-D allows a trained interviewer to assess the severity of five dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration.[95] The Dissociative Experiences Scale (DES) is the most commonly used instrument for assessing dissociative experiences.[96] It is a 28-item self-report inventory that can be completed in about ten minutes.[97] It asks the respondent to indicate the frequency with which certain dissociative experiences occur.[98] Another common test is the Dissociative Disorders Interview Schedule (DDIS); a 35-40 minute structured interview developed for both clinical and research purposes.[99]

Although controversial, diagnostic interviews can be induced by hypnosis or sodium amytal.[100] Hypnosis can aid in diagnosis through the identification and elicitation of alternate personalities.[101] It may also help a person to recall traumatic memories and facilitate communication between alternate personalities.[102] Frequently it is difficult to confirm the existence of a disorder as complex as DID in a single interview or short time frame.[103] Multiple interviews and repeated observations are often required. Hypnosis is particularly useful because it helps DID patients return to a state similar to the one in which they registered a particular memory, making recall easier.[104] Multiples lack conscious recall of their traumatic experiences because they were in a dissociative state when the memories were stored.[105] If evaluation time is restricted, some clinicians feel that hypnosis and sodium amytal are very useful, and sometimes even necessary in DID cases.[106]

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94. *See* PSYCTRAUMA GLOSSARY, *supra* note 2, at 19.

95. *See id.*

96. *See* Becky E. Katz & David H. Gleaves, *Dissociative Symptoms Among Patients With Eating Disorders: Associated Feature or Artifact of a Comorbid Dissociative Disorder?*, DISSOCIATION 28, 29 (1996).

97. *See* THE SIDRAN FOUNDATION, *supra* note 3, at 8.

98. *See id.*

99. *See id.*

100. *See* ISSD GUIDELINES, *supra* note 60.

101. *See* Fike, *supra* note 59, at 1000.

102. *See id.* Hypnosis is also widely used in DID therapy. *See id.*; *see also* Kanovitz et al., *supra* note 6, at 439.

103. *See* Fike, *supra* note 59, at 1002.

104. *See* Kanovitz et al., *supra* note 6, at 439.

105. *See id.*

106. *See* EUGENE L. BLISS, MULTIPLE PERSONALITY, ALLIED DISORDERS, AND HYPNOSIS 118 (1986).

> The very obvious cases, in which personalities are on parade, are uncommon, but more subtle examples are frequent. If one wishes to see bacteria, one needs a light microscope; if one wishes to see a virus, one needs an electron microscope; if one wishes to encounter subtle cases of multiple personalities, one needs to use hypnosis.

However, in some jurisdictions, hypnotic and sodium amytal interviews are inadmissible.[107] For example, in *Alley v. Tennessee*, the defendant's contention on appeal that the trial judge erred by refusing to allow the jury to view videotapes of his hypnotic and sodium amytal sessions was rejected.[108] One opposition to hypnosis and sodium amytal is that they may not be considered generally accepted in the scientific community.[109] For example, in *Khatain v. Jones*, Dr. Wayne Jones conducted a sodium amytal interview with a DID patient who disclosed that she had been sexually abused by her father as a child and that her mother was aware of the abuse.[110] Although Dr. Jones had conducted a sodium amytal interview with his patient and disclosed its results to her family, he stated in his testimony that sodium amytal interviews could not be relied upon.[111]

Another opposition to hypnosis and sodium amytal is the possibility that they can enhance a person's ability to be influenced.[112] In *United States v. Swanson*, the defense contention that a mail conspiracy and extortion scheme was a prank was undercut by a taped sodium amytal interview of a defendant diagnosed with a dissociated state.[113] It appeared on tape that the interviewing clinician may have suggested to the defendant that the crime was a prank.[114] Thus, the prosecution contended that the defendant had been unduly influenced.

In order to increase the probability that hypnotic evidence will be admissible, all forensic hypnotic sessions should be conducted in conformance with guidelines promulgated by the American Medical Association Council on Scientific Affairs which requires, among other practices, awareness of the possibility of interviewee deception, interviewer training in the forensic use of hypnosis, avoidance of suggestive questioning techniques, and videotaping.[115]

Id.

107. *See* Savitz, *supra* note 10, at 201.

108. 1997 Tenn. Crim. App. LEXIS 428 *1, *51.

109. *See* Marlene Steinberg et al., *Multiple Personality Disorder in Criminal Law*, 21 BULL. AM. ACAD. PSYCHIATRY & L. No. 3 at 345, 353 (1993).

110. 1993 WL 240049 *1, *1-2 (Tex. Crim. App.) (Dr. Jones held a family conference and informed the patient's husband and daughters about the abuse and disclosed the identities of the abusers; subsequently, the patient's parents sued the doctor for defamation and negligent infliction of emotional distress).

111. *See id.* at *3.

