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Why Are They Boxing Us in Like This?

Edmund G. Howe

Edmund G. Howe, MD, PhD, is a Professor of Psychiatry and the Director of Programs in Medical Ethics at the Uniformed Services University of the Health Sciences in Bethesda, Maryland; and is Editor in Chief of *The Journal of Clinical Ethics*. © 2005 by *The Journal of Clinical Ethics*. All rights reserved.

In this issue of *The Journal of Clinical Ethics*, in "Emancipation, Capacity, and the Difference Between Law and Ethics," Evan G. DeRenzo, Phillip Panzarella, Steve Selinger, and Jack Schwartz discuss the hospital course of TE, a 16-year-old girl who was pregnant with a 29-week-old fetus. TE had a 103° temperature, due to a kidney infection, and wanted to walk out of the hospital against medical advice (AMA). The hospital risk manager and the hospital attorney indicated to TE's careproviders that they should allow TE to leave. The core dilemma her careproviders faced was whether to let TE walk out of the hospital, knowing that, if she did, she and her fetus might well die. Since TE appeared to be lucid, the grounds on which they could keep and treat her against her will were unclear. As the authors point out, "TE's talk of leaving based on room size and the need for a bath" could reasonably be seen as not "manifesting decisional impairment."

TE's careproviders wondered what could—and should—be done in this situation. This same question applies any time that patients clearly act against their own best interests, but appear to be rational. The answer may determine whether a patient lives or dies. In the present case, TE's careproviders found bases on which they could treat her, but the authors acknowledge that it is "open to debate" whether careproviders are ethically required to protect such patients from harming themselves. They believe that TE was suffering from a dissociative disorder, and that, while this is what a "highly skilled psychiatrist would most probably have determined," a psychiatric evaluation by a psychiatrist not as skilled could "perhaps have made matters worse."

This speculation, if true, is highly troubling. In such situations, patients may die. Given this, what should careproviders do when a patient isn't incompetent in a way that is clear to everyone, but is making a decision that is wholly against her or his best interests and is in a dissociative state? Should careproviders let such decisions ride on the skill of a psychiatrist? What careproviders should do in this kind of circumstance is the focus of this essay. These interventions are "cutting-edge" treatments used by psychiatrists to best reach patients—I will describe them here as they can be used by ethics consultants.¹

UNDERSTANDING PATIENTS LIKE TE

The first step in trying to help patients like TE is to try to understand them. TE had seven factors that may have affected her judgment. She was 16; she was pregnant; she was in the intensive care unit; she had recurrent high fevers; she had pain; she wasn't speaking to her baby's father; and, although she spoke to her mother, she was verbally abusive when she did.

All of these factors may have affected TE so that her intentions vacillated; sometimes she wanted to stay and be treated; sometimes she wanted to leave. This vacillation was not between two choices that made

sense; rather, to choose to leave the hospital could not have benefited either TE or her baby. The difference between vacillating between two reasonable choices and vacillating between one that is reasonable and one that is not is critical. This difference probably reflects totally different psychological causes. That is, when patients vacillate between two choices that make sense, it is "normal ambivalence." When one of the choices makes no sense, however, it suggests that some part of the patients' mind, outside their control, has temporarily, as it were, "taken over."²

This may sound bizarre, but this kind of behavior has been well acknowledged for some time in several other contexts. In the research context, it is known as state-dependent learning. Animals may, for example, learn how to run through a maze when they have a specific drug in their system, but forget how to run the maze until they are given the same drug again. The drug causes a different part of their brain, presumably, to take over. Humans, analogously, may have more access to buried memories when they are given sodium amytal intravenously. (This is the drug commonly known as "truth serum.") Careproviders sometimes interview patients using this drug to elicit such memories. Under the influence of the drug, another part of patients' brain seems to take over. One example with which we are most familiar is alcohol. When intoxicated, persons can behave as though they are "someone else." This can happen also without drugs; it is known as a dissociated state. It can occur also when persons aren't using alcohol or drugs. The best-known example is patients who have what used to be called a multiple personality.³

