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# Psychiatric Expertise and Forensic Management in Cases of Dissociative Identity Disorders

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ABSTRACT: Dissociative identity disorders are still one of the most controversial entity within the psychiatric domain. Formerly known as "multiple personality disorder" until late 1994, the assessment of this condition has split the world of psychology and psychiatry between believers and skeptics as the characteristics of the pathology are very hard to assess with objective tools. Different theories have circulated about dissociative identity disorder over the years and some cases reached mass-media attention due to its spectacular aspect. Being a pathology with extreme and contrasting changes in behavior, judgment and affect within one individual, theoretically without control and memory on the actions of each personality, justice management can hit many blockages if that person is involved in antisocial activities. Forensic psychiatry is again the mediator of the investigation and legal conclusions over such cases but even in the moment of the psychiatric expertise, objective assessment can be complicated by the specifics of the disorder. This paper proposes a review of the current knowledge of the disorder with the theoretical legal appliance in cases of antisocial behavior with law involvement.

KEYWORDS: psychiatry, forensic, dissociative, personality, law

## Introduction

The possibility of one individual developing multiple personalities within itself, each of them being unaware of the other, has brought the attention of the media and non-medical community over the years. Inside psychiatry and related domains, the disorder has only lifted questions and the answers remain even now controversial in the scientific community. In Romanian medical society, psychiatric institutions declare under 5% of the total cases being addressed and diagnosed as dissociative identity disorder in the last ten years. Much of those diagnostics are questioned as clinical aspects could mislead the specialist and really have elements of hysteria, schizophrenia or other personality disorders.

Theoretically, the multiple personality disorder has been changed into current name, Dissociative Personality Disorder by the DSM IV psychiatric manual and defined as the presence of two or more identities that recurrently take control of the individual's behavior accompanied by the inability to remember important personal information. Moreover, the disorder was thought to be more of an identity fragmentation rather than a proliferation of separate personalities (DSM IV, 1994). So, even with the contrasting personality changes and extreme differences between each self, the medical world did not recognise the ability of one individual to develop different personalities, each of them with unique emotional state, judgment criteria, personal options, future plans and even cognitive maturity. The 2013 DSM V evolves the criteria of diagnostic and reveals new elements to characterise the disease which changed the way the psychiatric community tended to avoid this type of diagnostic. As such, the new DSM psychiatric manual defines the disorder as "a) Disruption of identity

characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of marked discontinuity in the sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual. b) Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting. c) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. d) The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play. e) The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures)" (DSM 2013).

Differential diagnostics are stated in the DSM manual in an attempt to objectively part the other conditions from the dissociative identity disorder but still, in the first step of the medical assessment, it is a common thing to first think about other pathologies such as Borderline or bipolar disorder, psychotic disorder, substance abuse effects, or major depression and post-traumatic stress disorder. This is understandable as two or more personalities are hard to become dominant within the same examination and it is easy to become sceptic at the first interview with the patient. Moreover, some studies state that the majority of the personalities within one individual have at least one form of psychological imbalance, especially due to the trauma that has caused the split and that follows the subconscious of the individual throughout his life, the subconscious being the central hub of all identities that activates and releases each personality by assessing the environment and pushing the necessary self to emerge.

The general characteristic of the disorder is the conversion between different states of the self. Initially, there is an extreme trauma, usually at a young age that activates the need to escape from the suffering and abuse. The first personalities are adaptive forms to the disrupted environment but they soon become un-adapted to the new external and internal development so the personalities begin to develop as new factors influence the individual and the main self. The conversion acts on two main directions: a vertical one which is dissociation and a horizontal one which is repression. The repression acts horizontally as all material aspects of the environment are translated to the dynamic subconscious. The dissociation acts vertically as the cognitive and emotional luggage is being separated into different consciences. The dissociation and repression are actually both defensive psychological mechanism that individually appear in other psychopathologies but in this case, they push all the disrupted material knowledge outside the conscient area. The way that those mechanisms work is related to the balance between outer and inner activation factors. Repression is apparently activated by inner strong desires and dissociation is activated by external impact factors (Reinders & Veltman 2021).

Basically, each personality has repressive and dissociative mechanisms involved in a higher or lower proportion. They develop in an adaptive way for the individual to be pushed further from the traumatic experience and reality. As the person reaches different points of maturity, the personalities gain more and more autonomy and the main character becomes more convinced that he is no longer in control of them. The interesting part is that there is no apparent control over the different forms of self but they activate and change as the individual changes excitatory states and environmental forms, adapting him to new situations or "saving" him from more trauma. As such, we could state that there is a subconscious network centre that acts a mediator and decision factor in order to highly protect the main self from further damage (Ross & Ness 2010).

