MULTIPLE PERSONALITY DISORDER AND HOMICIDE: PROFESSIONAL AND LEGAL ISSUES

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ABSTRACT

Unfortunate complexities encountered during the treatment of a 49 year old male with diagnosed multiple personality disorder (MPD) are described. Treatment sessions extending over a one year period were abruptly terminated after the patient's murder of his live-in girlfriend. Clinical hypotheses regarding the mechanism of the dissociation which occurred prior to and ensuing the killing are presented. The need for special attention to concealed aspects of the dissociation is addressed. The difficulties of case management on an out-patient basis in a large urban hospital are outlined, with implications for optimal treatment conditions. Skepticism among service providers regarding the diagnosis of MPD is also discussed.

INTRODUCTION

This paper describes some experiences of a therapist attempting to treat a patient suffering multiple personality disorder (MPD). The complexities of treating MPD include not only those of a clinical nature. In some instances they extend into the realm of behaviors that bring the patient into contact with the laws of society, and effectively transfer the patient from the therapist's office to the criminal justice system. In this report the identities of all individuals mentioned have been disguised to provide confidentiality to the parties concerned. The patient whose situation is described herein has authorized the publication of a scientific communication based upon his circumstances. The discussion of legal issues in this article is meant to be only a general summary of the law throughout the United States. The laws of any particular state may vary from the summary. Therefore, in considering the legal issues facing practitioners in a particular state, legal counsel in that state should be consulted.

CLINICAL DATA

The patient, John Jason Davis, is a 46 year old, divorced male of who had presented with symptoms of a dissociative disorder at a large urban hospital. During the initial intake, the diagnosis of MPD was suspected based on the patient's account of a variety of life events, such as losing large amounts of time, finding strange items in his possession, and numerous other symptoms both suggestive and characteristic of this condition (Kluft, 1987).

John spoke of having an alternate personality, never directly experienced by him, but described by others as the angry, obnoxious antithesis of his usual good-natured demeanor. Appearances of the alter were correlated with the timing of notable lapses in John's memory. The alternate personality, Billy Jack, was suspected of committing various illegal acts ranging from thievery to drunk and disorderly conduct. John would find himself in various local jails facing charges for behaviors of which he had no recollection. The alter's actions would dominate the system and radically change John's behavior. Billy Jack eventually revealed himself as a complex, unique character with his own set of morals, attitudes, vocabulary, accent, habits, social relationships, and even facial expressions.

Upon diagnosis of the case, a tremendous amount of skepticism was encountered from the clinical staff. The diagnosis was eventually discounted due to staff's perceptions of MPD as an extreme rarity, and doubts about its legitimacy as a clinical disorder. The official diagnosis was recorded as bipolar disorder. Approximately one month into his treatment at a day hospital, John attempted suicide by overdose. He claimed that suicide was the only way to stop Billy Jack's terrible deeds. A psychiatric consultation minimized both the patient's suicide attempt and references to an alternate self as manipulative behavior. The apparent difficulty of the clinical staff across the disciplines of psychiatry, psychology, and social work to consider the diagnosis of MPD contributed to the delay of instituting proper treatment for nearly a year after the patient had entered the hospital system. This same phenomenon appeared to have contributed to the decisions of professionals at many other facilities to minimize the numerous suicide attempts that had precipitated 18 hospitalizations over the previous ten year period.

During the next six months, frequent incidents occurred during which Billy Jack's violent tendencies were displayed. During one such episode, he struck his live-in girlfriend, Patricia, on the head. (Patricia was a troubled individual with an extensive psychiatric history.) Billy Jack "fainted" or switched on the scene. Patricia summoned the police, and the patient was taken into custody where he remained for 15 days, was fined, and released. The diagnosis made by the emergency ward clinician at the time of the

arrest was alcohol abuse.

PREVIOUS PSYCHIATRIC HISTORY

Medical records reveal a total of 18 psychiatric hospitalizations, beginning in 1978. Twelve of these were general hospital psychiatric admissions ranging from two days to one month's duration. There were also two state hospital admissions, plus four stays at Veteran's Administration Hospitals.

FAMILY HISTORY

John Jason Davis was born the youngest of seven children. He had three older brothers and three older sisters. His father was alcoholic, but employed regularly in a professional and managerial capacity. He died at age 56 of cirrhosis of the liver, when John was 16 years old. He recalls his father to have been violent and both physically and verbally abusive. The patient describes his mother as demanding and a harsh disciplinarian. He was born when she was 39 years old, after a series of miscarriages. There was constant conflict between John and his mother. He recalled one incident (at approximately age 4) of being locked in a closet after being spanked repeatedly for "getting on his mother's nerves." He always felt unwanted by his mother. He maintained that she favored the older children and resented him.

