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CRIMINAL RESPONSIBILITY OF THE PERPETRATOR WITH ALTERNATING SPLIT PERSONALITY

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Abstract

The study is devoted to the issue of criminal liability of a perpetrator suffering from conversion identity disorders. Therefore, its aim is to highlight the dilemmas arising from a split personality disorder in the context of the insanity of the perpetrator of a prohibited act. Based on the example of Kenneth Bianchi (case study), the difficulties related to the diagnosis of this disorder and its consequences in relation to criminal liability are shown. In turn, the analytical-dogmatic method is used to consider the issue related to the recognition of these disorders as a specific category of causes of the condition referred to in Article 31 § 1 of the Polish Criminal Code. Regardless of this, the study also presents an approach to this issue that differs from that previously presented in the literature. The conclusions drawn on this basis also allow for filling a certain gap in the Polish literature on criminal law, which is a lack of studies on the subject matter.

Keywords: insanity, diminished sanity, Dissociative Identity Disorders (DID), alternating split personality

INTRODUCTION

The issue of criminal liability of a perpetrator suffering from mental disorders has been the subject of many studies. It is understandable that issues related to a perpetrator's insanity are first of all raised in the literature on criminal law while the characteristics of disorders that may constitute grounds for an insanity diagnosis

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are presented in psychopathology literature. On the other hand, an alternating split personality, also called "double consciousness",[1] is a disorder, which so far has received relatively little attention in the Polish literature. Criminal law seems to ignore this issue completely. Double consciousness concerns disorders, which are also referred to as "multiple personality"[2] and in specialist terminology: "dissociative (conversion) identity disorder" (hereinafter: DID). However, it is inadvisable to marginalise the issue. Contrary to the possibly erroneous assumptions that the scale of the problem is insignificant, the field-related research proves that the issue cannot be underestimated. It shows that the disorders may affect up to almost 18.3% of adults (as regards dissociative disorders) and over 3% (as regards dissociative identity disorder).[3] In the light of other studies conducted on outpatients treated in mental health centres, these values are even more alarming. They show that the percentage of adult population suffering from dissociative disorders may be even close to 41%, and a dissociative identity disorder – 7.5%.[4]

First and foremost, one should point out that even though the term "double consciousness" is reminiscent of colloquial language, it nonetheless refers to a medical condition (disease) classified nosologically. Pre-empting its closer characteristics, which shall be relevantly presented hereunder, it seems imperative to distinguish this condition from schizophrenia, which is a psychotic disorder.[5] The latter is also referred to as "split mind" (from *schízō* – 'split', and *phrḗn* – 'mind' in Greek[6]) or "simultaneous personality disorder".[7] Furthermore, schizophrenia constitutes an entirely different category of disorders,[8] a fact which is also confirmed by diagnostic classification. Similarly, it would not be correct to equate the above-mentioned disorders with dissocial disorders (classified in ICD-10 as "Disorders of adult personality and behaviour", code F60.2), which will be further supported by a relevant example.

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[1] Hacking, I., 'Double consciousness in Britain 1815–1875', *Dissociation*, Vol. 4, No. 3, pp. 134–146.

[2] Zimbardo, P., *Psychologia i życie*, Warszawa, 2012, p. 649.

[3] Cf. Tomalski, R., Pietkiewicz, I.J., 'Rozpoznawanie i różnicowanie zaburzeń dysocjacyjnych – wyzwania w praktyce klinicznej', *Czasopismo Psychologiczne – Psychological Journal*, 2019, Vol. 25, No. 1, p. 47. On the same subject matter, also: Orlof, W., Wilczyńska, K.M., Waszkiewicz, N., 'Dysocjacyjne zaburzenie tożsamości (osobowość mnoga) — powszechniejsze niż wcześniej sądzono', *Psychiatria*, 2018, Vol. 15, No. 4, pp. 229–230.

[4] Tomalski, R., Pietkiewicz, I.J., 'Rozpoznawanie…', op. cit., p. 47. Cf. also: Brand, L., Sar, V., Stavropoulos, P., Krüger, Ch., Korzekwa, M., Martínez-Taboas, A., Middleton, W., 'Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder', *Harvard Review of Psychiatry*, 2016, Vol. 24, No. 4, pp. 260–262.

[5] In the literature on psychopathology, it is suggested that schizophrenia should also be distinguished from a broader category of schizophrenia-related disorders – cf. Wciórka, J., 'Psychozy schizofreniczne', in: Bilikiewicz, A. (ed.), *Psychiatria. Podręcznik dla studentów medycyny*, Warszawa, 2009, pp. 272–275, 285–295, 307–309; and also: Hadyś, T., 'Zaburzenia psychotyczne', in: Kiejna, A., Małyszczak, K. (eds), *Psychiatria. Podręcznik akademicki*, Wrocław, 2016, pp. 147–157.

[6] Cf. the entry: "schizofrenia" in: *Encyklopedia PWN*: https://encyklopedia.pwn.pl/haslo/schizofrenia;3973032.html, accessed on 15 June 2022.

[7] Under the International Statistical Classification of Diseases and Related Health Problems, ICD-10, schizophrenia is assigned code F.20. The classification is available at: https://icd.who.int/browse10/2010/en#/F44, accessed on 20 June 2022.

[8] Wciórka, J., 'Psychozy…', op. cit., pp. 272–275.

These reservations seem necessary due to the fact that over years the doctrine of criminal law and the judicature have worked out a relatively uniform stance in relation to both schizophrenia-related disorders and the so-called "psychopathy", acknowledging that they can constitute reasons for insanity, as in case of schizophrenia; or, conversely, usually they do not even cause limitation of sanity to a considerable extent as it is the case with dissocial disorders. This position is also confirmed in courts' adjudication practice.[9]

It is also worth pointing out that the issue of personality disorders *per se* is a multifaceted one.[10] This fact has a considerable influence on the conclusions drawn in the present paper. They refer to theoretical issues related to answering the question whether dissociative identity disorders may (and under which category of reasons) determine the abolition or significant limitation of the prohibited act perpetrator's ability to recognise the meaning of that act or to control his behaviour.

