DISSOCIATIVE IDENTITY DISORDER IN A FORENSIC PSYCHIATRIC PATIENT: A CASE REPORT

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ABSTRACT

Criminal acts can be performed in a dissociative state. Since a percentage of male and female patients with dissociative disorders act out aggression and display criminal behaviors, some of them may be found in the criminal justice system. This case report demonstrates that the long-term failure to diagnose dissociative identity disorder in a forensic psychiatric patient permitted the continued existence of highly aggressive dissociative identity states, and near-relapses into homicidal behavior. The author concludes that careful screening for dissociative disorders and the provision of treatment for dissociative disorders in forensic settings is necessary. The risks of both false negative and false positive diagnoses should both be recognized.

Criminal acts may be performed in a dissociated state (Bliss & Larson, 1985; Hall, 1989; Bisson, 1993), and some offenders display dissociative amnesia for their crimes (Vivian & Gudjonsson, 1986; Coons & Milstein, 1992). Putnam (1989) remarked that patients with dissociative disorders may encompass dissociative identity states whose functions may include or lead to fighting, theft, or rape. Nineteen percent of the male and 7% of the female dissociative identity disorder (DID) patients studied by Loewenstein and Putnam (1990), reported successful perpetration of a homicide, while 47% of the males and 35% of the females reported having been engaged in criminal activity. Accordingly, some cases of dissociative disorders may present in the criminal justice system rather than in the mental health system. However, the prevalence of dissociative disorders among offenders is presently unknown, and an estimation of the relevant false negative rates for males and females in forensic settings is not available.

Scientific evidence shows that dissociative disorders are more common than was once thought (Horen, Leichner & Lawson, 1995; Latz, Kramer, & Hughes, 1995; Ross, Anderson, Fleisher, & Norton, 1992; Saxe, Van der Kolk, Berkowitz, Chinman, Hall, Lieberg, & Schwartz, 1993). Moreover, these disorders can be reliably and validly diagnosed (Boon & Draijer, 1991, 1993; Ross, Heber, & Anderson, 1990; Steinberg, 1993; Steinberg, Rounsaville, & Cichetti, 1990, 1991). However, in some circumstances efforts may be questioned. It has been suggested that the recent rise in detected cases is due to iatrogenitc influences, self-suggestion, or malingering (that is, motivated by wishes to escape social responsibility or legal responsibility with respect to criminal deeds) (Piper, 1994). Factitious or malingered DID has been described in forensic and clinical settings (Coons, 1978; Orne, Dingus, & Orne, 1984; Kluft, 1987a; Coons, 1988; Coons & Grier, 1990; Chu, 1991; Coons, 1991; Coons & Milstein, 1994). With growing public availability of knowledge pertaining to dissociative phenomenology, simulators may have become more sophisticated in their fabrication of dissociative disorders. Therefore, the differentiation of true and false cases may have grown more difficult. Diagnostic efforts demand more clinical skill and consume more time (Chu, 1991). In a recent paper, Coons and Milstein (1994) report that about 10% of the patients who were referred to a dissociative disorders clinic because they were suspected to suffer from a dissociative disorder actually were false positive diagnoses. Coons (1991) stated that a high index of suspicion is required by any clinician evaluating a homicide defendant alleging DID.

While the risk of diagnosing false positives both in clinical and in forensic settings should thus be recognized, the risk of failing to diagnose true positives, especially in forensic settings, should no less be considered a serious error. Since chances of spontaneous recovery of dissociative disorders seem to be minimal (Kluft, 1985, 1993), forensic patients with dissociative disorders who are not properly diagnosed and specifically treated for their psychiatric condition, could run a considerable risk of relapsing into criminal behavior.

