Dissociated Decision-Making: Contract Competency Evaluations of Individuals with Dissociative Identity Disorder

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Dissociative Identity Disorder (DID) is a mental disorder in which the impacted individual develops multiple independent personality states. The existence of DID calls into question countless existing legal concepts, but the vast majority of existing legal scholarship addressing DID primarily discusses criminal issues. Just as it is to the general population, the ability to enter into enforceable contracts is important to the DID community. Without a legal framework that adequately addresses the unique needs of those with DID, these individuals risk losing their right to contract entirely.

This Note seeks to further expand the discussion of DID to non-criminal issues by (1) presenting background information on DID as a disorder, (2) examining New York mental health contract law doctrine and its standards governing the competency to enter into a contract, and (3) suggesting that an alternative standard apply to individuals with DID.

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INTRODUCTION

"[P]olicy considerations must be based on a sound understanding of the human mind and, therefore, its illnesses."
Judge Charles David Breital[1]

Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder,[2] is a complex and largely misunderstood condition impacting approximately 1.5% of New York's population.[3] To receive a DID diagnosis, a person must show several pervasive symptoms, including frequent amnesia of personal information and multiple distinct personalities, each of which with independent memories, behaviors, and perceptions.[4] These personality states, which together make up a "system,"[5] control the individual's actions at different times.[6] While knowledge on DID is constantly evolving and the psychiatric

1. Ortelere v. Tchrs.' Ret. Bd., 25 N.Y.2d 196, 203 (1969).

2. This Note will refer to the disorder solely as Dissociative Identity Disorder or DID. *See generally Dissociative Identity Disorder (Multiple Personality Disorder)*, WEBMD (Jan. 22, 2022), https://www.webmd.com/mental-health/dissociative-identity-disorder-multiple-personality-disorder [https://perma.cc/YS8T-PW3A] [hereinafter Bhandari WEBMD] (medically reviewed by Smitha Bhandari, MD).

3. Multiple studies have attempted to assess the prominence of DID in the general population. However, these studies have had limited sample sizes and varied results. According to a study conducted in 2006 in New York, 1.5% of study participants had DID and 8.6% had a dissociative disorder. Johnson et al., *Dissociative Disorders Among Adults in the Community, Impaired Functioning, and Axis I and II Comorbidity*, 40 J. PSYCHIATRIC RSCH., 131, 135 (2006). This prevalence is comparable to that of other mental health disorders in the United States. *Mental Health Disorder Statistics*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics [https://perma.cc/AFM6-94FN] (referencing studies showing, of adults in the United States, approximately 2.6% have bipolar disorder and 1% have schizophrenia). Frequent misdiagnoses and significant stigma around the condition, however, suggest that there are many undiagnosed individuals not accounted for in statistical data. *See* B. L. Brand et al., *Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder*, 24 HARV. REV. PSYCH. 257, 260–61 (2016) (discussing the impact of physicians' disbelief of DID on under-diagnosis).

4. ACCIDENT COMP. CORP., DISSOCIATIVE IDENTITY DISORDER DIAGNOSTIC GUIDE 3–4 (2019) https://www.acc.co.nz/assets/provider/did-diagnostic-guide-acc8024.pdf [https://perma.cc/4RX3-UF5M].

5. "DID system" or "system" are terms commonly used to refer to a person with DID. *See* Gergő Ribáry et al., *Multiplicity: An Explorative Interview Study on Personal Experiences of People with Multiple Selves*, 8 FRONTIERS PSYCH. 1, 3 (2017) (indicating that "system" is used as terminology in the DID community to refer to a "system of persons," or an individual with DID).

6. Each personality state often has no memory of what occurred when not in control. *See generally* Martin J. Dorahy, *Dissociative Identity Disorder and Memory Dysfunction: The Current State of Experimental Research and Its Future Directions*, 21 CLINICAL PSYCH. REV. 771, 773 (2001).

community has garnered a much better understanding of the disorder over the last 40 years,[7] DID is still the subject of much controversy, misinformation, and disbelief.[8] DID stigma, including that in the legal field, impacts individuals in all areas of life.[9]

Interactions with the DID community raise important legal questions. It is not immediately clear how a single person living with many autonomous personality states fits into legal definitions[10] and frameworks,[11] especially when some or all of these personality states may not be aware of the others.[12] While legal scholarship has occasionally grappled with these and other questions related to DID, most of this scholarship is in the context of criminal law, even though most adults with DID do not interact with the criminal justice system. Most if not all adults with DID, however, have civil legal needs; for example, those with DID may have needs concerning parental rights,[13] testament formation, consent to treatment, ability to marry, and contract enforceability, all of which can involve a competency evaluation of mentally ill parties.[14] The little existing DID scholarship related to civil law primarily discusses competency standards and liability in consent to treatment and will creation

7. Brand et al., *supra* note 3, at 258.

8. *See id.*

9. *See generally* Jared Slater, Note, *Can Dr. Jekyll Sign for Mr. Hyde?: Examining the Rights of Individuals Suffering from Dissociative Identity Disorder in Civil Contexts*, 24 S. CAL. REV. L. & SOC. JUST. 239, 241 (2015) (discussing the heightened risk of legal stigma in the DID community).

10. *Id.*

11. *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 15 cmt. b (Am. L. Inst. 1981) (discussing "delusions, hallucinations, delirium, confusion and depression" as symptoms of mental illness in the contract capacity context, but making no note of symptoms particularly relevant to DID, such as: amnesia, memory loss, dissociation, blurred sense of identity, time loss, and varying levels of functioning); *see also infra* Part II.A.

12. Heather Jones, *What Causes Someone to Have Multiple Personalities?*, VERY WELL HEALTH (Feb. 22, 2022), https://www.verywellhealth.com/what-causes-dissociative-identity-disorder-5215201 [https://perma.cc/3G3M-ASJ8] (medically reviewed by Stephanie Hartselle, MD) ("The person [with DID] often is unaware these other identities exist and is unable to remember what took place when another identity was in control.").

13. Elyn R. Saks, *Mental Health Law: Three Scholarly Traditions*, 74 S. CAL. L. REV. 295, 306–10 (2000) (discussing potential parental fitness evaluations of DID parties) [hereinafter *Three Scholarly Traditions*].

14. *See generally* Anna Glezer & Jeffrey J. Devido, *Evaluation of the Capacity to Marry*, 45 J. AM. ACAD. PSYCH. & L. 292 (2017) (comparing the capacity to marry to other areas of mental capacity evaluations under the context of Mississippi law).

contexts.[15] To date, scholars have paid strikingly little attention to DID competency evaluations under contract law. By having a protected freedom of contract, people with DID can increase their independence and limit exploitation.[16] The ability to contract is critical, for example, in acquiring employment and housing.[17] This Note aims to expand the scholarship to include analysis of contract law generally.

Part I of this Note provides a detailed look at DID as a disorder. Part II provides a brief overview of DID legal scholarship, notes relevant contract law policy considerations, and outlines contract competency evaluation doctrine in New York. Part III addresses the issues in competency evaluations under New York common law, including cognitive tests, but-for analysis, and the application of the affective test from the Second Restatement of Contracts § 15. Part IV provides a proposal wherein courts base their competency evaluations on a person's self-awareness of their DID.

I. PSYCHIATRIC AND HISTORICAL BACKGROUND

To better understand how the manifestation of DID impacts the formation and performance of contract promises, one must first understand the complexity and expression of the disorder generally. The diagnostic criteria, common symptoms, recommended treatment, and the variety and validity of the different personality states are all important to create a full understanding of the disorder. Although there are historical accounts of DID from as early as 1584,[18] the medical understanding of DID has developed exponentially since 1975

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15. *See* Slater, *supra* note 9 (discussing DID in the context of competency evaluations under consent to treatment and will creation standards in California); *Three Scholarly Traditions*, *supra* note 13, at 306–10 (discussing civil competency evaluations applied to DID, specifically in consent to treatment and will creation contexts).

16. Those with DID report high rates of abuse and exploitation. *See Dissociative Identity Disorder (DID)*, SHEPPARD PRATT, https://www.sheppardpratt.org/knowledge-center/condition/dissociative-identity-disorder-did/ [https://perma.cc/B74Y-BAMA].

17. *See generally* Robert Dugan, *Civil Rights and Freedom of Contract: Employment, Housing and Credit Transactions (Part I—Employment)*, 26 S.D. L. REV. 259 (1981) (considering the intersection of civil rights and contract laws in the employment context); Robert Dugan, *Civil Rights and Freedom of Contract: Employment, Housing and Credit Transactions (Part II—Housing)*, 27 S.D. L. REV. 181 (1982) (considering the intersection of civil rights and contract laws in the housing context).

18. Nonno van der Hart et al., *Jeanne Fery: A Sixteenth-Century Case of Dissociative Identity Disorder*, 24 J. PSYCHOHISTORY 1, 1 (Summer 1996).

alongside enhanced knowledge of psychiatry, neuroscience, biology, and psychology.[19]

A. BACKGROUND ON DID

1. *Causes and Diagnostic Criteria*

DID develops during childhood as a defense mechanism to severe, prolonged abuse and trauma and persists throughout the individual's life.[20] "Dissociation," a critical component of DID, is "a defense mechanism in which conflicted impulses are kept apart or threatening ideas and feelings are separated from the rest of the psyche."[21] In other words, dissociation is a short or long-term separation from one's own surroundings, thoughts, feelings, memory, or sense of self.[22] Dissociation episodes can range from mild to severe and can present differently in different people.[23] Many people without dissociative disorders have likely experienced mild forms of dissociation; for example, suddenly becoming aware while driving and having no memory of the last few miles of the trip,[24] becoming completely absorbed in a piece of media, or daydreaming.[25] Those with DID and other dissociative disorders experience dissociation on the more severe end of the spectrum: a person may dissociate from entire traumatic life experiences, have regular gaps in memory regarding daily events and personal information, or experience events like a third party onlooker.[26]

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19. Brand et al., *supra* note 3, at 259.
20. *Dissociative Identity Disorder*, AM. ASS'N. FOR MARRIAGE AND FAM. THERAPY, https://www.aamft.org/Consumer_Updates/Dissociative_Identity_Disorder.aspx [https://perma.cc/QN44-PSZT].
21. *Dissociation*, AM. PSYCH. ASS'N., https://dictionary.apa.org/dissociation [https://perma.cc/8DVP-JT6V].
22. Keri Wiginton, *What is Dissociation?*, WEBMD (June 28, 2021), https://www.webmd.com/mental-health/dissociation-overview [https://perma.cc/5VLT-4ALD] (medically reviewed by Jennifer Casarella, MD).
23. *Dissociation and Dissociative Disorders*, MIND (Mar. 2019), https://www.mind.org.uk/information-support/types-of-mental-health-problems/dissociation-and-dissociative-disorders/about-dissociation/ [https://perma.cc/HW6S-L37L].
24. *Dissociation and Dissociative Disorders*, MENTAL HEALTH AM., https://mhanational.org/conditions/dissociation-and-dissociative-disorders [https://perma.cc/N2X8-TMUZ].
25. *What Are Dissociative Disorders?*, AM. PSYCHIATRIC ASS'N, (Aug. 2018), https://psychiatry.org/patients-families/dissociative-disorders/what-are-dissociative-disorders [https://perma.cc/9C94-6NP4] (reviewed by Philip Wang, MD).
26. *Id.*

Children who have a higher proclivity to dissociate may begin to use dissociation as a defensive coping mechanism when experiencing persistent trauma with no opportunity to escape or prevent the abuse; these children disconnect from the situation and mentally replace their own presence with that of a separate "person" or identity.[27] DID is then best understood as a neurological response to severe, sustained abuse and trauma occurring in early childhood, with dissociative symptoms and alternate personality states manifesting before age ten.[28] Because this extreme dissociation occurs early in life while the child's neurological sense of self-identity is in development,[29] the dissociated states eventually form into fully independent personality states.[30] While a non-traumatized child grows up and develops a concrete sense of identity, a child with DID develops multiple concrete senses of identity through regular dissociation,[31] with the personality states developing and complexifying independently of one another.[32] The development of these personality states occurs as an immediate or postponed attempt for the body to process the trauma it experienced.[33] These personality states, or "alters,"[34] can take control of the body and its interaction with the outside world at different times.[35]

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27. Erdinc Ozturk & Vedat Sar, *Formation and Functions of Alter Personalities in Dissociative Identity Disorder; A Theoretical and Clinical Elaboration*, 6 J. PSYCH. & CLIN. PSYCH. 1, 2 (2016); *About Dissociative Identity Disorder*, MCLEAN HOSP. (Jan. 13, 2021), https://www.mcleanhospital.org/essential/everything-you-need-know-about-dissociative-identity-disorder [https://perma.cc/T43W-44XU] [hereinafter MCLEAN].

28. Paulette Marie Gillig, *Dissociative Identity Disorder: A Controversial Diagnosis*, 2009 PSYCH. (EDGMONT) 24, 27 (Mar. 2009).

29. *Dissociative Identity Disorder*, *supra* note 20; *see generally* NAT'L. ACAD. SCI., ENG'G., AND MED. ET AL., THE PROMISE OF ADOLESCENCE: REALIZING OPPORTUNITY FOR ALL YOUTH, 59–60 (Emily P. Backes et al. eds., 2019) (discussing the cognitive development of identity through adolescence).

30. *See* Ozturk & Sar, *supra* note 27 at 2.

31. *See* JANE WEGSCHEIDER HYMAN, I AM MORE THAN ONE 30 (2007) ("Along with changes in the brain, a profound difference in the structure of the mind can result from abuse or neglect. The separate states of mind of infancy, called behavioral states, which would normally integrate over time into a cohesive personality, may not unify.").

32. *Id.* at 31 (discussing theories on the individualization processes of alters, including the theory that the accumulation of unique memories and experiences of one dissociated state eventually leads to the development of a personality unique from other ununified personality states).

33. In cases where the individual has delayed processing of the events, the personality states often develop in the individual's twenties. Ozturk & Sar, *supra* note 27.