One of John's brothers committed suicide at age 49 by shooting himself. His two other brothers have been married twice. The patient can recall homosexual advances by one brother when he was 19 year old. This same brother was later charged with the sexual abuse of his own child. John stated that his three sisters are all married. He recalled that one of his sisters (approximately 3 years his senior) introduced him to sex when he was 12 years old. The patient described extreme anxiety and guilt about their repeated sexual encounters. He was terrified of being caught. He had wanted to cease these exchanges on several occasions. However, the sister threatened that if he did so, she would tell their mother that he was her seducer.

The patient attended parochial school until the eleventh grade. He graduated public high school at age 19 after repeating his junior year when transferring to public high school from the parochial school. He described himself as a loner, and an average student who made no efforts to study. John can recall incidents of lost time from age 7. He was reported to have set a tree ablaze in front of his house, but had no memory of this event. At 13 he was told that he broke a boy's arm, but again had no recollection. At age 19, John joined the Army and did code work in security. He enjoyed the service very much and bitterly resented his mother for manipulating a clergyman to petition for his return home. A claim of hardship was made on the basis of his mother's ill health. The patient felt that his mother's arthritis was not a serious enough condition to cause him to return home, and believes his siblings forced the responsibility of his mother's care onto him.

John met his wife after living with his mother for four years after his brief military service. He decided to marry despite objections from his siblings. He was married for 22 years and fathered two children, presently in their twenties. Both his children are estranged from him, as is most of his family. His mother died at age 85, when John was 46. He was separated approximately two years before the murder, and his divorce was finalized before this tragic occurrence.

PSYCHOLOGICAL TESTING

John was administered the Weschsler Adult Intelligence Scale-Revised (WISC-R). He performed within the Above Average range, with a full scale IQ of 114. His verbal IQ was 122 and his performance IQ score was 103. His Rorschach was described as unremarkable with 26 common percepts offered as responses. There were no bizarre responses; some dependency traits were noted. The Thematic Apperception Test revealed some depressive tones, but no other abnormalities. The Minnesota Multiphasic Personality Inventory (MMPI) results were considered invalid due to the patient's responding in an exaggerated manner. An analysis of critical items, however, did suggest an abundance of somatic complaints, concerns with sexual deviance, persecutory ideas, and past threats of assault. He responded to questions in ways that suggest acute anxiety, depression, antisocial attitudes, family conflict, and suicidal ideation. The patient's medical history reveals that he had been in relatively good health, except for a long history of severe headaches which had no discernable organic cause.

COURSE OF TREATMENT

John began treatment that addressed his MPD once referred back to the outpatient unit. He was seen twice weekly, which was the maximum limit allowed for therapy sessions. A third personality was eventually identified as Henry. He presented as a suave, intellectual, narcissistic, manipulative, and seductive individual. The realization of there being a third personality elicited much anxiety; John again expressed suicidal ideation. A second psychiatric consultant advised that the issue of the client's dramatic symptoms posed a serious problem, yet he felt these behaviors should be ignored or suppressed, and that the patient be instructed to control himself to as great an extent as possible. The topic of multiple personalities was to be avoided strenuously; the patient's efforts to discuss it were to be ignored. It was hoped that his concern with the personalities could be reduced and he might be instructed to put the whole subject out of his mind.

In the days that followed, John continued to be depressed, and hospitalization was imminent. Therapy had become more intensive at this point, and it was hoped that hospitalization would function as a safe and structured support to stabilize his suicidal ideation. After fifteen days in the hospital, John was discharged. However, there was no notable improvement in his affect or disposition.

The next eight months brought continued progress through outpatient treatment. Suicidal ideation subsided. During the ninth month, the therapist scheduled a vacation and terminated employment simultaneously. John had been prepared well in advance, and arrangements had been made

to continue his treatment in private practice.

John was tardy for the final session in the outpatient unit. He had consumed an overdose of prescription pills and a pint of vodka. He manifested tachycardia, a flushed face, and staggering gait. After discussion with his three personalities, John finally agreed to be escorted to the emergency room.

The therapist considered it to be crucial that John be contained in a safe setting during the therapist's absence. After a brief admission, however, John was discharged from the hospital with routine outpatient support.