As the present case report demonstrates, dissociative identity states may have an inclination to commit murder, and be capable of performing this act. If the patient is not treated for the dissociative condition, the patient's aggressive feelings, ideas, and impulses may remain encapsulated

in alter personality states which are insufficiently connected with other parts of the personality. These aggressive, violent or murderous dissociative states, may as other dissociative states, have a restricted field of consciousness, and be organized around one main fixed idea (*monideism*) or a limited set of related fixed ideas (*polyideism*) which direct their thoughts, emotions, perceptions, sensations, and actions (Janet, 1901). These states therefore lack a normal sense of ambivilence. For example, due to their insufficient connectedness with other mental states, aggressive dissociative states may escape influence or control by other states which otherwise might modulate and contain the aggressive feelings, thoughts, and impulses that render the patient potentially dangerous. The risk of such individuals for relapse into criminal behaviors probably will be particularly high when they are faced with relevant potent (conditioned) stimuli; i.e., stimuli which are highly reminiscent of events that induced the aggression in the first place, and which could reactivate the aggressive dissociative state(s). Obviously, such relapses would imply highly negative consequences for the patient, possible victims, and society at large. In contrast, as this case report also shows, treatment for DID along the lines of what may be called the present standard of care may have a favorable effect on the dissociative condition in general, and on dissociated, trauma-induced aggression in particular.

CASE DESCRIPTION

After having stood trial for murdering a woman, Wim (a pseudonym), a 42-year-old male was put at the government's disposal. (He consented to the preparation and publication of the present case report upon being informed of its aim and nature.) In the Netherlands being put at the government's disposal means that the subject is imprisoned for an undetermined length of time. The subject's release is dependent upon the results of psychiatric treatment, as evaluated by the court. To that end, repeated assessments are performed in due course.

After twelve years of imprisonment, Wim was considered fit to reenter society. However, it was thought that he had developed severe agoraphobia which prevented him from leaving the penal institution. Wim was a poor communicator; he had provided little information with respect to his fears. He had hardly engaged in human contact throughout the time of his sentence. His response to psychiatric treatment, which consisted of behavior therapy and the prescription of a broad spectrum of medications, had been disappointing. For example, graded exposure in vivo did not influence his agoraphobic symptoms. Wim was considered to have a poor prognosis. In addition to his avoidant behavior, he displayed poor social skills and extremely low emotional expressiveness. When he experienced conflict, Wim manifested coercive and aggressive behaviors. However, with minor exceptions, he did not use physical force. Many people, at times reported a "wild" look in his eyes and were scared of him.

When Wim was about to be released, a psychologist who was receiving training in the diagnosis and treatment of dissociative disorders observed several symptoms suggestive of a dissociative disorder, including dissociative amnesia and depersonalization. Re-assessment (by the present author) using the *Structured Clinical Interview for DSM-IV Dissociative Disorders, SCID-D* (Steinberg, 1993), confirmed the presence of a cluster of dissociative symptoms including dissociative amnesia pertaining to the past and the present (SCID-D score 4), depersonalization (score 3), derealization (score 2), identity confustion (score 3), and identity alteration (score 4). The total SCID-D score was 16.

Wim had amnesia for a range of past events, including the murder, as well as amnesia for recent events. For example, more than once, Wim, upon awakening in the morning, detected traces of mud on the floor and his shoes that he could not account for. He concluded that he must have temporarily left the half-way house where he resided at the time, even though he was not allowed to leave this house at night. He was unable to estimate the amount of time involved in his absence. The amnestic episodes were unlikely to be explained by the abuse of alcohol, because Wim was unable to buy alcoholic drinks within the institution, and he did not miss any money, which precluded the possibility of his having bought alcohol elsewhere.

Wim feared he might have performed bad acts under the influence of two disturbing inner voices, which commanded him to kill all women. According to both voices, women without exception were mean whores. Wim's phobic behavior could be reinterpreted as a fear of encountering women and girls if he ventured outside. When he met females, when he occasionally did some shopping the voices became highly active and caused Wim to panic and withdraw from contact with the women as soon as possible. Women who chatted with him in a friendly manner during a bus or train ride were shocked by Wim's sudden violent utterances (e.g., "Shut up, whore!"). Unable to control his behavior, Wim was afraid he might commit another murder. He felt highly ashamed and sought refuge in social isolation. Fearing he would be labeled insane or be ridiculed, he had not spoken about these dissociative phenomena for years. No alter personalities took control over consciousness and behavior during the SCID-D interview. The assessor diagnosed Wim as suffering dissociative disorder not otherwise specified, rule out DID. Wim accepted the diagnosis with a degree of relief. He was glad to receive treatment for his subjectively puzzling condition.