112. *See* Stanley Abrams, *The Multiple Personality: A Legal Defense*, 25 AM. J. CLINICAL HYPNOSIS 225, 225 (1983); *see also* ISSD GUIDELINES, *supra* note 60.

113. 572 F.2d 523, 526 (5th Cir. 1978).

114. *See id.*

115. *See* AMERICAN MEDICAL ASS'N COUNCIL ON SCIENTIFIC AFFAIRS, *Scientific Status of Refreshing Recollection by the Use of Hypnosis*, 253 J. AM. MED. ASS'N 1918, 1923 (1985).

B. Psychological Testing

The medical community uses various psychological tests to evaluate DID patients and their alternate personalities.[116] Psychological tests frequently used with multiples are the Wechsler Adult Intelligence Scale,[117] the Bender-Gestault,[118] the Rorschach[119] and the Minnesota Multiphasic Personality Inventory (MMPI).[120] The results of these standardized tests often differ as much for each defendant's personality, as they do for separate defendants.[121] For example, alternate personalities tend to respond differently when taking the Rorschach Test, particularly in their movement and color perception.[122] In one study, a patient's more passive personality described seeing persons sitting at a table, whereas a more aggressive personality saw something carrying or dragging them off.[123] The same patient's more passive

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116. *See* ORNE, *supra* note 42, at 120; *see also* Saks, *supra* note 64, at 57-61. In a civil context, psychological tests can be given to determine the extent of mental disability for employment disability benefit determination. *See* Mangold v. Chater, 1995 WL 580099 *1 (D. Kan) (Ted Mangold applied for disability benefits alleging a variety of disabilities, among which was a potential diagnosis of DID; he was given two psychiatric tests which showed that he suffered from severe depression and suicidal thoughts to the point of severely impairing his employment potential thus entitling him to disability benefits).

117. The Wechsler Adult Intelligence Scale (WAIS) is an individual general intelligence test which yields verbal and performance IQ's as well as a total IQ. *See* CHAPLIN, *supra* note 11, at 493. The test is also believed to have diagnostic significance for certain psychiatric problems. *See id.*

118. The Bender-Gestault is a test consisting of nine designs that the individual is asked to copy. *See id.* at 54. Analyses of the spatial errors are held to be significant for diagnosing psychological disorders. *See id.*

119. The Rorschach Test is a projective technique in which the subject is shown 10 plates or cards containing bisymetrical inkblots. *See id.* at 404. Five of the blots are in black and white with various shaded areas; 2 contain black, white, and colors in varying amounts; 3 are in various colors. *See id.* The cards are presented to the subject in a prescribed sequence and he is asked: what does it look like? What could this be? *See id.* Responses are categorized and evaluated according to such factors as the amount of movement seen, the content of the blot, color responses, shading, form, and originality or popularity. *See id.* Responses to color are indicative of the individual's impulsive and emotional life. *See id.* Form and location are important indices of the individual's overall apperception or approach to his world; movement is indicative of introversion; original responses are indicative of intelligence, although bizarre responses may be indicators of mental disturbance. *See id.* A number of ratios are also calculated and evaluated in scoring the Rorschach, and the final evaluation is a diagnostic of the personality as a whole. *See id.*; *see also* Fike, *supra* note 59, at 1002.

120. The MMPI is "a personality inventory containing over 500 statements with which the subject indicates agreement or disagreement." CHAPLIN, *supra* note 11, at 283-84. Patterns and responses are scored for the individual's tendencies toward various conditions such as schizophrenia, hysteria or depression. *See id.*

121. *See id.*

122. *See* Irwin M. Perr, *Crime and Multiple Personality Disorder*, 21 AM. ACAD. PSYCHIATRY & L. 70, 70 (1991).

123. *See id.*

personality saw forms such as flowers and leaves whereas the more aggressive personality saw blood and the inner organs of someone.[124]

In a 1990 study, DID patients demonstrated partial or alternating responses on IQ tests indicative of different cognitive levels.[125] For example, a DID subject initially received an IQ score of 115.[126] On the retest, her IQ rose to 129, a change that is outside normal retest parameters.[127] Similarly, in *New Jersey v. Moore*, the defendant, Marie Moore was accused of capital murder and diagnosed with DID.[128] An examining physician conducted intelligence quotient, personality and neuro-psychological tests on Ms. Moore's host personality, Marie, as well as on an alternate personality, Billy.[129] Marie's test results differed significantly from Billy's.[130] These test results and observations were partial bases for the examining physician's DID diagnosis of the defendant.[131]

C. *Psychotherapy*

A defendant may attempt to enter into evidence a preexisting diagnosis of DID or another Dissociative Disorder.[132] A pre-existing diagnosis prior to litigation may counter, for example, accusations of

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124. *See id.*

125. *See* Judith G. Armstrong, & Richard J. Lowenstein, *Characteristics of Patients with Multiple Personality and Dissociative Disorders on Psychological Testing*, 178 J. NERVOUS & MENTAL DISORDERS 448, 451 (1990).

