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Three Keys to Treating Inmates and their Application in Ethics Consultation

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In this issue of *The Journal of Clinical Ethics*, several authors discuss ethical problems relating to the treatment of inmates. One of the authors, Bernice S. Elger, emphasizes in "Medical Ethics in Correctional Healthcare: An International Comparison of Guidelines," that the treatment that inmates receive may depend largely on the resources society is willing to provide.

Beyond the question of resources, however, the all-important clinical question is, *how* can careproviders best help patients who are inmates? The answer is that, to a large degree, we don't know.[1] Given this, even when resources are available, careproviders may not know how to help.

In this introduction, therefore, we will discuss what are likely to be the three optimal approaches to help inmate-patients:

- Become as non-judgmental as possible,
- Become patients' allies to the greatest extent possible, and
- Treatment of inmate-patients should start wherever they happen to be "at."

While these approaches may sound standard, we propose them to stretch prison careproviders' usual boundaries. The approaches may pose ethical quandaries, but may be the only way careproviders can assist inmate-patients who otherwise might remain wholly "recalcitrant." This is because, as the cliché says, inmates may change only if they want to. The only way they may want to change is if their careprovider can establish a unique, perhaps even unprecedented, relationship with them.[2]

The second author of this introduction, Chelsea Howe, has been doing counseling in a women's prison, and kept a diary of the clinical problems that arose and the ethical problems they posed. We will use examples from the diaries to illustrate the three approaches presented. Although the approaches haven't been proven to be effective for this population of patients, the approaches have been subjected to empirical study in other contexts.

A threshold ethical question could be, why should we want to provide optimal care to inmates in the first place? For some, this question precedes all others. One answer may be that, ethically, inmates are worse-off than those at liberty. Rather than focus on this question, though, we will describe instead why inmates do what they do — for two reasons. First, some careproviders may not be interested in providing optimal care unless they can see inmates as deserving an improved level of care. Second, even those careproviders who see inmates as deserving may have difficulty overcoming negative feelings toward inmates, especially in-

mates who commit heinous crimes; for example, it may be difficult not to feel contempt for them.

A better understanding of why inmates act as they do may help careproviders overcome negative feelings that can thwart their success in treating inmate-patients, and so this will be our first consideration. Second, we shall present three key approaches to treating inmate-patients. Third, we will consider how to use the same approaches in ethics consultation.

WHY HELP INMATES?

As above, some may wonder why we would want to improve the care given to those who commit heinous crimes. Perhaps understanding inmates better may make careproviders more open to providing optimal care to inmate-prisoners. To increase understanding, we will discuss three different types of inmate:

- Those who commit crimes impulsively,
- Those who commit ongoing crimes but have denial, and
- Those who may ruthlessly plan their crimes.

Clearly there are problems in categorizing inmates — as there would be for any person, in any way. All persons differ, sometimes substantially. Yet to answer the question of why we should treat inmates optimally, it may be that we must categorize inmates in one way or other to better understand them.

Inmates Who Lack Control

Some inmates commit crimes in part because they lose significant control. Often, inmates describe these times as moments in which it seemed that another part of their mind took control. One way that this can occur is that inmates experience dissociation, in which they go, as it were, on "automatic pilot," and thereafter remember nothing that occurred in this altered state. Dissociation occurs in most persons. An example is driving on a highway and passing several exits. We may not notice the exits we pass. Our mind may be off somewhere else; this is called "highway hypnosis." The most severe example of dissociation is what the public knows as "multiple personality." Multiple personality usually occurs in persons who have experienced severe trauma early in childhood. Those who have this disorder, even to a less serious degree, often have an angry "part of themselves" take over. Commonly, they don't remember what occurs.

Sybil is the masked name of a famous patient who had multiple personality.[3] She became well known when her life and successful psychotherapy were depicted in a book and films. Cornelia Wilbur was Sybil's psychiatrist. The first author had the opportunity to talk with Wilbur decades ago. She was interested in how many persons with dissociative disorders, like Sybil, due to this disorder commit violent crimes, but are arrested and convicted without anyone ever discerning that they have this disorder. Consequently, Wilbur obtained permission to examine inmates in prisons, and she found that what she had suspected was the case: many inmates did have dissociative disorders that had not been detected, and they didn't remember how their crimes had occurred. Her findings subsequently have been reaffirmed.[4] One investigator studied 145 serial killers in depth. He concluded that the inmates "often" came from "horrific backgrounds, where they were brutalized by one or both parents."[5]