A dissociated state in which another part of a patient's brain takes over may be what TE and patients like her experience if and when they make a choice that can't benefit them at all, in any understandable way. This is what DeRenzo and colleagues thought was the case. One part of a patient's mind, the "normal" self, may say, for instance, "I want what I need. I want to be treated and live." Minutes later, however, another part may "take over" and then the patient will say, "I don't care. It is fine with me, even if I die. In fact, I'll try to make this happen!" This other part is most likely to take over when a patient is provoked. This may have been what happened with TE. When she was asked if she cared about her pregnancy, we are told, she said she wanted to have a healthy baby, but "moments later she would act again as though she would leave." TE, or, as it were, another part of TE that could take over, may have experienced the question about her wanting to have a healthy baby as insulting. In response to this anger, this part may have emerged, taken over, and wanted to leave the hospital AMA.

Dissociation occurs in its fullest extent when patients have a multiple personality. This disorder often occurs in persons who have been badly abused during their childhood. It is believed that a "part of them" experienced overwhelming fear and anger, but, if they expressed that openly, they would have been beaten more. Thus, their brain may have cut these fearful and angry parts "off," or dissociated them, so that those feelings were no longer part of their conscious awareness. Thus, even just moments after having been badly beaten, they would have been able to "be," and thus wholly appear, smiling and loving. If they were smiling and loving, it would have reduced the likelihood that they would have undergone further beatings.

Later on in their lives, however, these "cut off" parts of patients emerge. The angry part may come out, for example, in response to being exceptionally provoked. This is what I have suggested just above, for instance, using the example of TE. It is probably very difficult to imagine that one part of a person could say, "It is fine if I die." This is, however, often the case when patients have a multiple personality. They may have made several past suicide attempts that remain wholly unexplained. In these cases, as far as these patients or anyone else can tell, they were "happy" one minute but tried to kill themselves in the next. The most plausible explanation for this, especially if this is a repeated pattern, is that these persons have dissociated one part that wants to kill them, and that this part repeatedly takes over.

I remember interviewing such a person, who had no memory of having driven his motorcycle into a tree. He had life-threatening injuries at that time, but had survived. He had also survived similar life-threatening injuries many times before. When I first talked with him, he seemed "happy," and was very warm to me. He had no memory of his motorcycle accident. The last thing he remembered was riding his motorcycle, feeling "good." I must have said something to provoke him, for his demeanor abruptly changed. He was not happy, but angry, and could remember exactly what had happened. He had driven his motorcycle into the tree

intentionally, he said. "Why?" I asked. "Because I wanted to kill the person to whom you have just spoken," he said. "But if you had, you wouldn't now be alive," I said. "Yes I would," he responded; "I didn't need his body to live before I came into existence. I don't need it now." There is only one word that best describes how his saying this affected me—it was "chilling." The individual speaking to me seemed to be another part of the "warm" person with whom I had been speaking just before the part that wanted to kill himself "took over."

This kind of "taking over" need not be complete. A renowned expert on dissociative states, John Watkins, states, "We believe that dissociation exists on a continuum. [Individuals] are a family of selves."⁴ If Watkins is right that dissociation can occur to only a limited degree, this may be of utmost importance in understanding patients like TE. What this may mean is that she totally lacked control over some part of her that could take over and act against her interests, such as wanting to leave the hospital AMA. If so, the only way TE, and others like her, pregnant or not, may not die is if her careproviders do something to prevent it.

But, before we ask *how* careproviders can best do this, we might well ask, Is this all only theory? It was first speculated that dissociation like this occurred more than a century ago. William James, in the nineteenth century, noted that some persons showed behavior that suggested that another part of the brain had taken over. When this occurred, he called it an "ideo-motor act." He distinguished this behavior from a "genuinely willed act."⁵ A decade or so ago, due to new electroencephalogram (EEG) and brain-imaging techniques, researchers became able to better understand what happens in the brain when this behavior occurs. As a result of these studies, they came to believe that persons have "subsystems of control" that can be "automatically activated."⁶ The mind's apparent unity, they think, as a result of these studies, is, at least in part, an illusion. They theorize further how, physiologically, dissociation occurs. They believe that when an emotion such as TE's agitation reaches a certain threshold of intensity, another part of the brain is, as it were, "unleashed."⁷ They believe that when this automatic activation of a subsystem occurs, a "higher level control system" is no longer needed.⁸ What this suggests is that when persons can make choices wholly against their interests (as TE did), that, at these times, they can't meaningfully reflect. This would explain why TE was willing to leave the hospital and why the patient I saw years ago was willing to ride his motorcycle into a tree.