126. *See id.*

127. *See id.*

128. 550 A.2d 117, 130 (N.J. 1988).

129. *See id.* at 140.

130. *See id.*

131. *See id.*

132. In civil cases, psychotherapy can play an important role in recovered memory cases. *See, e.g.*, Gregory G. Gordan, *Adult Survivors of Childhood Sexual Abuse and the Statute of Limitations: The Need for Consistent Application of the Delayed Discovery Rule*, 20 PEPP. L. REV. 1359, 1367 (1993) (discussing therapist awareness of patient repression in sexual abuse cases). When an adult victim attempts to bring a tort suit against a childhood abuser, the statute of limitations has often passed. *See* Jacqueline Kanovitz, *Hypnotic Memories and Civil Sexual Abuse Trials*, 45 VAND. L. REV. 1185, 1198 (1992). The treating therapist can testify about whether the patient has genuinely recovered repressed or dissociated memories. *See, e.g., id.* (commenting on psychotherapist awareness of patient's traumatic memory retrieval). The therapist's testimony is valuable in aiding the judiciary to determine whether to toll the statute of limitations. *See id.* Alternatively, the absence of such testimony can be damaging. *See* Johnson v. Johnson, 766 F. Supp. 662, 662-63 (N.D. Ill. 1991) (Deborah Johnson brought suit in the state of Illinois against her parents claiming that her father sexually abused her between 1955 and 1968 and that her mother was aware of the abuse but failed to protect her; the personal injury statute of limitations was two years, but Deborah claimed that she did not become aware of the abuse until beginning psychotherapy in 1987).

malingering.[133] Although all fifty states have enacted some form of the psychotherapist-patient privilege, the patient has the right to waive that privilege and allow the testimony.[134] For example, Robin Grimsley was arrested for driving under the influence of alcohol and claimed insanity based on a preexisting DID diagnosis.[135] To bolster her defense, she provided information about her five years in psychotherapy and her recent work on integrating[136] her personalities.[137] The Ohio Court of Appeals held that whether Robin —or "Jennifer," her alternate personality— was in control at the time, Ms. Grimsley was "conscious and her actions were a product of her own volition."[138]

Even if a person does not have a preexisting diagnosis of DID, they may have a history of other mental disorders. People with DID on the average spend almost seven years in the mental health system before they are correctly diagnosed.[139] Of course, the lack of a documented history of mental illness does not confirm a lack of mental illness. It may just signify that the person did not have the finances or desire to seek medical treatment.

D. Physiological Testing

Medical observations confirm dramatic differences in physical manifestations of alternate personalities.[140] Alternate personalities can require different eyeglass prescriptions, speak different languages, work with different hands, respond differently to physical tests such as electroencephalograms[141] and galvanic skin response tests,[142] and may respond differently to the same type of medication.[143] Some have headaches or allergies that are specific to only certain personalities.[144] Physical results can be convincing indicators.[145] Therefore, if

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133. *See infra* notes 176-88 and accompanying text (for further discussion of malingering).

134. *See* Jaffee v. Redmond, 116 S.Ct. 1923, 1924 (1996).

135. *See Grimsley*, 444 N.E.2d at 1073; *see also supra* note 5.

136. Integration is a unification or fusion of personalities that a person can maintain on a long-term or permanent basis. *See* COHEN ET AL., *supra* note 24, at 227.

137. *See Grimsley*, 444 N.E.2d at 1075.

138. *Id.*

139. *See* James A. Chu, *On the Misdiagnosis of Multiple Personality Disorder*, IV(4) DISSOCIATION 200, 200 (1991).

140. *See* United States v. Denny-Shaffer, 2 F.3d 999, 1008 (10th Cir. 1993) (citing Saks, *supra* note 6, at 44-45).

141. An "electroencephalogram" is a graphic record of the electrical currents developed by a sensitive galvanometer. J.P. CHAPLIN, *supra* note 11, at 150.

142. A "galvanic skin response" is a change in the electrical resistance of the skin as detected by a sensitive galvanometer. *Id.* at 189.

143. *See id.*

144. *See* NORTH ET. AL., *supra* note 66, at 59-60.

wide variations are found in physical test results, a DID diagnosis may be supported.[146]

E. Social Service, Medical, and Academic Records

Social service, medical, and academic records may provide documentation of abuse or dissociative behaviors[147] and may identify causative indicators.[148] The probability that a person who was abused as a child will develop a mental disorder is higher than for a person with a functional family background.[149] However, a documented history of abuse is not a *per se* indication that a person has DID, or any mental disorder for that matter.

F. Family Interviews

Interviews with family members, friends, and significant others can provide insight into behavior consistent with the existence of alternate personalities such as amnesiac episodes and dramatic behavioral changes.[150] Although bias may exist with familial testimony, such testimony is often used by the defense because, among other things, family members can provide information about their own psychiatric

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145. *See* Terry Jane Field, *The Polygraph Paradox: Florida's Conflicting Approaches Toward the Admissibility and Use of Polygraph Results*, 20 NOVA L. REV. 1369, 1386 (1996) (people who have been known to "beat the polygraph" may not necessarily "beat the electroencephalogram").