Within the next ten days, John murdered his live-in girlfriend, dismembered her body, and scattered the body parts in plastic bags throughout the county. He was not arrested until 17 days later, because his carefully calculated disposal of the remains had made identification of the body nearly impossible. He had severed the fingertips from the hands which eliminated fingerprint identification, and had removed all the teeth so that dental records were useless. The body parts of the victim were discovered one at a time, creating an element of grisly mystery that was sensationalized by the press.

Body parts were discovered for a week and a half before the identity of the victim could be established. This case would have remained an unsolved mystery if not for one flaw in the disposal of the body. A steel plate had been inserted in the victim's right forearm to mend a fracture approximately two years before the slaying. This fact was unknown to John. The plate bore a manufacturer's identification number which enabled the distributor to provide the addresses of the three local hospitals that had received portions of the particular shipment of plates. One hospital determined from surgical records that they had implanted that specific numbered plate in the arm of one Patricia Morrow. Additional x-rays on file at the hospital aided in the positive identification of the body. The coroner's report determined that the cause of death was blunt trauma to the head and exsanguination due to decapitation and dismemberment.

John was arrested at the couple's mutual residence shortly after identification of the body. The apartment was blood-stained throughout. Various murder weapons, including a boning knife and a saw, were discovered. John was charged with the murder of Ms. Patricia Morrow. At the time of the arrest the closets were in the process of being emptied, and a road atlas was on the bed. John had recently received a settlement of $15,000 in residual social security benefits for a claim of mental illness. Based on these factors, the state established John's intent to flee the area. He was arrested and held without bail.

DISCUSSION

Thoughts on the dynamics of dissociation

John had demonstrated artistic talent with woodworking during his vocational rehabilitation. He had taught patients how to use a power saw and made several attractive wooden gift items for staff and patients. The gross distortion of his talents during the homicidal act are obvious, suggesting that learned skills are indeed transferable from one personality state to another. Research has begun to explore these cognitive differences between altered states of MPD, but studies are limited and have not yet determined the mechanisms of transfer of knowledge and skills. Differences as well as similarities have been noted between personalities on a variety of measures (Wagner, 1974; Greenberg, 1985; Livingston, 1981).

During the initial investigation of the crime, which lasted several days, John had continued his daily routines, including attendance at the half-way house, displaying no signs of increased distress. He lived in the blood-stained apartment for the entire time in a dissociated state, apparently oblivious to his surroundings, and without attempting to disguise the evidence of the deed. There is one hypothesis about the mechanisms of dissociation before and after the murder worthy of note. When the third personality, Henry, emerged in treatment, Patricia expressed attraction to his sophisticated, seductive style. She openly professed her preference for Henry, perhaps hoping to encourage John and Billy Jack to become the personality she liked best. Perhaps this flirtation between Patricia and Henry led to a jealous rivalry between Henry and the other male personalities. A shocking twist to the facts would then suggest that the "lover's quarrel" which precipitated the murder, was not caused by Patricia leaving John for another man, but rather for another part of himself. Henry had claimed omnipotent control over the system, but so had Billy Jack. The battle between themselves for Patricia's affections may have escalated into a murderous rage. Billy Jack's impulsivity could potentially cause him to beat a person to death, yet performing the calculated disposal of the body seemed far beyond his capabilities. Such a scheme would correspond more with Henry's character, or that of still another self.

During the course of treatment, Henry mentioned two other alters. Ricky, a homosexual, corresponds clinically with John's history of being advanced upon by an older brother and repeatedly seduced into intercourse with an older sister. There was confusion as to whether or not he engaged in intercourse with his mother, who used to punish him severely. A fifth personality was described as so filled with rage, he was "unmentionable." Henry stated this personality rarely emerged and offered no name. During the arrest, however, the newspapers quoted John as mumbling, "Jeff did it." Perhaps Jeff was the murderous aspect of himself, drawn out during the quarrel to orchestrate the murder and disposal of the body.