ALTERNATING SPLIT PERSONALITY *AD CASU*: THE ISSUE DESCRIBED IN A NUTSHELL

Before characterising analysed disorders from the psychopathology perspective and explaining their essence, one should present the very core of the problem. To this end, the paper will refer to a particular case illustrating difficulties faced by specialists, such as expert witnesses, psychiatrists and forensic psychologists, as well as justice system bodies, in the course of each criminal proceeding. It is worth drawing attention to the factual situation presented below, as it demonstrates not only diagnostic difficulties in the context of possible simulation of dissociate identity disorders,[11] but also issues with their identification by expert forensic psychiatrists. On the other hand, from the criminal law perspective concerning an offence perpetrator's (in)sanity, this example is particularly interesting due to the rich medical documentation available *in extenso*, as well as the data collected in the course of the criminal proceeding. These provided, inter alia, really valuable (especially in the context of the issue analysed herein) biographical information. Last but not least, it is significant that the case description was provided by physicians who examined the defendant in the course of the trial many times, as well as the fact that the final conclusions turned out to be quite surprising.[12]

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[9] Golonka, A., *Niepoczytalność i poczytalność ograniczona*, Warszawa, 2013, pp. 149, 491–492.

[10] Cf. e.g.: Wojtyńska, R., Małyszczak, K., 'Osobowość i zaburzenia osobowości w modelu psychologicznym', in: Kiejna, A., Małyszczak, K. (eds), *Psychiatria. Podręcznik akademicki*, Wrocław, 2016, pp. 237–257; Jasińska-Kania, A., 'Socjologiczna koncepcja osobowości', in: Krawczyk, Z., Morawski, W. (eds), *Socjologia. Problemy podstawowe*, Warszawa, 1991, pp. 78–99; Gerstmann, S., *Osobowość. Wybrane zagadnienia psychologiczne*, Warszawa, 1970, pp. 90–118.

[11] For more on the subject matter, cf. Spett, K., Szymusik, A., 'Psychopatologia szczegółowa', in: Cieślak, M., Spett, K., Szymusik, A., Wolter, W., *Psychiatria w procesie karnym*, Warszawa, 1991, pp. 352–357.

[12] Dr Ralph B. Allison and dr Martin T. Orne.

First of all, it should be pointed out that the case concerns Kenneth Alessio Bianchi, a serial killer,[13] charged with ten counts of first-degree murder, which carried a death penalty in accordance with the criminal law binding in California (USA) at the time. There are suppositions, however, that there might have been more murder victims.[14] The proceedings in the case *State v. Bianchi* (1979)[15] actually concerned charges of murder during four months in 1977–1978. The case received widespread media coverage due to extraordinary cruelty and sadism demonstrated by the perpetrator (or perpetrators)[16] who had first brutally raped women and then strangled his(their) victims. As some of the victims were found naked on hillsides in the Los Angeles area, the killer was dubbed "Hillside Strangler". The murders caused sheer panic among women in Los Angeles, especially as, in spite of intense search conducted by the LA Police Department, the murderer(s) was(were) not apprehended.[17] Only a few months later, on 11 January 1979, when two women's bodies were found in Bellingham,[18] and after their injuries and other circumstances let the police to associate them with the perpetrator's modus operandi in California, it was possible to link them to Bianchi.[19] The evidence included the then 27-year-old Bianchi's fingerprints found at the crime scene, the fact that the victims were seen in his company shortly before their disappearance, and the lack of Kenneth's solid alibi. Although Bianchi stated, inter alia, that he was attending a business meeting, and he was working in another place where he had to commute to, and within the next six weeks he presented a series of other new circumstances, each time a supposedly unshakeable alibi, none of these was a verifiable fact or they happened at a different time than Bianchi suggested. Bianchi even referred to a meeting with a person who was in fact dead, a date with a woman (who admitted during the trial that… she had simply succumbed to Bianchi's charm), and a visit to his mother and her friend, which also turned out to be a false alibi.

In the course of the proceedings the LAPD investigators collected some crucial information. The most important, for the purpose of assuming that the suspect suffered from a dissociative identity disorder, concern Kenneth Bianchi's childhood.[20]

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[13] Cf. https://pl.wikipedia.org/wiki/Kenneth_Bianchi, accessed on 25 May 2022.

[14] Ibidem.

[15] Case description according to: Orne, M.T., Dinges, D., Orne, E., 'On the differential diagnosis of multiple personality in the forensic context?', *International Journal of Clinical and Experimental Hypnosis*, 1984, Vol. 32, pp. 121–169. Facts also based on: Allison, R.B., 'Difficulties diagnosing the multiple personality syndrome in a death penalty case', *International Journal of Clinical and Experimental Hypnosis*, 1984, Vol. 32, pp. 102–117.

[16] In the course of the investigation, some doubts about the number of perpetrators were raised.

[17] The LAPD conducted the investigation because the then suspected Kenneth Bianchi had a driving licence issued in this state – cf. Orne, M.T., Dinges, D., Orne, E., 'On the differential diagnosis…', op. cit., p. 123.

[18] Bellingham – a town in the northern part of the State of Washington, US – cf. https://en.wikipedia.org/wiki/Bellingham,_Washington, accessed on 25 May 2022.

[19] Orne, M.T., Dinges, D., Orne, E., 'On the differential diagnosis…', op. cit., p. 122.

[20] The research conducted for many years irrefutably confirm that the genesis of dissociative identity disorders develop as a result of childhood trauma – cf., e.g.: Brand, B.L., Sar, V., Stavropoulos, P., et al., 'Separating Fact from Fiction…', op. cit., pp. 261–262; Ellason, J.W., Ross, C.A., Fuchs, D.L., 'Lifetime Axis I and II comorbidity and childhood trauma history in dissociative