Inmates may also have diminished control because they are influenced by alcohol and drugs. They may experience dissociated states and impulses that are less within their control. It may be generally "easier," in these instances, to blame the inmates for their crimes; they chose, after all, to use alcohol or drugs *initially*, before they were addicted or lost control. Still, the inmates may have urges to drink or retake drugs that are triggered by cues wholly outside their awareness. One expert on substance abuse states, "when treated patients of addiction return to their normal environments, families, neighborhoods, and sources of stress, they are likely to relapse due to conditional responses — their brains form links that immediately activate the reward system."[6] Further, the environmental cues to relapse may be unimaginably strong. Cocaine, for example, may trigger feelings of pleasure 10 times the feelings of pleasure of having sex.[7]

Inmates Who Deny

A second wholly discrepant kind of crime involves inmates who don't imagine that what they do is wrong. This may be because they have rationalized away the wrongness of their behavior or because, from the outset, they had denial. An example of a person who may have done this is Gunter Grass, a writer who won the Nobel Prize. Grass served in the Nazi army during his youth. He has written since that he never imagined then that what he was doing was wrong. He regrets this now deeply. He depicts the process of denial he and others experienced, and we will use what he has written to illustrate how this may occur. Grass was a member of the Hitler Youth; he was a Young Nazi, he says, who believed in what he was asked to do with "untroubled unquestioning fervor."[8] Grass describes how his denial fell apart: "The image that was crystal clear. . . . [Then it turned] fuzzy around the edges."[9]

There were plenty of people like him, Grass writes, who wanted to belong among the "less guilty."[10] They told themselves, he reports, that they were only "obeying orders."[11] They related "mitigating circumstances that had blinded and misled them, feigning their own ignorance and vouching for one another's."[12] "How easily words came to me in the early sixties," he reports, "when I was oblivious enough to think I could give lie to the facts and pin clear-cut explanations on all sorts of absurdities."[13] He writes, "It was some time before I came gradually to understand and hesitantly to admit that I had unknowingly — or, more precisely, unwilling to know — taken part in a crime that did not diminish over the years and for which no statute of limitations would ever apply. . . . "[14]

Grass concludes: "Guilt and shame it engendered can be said, like hunger, to gnaw, gnaw ceaselessly. Hunger I suffered only for a time, but shame. . . ."[15]

Inmates Who Plan

The behavior of a third category of inmates may be still more troubling. These inmates may commit crimes as if they "have no heart." An example might be Richard Loeb, who, with Nathan Leopold, in 1924 notoriously killed a 14-year-old boy they kidnapped for ransom. Loeb seemed to feel no remorse. He said, "I enjoyed being looked at through the bars, because I was a famous criminal."[16] What sort of person is this?

An example of a person in this same category is a fictional character created by Edgar Allen Poe, in the short story "The Cask of Amontillado." The character seals another person in a tomb to exact revenge, and states, "I vowed revenge. . . . At *length* I would be avenged: but the very definiteness with which I was resolved precluded the idea of risk . . . my smile *now* was at the thought of his immolation."[17] How should we regard inmates who may have less control, who may deny, and who may knowingly act in ways that are unconscionable?

A character from a play by Pirandello may indicate a possible response. He has gone to a bordello, where he encounters his stepdaughter. He knows that his stepdaughter and her mother hold him in contempt. He says, "we are not wholly in that act, . . . therefore it would be abominably unjust to judge us by that act alone, to hold us suspended, hooked, in the pillory, our whole life long, as if our life were summed up in that act!"[18] This raises many relevant considerations. Even if we believe that some inmates are "evil," we may be unable to tell which inmates these are. Regardless of what one has done, he or she is still human. Some people believe that we are all prone to the same behaviors, but, by luck, we do not all engage in them — to the same degree.

"Luck" may contribute other effects: empirically, it is known that persons who have antisocial personalities and commit crimes statistically differ from the rest of the general population: they have different genes, an abusive or neglectful early childhood, or both.[19] Ethically, the principle of justice holds that persons shouldn't be treated unequally for what they can't help. They shouldn't be penalized accordingly because they "drew bad cards" in this regard.

THREE KEYS TO TREATING INMATES

What might enable careproviders to break through an inmate-patient's pattern of repeated criminal behavior, and help the inmate want to change? We would suggest that perhaps the only way is to establish a unique and even unprecedented inmate/careprovider relationship. There are, we believe, three keys to doing this.

Preparing to be Optimally Spontaneous

Dan Stern, an eminent psychiatric researcher, has done "micro-analyses" of filmed interactions of mothers and their infants.[20] On the basis of these studies he has reached a startling conclusion: he suggests that when many psychiatric patients get well, it may be due not to the therapy psychotherapists used, but to how the psychotherapists responded spontaneously during moments they were caught off-guard. Therapists tend to assume that how patients respond is primarily a function of what their therapists *consciously* choose to do. Stern claims that it may be just the opposite: his observations of parents and infants made him familiar with the "constant derailing and repairing in dyadic interactions." For certain stretches, he says, "interaction, rupture and repair constitute the main activity of mother and baby."