146. *See* Saks, *supra* note 64, at 57, 65-70. In civil cases, physical exams can be used to aid in determining whether a child has been subject to abuse and whether they suffer from a Dissociative Disorder. *See* McClelland v. McClelland, 595 N.E.2d 1131, 1133 (Ill. App. Ct. 1992) (after incomplete physical and psychological evaluations of a child involved in a custody battle, various doctors came to different conclusions about whether the child's father committed sexual abuse and whether the child had DID).

147. *See* Allison, *supra* note 70, at 189. Plaintiff, Raymond Andrews, diagnosed with "mixed personality disorder," Dysthymia, substance abuse, alcoholism, and Adjustment Disorder, applied for Supplemental Security Income Benefits based on his various conditions. Andrews v. Shalala, 53 F.3d 1035, 1037 (9th Cir. 1995). Andrews' medical records were reviewed to determine the effect of the conditions on his ability to work. *See id.* at 1038. The evaluators determined that although Andrew had various psychiatric diagnoses, he was no more than moderately limited in his ability to work and consequently, his request for benefits was denied. *See id.*

148. *See* New Jersey v. L.K., 582 A.2d 297, 298 (N.J. 1990) (a juvenile DID defendant's medical and psychiatric records were introduced as evidence because they contained information about severe physical and sexual abuse of the defendant by her father beginning when she was five years old); *see also* Arizona ex rel. Romley v. Arizona, 836 P.2d 445, 445 (Az. Ct. App. 1992) (defendant, charged with stabbing her husband, claimed self defense; she requested her husband's medical records be admitted into evidence to prove he suffered from DID and, at the time of the stabbing, was manifesting one of his violent personalities).

149. *See* NORTH ET AL., *supra* note 66, at 58-59.

150. *See* Savitz, *supra* note 10, at 200.

histories.[151] DID frequently results from dysfunctional family relationships.[152] If a parent or other caretaker has a history of mental illness, the existence of dysfunctional family relationships should be investigated. For example, in *State v. Adcock*, the defendant suffered from multiple personality disorder, and his father testified that the defendant suffered from depression and that the family had a history of mental illness.[153]

When there is no documentation of abuse, family members are often the only ones who can confirm or deny its occurrence. A disadvantage is that if the family member being interviewed was the abuser, it may be unlikely that they would subject themselves to criminal penalty and ostracism by acknowledging the abuse. Likewise, a person having a close relationship with the abuser may not reveal the abuse out of loyalty or fear.

G. Polygraph Examinations

Appellate records of cases involving DID defendants do not reveal widespread use of polygraph examinations (polygraphy).[154] In the past, polygraph results have frequently been inadmissible in many jurisdictions,[155] however, as of 1993, the year *Daubert* was decided, attorneys have more frequently sought to introduce them.[156] Most federal courts questioning the use of polygraph results under *Daubert* have admitted the results into evidence.[157]

Polygraph results could be used to support or deny the veracity of DID symptoms. For example, a person with DID may respond differently to questions asked while in various personality states. In that respect, polygraph results could potentially be part of a useful defense if admissible. On the other hand polygraph examinations can be manipulated by knowledgeable DID defendants.[158] Likewise, some studies have shown that polygraph examinations are not particularly reliable.[159]

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151. *See* Ulrich v. Senior and Disabled Services Division, 921 P.2d 982 (Or. App. 1996) (Plaintiff's husband's reports about the extent of her disability and his assistance to her were necessary because she claimed that he was her caretaker).

152. *See* HOCKING, *supra* note 22, at 7-8.

153. 310 S.E.2d 587, 587 (N.C. 1984).

154. *See* Owens *supra*, note 4, at 140-43.

155. *See* Richard C. Reuben, *Moment of Truth*, 83 ABA J. 38, 38 (1997).

156. *See* Thomas E. Zehnle, *Polygraph Admissibility in the Post-Daubert Era*, 12 CRIM. JUST. 11, 11 (1997).

157. *See* Reuben, *supra* note 155, at 38.

158. *See* David C. Raskin, *Hofmann, Hypnosis and the Polygraph*, 3-NOV Utah B.J. 7, 9 (1990).

159. *See* Zehnle, *supra* note 156, at 13.

H. Artwork Interpretation and Writing Analysis

Artwork interpretation and writing analysis —respectively known as art therapy and journaling— are used predominantly in psychotherapy and in-patient treatment programs.[160] These techniques are rarely used legally because their evaluation is highly subjective.[161] However, as the use of these clinical evaluation skills increases, they should become more consistent, and courts may be more prone to admit such evidence in the future.

