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Who Done It, Actually? Dissociative Identity Disorder for the Criminologist

Adah Sachs[1]
Clinic for Dissociative Studies and The Bowlby Centre, United Kingdom

To Paula, with gratitude

Abstract

Dissociative Identity Disorder (DID) (American Psychiatric Association 2013) is examined in this paper from the perspective of its relevance to the criminologist. As this psychiatric condition is linked to severe and prolonged childhood abuse, accounts of DID patients inevitably involve reports of serious crimes, in which the person was the victim, perpetrator or witness. These reports can thus contain crucial information for criminal investigations by the police or for court proceedings. However, due to the person's dissociation, such reports are often very confusing, hard to follow, hard to believe and difficult to obtain. They also frequently state that the person had 'no choice', a thorny notion for the criminologist (as well as for the clinician). Through the analysis of clinical examples, the paper explores how decisions are made by a person with DID, the notions of choice and 'competent reasoning', and the practical and ethical ways for interviewing a person with DID.

Keywords

Dissociative Identity Disorder (DID); childhood abuse; crime; identity; 'competent reasoning'; human rights.

Introduction

The relevance of Dissociative Identity Disorder (DID) to criminology is quite direct: DID is linked to severe and prolonged childhood abuse; that is, to crime. Furthermore, some people with this complex condition continue to be involved in a life of on-going abuse, that is, further crime. DID is thus a condition which brings together criminologists and mental health practitioners, and challenges them both.

Professionals in both fields regularly struggle with the question of what did actually happen in the traumatic past of a person with DID, as accounts given by such persons are often uncorroborated, inconsistent and confusing. Moreover, in some cases, it appears that the

person's childhood trauma has not ended in childhood, but continues as a life-long involvement in abuse. Such a person may still be a victim, a perpetrator or a silent witness to crime, and the uncertainty regarding their past is extended into their life in the present. Most confusingly, however, such a person often states that his or her current involvement in on-going abuse is in complete contradiction to his or her own wishes. Clearly, both criminologists and psychotherapists struggle with such a notion of 'no choice', which also implies no responsibility.

Given the breadth and complexity of the field, I have not aimed, in this paper, to offer comprehensive discourse about DID. Instead, I have limited myself to a brief description of this condition, and focus on three specific questions which are of special relevance to the criminologist:

1. Is it possible to find out what actually happened?
2. Did the person have a choice, and does he or she have capacity to make a choice in the first place?
3. How can a person with DID be interviewed effectively and ethically, without causing further trauma?

The clinical examples which I use to illustrate the discussion come from my clinical and supervisory work over the past twenty years. In order to preserve anonymity, all the examples are amalgamations of material from several cases, and never a description of a single person. The one exception is the case of Paula. Paula has specifically asked for her story to be told with only minimal changes, as part of her contribution to knowledge in the field of trauma and dissociation. This paper is dedicated to her.

Dissociative Identity Disorder

Dissociative Identity Disorder (DID) is the most complex of a group of disorders called Dissociative Disorders (DDs) (American Psychiatric Association (APA) 2013), which are associated with prolonged and severe childhood trauma and abuse.[2] Put in a nutshell, it can be said that the brain can develop the capacity to disown or dissociate experiences which are too extreme and overwhelming (Bromberg 1995; Chu 2011; Courtois and Ford 2013; Freyd 1996; Stein 2007). Such experiences are then stored or 'coded' (Sandler and Fonagy 1997) in the brain as though they were not real; as though they did not happen to one*self* but to someone else; or as though they did not happen at all.

Trauma-linked dissociation protects the person by separating him or her from a traumatic experience. For example, a man describes the seconds of a car-crash in which he lost his leg: 'It was as if I was watching myself from the outside, observing the collision. I didn't feel any fear or pain'. This man remembers the event, but as though he was 'watching it from the outside' rather than experiencing it. This dissociative experience (*depersonalisation* type) protects him from the full impact of the trauma.