A more recent study reports that a part of the brain can take over a function and another part of the brain, which normally is wholly in control, can shut off. For the first time, this study used persons as experimental "controls."⁹ How can careproviders who are treating patients like TE, who may be experiencing a dissociative state, best proceed?

TREATING PATIENTS LIKE TE

The clinical implications of this for ethics consultants and other careproviders who treat patients like TE are obviously far-reaching. If this is true, then, although the patients may "literally" understand their options when they choose to do something that won't benefit them at all, in a deeper sense, they may not. Rather, they may be like the person I interviewed who rode his motorcycle into trees. He knew at these times, *literally*, that he could kill himself. Yet, in a deeper sense, he didn't care. This was not because he was suicidal and no longer wanted to live. This was because he—or this part of him—when it took over, didn't really know what it meant to die. He didn't know this because, at these times, a part of his brain was cut off or disembodied, as it were, from other parts. Lacking access to these other parts, he, or this part, couldn't understand what dying really means. "I will live on," this part said. "I don't need a body to live." The single most important implication for careproviders is, as I have said, that patients may not be able, by themselves, to gain full awareness when they most need it. Thus, careproviders must help them, if possible. But how?

RECOGNIZING WHAT MAY BE OCCURRING

The first step is to imagine that this may be the case. Patients may feel genuine ambivalence. If they do, they may vacillate. The distinguishing feature between these non-dissociated patients and patients like TE is

as described: non-dissociated patients' choices all make *some* sense. The initial task is simply to imagine the possibility that dissociation is occurring when patients are vacillating.¹⁰ The second task is to assess whether all of the choices have understandable goals.

Obviously, there are cases in which these two possibilities can't be distinguished. I think, for example, of a patient who had AIDS, whom I asked about advance directives. "I want to be allowed to die with utmost dignity," he first said; "Don't keep me alive after I'm no longer aware, with tubes and the like." I came back a few hours later to be sure I understood exactly what he wanted. He then said, "I want to live on as long as possible. It doesn't matter to me what they do or what condition I'm in. I just want to live as long as I can." In cases such as this, it might still be best for careproviders to respond in the ways that will be described. If, to any degree, patients' reasons for vacillating are at all the same as for patients who severely dissociate, such as those with multiple personalities, the approaches I will suggest next may be more likely to "succeed."

NOT ELICITING THE "NEGATIVE PART" OF PATIENTS

Careproviders must at all cost try to not elicit the "negative part" of these patients. They might try to anticipate, for example, how, with a patient like TE, the question, "Do you want to have a healthy child?" could be offensive. How can they best do this? Donald Saposnek states that careproviders must have an "attitudinal stance [that] includes deep mutual respect for the basic goodness of all people and for their differences. . . ."¹¹ This recommendation applies to all patients. It is also critically important that careproviders not only watch what they *do*, but also watch what they *feel and think*. Saposnek goes on to describe the all-important "bottom line" of his approach, which is, indeed, the major purpose of this essay. He asserts that unless careproviders respond in the ways he suggests, "traditional therapists" will label these patients wrongly as "untreatable."¹² I will report here on Saposnek's best and most representative approach, which he refers to as a "one-down approach."¹³ Careproviders who use this approach take specific initiatives to try to ensure that patients don't conclude that careproviders think they are superior. He states, for example, "The therapist anticipates resistance . . . and pre-empts it." A careprovider might say, for example, "You are probably going to think I'm stupid, but. . . ."¹⁴ Likewise, if and when these patients' "negative parts" seem to assert themselves, a careprovider should repeatedly "redo" this.¹⁵ In Saposnek's words, a careprovider may have to "periodically apologize for his incompetence, inadequacies, and denseness."¹⁶ The rationale for this approach, he explains, can be conceptualized as analogous to that of the physical practice of a Japanese meditative martial art called Aikido: "Paradoxically, his power is born out of a no-power stance. . . ."¹⁷