HISTORY

Wim's father died soon after his birth. He was raised by

his mother and stepfather, and initially lived with one half-sister which his mother brought into the marriage with Wim's father, one sister, and two brothers. Wim's father and mother had been raised in abusive and neglectful families. Father grew up to be a physically and emotionally abusive man himself. More than once, he expelled Wim's mother and the children from the house, and left them to roam the streets. After his father's death, Wim's mother remarried a man who was looking for a wife to take care of his six sons and daughters. Another son was born. Wim's childhood memories, which went back to the age of three, included sexual abuse by his stepfather. According to Wim, several of his sisters and stepsisters were also sexually abused by his stepfather. Wim's sexaual abuse, amongst others, pertained to performing fellatio, being exposed daily to anal rape, and being forced by his stepfather – who watched the scenes – to have intercourse with his sister. His sister confirmed the abuse at a later point in time. Furthermore, he was physically and emotionally abused throughout his youth. His stepfather forbade him to speak about the abuse, and threatened to punish Wim severely if he revealed it. Yet, at the age of 13, Wim found the courage to inform the police, who asked his mother whether the alleged abuse was going on. Though knowledgeable of the emotional, physical, and sexual abuse, out of fear of her highly aggressive and alcoholic husband, Wim's mother denied the abuse. The alleged perpetrator was not interrogated. Wim subsequently informed the family physician, the minister, and a child protection officer, but no one believed him. He was verbally, as well as physically, punished for his "mean accusations," and was told to respect his parents. From then on, he sought relief in the use of alcohol. He was admitted to a corrective juvenile institution, where his diagnosis was conduct disorder. Because of the ongoing sexual abuse with the other children, his stepfather was finally sentenced to many years' imprisonment.

Wim escaped the family, the institution, and the abuse through an early marriage. One day, he found his wife engaged in sexual play with a friend. Both women challenged him to go along with it, which Wim refused. He disliked such joint activities and, moreover, was impotent in such circumstances. Shortly afterwards, his wife called for help. Both women had become involved in a serious argument, which Wim tried to settle. Upon awakening in a cell the next morning, he guessed he had been imprisoned because of public drunkenness. It was only then that he, to his utter dismay, was told that he had killed his wife's friend. Wim accepted full responsibility from the start, but until the treatment of his dissociative disorder twelve years later, he did not remember what had occurred.

DESCRIPTION OF THE TREATMENT

Treatment followed the threefold phasic course that has been found valuable with post-traumatic stress disorder and dissociative disorders since Janet (Herman, 1992; Van der Hart, Brown & Van der Kolk, 1989). It essentially consists of stages of 1) stabilization and symptom reduction, 2) treatment of traumatic memories, and 3) reintegration and rehabilitation. What follows is a description of Wim's therapy, focusing on issues of particular relevance to the forensic aspects of this case.

Phase I: Stabilization and Symptom Reduction

After diagnostic assessment, and the sharing and acceptance of the diagnosis, Wim was taught self-hypnosis as a means of relaxation, and thought imaginary behavioral rehearsal. He also learned to recognize and identify emotional responses, as well as alternative, non-dissociative ways of dealing with them. New coping skills included initial social withdrawal upon emotional upheaval, to be followed by assertive behavior when arousal had been sufficiently reduced. The therapist informed Wim about the consequences of traumatization. Generally, the therapist aimed to gain Wim's confidence by being understanding and predictable, but also by setting clear boundaries and limits. For example, in order to guarantee the therapist's safety, it was decided that a guard should be present while treatment was ongoing. Before entering the therapy room, Wim was searched for weapons. Upon Wim's request, which was motivated by his wish to discuss sexual themes the guard moved to the nearby waiting room in a later stage of treatment.

The "voices" were addressed by using ideomotor signalling. After the establishment of contact and a degree of trust, they were invited to talk to the therapist, initially under conditions of hypnotic paralysis of the extremities in order to safeguard both the therapist and Wim against Wim's potential loss of control. It was further suggested with hypnosis that at all times, the chair – not the entire therapy room – was to be his place for doing the work of the therapy. During all therapy work, Wim never left his chair. He never threatened the therapist.