34. There are many terms for the separate personality states in the DID context, including "alters," "alternate personalities," "parts," "head mates," "fragments," etc. "Alter" is a very common term among the DID community. This Note will primarily use the term "alter" when discussing these dissociated personality states within someone with

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), which serves as the primary manual for mental health diagnoses, lists several criteria for the diagnosis of DID.[36] First, the patient's symptoms must not be caused by outside substances, such as alcohol-induced memory loss,[37] or exist as part of a religious or cultural practice.[38] Second, a patient must have "disruption of identity characterized by two or more distinct personality states."[39] The alters must operate independently from one another, meaning they have different thoughts, opinions, memories, and behaviors.[40] The number of alters can vary greatly, from two to a hundred or more in a single system.[41] Before being diagnosed with DID, many individuals are unaware that various personality states are the cause of their symptoms.[42] Third, a patient must have "recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting."[43] Finally, a patient must have "significant distress or impairment in social, occupational, or other important areas of functioning."[44]

DID. *Alters*, DISSOCIATIVE IDENTITY DISORDER RSCH., https://did-research.org/did/alters/ [https://perma.cc/X3VU-5T8S].

35. *The Misconceptions of Dissociative Identity Disorder*, RACE TO A CURE (July 9, 2021), https://www.racetoacure.org/post/the-misconceptions-of-dissociative-identity-disorder [https://perma.cc/LES4-XW4T].

36. ACCIDENT COMP. CORP., *supra* note 4, at 8.

37. Bhandari WebMD, *supra* note 2.

38. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FIFTH EDITION 292, 292–98 (AM. PSYCH. ASS'N 2013) [hereinafter DSM-5].

39. *Id.*

40. Paroma Mitra & Ankit Jain, *Dissociative Identity Disorder*, STATPEARLS PUBL'G (May 17, 2022), https://www.ncbi.nlm.nih.gov/books/NBK568768/ [https://perma.cc/7EZS-SXX6].

41. *Dissociative Identity Disorder (Multiple Personality Disorder)*, CLEVELAND CLINIC (May 25, 2021), https://my.clevelandclinic.org/health/diseases/9792-dissociative-identity-disorder-multiple-personality-disorder [https://perma.cc/A4S7-ZE99].

42. *DID Fact Sheet*, NAT'L ALL. ON MENTAL ILLNESS MICH., https://namimi.org/mental-illness/dissociative-disorder/didfactsheet [https://perma.cc/4V95-58XG].

43. ACCIDENT COMP. CORP., *supra* note 4, at 8.

44. *Id.*

2. *The Manifestation of DID Symptoms*

In a single system, alters typically vary in age, gender, and more.[45] Numerous studies, described below, highlight the substantial physical and psychological differences between a person's alters, even though all exist within the same physical body. The substantial differences between alters in a system call into question issues of identity, consent, responsibility, and accountability.

A 2006 study showed that different alters within a DID system operated in a neurologically distinct way.[46] Comparing different alters, the study found that each had "different regional cerebral blood flow patterns" as well as different vital organ responses, such as significantly different heart rates, blood pressures, and emotional responses when shown the same trauma-related stimuli.[47] In reacting to these reminders of past trauma, "neural networks subserving the two different [alters] are to a great extent separate."[48] Using this data, the study found that different personality states within an individual with DID hold different memories and thus have different responses to triggers and can have different abilities to function in daily life.[49]

Psychological tests, specifically Rorschach test stimuli[50] and Inventory of Interpersonal Problems pathology assessments,[51] similarly found significant differences between alters.[52] In the

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45. Samara Macrae, *Dissociative Identity Disorder: Exploring the Reality Behind Having Multiple Personalities*, YOUTH MED. J. (Jan. 18, 2022), https://youthmedicaljournal.org/2022/01/18/dissociative-identity-disorder-exploring-the-reality-behind-having-multiple-personalities/ [https://perma.cc/477R-3KMK].

46. A.A.T. Simone Reinders et al., *Psychobiological Characteristics of Dissociative Identity Disorder: A Symptom Provocation Study*, 60 BIOL. PSYCH. 730, 734, 739 (2006).

47. *Id.*

48. *Id.* at 738.

49. *Id.* at 739.

50. The Rorschach test, also known as the Rorschach inkblot test, is a popular psychological tool used to interpret the subject's subconscious thoughts, personality, cognitive processes, and emotional functioning. Kendra Cherry, *The Rorschach Inkblot Test*, VERY WELL MIND (May 2, 2021), https://www.verywellmind.com/what-is-the-rorschach-inkblot-test-2795806 [https://perma.cc/X9JS-P63W].

51. The Inventory of Interpersonal Problems assessment, or IIP-64, is a well-known self-report test which measures the subject's ability to interact with other people, particularly focusing on issues in interactions with others. Daniel Leising et al., *Assessing Interpersonal Functioning: Views from Within and Without*, 45 J. RSCH. PERSONALITY 631, 633 (2011).

52. Ellen Hartmann & Kirsten Benum, *Rorschach Assessment of Two Distinctive Personality States of a Person with Dissociative Identity Disorder*, 101 J. PERSONALITY ASSESSMENT 213, 214–15, 221–22 (2017).

application of their test results, researchers found entirely different interpersonal profiles, perceptive and cognitive abilities, and senses of self.[53] In other studies and observational settings, alters have shown different handedness in writing,[54] different language capabilities and behaviors,[55] and different physical ailments such as allergies.[56] These major differences in turn lead to different opinions, perceptions of the world, and behavior.[57]

Especially in persons who do not realize that they have DID, one alter may not know what another alter does while in control of the body.[58] Many dissociative symptoms can interrupt the normal functioning of someone with DID and increase confusion and autobiographical gaps; for example, dissociative fugue is the process of wandering or traveling in a dissociative state, dissociative amnesia is an inability to recall information or events, and depersonalization and derealization describe the conditions of feeling like one's surroundings or self are not real.[59] In a study comparing those with DID to the general population, 47.6% of respondents with diagnosed DID responded that they had found evidence of doing some action without any memory of it, as compared to 13.5% of the general population.[60] Similarly, over half of respondents with DID have been unsure if at least some of their memories stemmed from reality or dreams, compared to 12.6% of the general population.[61] These symptoms can create significant barriers and struggles to daily living.[62]

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53. *Id.* at 219–20, 223.

54. Johnson Savits, MSc et al., *Dissociative Identity Disorder Associated with Mania and Change in Handedness*, 17 COGNITIVE & BEHAV. NEUROLOGY 233, 233–34 (2005).

55. *Fact Sheet III – Trauma Related Dissociation: An Introduction*, INT'L SOC'Y FOR THE STUDY OF TRAUMA AND DISSOCIATION (2020), https://www.isst-d.org/public-resources-home/fact-sheet-iii-trauma-related-dissociation-an-introduction/ [https://perma.cc/72C2-MCNV].

56. Daniel Goleman, *New Focus on Multiple Personality*, N. Y. TIMES (May 21, 1985), https://www.nytimes.com/1985/05/21/science/new-focus-on-multiple-personality.html [https://perma.cc/E92U-GKY5].

57. Mitra & Jain, *supra* note 40.

58. Jones, *supra* note 12.

59. *Id.*; *Mental Health and Dissociative Fugue*, WEBMD (Sept. 27, 2020), https://www.webmd.com/mental-health/dissociative-fugue [https://perma.cc/HUR2-BA9Y] (medically reviewed by Jennifer Casarella, MD).

60. Colin A. Ross et al., *A Factor Analysis of the Dissociative Experiences Scale (DES) In Dissociative Identity Disorder*, 8 DISSOCIATION 229, 232 (1995).

61. *Id.* at 231.

62. *The Facts About Dissociative Identity Disorder*, NEWPORT ACAD., https://www.newportacademy.com/resources/mental-health/dissociative-identity-disorder-treatment/ [https://perma.cc/T6XL-WHPJ].

3. *Treatment and Symptom Management*

Therapeutic treatment can help those with DID manage symptoms and facilitate daily functioning. Educating DID patients about the disorder is often an early treatment objective, alongside addressing any safety concerns.[63] Once these objectives are met, the International Society for the Study of Trauma and Dissociation (ISST) advises clinicians to work with the entire system of alters.[64] During this process, the ability for alters to communicate internally and become co-conscious[65] should improve.[66] Regardless of the ultimate goal of treatment,[67] the ISST has emphasized that "[h]elping the identities to be aware of one another as legitimate parts of the self and to negotiate and resolve their conflicts is at the very core of the therapeutic process."[68]

Even in instances where professional treatment is inaccessible,[69] people with DID implement various coping skills and strategies to manage the disorder and achieve high levels of daily functioning.[70] As is the case in professional treatment, education about the disorder can improve functioning.[71] To

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63. J. A. Chu et al., *Guidelines for Treating Dissociative Identity Disorders in Adults, Third Rev.*, J. TRAUMA & DISSOCIATION 115, 136–39 (2011).

64. *Id.* at 139.

65. Co-consciousness is the process of one or multiple alters being aware of the body's actions and surroundings while another alter is in control. As described by people with DID, when alters are co-conscious they feel as if they are watching the body, controlled by another alter, through a screen or a pair of eyes. They can often communicate and share information with the fronting alter while they observe their actions. HYMAN, *supra* note 31, at 251 (defining co-consciousness).

66. Chu et al., *supra* note 63, at 139.

67. Treatment goals can vary significantly between systems. HYMAN, *supra* note 31, at 224–49 (discussing different therapy goals and personal reasoning behind them). Some clinicians believe that "unification," also known as "final fusion," which is the merger of all alters into a single personality, is best for DID clients. Chu et al., *supra* note 63, at 133 (discussing different treatment goals among the clinical community). However, ISST found that a "considerable number" of those with DID will be unable or unwilling to reach a point of unification. *Id.* at 133.

68. Chu et al., *supra* note 63, at 132.

69. *See supra* Parts I.A.3, I.B.1.

70. *See generally* HYMAN, *supra* note 31 (discussing interviews with multiple women with DID who lead productive and successful lives).

71. *See, e.g.*, Theresa M. Urbina et al., *Navigating Undiagnosed Dissociative Identity Disorder in the Inpatient Setting: A Case Report*, 23 J. AM. PSYCHIATRIC NURSES ASS'N 223, 228 (2017) (discussing a patient whose symptom management improved after being taught more about the DID as a disorder); *see also* Jane Hart, *Conquering Each Day with Dissociative Identity Disorder*, NAT'L ALL. ON MENTAL ILLNESS: NAMI BLOG (Jan. 22, 2019), https://www.nami.org/Blogs/NAMI-Blog/January-2019/Conquering-Each-Day-with-

effectively communicate and thereby help with symptom management,[72] alters can engage in productive dialogue with each other through internal conversations,[73] communication during co-consciousness,[74] or external communication via notes or drawings.[75] People with DID can also use external tools, such as timers, to minimize confusion and lost time and improve their daily structure.[76] Even without professional treatment, self-awareness of one's disorder and symptoms can drastically improve the ability to manage symptoms and function daily.

B. BARRIERS TO DID DIAGNOSIS

Despite the increasing acceptance of DID in the medical field, DID diagnosis and treatment options are still not easily attainable. Lack of DID-informed care and healthcare accessibility are significant barriers to treatment. In addition, medical and social stigma affect clinicians' treatment of the disorder[77] and perpetuate existing treatment avoidance among

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Dissociative-Identity-Disorder [https://perma.cc/3VA6-M6LR] (an individual with DID discussing the benefits of self-education).

72. Urbina et al., *supra* note 71, at 225 (identifying "communication and coordination between the identities" as a treatment goal); *see also* HYMAN, *supra* note 31, at 81–82 ("For a person [with DID], smooth functioning in the world entails the ability to be switched in public unnoticeably and only when necessary for the host's functioning, to make decisions acceptable to most or all parts, and to pace the retrieval of traumatic memories. Inner organization can address one or more of these requirements.").

73. This Note does not delve into the "inner worlds" of those with DID. However, when not in control of the body, the alters in many DID systems are able to communicate with each other within the mind of the individual with DID. *See* George B. Greaves, *Precursors of Integration in the Treatment of Multiple Personality Disorder: Clinical Reflections*, 2 DISSOCIATION 224, 227 (1989) (distinguishing between co-consciousness and internal communication); "Alex" Caroline Robboy, *Dissociative Identity Disorder: Mapping Your System*, CTR. FOR GROWTH, https://www.thecenterforgrowth.com/tips/dissociative-identity-disorder-mapping-your-system [https://perma.cc/RB55-4LKP] (discussing ways to improve communication between alters).

74. M. Rose Barlow & James A. Chu, *Measuring Fragmentation in Dissociative Identity Disorder: The Integration Measure and Relationship to Switching and Time in Therapy*, 5 EUR. J. PSYCHOTRAUMATOLOGY 22250, 22253 (2014) (discussing methods of communication and awareness between alters).

75. *Id.* at 22255 (noting that some individuals in the study reported communicating with other alters through writing or drawing).

76. *See* Hart, *supra* note 71 (an individual with DID discussing how timers aid in daily functioning).

77. Leah A. Perniciaro, The Influence of Skepticism and Clinical Experience on the Detection of Dissociative Identity Disorder by Mental Health Clinicians 5 (2014) (Ph.D. dissertation, Massachusetts School of Professional Psychology) (ProQuest) (discussing studies of patients with dissociative disorders, stating that "[s]ome patients reported that

the DID community,[78] leading to exacerbated DID symptoms.[79] As a result of these barriers to diagnosis, many people with DID do not know they have the condition.[80]

1. *Barriers in the Psychiatric Field*

Although the diagnostic criteria seem straightforward, receiving an official DID diagnosis is often a difficult and prolonged process.[81] According to psychiatrist Dr. Richard J. Loewenstein, "[a]cross studies, DID patients spend an average of 5–12.4 years in the mental health system before correct diagnosis, receiving an average of 3–4 incorrect diagnoses."[82] Some of the barriers to obtaining a DID diagnosis and treatment include inadequate DID treatment options,[83] controversy and debate within psychological fields,[84] general lack of knowledge about the disorder,[85] stigma in personal, popular media, and treatment settings,[86] and a conscious and subconscious tendency[87] of traumatized individuals to avoid re-traumatization. In addition, general inaccessibility of mental healthcare in the

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they experienced hostility and suspicion from clinicians and were often given treatment inappropriate to their condition.").

78. *See id.* at 7; *see also* ACCIDENT COMP. CORP., *supra* note 4 (discussing barriers to DID diagnosis).

79. *See, e.g.*, Hart, *supra* note 71 (an individual with DID stating "I have found that if there is anything that will send me into a downward spiral—it's shame.").

80. MCLEAN, *supra* note 27, at 10 ("DID is also repeatedly found in people who are unaware of the disorder and in cultures where the condition is unknown.").

81. Richard J. Loewenstein, *Dissociation Debates: Everything You Know Is Wrong*, 20 DIALOGUES CLINICAL NEUROSCIENCE 229, 238 (2018).