FORMING A STRONG EMOTIONAL BOND

Careproviders must, if possible, form a strong emotional bond with patients. This can give the patients' "normal selves" enough support to enable them to remain in more control, perhaps in enough control to be able to choose what is best for themselves. How can careproviders do this? Leston Havens describes how to do this, in general: careproviders must convey, he says, that "I am on your side, we look out together, our search for trouble is more in the world out there than in you as a solitary being."¹⁸ The key here is to enable a patient to no longer feel so alone. It is as if a careprovider sits next to a patient and says, "Why are they boxing us in like this?"

To respond most effectively to a patient's negative responses, whether these responses come from the patient, or, as it were, some "negative part" of the patient, careproviders first must explore *why* a patient like TE responds negatively. Only if careproviders know this can they validate the patient's basis for doing what he or she does. Richard Kluft is a psychiatrist who has had, perhaps, more experience and success in treating patients with multiple personality as anyone.¹⁹ This illness, also called dissociative identity disorder (DID), is the most severe of the dissociative disorders. Kluft stresses the importance of respecting the negative parts of these patients by addressing them directly. He states, "To date, I have not been able to find a literature describing the successful definitive treatment of DID without addressing the alters. Therefore, the clinician who undertakes to treat DID without addressing the alters is following a path likely to prove therapeutically futile and to expose the patient to danger and excess morbidity."²⁰

His explanation of the rationale for addressing these "alters" is applicable to all patients who experience any dissociation, in any context, to any degree. Kluft says, "The alters are a curious phenomena. They express the structure, conflicts, deficits, and coping strategies of the DID patient's mind. . . . Bypassing or disregarding the alters creates a therapy in which major areas of the patient's mental life and autobiographic memory *will be denied an empathic hearing.*"²¹ As an example of how ethics consultants and other careproviders who lack Kluft's expertise can do this involves TE. We are told that she became verbally abusive with her mother. She did this for a reason. Careproviders should find the reason for such abusive behaviors; for example, if asked, TE might have said, "My mother didn't appreciate that they are telling me what to do."

After learning the reason, careproviders must take the initiative to support this part of the patient. If this isn't done, the patient may infer from the silence in response to the patient's disclosure that the careprovider is negatively judging him or her. What should a careprovider say then? "I can't stand it when someone tells *me* what to do," TE's careprovider might have said to support her. Validating some aspect of the response of the negative part of the patient may decrease the source of anger that fuels the "negative part." Consequently, the "healthy" or at least healthier part of the patient may be better able to stay "in control," and, thus, be better able also to make choices, in this "emergency context," that *do* serve the patient's best interests.

As Kluft states, in regard to patients with DID, "[Strengthening] the patient as a whole and across alters . . . to preserve and enhance the patient's current level of functioning . . . often [may] allow the DID patient *to feel for the first time that he or she can be effective rather than powerless* in the face of the DID psychopathology and life events."²² Careproviders who try to help these patients can't, however, do it only "half-way." They must be willing to acknowledge *every* way in which *any* person whom the patient experiences as having offended her or him could, indeed, have acted in a way that was "wrong." (Objectively, these other persons may have been "wrong" relative to how they might have acted if they had acted in a way that was ideal.)

How might a careprovider do this? She or he might say, "*I would have also wanted my mother to understand this. I would feel angry, too; if she didn't!*" To do this effectively, a careprovider must be willing to openly acknowledge the real, or at least relatively real, shortcomings of any other person, including family members, other careproviders, and even him- or herself. This is what makes this specific intervention unusual and maybe even radical. If a careprovider doesn't do this fully, but tries to "protect" anyone, to any extent, a patient is likely to perceive it. It may be perceived as the careprovider's willingness to implicitly deceive the patient, and the patient is likely then to not only lose trust; this may further the anger that is felt. The negative part of the patient may then be more likely to emerge, and the patient may then suffer more.