Such 'one-off' traumatic experiences may result in other forms of dissociation (often in conjunction with flashbacks as in Post Traumatic Stress Disorder (PTSD)): *derealisation,* in which the person feels that what happened was not real; or *amnesia,* the inability to recall the event altogether. All these presentations may be familiar to criminologists from interviews in the wake of a violent crime with victims as well as with perpetrators. Inasmuch as such experiences are limited to a one-off trauma, they constitute a dissociative symptom, but would not warrant a diagnosis of a dissociative disorder.

The following example, however, is quite different. A five-year-old girl explained her drawing to her therapist (Southgate 1996): 'this is me, sitting in the ceiling, watching daddy hurting little girl (on the floor)'.

Like the man in the car-crash, the girl describes 'watching herself from the outside'. Two factors, however, make this case different: the first is the girl's very young age; the second is that being abused by her father was not a one-off trauma but a regular part of her life. Where a traumatic experience followed by dissociation is repeated frequently and deeply, especially in childhood, the brain's state of dissociation can become a trait (Perry et al. 1995), a characteristic of the way the brain responds to any distress signal: in short, a dissociative disorder.

In all DDs the extent of the 'disowned' or dissociated material is not limited to a single traumatic event, but extends into most areas of the person's life and affects the ways he or she remembers or processes events or responds to new stressors. In DID, not only the traumatic events are dissociated, but also the very identity of the person (hence the name Dissociative Identity Disorder).

In the person with DID, different events, experiences, feelings, skills and stages of one's life are 'owned' by distinct, separate parts of the personality. These are often referred to as self-states, ego-states, personalities, parts or alters. We may say they are like people who live in separate apartments within the same building (the 'building' being the person's body), with only a few interconnecting doors between them. The person thus does not function 'as a whole', as he or she does not have access to their full identity, memories and abilities.

To illustrate this, consider a non-dissociative person, who may describe herself as follows: 'I am 50 years old, I have two children, I'm a computer engineer and I play the piano in my spare time'. These same facts, related to a person with DID, may be presented quite differently: a part of the person has the identity of a 50-year-old engineer. She always works. Another part is the mother of two children, and only manifests in their presence. She is thus not aware of ever going to work, and has never learned to play the piano. Another part is that woman when she was an abused child: this part feels and talks like a frightened five-year-old, and knows nothing about having had children or a professional life. And another part loves music. She plays the piano, always. Each of these alternate parts (or alters) has a different life story, age and name. We can see it clearly in the following clinical example:

> *Lily, aged 13, was adamant that 'nothing bad had ever happened to her'. Her many episodes of being abused did not happened to 'her', but to 'Rob', a little boy that was created in her dissociative mind. Lily didn't know that Rob existed, nor did he know that she did. From her perspective, which did not include Rob's perspective, she was perfectly truthful and correct in her assertion about her unharmed life. By contrast, Rob's life contained nothing but abuse.*

The confusing presentation and contradictory accounts provided by people with DID has given rise to considerable suspicion regarding their truthfulness, in forensic as well as in psychological and psychiatric settings. People with DID have often been – and still often are – deemed malingering, psychotically hallucinating or 'attention seekers'. Indeed, my assertion that these disorders are trauma-related has only recently become more widely accepted, following some 30 years of fierce debate. Notably, the third and fourth editions of the Diagnostic and Statistical Manual of Psychiatric Disorders (APA 1980, 2000) placed DDs next to the 'fictitious disorders' category. Only in the current, fifth edition of the DSM (APA 2013), are DDs explicitly placed next to 'Trauma and stressor-related disorders', this placement 'reflecting the close relationship between the two' (APA 2013: 291).

The origins of DID

Evidence is accumulating (Dorahy et al. 2014) to show that Other Specified Dissociative Disorder (OSDD) and DID are linked to severe childhood trauma and abuse. Almost invariably, people with these disorders (DID and OSDD) report years of continuous, most extreme trauma. Although their accounts are not always proven or provable, the sheer numbers of such accounts, the similarity of their details and the lack of any conceivable benefit to the person make the idea of malingering unlikely in most cases. In an interview, Chris Healey (2008), retired head of Portsmouth CID, describes several police investigations based on accounts of people with DID, most of whom he considered to be sound witnesses. Indeed, in many cases, people with DID report to the police information about their own past criminal activities.