They can be briefly summarised as follows: Bianchi was adopted when he was 3 months old. He grew up in Rochester (New York State). He was a difficult child and his adoptive mother even stated that he was "a compulsive liar from an early age"[21]. He showed no signs of mental retardation (he scored 116 in the full WAIS test). He was not particularly liked by his peers but there is no information about overt acts of aggression or violence that he could have committed at that time (apart from allegedly killing a cat and a dog, which has not been confirmed, however). His teenage rebellion took place when he was 13, and it was most probably connected with his adoptive father's death. He was not molested or subject to any form of physical or psychical violence, but he demonstrated high level of sexual activeness (bordering on promiscuity) from the age of 16, which was accompanied by inability to form stable relationships. At the age of 19 he married his high school classmate but the marriage did not last more than 8 months. When he was 26, he formed civil partnership with a young woman. Information collected in relation to his professional life turns out to be even more important. It was established in the course of the investigation that, as a young man, Bianchi was involved in theft in a shopping mall where he was employed as a security guard. When he moved to Los Angeles at the age of 24, he expanded his resumé by committing other thefts, drug trafficking, using stolen credit cards, pimping minors, contacting prostitutes, attempting blackmail, posing as a movie industry agent and even a municipal officer (namely, a California Highway Patrolman), which was the closest he ever came to his unfulfilled dream of becoming a police officer. However, as highlighted in the investigation files, in his professional life, he showed definite inconsistency rather than persistent pursuit of the chosen goal. Over a period of 9 years after finishing high school, he changed his job 12 times. At this point it seems that what turned out to be most important for the final diagnosis was his path to obtaining a degree in psychology and starting his own business as a specialist in the field ("Steve", described below). It is also not possible to ignore the deception Bianchi used in private life (e.g. he simulated suffering from cancer in order to convince his concubine that it was the reason their relationship deteriorated).

The issues turned out to be crucial to the outcome of the investigation and the conclusions drawn by the majority of clinicians who examined Bianchi.

Obviously, these concerned doubts about his mental state, and more specifically doubts about the diagnosis of the dissociative identity disorder ("multiple personality disorder", as it was generally referred to at the time).

It started with Bianchi's explanation of the lack of a confirmed alibi in the case of the two murders committed in Bellingham. It was the way in which Bianchi explained it that prompted his defence counsel, Dean Brett, to speculate that "there might be another part of Kenneth Bianchi".[22] The lawyer organised a meeting

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identity disorder', *Psychiatry*, 1996, Vol. 59, pp. 255–266; Swica, Y., Lewis, D.O., Lewis, M., 'Child abuse and dissociative identity disorder/multiple personality disorder: the documentation of childhood maltreatment and the corroboration of symptoms', *Child and Adolescent Psychiatric Clinics of North America*, 1996, Vol. 5, pp. 431–447.

[21] Orne, M.T., Dinges, D., Orne, E., 'On the differential diagnosis…', op. cit., p. 125.

[22] Ibidem, p. 124 and the trial files referred to therein.

with Dr John G. Watkins, a prominent hypnotherapist.[23] It was aimed at extracting information about some supposedly forgotten facts. Dr Watkins hypnotised Bianchi (on 21 March 1979). While under deep hypnosis, "Steve" (as an alternating personality) appeared, and he not only provided a detailed description of the murders committed in Bellingham but also confirmed that he committed them together with Angelo Buono (Bianchi's adoptive cousin).[24] Of course, later, Bianchi vehemently denied knowing that there was a Steve "in him". This was the reason why the defence counsel filed a motion to the court for considering his client's insanity (insanity defence).[25] It is worth pointing out that in the course of the first hypnosis session, Steve was eager to cooperate and relatively polite, he kept his voice low and issued no threats, although he appeared to be a bit cunning (a sneering laugh). However, he showed no remorse for the rapes and murders. On the other hand, a few days later, during an interview with Dr Allison (after he suggested to Kenneth that alternating personalities are usually radically different from the basic one), Steve's behaviour changed completely. He became aggressive, posed to be a macho man, did not laugh but shouted, "hurled insults" and issued threats.[26] This peculiar evolution of Steve's personality made the clinicians examining him suspect Bianchi of simulating multiple personality, especially as, which was established in the course of the investigation, he had been deepening his knowledge of multiple personality disorders within his psychology "specialisation" (Bianchi "had a degree" in psychology).[27] In the course of one of the examinations, it was suggested to Bianchi that in case of this disorder, there are practically not two but three personalities (including two *alter*).[28] After that, "Billy" appeared. He was described as "a rather enthusiastic, cooperative and pleasant fiddler", who admitted to some deceptions and accepted full responsibility for them.[29] Moreover, in order to validate the results of the examinations, some additional methods were used in his hypnotherapy, such as: double or single hallucinations, suggested anaesthesia or source amnesia.[30] It was actually during a hypnotic regression to the age of nine when Kenneth mentioned to Dr Allison that a "Billy Thompson" was his best childhood friend.[31] On the other hand, the investigation revealed Steve's real *alter*, or more precisely, the true genesis of this identity that turned out to be Thomas Steven Walker, MA. The man was one of the candidates who responded to Kenneth Bianchi's job advertisement for a position in his private counselling practice.

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[23] It is noteworthy that this session was suggested by John Johnson, a psychologist employed in DePaul Clinic, where Bianchi was consulted at the age of 11 (ibidem, pp. 124, 132).

[24] Ibidem, p. 129 and the sources referred to therein.

[25] Ibidem, p. 130.

[26] Ibidem.

[27] This was confirmed by the evidence collected in the course of the criminal proceedings, e.g. literature on the subject matter that Bianchi collected, evidence from his interrogations, in which he admitted watching the movie "Sybil" a week before meeting Dr Watkins, and, in case of Eve White, he learned about the headaches he "started" to suffer from when his attorney, J. Brett, suggested that he might suffer from the multiple identity syndrome, ibidem, p. 132.

[28] Ibidem, pp. 141–142.

[29] Ibidem, pp. 142–143.

[30] Ibidem, pp. 134–141.

[31] Ibidem, pp. 143–144.

Mr Walker sent Bianchi copies of his diplomas confirming his qualifications, and completed post-graduate studies. Bianchi, in turn, asked the institutions that issued the documents to "forward the fully completed diplomas EXCEPT for my name [i.e. Thomas Walker] (…)", because he wanted a calligrapher to write it in a fancy script.[32] Eventually, some psychological tests conducted confirmed the clinicians' doubts about the authenticity of the multiple personality syndrome occurrence; they included: the Minnesota Multiphasic Personality Inventory (MMPI) by Dahlstrom and Welsh (1960), the California Personality Inventory (CPI) by Gough (1964), and the Rorschach (1942), as well as a differential diagnosis.[33]

Based on these tests, Dr Faerstein and Dr Allison draw concluded that: "Kenneth Bianchi is quite 'sick' in the sense of having a perverted sexual need which allows him to obtain gratification from killing women, and one may reasonably assume that this is related to the profound ambivalence".[34] Nevertheless, the main motive behind the murders was indeed sexual in the form of expected gratification. This was confirmed by other evidence, such as, e.g., his concubine's pregnancy, which significantly limited their sexual relations and coincided with the two murders in Bellingham.