Art therapy is frequently used with multiples as a psychoanalytic vehicle of self-discovery.[162] It can increase their awareness of submerged conflict.[163] Expression through art can offer multiples relief from pain that they can not voice.[164] Drawing assignments can indicate problems of fracturing, depersonalization, abuse and multiplicity.[165]

Journaling involves writing on a regular basis to access inner feelings and expose conflicts,[166] and can reveal different signatures and handwriting styles.[167] It can take a relatively unstructured form, such as writing in a diary or creating poetry, or it can take a more structured form, such as completing sentences or drafting topical paragraphs.[168] Multiples use journaling to discover and identify alternate personalities as well as to uncover childhood conflicts.[169] They can use journals to recover "lost time"[170] and to recall lost exper-

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160. Therapists use journaling with more than half of all DID patients; art therapy is used frequently, as well. *See* Gail Zehner-Richert & Christy Bergland, *Treatment Choices: Rehabilitation Services Used by Patients With Multiple Personality Disorder*, 46 AM. J. OCCUPATIONAL THERAPY 634, 635 (1992).

161. *See* Emily E. Smith-Lee, *Recovered Memories of Childhood Abuse: Should Long-Buried Memories Be Admissible Testimony?*, B.C. L. REV. 591, 606 (1996).

162. *See* Becky Frye, *Art and Multiple Personality Disorder: An Expressive Framework for Occupational Therapy*, 44 AM. J. OCCUPATIONAL THERAPY 1013, 1013 (1990). ("Psychoanalytic vehicle of self-discovery" is a phrase created by Frye.)

163. *See id.* ("Submerged conflict" is a phrase created by Frye.)

164. *See id.*

165. *See generally id.*

166. *See* KATHLEEN ADAMS, THE WAY OF THE JOURNAL at vii (1993).

167. *See* Lewis & Bard, *supra* note 4, at 748; *see also* Johnson v. Johnson, 766 F.Supp. 662, 662-63 (N.D. Ill. 1991) (plaintiff brought suit against parents alleging child abuse; two handwritten letters exhibiting plaintiff's various personalities were submitted as evidence of plaintiff's DID).

168. *See id.* at vii-viii.

169. *See* HOCKING, *supra* note 22, at 42-43.

170. COHEN ET AL., *supra* note 24, at 227. Losing time involves having no recollection of what one did during a given period and may involve hours, days or even years. *See id.*

iences.[171] The contents of journals can be —but are rarely— used in litigation.[172]

V. CONTROVERSY SURROUNDING A DID DIAGNOSIS

Although included in the DSM-IV, DID remains a controversial diagnosis.[173] One reason that DID is so controversial is that some clinicians doubt its existence, despite the fact that it is now included in the DSM-IV.[174] Other clinicians feel that, even if it does exist, it is relatively easy for a person to simulate the disorder, and is highly manipulable.[175] Therefore, it is difficult to defend a DID case without discussing three persistent concerns. These concerns are malingering, misdiagnosis and iatrogenesis.

A. Malingering

Malingering is the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs."[176] For example, malingering could occur in a criminal context if a defendant felt that she could avoid prosecution by simulating a mental illness. Likewise, malingering could also occur in a civil context if a person wanted to obtain public benefits instead of working.

When a defendant alleges that he or she has DID, prosecution experts frequently make accusations of malingering due to a criminal defendant's increased motive to fabricate a mental disorder.[177] De-

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171. *See* Adams, *supra* note 166, at 73.

172. *See* Rutherford v. Rutherford, 401 S.E.2d 177, 179 (S.C. Ct. App. 1990) (the appellate court considered the fact that the defendant's journal did not contain any information about an alleged affair of one of her other personalities to reverse the lower court decision); *see also supra* note 7 and accompanying text.

173. *See* George Serban, *Multiple Personality: An Issue for Forensic Psychiatry*, 46 AM. J. PSYCHOTHERAPY 269, 269-71 (1992); *see also* Saks, *supra* note 64, at 45-46.

174. *See* Merskey, *supra* note 6, at 334-39.

175. *See* Lewis & Bard, *supra* note 4, at 751; *see also* Stephen H. Dinwiddie et al., *Multiple Personality Disorder: Scientific and Medicolegal Issues*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 69, 74-75 (1993); State v. Wheaton, 850 P.2d 507, 508 (Wash. 1993); Saks, *supra* note 64, at 47-50; *see also supra* note 68 and accompanying text.

176. DSM-IV, *supra* note 14, at 683.

177. *See* Savitz, *supra* note 10, at 200. Often, mental health specialists disagree as to the veracity of a DID defense. *See* Lowery v. Young, 972 F.2d 351, 351 (7th Cir. 1992) (evaluators were adamantly divided about whether a criminal defendant had DID or was malingering); *see also* Alley v. Tennessee, 1997 Tenn. Crim. App. LEXIS 428 at *3 (the defendant was evaluated by a mental health team for four months who determined and testified that Alley was malingering based on a variety of indicators including the fact that he acted normal around other patients and only acted dissociatively in the presence of medical

spite fear that defendants somehow fake DID, it is one of the most difficult mental disorders to feign.[178] Though a skilled actor could simulate various psyches and even some physical symptoms, they are generally unable to maintain a consistent simulation over a period of time.[179] In addition, some physical symptoms, such as neurological patterns, are extraordinarily difficult, if not impossible, to control.