Beyond the psychological aspect of the disorder, there are 2 psychiatric criteria that are specific for distinctive personality state emerges: the disruptive sense of self and agency and the recurrent dissociative amnesia. The disruptive sense of self is the state in which an individual finds himself in different clothes than they usually wear or being in an environment they usually do not attend or in any situation they are not usually comfortable with. From the outside, there re contrasting differences between the way people view a certain individual. For example, a usually social person can be suddenly observed as very shy and introverted for no apparent reason. Moreover, the person himself can suddenly wake in situation he usually cannot handle. The disrupted sense of agency refers to the person's affective states. He can find himself in emotional situations or sensing feelings that he has no reason to feel. Those are usually reminiscences of the alter personality that went suddenly dormant and the main identity is found in non-realistic effective states with emotions that don't belong to them. There are patients that have some form of subconscious awareness over the alter personalities and they describe themselves as a distant observer with no power or control over what is happening. Others describe the feeling as a body and mind possession or hijacking. The second important criteria of the disorder is the recurrent amnesia. In cases of dissociative identity disorder, recurrent amnesia can range from partial and inconstant memory loss to total amnesia. Some patients can remain partially aware of their actions but with no efficient control over the dominant state which is commonly known as co-consciousness but there are also total amnesia cases, in which the patient has apparently no memory of his behavior. Memory loss is first of all specific for all traumatic events in the individual's personal and affective life. As the alter personalities develop, memory is split between the different cognitive states as memory is a principal characteristic of conscience and cognition but remains of different entities can merge between them (Sar, Unal & Ozturk 2007).

**Psychiatric expertise in cases of dissociative identity disorder**

As recurrent amnesia is the defining criteria of the disorder as well as the different cognitive stets with contrasting emotional and behavioral characteristics, there are many questions of how deep the differences between alters go. Identity is formed by specific emotional filters, experience and memory that form behavior and every identity is characterized by a certain psycho-cognitive activity. Cognition is the body of cerebral mechanisms that sustain the critical judgment, filter environmental factors and emotional excitants and outer and inner elements, and control impulses to sustain the person in social, familial, and professional functions. Dissociative identity brings the question of whether each alter-personality has different cognitive levels with all its implications (Ross 2006).

Multiple personalities mean multiple consciences, each having identity characteristics such as different behaviors, different psychological balances and different forms of responses to emotion and stress. Impulsiveness and aggression are part of the human psychological foundation but cognition, critical judgment and cortical cerebral maturity are the filters that inhibit anti-social acts in order to fully adapt to environmental standards. We could state that theoretically, every identity of a dissociative individual is aligned to different levels of cognitive states and cerebral activity mechanisms. As such, through all alters, there could be found aggressive identities, anti-social behaviors, immature cognitive remains from the childhood stages, impulsive personalities, identities with psychotic manifestations, unemotional callous states with psychopathic characteristics or dependent personalities. All of these elements are understandable as alters develop as an adaptive and protective mechanism for the main self against negative feelings and trauma so, it wouldn't be unusual for aggressiveness to manifest at some point. Furthermore, there is a balance in the development of each alter so if one identity is incapable of doing harm to another person but there is a desire to do so, another

personality might take the initiative and act in that direction as a compensational mechanism. If anti-social behavior emerges and legal mechanisms are involved, the investigation and expertise of the case will become complex as recurrent amnesia and cognitive impairment bring the question of active discernment and critical judgment but also of legal responsibility of the person involved (Tsai, Condie, Wu & Chang 1999).

In the case of a person involved in an anti-social act with questions about his mental health state, the first step of the investigation will be a forensic psychiatric expertise in order to analyze if the individual was completely aware of his actions and understood all consequences of those actions. Such an expertise for a dissociative identity disorder could be a long-term assessment and it requires interdisciplinary cooperation and a parallel legal investigation. So, in this case, the psychiatric and legal expertise must sustain one another.

First of all, the psychiatric examination must follow two lines of work: one is the clinical review of the patient and the other is the psychological and psychiatric observation in a medication-free state and with adaptation to the person evolution and strong personal history knowledge in order to activate all possible identities (Paris 2009).