It may be feared that providing any support to a patient's negative responses may reinforce them. For example, it may be feared that supporting TE's rationales for wanting to leave the hospital AMA may make it more likely that she would do so, and then die. In one sense, this suggested approach does distort the truth. That is, persons never can act always in ways that are ideal. But patients, at some level, probably already know this. TE wanted to leave, she said, in part because her room was too small. Suppose her careproviders said, "Of course you don't want to stay in a room that feels too small! Some people, you know, have claustrophobia. The panic they feel may be as painful a feeling as there is!" Careproviders who respond in this way, rather than evoking anger, express empathy. In response to this empathy, a negative part of the TE that might "want" to leave the hospital would be *less* likely to emerge.

IF THE "NEGATIVE PART" PREVAILS

Careproviders may have no choice if they want to help patients like TE to pursue what is in their best interests. Careproviders may have to fully ally themselves with not only the patients' "normal part" that wants to live, but with other parts that are self-destructive. The question that remains is what careproviders should do if this approach fails. TE's situation is exceptional, as she was pregnant. DeRenzo and colleagues note, "at a minimum, some moral consideration is owed to the fetus."

This provides an excellent way to introduce the problem considered next. That is, in TE's case, if careproviders believe that TE's fetus is owed some moral consideration, and they tell TE this early on, it could only be expected to have a negative effect. TE might well say to herself, "I'm important too, but obviously you don't think so, so I will leave the hospital now, whereas otherwise I would not have!" Should careproviders risk having TE respond in this way? Or should they only tell TE they believe her fetus is owed consideration should she definitely decide she will leave the hospital? Should careproviders be totally honest at the beginning about how fully they may later oppose a patient, or should they validate the underlying rationales of a patient's self-destructive desires in an implicitly supportive way, in the hope that this will move the patient to do what is best?

If careproviders take the second approach, they will have to decide later whether to change perspectives and wholly oppose the patient. In the case of the motorcyclist, for example, this may have meant forcefully incarcerating him once he indicated that he had planned to run his motorcycle into a tree. Careproviders might indicate earlier, as they support patients' underlying rationales, that unless the patient makes choices that seem clearly in the patient's best interests, *other* careproviders may oppose the patient, to the degree that they can. TE's careproviders could have told her, for instance, that other careproviders might do all they could to oppose her leaving the hospital AMA. This may be enough, in some cases, to shock the "part of the patient" that is refusing treatment into accepting it. That is, the patient may, like an emotionally healthier patient might, see the soundness in what other careproviders say, and comply.

This, however, begs the issue. If patients don't comply, should their careproviders, who have supported even their negative parts, now seemingly betray them? I would answer—as DeRenzo and colleagues do—unequivocally, "Yes." Since DeRenzo and colleagues give most of the strongest arguments for this already, I will mention only a few more that support them, and I will suggest *how* this should be done.

The major argument for betraying a patient at this point is that is the only way that careproviders really can respect who a patient *is*—as DeRenzo and colleagues note. Patients like TE are, like all of us, subject to dissociative states. These states can "take over" any of us. This can occur when patients have severe illnesses such as schizophrenia.²³ It can occur when patients are depressed. Psychiatrist Peter Kramer writes, "This aspect of depression is one of its most painful: alienation from feelings that accord with one's values. . . ."²⁴ He illustrates this most poignantly by speaking about a patient who "wanted to know why, in our discussions, I had granted an imposter—the depression—such standing."²⁵ Kramer continues, "I had been negotiating with an occupying government, while the legitimate ruler was in exile."²⁶

Such a state may occur when patients have problems of substance abuse. One patient saw that he had a problem only after he attended Alcoholics Anonymous (AA) for other reasons (such as to find companions) *after seven years*. A dissociated self had been taking over and rejecting this reality whenever, I would suggest, this reality began to become clear and became too threatening. This dissociation occurs whenever we, in our daily life, do something that harms ourselves or others when we know, without question, we should not, and don't want to. Perhaps we have all heard from a loved one (or said ourselves): "You did this [unthoughtful act]" and then, added, wholly unnecessarily and indeed spitefully, "*again*." Dissociation occurs even in patients who have severe dementia.²⁷