82. *Id.*

83. Brand et al., *supra* note 3 ("Clinicians who accept these myths [such as that DID is a fad or rare] as facts are unlikely to carefully assess for dissociation. Accurate diagnoses are critical for appropriate treatment planning."); *see, e.g.*, MCLEAN, *supra* note 27.

84. Brand et al., *supra* note 3, at 258.

85. MCLEAN, *supra* note 27 ("It's hard for many therapists who are untrained in dissociative disorders to recognize [DID]. But with effective treatment from mental health providers who are trained in trauma and dissociation or able to receive consultation with someone trained, people with DID can and do recover.").

86. *E.g.*, Patrick W. Corrigan et al., *The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care*, 15 PSYCH. SCI. PUB. INT. 37, 37 (2014); HYMAN, *supra* note 31, at 80 ("The fear of being 'crazy' or being perceived as 'crazy' is a powerful incentive to keeping oneself and others in ignorance of having a mind in parts.").

87. Hannah May et al., *Having Permission Not to Remember: Perspectives on Interventions for Post-Traumatic Stress Disorder in the Absence of Trauma Memory*, 13 EUR. J. PSYCHOTRAUMATOLOGY 1, 10–11 (2022) ("[P]eople with [PTSD without memories] might avoid treatment due to beliefs it could trigger recall.").

United States,[88] particularly to diverse populations,[89] makes DID diagnosis and treatment even less likely.

The prevalence of misdiagnoses can be partially attributed to stigma and misinformation within the medical field[90] and conflation between DID symptoms and symptoms of other mental disorders.[91] In a 2014 study considering the influence of clinician skepticism in accurate DID diagnosis, nearly 40% of U.S. clinicians failed to diagnose DID.[92] Clinicians often instead misdiagnose DID as anxiety, depression,[93] schizophrenia, and borderline personality disorder.[94] The risk of a missed DID diagnosis becomes even greater when considering comorbidity: PTSD, C-PTSD, depressive disorders, and/or anxiety disorders are frequently comorbid with DID.[95] Those with DID receiving the wrong treatment often suffer from severe symptoms requiring high levels of medical intervention; when receiving proper treatment, however, those with DID have a reduced need of restrictive treatment.[96] As DID has become better understood, the psychiatric field has become more aware of how DID differs from these commonly confused disorders.[97]

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88. *See generally* Megan Leonhardt, *What You Need to Know About the Cost and Accessibility of Mental Health Care in America*, CNBC: MAKE IT (May 10, 2021), https://www.cnbc.com/2021/05/10/cost-and-accessibility-of-mental-health-care-in-america.html [https://perma.cc/6FW4-PH84]; MCLEAN, *supra* note 27.

89. Though mental health accessibility in the United States is poor, this impacts different segments of the population differently. As discussed by professors and healthcare researchers Thomas G. McGuire and Jeanne Miranda, "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated." Thomas G. McGuire & Jeanne Miranda, *New Evidence Regarding Racial and Ethnic Disparities in Mental Health: Policy Implications*, 27 HEALTH AFF. 393, 396 (2008). For information on the mental healthcare disparity among multiple diverse populations, see *Mental Health Disparities: Diverse Populations*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts [https://perma.cc/2C7K-F4PT].

90. *See* Brand et al., *supra* note 3, at 261 (explaining the impact of DID stigma in the medical field).

91. *See* DSM-5, *supra* note 38, at 296–97 (discussing other disorders commonly confused with DID).

92. Perniciaro, *supra* note 77, at 78; *see also* Brand et al., *supra* note 3, at 261 (discussing the study).

93. Perniciaro, *supra* note 77, at 61.

94. David Spiegal, *Expert Q&A: Dissociative Disorders*, AM. PSYCHIATRIC ASS'N (Oct. 2020), https://psychiatry.org/Patients-Families/Dissociative-Disorders/Expert-Q-and-A?id=5296 [https://perma.cc/L5JG-53JS].

95. *See* DSM-5, *supra* note 38, at 297–98.

96. Brand et al., *supra* note 3, at 265.

97. *See* Brand et al., *supra* note 3, at 258–59 (discussing how increased trauma and dissociative research led to DSM-5 distinguishing DID from other disorders).

2. *DID Stigma in American Culture*

Popular media, famously in the 1886 novel *The Strange Case of Dr. Jekyll and Mr. Hyde* and continuing to modern day, has often depicted those with DID as dangerous, violent, criminal, incompetent, or untrustworthy.[98] In all of the most popular films depicting DID over the last 25 years, the characters with DID behave in a violent or criminal way numerous times.[99] Their acts include murder, kidnapping, terrorism, robbery, and more.[100] Recent studies show, however, that the violent, unprincipled stereotype of those with DID is a myth.[101] As explained by neuroscientist Dr. Simone Reinders, such movies

> make it seem as if patients with DID are extremely violent and prone to doing bad things. This is actually not true and it very badly misrepresents the psychiatric disorder. Individuals with DID definitely do not have a tendency to be violent; more a tendency to hide their mental health problems.[102]

Because the general public has low awareness of DID,[103] misrepresentations of the disorder in popular media contribute to the widespread misconceptions of the disorder.[104]

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98. Steve Rose, *From Split to Psycho: Why Cinema Fails Dissociative Identity Disorder*, GUARDIAN (Jan. 12, 2017), https://www.theguardian.com/film/2017/jan/12/cinema-dissociative-personality-disorder-split-james-mcavoy [https://perma.cc/H9V6-G33Y].

99. Valerie Sampson, *The Portrayal of Dissociative Identity Disorder in Films*, 11 ELON J. UNDERGRADUATE RSCH. COMMC'N 79, 82–83 (2020) (analyzing the eight most popular films since the 1990s depicting DID based on listings on IMDb, an online movie database).

100. *Id.* at 84.

101. Although there are insufficient studies on the relationship between dissociative disorders and violence, recent studies seem to strongly contrast older studies that found significant links between criminal behavior and dissociative disorders. Aliya R. Webermann & Bethany L. Brand, *Mental Illness and Violent Behavior: The Role of Dissociation*, 4 BORDERLINE PERSONALITY DISORDER & EMOTION DYSREGULATION, no. 2, 2017, at 1, 10–11.

102. Rose, *supra* note 98.

103. *See* Peng Liu, *Dissociative Identity Disorder: Understanding of DID, Symptoms and Causes*, 11 INT'L J. PHARMA MED. & BIOL. SCI. 26, 26 (2022); *see also* Leah N. Millard, Dissociative Identity Disorder: Etiology, Media, and Stigma 2 (May 6, 2020) (unpublished student research paper) (on file with The Cupola: Scholarship at Gettysburg College) ("Even with the stigmatizing media portrayals, there is a true diagnosis that does not align with the public's interpretation and follows the posttraumatic etiological model.").

The prevailing conception of an individual with DID as dangerous and unstable has real consequences. These portrayals of DID characters create negative myths about DID. Commonly held beliefs include that those with DID are "crazy" and violent, that DID is a fake or extremely rare disorder, and that those with DID can control which alter is in control.[105] These myths contribute to the public's already troubled view of mental illness generally. Adults with mental health disorders are more likely to be perceived as dangerous, violent, and incompetent by members of the public.[106] For example, adults have expressed a desire to social distance from individuals with mental health disorders, including being unwilling to work with, live near, or include individuals with mental illness in various social situations.[107] This is a stigma that, beyond just its grave social and personal impacts,[108] intensifies healthcare treatment barriers.[109] With

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104. *Movie 'Split' Does Harm to People with Dissociative Identity Disorder, Experts Say*, HEALTHLINE (Feb. 14, 2017), https://www.healthline.com/health-news/movie-split-harms-people-with-dissociative-identity-disorder [https://perma.cc/5QPJ-HUCF].

105. Ariana DiValentino, *7 Myths About 'Multiple Personalities' You Need to Stop Believing*, INSIDER (Dec. 30, 2019), https://www.insider.com/myths-about-multiple-personalities-you-need-to-stop-believing-2019-12 [https://perma.cc/3VD7-S8NZ].

106. *See* Angela M. Parcesepe & Leopoldo J. Cabassa, *Public Stigma of Mental Illness in the United States: A Systematic Literature Review*, 40 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 384, 388–89 (2013).

107. *Id.* at 389–90.

108. Stigma can have negative impacts on individuals across mental health disorders. *See* Rebecca E. Young et al., *The Subtle Side of Stigma: Understanding and Reducing Mental Illness Stigma from a Contemporary Prejudice Perspective*, 75 J. SOC. ISSUES 943, 944 (2019) ("Public stigma can lead to self-stigma, which refers to a process by which individuals with mental illness internalize the negative stereotypes held by society and apply them to themselves. Self-stigma has been shown to lead to reduced self-efficacy and self-esteem, social withdrawal, treatment disengagement, and even suicide.") (internal citations omitted); *see also* Jessica Floris & Susan McPherson, *Fighting the Whole System: Dissociative Identity Disorder, Labeling Theory, and Iatrogenic Doubting*, 16 J. TRAUMA & DISSOCIATION 476, 480 (2015) (discussing the impacts of DID diagnoses on individuals, which included "self-stigma" where the individuals internalized external stigma).

109. Stigma and disbelief about DID prevents and disincentivizes people with DID from seeking diagnosis and treatment. *See* Kim Mills & Patrick Corrigan, *Speaking of Psychology: Fighting the Stigma of Mental Illness, with Patrick Corrigan, PsyD*, AM. PSYCHIATRIC ASS'N: SPEAKING OF PSYCHOLOGY, at 03:54 (Feb. 2022) https://www.apa.org/news/podcasts/speaking-of-psychology/mental-illness-stigma.html [https://perma.cc/3MT3-963X]; *see e.g.*, Millard, *supra* note 103, at 8 (discussing a woman with DID who "[b]ecause of the public sigma" was unable to find treatment and develop relationships with providers). In a transnational study of those with dissociative disorders conducted by the Towson University's Department of Psychology, 32.25% of participants identified stigma as a barrier to receiving mental health treatment. M. Shae Nester et al., *Barriers to Accessing and Continuing Mental Health Treatment Among Individuals with Dissociative Symptoms*, 13 EUR. J. PSYCHOTRAUMATOLOGY 1, 5 (2022). Even if someone with DID does pursue treatment, stigmatized beliefs held by clinicians could still prevent accurate

increased research and calls for legal protection, myths and misbeliefs about DID will hopefully fade, allowing a true depiction of the disorder to integrate into academia and society.

II. LEGAL BACKGROUND

A. CRIMINAL AND CIVIL LEGAL SCHOLARSHIP

New York courts have recognized that "the greatest movement in revamping legal notions of mental responsibility has occurred in the criminal law."[110] Much of the current criminal legal scholarship on DID, however, is outdated, misinformed, or disparaging. The limited concentration of DID legal analysis in the criminal context and its dated nature are damaging to an already stigmatized disorder. By concentrating on a civil law understanding, the legal field can deprioritize the common criminal framing of those with DID.

Discussions of DID in criminal law center mostly around whether a person can be held criminally responsible for the actions of one alter.[111] Within this debate, scholars have considered several relevant legal questions. First, scholars debate the conception of legal personhood as applied to those with DID.[112] Second, scholars and courts have differed in their mens rea analysis in the DID context, with some assessing individual alters and others assessing the person with DID as a single legal entity.[113] Third, scholars debate who should be held responsible for the criminal acts of an alter and the proper role of punishment. While some scholars argue that those with DID

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diagnosis and adequate treatment. *See* Millard, *supra* note 103, at 7 (discussing stigma as a barrier to adequate medical care for those with mental illness and DID specifically); *see also* Nester et al., *supra*, at 8 (discussing clinicians with stigmatized beliefs about dissociation). In the Towson study, 18.12% of participants stopped receiving treatment due to stigma. Nester et al., *supra*, at 5.

110. Ortelere v. Tchrs.' Ret. Bd., 25 N.Y.2d 196, 203 (1969).

111. *See, e.g.*, ELYN R. SAKS & STEPHEN H. BEHNKE, JEKYLL ON TRIAL: MULTIPLE PERSONALITY DISORDER AND CRIMINAL LAW (1997) (theorizing on the proper framework of criminal responsibility as applied to the DID context in 1997); Glenn Saxe, *Dissociation and Criminal Responsibility: A Developmental Perspective*, 10 S. CAL. INTERDISC. L. J. 243 (2001) (countering arguments regarding criminal responsibility of those with DID).

112. *See* Elyn R. Saks, *Multiple Personality Disorder and Criminal Responsibility*, 25 U.C. DAVIS L. REV. 383, 408–9 (1992) [hereinafter *Multiple Personality Disorder*]; Jens David Ohlin, *Is the Concept of the Person Necessary for Human Rights?*, 105 COLUM. L. REV. 209, 222–25 (2005) (discussing legal personhood as it relates to DID).

113. *See* Sabra McDonald Owens, *The Multiple Personality Disorder (MPD) Defense*, 8 MD. J. CONTEMP. LEGAL ISSUES 237, 244–47 (1997).

should be held responsible for the actions of any alter,[114] others contend that punishment of any innocent alter is unjust.[115] In consideration of the relevant legal issues, legal scholars have come to divergent conclusions on how the criminal law should treat those with DID.[116]

Although some of the logic used in the discussion of DID in the criminal context is relevant to civil law, legal scholars need to take a unique approach to DID in the civil context. In particular, civil law often requires a deeper look into the knowledge, intentions, duties, and expectations of both parties to determine liability in a case than that which is required in the criminal mens rea analysis.[117] A few scholars have addressed distinct civil legal issues regarding DID but often with insufficient detail.[118] In *Mental Health Law: Three Scholarly Traditions*, law professor Elyn R. Saks discusses criminal and civil responsibility of DID parties. Professor Saks emphasizes the differences between criminal and civil law, concluding that different areas of civil law

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114. *See, e.g.*, Saxe, *supra* note 111, at 249–50 (arguing that the law should treat criminal defendants with DID and with other mental disorders the same).

115. *See, e.g.*, *Three Scholarly Traditions*, *supra* note 13, at 306 (arguing that DID systems with at least one innocent alter should be found nonresponsible).

116. Such theories vary greatly. One example, the Discrete Behavioral State model, equates alters in a DID system to someone without DID who has demonstrated a developmental failure to properly regulate emotions. Saxe, *supra* note 111, at 249–50. This model proposes that alters are the equivalent to the different emotional states of one person. Because criminal liability hinges on state of mind at the time of the crime, the Discrete Behavioral State model proposes no distinction in treatment of defendants with DID. *Id.* at 250. On the other end of the spectrum, Elyn R. Saks has proposed that all alters in a system are essentially different people; therefore, unless all alters were complicit in the crime, the defendant with DID should not be held criminally responsible. SAKS & BEHNKE, *supra* note 111, at 106. Somewhere in between are theories like that of Collective Responsibility, proposing that even if the personalities are separate, the group should be held responsible for the criminal actions of the one. Andrew E. Lelling, *Eliminative Materialism, Neuroscience and the Criminal Law*, 141 U. PA. L. REV. 1471, 1557–60 (1993).