**Clinical evaluation**

The pathophysiology of dissociative identity disorder is still inconstant but studies have captured some elements beyond the DSM manual criteria that are strictly related to the psychiatric and psychological assessment. One of the first elements cited by the studies are severe headaches.

It seems that there are major tensional and vascular headaches during personality swifts, which could prove that there is a physiological mechanism involved in the disorder, more than just a psychological change. The headaches are described as different in intensity and location by every alter, and they are more present during the identity change (Piper and Merskey 2004).

Another element that could be assessed is the voice changes. It appears that every alter has secondary voice characteristics modifications that affect the voice quality. Some patients change voice in a deeper or higher intensity level or add hoarseness or tics in their speech. A spectral analysis of the voices could be used for the clinical assessment as well as for the legal investigation in order to recognize and compare what possible witnesses may have heard during the offence (Lewis, Yeager, Swica, Pincus & Lewis, 1997).

Conversive symptoms have been cited through studies. Conversive disorders are characterized by organic extreme symptoms with no somatic alteration to cause them and they are responses to acute stress, intense emotions, or they can be an expression of generalized anxiety. Manifestations may range from temporary blindness, deafness, partial or total paralysis and they usually appear in one of the identities. Another interesting feature, stated in some studies, is the changes in vision acuity amongst different identities. There are ophthalmologic examinations that reveal changes in the eye tension, refraction, visual field or colour perception within each identity of one individual (Tyrer 2019).

Neurologic examination throughout studies did not reveal Electroencephalogram or clinical neurologic alterations between different alters until brain imaging had begun studying the disorder. Recent clinical observations based on functional MRI of the brain had indeed showed changes in biomarkers and volumes of different cerebral regions proportional with the changes of the personality in one individual. Especially the hippocampus and amygdala were revealed to be highly contrasting in changes as the alters emerge. As such, future investigative directions in these cases could find objective evidence (Galton 2018).

Neuromuscular activity is another factor that can be taken to consideration during examinations. Specifically, there are uncontrolled, reflex muscular activities that often predict the alter ego switch. The transition doesn't take more than 5 seconds in most cases and during

those seconds and a few more after the change, tics may be observed, such as eyelid rapid movement, asymmetrical facial muscle spasm, uncontrolled extremity movement. Other elements that may be observed are changes within temperature sensitivity as one identity cannot tolerate heat and the other has no reaction to it or, there are cases that describe immobility or trance-like aspect during the swift to another alter (Sekine 2000).

Cardiovascular and blood pressure changes are rather inconsistent elements of the dissociative identity disorder observations as most studies do not reveal specific important differences and within these systems, it is not unusual for the blood pressure and heart rate to alter as a response to stress level. The only modifications are based on how sensitive to stress is each identity and how the body reacts to the stress factors. Respiratory rates and volumes may also change between alters as these are also direct neurologic responses to external factors.

Gastrointestinal and genitourinary symptoms may appear inconsistent within some individuals with dissociative identity. Some of the identities manifest food intolerance, chronic nausea, anorexia as others manifest menstrual and sexual alterations. Observing those symptom range, reveals an interesting involvement of neurologic and psychologic somatization possibility, especially within different types of anxious and depressive identities. The examinations are still inconsistent and are far from the objective observation these cases need (Merckelbach 2002).

Self-mutilation is not uncommon amongst dissociative identity individuals. Although it is not found in all of them, there are some patients that manifest this behavior in one of the identities. Particularly, there are alters that make a statement to their other consciences by mutilating them and there are identities that manifest such symptoms as part as their inability to feel pain and even emotions, that being the case of alters involved in extreme antisocial acts (Farell 2011). Skin reacts to electric stimulus by its autonomic nervous system. By measuring galvanic skin response during different alter ego states and during swifts there are some modifications that could appear. Especially during transitions, studies state that there are important drops in the skin responsive potentials and the actual response differs from one personality to other. That could be on physical proof of the unconscious process that takes place behind the disorder.