In therapy, people with DID (or their alters) describe growing up in the shadow of on-going sadistic sexual, psychological and physical abuse, usually by multiple perpetrators (Chu 2011; Kluft 1999; Mollon 1996; Sachs 2008; Stain 2007). Most of them explain that abuse is inseparable from their everyday life, and is practiced and suffered by every member of their family, for generations (Middleton 2013b; Miller 2012; Sachs 2011). Others report organised sexual abuse, human trafficking and group ritual abuse (Healey 2008; Miller 2012; Salter 2013; Sinason 2011), years of incestual abuse (Middleton 2013a, 2013b) and organised torture (Ross 2000). Many confess to abusing others (including family members) or to committing murders, and hold these recollections of perpetration as the most traumatic of all of their experiences (Sachs 2013a). Indeed, as recollections of inflicting abuse are so traumatic, they tend to be some of the most heavily dissociated, and require much therapeutic help before they can emerge.

It is important to bear in mind that the abuse described above occurs within a setting to which one belongs (willingly or otherwise). Freyd (1996) talks about the devastating impact of betrayal on the incestually abused child, and how amnesia to (that is, dissociation of) the incest serves as protection. For the person with DID, this usually means that some of their alters are aware of the abuse and want to avoid it, while other alters are only aware of the 'sense of belonging' or even love. The latter alters have nothing to prevent them from continued involvement with the abusers (Sachs 2011; Sinason 2011). Moreover, some alters are identified with the abusers and admire their strength, cruelty or high standing within the group (for example, boy soldiers admire their commanders) or family. Such alters may feel nothing but loathing and contempt for the suffering of the abused whether the abused is an external person or one of their own alters. They, too, have no reason to change or stop a relationship in which abuse never stops.

Growing up with such level of continuous trauma is so devastating that the mind cannot contain it without extraordinary measures. DID is just such an extraordinary measure. It protects the person from experiencing the trauma, as well as from any knowledge about it. This protection, however, comes at a cost. As well as the chaos of a life run by a group of un-coordinated parts, such a person is also unable to learn from his or her life experience. For most people, memories of trauma, devastating as they are, also serve as warnings against dangerous situations or people. In their absence, however, the dissociative person is exposed to the risk of innocently walking into danger, over and over again.

The following clinical example demonstrates several of these features of DID: the vast differences between the experiences, views and accounts of different alters regarding traumatic events; the subsequent uncertainty that professionals feel regarding the reliability of accounts given by these patients; the on-going risk to their safety; and the question of how much choice they have regarding some of their actions.

Clinical example: Paula[3]

Kim distracted everyone's attention by starting a family row. While a dozen people were shouting at each other, she sneaked out of the house, taking her younger sister, Polly, with her. Once on the train, she rang John: 'I'm on the train, John! I can't wait to see you and the baby'. Polly, now realising that they were going to meet John, was horrified. She tried to object: John was a very dangerous man, he had hurt them badly in the past. Kim told her to shut up and mind her own business.

Kim and John, her cousin, were married as children. It was like a Romeo and Juliet story, Kim told me: they loved each other, and had a baby when she was 12. But then there was some serious feud between their families, and she and John were torn apart. John's parents, her aunt and uncle, ended up raising the baby. Kim was now 39. Her baby, that she was about to meet for the first time since he was two years old, was 27.

Two hours later, with Polly still frantically begging Kim to turn back, they stepped out of the station. A blue van waited for them right in front of the exit, and a man's voice that Kim recognised shouted 'get in, quick, he is waiting for you'. Three men helped them in, shut the doors and drove off. The small space reeked of garlic, alcohol and sweat. Kim looked around. No John. No baby. She went numb after that. Next to her, Polly was being brutally raped by the three men.