117. *See e.g.*, David G. Owen, *Expectations in Tort*, 43 ARIZ. ST. L. J. 1287 (2011) (explaining the role of reasonable expectations in tort law); *see also generally* Jay M. Feinman, *Good Faith and Reasonable Expectations*, 67 ARK. L. REV. 525, 533–37 (2014) (considering courts' treatment of reasonable expectations and good faith in contract law); RESTATEMENT (SECOND) OF CONTRACTS §§ 21, 90, 161 (AM. L. INST. 1981) (discussing disclosure duties, the reasonable expectations of promises, and the intent to enter into an enforceable contract, respectively); Zheng v. City of New York, 19 N.Y.3d 556, 564–65 (2012) (assessing mutual assent through parties' intent to enter into a contract).

118. *See generally* Slater, *supra* note 9, at 239–65 (discussing civil responsibility of individuals with DID generally); *Three Scholarly Traditions*, *supra* note 13 (analyzing criminal and civil legal issues and theory relevant to the DID community); Ralph Slovenko, *The Multiple Personality: A Challenge to Legal Concepts*, 17 J. PSYCHIATRY & L. 681 (1989) (briefly discussing the legal issues of consent to treatment in a DID context).

may require unique approaches, in part due to their different purposes.[119] In her article, she focuses on competency in the consent to treatment and will formation contexts.[120] Professor Saks reservedly concludes that "[a]ny competent alter's decision is valid so long as it is not unconscionable."[121] She does not address the application of specific competency evaluations in her analysis.

Jared Slater stands apart in producing a relevant, concentrated, and informed analysis of DID in the civil context in his piece *Can Dr. Jekyll Sign for Mr. Hyde: Examining the Rights of Individuals Suffering from Dissociative Identity Disorder in Civil Contexts*.[122] Slater considers California competency laws and how they impact individuals with DID in consent to treatment and the creation of wills. Slater discusses legal issues such as whether one with DID can consent to treatment[123] or create an enforceable will,[124] and if so, which alter can do so.[125] Slater also discusses the legal barriers that someone with DID could face upon drafting a will, such as challenges of insanity or undue influence.[126] Slater ultimately rejects California's competency tests in the will[127] and consent to treatment[128] contexts and suggests that "there is a significant need to establish a standard of competence for individuals with DID,"

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119. Saks additionally emphasizes the uniquely high stakes in civil law, stating that "finding a person generally incompetent means that he loses all decisional authority." *Three Scholarly Traditions*, *supra* note 13, at 306–07. For more discussion on this topic, see Clinton Luth, *The Color of Competency: The Differential Race Impact of Mental Health Assessment in Voidable Contracts*, 20 J. GENDER RACE & JUST. 563, 564 (2017) (discussing the impact of disparate competency evaluations under the law, and its weighted effect on racial minorities).

120. *Id.* at 307–09.

121. *Id.* at 308–09. Saks also proposes a secondary conclusion that a guardian would be required to find a democratic choice amongst alters. *Id.*

122. Slater, *supra* note 9.

123. *Id.* at 246–47.

124. *Id.* at 256–59.

125. *Id.* at 249–54.

126. *Id.* at 259–63.

127. *Id.* at 256–57 ("California has a specific statute enumerating who may not make a will. 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 testament.") (internal quotations omitted).

128. Slater, *supra* note 9, at 247 ("[I]n 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.") (internal quotations omitted).

noting that those with DID face many legal vulnerabilities.[129] This analysis is relevant beyond California state law and to a range of civil issues, such as the enforceability of contracts where at least one party has DID. Noting the heightened risk of exploitation of the DID community,[130] a desire of the public not to interact with mentally ill individuals,[131] and a not-atypical fear of DID malingering,[132] it is important to find a way to ensure both parties can confidently contract together without unnecessarily limiting the freedom of contract and while preserving the humanity of those with DID. The following section explores considerations for achieving such an objective.

B. FREEDOM OF CONTRACT CONSIDERATIONS

"Freedom of contract," meaning the freedom to enter into contracts with other private individuals without interference or regulation,[133] is a critical concept within American contract law.[134] Courts have weighed freedom of contract against the

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129. *Id.* at 265.

130. *See Dissociative Identity Disorder (DID)*, *supra* note 16.

131. *See* Parcesepe & Cabassa, *supra* note 106, at 390–91.

132. *See* Sarah K. Fields, *Multiple Personality Disorder and the Legal System*, 46 J. URB. & CONTEMP. L. 261, 287 (1994) ("More often than not, the trier of fact concludes that despite — or because of — the testimony of various experts, the defendant is malingering.").

133. It is significant to note that this concept narrowly refers to freedom from outside interference as outside *government* interference. The interference of other private individuals does not infringe on the idea of freedom of contract, even if in practice it does limit the ability of individuals or groups of people to enter freely into contracts. *See Freedom of Contract*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/freedom_of_contract [https://perma.cc/U3K9-ZCKG] (defining freedom of contract as freedom without government interference); *see also* Mark Pettit, Jr., *Freedom, Freedom of Contract, and the 'Rise and Fall'*, 79 B.U. L. REV. 263, 281–82 (1999) (arguing that instances of non-governmental action can limit freedom of contract).

134. Constitutional coverage of the freedom of contract began to formulate in the late 1800s. In the start of the 20th century, the U.S. Supreme Court famously prioritized freedom of contract over state public policy concerns, expanding Fourteenth Amendment protection to the freedom of contract in Lochner v. New York, 198 U.S. 45 (1905). The strength afforded to the freedom in Lochner quickly saw a decline and was not revived until the 1920s. The Great Depression then, once again, weakened the freedom in pursuit of broader protection of "public interests." By 1963, the Supreme Court seemingly abandoned the constitutional freedom of contract in Ferguson v. Skrupa, 372 U.S. 726 (1963). Since then, the freedom of contract has not been revived to Lochner-era thinking federally, but states have independently weighed freedom of contract as a consideration in local policy. *See generally* David E. Berstein, *Freedom of Contract*, 2 ENCYCLOPEDIA OF THE SUPREME COURT OF THE UNITED STATES 263 (David S. Tanenhaus ed., 2008) (reviewing the history of the interpretation of the freedom to contract); *see also* Pettit, *supra* note 133.

competing policy concern of protecting public interests, or "the safety, health, morals, and general welfare of the public."[135] The principle of the freedom of contract is important in weighing two potentially conflicting priorities in the DID context. First, it is critical to preserve the right of individuals in the DID community to contract freely. Unacceptable limitations on this freedom can be explicit, such as limiting the terms of contracts,[136] but they could also occur from the application of inappropriate standards.[137] Second, any reform must preserve the non-DID, general public's freedom to contract freely. Courts could improperly limit this freedom by requiring contract participation against one's wishes[138] or by unnecessary regulations.[139] In considering past, current, and potential future contract standards, one must consider if the proper balance between all parties' freedom of contract is being met.

C. NEW YORK CASELAW: EVOLUTION OF THE COMPETENCY TO CONTRACT IN MENTALLY ILL PARTIES

Current contract doctrine in New York leaves the DID community largely unprotected. New York courts interpret contracts' plain meaning, with little to no consideration of outside factors when text is unambiguous.[140] Although a switch of alters would render performance impossible in several scenarios, such as an alter taking control who is unaware of their contractual responsibilities, New York courts strongly prefer to avoid using the impossibility doctrine, opting instead for breach liability, especially when the event rendering performance impossible could have been foreseen.[141] Thus, in New York, judicial

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135. *Lochner*, 198 U.S. at 53 (discussing justifications for limiting the freedom of contract).

136. This is frequently seen in the labor and employment context, where employers and employees are prohibited from entering into employment contracts which violate wage and hour laws. *See* Berstein, *supra* note 134, at 5–8 (discussing the Supreme Court's limitation of the freedom of contract in the face of minimum labor standards).

137. *See* Slater, *supra* note 9, at 245.

138. *See generally* Eric Mack, *In Defense of 'Unbridled' Freedom of Contract*, 40 AM. J. ECON. & SOCIO. 1, 4–9 (1981) (discussing the freedom to not enter into contracts).

139. *See also* Jerome C. Knowlton, *Freedom of Contract*, 3 MICH. L. REV. 619, 619–20 (1905) (critiquing the use of police powers restricting freedom of contract).

140. *See, e.g.*, Mitchill v. Lath, 247 N.Y. 377, 380–81 (1928).

141. Lagarenne v. Ingber, 273 A.D.2d 735, 738 (N.Y. App. Div. 2000); *Impossibility of Performance as a Defense to Breach of Contract*, STIMMEL LAW, https://www.stimmel-

determinations on contracts where one party has DID are less likely to take into account the distinct obstacles and issues that can arise in these transactions.

Most jurisdictions use a cognitive or affective test to determine the contract competency of mentally ill individuals.[142] A cognitive test, generally speaking, determines a party's ability to *understand* a transaction and its consequences.[143] By contrast, an affective test considers a party's ability to *act reasonably* in relation to the agreement.[144] New York courts initially relied on a cognitive test (hereinafter the "traditional test")[145] to determine if a party had sufficient competence to engage in a contract.[146] As the common law of contract competency evaluations developed, New York courts broadened the analysis to include the affective test as outlined in the Restatement alongside the existing common law traditional test.[147] Because versions of the cognitive and affective tests are used in most jurisdictions, other states can follow this analysis of New York's rules as applied to the DID context.

1. *Traditional Measures of Competency*

The common law traditional test of contract competency originated in the 1892 decision *Aldrich v. Bailey*.[148] The *Aldrich* court applied a cognitive test, asking whether someone was so impacted by mental illness that they were "wholly and absolutely incompetent to comprehend and understand the nature of the

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law.com/en/articles/impossibility-performance-defense-breach-contract [https://perma.cc/S4HP-BATC] (explaining the doctrine of impossibility).

142. *See* MICHAEL L. PERLIN ET AL., COMPETENCE IN THE LAW: FROM LEGAL THEORY TO CLINICAL APPLICATION 198 (2008) ("In most jurisdictions, the standard for contractual capacity includes both the traditional cognitive standard and also an alternative standard, referred to as the affective test, the modem test, or the volitional test.").

143. *See* 5 WILLISTON ON CONTRACTS § 10:3 (4th ed.) (The cognitive test asks "whether, at the time of the transaction, the alleged incompetent party was so deprived of her mental faculties as to be wholly unable to understand or comprehend the nature and consequences of the transaction (the majority cognitive test). . . .").

144. *See id.* (The affective test asks "whether the alleged incompetent is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of her condition (the minority affective test).").

145. This Note will refer to New York's cognitive test as the "traditional test" to distinguish between it and the standard cognitive test as is outlined in the Restatement.

146. *See* Aldrich v. Bailey, 132 N.Y 85, 89 (1892).

147. PERLIN ET AL., *supra* note 142.

148. *See Bailey*, 132 N.Y. at 89.

transaction."[149] In the same year, the New York Court of Appeals made a competency determination in *Paine v. Aldrich* by considering if the grantor in the case was able to make a rational judgment in regard to the transaction.[150] These approaches combined to act as a bi-fold cognitive test that considered both if the party was incompetent to understand the transaction and if they were able to make a rational judgment.[151] This traditional test became the primary method of determining competency in New York.

In a 1912 decision, New York showed a willingness to depart from strict compliance to the traditional test in competency evaluations. In applying the traditional standard, the judge in *Moritz v. Moritz* used a "but-for" analysis to evaluate competency when one's mental delusions are significantly related to the transaction. In this case, the party suffered from "melancholia," a type of depression.[152] As part of this condition, the defendant had obsessions and delusions.[153] While apparently under influence of an obsession regarding an intense fear of poverty and financial instability of his children, the defendant entered into a will to transfer property to his wife before he killed himself and his children.[154] The court applied the traditional test and, in finding that the transaction was not void due to mental incapacity, stated that:

> There must be some such connection between the insane delusions and the making of the deed as will compel the inference that the insanity induced the grantor to perform an act the purport and effect of which he could not understand, *and which he would not have performed if thoroughly sane*.[155]

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149. *Id.*
150. Paine v. Aldrich, 133 N.Y. 544, 546 (1892).
151. Ortelere v. Tchrs.' Ret. Bd., 25 N.Y.2d 196, 202 (1969) (citing *Bailey*, 132 N.Y. at 89; *Paine*, 133 N.Y. at 546) (describing traditional standard for measuring contractual mental capacity).
152. Moritz v. Moritz, 153 A.D. 147, 150–52 (N.Y. App. Div. 1912).
153. *Id.* at 148–49.
154. *Id.*
155. *Id.* at 152 (emphasis added).

Thus, in its interpretation of the traditional test, the *Moritz* court found that a transaction could be void if, but-for the mental delusion, the transaction would not have been created.[156]

The New York Supreme Court's 1963 decision *Faber v. Sweet Style Mfg. Corp.* solidified the *Moritz* but-for test and began a slow shift away from strict compliance to the traditional standards.[157] The *Faber* plaintiff purchased property during a manic episode and then initiated several "abnormal acts," such as hiring laborers, making architecture plans, and seeking to begin construction on the property all before title closing.[158] In this decision, the *Faber* court used the *Moritz* opinion to establish a separate test of competency alongside the traditional standard. The judge recognized that the traditional test on its own failed to account for the diverse natures and effects of different mental disorders by relying solely on mental comprehension in capacity decisions.[159] The judge pointed out this deficiency in regards to the *Faber* party, who was diagnosed with manic-depressive psychosis.[160] The judge reasoned that the inquiry into cognitive capacity alone is insufficient for manic-depressive psychosis, which impacts a party's motivation to act, not their ability to understand, attributing the inapplicability of the traditional test to the fact that it was established before the recognition of manic-depressive psychosis as a valid disorder.[161] The judge, however, reasoned that, according to the previous case law, "[c]apacity to understand is not, in fact, the sole criterion" in making competency evaluations.[162] The judge clarified that, beyond the traditional test used in New York, "incompetence to contract also exists when a contract is entered into under the compulsion of a mental disease or disorder but for which the contract would not have been made."[163] In following the approach in *Moritz* and

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156. *Id.*

157. *See* Faber v. Sweet Style Mfg. Corp., 242 N.Y.S.2d 763, 767 (Sup. Ct. N.Y. Cnty. 1963).