Jeff never presented in therapy. This would make sense if he were indeed the murderous self. There would be no reason for Jeff to present in treatment until murderous intentions surfaced in connection with issues in the therapy or developed towards the therapist in the course of the intensification of the treatment or the evolution of the transference. There is very little written about the dangers to therapists who treat MPD patients. It is essential that therapists become keenly aware of the possible dangers (Watkins, 1984). It is hoped that this account will emphasize the necessity of recognizing the potential violence inherent in MPD patients. Hostile personalities may embody authentic impulses of murderous rage and must be regarded with ex-

treme caution. Special attention to the possibility of concealed aspects of dissociation is also essential. Kluft (1984) has written about the phenomenon of "layering," in which one cohort of personalities may overlie still other cohorts, the existence of which is unexpected. A clinician must never assume he or she has discovered and engaged in treatment all aspects of an MPD patient. There remains the possibility that additional elements too aggressive to partake in productive clinical interaction remain hidden. It may not be wise to expose these alters unless the therapeutic value of doing so is both obvious and compelling, the pacing of the intervention is most cautious, and proper security is at hand. Most such attempts should be made in the security of a hospital setting. Unknown forces which drive the MPD patient's system of personalities towards destruction may lie deep within as the ultimate crux of power to sabotage the therapeutic process.

Allison (1974) describes the internal self helper, ISH, as a valuable ally to the therapist. It remains uncertain whether ISHs are found in all MPD patients, and unclear whether they are always helpful to the therapy. It is possible that for certain entrenched and chronic cases no such self helper exists, or if one exists, it cannot be accessed or employed in a useful manner. It has not yet been determined whether the ISH is a part of the core of the patient that emerges to assist in therapy, or is created as a result of the positive therapeutic relationship via an internal representation of the therapist. If the latter possibility is accurate, the prognosis to eventually connect with a hardened aspect of the personality such as Jeff would be more positive. If the ISH is an internal fragment or core that can somehow become destroyed via repeated trauma, it may play no role in treatment, which may cause the prognosis for success to be guarded in certain cases. This, as all comments about the ISH phenomenon, must be regarded as speculative. As the scientific community studies MPD further, various types of MPD may be identified, depending on the variety and severity of patients' life traumas.

The importance of displaying equal regard for all personalities has been mentioned in writings that describe the most widely accepted treatment techniques for MPD (Kluft, 1987). The goal is toward the greater cooperation and eventual integration of all personality parts, although the variant selves may express much trepidation.

Destructive personality elements may pose a serious threat to treatment progress. Entrenched antisocial components may resist integration not only for fear of surrendering their individuality, but more because they wish to retain their power to rule or destroy the person at all costs. This can be regardless of their risking their own demise. The grandiose nature of such personalities is so pervasive that they may feel strangely immune to death or punishment, almost as a terrorist sees death as no deterrent against implementing "the cause." The prognosis may be questionable for MPD patients with such characteristics, because they may have an inability to develop the trust essential for lasting therapeutic change.

The author speculates that it is also feasible that new personalities may be generated as MPD patients continue to go untreated and additional traumatic events befall them in their lives. Perhaps in some cases the disorder is "progressive," such that more volatile selves become "distilled" as the disorder worsens over time, forming a hard core that rejects therapeutic endeavors. Longitudinal research on the course of the disorder would be of great value in the study of the mechanisms of dissociation.

Legal Issues

This case offers tragic testimony to one of the possible consequences of the diagnosis of MPD remaining unaccepted. MPD patients do not respond to treatments that fail to address their MPD directly (Kluft, 1987). Individuals like John are capable of becoming unsettled and engaging in abrupt and troublesome behavior. Numerous situations that occur in daily life can easily trigger violent outbursts, such as John's perceiving Patricia to be abandoning him.

The deinstitutionalization movement of the 1960s, while protecting the civil rights of the mentally ill, has inadvertently crippled the effectiveness of the mental health community to provide appropriate care (Erickson & Hyerstay, 1980). There are many restrictions on commitment and long term care that exacerbate recidivism; a patient's stay on an inpatient ward is oftentimes far too brief. John's length of stay during many of his admissions was relatively short term. Prolonged treatment in a specialized unit and implementation of a hospital treatment plan designed to acknowledge and address his MPD may have been more productive. The legal requirements for long term hospitalization make successful commitment of MPD patients highly unlikely since they may not present as violent, psychotic, or actively suicidal upon psychiatric examination. The possibility is rendered further remote if the MPD diagnosis is not recognized as essential to include in differential diagnoses.