They were let out of the van in an unfamiliar street. Lea, beside herself with worry when she realised they were gone, had found them there: Polly dishevelled, shaking and crying, Kim silent and pale. Lea phoned me in panic, and we spent the next two hours on the phone, while I directed her through bus lines and trains on her way home. As well as being upset, Lea was worried about how to tell the story to the family: 'they can be very funny about things, you know, with beatings and punishments; I don't want no one hurt'. We agreed that she should settle the girls first, help them change and put all their clothes into a plastic bag to take it to the police, before talking to the rest of the family.

When they arrived home, they received a very mixed reaction from the family: some were furious with Kim for taking such a risk. Some never noticed that the girls were gone, and didn't believe any of it. Some didn't want to hear Lea's story. Some were deeply upset, one felt suicidal because it reminded her of her own history. Kim herself, sniggering, went to have a bath. She couldn't stand all this fuss over her private affairs. Someone else - I don't know who - took the plastic bag with the clothes and washed everything. Polly was too distraught to talk to anyone. She had a bleach bath, because she felt dirty. The next morning, at Lea's insistence, Polly went to see the GP, because she was in so much pain. The GP said that Polly had grazes and bruises around her genitals, ribs, ankles and wrists, but having washed herself with bleach, no other signs of rape could be found.

And was there a rape?

Paula is a woman with DID. She has over 90 alters, including Kim, Polly and Lea. They all share one body. Kim maintains that it is her body, and that she was never raped. Polly believes that the body is hers, and that she was. Lea believes Polly, but she wasn't there when it happened so she can't testify. The 'main person', Paula, knew nothing of the whole affair: she was at home, ironing.

Discussion: What really happened?

Paula was not able to answer this question. The memories of her childhood, as well as of her recent past, have been divided across a large number of alters, each of whom holds a few pieces of the puzzle. By the re-appearance of injuries on her body she gathers that she often gets hurt. She remembers having been pregnant twice, but she can't recall ever having intercourse. She doesn't know if she has ever had any babies. According to Paula, John was a distant relative who always mocked and teased her as a child. He now owned a building firm, and she saw him from time to time in the neighbourhood, driving his blue work-van.

Several of her alters spoke of having had abortions (which suggests that Paula may have been pregnant more than twice). The alter Kim has had one baby, and was devastated at his being taken away from her. Kim is frozen in time, aged 15. She is a spunky teenager and has never lost hope to get her baby back. She and John continue to meet secretly and have sex.

Polly is a child alter, aged eight years, who has reported being raped by John many times. She has never been pregnant.

Lea, an alter aged 35 years, said that John is a 'nasty piece of work', and that his son was as bad as he was, though 'looking every bit like his mother (Paula), who couldn't hurt a fly'. She explained to me that Paula didn't know that she was the mother of John's son. Rather strikingly, Lea never seemed to realise that, as she and Paula shared a body, John's son was also her own son; nor did she notice how similar his face was to her own face.

A male alter of Paula, named John, is (the external) John's best mate. The two Johns often go together for a beer, and, as the alter John tells me, they 'always have a laugh'.

As we can readily see, each one of these accounts or perspectives is truthful; but none of them is the truth. Even the eye of an external witness – say, a neighbour – could not get us much closer to the truth: what is visible is the pair Paula and John, who had a baby together when they were teenagers; the baby was later adopted by John's parents. The two of them are now adults, both single. They sometimes go to the pub together, sometimes have violent sex, and sometimes seem estranged for months. Nothing in this information can help to prove or disprove a possible rape.

In order to understand, and help Paula understand, the events of the day in which she was ironing at home (or of any other day in her life), we need an internal witness: one who is able to hear the communication of each of the alters, understand the significance of certain events for each of them, and help them to create a picture which will reflect their joint perspectives. This, in my view, is the most important and challenging task of psychotherapy with DID patients, and it is equally challenging for the criminologist who attempts to interview them.

