CAN DR. JEKYLL SIGN FOR MR. HYDE?: EXAMINING THE RIGHTS OF INDIVIDUALS SUFFERING FROM DISSOCIATIVE IDENTITY DISORDER IN CIVIL CONTEXTS

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ABSTRACT

How should California competency laws, regarding consent to medical treatment and competency to draft a last will, apply to individuals suffering from Dissociative Identity Disorder? The current standard—a combination of (1) communicating a decision; (2) understanding the information given; and (3) "knowingly and intelligently" acting upon such information—is too difficult to apply to cases in which the individuals might be acting under a different identity at in a critical situation. Instead, these individuals should be given a different standard of competence to maintain in order to have their autonomous wishes fulfilled, rather than being declared presumptively incompetent to make decisions in these civil matters.

Specifically, in consent to treatment cases, instead of being declared incompetent by virtue of having different identities desiring different courses of treatment or otherwise withholding consent, it should instead be determined (1) which identity, if any, should govern the decision, and (2)

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how to elicit such information.

In consent to draft a last will and testament cases, rather than being declared incompetent because one identity does not know the property and assets of every other identity, each identity should be able to draft separate wills. As such, this would further the public policy of respecting individuals' autonomous decision-making and giving a voice to those suffering from Dissociative Identity Disorder.

TABLE OF CONTENTS

I. INTRODUCTION

Imagine individuals who, at different times and under different stresses or circumstances, believe they are someone else.[1] Next imagine that these individuals believe it so much that their posture, speech,

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[1] *See Dissociative Identity Disorder (Multiple Personality Disorder)*, PSYCHOLOGY TODAY (Nov 3, 2013), http://www.psychologytoday.com/conditions/dissociative-identity-disorder-multiple-personality-disorder (describing DID and its symptoms).

handwriting, name, and personal history change along with their identities.[2] These identity swaps can be so severe that when one identity switches for another, the first identity has no recollection of the events that took place under the control of the second identity, resulting in significant amnesia.[3] These are the primary symptoms of dissociative identity disorder ("DID"), a disorder that afflicts as much as 1–3 percent of the general population,[4] with incidence rates that are even higher among psychiatric patients.[5] However, both of these figures may underrepresent the true extent of the disorder, because DID can be difficult to diagnose due to a "lack of education among clinicians about dissociation, dissociative disorders, and the effects of psychological trauma, as well as . . . clinician bias."[6]

This undiagnosed group of individuals is at a significant risk of being legally stigmatized, given that their legal competence to perform certain civil acts must be called into question.[7] This Note will examine California law as it applies to individuals suffering from DID in two specific civil contexts: consenting to treatment, and drafting a last will and testament. This examination will enumerate the symptoms of DID, identify the standards for competency, and apply them in the context of California statutory and common law. This application will help to determine whether these individuals may legally act for themselves in these matters. If it is determined that they cannot, this Note will identify possible remedies to give these individuals a voice in the legal system. Part II of this Note describes DID symptoms and raises the issue of legal competency of those suffering from this disorder. Part III of this Note begins by describing the standard of legal competency in California, then applies that standard to individuals suffering from DID in consent to

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[2] *Id.*

[3] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 291 (5th ed. 2013) [hereinafter DSM-5]; *see also Dissociative Identity Disorder*, *available at* http://www.dissociative-identity-disorder.org/references.html (providing a list of resources concerning DID).

[4] *Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision*, 12.2J. TRAUMA & DISSOCIATION 117, 117 (2011), *available at* http://www.isst-d.org/downloads/GUIDELINES_REVISED2011.pdf.

[5] *Id.* (noting that clinical studies show that between 1 percent and 5 percent of psychiatric patients may meet the DSM-5 diagnostic criteria for DID).

[6] *Id.* at 117–18 (noting that relatively few people suffering from DID consistently switch between "visibly distinct alternate identities," but instead they present a wide range of dissociative, posttraumatic stress symptoms, and as a result, clinicians typically diagnose these latter, familiar symptoms while leaving the root disorder undiagnosed).

[7] *See infra* p. 5.

treatment and last will and testament drafting cases. Part IV presents the conclusions and a summary of remedial approaches to be applied in these types of cases for individuals with this disorder.

II. DISSOCIATIVE IDENTITY DISORDER

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5") defines Dissociative Identity Disorder—formerly known as Multiple Personality Disorder ("MPD")—as a disruption of identity characterized by "the presence of two or more distinct personality states . . . [and] . . . recurrent episodes of amnesia . . . marked [by] discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning."[8] Additionally, the individual suffers:

> (1) Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events, which are inconsistent with ordinary forgetting;
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> (2) Clinically significant distress or impairment in social, occupational, or other important areas of functioning;
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> (3) Disturbance that is not a normal part of a broadly accepted cultural or religious practice; and
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> (4) Symptoms not attributable to the psychological effects of a substance or another medical condition.[9]

While most people have a single unified or integrated personality, those suffering from DID have several distinct personalities that are typically separate off from one another.[10] This is a condition referred to as "identity fragmentation,"[11] in which one personality takes over as the primary, or host, self and controls the body for the greatest amount of time, while the other personalities—known as "alters"[12]—lay dormant.[13] Usually, the primary self "carries the individual's given name,"[14] along

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[8] DSM-5, *supra* note 3, at 292.

[9] *Id.*

[10] *See Dissociative Identity Disorder (Multiple Personality Disorder)*, *supra* note 1 ("DID is a severe condition in which two or more distinct identities, or personality states, are present in—and alternately take control of—an individual.").

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] *Id.*

with the history and identity of the individual. However, individual alters have their own direct history, memories, and identity, which "contrast with those of the primary identity."[15] This contrast can be so severe that alters represent themselves as being of a "different age, race, gender, and sexual orientation,"[16] than the host, and the alters can even differ from the host in "handwriting, voice, vocabulary . . . and . . . preferred language."[17]

Alternate identities can present themselves in several different ways.[18] Most individuals suffering from DID can exhibit multiple identities at the same time.[19] When these identities overlap, the individuals suffering from DID can hear voices, as well as have trouble remembering the past correctly.[20] Alternatively, in some individuals there is overt switching between identities.[21] In such a situation, a previously dormant alter will take full and conscious control of the individual, while the host is forced into dormancy.[22] When the host resurfaces, individuals with DID typically have significant amnesia because they are often unaware of the alters, their memories, or their actions when they are in control of the individual's body.[23] According to the DSM-5 there are three ways that DID normally manifests itself. These are:

> (1) gaps in remote memory of personal life events . . . ;
>
> (2) lapses in dependable memory . . . ; and
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> (3) discovery of evidence of their everyday actions and tasks that they do not recollect doing.[24]

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[15] *Id.*

[16] Richard P. Kluft, *The Diagnosis and Treatment of Dissociative Identity Disorder*, *in* THE HATHERLEIGH GUIDE TO PSYCHIATRIC DISORDERS 49, 55 (1996).

[17] *Id.* at 55–56; Alejandra Swartz, *Dissociative Identity Disorder*, ALLPSYCH J. (Dec. 10, 2001), http://allpsych.com/journal/did.html.