When patients make choices that may greatly harm themselves, like TE's harm to herself and her fetus, which might have brought about both of their deaths, careproviders should act. They should not, as the risk manager and hospital attorney advised, let patients go after explaining the risks. They should go to court when and if necessary. If they must go to court, they should bring to the court's attention the kind of information discussed here. Judges and juries may find such patients incompetent to refuse treatment, in large part because their refusal so strongly opposes their best interests. Judges actually have much greater discretion in interpreting what they and juries may do under the law than most persons appreciate. Thomas Gutheil and Paul Appelbaum state in their authoritative text, *Clinical Handbook of Psychiatry and the Law*, now in its third edition, for instance, "It seems apparent, from a review of the law, that the tendency has been to give the judiciary maximal flexibility in determining that an individual is incompetent. . . ."²⁸ They go on, "Each court tends to try to devise standards *de novo*, without relying on precedents from other courts."²⁹ They state,

finally, "Regardless of the formal standards in place in any jurisdiction, it is likely that a sliding scale approach, with regard at least to cut-offs, is being used in practice in health care settings, and probably in courts, as well."³⁰ The sliding scale to which they refer allows judges to vary the requirements for determining legal competency, such that the more that patients make choices that are against their own best interests, the grounds for finding them incompetent become less.

Ethically, careproviders could tell a patient that they have changed their mind and will "go against the patient" because the patient's situation has changed. For example, the situation is changed when a patient who merely *considered* leaving the hospital AMA now *decides* to leave. But the most solid reason does not involve ethical reasoning; it is based, instead, on a presupposition of what it means to be *most human*. And this is something that careproviders should share with patients.

This is a view that comes from both Martin Buber and Emmanuel Levinas. Buber argues for what he calls inclusion: "Inclusion is . . . that one person . . . lives . . . from the standpoint of the other."³¹ Levinas speaks to the moral obligation that persons have, or should have, when they live from this standpoint, especially when this is triggered by confronting another person face-to-face. Levinas says, "Here we are . . . taking a few steps outside Buber."³² And he continues, "Ethics begins . . . as I like to put it, before the face of the other, which engages my responsibility by its human expression."³³ He goes on, "Face to face, [we experience] the defenseless nakedness, [the] misery [and the] loneliness of the face. . . . [We thus have] the categorical imperative of assuming responsibility for that misery."³⁴

I think Levinas is, in one aspect, wrong. Face-to-face interaction is not necessary to trigger this most human, universal responsibility. It is rather, as Buber says, that inclusion is living from the standpoint of the other "even when they are separated in space."³⁵ This truth of Buber's claim came to my attention recently when I spoke in a trial in which the defendant could have been sentenced to death. (His case is now being appealed.) He sat behind me, not face-to-face. The court carried on its proceedings as if the defendant wasn't there, but he *was* there, and I was acutely aware of him and of his presence, every minute. I felt for his pain. He had committed a heinous crime, but had committed it, I feared, while he had been experiencing a dissociated state. The law often rejects a dissociated state as a defense for a criminal offense. This may be for good reason. As Buber notes, if this were not the case, it would be "likely to exonerate every person found guilty of violating the law, for every violation is occasioned by some condition . . . that paralyzes otherwise restraining tendencies. The rapist is overcome by lust; the murderer by hatred."³⁶

CONCLUSION

Patients like TE may be tried in court for committing a crime. Thus, as DeRenzo and her colleagues state, when these persons are *patients*, we should respond to them as they *really* are when they become unequivocally self-destructive, due to what looks to be a dissociated state. As Levinas (and I) believe Buber would add, we have a categorical imperative not to do otherwise.

Careproviders should explain that they respond in this way because they care too much to allow the patient to be self-destructive. Judges or juries may find a patient like TE incompetent to refuse treatment. If this proves not to be the case, the patient may have one more hope: that the "betrayal" by his or her careprovider, who has gone to court to get the patient treatment, may "get through" to the patient, as it conveys how much the careprovider truly cares. The careprovider's prior support conveys this care. When a careprovider responds to a patient as an "equal," is wholly honest regarding his or her own flaws and the flaws of others, and recognizes and supports the patient's sound (even if self-destructive) rationales, this expresses how the careprovider is committed to the patient's interests. Even when these approaches are not enough to make a patient "competent," in and of themselves, they may set the groundwork so that a subsequent "betrayal" may help the patient. At that time, the patient may be better able to see such a betrayal is, as Gutheil and Appelbaum suggest, a sincere expression of concern by a friend.