Risk, choice, capacity and human rights

It is clear that Paula is at a high risk of being raped or otherwise hurt by John, as well as by other people. However, the attacks which she suffers are always supported and aided by some of her own alters. Can we say that being attacked is thus her choice? Should a person with DID be seen as having capacity, if they make such choices? Can such person be deemed a 'competent, practical reasoner' (Schopp 2001)?[4]

Paula's full history is divided between many alters and thus not accessible to her. This means that, for example, the part of her which is still in love with John of her teenage years (the alter Kim, aged 15 years) has no knowledge of any danger, and is always eager to meet him and her baby. She is not alarmed by invitations to get into dark vans with unfamiliar men, as she has never been hurt in such circumstance: before any hurt begins, she 'switches' into the child-alter Polly. Polly, who is scared of John and wants to escape him, has no power to prevent the

meetings. The alter Lea seems wise and able, but her role in the system is to 'pick up the pieces', so she never appears early enough to change the outcome. And Paula, dissociative to all of this, knows nothing before or after these episodes. In fact, she finds any remotely sexual situation so distressing that another alter instantly takes over, thus leaving her (that is, the Self that she is as Paula) no choice over what will happen next.

One may argue that Paula, as the victim, should be protected by the police. But she has not requested such protection, and not being aware of being attacked, does not deem herself a victim. Polly and Lea would welcome help and protection, but the alter Kim would be very upset if her beloved man was arrested. Police intervention would thus be against her will, rather than offer her protection. The alter John, similarly, would argue that his mate is innocent, as he has never witnessed him doing any wrong. Any action by an external agent (for example, a social worker, a police officer or a therapist) would inevitably violate some human rights, by taking choice away from some alters and acting on behalf of others; and it is hard to justify such violation when one cannot be certain who (if any) of the alters provides the most accurate account of the events.

Questioning one's capacity and agency must be considered extremely carefully, as it inevitably presents a degree of threat to one's human rights under the Human Rights Act (1998): notably, the right to liberty and security (article 5); the right to respect for privacy and family life (article 8); and the right to marry (article 12). This question becomes far more complex when we meet a number of alters, each of whom claims to be 'the person' and where each demands the right to make her/his own choices.

The parts and the whole

Looking at the individual alters while keeping in mind their perspectives and interests, we would usually be impressed with the fact that their choices reflect coherent and reasonable thinking. They are certainly not confused, erratic or 'mad'; and it is relatively easy to agree that each one has capacity.

The difficulties arise in the communication – or lack of it – between the alters, which may mean that disparities between their respective wishes could result in violent conflict between their subsequent actions. Indeed, this is a key characteristic of DID: while the non-dissociative person, perhaps through great *internal* conflicts, eventually reaches a decision which shapes his or her actions, the person with DID experiences an *external* conflict between warring alters, who would each gladly 'hijack' the action if they could. Furthermore, this external struggle is often fought with blindfolds on, so to speak, as alters may not even know who opposes their actions, when they have no knowledge about the alters who do so.

Are we then to assume that the actions of a person with DID are quite random, and express the wishes of whoever happens to be the 'up' alter at a given moment? This is a critical question. A positive answer to it will lead us to the conclusion that the person with DID has no overall identity, and thus no agency or capacity beyond the individual alters. A negative answer will ignore and deny the reality of DID and the incredible everyday difficulties of the person with DID.

I believe that part of the answer can be found in close examination of the 'switching' process. Who – or what – determines which alter will replace the alter currently in control, and at what exact moment? Is the switching random, or is it governed by some 'internal logic' of the system as a whole, which can be seen as the pre-cursor of the capacity to make choices?

People's choices, even when appearing to be 'bad choices', always reflect their own deepest sense of what is 'good for them'. A person may work cripplingly hard for a cause which is felt

worthy; betray a friend to satisfy a personal wish; deny one's own needs for the sake of a loved one; punish oneself to relieve guilt or to please God. One may murder out of greed, hatred or fear, or commit suicide when the alternative seems worse. Such actions, controversial as they may be, reflect the deepest and most personal choices that one can make.