158. *Id.* at 768–69.

159. *Id.* at 767 ("The standards by which competence to contract is measured were, apparently, developed without relation to the effects of particular mental diseases or disorders and prior to recognition of manic-depressibe [sic] psychosis as a distinct form of mental illness. . . . Primarily they are concerned with capacity to understand. . . ." (citations omitted)).

160. *Id.*

161. *Id.*

162. *Id.* at 768.

163. Faber v. Sweet Style Mfg. Corp., 242 N.Y.S.2d 763, 768 (Sup. Ct. N.Y. Cnty. 1963).

recognizing the deficiencies of the traditional test, the *Faber* judge began to solidify a state-wide expansion from the traditional test.

As seen in *Faber*, the competency evaluation in New York developed to be a multi-faceted review, considering a party's ability to comprehend the transaction,[164] ability to make a rational judgment,[165] and the mental disorder's impact on the existence of the contract.[166] *Faber* showed the willingness of New York courts to be flexible in the use of doctrines instead of strictly adhering to one traditional standard, especially as new, distinctive mental disorders were recognized.

2. Ortelere v. Teachers' Retirement Board *and the Restatement (Second) of Contracts § 15*

The 1969 case *Ortelere v. Teachers' Retirement Board* marked a significant and innovative move from the traditional standards in New York. In *Ortelere*, Mrs. Ortelere suffered from psychosis melancholia, or "disruptions in the personality."[167] The New York Court of Appeals found that there was sufficient evidence showing that Mrs. Ortelere altered her application for retirement without capacity to do so due to her psychosis melancholia.[168] In its decision, the court recognized that the traditional test governing mental illness was too restrictive and "primitive" to account for the vast diversity of mental illness.[169] The court criticized civil law for moving too slowly to adhere to modern psychiatric views.[170] Although the *Ortelere* court agreed with the

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164. *See* Aldrich v. Bailey, 132 N.Y. 85, 89 (1892) (asking whether someone's mental illness made them "wholly and absolutely incompetent to comprehend and understand the nature of the transaction.").

165. Paine v. Aldrich, 133 N.Y. 544, 546 (1892).

166. Moritz v. Moritz, 153 A.D. 147, 152 (N.Y. App. Div. 1912) (asking whether someone would not have performed a deed *but-for* their mental delusions); Faber v. Sweet Style Mfg. Corp., 242 N.Y.S.2d 763, 768 (Sup. Ct. N.Y. Cnty. 1963).

167. Ortelere v. Tchrs.' Ret. Bd., 25 N.Y.2d 196, 199 (1969).

168. *Id.* at 206.

169. *Id.* at 203 (noting failure of traditional standards to "account for one who by reason of mental illness is unable to control his conduct even though his cognitive ability seems unimpaired.").

170. *See id.* at 204 (noting that there was "some movement on the civil law side to achieve a modern posture. For the most part, the movement has been glacial and has been disguised under traditional formulations.").

approach used in *Faber*,[171] it ultimately opted to use the Restatement's affective[172] test, stating that "because the cognitive rules are, for the most part, too restrictive and rest on a false factual basis they must be re-examined."[173]

The Restatement's provisions on mental illness or defect provide model frameworks for evaluating competency to contract.[174] Under its affective test, a person "incurs only voidable contractual duties by entering into a transaction if by reason of mental illness or defect . . . he is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of his condition."[175] In other words, if a party is unable to reasonably act or perform their duties because of a mental illness, their duties are voidable only if the other party was on notice of the mental defect.[176] The *Ortelere* court viewed the knowledge requirement in the Restatement as a way to balance the competing policy concerns of protecting the expectations of parties and protecting the mentally ill population.[177] This test, according to the court, is meant to "provide protection to those persons whose contracts are merely uncontrolled reactions to their mental illness, as well as for those who could not understand the nature and consequences of their actions."[178] After over fifty years of using mental inquiries alone to determine capacity, New York's usage of the Restatement redefined how courts view competency, now also considering a party's ability to understand or act reasonably in relation to a

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171. The court clarified that it approved of the standard used in *Faber* finding incompetence when, but for the impulse produced by a mental disorder, a contract would not have been formed. *Id.* at 204.

172. The affective test, as used by New York courts, is also referred to as a "motivational" test. This Note will refer to the test as the "affective" test.

173. *Id.*

174. RESTATEMENT (SECOND) OF CONTRACTS § 15 (Am. L. Inst. 1981).

175. *Id.*

176. *See id.* at § 15 cmt. b ("Even though understanding is complete, he may lack the ability to control his acts in the way that the way that the normal individual can and does control them; in such cases the inability makes the contract voidable only if the other party has reason to know of his condition.").

177. *See Ortelere*, 25 N.Y.2d at 205 ("There must be stability in contractual relations and protection of the expectations of parties who bargain in good faith. On the other hand, it is also desirable to protect persons who may understand the nature of the transaction but who, due to mental illness, cannot control their conduct. Hence, there should be relief only if the other party knew or was put on notice as to the contractor's mental illness.").

178. *Id.* at 205 (quoting Robert M. Brucken et al., *Mental Illness and the Law of Contracts*, 57 MICH. L. REV. 1020, 1036 (1959)).

contract, as well as the other party's knowledge of the mental illness under the affective test.[179]

III. INADEQUACY OF NEW YORK CONTRACT DOCTRINE

This Part assesses the applicability of New York contract law to DID. To help illustrate the inadequacy of current doctrine, Part III.A depicts two hypothetical scenarios.[180] Part III.B then shows how current competency rules are not suitable for those with DID.

A. ILLUSTRATIVE HYPOTHETICALS[181]

1. *Hypothetical: Sarah and Sophia*

Sarah is a twelve-year-old girl who enjoys drawing, skateboarding, and dressing up in costumes.[182] She is fun to be around and very social; however, Sarah has the reading comprehension skills of an average twelve-year-old and struggles to understand big words and complex sentences.[183] Suddenly, she finds herself in a room with other adults, instructing her to read the papers in front of her and sign or initial all pages. Sarah is not sure how she got there, but knows she wants to leave. She flips through the papers detailing a bank loan, confused on what they mean or why she needs to sign them. She is even having

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179. RESTATEMENT (SECOND) OF CONTRACTS § 15 (Am. L. Inst. 1981).

180. Although these hypotheticals outline potential issues in the DID contracting context, many DID systems would be able to ensure complete performance of contracts in a predictable, consistent, and reliable way. *See generally* HYMAN, *supra* note 31, at 224 ("Parts can also become quiescent so that the mind mainly functions as one consciousness even though the parts continue to be separate entities."). However, as with any other mental disorder, there may be cases of lower functioning or unpredictability caused by stigma, inaccessible healthcare, triggers, or other environmental factors. This Note highlights the issues that could happen so that appropriate safeguards are in place if these situations were to arise.

181. The following hypotheticals are fictional but based on real presentations, symptoms, and manifestations of DID.

182. HYMAN, *supra* note 31, at 41 (discussing how alters can have a wide range of interests, hobbies, and abilities that reflect the range of the same among strangers in different bodies).

183. *Id.* at 43 ("[T]here are child and adolescent parts, most of whom are frozen in time . . . . Those child parts who are aware of the present nonetheless remain emotionally and intellectually children trying to fulfill their original functions in spite of their changed circumstances.").

trouble remembering her legal name for her signature.[184] Intimidated, anxious, and feeling a panic attack coming on, Sarah signs all the papers as quickly as possible so she can go home.

Sophia is a forty-year-old woman, an avid reader,[185] a sharp debater,[186] and a fierce protector of herself.[187] Sophia experiences some memory loss and tends to dissociate. During some of that lost time, Sarah controls Sophia's body. Sophia does not know, however, who Sarah is or what Sarah does during Sophia's amnesia episodes. Sophia is concerned about her symptoms but does not have adequate health insurance to seek treatment and is regardless afraid of being labeled as crazy.[188] After finally leaving an abusive relationship[189] and searching the rental market, Sophia finds an apartment that she loves. Sophia goes to the rental office, reads over the lease, and discusses terms with the property manager. She feels satisfied with her review of the lease and signs, agreeing to pay rent by the first of the month every month. When Sophia comes to after an episode of memory loss, she realizes it is the tenth of the month. She checks her email and sees that she has several threatening emails from her landlord, massive late fees for her apartment, and her credit score has tanked. She sees she has missed loan payments but has no recollection of applying for a loan. After some research into her credit and email history, she realizes she has received a bank loan of which she has no memory—a loan that she has had for two months, during which time she has not been making payments.

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184. *See, e.g.*, *id.* at 41 (discussing an anecdote of a child alter in a system signing papers for school with their individual name, not the legal name of the body).

185. *See, e.g.*, *id.* at 98 (a woman with DID discusses the differences between her alters: "I don't like reading very much; [another alter] likes to read, but he doesn't want to read anything but medical journals.").

186. *See, e.g.*, *id.* at 122 (discussing a DID system where one alter works as an attorney: "[the attorney alter] makes it clear that she is determined to be a conscientious lawyer in spite of the needs of the other parts.").

187. *Id.* at 48–49 (discussing the common role of a "protector" within DID systems).

188. HYMAN, *supra* note 31, at 80 ("The fear of being 'crazy' or being perceived as 'crazy' is a powerful incentive to keeping oneself and others in ignorance of having a mind in parts.").

189. *See, e.g.*, Aliya R. Webermann et al., *Childhood Maltreatment and Intimate Partner Violence in Dissociative Disorder Patients*, 5 EUR. J. PSYCHOTRAUMATOLOGY 24568, 24573 (2014) (studying the relationship between childhood abuse and future intimate partner violence in those with dissociative orders and finding that those with dissociative disorders have a higher likelihood than the general population to face intimate partner violence).

2. *Hypothetical: Candace and Kristen*

Candace is an alter in a diagnosed DID system which is twenty-eight years of age. Candace controls the body most frequently and has the mental capacity of an average twenty-eight-year-old. She has been living with DID for as long as she can remember but has only been aware of her DID for four years. In those four years, she has learned much about herself and her twenty alters.[190] Most of the alters in the system have remarkable communication skills: they frequently discuss issues and ideas internally and externally.[191] Although Candace still experiences amnesia, confusion, and forgetfulness, she functions well in her daily life and manages these symptoms.[192]

Candace had been thinking about moving to a new city for months. After searching for and finding an apartment, she and a property manager scheduled a time to go over and sign a lease. When at the property management office, Kristen, a twelve-year-old alter, takes control of the body. She does not comprehend the lease or any explanations provided by the property manager. Kristen knows, however, that the system had been discussing this apartment for weeks. She is aware that today they had planned to sign the lease. Although she is confused by the document itself, Kristen knows that adult alters in the system fully intended to sign that lease that day.[193] Kristen signs the lease, allowing the system to move into the new apartment the following week. Although Candace cannot be sure who will have control of the body when it is time to pay rent every month, she initiated a savings system for her finances and uses intra-system communication, through methods such as sticky notes, internal conversations, and phone reminders, to ensure rent is always paid on time.

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190. *See, e.g.*, Robboy, *supra* note 73 (discussing mapping the relationships between alters as a therapeutic technique to manage DID).

191. HYMAN, *supra* note 31, at 82 ("Parts frequently converse informally among themselves and sometimes with the host as part of everyday life. Hearing voices converse or argue, or finding written conversations in different handwritings are, or have been, experiences common to all my interviewees.").

192. *See generally* HYMAN, *supra* note 31 (interviewing women with DID and discussing their ability to live successful personal and professional lives).

193. *Id.* at 82–83 (discussing democratic decision-making used by interviewed DID systems).

3. *Comparison of the Hypotheticals*

When comparing Candace and Kristen's hypothetical to Sarah and Sophia's, it initially seems like the contract formation was the same: by reason of a mental health-related impulse, an adult with the mental capacity of a child and an inability to comprehend the agreement entered into a contract. Because Sophia was unaware of her other alters and her DID diagnosis, however, she could not account for the possibility that another personality state with much lower comprehension would make decisions on her behalf. In Candace's case, she and Kristen were aware of their status as a DID system. As a result, Candace was able to intentionally enter into a contract, even without comprehension at the time of agreement, and could have structures in place to prevent younger alters from making unwanted decisions.

B. SHORTFALLS OF CURRENT CONTRACT DOCTRINE

Despite DID being a mental health disorder, it does not neatly fit into the current Restatement or New York caselaw controlling mentally ill contracting parties. Multiple personality states exist simultaneously within someone with DID,[194] making any sort of simple, binary mental evaluation of competency difficult or impossible. Without proper guidelines and protections, it is possible that by simply engaging in their right of contract, someone with DID could be a victim of exploitation via another contracting party, be held to contractual duties entered into without the proper capacity, or be inappropriately deemed incompetent to enter into previous and future contracts.

1. *Limited Scope of the Traditional Test*

The traditional test places too much emphasis on evidence of competency at the time of contract formation: the limitation of evidence to a single point of time and common presentations of DID may lead to false incompetency determinations. As established in *Aldrich v. Bailey* and *Paine v. Aldrich*, the

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194. *Dissociative Identity Disorder*, BRIDGES TO RECOVERY, https://www.bridgestorecovery.com/dissociative-identity-disorder/ [https://perma.cc/AJ6G-VPJE].

traditional test asks if the party was so "wholly and absolutely incompetent to comprehend and understand the nature of the transaction"[195] and if they were able to make a rational judgment in regard to the transaction.[196] This inquiry assesses capacity at the time the agreement was executed.[197] In applying this standard, the Appellate Division has found evidence concerning testimony of the alleged incompetent party, testimony of mediators and other witnesses, physician letters, and presence of counsel relevant in determining capacity at time of execution.[198]

In *Feiden v. Feiden*, the court evaluated a party's capacity to enter into a contract based on conflicting evidence of his competency.[199] Two clinicians testified to the party's incompetency.[200] Of note here, one psychiatrist testified that the party had "lucid intervals," and thus was not "wholly incompetent" as the test requires.[201] The court made note that "[t]here was also no testimony by the physicians as to [the party's] mental condition *on the day the deeds were signed*."[202] Ultimately, due to the lack of evidence of incompetency at the time of the transaction, the Appellate Division affirmed the county Supreme Court in maintaining the presumption of competency in the case.[203]

Under the traditional test, testimony of any witness[204] would become especially important in DID cases, to the likely detriment of the DID party.[205] The same reasoning used in *Feiden* could be

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195. Aldrich v. Bailey, 132 N.Y 85, 89 (1892).