> Malingering [DID] would seem to require a great deal of acting talent. One needs to portray a range of personality styles - each with its own characteristic affective tone, style of thinking and viewing the world, likes and dislikes - consistently over time, without confusion of one personality with another. In essence, one needs all the skills of a good actor, indeed, a good actor portraying several characters in the same play.[180]

In one study comparing true multiple defendants with malingerers, none of the malingerers were able to maintain consistency in an assumed personality's voice, movement characteristics, and memory.[181] The researchers noticed distinctive characteristics in malingerers that were different than in true multiples.[182] For example, true multiples are much more likely to have long histories of prior unsuccessful medical treatment or therapy.[183] Malingerers tended to focus much more on their legal troubles during interviews.[184] Malingerers usually reported only one or two alternate personalities whereas genuine multiples tended to report more.[185] Malingerers tended to overdramatize their symptoms whereas true multiples tried to hide theirs out of embarrassment or denial.[186] For example,

> A patient charged with shoplifting was hospitalized on a unit with three DID patients. She rapidly claimed she suffered from DID and must have stolen while in another personality. She had an extensive public history of discrepant disremembered behaviors, and many people were ready to attest to her being like two different people. Her personalities were po-

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evaluators; however, a noted DID expert, Dr. Allen Battle, conducted hypnotic interviews of the defendant and testified that the defendant had DID).

178. *See* ORNE, *supra* note 42, at 120.

179. *See id.*

180. Saks, *supra* note 64, at 55.

181. *See* Richard P. Kluft, *The Simulation and Dissimulation of Multiple Personality Disorder*, 30 AM. J. CLINICAL HYPNOSIS 104, 109-12 (1987).

182. *See id.*

183. *See id.*

184. *See id.*

185. *See id.*

186. *See* Kluft, *supra* note 181, at 109-12.

> larized, extreme, and quite convincing when forensic matters were under discussion. She had no history or signs and symptoms to suggest DID other than the presence of the second personality. Several times a day she engaged in dramatic DID behaviors, ensured that they received attention, and claimed amnesia for them. Interviewed at length, it became clear that the second personality could not maintain consistency unless focused on the alleged offense.[187]

Because a criminal defendant has a motive to malinger in the hopes of avoiding prosecution, any evidence of malingering must be critically evaluated.[188] Consequently, it is important to evaluate behavioral indicators such as overdramatization of personality changes and an extreme focus on legal ramifications. Though not definitive, because some personality changes are in fact dramatic, any such indicators should be identified and critically evaluated.

B. Misdiagnosis

Misdiagnosis can easily occur because of the wide variety of mental disorders and their overlapping symptoms. Multiples are misdiagnosed on the average for almost seven years before they receive an accurate diagnosis.[189] During that time they receive an average of almost four erroneous diagnoses.[190] DID is frequently misdiagnosed for a variety of reasons such as diagnostic opposition, diagnostic predisposition, or time exigency.[191] Some experts allege that DID is underdiagnosed.[192]

> Like child abuse, particularly incest, there is a professional reluctance to diagnose Multiple Personality Disorder. In all likelihood this reluctance stems from a number of factors including the generally subtle presentation of the symptoms, the fearful reluctance of the patient to divulge important clinical information, professional ignorance concerning dissociative disorders, and the reluctance of the clinician to believe that incest actually occurs and is not the product of fantasy. Individuals may go through prolonged periods with-

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187. *Id.* at 112-13.

188. *See* ORNE, note 42, at 120-21 (discussing the possibility of malingering in DID criminal cases as illustrated by Kenneth Bianchi, the hillside strangler); *see also* Dinwiddie et al., *supra* note 175, at 74.

189. Frye, *supra* note 162, at 1016.

190. *See id.* at 1017.

191. *See* Eve Bernstein Carlson et al., *Validity of the Dissociative Experiences Scale in Screening for Multiple Personality Disorder: A Multicenter Study*, 150 AM. J. PSYCHIATRY 1030, 1030 (1993); *see also* Hindley, *supra* note 49, at 966.

192. *See* Kanovitz et al., *supra* note 6.

> out dissociation, accordingly the diagnosis is missed because a window of diagnosibility did not exist at the time of the clinical examination.[193]

Another reason why DID may be underdiagnosed is that it shares symptoms with some other disorders.[194] As mentioned above, people with DID are often misdiagnosed for several years before they receive an accurate diagnosis.[195] For example, dramatic changes of mood or demeanor are characteristic of individuals with DID but also of people with manic-depressive illness.[196] Likewise, symptoms associated with schizophrenia, such as hearing voices, are also characteristic of DID.[197] Most mental health professionals simply do not have experience diagnosing DID, and consequently they are more likely to make a false negative diagnosis.[198] Additionally, people being evaluated may not be forthcoming about their symptoms.