I suggest that the person with DID does the same. It is not only the alters who make choices (according to their own wishes, fears or desires). The whole system, or the person as a whole, also makes choices about which alter is felt to be the most suitable alter for the situation; and these choices are surprisingly sensible and not in the least random. For example, an alter called 'the professional' is always 'up' when the person is in their work environment. An alter called 'the mother' is present most of the time when the person's children are present, especially if they are young. A compliant, young and powerless alter is in position when (like in the person's childhood) it is not possible to resist the abuser, and the best chance for survival is to 'freeze' and give in. Similarly, a promiscuous alter called 'red dress' gets triggered by a man who makes a pass at her on the train. Mute, very young or learning disabled alters appear when questioned by the police, thereby keeping safe the family secrets; and an alter called 'the avenger' may be willing to speak to a seasoned therapist and explain that the mute child was going to be killed if the child spoke. An alter called 'fish' appears when recalling a maternal attempt to drown the child (being a fish relieves the terror of drowning); and an alter called 'robot' may report, in a mechanical voice, having attempted to drown a child who told secrets. Each of these alters appears, on cue, when the external situation requires their particular skills. And the ability to bring to the fore the right alter at the right time could only be understood as some centralised functioning, overall identity or a rudimentary Self.

For the psychotherapist, this recognition points towards focusing much of the therapeutic efforts on helping that rudimentary Self to develop and grow (Sachs 2014).

Paula: So what *really* happened?

After years of therapy, this is how Paula explained what had happened to her while she was ironing.

Her need to see her baby and the boy she loved (as expressed by her Kim alter) were sometimes stronger than her own (Paula) aversion to sex, and broke through her amnesia of ever having had a baby. The longing for the baby also prevailed over her fear of John's brutality and her previous experiences of meeting with him (as expressed by the alter Polly). She was indeed raped (as Polly) by John, his brother, and by her 27-year old son: even Kim, who may have wanted to have sex with John, was not consenting to the other two men. After it was all over, she (as the alter Lea) did all the sensible things: called for help, prepared for going to the police, went to see the GP. But Kim's longing to see her baby was so strong that it only allowed Lea to appear on the scene at the end, when she couldn't stop the meeting from happening.

Most interestingly, Lea also tried to evoke Paula's centralised functioning, by 'telling the story to the whole family' (of alters). At the time this attempt failed because the other alters didn't listen or didn't believe the story; and whoever did believe it took the action of destroying the evidence (washing the clothes, bathing in bleach). This, in part, was to protect John, but it also protected Paula from learning the truth. Paula's 'sensible life' was fully protected, while her body continued to get hurt over and over again.

When Paula recovered her centralised functioning to the point of being able to hear all her alters describe what had happened to them over the years, her condition deteriorated sharply. Rage, fear, guilt, physical pain and the crushing realisation of the loss of her baby made her sink into severe depression, and self-loathing made her suicidal. At the same time, her self-loathing also

had a healing – and even thrilling – feel, as it implied an actual Self. In due course, the loathing changed into compassion, while her overall Self continued to develop and grow.

Interviewing a person with DID

For all the reasons discussed in this paper, people with DID are usually considered to be unreliable witnesses, difficult (or even impossible) to interview, and potentially at risk of deteriorating through the process of an interview. As a result, clinicians and criminologists alike tend to avoid asking, listening to and relying on anything said by people with DID, and their accounts, which could be critical for understanding situations, may be missing. This omission, though understandable, compromises our ability to learn the truth ('the interests of the case'), as well as the interests – and human rights – of the person with DID. I suggest that interviewing a person with DID regarding crimes that they have been involved in is necessary, possible, and often quite therapeutic.

Perhaps surprisingly, given the severity of this condition, recovery from DID is often successful (Brand, Loewenstein and Spiegel 2014; Brand et al. 2013; Dorahy et al. 2014). However, the process is complex, requires specialised psychotherapy, and is lengthy: five years and upwards (International Society for the Study of Trauma and Dissociation 2011). The interviewer of a DID patient (in court, hospital, victim support centre or prison) needs to gain insight into situations like Paula's rape quickly, while not compromising the patient's well-being. In the following section I offer some guidelines for an ethical and useful interview with a person with DID.