[18] *See, e.g.*, Bo Wilson, *Patient With Multiple Personalities Sketches Her 17 Alter Egos*, MAILONLINE. (Oct. 2007), http://www.dailymail.co.uk/news/article-489655/Patient-multiple-personalities-sketches-17-alter-egos.html.

[19] *Id.*

[20] Bethany L. Brand & Richard J. Loewenstein, *Dissociative Disorders: An Overview of Assessment, Phenomonology, and Treatment*, PSYCHIATRIC TIMES, Oct. 2010, at 65.

[21] *Id.*

[22] *See, e.g.*, Paulette Marie Gillig, *Dissociative Identity Disorder: A Controversial Diagnosis*, 6.3 PSYCHIATRY 24, 24–25 (2009) (illustrating a case in which one woman had a primary personality and two alters but would overtly switch between them).

[23] FRANK W. PUTNAM, DIAGNOSIS AND TREATMENT OF MULTIPLE PERSONALITY DISORDER 114 (1989) ("The host personality . . . generally does *not* know about the existence of other personalities.").

[24] DSM-5, *supra* note 3, at 293.

Furthermore:

> [d]issociative fugues, wherein the person discovers dissociated travel, are common. Thus, individuals with dissociative identity disorder may report that they have suddenly found themselves at a beach, at work, in a nightclub, or somewhere at home . . . with no memory of how they came to be there. Amnesia in individuals with dissociative identity disorder is not limited to stressful or traumatic events; these individuals often cannot recall everyday events as well.[25]

Such amnesia "wall[s] off character traits and prior learning experiences that are available in integrated personalities to counterbalance, offset, and inhibit impulsive feelings and behaviors."[26] As a result of the nonintegrated experiences, different worldviews and standards of morality may develop.[27] Accordingly, because the impact of the distinct personalities and amnesia is so significant, questions of the individual's competency are raised.

III. COMPETENCY

Determining an individual with DID's legal competence in civil proceedings requires a preliminary assessment of their mental capacity.[28] As long as an assessment is required, individuals suffering from DID are at particular risk of being found incompetent, especially in a civil proceeding.[29] While competency of individuals suffering from this

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[25] *Id.*

[26] Sabra M. Owens, *Criminal Responsibility and Multiple Personality Defendants*, 21 MENTAL & PHYSICAL DISABILITY L. REP. 133 (1997).

[27] *See* Marlene Steinberg, Jean Bancroft & Josephine Buchanan, *Multiple Personality Disorder in Criminal Law*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 345, 349 (1993) (noting that DID can lead to "depersonalization, derealization, identity confusion, and identity alteration"); *see also* Harald Merckelbach, Grant J. Devilly & Eric Rassin, *Alters in Dissociative Identity Disorder: Metaphors or Genuine Entities?*, 22 CLINICAL PSYCHOLOGY REVIEW 481, 487 (citing a study in which nine DID patients were given a memory tasks in two different alter states, during which the patients claimed they had no memory of the tasks while in the altered state).

[28] Alec Buchanan, *Mental Capacity, Legal Competence, and Consent to Treatment*, 97 J. R. SOC. MED. 415, 415, *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1079581/#__sec2title ("Doctors, patients' relatives and, in contested cases, the courts have to decide, where someone's right to accept or refuse treatment is in doubt, whether that person's mental capacity is sufficient for legal competence and their stated wishes should therefore be respected."); *see, e.g.*, CAL. PROB. CODE § 6100.5 (2015) (establishing the standard for competency with regards to making a will).

[29] As previously mentioned, the recurring amnesia and manifestations of distinct personalities likely call into question an individual's mental capacity. *See supra* Part II.

disorder has often been discussed in criminal contexts,[30] little has been written regarding civil contexts.[31] Therefore, an examination of statewide civil competency as applied to people suffering from DID is necessary.

Generally, in a civil context, legal competence "requires the mental capacities to reason and deliberate, hold appropriate values and goals, appreciate one's circumstances, understand information one is given, and communicate a choice."[32] This general standard may pose a problem for individuals suffering from DID. For example, Karen Overhill, a white American woman, illustrated her seventeen alters including: 1) Sandy, eighteen-years-old, a depressed binge eater; 2) Jensen, eleven, an African-American boy; 3) Karen Boo, two, an abused infant girl; and 4) Holdon, thirty-four, a father figure.[33]

In Ms. Overhill's case, the traditional standard for competence described above, if applied, would make it impossible for her to be found civilly competent for several reasons. For instance, if Karen Boo is in control of the body, she could not be found to reason and deliberate, understand any information given, or even possibly communicate a choice. Alternatively, if Sandy is present, our society probably would not deem that she holds "appropriate values and goals." Moreover, if Ms. Overhill's alters are completely unaware of each other or the fact that that they even are alters, then it is impossible for them to appreciate their circumstances (that fact that they are a representation of one aspect of a larger identity that is only present for a short period of time). However, from a strictly psychological point of view, "[t]he capacity to dissociate allows many of these [individuals] to develop domains of competence that can make them quite successful [sic] in some areas of life."[34] Accordingly, the law poses a significant problem for people with DID. Specifically, the

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[30] *See generally* Jacqueline R. Kanovitz et. al., *Witnesses with Multiple Personality Disorder*, 23 PEPP. L. REV. 387 (1996) (discussing the issues of witnesses with dissociative identity disorder); Owens, *supra* note 26 (discussing the validity of dissociative identity disorder as a defense); Elyn R. Saks, *Multiple Personality Disorder and Criminal Responsibility*, 10 S. CAL. INTERDISC. L.J. 185 (2001) (discussing criminal responsibility of individuals with dissociative identity disorder). Importantly, issues regarding DID and criminal responsibility, DID as a valid defense, and witnesses with DID each warrant separate discussions given the widely varying analyses and assumptions required and will not be addressed in this Note.

[31] *See* Elyn R Saks, *Mental Health Law: Three Scholarly Traditions*, 74 S. CAL. L. REV. 295, 306–10 (offering possible solutions to the question of civil competency without citation, implying it is an untouched area of law).

[32] Buchanan, *supra* note 28, at 415.

[33] Wilson, *supra* note 18.

[34] BESSEL A. VAN DER KOLK ET AL., TRAUMATIC STRESS: THE EFFECTS OF OVERWHELMING EXPERIENCE ON MIND, BODY, AND SOCIETY192 (1996).