NOTES

1. For discerning and teaching such cutting-edge approaches, I am particularly indebted to Leston Havens, David Mee-Lee, and Marsha Linehan, among many others.
2. E.Z. Woody and K.S. Bowers, "A Frontal Assault on Dissociated Control," in *Dissociation*, ed. S.J. Lynn and J.W. Rhue (New York: Guilford, 1994), 52-79.
3. For an autobiographical account by a patient who experienced multiple personality, see C.Z. Sizemore, *Mind of My Own: The Woman Who Was Known as "Eve" Tells the Story of Her Triumph over Multiple Personality Disorder* (New York: William Morrow, 1989).
4. John Watkins, from a transcript of "The Splitting of the Mind," a series on the radio show *Ideas*, 22 April-6 May 1985, Canadian Broadcasting Corporation, quoted in *Mind of My Own*, *ibid.*, 289.
5. See note 2 above, p. 60.
6. *Ibid.*, 58.
7. *Ibid.*, 59.
8. *Ibid.*, 61.
9. E.L. Glisky et al., "A Case of Psychogenic Fugue: I Understand, Aber Ich Verstehe Nichts," *Neuropsychologia* 42 (2004): 1132-47.
10. "... [O]ne method of tracking when the bad me and not me are emerging into the patient's awareness is to look for periods of an escalation in typical interpersonal style." T.F. Van Denburg and D.J. Kiesler, "An Interpersonal Communication Perspective on Resistance in Psychotherapy," *Journal of Clinical Psychology* 58, no. 2 (February 2002): 195-205, 200.
11. D.T. Saposnek, "Aikido: A Model for Brief Strategic Therapy," *Family Process* 19, no. 3 (September 1980): 227-238, 232.
12. *Ibid.*, 233.
13. *Ibid.*, 231.
14. *Ibid.*, 232.
15. "... [W]hen resistance is encountered, its appearance takes interventive priority." See note 10 above, p. 203.
16. See note 11 above, p. 231.
17. *Ibid.*, 231.
18. L. Havens, *A Safe Place* (New York: Ballantine Books, 1989), 59.
19. See R. Kluff, "An Overview of the Psychotherapy of Dissociative Identity Disorder," *American Journal of Psychotherapy* 53, no. 3 (Summer 1999): 289-319.
20. *Ibid.*, 299-30.
21. *Ibid.*, 300; emphasis added.
22. *Ibid.*, 291; emphasis added.
23. F. Fromm-Reichmann, "Basic Problems in the Psychotherapy of Schizophrenia," *Psychiatry* 21, no. 1 (February 1958): 1-6.
24. P. Kramer, *Against Depression* (New York: Viking, 2005), 23.
25. *Ibid.*, 24.
26. *Ibid.*, 25.
27. A. Lewis, "Hysterical Dissociation in Dementia Paralytica," *Monatsschrift für Psychiatrie und Neurologie* 125, no. 5-6 (May-June 1953): 589-604.
28. T.G. Gutheil and P.S. Appelbaum, *Clinical Handbook of Psychiatry and the Law*, 3rd ed. (Philadelphia, Pa.: Lippincott, Williams and Wilkins, 2000), 221.
29. *Ibid.*, 222.
30. *Ibid.*, 224.
31. M. Buber, *Between Man and Man*, trans. R. Gregor-Smith (New York: Routledge, 2002), 115

32. E. Levinas, *Outside the Subject*, trans. M.B. Smith (Stanford, Calif.; Stanford University Press, 1993), 34.

33. *Ibid.*, 35.

34. *Ibid.*, 158.

35. See note 31 above, p. 115.

36. D.N. Robinson, *Psychology and Law* (New York: Oxford University Press, 1980), 56.