Likewise, there are empathic "mishaps," he reports, "every minute," in even the best of therapeutic interactions, and the majority of them are quickly repaired by one or both partners. *These* moments can lead to "sudden dramatic therapeutic changes."[21] He gives as examples of a patient saying something funny and the therapist breaking into "explosive laughter," or of a therapist going to a movie and then finding him- or herself just behind a patient in line.[22] Stern calls this process of spontaneous interaction a "shared feeling voyage."[23] The participants create, Stern says, "a shared private world . . . their *relationship is changed* . . . there has been a *discontinuous leap* . . . it is co-created by both partners and lived originally by both."[24] "This delicate choreography goes on mostly outside of consciousness."[25] Further, Stern writes, ". . . I view the intersubjective exchange within the dyad as going on all the time, every . . . minute . . . I see it as *a basic motivation* . . . for the treatment."[26]

How might careproviders use this in their work in prisons, and what sort of ethical boundaries would it push? An example reported by the second author (CH) may be useful. One of the strongest rules in all prisons — as in all in-patient psychiatric settings — is that therapists shouldn't physically embrace patients. CH had been working with one inmate intensely for some time. The patient had been denied parole, but CH thought she knew her well enough, especially on the basis of what she'd heard from other patients. CH appealed on the inmate's behalf. This initiative illustrates the kind of unconditional regard and commitment we will discuss below. The inmate was given parole on the basis of this appeal. When the inmate saw CH, she spontaneously moved to give CH a hug. CH hugged the inmate back, although she fretted whether she should have violated this rule.

If CH hadn't hugged back, the inmate would not have felt the same way about her, and may have continued to feel worse over time. The inmate, however, did well. What is worth highlighting is that, in addition to the other positive effects of careproviders showing such spontaneous warmth, the effects of *not* showing warmth may be incredibly harmful to patients in the long run. For example, the first author (EH) worked with a parent who had an infant with very extensive special needs. The infant's mother was referred to a genetic counselor. The first thing this counselor said was, "Why didn't you ever get genetic counseling?" The mother remains bitter and hasn't forgiven the counselor to this day. A second negative example will be presented when discussing ethics consultation, below.

CH's response to the inmate's hug seems exactly the kind of spontaneous response that Stern had in mind. Stern sees this as critical to therapists' success. The problem for careproviders, of course, even if they agree with Stern, is that spontaneous responses can't be planned. What, then, can be done? We can try to maximize the likelihood of responding optimally, but how? We would suggest that careproviders try to assess themselves, and if necessary change, so that when spontaneous moments happen, they can respond as

positively as possible. For instance, they can try to assess the degree to which they consciously may feel contempt for an inmate, based on what the inmate has done. This may enable them to change.

Change *is* possible. Careproviders should not avoid trying to change simply because they think they can't. The following example may be convincing and compelling. Fear is one of the most difficult feelings to change and overcome, particularly when it is realistically based. Some people fear horses, because they can kick and bite, and they are big. A man known as the "horse whisperer" has had unusually great success in calming horses when others can't. He relates that when he first worked with horses he felt fear. Yet he willed himself to not feel fear, and was abe;e to overcome it. He states, "I . . . realized the fear blocked our communication . . . we lost our sense of partnership and didn't communicate anything constructive to one another."[27] It is equally important to change negative emotions to avoid being caught off-guard when acting as ethics consultants, as will be discussed below.

Putting Inmate-Patients First

Stern's idea is that many patients — including inmates — may be moved to change when they observe that careproviders genuinely care for them, as revealed in such off-guard, spontaneous moments. For decades it has been empirically known that the relationship between patients and psychotherapists makes the most difference, not the type of psychotherapy used. We also know that persons must feel sufficiently motivated to actually change.

Another useful concept may seem self-evident: careproviders who want to help patients change should do whatever they can to demonstrate that they are genuinely committed to the patient, and like a parent, not place conditions on this commitment. Even when an inmate has committed a horrendous crime, a parent still might say, "I continue to love you absolutely and will continue to do whatever I can do for you." The impact of this kind of commitment, especially when an inmate feels wholly alone, may be staggering. The inmate is accepted despite the crime, and because of this no longer feels alone.

The data here supporting the importance of persons having another ally is beyond question. If people have just one person who stands by them, they feel incomparably better. The first author felt this as a child when he had done something wrong. He felt alone. Another child he knew then said to all their friends, "I know that he didn't mean it." EH remembers this, still, with heartfelt appreciation, more than half a century later.