Shortly after the start of therapy alter personalities emerged during therapy sessions. At that point the diagnosis was changed to DID. Four dissociative identity states were found, two of which were aggressive. One state pertained to an identification with the stepfather, and bore his name, "Harry." The other was called the "Suicide Man." This state embodied complete hopelessness. It was dedicated to committing suicide, but it also brooded on revenge. Out of rage towards authorities and the society at large, who had failed to provide Wim proper protection and care, Suicide Man planned to kill several citizens and policemen before shooting himself. Harry and "Suicide Man" both had quite restricted fields of consciousness, which were dominated by coherent sets of fixed ideas (polyideism: e.g., "I am Harry," "I am powerful," "women are mean whores, and deserve to be killed").

In the process of contacting the dissociative identity states,

the therapist explicitly took the position that previous and current aggressive behavior was unacceptable, and he held Wim responsible for his behavior. He also showed willingness to explore the motives for these acts, overtly assuming that the involved dissociated states had some understandable, if not essentially positive motive for their behaviors. Along these lines, contacts and cooperation with these states could be secured (cf. Watkins & Watkins, 1988).

Recognition of the dissociative identity states, their functions and backgrounds, as well as promotion of controlled and gradually elaborated interstate contacts and cooperation, resulted in both increased behavioral control and in a reduction of the mutual phobia of the dissociative identity states for one another (Nijenhuis, 1994, 1995). Wim's fear of these states and the phobic reactions of these states toward one another gradually subsided. Contacts and cooperation with dissociative states also allowed for contracting. For example, it was agreed Wim in neither state was to commit homicide or suicide in exchange for dealing with aggressive feelings in therapeutically controlled ways. These contacts also allowed for identification of conditioned stimuli which reactivated traumatic memories and related responses, including reactivations of dissociated parts of the personality. Such knowledge paved the way for learning to respond to these "triggers" more adaptively.

The contacts with the aggressive states yielded three alarming revelations: First, Suicide Man had an urge to run in the woods naked because it provided him a sense of freedom, but he did not want to be spotted. One night a girl on a bicycle noticed him. Immediately, Harry decided she should be killed, took full control over behavior and consciousness, and went after her. The girl barely escaped. As was described previously, Wim had been amnestic for these nightly fugue-like episodes. He was aware only of the unexplained mud on his shoes.

Second, another personality state despised grown-ups – males and females alike – since many had betrayed him. More specifically, this alter had a strong aversion of pubic hair and menstrual blood, both of which reminded him of sexual abuse, the extravagant sexual practices of Wim's wife and her friend, and the sadistic practical jokes they played on him, which included the use of menstrual blood. For these reasons, Wim meticulously removed all pubic hair from his body, and only watched pornography that showed actors without pubic hair. As his trust of the therapist increased, Wim disclosed that he preferred to fantasize about young girls as sexual partners. He regarded them as "unspoiled." According to Wim, this preference was a result of the intimate contacts he had had with his sister when they were children. Initially these contacts included sexual acts. Soon both sexually abused children came to feel that the incestuous contacts were improper. From then on, they restricted their intimacies to bodily closeness, which provided them with a sense of safety and consolation. Bodily contact ended when his sister got a boyfriend, but their relationship remained close. Wim stated that he managed to limit his sexual preference for young girls to imaginative acts, although he occasionally watched child pornography.

Third, as Wim felt it, a social worker had repeatedly overstepped boundaries, which enraged Harry, his most aggressive dissociative state. Since Wim feared losing control over Harry, he applied assertive skills learned in therapy, and pointedly warned the man that his behavior was unacceptable and that it might endanger him. His warnings were to no avail. When the social worker again behaved intrusively, a fight for bodily control between Wim and Harry ensued. As Wim later described it, Harry controlled one arm which almost strangled the social worker, while Wim, desperately using coping skills he was taught in therapy, managed to stay in control of the other arm and phoned the guards to rescue all from further danger.

From the start of Wim's treatment, the therapist also met with the staff of the department where Wim stayed. The goals of these conferences were for the staff to inform the therapist of Wim's conduct, and for the therapist in turn to educate the staff with respect to the phenomenology, diagnosis, and treatment of dissociative disorders in general, and Wim's case in particular. Wim was the first patient of the institution diagnosed to have a dissociative disorder. Furthermore, the therapy was periodically evaluated, and the therapist instructed the staff how to assist Wim in reaching therapeutic objectives.