> In addition to a subtle presentation of multiple personality, most individuals with this disorder consciously withhold vital clinical information about memory loss, hallucinations, and knowledge of other personalities in order to avoid being labeled crazy. Others withhold information out of distrust. Still others are totally unaware that they are symptomatic. For instance, they may be completely unaware of alter personalities, and the time loss or time distortion which they experience may have occurred for such a long time that they consider it to be normal.[199]

Alternatively, some therapists may tend to overdiagnose DID.[200] For example, a clinician fascinated by DID might communicate his or her fascination to the person being observed.[201] As a result, cases might be unconsciously shaped through subtle encouragement and unintentional selective reinforcement.[202] One researcher "compared clinicians' fascination with their DID cases to the reaction of new parents; they can never miss an opportunity to show photographs, movies, or videos of their uniquely talented offspring, or to tell you about

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193. Philip M. Coons, *Child Abuse and Multiple Personality Disorder: Review of the Literature and Suggestions for Treatment*, 10 CHILD ABUSE & NEGLECT 455, 459 (1986).

194. *See* Serban, *supra*, note 173, at 270.

195. *See* COHEN ET AL., *supra* note 24, at xxi.

196. *See* Lewis & Bard, *supra* note 4, at 748.

197. *See id.* at 749.

198. *See* Carlson, *supra* note 191, at 1035.

199. Coons, *supra* note 193, at 459.

200. *See generally* Kanovitz et al., *supra* note 6.

201. *See* NORTH ET. AL., *supra* note 66, at 33-34.

202. *See id.*; *see also* State v. Wheaton, 850 P.2d 507, 508 (Wash. 1993) (citing Saks, *supra* note 6, at 400); *supra* note 175 and accompanying text.

their latest cute trick."[203] Prosecutors may challenge a clinician's predisposition to diagnose DID. For example in *Scripps Memorial Hospital v. San Diego*, the prosecutor intended to prove that the diagnosing physician had been criticized by his peers for overdiagnosing DID.[204] In order to prove his assertion, the prosecutor requested all records from the physician's employer to include: current employment status, disciplinary action reports, peer review reports, patient complaints and reprimands.[205]

Evaluators may lack the time or expertise necessary to make an accurate assessment of DID. A potential problem in court ordered diagnostic interviews is that the evaluator may not have sufficient time available to make an accurate diagnosis because of their heavy caseload. A minimum of three to five hours of clinical examination is often required in order to make an initial diagnosis of DID.[206] Furthermore, an evaluator should conduct at least three separate interviews to verify consistency of presentation.[207] In the more difficult cases, upwards of twenty clinical hours may be necessary in order to make an accurate diagnosis.[208] Court-appointed forensic evaluators often do not have this much time to spend with each defendant. Therefore, defense attorneys should retain their own forensic evaluator.

C. *Iatrogenisis*

Some clinicians assert that DID can be iatrogenically induced.[209] Iatrogenesis occurs when medical treatment or therapy causes an illness or aggravates an existing illness.[210] Hypnosis and sodium amytal purportedly can enhance vulnerability to suggestion.[211] Another method by which personalities can allegedly be created is through the use of leading questions, suggestions or positive reinforcement of traumatic memories.[212] Comparatively, some clinicians and layper-

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203. NORTH ET. AL., *supra* note 66, at 33.

204. 37 Cal. App. 4th 1720, 1723 (1995).

205. *See id.* at 1722-23.

206. *See* Philip M. Coons, *Iatrogenesis and Malingering of Multiple Personality Disorder in the Forensic Evaluation of Homicide Defendants*, 14 PSYCHIATRIC CLINICS N. AM., No. 3, at 757, 763-64 (1991).

207. *See id.*

208. *See id.*

209. *See* Merskey, *supra* note 6, at 328; *see also* Saks, *supra* note 64, at 46-48.

210. *See* THE SIDRAN FOUNDATION, *supra* note 3, at 11.

211. *See* Serban, *supra* note 173, at 278; *see also* Frank W. Putnam, (response to article by Paul R. McHugh), 7/1/95 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 960, 960 (1995).