196. Paine v. Aldrich, 133 N.Y. 544, 546 (1892).

197. *Id.*; *Bailey*, 132 N.Y at 89.

198. *See* Adsit v. Wal-Mart Stores, Inc., 79 A.D.3d 1168, 1170 (N.Y. App. Div. 2010); *see also* Whitehead v. Town House Equities, Ltd., 8 A.D.3d 367, 369 (N.Y. App. Div. 2004); Blatt v. Manhattan Medical Group, P.C., 131 A.D.2d 48, 52–53 (N.Y. App. Div. 1987) (using the fact that the plaintiff was accompanied by counsel to determine that the party was not wholly and absolutely incompetent).

199. Feiden v. Feiden, 151 A.D.2d 889, 891 (N.Y. App. Div. 1989).

200. *Id.*

201. Similarly, different attorneys had conflicting testimony regarding the party's competency. *Id.* at 890.

202. *Id.* at 891 (emphasis added).

203. *Id.*

204. Paine v. Aldrich, 133 N.Y. 544, 546 (1892) (considering testimony of the witnesses); Adsit v. Wal-Mart Stores, Inc., 79 A.D.3d 1168, 1170 (N.Y. App. Div. 2010) (considering an affidavit of a mediator).

205. Unless clear physical evidence was produced, such as notes or unique handwriting, a court cannot determine after the fact which alter was controlling the body at time of contract, thus what level of capacity existed. Due to the inconsistent nature of psychiatrist expert testimony, New York courts have given more weight to "objective

applied to a party with DID. Like in *Feiden*, those with DID have a varying degree of competency and ability; without evidentiary context, the level of capacity, or which alter, an individual possessed at the time of contract formation would be uncertain. By relying only on evidence of behavior at time of contracting, especially testimony, this approach exacerbates an uneven power dynamic in the contracting relationship. In situations without neutral third-party witnesses, the testimony of the other party could theoretically determine the enforceability of the contract. This outcome is even more likely if a court deems the testimony of the party with DID not credible or less credible than the non-DID party.[206]

When analyzing the behavior of a party with DID at time of contract, common presentations of DID may give false evidence into the mindset of the fronting alter. While dissociating, someone may appear spacey, have difficulties remembering basic information, present with irregular moods, act strangely, or speak differently.[207] Although this behavior during contract execution could be used as evidence that the DID party was lacked capacity under the traditional test, these symptoms are not necessarily indicators of an incompetent mindset. Multiple studies have assessed the relationship between dissociation and cognitive function, finding that the presence of dissociation does not impact the ability to focus, and may at times be advantageous.[208] The lack of a clear association between negative cognitive function and dissociation shows that this presentation does not imply incompetence to comprehend an agreement. Furthermore, alters can be co-conscious at time of contract execution. When co-conscious, although an incompetent alter is

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behavioral evidence" than to mental health experts. Faber v. Sweet Style Mfg. Corp., 242 N.Y.S.2d 763, 768 (Sup. Ct. N.Y. Cnty. 1963).

206. *See Faber*, 242 N.Y.S.2d at 766 ("Testimony of the claimed incompetent often is not available, and in any event is subject to the weakness of his mental disorder, on one hand, and of his self interest on the other."); *see also generally* Mark A. Miller, *The Unreliability of Testimony from a Witness with Multiple Personality Disorder (MPD)*, 27 PEPPERDINE L. REV. 193 (2000).

207. *Dissociative Disorder Signs, Symptoms, and Treatment*, SUNRISE HOUSE TREATMENT CENTER (July 14, 2022) https://sunrisehouse.com/co-occurring-disorders/dissociative-disorder/ [https://perma.cc/M3YB-VTCF].

208. Although there are multiple studies that make this conclusion, there are also studies showing the opposite is true. Despite contradictions in the area of study, sufficient research casts doubt on the association between negative cognitive ability and dissociation. *See generally* Özdemir et al., *The Relationships Between Dissociation, Attention, and Memory Dysfunction*, 52 ARCH NEUROPSYCHIATRY 36, 40 (2015).

the one in control of the body, competent alters may be aware of the external surroundings and actively communicate with the incompetent alter, instructing them on which actions to take in real-time.[209] Ultimately, although the incompetent alter may show signs of incompetency in their presentation, the competent alters still effectively made the decision. By prioritizing presentation at contract formation, the traditional test then puts those with DID at a disadvantage.

A test of capacity at a single point[210] of time is incompatible with the nature of DID: various configurations of control can further complicate this inquiry. Although one alter typically controls the body at a time, the ownership of control and influence are often not that simple.[211] For instance, the agreeing alter may not understand the contract but have other competent alters advise them to enter into the contract, as was the case in the Kristen and Candace hypothetical. Kristen, the child alter who signed the contract, may have seemed confused and dissociative during contract formation, giving a false impression of incapacity under the traditional test; in actuality, Candace made a rational, reasoned decision to enter into the contract and instructed Kristen on what to do beforehand.[212] In many self-aware systems, alters work together to make future decisions.[213] At time of contract execution, whichever alter happens to be in control acts as an agent to make the previously-approved decision. If this alter happens to be incompetent, they could still move forward with the decision as instructed by the competent alters in their system, not their own comprehension of the

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209. Co-consciousness can be a way to increase system comprehension and functioning, as well as a result of a system improving their inner-functioning. *See* Carolyn Spring, *A Brief Guide to Working with Dissociative Identity Disorder*, CAROLYN SPRING (Jan. 2010), https://www.carolynspring.com/blog/a-brief-guide-to-working-with-dissociative-identity-disorder/ [https://perma.cc/6H57-28TA] ("By working on increased communication and cooperation between parts, often there is a corresponding increase in levels of co-consciousness, which can help the DID client to feel [sic] in much better control of their life.").

210. See George J. Alexander & Thomas S. Szasz, *From Contract to Status via Psychiatry*, 13 SANTA CLARA L. REV. 537, 545–48 (1973) for a discussion on incompetence as a test at time of contract formation.

211. For a discussion of how some DID systems experience the presence of multiple alters at once, including the ability of adult alters to supervise adolescent alters and temporary integration between multiple alters, see HYMAN, *supra* note 31, at 224–27.

212. *See supra* Part III.A.2.

213. *See* HYMAN, *supra* note 31, at 82–86 (discussing interviewees with DID's use of internal communication to make democratic decisions).

situation.[214] In this case, competence as measured at the time of contract formation is not a clear indication of the competency to enter the contract. Because evidence of internal agreements or co-consciousness at time of contract formation would be very hard to prove in a court setting, the traditional test would fail to account for the unique circumstances of those with DID.

2. *Issues Under the* Faber *Test*

The *Faber* test is unsuitable for DID contexts because it minimizes the decision-making freedom of mentally ill parties and requires analysis of a party's course of action had it not been impacted by the mental disorder. Under the *Faber* test, one is found incompetent "when a contract is entered into under the compulsion of a mental disease or disorder but for which the contract would not have been made."[215] Broken down, the court first assesses if the party entered into a contract due to a compulsion caused by a mental disorder.[216] If so, the court then determines if the party would have entered into the contract if not for the compulsion.[217] The rationality of a decision can help determine whether a decision was made due to a mental disorder–related compulsion.[218] Few New York appellate-level decisions have applied this test.[219]

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214. The situation of an incompetent decision not following the will of the system is discussed *supra* Part IV.

215. Faber v. Sweet Style Mfg. Corp., 242 N.Y.S.2d 763, 768 (Sup. Ct. N.Y. Cnty. 1963).

216. *Id.* at 768–69.

217. *Id.* at 768.

218. *Id.* at 768–69.

219. In *Faber*, the plaintiff purchased a property in order to start a business, "moved to obtain an architect and plans, hire laborers, begin digging on the property, and . . . obtain building approval" prior to title closing on the property. *Id.* at 768. The court considered the unusually quick speed the plaintiff acted on his decision to support a finding that he had a compulsion-induced motivation. *Id.* In *Ortelere*, the court found that the plaintiff had made a retirement contract "so unwise and foolhardy that a factfinder might conclude that it was explainable only as a product of psychosis." Ortelere v. Tchrs.' Ret. Bd., 25 N.Y.2d 196, 206 (1969). A County Supreme Court case, affirmed by the First Department, found relevant evidence under the inquiry to be "the personality of the plaintiff, the nature of the deal at stake, the circumstances and the manner in which the contract was entered into, the behavior of the plaintiff juxtaposed to the contract and in some aspects of his life going beyond the limited range of the making of the contract, the medical history and evaluations regarding plaintiff's alleged [mental disorder] or lack thereof." Fingerhut v. Krayln Enterprises, Inc., 337 N.Y.S.2d 394, 400 (Sup. Ct. N.Y. Cnty. 1971), *aff'd*, 40 A.D.2d 595 (N.Y. App. Div. 1972), *denied appeal*, 291 N.E.2d 589 (N.Y. 1972).

The *Faber* test inappropriately relies on the rationality of a decision, substituting the mentally ill party's logic for that of the court in its competency evaluation. In determining if a "compulsion" under the test impacted contract formation, the application then leads to heightened scrutiny of the *content* of a decision based solely on the existence of a mental disorder. Without a straightforward definition of "compulsion," this inquiry may be overinclusive when applied to DID parties.[220] Sophia and Sarah likely would not have unknowingly signed a loan agreement but-for an untimely switch of alters, or compulsion of DID.[221] The analysis is less clear, however, in Candace and Kristen's hypothetical. Because the facts are indistinguishable (i.e., someone with DID and the temporary capacity of a child entered into a contract), Candace and Kristen's scenario could similarly be found to be a result of a compulsion of DID.[222] Candace would have difficulty proving that Kristen's presence was not a compulsion that caused her to enter into the contract. Due to the existence of a serious mental health disorder, a competently made decision can be questioned and the DID party's right to freely enter into a contract is limited: although other parties have the right to enter into a contract without clear, external, and elongated validation of that intent, the weight of the contextual evidence could provide that one with DID is unable to do the same.

Some conduct may be indicative of a compulsion of mental illness regardless of the specific disorder. For example, as was the case in *Faber*, quickly using one's own resources to start a business at a property of which the title has not yet closed would likely be evidence of some sort of compulsion of mental illness, regardless of the specific alleged mental disorder, due to its lack of rationale.[223] However, the limits to this assessment of rationality are unclear. If a court found the *content* of a decision irrational, it could view the switch of alters as a compulsion causing the decision under *Faber*. By applying higher scrutiny to

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220. DID inherently impacts daily decision-making, and any switch of alters could be akin to a "compulsion"; under *Faber*, virtually all decisions could be argued to be due to a DID-related impulse. *See generally* Slater, *supra* note 9, at 244–45 (stating that DID parties are particularly vulnerable to findings of incompetency in capacity evaluations).

221. *See supra* Part III.A.1.

222. *See supra* Part III.A.2.

223. Faber v. Sweet Style Mfg. Corp., 242 N.Y.S.2d 763, 768–69 (Sup. Ct. N.Y. Cnty. 1963).

the content of decisions, the *Faber* test prioritizes a court's idea of a logical decision over that of a mentally ill party and risks unnecessarily limiting competent DID systems' freedom of contract.[224]

If a court were to decide that a party made a decision due to a mental compulsion of DID, the next part of the analysis would be nonsensical to apply. Because DID splits the consciousness of an individual into multiple parts and defines several unique senses of identity, determining what an individual with DID would have done but for a switch or dissociation would be nothing more than guesswork.[225] One cannot know what the person as a whole would have done, because the individual's personality is split into multiple states. If a court tried to determine what a certain alter would have done, it would struggle to determine which alter would be the correct to assess.[226] The court may be inclined to base their decision off what the "main" alter or "original" personality would have done.[227] However, in many cases, there is not one "default" or "original" person that claims ownership of the identifiers or body.[228] This approach is further complicated when considering the many systems who have multiple alters who regularly take control of the body.[229] The law may be inclined to address the alter that responds to the legal name of the system. There is a chance, however, that no active alter self-identifies

224. Due to the existence of a serious mental health disorder, a competently made decision can be questioned and the DID party's right to freely enter into a contract is limited: although other parties have the right to enter into a contract without clear, external, and elongated validation of that intent, the weight of the contextual evidence could provide that one with DID is unable to do the same.

225. *See Three Scholarly Traditions*, *supra* note 13, at 306 ("[O]ver time [those with DID] are simply so divided that it may be wrong to see them as single, responsible agents").

226. This difficulty would increase if a DID system was not aware of their status as a system. *See* Slater, *supra* note 9, at 245 ("[I]f [a system's] alters are completely unaware of each other or the fact 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).").

227. *Id.* at 251–52 (discussing approaches to select which alter should be the basis of a competency evaluation).

228. Some systems do not have a single "host" alter and sometimes which alter is the "original" personality is unknown or inaccessible. HYMAN, *supra* note 31, at 44 ("The host is not necessarily the body's original identity and may or may not be one single part . . . . Sometimes other parts described the earliest identity as having been 'put to sleep' because she could not bear the abuse.").

229. *Id.*

with the legal name of the system.[230] Without knowing which personality from which to base a "but-for" analysis, the court is not able to determine what a party would have done had they not had a compulsion of DID.

3. *Concerns Under the Restatement (Second) § 15's Affective Test*

Although the *Ortelere* court recognized issues with the traditional test and thus began incorporating the Restatement, the affective test still falls short of meeting the needs of those with mental illness due to its notice requirement and deep reliance on medical evidence. As noted by the *Ortelere* court, the affective test states that a party will be found mentally incompetent to participate in a contract if "he is unable to act in a reasonable manner in relation to the transaction"[231] and "the other party knew or was put on notice" of the mental illness.[232] In the same decision, the court noted that application of this test is limited to mental disorders no less serious than "medically classified psychosis."[233]

The case law is not clear on what constitutes "notice" as applicable under the affective test. In one case, a plaintiff with an alleged mental illness "never told" the defendant of his illness: he only spoke about it in terms that could be consistent with his physical disability.[234] There, the Southern District of New York (SDNY) found that the defendant was not on notice of the alleged mental illness.[235] In another SDNY case, the court found that the defendants were not on notice of plaintiff's alleged mental illness when, without other evidence, the plaintiff "appeared coherent" and never told the defendants of the illness.[236] When the other party knew that the allegedly mentally incompetent party was

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230. *See* HYMAN, *supra* note 31, at 44 (explaining that in some cases, the "earliest identity" may be "put to sleep" due to an inability to handle the trauma they faced).