Phase II: Treatment of Traumatic Memories

The Phase I interventions set the stage for Phase II, which essentially pertained to the emotional processing of traumatic events. Important interventions of this phase included graded exposure to traumatic memories to overcome the patient's phobia of traumatic memories and related emotions (Janet, 1904; Van der Kolk & Van der Hart, 1989).

The exposure to traumatic memories initially was restricted to cognitive information by suggesting that dissociative states could show pictures of the past using video equipment, while Wim was to operate the remote control switches. In this way, the aggressive dissociative states, amongst others, provided a detailed description of the actual murder. Suicide Man had been triggered when Wim's pregnant wife was kicked in the stomach by her friend. He felt enraged that the unborn child was the next in line to be abused. The anger further released Harry, who grabbed a knife and cut the friend's throat. Other memories pertained to severe emotional, physical, and sexual abuse, as well as emotional neglect.

Next, Wim was gradually introduced to his personality states' dissociated emotional responses to these overwhelming events. Several means were used to control the intensity and duration of the exposure, including imaginary filters controlling stimulus intensity and hypnotic time distortion

(Van der Hart, Steele, Boon, & Brown, 1993). In order to further control the degree of arousal, the various emotional responses were assessed one at a time. While exposure was ongoing, the therapist encouraged Wim to be aware of the past and the present simultaneously in order to promote discrimination learning; i.e., learning that traumatic memories pertain to memories, not actual events. To that end, imaginary pictures symbolizing safety in the present were inserted. Next, controlled imaginary expression of aggression directed at perpetrators, as well as expression of sadness and other emotions was introduced. Imagery directed toward intimate but non-sexual interactions with one of his sisters constituted one of the means of consolation.

These and related interventions further turned inhibitive relationships between Wim and his dissociated states, which may be regarded as complex memory networks (Yates & Nasby, 1993), into excitative connections, which finally allowed for complete fusion of the dissociated states. In other words, after therapeutic exposure to traumatic memories, the phobia of traumatic memories (Janet, 1904) and dissociative identity states (Nijenhuis, 1995) subsided. Theoretically, exposure therapy alters conditioned fear responses through discrimination learning; i.e., learning that acquired propositional associations between conditioned and unconditioned stimuli (i.e., conditioned stimuli *signal* the appearance of unconditioned stimuli) do not apply in all situations (Eelen, Van den Bergh, & Bayens, 1990; Nijenhuis, 1994). That is, through exposure the subject learns that the acquired propositional relationship between conditioned and unconditioned stimuli apply in some contexts, but not in others. However, exposure does not necessarily alter the effects of evaluative conditioning (Bayens, Eelen, Van den Bergh, & Crombez, 1989). Evaluative conditioning refers to the observation that the mere pairing of neutral with (dis)liked stimuli changes the valence of the originally neutral stimuli in a (negative) positive direction. This kind of learning is probably based on the conditioned stimuli acquiring a mere *referential* value to the unconditioned stimuli, without any genuine expectancy involved that the conditioned stimuli *predict* the unconditioned stimuli. As a result, exposure therapy will not affect referential relationships. In consonance with these theoretical predictions, after therapeutic exposure to traumatic memories Wim indeed no longer feared, but yet still *despised* pubic hair, menstruation blood, and adult females in general. Counterconditioning procedures and cognitive restructuring therapy were effective in gradually changing these negative evaluations into more neutral or even positive ones. Marked behavioral change towards women ensued. While masturbating, he was able to refrain from imagery involving young girls, and to concentrate on adult females instead. His interaction with women in vivo greatly improved.

Phase III: Reintegration and Rehabilitation

After fusion further gains in assertive and social behaviors, as well as emotional expressiveness were pursued and reached. Wim intended to leave the institution, as he legally was allowed to. Unfortunately Wim lacks vocational training and experience. He was unsuccessful in finding paid or voluntary work and envisioned social isolation. He continued to fear independent life, and chose to stay in the institution. Presently he receives behavioral treatment directed at overcoming his state of hospitalization.