On the other hand, with regard to the multiple personality diagnosis, the clinicians' conclusions were rather unanimous in stating that memory (amnestic) barriers were fundamental to Bianchi's diagnosis of DID. However, as it was eventually assumed (based on the hypnosis sessions), such disorders did not actually occur in his case.[35] It was assumed that Kenneth Bianchi "tried to erase" the crimes from his memory; for example, when "Ken" directly admitted to a psychiatrist examining him, M.T. Orne, that he "doesn't want to remember" what Steve knew about the crimes (although initially Kenneth had denied that he knew about the existence of Steve).[36] Apart from that, in the light of the diagnosis made by the clinicians examining Bianchi, the man probably suffered from a psychosexual disorder (classified in the then binding DSM-III as sexual sadism) although, as it was emphasised: "this disorder in and of itself rarely leads an individual to commit murder".[37] However, it can lead to such acts when it occurs, for example, in conjunction with the antisocial personality disorder. According to experts, this was actually the case with Bianchi,[38] as well as the reason for his "perverted sexual impulse", which along with the lack of empathy, led to the removal of moral barriers constituting a natural barriers preventing certain behaviour.

The above-presented case demonstrates exceptionally well the issues related to diagnosing DID and difficulties in distinguishing it from dissocial personality disorders.

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32 Ibidem, pp. 147–148.
33 Ibidem, pp. 149–158.
34 Ibidem, pp. 159–160.
35 Ibidem, pp. 155–158.
36 Ibidem, p. 158.
37 Ibidem, p. 163.
38 Ibidem.

It is also worth highlighting that the professional, mainly American and British, literature describes numerous cases of perpetrators of prohibited acts concerning DID.[39] The need to demonstrate medical difficulties resulting from the diagnosis of conversion disorders was noticed in the Polish literature as well.[40] The analysis of those sources results in an interesting observation that *alter* does not always have to have a human form (!). Inter alia, K.M. Hendrickson, T. McCarty and J. Goodwin present examples of *animal alters*.[41] In one of the studies, they describe a case of a woman charged with, and finally convicted of, first-degree murder. The homicide was committed "by gutting".[42] The only witness present at the scene of crime testified that he first saw her kneeling next to the disembowelled victim and next she began creeping on all fours towards him, and then, when she approached the victim, she got up and walked away. The evidence proceeding confirmed that the victim's body had the impressions of the accused's teeth, as well as injuries caused by claw scratches. The accused herself did not remember the event. She was hypnotised and, while under hypnosis, she stated that she was a panther in a jungle and that she "has recently attacked and torn a warthog". She also described the scene (a jungle) and the taste of the victim's blood. Eventually, it was not possible to obtain a clear and indubitable description of the whole event. The communication with the accused was difficult because the *alter* that committed the crime was impersonal in nature and another *alter* "reported" it. There were no indications that she suffered from psychotic disorders, which in conclusion justified her sanity at the time of the crime. It is, however, the case of Billy Milligan, who was diagnosed with 24 different personalities, that was undoubtedly the most famous and had the most widespread media coverage.[43] Other examples of perpetrators suffering from DID described in the literature only confirm how difficult it is to diagnose this disorder.[44] In each of them, there is invariably a dilemma related to the sanity of the perpetrator of a crime. However, before this issue is raised in relation to the domestic system of criminal law, it seems necessary

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[39] Cf. e.g.: Stuckenberg, C.F., 'Comparing Legal Approaches: Mental Disorders as Grounds for Excluding Criminal Responsibility', *Bergen Journal of Criminal Law and Criminal Justice*, 2016, Vol. 4, No. 1, pp. 48–64; Behnke, S., Sinnott-Armstrong, W., 'Criminal Law and Multiple Personality Disorder: the Vexing Problems of Personhood and Responsibility', *Southern California Interdisciplinary Law Journal*, 2001, Vol. 10, No. 2, pp. 277–296; Hacking, I., 'Double consciousness in Britain…', op. cit., pp. 134–143.

[40] Cf. Rottermund, J., Knapik, A., Myśliwiec, A., 'Zaburzenie konwersyjne – opis przypadku', *Journal of Ecology and Health*, 2012, Vol. 16, No. 1, pp. 39–46.

[41] Hendrickson, K.M., McCarty, T., Goodwin, J., 'Animal alters: case reports', *Dissociation*, 1990, Vol. 3, No. 4, pp. 218–221.

[42] Ibidem, pp. 219–220.

[43] It is worth pointing out that the case of Billy Milligan also inspired movie producers, e.g. of the "Split" (2016), directed by M. Night Shyamalan – cf. https://www.imdb.com/title/tt4972582/trivia?item=tr3410045, accessed on 21 May 2022, and writers, e.g. Keyes, D., *Człowiek o 24 twarzach* [original title: *The minds of Billy Milligan*], Warszawa, 2015 (ISBN: 9788380320413).

[44] Cf. e.g.: Perr, I.N., 'Crime and multiple personality disorder: A case history and discussion', *The Bulletin of the American Academy of Psychiatry and the Law*, 1991, Vol. 19, No. 2, pp. 203–214 and a description of the case in which the perpetrator (ultimately diagnosed with the Dissociative Identity Disorder) had been formerly diagnosed with 15 different disorders, including psychoses.

to indicate the essence of the disorders in question from the psychopathological point of view, based on the current state of medical knowledge. It will allow for a more reliable approach to the criminal and legal issue raised in this paper.

ALTERNATING SPLIT PERSONALITY: THE ESSENCE OF DISSOCIATIVE IDENTITY DISORDERS

First of all, it should be pointed out that the issue of dissociative identity disorders was discussed in the Polish literature on psychiatry over half a century ago, and it was described as alternating split personality (in Latin: *personalitas duplex alternans*), which "classically occurs in twilight states".[45] On the other hand, the International Statistical Classification of Diseases and Related Health Problems – 10, Rev., ICD-10,[46] which is currently binding in Poland, classifies the disorder as a separate nosological unit marked with a diagnostic code No. F44.8.[47] Thus, DID is included within dissociative (conversion) disorders (F44), and more precisely, "other dissociative (conversion) disorders – multiple personality (F44.81)". This way, ICD-10 clearly distinguishes those disorders from other personality disorders, especially from those classified as dissocial personality disorders (F60.2) and occurring in the form of amoral, antisocial, asocial, psychopathic or sociopathic personality.