"discontinuity in sense of self and sense of agency"[35] and the alterations in behavior, consciousness, and memory, create significant questions of whether an individual, under the control of so many different identities, can be considered competent.[36]

A. LEGAL STANDARDS FOR ASSESSING DECISION MAKING COMPETENCE[37]

There are typically four standards used to measure legal competence in a civil context: the ability to communicate a choice, the ability to understand relevant information, the ability to appreciate the situation and its likely consequences, and the ability to manipulate information rationally.[38] Although these standards have been expressly applied in "consent to treatment contexts," they can be applied broadly to other aspects of civil law to determine whether an individual suffering from DID should be found competent.[39]

Each standard focuses on a different aspect of an individual's ability to rationalize or filter information. Under the first standard, the ability to communicate a choice, an individual may be unable to communicate a decision due to either a physical inability to speak or otherwise communicate,[40] or when, as a result of illness, an individual's "decisions vacillate to such an extent that a course of treatment cannot be implemented before they change their minds again."[41] Courts typically use this standard for competency in the most clear-cut cases because this standard accepts the decision as valid as long as the patient is able to communicate that decision.[42] The second and most common standard of competence is the ability to understand relevant information.[43] Here, the

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[35] DSM-5, *supra* note 3, at 292.

[36] DSM-5, *supra* note 3, at 291; *see also* Saks, *supra* note 31, at 306 ("[Individuals with DID] are simply so divided that it may be wrong to see them as single, responsible agents.").

[37] Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment*, 19.2 LAW & HUM. BEHAV. 105, 108 (1995).

[38] *Id.*

[39] *Id.* at 111.

[40] *See, e.g., In re* Conroy, 486 A.2d 1209, 1241 (N.J. 1985) (finding a non-responsive, eighty-four-year-old woman to be incompetent); *see also In re* O'Brien, 517 N.Y.S.2d 346, 348 (N.Y.1986) (finding an eighty-three-year-old patient disabled by stroke to be incompetent to make medical decisions even though able to react to basic needs and wants).

[41] Appelbaum & Grisso, *supra* note 37, at 109.

[42] *Id.*

[43] *Id.*

emphasis is on an individual's comprehension of the information given.[44] Under the third standard, an individual must be able to appreciate the nature of the situation and its likely consequences.[45] Unlike the second standard, here, individuals must be able to apply the information to their own situations.[46] For example, in medical situations, individuals "who understand that their physicians believe they are ill, but, in the face of objective evidence to the contrary, deny that this is so, or who understand that an effective treatment exists, but refuse to believe that is likely to help them, will be said to lack appreciation."[47] The final competency standard requires the individual to have the ability to manipulate information rationally.[48] This standard requires individuals to process information logically,[49] but does not require them to understand their situations. For example, persons under the influence of alcohol are still able to turn on a car, put it in drive, and use the pedals to increase and decrease speed. However, they are not able to think abstractly about their situation (that is, that they are drunk and are probably too impaired to drive safely).

Because each standard has its own shortcomings, some courts have applied multiple legal standards simultaneously, thereby creating a high standard for legal competency.[50] California is among these jurisdictions.[51] For example, in consent to treatment cases, to be found competent, an individual suffering from a mental disorder is required to be able to show a combination of abilities, including the ability to manipulate information rationally, communicate a decision, and "knowingly and intelligently evaluate the information."[52] Accordingly, this is a significant hurdle that those suffering from DID must overcome to make their own decisions in California.

B. COMPETENCY TO CONSENT TO TREATMENT IN CALIFORNIA

Perhaps the most significant question facing individuals suffering from a mental disorder, including DID, is whether they may consent to

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[44] *Id.*

[45] *Id.* at 110.

[46] *Id.*

[47] *Id.*

[48] *Id.*

[49] *Id.*

[50] *Id.*

[51] *Id.*

[52] Riese v. St. Mary's Hosp., 271 Cal. Rptr. 199, 212 (Cal. Ct. App. 1987).

their own treatment. In California, this question centers on whether a patient is able to give "written informed consent."[53] Written informed consent requires that:

> (1) [An individual] knowingly and intelligently, without duress or coercion, clearly and explicitly manifest[] consent to the proposed therapy to the treating physician and in writing on the standard consent form prescribed.
>
> (2) The physician may urge the proposed treatment as the best one, but may not use, in an effort to gain consent, any reward or threat, express or implied, nor any other form of inducement or coercion, including, not limited to, placing the patient in a more restricted setting, transfer of the patient to another facility, or loss of the patient's hospital privileges.
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> (3) A person confined shall be deemed incapable of written informed consent if such person cannot understand, or knowingly and intelligibly act upon information required for such consent.
>
> (4) A person confined shall not be deemed incapable of refusal solely by virtue of being diagnosed as mentally ill, disordered, abnormal, or mentally defective person.
>
> (5) Written informed consent shall be given only after 24 hours have elapsed from the time the [required voluntary consent information] has been given.[54]

Although the presumption that people with mental illness cannot make legally significant decisions has been mitigated, in part due to the advent of informed consent law, people suffering from mental disorders, such as DID, are at a significant risk of being found incompetent.[55] California has incorporated the use of several of the aforementioned standards into its informed consent law.[56] Individuals must be able to (a) communicate a decision; (b) understand the information given; and (c) "knowingly and intelligently"[57] act upon such information.[58] The California courts impose an even more exacting standard.[59] In *Riese v. St. Mary's Hospital*, the court found that a patient must "utiliz[e] rational modes of thought" when

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[53] CAL. WELF. & INST. CODE § 5326.5 (2015).

[54] *Id.*

[55] Appelbaum & Grisso, *supra* note 37, at 110.

[56] CAL. WELF. & INST. CODE § 5326.5.

[57] Appelbaum & Grisso, *supra* note 37, at 110.

[58] CAL. WELF. & INST. CODE § 5326.5(c).

[59] *See* Riese v. St. Mary's Hosp., 271 Cal. Rptr. 199, 210 (Cal. Ct. App. 1987) (California is not bound to follow the federal standard).

giving consent.[60] In the "absence of a clear link between the patient's delusional or hallucinatory perceptions and his ultimate decision to consent or refuse treatment," a patient would be presumed to be thinking rationally.[61]

These requirements pose significant problems for people suffering from DID. Consider the following scenario, originally offered by Professor Elyn Saks:

> [An individual with DID] shows up at an emergency room acknowledging that she [has DID], and it turns out she needs an immediate blood transfusion in order to survive. Suppose further that, when consent is sought, the alter who is out says "no," because he is a Jehovah's Witness. None of the other alters is a Jehovah's Witness, and they are each desperate to say "yes" to the transfusion in order to survive. But the Jehovah's Witness alter stays in control of the body and won't let the others out. Should the doctor accept the refusal of the Jehovah's Witness and die?[62]

Now, slightly change the scenario so that the host enters the emergency room and retains control over the body, but acknowledges that he or she has DID and that only one alter refuses to consent, while the others consent. The issue then, is whether the doctor should still apply the treatment.

1. Arguing With "Yourself": The Dilemma of Disagreeing, "Competent" Personalities

The doctor in question, and legal scholars studying the case detailed above, would be forced to determine which personality should be listened to. It is important to note that the alters are not delusions or hallucinations.[63] Rather they are unintegrated personalities, typically isolated, that surface during stressful or traumatic events.[64] For this reason, such an individual would satisfy part of the *Riese* standard, which requires an "absence of a clear link between an individual's delusional or hallucinatory perceptions and [that individual's] ultimate decision" to

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[60] *Id.*

[61] *Id.*

[62] Saks, *supra* note 27, at 309 (notwithstanding the fact that such a case may never present in such a clear cut manner, such that an alter overtly takes control of the body and announces itself, the discussion is still valuable in reaching a better understanding of DID and civil competency).