231. Ortelere v. Tchrs.' Ret. Bd., 25 N.Y.2d 196, 204 (1969) (quoting RESTATEMENT (SECOND) OF CONTRACTS § 15 (Am. L. Inst. 1981)).

232. *Id.* at 205.

233. *Id.* at 206.

234. DuFort v. Aetna Life Ins. Co., 818 F. Supp. 578, 583 (S.D.N.Y. 1993).

235. *Id.*

236. Reid v. IBM Corp., No. 95 Civ. 1755 (MBM), 1997 WL 357969, at *9 (S.D.N.Y. June 26, 1997).

receiving psychiatric treatment, courts have found this knowledge to constitute notice under the test.[237]

The notice requirement improperly encourages those with DID to disclose personal information related to their mental disorder. As Rebecca E. Young points out in her study into stigma and mental illness, mental disorders are "invisible disabilities" and others are not likely to know that one suffers from one "unless the individual discloses it."[238] This is notably the case with many in the DID population who often try to hide symptoms of their mental disorder.[239] In the Kristen and Candace hypothetical, the DID system intentionally tried to present as if they were one person completing acts over an extended period of time.[240] Sophia and Sarah, conversely, were unaware of their condition due in part to healthcare inaccessibility.[241] Because Sophia and Sarah's struggles were internal and Sophia was fearful of outside stigma, others likely would not be on notice of their mental illness.[242] If the party with DID was attempting to mask their symptoms and the other party had no reason to know of their medical treatment,[243] their contractual duties would not be voidable, even if incompetent, due to lack of notice.

Federal courts in New York have provided some insight into the evaluation of the ability "to act in a reasonable manner" as used in the affective test. District court judges in the Southern, Northern, and Eastern Districts of New York all determined that the allegedly incompetent party's own assessment of their mental

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237. Ortelere v. Tchrs.' Ret. Bd., 25 N.Y.2d 196, 205 (1969) (finding that the other party's knowledge of plaintiff's psychiatric treatment and medical leave of absences was enough to put that party on notice of the mental disorder); *see also* Indelicato v. Provident Life and Acc. Ins. Co., No. 89 Civ. 8436 (RJW), 1990 WL 145149, at *6 (S.D.N.Y. Sept. 28, 1990).

238. Young et al., *supra* note 108, at 944.

239. ELIZABETH F. HOWELL, UNDERSTANDING AND TREATING DISSOCIATIVE IDENTITY DISORDER 2–3 (Lewis Aron & Adrienne Harris eds., 2011) ("[T]o the extent that they are aware of their extreme dissociativity, many highly dissociative people work to hide it. Often, they are afraid that they will be considered crazy . . . . Their fragmentation may not be recognized until attentive emotional intimacy with another human being, often a therapist, allows it to be known."); HYMAN, *supra* note 31, at 117, 246 (interviewees discussing why they felt the need to hide their DID identity from others); *see also generally* Young et al., *supra* note 108, at 944 (discussing the impact of stigma on the mentally ill population, generally).

240. *See supra* Part III.A.2.

241. *See supra* Part III.A.1.

242. *See supra* Part III.A.1.

243. As discussed *supra* Part I.B, there are significant barriers to those with DID to receive treatment, lessening the likelihood that such treatment could put the other party on notice.

capacity, without objective evidence, is insufficient to overcome the presumption of competency.[244] The Southern and Eastern Districts have noted that failing to provide medical evidence related to the condition at time of contract formation is persuasive in upholding the presumption of competency.[245] The Southern District[246] has also found that "mere evidence of diagnostic labels without content tying them to capacity to give valid consent" is insufficient basis to void a contract.[247]

Based on the significance of medical evidence, especially at time of contract, those who were not diagnosed with DID or receiving medical treatment could not refute the presumption of capacity under the affective test.[248] As discussed *supra* Part I.B, mental healthcare treatment in the United States is widely inaccessible.[249] In 2017, nearly half of the individuals in the United States suffering from mental illnesses were not receiving treatment.[250] Moreover, mental healthcare access is not equal and widens existing disparities in the population.[251] Beyond inaccessibility, stigma may discourage individuals from seeking treatment and diagnosis.[252] Barriers to mental healthcare

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244. *See* Reid v. IBM Corp., No. 95 Civ. 1755 (MBM), 1997 WL 357969, at *8 (S.D.N.Y. June 26, 1997) (refusing to rule that a party lacked capacity to contract based on the party's own affidavit of his condition, which as diagnosed was only to have a duration of less than 6 months); Livingston v. Bev-Pak, Inc., 112 F. Supp. 2d 242, 248 (N.D.N.Y. 2000) ("Plaintiff's simple assertion that he lacked the capacity to execute the release agreement is insufficient . . . to defeat Defendant's motion for summary judgment."); Rivera v. Sovereign Bank, 976 F. Supp. 2d 270, 274–75 (E.D.N.Y. 2013).

245. *See Reid*, 1997 WL 357969, at *8; *Rivera*, 976 F. Supp. 2d at 270.

246. In a separate matter, a district court judge in the Southern District of New York found that a psychiatric drug's impact on a mental state could be informative to a party's ability to act reasonably. Indelicato v. Provident Life and Acc. Ins. Co., No. 89 Civ. 8436 (RJW), 1990 WL 145149, at *6 (S.D.N.Y. Sept. 28, 1990) (denying motion for summary judgment).

247. *Reid*, 1997 WL 357969, at *8 (quoting Rivera-Flores v. Bristol-Myers Squibb Caribbean, 112 F.3d 9, 13 (1st Cir. 1997)).

248. *Id.* (reasoning that a party's lack of medical evidence of mental functioning at time of contract execution is persuasive in upholding the presumption of competence).

249. *See* NAT'L ALL. ON MENTAL ILLNESS, THE DOCTOR IS OUT: CONTINUING DISPARITIES IN ACCESS TO MENTAL AND PHYSICAL HEALTH CARE 4–6 (2017), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut [https://perma.cc/5TJX-2NYE].

250. *Id.* at 2.

251. *See* JOSHUA BRESLAU ET AL., RAND CORP., AVAILABILITY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES IN NEW YORK CITY 57 (2022), https://www.rand.org/pubs/research_reports/RRA1597-1.html [https://perma.cc/4V34-Y7C3] (click "PDF file" to download) (studying characteristics of people using mental health services in New York City and finding disparities based on insurance coverage and race/ethnicity).

252. Mills & Corrigan, *supra* note 109 ("[P]eople don't want that stigma. So the way they avoid the labels, they don't get care. And research suggests whether it's a pretty

treatment and diagnosis are especially rampant in the DID community, wherein stigma, disbelief, and misdiagnoses surrounding the disorder are commonplace.[253] Until accessibility barriers and concerns are properly addressed in the United States, courts should not use evidence of treatment at a certain period of time as determinative in its competency evaluations, which as of now risk disadvantaging those with DID and extending further disparities to the freedom of contract.[254]

Because objective medical evidence is often inaccessible, and those with DID often hide their symptoms from others,[255] someone with DID may be the best indicator of their own mental capacity. The cases previously cited stand for the proposition that a party's own assessment of their mental capacity cannot alone be the basis for an incompetency finding. In these cases, however, the parties alleging incompetence provided weak evidence in their self-assessments.[256] The case law does not show that, if one with DID could provide stronger self-assessed evidence, this would be enough to refute the presumption of capacity. Relying strictly on the standards in the previously cited cases, a strong argument could be made that this subjective evidence is not enough. However, one with DID could argue that stronger evidence, such as journal entries or notes, is distinguishable from the cases presenting weaker evidence. Although a potentially weak legal argument does not alone justify dismissing a test, courts must recognize the importance of

serious mental illness like schizophrenia or more a benign experience like a reactive disorder, up to 40% of people will not seek out care. Part of the reason is because of stigma.").

253. *See supra* Part I.B.

254. *Cf.* Luth, *supra* note 119 (discussing how misdiagnoses, especially as they disproportionally apply to racial minority groups, inappropriately lead to false holdings of incompetency).

255. *See* HOWELL, *supra* note 239, at 2.

256. In Reid, the party provided "his own affidavit stating that he was depressed, anxious, confused and under psychiatric treatment at the time he signed the release." Reid v. IBM Corp., No. 95 Civ. 1755 (MBM), 1997 WL 357969, at *8 (S.D.N.Y. June 26, 1997); *see also* Livingston v. Bev-Pak, Inc., 112 F. Supp. 2d 242, 248 (N.D.N.Y. 2000) ("Nowhere does Plaintiff state in what way or to what extent he was mentally incapacitated, nor does he offer any proof to show that he was incapacitated at the time that he signed the release agreement."); Rivera v. Sovereign Bank, 976 F. Supp. 2d 270, 273 (E.D.N.Y. 2013) ("[Plaintiff] does not offer any medical evidence supporting her argument as to incapacity at the time she signed the release. Indeed, Plaintiff never explains what about her illness impeded reasonable decision-making." (internal quotations and citations omitted)).

self-assessment with current treatment barriers those with DID face.

Assuming a DID party could overcome the notice and evidentiary requirements, New York courts' application of the test to conditions related to those created by DID is not clear. If a DID system is aware of their disorder and takes appropriate actions, like internal and external reminders and disclosure of their DID diagnosis to the other party, New York courts likely would deem that the DID system acted reasonably in relation to the agreement in their good faith attempts to perform.[257] However, a strong argument could be made that the unpredictability of personality switches and amnesia episodes inherently makes one with DID unable to act reasonably in regard to a contract, especially considering the high value of predictability in contracting contexts.[258]

IV. A Proposal for Updating Competency Evaluations for Individuals with DID

Current standards do not allow sufficient flexibility to account for the wide variety of mental illnesses or different presentations of the same mental disorder. Courts should apply some sort of individualization and use standards which uplift the ability of mentally ill individuals to make decisions, despite suffering with serious symptoms, with the controlling consideration being the ability to manage one's disorder. In the context of DID, courts should base their decision on the individual's knowledge of their disorder. As such, this Part provides a proposal for contract evaluation in different DID-related contexts.

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257. In applying the affective test, a judge in the Southern District found that, because the party alleging incompetency wrote "All Rights Reserved" on the agreement, he was able to act reasonably in relation to the transaction. Although not directly applicable, this case could be used to find that one with DID acted reasonably in writing notes to oneself. Cuffee v. City of New York, 15 Civ. 8916 (PGG), 2019 WL 11779186, at *2, *6 n.6 (S.D.N.Y. Mar. 20, 2019).

258. *See* 159 MP Corp. v. Redbridge Bedford, LLC, 33 N.Y.3d 353, 370 (2019) (Wilson, J., dissenting) ("Freedom of contract is based on the understanding that stability and predictability in contractual affairs is a highly desirable jurisprudential value." (internal quotations omitted)).

A. SHARED RESPONSIBILITY: A DID SYSTEM CONCEPT

System or shared responsibility is a popular principle within the DID community.[259] As discussed *supra* Part I.A.3, intra-system communication can be used to increase smooth functioning and internal management for all alter behavior.[260] The concept of system responsibility can be applied to the contracting context.[261] In managing DID day-to-day, those with DID commonly use several methods to increase independence and standard of living. For example, a system can create an internal behavioral contract,[262] use sticky notes and daily logs, practice internal conversation, avoid triggers, and set expectations for different alters.[263] DID contract parties can use these methods, in addition to managing daily responsibilities, to reduce the risk of breach. Although these methods are not always 100 percent effective and foolproof, they greatly mitigate the risk of lost time and neglected responsibilities in contract performance. In these cases, failure of an alter to perform is akin to a system failure—something that all alters could take responsibility for, even if not all of them were involved in the failure.[264]

While a not self-aware DID system can use many of these methods, this level of inner communication and functioning may be unlikely or impossible if a system does not know the cause of their lost time, amnesia, and dissociation.[265] These barriers to

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259. *See* Crystalie Matelewicz, *Should Alters Share Responsibility in the DID System?*, HEALTHYPLACE (Apr. 20, 2018), https://www.healthyplace.com/blogs/dissociativeliving/2018/04/sharing-responsibility-within-the-did-system [https://perma.cc/9B79-TMRU].

260. *See generally* HYMAN, *supra* note 31 (describing several systems that use inter-system communication and responsibility sharing to function at a high level).

261. *Cf.* Chu et al., *supra* note 63, at 139 ("The patient's accountability for the conduct of all alternate identities—*in the external world*, in therapy, and internally—is usually discussed early in treatment.") (emphasis added).

262. An internal behavioral contract is an informal agreement between alters meant to increase stabilization of behavior. These internal behavioral contracts set behavioral standards, violation consequences, and a length of agreement. Tracy Appleton, *Behavior Contracts in DID Clients*, ONLINECEUCREDIT, https://www.onlineceucredit.com/ceus-online/did-dissociative-identity-disorder/trkDID03.html [https://perma.cc/C34T-YZPF].

263. *See generally* HYMAN, *supra* note 31 for more on internal systems that those with DID use for daily functioning.

264. This concept is similar to what Lelling refers to as "collective responsibility." Lelling, *supra* note 116, at 1557–59 (drawing comparisons between liability assigned to a group of people (such as through a corporation or conspiracy) to the collective responsibility of groups of neurons within an individual (although noting that DID could be an exception to this theory)).

265. *See* Laurel Nowak, *How Dissociative Identity Disorder Affects Daily Life and How You Can Help*, BRIGHTQUEST (Feb. 8, 2019), https://www.brightquest.com/blog/how-

smooth inter-system communication are significant. The lack of knowledge increases unpredictability, as even with reminders, switches between alters could prove detrimental to contractual expectations. Thus, a standard that works for a diagnosed DID system may be inappropriate for a non-self-aware system.[266] This Note proposes that courts treat self-aware and not self-aware DID systems differently.

B. COURSE OF ACTION FOR SELF-AWARE DID SYSTEMS

Because self-aware DID systems should be more efficient at managing symptoms[267] that could prompt legal issues, courts should avoid finding a known DID system to be incompetent or unable to act reasonably in relation to the contract by reason of DID.[268] For systems under treatment, medical documentation would establish that a system is self-aware. For systems not being treated, other evidence that the party was aware of their DID would do the same.[269] A self-aware DID system should not be found incapable by reason of mental illness unless shown to be acting by impulse of a comorbid disorder, such as depression,

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dissociative-identity-disorder-affects-daily-life-and-how-you-can-help/ [https://perma.cc/L8FF-HEFP].

266. *See* Laurel Nowak, *Can a Person with Dissociative Identity Disorder Live a Normal Life? DID Prognosis and Treatment*, BRIGHTQUEST (Oct. 12, 2018) https://www.brightquest.com/blog/can-a-person-with-dissociative-identity-disorder-live-a-normal-life-did-prognosis-and-treatment/ [https://perma.cc/Q4KG-3U54].