It is also worth highlighting that in June 2018, the 11th, revised version of the former classification entered into force.[48] It establishes significant changes in the classification of personality disorders, including e.g. direct differentiation of personal disorders and "other features related to them" from dissocial (antisocial) disorders.[49] Moreover, within the former category, ICD-11 distinguishes not only dissocial personality disorders but also intrusive thoughts-related dissociative disorders as another form of multiple personality disorders.[50]

On the other hand, the American DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition)[51] determines 10 subcategories of identity disorders

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[45] Bilikiewicz, T., *Psychiatria kliniczna*, Warszawa, 1973, p. 38, and also: Falicki, Z., Wandzel, L., *Psychiatria sądowa dla studentów Wydziału Prawa*, Białystok, 1990, p. 37.

[46] On maintaining the application of ICD-10 in Poland and an implementation period for the next revised version of ICD, see the Minister of Health's reply of 14.04.2021 to a petition of the Citizens' Initiative as an "E-petition" [PET/IV/38/21] of 12 April 2021 (the Minister's of Health reply no.: DLU.055.10.2021.EW).

[47] Polish language version of the Classification is available at: http://lista.icd10.pl//, accessed on 20 June 2022.

[48] Classification ICD-11 is available at: https://icd.who.int/browse11/l-m/en, accessed on 21 June 2022. For more on the differences between ICD-10 and ICD-11, cf. Krawczyk, P., Święcicki, Ł., 'ICD-11 vs. ICD-10 – przegląd aktualizacji i nowości wprowadzonych w najnowszej wersji Międzynarodowej Klasyfikacji Chorób WHO', *Psychiatria Polska*, 2020, Vol. 54, No. 1, pp. 7–8.

[49] Cf. Gaebel, W., Zielasek, J., Reed, G.M., 'Zaburzenia psychiczne i behawioralne w ICD-11: koncepcje, metodologie oraz obecny status', *Psychiatria Polska*, 2017, Vol. 51, No. 2, pp. 174–177.

[50] Ibidem, p. 182.

[51] Currently binding classification developed by the American Psychiatric Association.

depending on the factors determining possible changes in human personality.[52] Thus, Dissociative Identity Disorder (DID) assumes recognition of the following symptoms: the presence of two or more distinct identities (or personality states), each of which has "its own relatively stable pattern of perceiving, relating to and thinking about the environment and oneself", amnesia, i.e. oblivion, memory lapses concerning e.g. events, people, dates or places, problems with adaptation and difficulties in functioning in the main areas of life, caused by the disorder. Another requirement for the above-mentioned symptoms is that they should not be part of standard cultural background or religious practices, they should not result from the use of drugs, and they should not constitute a symptom of another disorder (e.g., one manifested by seizures involving oblivion of events).[53] Thus, in case of people suffering from DID, not only "every personality has their own separate identity, name and specific patterns of behaviour",[54] but also they are usually very distinctive in many ways (e.g., they may differ in gender, sexual orientation, IQ, and age; what is significant, one of them is almost always a child).

In this part of the paper, one should address another issue, namely certain similarities (once again, despite full classification distinction), characterising both behaviour of a perpetrator suffering from dissocial personality disorder, and quite frequently also acts committed by a perpetrator with a diagnosed DID. It should be pointed out here that, understandably, these characteristics do not concern any parameterisation of a perpetrator's *modus operandi* (since this is not possible *in abstracto*), but rather certain features of a perpetrator determined based on the acts committed, which may be of critical importance in the context of diagnostic difficulties, and in particular justify a (not necessarily inaccurate) conviction that a perpetrator's personality is irregular. There can be no doubt that a person suffering from dissocial disorders, the so-called psychopath,

> "is an impulsive, irresponsible, hedonistic, »two-dimensional« person who lacks the ability to experience standard, emotional components of interpersonal behaviour, i.e. the sense of guilt, remorse, empathy, and a genuine emotional attitude towards the wellbeing of other people (…), that his social and sexual relationships with others remain superficial and exploitative. A psychopath's judgements are shallow and he seems incapable of postponing satisfying his immediate needs regardless of the consequences for him and other people".[55]

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[52] Cf. Ruben, D.H., *Behavioral Guide to Personality Disorders (DSM-5)*, Springfield – Illinois, 2015, pp. 3–6.

[53] McDavid, J.D., 'The Diagnosis of Multiple Personality Disorder', *Jefferson Journal of Psychiatry*, 1994, Vol. 12, No. 1, pp. 29–42, as well as: Tomalski, R., Pietkiewicz, I.J., 'Rozpoznawanie i różnicowanie…', op. cit., pp. 43–51.

[54] Zimbardo, P., *Psychologia i życie…*, op. cit., p. 649.

[55] Cf. Cierpiałkowska, L., Soroko, E., *Zaburzenia osobowości. Problemy diagnozy klinicznej*, Poznań, 2014, p. 217 (based on Hare's characteristics). Cf. also: Hare, R.D., *Psychopaci są wśród nas*, Kraków, 2021, pp. 52–79; Radochoński, M., *Osobowość antyspołeczna*, Rzeszów, 2000, p. 121.

The above-described case of Kenneth Bianchi is the most striking example of this phenomenon. Yet another characteristic of such perpetrators is their inclination to breach the legal order.[56] This similarity also applies to perpetrators who suffer from DID and for whom at least one of the alternating personalities in almost each case demonstrates a high level of aggression with a tendency to behave in the way going beyond the adopted moral and legal norms, and sometimes even commits brutal and sadistic acts.[57] This may be explained by the genesis of DID, associated with past traumatic experiences (usually in childhood), in particular various forms of physical and psychic abuse.[58]

SANE OR INSANE: THE ISSUE OF CRIMINAL LIABILITY OF PERPETRATORS SUFFERING FROM DISSOCIATIVE IDENTITY DISORDERS

The above-presented case of Kenneth Bianchi, as well as other cases concerning perpetrators suffering from DID, which were mentioned in the context of diagnostic difficulties, demonstrate that it is necessary to ask a fundamental question about sanity, or rather the possibility of recognising DID as grounds for a perpetrator's insanity. It should be reminded that in the light of Article 31 § 1 CC, criminality of an act is excluded (due to the circumstances excluding fault), when the person concerned is incapable of recognising the significance of the act or controlling their conduct due to a mental illness, mental deficiency or other mental disturbance. This, in turn, renders it necessary to consider two issues. Firstly, the issue that can be considered *in abstracto* at all, namely determining whether dissociative identity disorders, bearing in mind the above-indicated diagnostic criteria, can be recognised as mental illness or "other mental disturbance", referred to in Article 31 § 1 CC. The second issue is whether, in case of a perpetrator with a diagnosed DID when the prohibited act was committed by his *alter*, it should necessary to exclude on a case-by-case basis the (fully) retained ability to recognise the significance of the act or to control one's conduct if the basic personality is not aware of this behaviour.