[63] *See* DSM-5, *supra* note 3, at 292 (making no mention of delusions or hallucinations as symptoms of DID).

[64] *Id.*

consent or refuse treatment.[65] Because there is no delusion or hallucination affecting the individual's judgment in the above hypothetical, there is a de facto "absence of a clear link"[66] between these nonexistent perceptions and the decision regarding treatment.[67]

By simply applying the language of the statute such individuals would likely be found competent to make their own medical decision. The individual in this hypothetical has "knowingly and intelligently"[68] expressed a refusal to consent for religious reasons. However, a significant problem still exists—the alters still desperately desire treatment to keep the body alive.[69] The text of the law in California seemingly does not give the host or other alters any recourse when one of the alters is in full, competent control.[70]

Scholars have suggested several views to evaluate competency in such right to treatment cases.[71] However, nearly all are of these views are inapplicable to this situation because they identify delusions as a primary factor.[72] One theory inadvertently, but aptly, addresses the question of dissociative identity disorder and civil competency: the Different Person View ("DPV").[73]

DPV establishes that, "a person is incompetent, not if [his or] her values and beliefs are unacceptable according to some external standard, but rather if they are not [his or] her values or beliefs—because [he or] she is transformed (for example, by mental illness) into a different person."[74] Rather than identify whether an individual is suffering from DID, or is "utilizing rational modes of thought,"[75] DPV deftly sidesteps the irrationality and unconventionality criteria, inasmuch as the

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[65] *Riese*, 271 Cal. Rptr. at 212.

[66] *Id.*

[67] *Id.*

[68] *See* CAL. WELF. & INST. CODE § 5326.5(a) (2015) (requiring the ability to "knowingly and intelligently . . . manifest[] consent").

[69] *See supra* Part III.C.

[70] *See* CAL. WELF. & INST. CODE § 5326.5 (making no mention of the possibility of DID affecting the competency of an individual).

[71] Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 948–62 (1991) (addressing several views of decisional competency in medical treatments); *see* Lawrence Hipshman, *Defining a Clinically Useful Model for Assessing Competency to Consent to Treatment*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 235 (1987).

[72] Saks, *supra* note 75, at 962–77.

[73] *Id.* at 959–63.

[74] *Id.* at 959.

[75] Riese v. St. Mary's Hosp., 271 Cal. Rptr. 199, 212 (Cal. Ct. App. 1987).

decisonmaker's irrationality is irrelevant . . . ."[76]

Moreover, DID undercuts one of the main criticisms of DPV: a lack of clear criteria for identifying different identities in general mental health cases.[77] If individuals acknowledge that they have DID and that they are an alter, then there is a very clear and acceptable contrast with which to identify different identities. However, DID then poses a unique problem for DPV: which identity constitutes the "different person," and which constitutes the normal self? Four methods to make this determination are immediately apparent: (1) because the host is the primary personality, the host's wishes should be followed; (2) because the totality of the host and the alters comprise a single identity,[78] although fragmented,[79] a majority of the personalities should decide the course of treatment; (3) if an alter is in control of the body and it is the dominant part of the personality at the time of the decision, the alter's decisions should be followed; and (4) even if the alter is not in control, such as in the second scenario, but still voices dissent, that minority's dissent should govern the course of treatment because there is not a unanimous decision amongst the identities. Each of these possibilities is problematic for determining the individual's consent to treatment.

a. Follow the Host's Decision

Following the host's decision may seem attractive, but it presents several distinct problems. First, the host may not be able to communicate a choice, especially when an alter is in control of the body.[80] When the body is in a stressful situation, like a medical emergency, it is common for the host to retreat and let a more dominant personality surface.[81] Alternatively, in the event that the host can communicate a desire to the controlling alter, the host's communication may be ignored.[82] In either scenario, the host's decision will remain unknown, regardless of ability and desire to make a

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[76] Saks, *supra* note 75, at 959.

[77] *Id.* at 960.

[78] Kluft, *supra* note 16, at 55–56 (1996).

[79] *Dissociative Identity Disorder (Multiple Personality Disorder)*, *supra* note 1.

[80] ONNO VAN DER HART, ELLERT R. S. NIJENHUIS & KATHY STEELE, THE HAUNTED SELF: STRUCTURAL DISSOCIATION AND THE TREATMENT OF CHRONIC TRAUMATIZATION 86 (2006) (discussing several alters that dominate the consciousness when they are the active alter).

[81] *See generally* Swartz, *supra* note 17 (indicating that a typical type of alter personality is a "strong, angry protector").

[82] *See* Brand & Loewenstein, *supra* note 20, at 65 (noting that individuals with DID can sometimes hear voices from one of their dormant identities).

decision.

Second, host personalities typically are meek and subservient, and they often give way to the more dominant, self-destructive personalities, especially in times of stress.[83] As a result, the host may retreat and refuse to communicate when under psychological stress.[84] No matter the scenario, if an alter is in control of the body, there is a significant likelihood the host will be considered incompetent solely by virtue of being unable to communicate a decision.[85]

b. Follow the Majority Decision

Following the majority of a host and alter's decisions is perhaps the least problematic solution. On one hand, this method circumvents the issue of determining the host's decision in the event that he or she is unable to verbally communicate, because the doctor would not have to guess which identity is seeking treatment. However, this method can be problematic if the host and its other alters are unable to communicate, leaving a single alter in control.[86] In that situation, a doctor will likely be unable to determine the majority's decision. However, in an emergency situation, it is reasonable to infer the majority desires treatment based on the fact that the body has arrived at the hospital.[87] This inference is reasonable because the personalities not in visible control may still intrude on the dominating personality and influence how the body acts.[88] Moreover, the statute does

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[83] *See, e.g.*, Gillig, *supra* note 22, at 24–25 (providing an example of an alter who took control and was more aggressive than the host); Swartz, *supra* note 17 (noting that some alters are "strong, angry protectors"). *See generally* Margaret M. McAllister, *Dissociative Identity Disorder: A Literature Review*, 7.1 J. PSYCHIATRIC AND MENTAL HEALTH NURSING 25 (2000), *available at* https://www.researchgate.net/publication/12300336_Dissociative_identity_disorder_a_literature_review?ev=srch_pub (describing varying approaches to understanding DID and its symptoms).

[84] *See, e.g.*, Gillig, *supra* note 22, at 24–25 (describing a case in which an alter would not communicate for the host).

[85] *See* CAL. WELF. & INST. CODE § 5326.5(c) (2015) (requiring an individual to be able to "act upon[] the information" presented to them to give consent); *see also* Appelbaum & Grisso, *supra* note 37, at 109 ("Ability to communicate a choice is the first, and least stringent, standard that ordinarily is applied. When patients are unable, as a result of illness, to reach a decision or to indicate to their caregivers what course of treatment they desire, they uniformly will be considered incompetent.").

[86] Specifically, the alter may have such firm control over the mind and body that the host and other alters cannot communicate their thoughts physically or verbally.