The inability to accurately predict homicidal/suicidal intent creates an additional caveat when working with MPD patients. This involves the clinical issue of "duty to warn" potential victims of a crime. Billy Jack boasted about various illegal acts including fraud, assault, and rape. He alluded to a past history of murder but would not specify details. His braggadocio and macho manner made it difficult to discern if he were attempting to intimidate the therapist or relating omnipotent homicidal fantasies about "getting away with murder." The absence of specific evidence of past murders made criminal investigation impossible. The only solution was to urge Patricia to terminate co-habitation due to the hazardous nature of John's illness. She had been threatened with knives and physical violence on countless occasions, yet, despite repeated warnings, she continued in the tumultuous relationship, predominantly due to her own personality issues.

According to the ruling of Tarasoff vs. Regents of the University of California (1974, 1976), "duty to warn" is required when danger is threatened towards any third party by a psychiatric patient. Subsequent rulings have upheld the Tarasoff decision with variations on the extent of therapist liability (Verdicts and Settlements, 1984). Most recently, legislation in several states has protected therapists from liability, except in cases where the patient specifically names

a potential victim of the violent threats (Beck, 1987). The case of John demonstrates the limits of the "duty to warn" ruling as a protection for society when working with MPD patients. It must be noted that at no time did the patient ever express a verbal intent or threat to murder anyone. In such a case, the Tarasoff ruling is not a sufficient remedy to address what actually happens in people's daily lives. Despite professional cautions and warnings, many individuals, like Patricia, may remain with abusive spouses or companions, separating and reuniting in dangerous cycles. In addition, many homicides, like this one, are committed without a single warning or possible prediction. The only safe solution in cases such as these would be to remove the potentially dangerous individual by long term hospitalization, the restrictions upon which have already been discussed.

The nature of the crime John committed would have brought forth prosecution on capital punishment charges, should he have been found competent to stand trial. Expert testimony by two psychiatrists concurred on the patient's incompetence to stand trial, recognizing the possible accuracy of the MPD diagnosis. Progress was made in that the court recognized John's mental illness and remanded him to the state's psychiatric facility.

Unfortunately, most institutional settings within the penal system, as well as the private sector, are not equipped to provide appropriate treatment for MPD. In addition, the courts do not invariably require expert witnesses to generate a treatment plan specific to the diagnosis that they determine to be the probable reason for incompetence. It is a disservice to patients to deem them incompetent to stand trial and incarcerate them until they establish competency, and then not provide the proper treatment for their disorder so that they may gain competency.

It would be highly desirable if courts could begin to require expert witnesses to generate an appropriate treatment plan to address the nature of the diagnosis determined in competency hearings, especially for offenders diagnosed as MPD. Allison (1981, 1982) is one of the few who address this concern. He advocates quick and correct diagnosis of such violence-prone individuals. Some small but noteworthy progress in this area occurred recently in Douglas County, Colorado. In the case of The People of the State of Colorado vs. Ross Michael Carlson (Criminal Action No. 83, CR73, Division 1), on October 27, 1987 the court ruled that the clinical treatment being provided at the Colorado State Hospital was inadequate and inappropriate for the prisoner's condition of MPD. The court further mandated that proper professionals be sought and engaged to treat the MPD appropriately.

The diagnosis of MPD is one viable scientifically sound explanation for John's ability to endure the carnage of the murder without the slightest discernible change in mood or anxiety level. It is intriguing to speculate about the act of dismemberment and its unconscious symbolism. This crime creates a chilling imagery of the outward projection of John's "dismembered self" upon his victim. It conveys an inner sense of the murdered self in childhood. This leads one to question how many offenders of similar crimes throughout the country may also suffer from undiagnosed MPD and may not be receiving proper treatment.

There is an ever-increasing body of professional literature documenting the direct relationship between child abuse and MPD (Allison, 1974; Boor, 1982; Coons, 1986; Saltman & Solomon, 1982). Child abuse has only recently been recognized as a reality in our society. It is an enduring, devastating assault on the personality development of young children. Professionals must begin to accept the unpleasant reality that children are abused physically, verbally and sexually, often by their own parents. It must no longer seem like a remote possibility that many of these same children defended themselves by the dissociation process of MPD, and formed personalities based upon those who mistreated them, personalities capable of perpetuating such unfortunate patterns of behavior.

In conclusion, the author can only propose that intensive educational programs about MPD be made available to continue to inform the medical, legal, and mental health communities. The establishment of institutional settings and half-way facilities, where MPD patients can receive appropriate treatment for their disorder in a secure environment, is also essential. Further study and consciousness raising about the relationship between MPD and child abuse must be underscored. The diagnosis of MPD must become accepted with the same validity as any other. The reality is that MPD is not rare . . . only rarely identified. ■

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