With regard to the first dilemma, it seems crucial to indicate what a "mental illness" is within the meaning of Article 31 § 1 CC. Unfortunately, this concept

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[56] Radochoński, M., *Osobowość…*, op. cit., p. 121; Lewis, D.O., Yeager, C.A., Swica, Y., Pincus, J.H., Lewis, M., 'Objective Documentation of Child Abuse and Dissociation in 12 Murderers With Dissociative Identity Disorder', *American Journal of Psychiatry*, 1997, Vol. 154, No. 12, pp. 1703–1709.

[57] Webermann, A.R., Brand, B.L., 'Mental illness and violent behavior: the role of dissociation', *Borderline Personality Disorder and Emotion Dysregulation*, 2017, Vol. 44, No. 2, pp. 1–13. Available (together with the list of studies) at: https://bpded.biomedcentral.com/articles/10.1186/s40479-017-0053-9, accessed on 13 June 2022, and also: Saks, E.R., 'Multiple Personality Disorder and Criminal Responsibility', *Southern California Interdisciplinary Law Journal*, 2001, Vol. 10, No. 2, pp. 186–188.

[58] Cf. Helios, J., Jedlecka, W., *Dysocjacja jako hard case w systemie prawa*, Wrocław, 2015, pp. 21–30.

is not included in the dictionary of psychopathological terminology. According to professional literature, the term "mental illness" covers

> "(…) all mental disorders that are of interest to psychiatry due to the need for treatment; a psychical illness is usually distinguished for practical reasons related to the introduction of the rules of medical, social or legal proceeding (rights or limitations, privileges), differentiated in relation to people meeting the established criteria for a mental illness (e.g. in Poland, people suffering from mental illnesses have wider access to free healthcare services than most people with mental disorders, but only people suffering from mental illnesses can be treated without their consent). (…) Classifying certain disorders as mental illnesses is often connected with stereotypes and prejudices; that is why more and more often there are proposals to give up the use of this term and adopt a less burdensome term deprived of negative connotations: mental disorder".[59]

Therefore, the most convincing position is that as "(…) the term »disorder« is used for the entire classification",[60] it should be used in general "(…) to avoid serious doubts about the term »disease« or »illness«".[61] On the other hand, the latter is used only "for the purpose of indicating the existence of a set of clinically recognisable symptoms or behaviour connected in most cases with distress and disturbance to personal functioning".[62] At the same time, the basic division of mental illnesses into psychotic and non-psychotic disorders remains relevant.[63] Taking into account the essential characteristics of an "illness", namely its relatively permanent nature, dynamic course, as well as a certain process related to its development,[64] and at the same time the typical DID symptoms, in particular quantitative changes in consciousness in the form of memory lapses (amnesia),[65] one can reasonably assume that it is a sign of a mental illness rather than a certain (most often but not necessarily) short-term state. Without question, in this case, it concerns a non-psychotic disorder.[66] However, it is worth noting that some authors proposed to consider DID within the category of "other mental disturbance" within the meaning of Article 31 § 1 CC.[67]

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[59] Hajdukiewicz, D., *Zagadnienia psychiatrii sądowej. Cz. 1. Podstawy prawne i medyczne*, Warszawa, 2016, p. 21; Brand, B.L., Sar, V., Stavropoulos, P., et al., 'Separating Fact from Fiction…', op. cit., pp. 261–262.

[60] Pużyński, S., 'Choroba psychiczna -- problemy z definicją oraz miejscem w diagnostyce i regulacjach prawnych', *Psychiatria Polska*, 41(3), pp. 299–308.

[61] Ibidem.

[62] Ibidem.

[63] Cf. Bilikiewicz, A., Lewandowski, J., Radziwiłłowicz, P., *Psychiatria – repetytorium,* Warszawa, 2003, p. 18; Hajdukiewicz, D., *Zagadnienia psychiatrii sądowej*…, op. cit., p. 20.

[64] Cf. *Encyklopedia popularna PWN. Edycja 2011*, Warszawa, 2011, p. 179.

[65] Hajdukiewicz, D., *Zagadnienia psychiatrii sądowej*…, op. cit., p. 299, similarly: Falicki, Z., Wandzel, L., *Psychiatria sądowa*…, op. cit., p. 56. Differently: T. Przesławski, who classifies the twilight state as qualitative disorders of consciousness, idem, *Psychika. Czyn. Wina,* Warszawa, 2008, pp. 100–101.

[66] Cf. Bilikiewicz, A., Lewandowski, J., Radziwiłłowicz, P., *Psychiatria – repetytorium,* Warszawa, 2003, p. 18; Hajdukiewicz, D., *Zagadnienia psychiatrii sądowej*…, op. cit., p. 20.

[67] Thus, e.g. Helios, J., Jedlecka, W., *Dysocjacja*…, op. cit., pp. 86–87.

On the other hand, with regard to psychological consequences,[68] it is important to determine whether a perpetrator's ability to recognise the significance of an act or to control his conduct has been prevented or limited (and to what extent), and whether this person (the basic identity) is capable of controlling the behaviour of his *alter*. The representatives of clinical psychiatry who specialise in the treatment of people suffering from dissociative identity disorders indicate that it is possible at a certain stage of "integration", which is defined as "(…) combining *alter ego* into one coherent whole together with one hierarchy of values and a shared stock of memories".[69] Then, at least the dominant personality has the ability to understand the behaviour of the *alter* and to "control" it; and when the process of "fusion" also includes the basic personality, it seems that one can rationally assume the offender's sanity is maintained. Another thing is that, undoubtedly, "Not focussing on many personalities but on the memory barriers dividing them is the key to understand DID"[70]; and overcoming a specific barrier to "remembering",[71] with which we have to deal in case of this illness, is a success.