[87] Brand & Loewenstein, *supra* note 20, at 65.

[88] *Id.*

not require a verbal decision.[89] Therefore, taking the body to the hospital could be considered "clearly and expressly manifesting consent"[90] to treatment as a decision on behalf of at least one of the alters.

c. Follow the Alter in Control's Decision

Allowing the alter in control to decide presents a particularly glaring problem, given the typical personas an alter adopts.[91] For example, an individual with the identity of an "internal persecutor who blames one or more of the alters for the abuse they have endured"[92] may choose to refuse treatment as a punishment.[93] However, if the same individual were to come in with a "helper"[94] identity, he may instead choose to accept the prescribed treatment. These examples illustrate the discord that DPV seeks to resolve; identifying the fundamental values and beliefs of the individual and distinguishing them from those of a different identity.[95] Therefore, following the decision of the alter in control is tantamount to ignoring the DPV.

d. Follow the Minority Decision

Using the minority decision to guide medical treatment is also problematic. The argument for following the minority decision under DPV is based on the notion of unanimity. Principally, because each alter is an aspect of a single identity,[96] at least some part of the whole identity does not consent to treatment. This argument is tenuous at best, and runs into many of the same problems as the other options. If the majority view is expressed by an alter in control, the minority might not be able to communicate a decision, either expressly or impliedly. The different identity's view is wholly ignored because the minority is fundamentally at odds with the majority, just as when the alter's decision is followed. Additionally, this argument also ignores the fact that many individual's decisions are not based on a cost-benefit analysis, and thus any rational

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[89] *See* CAL. WELF. & INST. CODE § 5326.5(a) (requiring only that the individual "clearly and expressly *manifest* consent") (emphasis added).

[90] *Id.*

[91] *See* Swartz, *supra* note 17 (listing five prototypical personas, each conflicting with the others).

[92] *Id.*

[93] *Id.*

[94] *Id.*

[95] Saks, *supra* note 75, at 959.

[96] Kluft, *supra* note 16, at 55–56.

individual will have reservations or even refuse to consent to a treatment.[97] Accordingly, it seems possible for a individual with DID to be found competent to consent or refuse treatment in California.

2. Protecting Dr. Jekyll from Mr. Hyde: Appointing a Guardian for the True "Self"

Alternatively an appointed third party who makes decisions for the dissociative individual could sidestep the issue of determining competency entirely. For instance, dissociated individuals who consistently change their desire to consent with each shift in personality would be irrelevant if a guardian, such as a family member, spouse, or other legally appointed individual, could make decisions for them.[98]

However, appointing a guardian raises several issues. First, as a general policy matter, a presumption exists that every individual possesses legal competency, which encourages autonomy and self-determination.[99] In trying to sidestep the issue of competency for dissociative individuals, this policy would eliminate this presumption as applied to them.

Removing a presumption of competency is highly debatable because a treating physician may be reasonably unsure of an individual's capacity, therefore necessitating an appointed guardian. *Riese* only allows a "surrogate" in very specific circumstances and subject to certain restrictions.[100] A guardian may only be appointed in the event an individual has been incapable of giving informed consent and confined for fourteen days, and should decide treatment either with first-hand knowledge of the individual's desires and feelings, "to the extent that they were expressed before the [individual] became incompetent"[101] or, if this is not possible, should decide based on "the [individual's] best

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[97] *See* CAL. WELF. & INST. CODE § 5326.5(a) (2015) (requiring only clear and explicit consent). There is no indication that hesitation or deliberation is impermissible. Ultimately, clear and express consent can translate to a fifty-one percent yes and forty-nine percent no, in favor of treatment (or vice versa).

[98] *See generally* Raphael J. Leo, *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, 1.5 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 131 (Oct. 1999), *available at* http://ncbi.nlm.nih.gov/pmc/articles/PMC181079 (discussing typical competing interests in cases involving mental capacity, legal competence and consent to treatment).

[99] *Id.*; *see also* Riese v. St. Mary's Hosp., 271 Cal. Rptr. 199, 208 (Cal. Ct. App. 1987) (noting that individuals have control over there bodily integrity).

[100] *Riese*, 271 Cal. Rptr. at 212.

[101] *Id.*

interests."[102]

The primary advantage of guardianship is the promise of a clear and decisive answer in a reasonable amount of time. However, in either scenario, the guardian will be no better than the dissociated individual in determining the correct course of action. At best, the guardian is an alternative and competent, "alter."[103] As DID typically begins at a young age,[104] it would normally be impossible to determine the individual's desires and feelings before suffering from dissociation.[105] At the same time, the guardian encounters the same problem as the doctor or individual in trying to decide based on the individual's best interests. As in the Jehovah's Witness example, several alters and the host believe taking the blood transfusion is in the individual's best interest.[106] At the same time, the alter who is dominating the physical body believes it is in the individual's interest to refuse treatment.[107] The guardian would then likely have to do a similar analysis as discussed previously and decide whether the host personality, the alter in control, the majority, or the minority's decision is in the best interest of the patient.

A second advantage that a guardian may provide is the power to negotiate between each competent alter to form a unified resolution. As one scholar noted, "the guardian could be required to speak with as many of [the alters] as possible, and try to get them all to agree. . . . By contrast, any competent alter may not have the interests of the [other] alters in mind in the same way."[108] However, the flaws in this strategy are nonetheless apparent because "it may be well-nigh impossible for such a solution to be reached. In that case, adding the guardian helps very little and, of course, has huge costs of its own in terms of time expended, stigma imposed, and all the discomforts of not having one's choice respected."[109]

Indeed, consider the Jehovah's Witness blood transfusion scenario, in which the alter is willing to go so far as to die (by rejecting the transfusion) for religious beliefs, whereas the other identities strongly

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[102] *Id.*

[103] Saks, *supra* note 31, at 309.

[104] *See* DSM-5, *supra* note 3, at 294 (noting that DID is often associated with childhood trauma).

[105] Am. Acad. of Pediatrics v. Lungren, 940 P.2d 797, 851 (1997) (stating that there is a "general presumption that an unemancipated minor . . . is incapable of informed consent.").

[106] Saks, *supra* note 31, at 309.

[107] *Id.*

[108] *Id.*

[109] *Id.*

desire to continue to live.[110] In situations such as this, a negotiated resolution is impossible.[111]

There is a danger that "the guardian is simply going to decide, more likely than not, as the guardian sees best."[112] Thus, appointing a guardian would amount to involving a third-party unnecessarily, and perhaps even to the detriment of the patient.[113] Further, putting a blanket generalization on dissociative patients as requiring an appointed guardian ignores the severity of each individual's condition while undermining the common law policy of autonomy and self-determination. Conversely, appointing a guardian on a case-by-case basis as the need arises may be insufficient in cases that require immediate decisions.