**Psychological and psychiatric observations**

The psychiatric expertise in cases of offenders with dissociative identity disorder must answer the questions of the presence of critical judgment at the time the crime was committed and whether the patient isn't simulating the disease. Establishing one's state of cognitive responsibility is more difficult with multiple identities emerging and deciding which is the guilty one and assessing if the individual is a mentally ill person in this case has its provocations. With these case, clinical examinations must be featured alongside legal investigations and pathophysiological elements such as involuntary neuromuscular moves, vision changes, skin neurologic responses, voice spectral alteration and functional brain imaging differences could be objective first steps to proof that the person is suffering from a real condition and is not simulating. Furthermore, serial interviews, individual discussions and monitoring the patient are part of the psychiatric expertise that will take a longer period of time to conclude. It takes time to learn about the patient personal history, the trauma that begun his disorder, to learn the triggers of different personalities and in some cases, the offender alter could even not emerge during any sessions, which will make the expertise even harder. Recurrent amnesia must be well observed and described from a psychiatric point of view and psychological examination must undergo different psychometric evaluation in order to release every subjective element. In many of the cases, the history of the offence is lost inside the patient's memory gaps and the question of the discernment remains only a

tangential discussion based on circumstantial observations. The only way to a strong expertise is well documented clinical and psychometric evaluations combined with well documented legal investigations (Brand 2006).

## Forensic handwriting expertise

Although most of the investigation on dissociative identity disorder offenders is based on the psychiatric expertise, law enforcement must actively complete the medical evaluation by finding all the history, daily activity bases and personal characteristics of that person. Investigative protocols must bring strong proofs in court. As lie detector methods and hypnosis are not recognized methods of investigation in court, other objective methods of investigation must be found. One of the strongest expertise in forensic sciences, that could proof if one individual has dissociative personalities, is the handwriting expertise. The modifications in the handwriting between different identities of the same individual have been noticed as well in the medical field and also during investigations of such cases over the years. Recently, the forensic scientific community have begun to publish evidences and case expertise that detail the elements of the handwriting observations between alters. One study, published in 2013, is particularly well documented as the authors, being forensic handwriting experts, have taken a case of an offender with 3 theoretical identities and have documented their actual writing and all possible documents written by the alters since the dominant personality became aware of the others. It is well known that handwriting evolves over the years and theoretically an individual could try different forms of writing but similarities can always be found during an efficient expertise and investigative methods can proof that the writing belongs to a single individual. The study mentioned above, conducted by Schwid and Tuelings observed the writings of a person with 3 personalities. The study of present and personal history of hand-writing concluded that there are too many differences between each document so there is no objective way to state that the handwriting belongs to the same person. Moreover, it seems that each handwriting did not evolve in any detail over time which could mean that not only that each identity is an individual entity but they are frozen at the time and age that they first emerged (Schwid & Tuelings 2013).

Since 2013, more and more forensic scientific expertise have shown that real dissociative identity disorder manifests in unique ways within social, personal, psychological and professional environments.

## Conclusions

Dissociative identity disorder stands for a medical, social and legal controversial disorder. A severe traumatic event activated neurologic, psychologic and emotional adaptative systems which begin to form different personalities in order for the host identity to be protected and pushed away from the trauma. As the host reaches maturity, the identities begin to evolve as strong individual entities and as the outer environmental factors change, other alters can be created.

As neuropsychologic features are different for each cognitive state, more impulsive and aggressive alter egos be present in one individual in order to compensate some situations. As such, it is not uncommon for one alter ego to engage in antisocial acts, especially if a psychiatric disorder is more evident in that identity (callous unemotional, psychotic disorder, major depression and anxiety, cortical immaturity). Being such a controversial and complex disorder, the question of critical judgment and legal responsibility is placed in the hands of forensic experts and psychiatric experts. The 2 departments must lead strong and efficient investigations in such cases. Nowadays, clinical examinations offer objective elements in order to proof or disproof the reality of the disorder and functional MRI is the examination

that offers the most promises for the future in this matter. As for forensic expertise, the handwriting examination could offer the most pro and counter proofs in the matter as studies already made specific descriptions of the cases.

For real, non-simulating patients, court could make different decisions based on psychiatric and forensic expertise. Interpretations of psychiatric evaluation can lead to stating that the person is insane and without discernment if one or two identities present severe psychiatric disorders or it can decide that the person can be held responsible for his actions with some attenuating circumstances. Whatever the decision and the court's interpretation, the follow up of the case consists in long-term medical and psychological intervention, in a free or contained environment, as the court will decide. In order to fully reintegrate such a person into society there are 3 steps for the medical assessment: symptoms reduction and psycho-emotional balancing, psychotherapy and medication for trauma history and psychiatric manifestation (taken step by step and alter ego by alter ego) and rehabilitation with long-term monitoring and re-assessment.

Court decisions are entirely based on the scientific and medical evaluations but conclusions in legal domain remain controversial in many cases. Future studies are still required in order to bring objectiveness and efficiency for social wellbeing and for the individuals with dissociative identity disorder as they are also part of that environment.

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