267. Chu et al., *supra* note 6363, at 132 ("Helping the identities to be aware of one another as legitimate parts of the self and to negotiate and resolve their conflicts as at the very core of the therapeutic process."); Robboy, *supra* note 73 ("Knowing the relationships between your alters can help you increase internal communication and enable everyone to work together more cooperatively."); *see also How Dissociative Identity Disorder Affects Daily Life and How You Can Help*, *supra* note 265 (stating that ignorance of one's own DID can decrease daily functioning and contrasting that fact with the efficient functioning possible of a knowledgeable, cooperative system).

268. *See* Loewenstein, *supra* note 81, at 238 ("When not overwhelmed by posttraumatic intrusions, DID patients show good reality testing, diminished cognitive distortions, and a hyperdeveloped capacity to observe their own psychological processes.").

269. As mentioned in previous Sections, obtaining a DID diagnosis is an uphill battle for an individual, even if they suspect they have DID. ACCIDENT COMP. CORP., *supra* note 4. For those who are completely unaware of their DID, diagnosis is much harder. However, mindful discovery could show that, even without an official diagnosis, a DID system was aware of their disorder and acting to manage it daily. This could include witness testimony of those who know the party, evidence of external communication or tracking of DID symptoms or alters in notebooks, evidence of online discussion of DID, or post-contract formation medical records.

bipolar, or PTSD. In those cases, the comorbid disorder would be the basis of the incapacity.[270]

This proposal for self-aware systems closely follows the conclusion that Professor Saks reaches in her theory regarding civil liability.[271] In contracting scenarios, Professor Saks states that "any competent alter's decision is valid so long as it is not unconscionable."[272] The main alteration that this Note's proposal makes to Professor Saks' conclusion is that *any* alter's decision signed with the legal name of the individual would be valid in a self-aware system.[273] Although this proposal may allow incompetent and child alters to enter into legal agreements, internal system processes, as well as additional legal safeguards,[274] mitigate this risk greatly.

Under this proposal, courts would be able to avoid the logistical issues of establishing mindset at time of contract or determining which alter to assess. As discussed, it would be very difficult in most cases for a court to reliably determine the personality state in control at time of contract formation. Self-report, if true, is the most probative evidence in these scenarios; however, self-reports are particularly vulnerable to subjective

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270. It should be noted that DID is not the only disorder with its level of complexity, and arguments can be made that some or all mental disorders should be treated in a similar way to this proposal. *See generally* Susanna L. Blumenthal, *The Default Legal Person*, 54 UCLA L. REV. 1135 (2007) (discussing generally the issues throughout history of defining a legally competent individual).

271. *See Three Scholarly Traditions*, *supra* note 13, at 309.

272. *Id.*

273. One factor that can reliably give insight into the alter involved in the transaction and their capacity is the name used while signing a contract. Instead of signing a contract with one's legal name, an alter may mistakenly sign the contract with their own name. If an alter signs a contract with a name other than that of the legal individual, one could make the argument that the alter was not being careful enough in their consideration of the contract to be found competent. In these scenarios, a compulsion caused by DID (i.e., mistaking their name) could be used as evidence of incapacity and voidable contractual duties. However, amnesia of personal information (i.e., legal name) is not directly related to cognitive ability in relation to the contract. Under the current proposal where many with DID would not be found incompetent due to their DID, mistaken name could be evidence of a material error in contract formation. See also A. L. Goodhart, *Mistake as to Identity in the Law of Contract*, 57 L. Q. REV. 228 (1941) for a thorough argument of holding mistake as to identity as a material error in the context of English contract law.

274. The non-DID party's duty of good faith would include to not take advantage of someone with DID or use the existing symptoms to their advantage. *See generally* Market Street Associates Limited Partnership v. Frey, 941 F.2d 588 (7th Cir. 1991) (discussing good and bad faith actions). Thorough discussion into the duties of both parties, including duty of good faith and duty of disclosure, is beyond the scope of this note.

motivations.[275] Here, the only self-report used is determining if an untreated individual knew they had DID. Even if the individual feigns ignorance of their DID, courts would continue the liability inquiry under the second part of this test, as discussed in Part IV.C *supra*. Under this proposal, courts would not have to attempt the convoluted task of determining capacity or presentation of DID at a single point of time in the past.

Although the concern of malingering is greater than realistically warranted,[276] this proposal would discourage DID malingering. Under current case law, some individuals with DID may feign more severe symptoms to avoid liability.[277] This proposal, however, only considers the self-awareness of DID, not the severity of symptoms.[278] If the party has DID, feigning more severe symptoms would not excuse them of contractual duties. If the party does not have DID, claiming to have the disorder would not help them avoid liability.[279] By reducing the incentive to feign DID symptoms, both parties are protected by the knowledge that their agreements will be enforced and not arbitrarily set aside.

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275. Helen M. Farrell, *Dissociative Identity Disorder: Medicolegal Challenges.*, J. AM. ACAD. PSYCHIATRY & L. 402, 404 (2011).

276. Elyn R. Saks, *Multiple Personality Disorder and Criminal Responsibility*, 10 S. CAL. INTERDISC. L. J. 185, 201 (2001) ("But there is no evidence whatsoever (as opposed to bald assertions) that [DID] is easier to malinger than any other disorder.").

277. See Richard J. Loewenstein, *Firebug! Dissociative Identity Disorder? Malingering? Or . . .? An Intensive Case Study of an Arsonist*, 13 PSYCH. INJURY & L. 187 (2020) for a thorough case study of a criminal defendant who met criteria for malingering an exaggeration of DID symptoms.

278. Under this proposal, there will be individuals who are aware of their DID, unsuccessful in its management, and unable to receive treatment. They may be experiencing severe symptoms, despite their self-awareness. These systems would not be able to avoid the presumption under this proposal. However, simple awareness of the reasoning behind the symptoms will allow for some mitigation of risk, either by informing the other party, taking precautions to avoid entering into unwanted agreements, or a lesser effective manifestation of inner communication techniques. Any proposal will need to balance competing risks of inappropriate limitations of rights and inappropriate instances of liability. The present proposal balances these concerns, but until healthcare is fully accessible, there will be subsets of mentally ill groups that are particularly at risk of one of these outcomes.

279. A person could hypothetically not have DID and not claim DID, but feign the symptoms in hopes that they would be diagnosed and protected by the second part of this proposal. However, this malingering would not be an easy feat: ISST's DID Treatment Guidelines specifically warm clinicians of this possibility. Chu et al., *supra* note 63, at 129–30 ("Clinicians should be alert to this [malingering] concern, especially in situations where there is strong motivation to simulate an illness (e.g., pending legal charges, civil litigation, and/or disability or compensation determinations). Research studies have shown that . . . diagnostic inventories can be useful in differentiating feigned DID from bona fide DID patients.").

Public policy demands that those with DID who are aware of their disorder mitigate related risks and exercise their freedom of contract. In the piece *Duress by Economic Pressure*, Professor John Dalzell states that "[w]e have been proud of our 'freedom of contract,' confident that the maximum of social progress will result from encouragement of each man's initiative and ambition by giving him the right to use his economic powers to the full."[280] Limiting the freedom of contract within a population of people able to account for their own risks is unnecessary. Instead, contract law should encourage individuals with mental illness to show responsibility in their dealings with others whenever possible.[281] By limiting the current mental incompetency doctrine to exclude self-aware DID systems, courts would effectively push back against stigma facing the DID community by recognizing their ability to act reasonably and refusing to make simple and narrow assessments for an all-encompassing, complex disorder.

C. COURSE OF ACTION FOR NOT SELF-AWARE DID SYSTEMS

DID systems who are unaware of their disorder will likely struggle[282] to mitigate the risk of unpredictability and breach.[283] As discussed by BrightQuest, a treatment center for complex psychiatric disorders, "[i]f the individual isn't even aware that they are living with [DID], it can be extremely destabilizing to endure a rollercoaster of personalities and thoughts and behaviors. The unpredictable patterns and inability to cope can severely upset . . . basic life responsibilities."[284] Because awareness of one's DID is an important factor in effective

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280. John Dalzell, *Duress by Economic Pressure I*, 20 N.C. L. REV. 237, 237 (1942).

281. *See id.*

282. Although this part of the proposal focuses on the fact that aware systems are more likely to effectively manage their systems, that is not to say that unaware systems are unable to manage their symptoms and live normal lives. This proposal simply notes that symptom management is likely to *improve* with treatment and awareness. *See Research Network on Mental Health & the Law*, MACARTHUR FOUND., https://www.macfound.org/networks/research-network-on-mental-health-the-law [https://perma.cc/Z3LP-G3RJ] ("[M]ental illness alone — even serious mental illness — does not necessarily impair a person's ability to make treatment decisions; most impairments . . . improve with treatment.").

283. *See generally How Dissociative Identity Disorder Affects Daily Life and How You Can Help*, *supra* note 264; *see also* Brand et al., *supra* note 3, at 262 (finding that inappropriate treatment for DID, for instance due to misdiagnosis, can exacerbate DID symptoms).

284. *How Dissociative Identity Disorder Affects Daily Life and How You Can Help*, *supra* note 265.

symptom management,[285] the higher unpredictability in unaware systems[286] will potentially negatively impact the other party, who likely entered into the contract for assurance of predictable performance.[287] For these reasons, under this proposal one who is not self-aware of their DID should not be treated in the same deferential way as those self-aware of their disorder.

In cases of unaware DID, a holistic, fact-intensive look at the totality of the circumstances is most appropriate. In these cases, courts may have to take a closer look at mental functioning. This inquiry could consider factors such as if the other party had reason to suspect incompetency; any reliable data of the mindset at contract formation;[288] if the DID party was mitigating risk to the best of their ability; who is alleging the incompetency; who, if anyone, would benefit from avoidance; and if performance is still possible.[289] Determining which alter was in control[290] during

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285. *See generally* Hilary I. Lebow, *Treating Dissociative Identity Disorder (DID)*, PSYCHCENTRAL (May 28, 2021), https://psychcentral.com/disorders/dissociative-identity-disorder/treatment#treatments [https://perma.cc/2GTM-6TRG] (medically reviewed by Jeffrey Ditzell, DO).

286. *See* JAHANGIR MOINI ET AL., GLOBAL EMERGENCY OF MENTAL DISORDERS 171–83 (2021).

287. *See* 159 MP Corp. v. Redbridge Bedford, LLC, 33 N.Y.3d 353, 370 (2019) (Wilson, J., dissenting) ("Freedom of contract is based on the understanding that stability and predictability in contractual affairs is a highly desirable jurisprudential value." (internal quotations omitted)).

288. This would include evidence of amnesia episodes.

289. A totality of the circumstances review will likely involve analysis of some of the factors that this Note previously rejected. However, the strict nature of review is a significant problem in the current standards. By using a broad standard, courts would be able to use whichever methods can be applicable to DID parties and have the flexibility to mindfully determine which considerations would be harmful to apply. *See supra* Part III.B.

290. Scholars have argued that it is inappropriate to regard different alters as different people. Stephen S. Marmer, *A Theory of Command and Control: A Reply to Elyn Saks*, 10 S. CAL. INTERDISC. L. J. 276, 272 (2001). Under this perspective, issues of consent or accountability would be mute: one alter's consent would apply to the system as a whole and all alters would be held accountable for the actions of another. Applied to the context of competency evaluations, this theory would imply that one alter's inability to comprehend would not be distinguished from the rest; any inability to understand would be attributed to the system as a whole. Fields, *supra* note 132, at 287–89. However, as discussed, research has shown the autonomy between different alters. *See infra* Part I.A.2. In order to evaluate mental illness at the level as has been proven, this involves treating each alter as unique in their abilities, memories, and understanding. But even accepting the premise that alters are non-unique parts of a single personality, the law already distinguishes between non-DID dissociated states and dissociated states. Saks, *supra* note 276 at 193 (giving examples such as "sleepwalking, acts performed under hypnosis and posthypnotic suggestion, and acts performed in certain epileptic states"). Thus, as Saks writes, "dissociation is different, and people with the extreme dividedness

contract formation, especially in cases where the individual is unaware of who the alters are, and their respective abilities and related implications is likely to be a very difficult process. As a result, this proposal does not endorse that courts use the alter in control at time of contracting as a determining factor in competency evaluation.[291]

This approach would reduce instances of malingering and moral hazard. By disallowing known cases of DID as a basis of incompetency in contracts, this risk is necessarily lower. Claiming incapacity due to DID as an excuse, valid or not, can only be a basis for alleging voidable duties one time. Once someone is shown to have DID, the courts will apply higher standards of accountability, expecting them to work to manage their DID in future decisions. In addition, individuals without DID will be less likely to feign the disorder to avoid contract performance or liabilities because, even if the false diagnosis is accepted, a diagnosis on its own will not be enough within the totality of the circumstances to avoid liability or performance.

CONCLUSION

As law professor Susanna L. Blumenthal wrote in *The Default Legal Person*, "[s]o long as judges articulated legal standards of competence in Enlightenment terms—conditional legal competence upon the capacity to reason—there was some basis for questioning the sanity and freedom of those who deviated from conventional standards of rationality and morality."[292] American courts have tried and struggled throughout their existence to determine an objective standard by which to evaluate competency under the law.[293] Perhaps mental illness is too

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found in most dissociation—such as [those with DID]—should be found nonresponsible," or as is proposed in this Part, held to an individualized evaluation. *Id.* at 194.

291. The reason this proposal does not endorse such is not because those with DID should be regarded as a single identity or that the alters are invalid. In a theoretical situation where past alters' actions and mindsets could be identified in a dependable and consistent way, this would be the ideal and most accurate method. However, in practice, this is not the case. This proposal's endorsement of a fact-intensive, totality of the circumstances review is in recognition and respect of the complex nature of DID systems and the significant variety between alters.

292. Blumenthal, *supra* note 270, at 1179.

293. *See generally id.*; *see also* OLIVER WENDELL HOLMES, JR., THE COMMON LAW 109 (Boston, Little, Brown & Co. 2d ed. 1909) (1881) ("But if insanity of a pronounced type exists, manifestly incapacitating the sufferer from complying with the rule which he has broken, good sense would require it to be admitted as an excuse.").

complex, and surely too poorly understood at present, for a general, objective rule. Until the day comes where one can hope for a more consistent and fair way to judge mental competency in mentally ill populations, courts must remain open-minded and adaptable to account for a wide range of illnesses and their unique manifestations.