C. COMPETENCY TO WRITE A WILL IN CALIFORNIA

A second significant question for individuals with DID is to determining whether they may make a valid will in California.[114] For instance consider another scenario originally provided by Professor Saks:

> A very wealthy [individual with DID] with several children in dire need goes to make a will, announcing to his lawyer that he [has DID]. But the alter who comes out in the lawyer's office is one who identifies with his aggressors and his abusers and, thus, wants to leave his vast estate to a pedophile organization. Should he be able to bind his fellow alters to this course even though it's exactly what they would not have chosen? If the testator is hit by a car on the way out of the lawyer's office, is this will valid?[115]

In California, drafting a valid will requires a different standard of competency than consenting to treatment.[116] California has a specific

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[110] *Id.*

[111] Indeed, most consent to treatment cases are necessarily zero-sum because the only available options are "consent" or "no consent." If one identity consents and a second does not, there can be no room for negotiation.

[112] Saks, *supra* note 31, at 309.

[113] *Id.* (pointing out several reasons why a guardian would result in high costs with little gain, including "time expended, stigma imposed, and all the discomforts of not having one's choice respected").

[114] *Id.*

[115] *Id.*

[116] *Compare* CAL. WELF. & INST. CODE § 5326.5 (2015) (requiring that "written informed consent" be given "knowingly and intelligently, without duress or coercion"), *with* CAL. PROB. CODE § 6100.5 (2015) (requiring an understanding of "the nature of the testamentary act . . . the nature and situation of [one's own] property," one's relatives and inheritors, and a lack of a delusional or hallucinatory mental disorder that results in a testamentary act different from what

statute enumerating who may not make a will.[117] That statute finds an individual incompetent to make a will if they lack "sufficient mental capacity to be able to . . . understand the nature of the testamentary act."[118] Furthermore, California also finds individuals incompetent if they "suffer from a mental disorder with symptoms including delusions or hallucinations, which delusions or hallucinations result in the individual's devising property in a way which, except for the existence of the delusions or hallucinations, the individual would not have done."[119]

Given this rigorous standard, individuals suffering from DID are less likely to be deemed competent to draft their own will. Although not every degree of mental instability or weakness will destroy testamentary capacity,[120] the text of the statute renders such individuals especially vulnerable.

In one respect, this statute may be misguided, as it could allow the alter in the above scenario to bind the other identities to a course of action they unanimously disagree with. Specifically, individual alters may wrongfully be deemed competent and may therefore legally bind the rest of the identities.[121] In the scenario above,[122] the alter appears to be stable, is not suffering from delusion or hallucinations,[123] and has an understanding of the nature and situation of the property in question.[124] Ultimately, the statute would likely leave the host and the remaining alters without recourse.

In a different scenario, the statute may be too restrictive toward individuals suffering from DID. Because the statute is disjunctive, if the individual cannot comply with every aspect, that individual would require a guardian to control the distribution of assets.[125] Unlike the consent to

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would have occurred without the disorder).

[117] CAL. PROB. CODE § 6100.5.

[118] *Id.* § 6100.5(a)(1).

[119] *Id.* § 6100.5(a)(2).

[120] *See In re* Dunne's Estate, 278 P.2d 733, 738 (Cal. Ct. App. 1955) (finding there was no evidence that the testator was under the influence of opiates when he made his will, that undue influence was exerted, or that fraudulent representations were made).

[121] *See* Saks, *supra* note 31, at 309 (presenting hypotheticals in which an alter appears competent and makes a decision that would bind the entire individual, even if that decision goes against the wishes of the other identities).

[122] *Id.*

[123] *See* DSM-5, *supra* note 3, at 292 (making no mention of delusions or hallucinations as symptoms of DID).

[124] Saks, *supra* note 31, at 309.

[125] *See* CAL. PROB. CODE § 6100.5 (2015) (finding that individuals lack capacity if they do not

treatment scenario, this would defy the common law policy of autonomy and individual choice because that individual would fail the statutory criteria to draft a will and a guardian would be appointed to distribute the individual's assets.[126] Here, the guardian is not protecting the true "self's" decision, but is making the decision for them. Accordingly, an analysis of the statute is necessary to determine whether an individual suffering from DID may be considered competent to create a will, and, if so, which identity should control how the assets are distributed.

For an individual to understand the nature of the testamentary act, that individual testator must be able to show:

> (1) that the testator understands that he is making or amending a will;
>
> (2) that he [or she] knows something about the property to be disposed of;
>
> (3) that he [or she] knows the natural objects of his bounty; and
>
> (4) that he [or she] understands the disposition of the property.[127]

This poses a problem for individuals with DID. At any given point, the individual may switch to a juvenile alter, who does not understand what a testamentary act is, or even switch to an identity who is unaware of all of the host's assets.[128] However, it is important to note that at least one identity does "have the ability to comprehend, know, recall, or collect in mind" the nature of the estate, even if that identity is not controlling.[129] The question then becomes whether the controlling identity must understand the nature of the testamentary act. The answer is very likely that it must.[130] For instance, assume an infantile alter controls the body at the time of the creation or amending of the will. In that situation, it is irrelevant that a dormant host or alter knows the extent of the assets if the identity in control does not.

By the same line of reasoning, the identity in control of the body

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understand the testamentary act, the extent of their property, and cannot recognize their bounty, or separately if they have a "mental disorder with symptoms including delusions or hallucinations").

[126] *See* Leo, *supra* note 98, at 131 ("[O]ne can be determined to be incompetent to execute a will, but may be deemed competent to make treatment decisions.").

[127] Michael D. Chafetz, *Assessing Testamentary Capacity: Some Sensible Advice*, EXPERT PAGES, http://expertpages.com/news/assessing_testamentary_capacity.htm (last visited Nov. 11, 2014); *see also* 38 AM. JUR. 3d *Proof of Facts* § 3 (1996) (listing similar criteria to Chafetz).

[128] *See* Owens, *supra* note 26, at 133–34 ("[U]nless the host personality is co-conscious with the alter who commits the crime, the host will not even know that a crime occurred.").

[129] Chafetz, *supra* note 127.

[130] *In re* Estate of Sexton, 251 P. 778, 780–81 (Cal. 1926).

likely must also "understand and recollect the nature and situation of the property"[131] and understand the interests to be affected by the creation or amendment of the will.[132] Similarly, since a will may be created any time after age eighteen, individuals suffering from DID may not be incompetent because they are unable to understand the situation, the interests affected, and all other required components, at one given point in time. Rather, if they can understand these factors at a different time, they may still be competent.[133]

However, unlike medical situations, in which time can be a critical factor in decision-making, adults of sound mind may draft a will at any time before death.[134] As such, while an alter who may not understand the nature of the testamentary act may control the body at one point in time, the host or alter who does may surface at a different time, and then validly create or amend the will. As such, an individual suffering from DID is able to understand the nature of the testamentary act.

1. "Insanity" by Virtue of Delusion or Hallucination[135]

Just as insanity is highly scrutinized in criminal law,[136] the burden of proving incompetence is equally difficult in estate cases.[137] In California, as recently as 1994, proving incompetence by reason of delusion or hallucination required evidence to establish "the will itself was the creature or product of such hallucination or delusion; that the hallucination or delusion bore directly upon and directly influenced the terms of the testamentary instruments" and that the individual would not have bequeathed his or her property in such a way but for these hallucinations or delusion.[138] A hallucination or delusion is a "false or mistaken belief about the existence of a fact."[139] In one case, a father left all his property to

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[131] CAL. PROB. CODE § 6100.5(a)(1) (2015).