- The environment must be (and feel) as safe as possible. Owing to their severe trauma history, DID patients are highly sensitive to any perceived threat or manipulation. Importantly, the interviewer has to be open and respectful, and acknowledge their own limitations truthfully ('I don't know all that much about alters; perhaps you could correct me where I make a mistake or say the wrong thing').
- Even though you only see one person sitting opposite you, remember that you are always talking to a group. The relationships between the members of the group range from friendliness to war. Some of those present are young children and some are older than the main person (and perhaps older than you). Many of the members are wearing blindfolds and are not aware of other alters. Your questions or comments thus must be very carefully worded, so as to respect the feelings and the safety of everyone present.
- There are many accounts of the same event. For each alter who participated in or witnessed it, the event had a different meaning; and many alters were not there and will state that it did not happen at all. Each of them tells the truth (as they know it). Alters very rarely lie, as they rarely possess the complexity required to do so.
- The more accounts you hear, the closer you get to a true representation of the events. It is thus important to listen to all communication, rather than to let only the 'main person' speak. As in the case of Paula, the main person or the ANP (the Apparently Normal Personality) may know the least about what happened or about the risks that they are facing.
- Some of the more confusing presentations (for example, a very young child, a dog, an alter who is 237 years old or a monster) may be able to tell more than the ANP. Be polite and respectful, thank them for their willingness to talk to you, and pay attention to how they communicate. If they can't talk (because they are a dog or because they are not allowed to speak), they may be able to write, draw, point or nod.
- Some alters are there in order to obscure the picture that you are trying to discover. They do that because they have no reason to trust you, and they have always managed life by creating smoke-screens. This has to be respected as the limit which the person

sets. If you have more than one interview, and if you have been respectful and thoughtful, this limit may gradually shift.

- The striving for survival unites all the alters, even the suicidal ones. This is often expressed by striving for closeness with the *attachment figure* (Bowlby 1958, 1988) even when that attachment figure is dysfunctional or plain dangerous. This seemingly paradoxical reach towards a dangerous person occurs in all cases of *disorganised attachment* (Bentovim 1995; Liotti 1999; Main 1995; Sachs 2008, 2011, 2013a, 2013b). As the striving for survival is so highly valued by all the alters, you will always be correct in praising each alter for doing all that was in their power for being safe. It enhances the self esteem of all the alters, and promotes a sense of a shared achievement and their overall identity.
- The relief of being heard, understood and believed is quite rare in the lives of people with DID. Having such an experience has the power to break through the isolation in which they live, and create a sense of connection between the dissociative person and all those who have not been abused.

Conclusions

This paper attempted to address questions which are very difficult to answer regarding people with DID. Is it possible to determine what exactly happened in the traumatic past of a person who does not have full access to his or her memories? Is a person who is barred from knowing about risks to their safety (as this knowledge is held by separate alters) capable of making an informed decision, and does he or she have a real choice? Do we have the right - or the duty - to protect the person's safety, if by doing so we transgress some of their human rights? And, most fundamentally, does a person with DID have an overall identity or Self?

My view is that the sequence of the 'switching' of alters in a person with DID reveals a non-random pattern: the alters who 'appear' and take over the person's functioning are always the ones who can best handle the challenges of the moment (even if their choices may not be to our liking). I therefore conclude that the person with DID does have a mode of centralised functioning, overall identity or Self, with the capacity to make choices for the whole person (at the very least, regarding which alter should come up). I further conclude that therapeutic efforts (as well as interviewing techniques) must focus on acknowledging that Self, rudimentary as it may be, and help it to grow and develop. Ultimately, that will increase the person's ability to access their past, make progressively more informed decisions and be safer.

Correspondence: Dr Adah Sachs, The Bowlby Centre, 1 Highbury Crescent, London N5 1RN, United Kingdom. Email: a.sachs@mac.com

[1] Dr Sachs is an attachment-based psychoanalytic psychotherapist.
[2] The early traumatic origin of depersonalisation and derealisation dissociative disorders is not proven at this stage.
[3] This case is presented with only minimal changes, at the request of Paula.
[4] The question whether persons with DID have agency and capacity has been much debated with regard to their liability to bearing criminal responsibility. For an excellent summary of relevant court cases, see Farmer, Middleton and Devereux (2008).

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