Treatment for his dissociative disorder took 3.8 years. Because the sessions took place at a low density, no more than 67 sessions were involved. At a one year follow-up, no further dissociative behavior was observed. Wim reported an absence of dissociative amnesia, fugues, complete loss of control over behavior and consciousness, aggressive inner voices, or passive influence experiences. Hypnotic inquiry did not reveal signs indicating continued presence of dissociative states. Wim's general condition as well as his social behavior had changed for the better, and aggressive behaviors were lacking. His attitude towards women was normalized, and he ceased to feel sexually attracted by young girls. Symptoms of post-traumatic stress, such as nightmares and relivings of traumatic events, also had disappeared. It was unsure though whether Wim will be able to lead a fully independent life because he continued to display signs of "hospitalism." Living in a protected residence seemed to be a reasonable alternative and the goal was pursued. Another year later, Wim did not report and the staff had not observed further dissociation. However, Wim still lived in the institution and continued to resist efforts to encourage him toward an independent life.

DISCUSSION

Although the treatment was successful in reaching important affective, cognitive, and behavioral changes, as well as fusing the four alter personalities, Wim did not attain independent life. Since the fusion no more dissociative symptoms were observed by the staff or reported by Wim, but, as Kluft (1987b) stated, one can only be reasonably sure of absence of further dissociation at 27 months after final fusion. Indeed, considering the intensity, time of onset, and duration of traumatization, more than four alters might have been expected, in particular child alters. It may be that the close and stable relationship with his sister prevented more elaborate fragmentation. However, it could also be that Wim's refusal to leave the penitentiary institution, apart from other reasons, was related to a fear of reactivation of additional dissociative (identity) states. It might be argued that if there is residual unresolved trauma, states related to those traumata could be triggered by stimuli presenting in extra-institutional life.

The present case suggests that thoughtful screening for

dissociative disorders in offenders is indicated, especially when dissociative symptoms are observed or volunteered. Wim reported amnesia for his criminal act from the start, but this statement does not appear to have been considered significant. The costs of false negatives can be high. There were many missed opportunities to assess Wim's report of chronic abuse. Wim's dissociative condition resulted in extensive personal suffering, and in a criminal act that possibly could have been prevented. Further, failure to diagnose this condition in a timely manner indicates a waste of therapeutic effort. The case also suggests that relapses of aggressive and criminal behavior may be related to continued dissociation, and that treatment for DID may reduce those risks.

The risk of making occasional false positive diagnoses should also be recognized. As Coons and Milstein (1994) argue, some cases of simulation may be quite obvious, but others may be extremely difficult to discern. On the basis of their examination of 11 cases of simulated DID, they advise clinicians to look for signs characteristic of factitious disorder or malingering. In retrospect, the present case shows that some of these signs were positive (+), and others were negative (-) in Wim's case, which casts some doubt on their general validity. The indicators (followed by their applicability in Wim's case) that were provided by Coons and Milstein (1994) include severe disability since late adolescence (+), lack of consistent work history (+), dramatic or exaggerated presentation of symptoms (-), pseudologica phantastica (-), demanding (-) and depreciating (+/-) attitudes towards health care providers. At the time of his trial, Wim strongly mistrusted most professionals due to his being disbelieved and physically abused by some of them previously, refusal of collateral interviews (-), selective amnesia (+), and hospital seeking behavior (+), and, in a case of factitious disorder, a psychological need to take the sick role (-). Coons and Milstein (1994) argue that a clinician should routinely seek collateral verification regarding symptoms and past behavior. It should be mentioned that Wim's dissociative symptoms were independently observed by several staff members, but only after they had been introduced to the phenomenology of dissociative phenomena and dissociative disorders. Such staff training thus is indispensible. Yet, differential diagnosis in a few cases may remain difficult, and probably requires repeated evaluations over a period of time (Chu, 1991). In the criminal justice system, seeking to escape legal responsibility for criminal behavior is held to be a reason for malingering. Importantly, Wim fully accepted responsibility and never showed any desire to receive a DID diagnosis. Further, he displayed continued dissociative symptoms after his conviction. Also, as many non-forensic DID cases do, he was hiding his dissociative symptoms, confirming that he did not seek legal or social secondary regains from them (Kluft, 1987). The characteristics of continued dissociation after conviction and covert presentation of a dissociative disorder may be among the valid indicators of dissociative disorders. At the same time, dissimulation obviously constitutes a risk to accept false negatives. It may be concluded that offenders and society are served by a thoughtful clinical effort to screen for dissociative disorders in forensic cases. ■

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