[132] *Id.*

[133] *See Estate of Sexton*, 251 P. at 780 ("Evidence as to mental condition before and after the execution of the will may be relevant and admissible, but it is important only in so far as it tends to show mental condition at the time of executing the testamentary document.").

[134] CAL. PROB. CODE § 6100.

[135] CAL. PROB. CODE § 6100.5; Goodman v. Zimmerman, 32 Cal. Rptr. 2d 419, 424–25 (Cal. Ct. App. 1994).

[136] *See generally* 41 AM. JUR. 2d, *Proof of Facts* § 615 (1985) (describing the various burdens of proof required to prove insanity).

[137] *Goodman*, 32 Cal. Rptr. at 424–25.

[138] *Id.*

[139] 64 CAL. JUR. 3d, *Wills* § 81 (2015).

his sister's stepdaughter based on a delusion that she was his biological daughter.[140] Moreover, the father believed he had married and fathered a child, when, in reality, he had not.[141]

While delusions and hallucinations are characteristic of some mental disorders such as schizophrenia, they are not a common characteristic of dissociative disorders such as DID.[142] The alternate identities exhibited in DID are not delusions or hallucinations.[143] Rather, they are unintegrated subconscious aspects of the individual, not "false or mistaken beliefs."[144] Given the strict application of the term insanity in the legal system,[145] the lack of delusions and hallucinations as symptoms of DID,[146] and the general policy seeking to allow individuals to determine how their property should be distributed,[147] individuals suffering from DID should be considered competent under the statute.

2. Undue Influence[148]

Although it appears individuals suffering from DID should be found competent to create a will under the statute, there is another hurdle they must overcome. Though not explicitly included in the statute, another method of challenging a testator's competence is through a claim of undue influence, which occurs when "one person has overridden the free will of the testator in the distribution scheme, to the extent that the will is not considered a voluntary act of the testator."[149] Claims of undue influence have been typically brought forth in cases in which the testator has a "weak mind" that is easily dominated by the will of another, thus making

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[140] *In re* Estate of Rask, 214 N.W. 2d 525, 530 (N.D. 1974).

[141] *Id.*

[142] CAROL KNISEL & EILEEN TRIGOBOFF, CONTEMPORARY PSYCHIATRIC-MENTAL HEALTH NURSING 371 (2nd ed. 2009); *see* DSM-5, *supra* note 3, at 292 (making no mention of delusions or hallucinations as symptoms of DID).

[143] *See* DSM-5, *supra* note 3, at 292 (describing the symptoms associated with DID).

[144] *Id.* at 291 (describing the nature of DID); 64 CAL. JUR. 3d *Wills* § 81 (defining a delusion as a "false or mistaken belief").

[145] 41 AM. JUR. 2d, *Proof of Facts* § 24 (1985) (listing the numerous elements of proof for proving insanity).

[146] *See* DSM-5, *supra* note 3, at 292 (making no mention of delusions or hallucinations as symptoms of DID).

[147] *See* Leo, *supra* note 98, at 131 (describing the importance of the right to self-determination).

[148] *See* 38 AM. JUR. 3d, *Proof of Facts* § 5 (1996) ("Another basis for challenging a will because of the testator's state of mind is undue influence.").

[149] *Id.*

the testator incapable of understanding the testamentary act.[150]

Because of the difficultly in proving undue influence, a combination of factors must be shown to illustrate that undue influence over the testator has occurred:

> (1) the provisions were unnatural;
>
> (2) the dispositions of the will varied from the intent of the testator before and after its execution;
>
> (3) the chief beneficiaries of the act had an opportunity to control its outcome;
>
> (4) the testator's mental or physical condition were such that [the testator's] freedom of will could be subverted; and
>
> (5) the chief beneficiaries under the will were active in procuring the instrument to be executed.[151]

Importantly, not all of these factors must be met, but a combination of them sufficient to establish a claim beyond a preponderance of the evidence must be shown.[152]

Undue influence is typically exerted by those in confidential family relationships with the testator.[153] Notably, given the combination of the factors, testamentary acts created by individuals suffering from DID are likely to be challenged.[154] Consider the above example in which a wealthy multiple who chooses to leave his estate to an abusive group rather than the children he has fathered.[155] Further assume that the host desired to leave his estate to his children.

Although not solely probative, an important indication of undue influence is that the will "prefers strangers . . . to the natural objects of the testator's bounty."[156] In the provided example, the children would almost certainly contest the will's decision to leave the estate to a pedophilic organization. Further, the provisions of the testamentary act (provided by

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[150] *Id.*

[151] 14 WITKIN SUMMARY 10th, *Wills* § 132 (2005).

[152] *Id.*

[153] *In re* Estate of Gelonese, 111 Cal. Rptr. 833, 839 (Cal. Ct. App. 1974).

[154] Having multiple identities will undoubtedly create a presumption of undue influence, given that at best, it may be impossible to tell which personality influenced the controlling identity to create a particular provision in a will. At worst, the provision may be so at odds with the rest of the will, it could not be legally enforced given that the individual will be deemed unduly influenced.

[155] *See* Saks, *supra* note 31, at 309 (presenting the given scenario).

[156] 14 WITKIN SUMMARY 10th, *Wills* § 132.

the abusive alternate identity) will vary from the host's intention before and after its execution, given that the host wants to leave his estate to his children, while the alter in control desires otherwise.

The most important factor, however, is the confidential relationship factor. Unlike other fiduciary relationships between multiple individuals, this relationship lies within the same individual. For many individuals suffering from DID, the alternate identities can interfere and unduly influence the host personality, either by dominating it entirely and causing overt personality switching, making desires known as a disembodied voice, or more subtly by inserting a thought into the host's mind.[157] In either scenario, one or more alternate identities can have direct influence, regardless of which identity manifests.[158]

It should be understood that the different identities in the same body, each of whom attempt to insert their thoughts and desires, are completely distinct from an individual with a single identity who may perform a cost-benefit analysis when making a decision.[159] A typical individual[160] will almost certainly have reservations about making a life decision such as drafting a last will and testament.[161] However, these reservations are clearly distinct from a separate identity attempting to override the host identity.

Under this line of reasoning, any testamentary act written or dictated by an individual suffering from DID will almost certainly be invalidated by virtue of undue influence. Accordingly, such reasoning assumes that the host personality, when not interfered with, should always be followed, and the alternate identities are simply nuisances to be controlled.

Professor Saks, however, accepts and operates under the premise that there does not need to be unanimity, or even accord amongst the alters, for competence.[162] Instead, if the dominant personality displays a combination of the factors for competence,[163] then the individual is presumed

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[157] Brand & Loewenstein, *supra* note 20, at 65.