212. *See* Savitz, *supra* note 10, at 201. For example, Elizabeth Loftus conducted an experiment in which her research assistant convinced his younger brother Chris that he had

sons feel that DID is an iatrogenic illness produced by a client to meet the expectations of a therapist.[213]

In a number of recent lawsuits there have been allegations that false memories[214] of childhood sexual abuse have been planted in patients' minds during therapy.[215] Some therapists may be predisposed to uncover histories of abuse in their patients. Therapists who believe that abuse is at the heart of many psychological problems, and that the typical abuse victim does not realize that she is a victim, may interact with clients in a manner which may encourage memories of abuse.[216] Some therapists, when confronted with patients who refuse to admit abusive pasts, may tell them that they are in denial, encourage the clients to tell stories or imagine hypothetical incest scenes, or interpret dream symbols as signs of abuse in an over-eager attempt to confirm their theories.[217]

Others assert alternatively that the theory of iatrogenisis in DID is unsupported.[218] There is no confirmed case of iatrogenic DID.[219] Although, hypnosis or amytal can produce some DID symptoms, they can not produce the entire syndrome.[220] To the contrary, scientific evidence demonstrates that people with DID are significantly and genuinely different on standardized psychological measures, structured

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been lost at age five in a shopping mall and was found by a man wearing a flannel shirt, something that never actually happened. *See* ELIZABETH LOFTUS ET AL., THE MYTH OF REPRESSED MEMORY: FALSE MEMORIES AND ALLEGATIONS OF SEXUAL ABUSE 97-102 (1994). Over time, Chris "remembered" additional details of the event. *See id.* Two days after being told the story, Chris described how scared he felt when he was lost. *See id.* Three days later he claimed that he remembered his mother telling him never to do that again. *See id.* A couple of weeks later Chris even described the man as wearing a blue flannel shirt and glasses and having gray hair. *See id.* When he was eventually told that the event never occurred, Chris did not believe it. *See id.*; *see also* THE SIDRAN FOUNDATION, *supra* note 3, at 11.

213. *See id.*

214. The term false memory was developed in the early 1990's by the False Memory Syndrome Foundation to describe memories that are not based on actual events. *See* THE SIDRAN FOUNDATION, *supra* note 3, at 10.

215. *See* Dalrymple v. Brown, 701 A.2d 164 (Penn. 1997); Halbrooks v. Moore, 1997 WL 198748 (Tex. App. Dallas 1997); S.V. v. R.V., 933 S.W.2d 1 (Tex. 1996) (each exemplifying a false memory lawsuit).

216. *See* DONALD P. SPENSE, NARRATIVE AND HISTORICAL TRUTH: MEANING AND INTERPRETATION IN PSYCHOANALYSIS 94 (1982); *cf.* Saks, *supra* note 64, at 51-54.

217. *See* Saks, *supra* note 64, at 51-54.

218. *See* PSYCHTRAUMA GLOSSARY, *supra* note 2, at 11.

219. *See* NORTH ET AL., *supra* note 66, at 29.

220. *See* Kluft, *supra* note 181, at 105; *see also* Steinberg et al., *supra* note 109, at 353; Putnam, *supra* note 211, at 963 (no scientific evidence demonstrating that the entire clinical syndrome can be induced).

diagnostic interviews, clinical phenomenology, central and autonomic nervous system activity, memory and cognition.[221]

VI. CONCLUSION

DID is the mental disorder most strongly associated with child abuse, especially sexual abuse.[222] Because DID is often the result of child abuse, a wide repertoire of diagnostic evidence should be admitted when DID is alleged. Little evidence is frequently available concerning sexual abuse because, due to the nature of the crime, there are few witnesses. Although it is true that some people may attempt to simulate DID, a wider variety of evidence should be accepted in DID cases in light of the abusive origins of the disorder. Because evidence of child abuse is so elusive, especially years after its occurrence, all diagnostic evidence in DID cases, both criminal and civil, should be evaluated using a totality of the circumstances approach. Some controversial procedures, such as hypnosis, may not be deemed reliable in some jurisdictions. However, the value of controversial evidence should not be ignored because, for example, hypnosis may be the only effective method of eliciting alternate personalities in a short time frame.[223] Sometimes use of the more controversial evidence, such as hypnotic and sodium amytal interviews, is the only way to establish a DID diagnosis.[224]

Controversial information may be counterbalanced with more generally accepted evidence, if available. Safeguards can be used which enhance the reliability of controversial procedures. For example, videotaping can create a permanent record of diagnostic interviews. If videotaping is not practical, audiotaping could substitute. Also, the use of leading questions should be avoided during interviews to avoid the appearance of suggestibility, especially during hypnotic sessions.[225] Also, repeated interviews can be conducted over a period of time to add more credibility to the diagnosis. Appropriate safeguards enhance the probability that malingering, misdiagnosis or iatrogenesis will be detected. DID defendants often rely on controversial diagnostic evidence because it is the only evidence available, due both to the nature of the disorder and to time constraints.

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221. *See* Putnam, *supra* note 211, at 963.

222. *See* Ross et al., *supra* note 25, at 328.

223. *See* THE INTERNATIONAL SOCIETY FOR THE STUDY OF DISSOCIATION, *supra* note 91, at 3.

224. Arguably, even if controversial evidence is admitted in DID cases ultimately resulting in more acquittals, the defendants and society will benefit more from DID oriented treatment.

225. *See* Lewis & Bard, *supra* note 4, at 750.

Enhanced admissibility in multiple personality disorder cases would support concepts of fundamental fairness.

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