CONCLUSIONS AND PROPOSALS *DE LEGE FERENDA*

In conclusion, the above-presented dilemmas make conversion identity disorders an issue that deserves attention not only from the judicial-psychiatric but also criminal law perspective. According to the research mentioned in the Introduction and supported with examples, neither the importance of the issue, nor the scale of the phenomenon is as trivial as it might seem on the surface. At the same time, they allow for concluding that, to a considerable extent, dissociative identity disorders may be a source (genesis) of insanity or diminished sanity. In this regard, recognition of the disorders as a "mental illness" or "other mental disturbance", referred to in Article 31 § 1 CC, depends on the adopted interpretation of the terms. In view of their highly indefinite nature – from the psychopathological (as in case of a "mental illness") and criminal law perspective (as in case of "other disruptions to psychical activities"[72]) – the category of reasons for

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[68] The term, in other words "psychological part" of the statutory description of insanity, is used to refer to the "ability to recognise the significance of an act or to control one's behaviour" – cf. e.g.: Gałecki, P., Szulc, A., *Psychiatria*, Wrocław, 2020, p. 421; Budyn-Kulik, M., in: Mozgawa, M. (ed.), *Prawo karne materialne. Część ogólna,* Warszawa, 2020, p. 332; Barczyk, A., *Psychologia, psychiatria i prawo wobec podsądnych zaburzonych psychicznie*, Mysłowice, 2006, p. 26; Tarnawski, M., *Zmniejszona poczytalność sprawcy przestępstwa*, Warszawa, 1976, p. 70. In the literature on criminal law, they are also referred to as psychological consequences or "psychological effect" – cf. Lachowski, J., in: Konarska-Wrzosek, V. (ed.), *Kodeks karny. Komentarz*, Warszawa, 2016, pp. 197–198.

[69] Cf. Oxnam, R.B., *11 x ja – moje życie z osobowością mnogą*, Kraków, 2008, p. 71.

[70] Ibidem, p. 277.

[71] Ibidem, p. 283.

[72] The criminal law-related aspect of the features concerns covering the so-called pathological and (optionally also) the so-called physiological aspects with it; for more on the issue, cf. Golonka, A., *Niepoczytalność*…, op. cit., pp. 123–150, as well as: idem, '»Other disturbances of mental function« as a cause of the insanity of the offender in light of the Polish Criminal Code – questions and concerns', *Journal of Forensic, Legal & Investigative Sciences*, 2016, Vol. 2, Issue 1, pp. 2–5.

insanity attributed to these disorders will depend on particular meaning assigned to them. It seems that apart from the above-mentioned need to "classify" them under an appropriate category of reasons, i.e. stating that the disorders constitute a "mental illness" or "other mental disturbance", it is also necessary to assess the state of a perpetrator's consciousness, including his basic personality and his *alter*, conducted *in concreto*. Naturally, it does not concern the obvious fact that in each case the conclusion regarding the incapability to recognise the significance of an act or to control one's conduct, based on the expert psychiatrists' opinions, is related to a particular perpetrator and an act he commits. Rather, it concerns the fact that, unlike in case of e.g. psychotic disorders, which as a rule constitute (or more precisely, can be recognised as) the reason for such incapability as far as the DID is concerned, it is not possible to draw such a conclusion. At the same time, unlike in the case of the absolute majority of personality disorders, in particular ones the etiopathogenesis of which does not show changes in the CNS, also (full) sanity of a perpetrator suffering from DID cannot be "assumed". The specificity of the disorders in which *alter* differences and qualitative changes in consciousness are important allows for drawing such a conclusion. It is not possible to exclude even a scenario that an alternating personality (at the same time "responsible" for the criminal act) will suffer from a psychotic disorder and a prohibited act (of course, attributed to a given person and not his *alter*) will be also committed in this state. Other circumstances are no less important, including the pivotal issue of person's awareness regarding the existence of his *alter*, as well as acts committed by the alternating personality. When the awareness is maintained (even with limited control and influence on the behaviour of his *alter*), it seems reasonable to assume reduced sanity.

On this occasion, it is worth proposing to abandon the use of the term "mental illness" since, as it was indicated above, it actually constitutes a legal rather than psychiatric term (and, at the same time, it is believed to be stigmatising[73]), and to substitute it with an adequately defined term referring to mental disorders. The present wording "or other disruptions" raises doubts, as it could suggest that a mental illness is a "disruption" to psychical activities. Meanwhile, in the literature on psychiatry, it is emphasised that a mental illness is one "the symptoms of which are psychotic disorders", and in relation to other disruptions, "psychiatrists most often use the term of mental disorders; they include, inter alia, personality disorders, neurotic disorders, use of psychoactive substances and addictions, milder forms of dementia, and eating disorders)".[74] Therefore, determining the origin of insanity (psychiatric reasons) requires, at minimum, referring to psychotic disorders or other psychiatric disorders. At the very least, relying solely on this "scheme" for determining insanity does not seem to be satisfactory. It has been emphasised in psychopathology for years that this science in fact covers symptoms and syndromes,[75] and "the description of nosological units is a construction that

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[73] Cf. Świtaj, P., 'Rola diagnozy psychiatrycznej w procesie stygmatyzacji osób z zaburzeniami psychicznymi', *Postępy Psychiatrii i Neurologii*, Vol. 18, Issue 4, 2009, pp. 377–386.

[74] Pierzgalska, K., Woźniak, A., 'Zagadnienia prawne dotyczące postępowania leczniczego', in: Jarema, M. (ed.), *Psychiatria,* Warszawa, 2016, pp. 641–642.