[158] *Id.*

[159] Toby MacDonald, *How Do We Really Make Decisions?*, BBC NEWS SCIENCE & ENVIRONMENT (Feb. 23, 2014), http://www.bbc.com/news/science-environment-26258662.

[160] *See supra* text accompanying note 102.

[161] William D. Zabel, *About Men; Last Will and Testament*, N.Y. TIMES, May 20, 1984, http://www.nytimes.com/1984/05/20/magazine/about-men-last-will-and-testament.html (describing how men often do not want to create or sign their wills because "they are unable to resolve their true feelings about their deaths, their property, and their families.").

[162] Saks, *supra* note 31, at 309.

[163] Appelbaum & Grisso, *supra* note 37, at 109 (citing the importance of the ability to communicate a choice, the ability to understand relevant information, the ability to appreciate

competent, even if the other personalities fundamentally disagree with the decision.[164] However, because undue influence is still a legitimate challenge even if the dominating personality is competent, alternative solutions should be considered.[165]

3. Solution to the Problem of Undue Influence

A reasonable remedy is the appointment of a guardian or conservator,[166] because that individual's decision-making process will likely not be affected by the overt shifts in personality or any thought insertions that occur.[167] However, similar to consent to treatment cases, appointing a guardian provides, at best, a limited solution.[168] As Professor Elyn Saks argued, guardians are just another competent alter who will decide what they think is best.[169] Accordingly, because of the general view against taking away an individual's decision-making power,[170] a guardian or conservator should not be given the absolute duty to decide the best interests for the individual.[171] Rather the guardian should seek to facilitate a negotiated solution between the alters.[172] Unlike medical situations in which time is a valuable commodity, determining the content of a last will and testament may be accomplished over the course of several years. As such, there is a greater chance that an effective settlement amongst the identities may be reached.

Professor Saks, however, argues that no matter the length of time,

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the situation and its likely consequences, and the ability to manipulate information rationally).

[164] *See* Saks, *supra* note 31, at 309 (illustrating how an alter could appear competent and make a decision against the will of the other identities).

[165] *See* 38 AM. JUR. 3d, *Proof of Facts* § 5 (1996) ("Another basis for challenging a will because of the testator's state of mind is undue influence.").

[166] *See* CAL. PROB. CODE § 2400 (2015) (establishing guardianships and conservatorships as an acceptable means of caring for an estate); *see also Conservatorship of Bookasta*, 265 Cal. Rptr. 1, 3 (Cal. Ct. App. 1989) (noting that a conservatorship can be appropriate when an individual lacks competency).

[167] *See* Brand & Loewenstein, *supra* note 20, at 64 (noting how some individuals with DID can rapidly shift identities).

[168] *See* Saks, *supra* note 31, at 309 ("[A] guardian will generally be no better a decisionmaker than any competent alter.").

[169] *Id.*

[170] *See* Leo, *supra* note 98, at 131 (noting the importance of self-determination).

[171] *See* Saks, *supra* note 31, at 309 ("[A] guardian will generally be no better a decisionmaker than any competent alter.").

[172] *Id.* at 308 ("[A] guardian could be under a duty to try to negotiate consent among the alters.").

some alters will simply never reach an understanding.[173] If this is the case, then appointing a guardian in any capacity—either as a mediator or as a decision maker—will only result in high costs with little benefit, and thus, another alternative solution must be considered.[174]

Perhaps the best alternative is to allow the host personality to have controlling authority over this type of legal decision while subsequently invalidating aspects of the will that may be the product of undue influence. This solution stems from the understanding that the host "carries the individual's given name," as well as the personal history and experiences with which that individual is associated; whereas the alters are unique individuals with their own identities, experiences, and memories.[175] To this end, these alters would only have a limited knowledge of the host's assets and relationships, especially given that amnesia from switching identities is an aspect of DID.[176] Choosing the host as the legally binding personality is ideal because that identity interacts the most with the world, cultivating relationships and accumulating assets, and therefore has the most to distribute.[177]

This remedy is not without drawbacks. Although the host personality is the identity that spends the most time in the world,[178] other identities may have their own assets and holdings. Just as the alters have a limited knowledge of the host's relationships and assets, the host is likely similarly disadvantaged with respect to the alternates' relationships and holdings.[179]

In the interest of providing a sense of autonomy and self-determination to each competent alter,[180] instead of letting one personality

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[173] *See id.* ("[I]t may be well-nigh impossible for such a solution to be reached.").

[174] *Id.* at 309.

[175] *Dissociative Identity Disorder (Multiple Personality Disorder)*, *supra* note 1; Kluft, *supra* note 16, at 55–56.

[176] DSM-5, *supra* note 3, at 291 (notwithstanding that some alters may be aware of the host's memories and experiences, their perception and understanding of them would be as limited and biased as that of an outside third party).

[177] *Dissociative Identity Disorder (Multiple Personality Disorder)*, *supra* note 1.

[178] *Id.*

[179] *See* PUTNAM, *supra* note 23, at 114 (stating that the host typically does not remember events when he or she is forced into dormancy, while an alternate personality is in control of the body). As such, it would be very unlikely that the host is aware of the alternate's personal relationships and assets.

[180] Given the discussion above regarding competency, incompetent personalities such as infantile alters would likely be unable to form personal relationships, acquire assets, or communicate decisions.

decide for the whole, an alternate solution is to allow the personalities to be in control of their own assets separately. This solution takes into consideration that each identity is analogous to a different individual, distinct from that of the host.[181] Moreover, this solution sidesteps the issue of requiring a host or competent alter to have full knowledge of the other identities' relationships and assets.[182] Finally, this may have a limiting effect on undue influence challenges, given that, with the exception of the difficulty in discerning thought insertions and made actions,[183] any overt switch would likely be apparent given differences in demeanor, voice, and handwriting, among other indicators.[184] As a result, such a switch would then invalidate the original testator's will until such time as the host reemerges.

IV. CONCLUSION

Similar to the criminal side of the spectrum, different civil contexts require different standards of legal competence. In California, individuals suffering from DID are particularly vulnerable to statutory and common law restrictions when establishing their competence. In consent to treatment cases, in which time is a critical factor, these individuals may be assigned a guardian due to the need for expediency, even without adequate deliberation over whether they are actually competent. By not establishing a standard specifically for these unique individuals, their autonomous decisions may be easily dismissed in favor of a third party because they must be subjected to a rigorous, general standard. In cases in which a last will and testament is being drafted, people suffering from DID may rightfully be considered competent under the statutory and common law because of a more relaxed standard. However, even in these situations, they can still have their desires overruled due to a presumption of undue influence. Fortunately, there are several alternative methods of mediating such situations because there is little time pressure and little need for immediate decisions. In both contexts, however, there is a significant need to establish a standard of competence for individuals with DID so they will be less vulnerable in making necessary legal decisions.

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[181] Kluft, *supra* note 16, at 55–56.

[182] *See* CAL. PROB. CODE § 6100.5 (2015) (making no mention of the requirements of conservators).

[183] Brand & Loewenstein, *supra* note 20, at 65.

[184] Swartz, *supra* note 17.