[75] Cf. Spett, K., Szymusik, A., 'Psychopatologia szczegółowa', in: Cieślak, M., Spett, K., Szymusik, A., Wolter, W., *Psychiatria w procesie karnym*, op. cit., pp. 145–146.

constitutes an abstract model of a certain fragment of reality. In clinical diagnosis, the model plays a special role, because it introduces an objective procedure to describe disorders, determines the exponents of individual illnesses, and moreover, indicates the mechanism explaining human functioning under particular biological and psychological conditions".[76] It may, therefore, be suggested that Article 31 § 1 CC should be amended in this regard and the provision should be given at least such wording: "*A person who because of a psychotic disorder, intellectual development disorder or another mental disorder diagnosed in accordance with the current state of knowledge is, in the course of an act, unable to recognise its significance or to control his conduct does not commit a crime*." The proposal takes into account terminology adopted in ICD-11 for the purpose of classifying intellectual development disorders,[77] and at the same time is not limited to the classification-related diagnosis (i.e. based only on the Classification of Diseases and Health Problems),[78] also allowing it to be supplemented with the functional diagnosis (ICF).[79] Moreover, it aims to approach causes of insanity in a way that also covers syndromes and co-occurring disorders. Finally, what is most important from the criminal law perspective, it will help to avoid difficulties that may arise due to the need to assign a particular disorder to one of the categories of the reasons for insanity (i.e. a mental illness or "other mental disturbance", as it is in the present legal state). Dissociative identity disorder, which is discussed in this paper, demonstrates the issues in this regard.

In the current legal state, however, significantly diminished sanity (Article 31 § 2 CC) does not raise any of such issues. Although the criminal law literature sometimes points to the fact that sanity is also determined based on a combined method and that it is necessary to infer the psychiatric (biological) component from Article 31 § 1 CC,[80] with the justification referring to the statutory systematics,[81]

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[76] Panasiuk, J., 'Dysocjacja czy neurodegeneracja Problemy diagnozy, leczenia i terapii', *Logopedia Silesiana*, 2017, Vol. 6, p. 28.

[77] Cf. ICD-11; 6A00.0-6A00.4: https://icd.who.int/devct11/icd11_mms/en/beta, accessed on 7 February 2023.

[78] For justification on distinguishing psychotic disorders, cf. Gaebel, W., Zielasek, J., Reed, G.M., 'Zaburzenia psychiczne i behawioralne…', op. cit., pp. 171–178.

[79] Cf. Kurzeja, T., *ICD-11 nowa, międzynarodowa klasyfikacja chorób*. The article is available at: https://ppp.edu.pl/2019/07/14/icd-11-nowa-miedzynarodowa-klasyfikacja-chorob/, accessed on 7 February 2023; Łoza, B., Heitzman, J., Kosmowski, W., 'W kierunku nowej klasyfikacji zaburzeń psychicznych', *Psychiatria Polska*, 2011, Vol. 45, No. 6, pp. 789–796, as well as: "Międzynarodowa Klasyfikacja Funkcjonowania, Niepełnosprawności i Zdrowia" (*International classification of functioning, disability and health, ICF),* published by WHO in 2001, available at: https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health, accessed on 7 February 2023.

[80] Zoll, A., in: Zoll, A. (ed.), *Kodeks karny. Część ogólna. Tom I. Część I. Komentarz do art. 1–52,* Warszawa, 2012, p. 531; Gierowski, J.K., Paprzycki, L.K., in: Paprzycki, L.K. (ed.), *Nauka o przestępstwie. Wyłączenie i ograniczenie odpowiedzialności karnej. System Prawa Karnego. Tom 4*, Warszawa, 2013, p. 543; Budyn-Kulik, M., in: Mozgawa, M. (ed.), *Kodeks karny. Komentarz aktualizowany, LEX/el.*, 2022, Article 31, thesis 12; Warylewski, J., *Prawo karne. Część ogólna,* Warszawa, 2020, p. 409. For a different approach to the determination of the method of regulation, cf. Królikowski, M., Zawłocki, R., *Prawo karne,* Warszawa, 2020, p. 299; Gardocki, L., *Prawo karne*, Warszawa, 2021, p. 144.

[81] Zoll, A., in: *Kodeks karny. Część ogólna*…, op. cit., pp. 543–544.

it is, nonetheless, also true that Article 31 § 2 CC is actually "silent" on the matter.[82] Therefore, it is more reasonable to assume that in this instance the legislator refrained from indicating category of disorders resulting in significant limitation of the ability to recognise the significance of an act or to control one's conduct. Thus, it may be assumed that the criminal law-related nature of this state is constituted only by the consequences in the psychological sphere,[83] without the need to interpret them narrowly, which is desired in relation to insanity due to the consequences in the area of criminal liability (exclusion of criminality of an act).[84]

Such an approach justifies the conclusion that, in the light of the current state of knowledge, dissociative identity disorders can undoubtedly constitute the reason for significant limitation of the ability to recognise the significance of an act or to control one's conduct. On the other hand, refraining from their classification as a category of reasons laid down in Article 31 § 1 CC leads to a conclusion that DID *per se* does not result in the elimination of sanity, unless this is justified by the co-occurrence of another psychiatric disorder resulting in the inability to recognise the significance of an act or to control one's conduct (e.g. a psychotic disorder).

The issue of simulating DID is another matter. The analysis of literature allows to conclude that the case described in this paper was not an isolated one.[85] This not only exacerbates the difficulties in diagnosing a perpetrator suffering from DID but also quite often becomes, rather wrongly, a seedbed for polemics on the insanity of a perpetrator of a crime.[86] The issue presented in this way gives rise to a final reflection that alternating split personality is a serious disorder that may cause considerable difficulties in the judicial practice and becomes a real challenge to the theory of criminal law.

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[82] Article 31 § 2 CC stipulates that: "If at the time of the commission of an offence the ability to recognise the significance of the act or to control one's conduct was diminished to a significant extent, the court may apply an extraordinary mitigation of the penalty" (consolidated text, Journal of Laws of 2022, item 1138, as amended).

[83] Cf. Golonka, A., *Niepoczytalność*…, op. cit., pp. 252–256.

[84] Ibidem, pp. 130–150.

[85] Cf. Dinwiddi, S.H., North, C.S., Yutzy, S.H., 'Multiple personality disorder: Scientific and medicolegal issues', *The Bulletin of the American Academy of Psychiatry and the Law*, 1993, Vol. 21, No. 1, pp. 74–75.

[86] Cf. e.g. Behnke, S., Sinnott-Armstrong, W., 'Criminal Law and Multiple Personality…', op. cit., pp. 277–296.

Bilikiewicz, A., Lewandowski, J., Radziwiłłowicz, P., *Psychiatria – repetytorium*, Warszawa, 2003.
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