The effect of forming a unique relationship with an inmate-patient is suggested by a new approach to therapy for chronic depression. James P. McCollough, Jr., the person who founded this therapy writes,

> Treating the chronically depressed adult — dislodging the refractory cognitive-emotional and behavioral armor that is the disorder — is analogous to breaking through a granite wall using a 10-pound sledgehammer. One hits the wall repeatedly in the same area with little or no effect until, almost imperceptibly, a slight hairline crack appears. Under continuous pounding, the crack gradually enlarges until, finally, the wall breaks and crumbles.[28]

This statement could apply just as well to "recalcitrant" inmates. Since symptoms of depression may include decreased tolerance to frustration and increased impulsivity, it may be that this treatment for chronic depression is what many inmates need and require. McCollough continues: "I know of no other therapy program recommending that clinicians become personally involved with their patients."[29] Therapists who use this approach, he adds, have "a unique opportunity to teach them what it is like to interact with a decent and caring human being."[30] How might careproviders go about doing this? One example is as telling as it is astounding. At the most recent meeting of the American Psychiatric Association in May 2008, a psychiatrist described what he did in his office with one patient, to try to get through to the patient — he literally stood on his head.[31]

Have any of us ever heard of anyone who would do this? More importantly, how can this be applied in a prison setting? An example from the second author may help. She was with an inmate and a prison staff member. The staff member spoke to her about the inmate in the third person, as if the inmate wasn't there.

(This, as we all should know, is demeaning, but is nonetheless common. Careproviders commonly do this when they have patients with Alzheimer's disease. They talk to these patients' loved ones, who often bring them, as if the patients aren't there.) CH interrupted the staff person, and told him the inmate's name. This may seem to be a small matter, but, to an inmate, maybe it's not. To an inmate, it may be disproportionately important for a careprovider to "stand up" for her or him. This is especially the case when the careprovider is willing to pay a price on the inmate's behalf. CH did pay a price, as the staff member, then and forever after, wasn't pleased. But the inmate, of course, knew this.

Starting Wherever the Inmate-Patient Is

The last intervention is equally as valid in other contexts, including ethics consultation. It may all too often be missed. Careproviders may be too quick to confront patients who see things differently than they do. Careproviders should instead start from wherever these patients are "at." This is particularly important with inmates because often inmates have denied or rationalized away what they have done. An example from the experience of the first author is a serial murderer who told him, "But I was a leader in the Boy Scouts." It may be exceptionally hard for many careproviders to initially validate and support such views, but it is essential; it may be the only way careproviders can connect with their patients.

Regarding making connections, Leston Havens and Nassir Ghaemi write, on manic patients (who, for biological reasons, are known for having fixed, grandiose views):

> First, one must meet the patient. This involves empathic connection. There needs to be a meeting on common existential ground. In this work, the therapist must struggle to avoid theorizing or judging, but rather should seek simply to think, feel, and experience what is happening as the patient is thinking, feeling and experiencing it. The second step, *after connecting with the patient*, is to help the patient put perspective on his/her experiences.[32]

Careproviders who treat inmates must find some way to confirm the patients' positive view of themselves or of what they have done. An example from the second author may illustrate this. CH was seeing a patient who had multiple personality, which, as we have suggested, may not be uncommon within prison populations. CH was introducing the inmate to one of the prison staff. Although the inmate was an adult, she was at that time in an altered state, like a young child. She was wholly dependent on CH, and feeling scared. CH sensed that if she introduced the inmate to the staff member in a formal way, it would increase the child-like personality's fear. Consequently, CH "bit the bullet" and told the staff member the inmate was her "friend." This was not classically professional, and CH could have been criticized for calling this inmate — or any inmate — her friend. But the inmate, in this child-like state, only beamed.

ETHICS CONSULTATION

The three approaches described are also exceptionally effective in ethics consultation. Patients may feel like outsiders in healthcare settings, and, like inmates, lack power, relative to others on whom they are wholly dependant.

Being Spontaneous

As previously discussed, careproviders can't will themselves to always be spontaneous. But they *can* prepare themselves for unanticipated encounters by assessing themselves to discern whether they can accept patients as they are, regardless of what patients want. When this is the case, (hopefully) only positive spontaneous responses will "emerge" in unguarded moments. A common example is when patients request an intervention that careproviders may see as futile. If careproviders do not anticipate and assess their feelings about this, they may respond in a way that profoundly affects patients and their loved ones in a negative way, as in the following case, from the experience of the first author.

A patient was in a coma, and it would have been reasonable, at that time, to withdraw *or* maintain his life-sustaining treatment. The patient hadn't indicated at all what he would have wanted. The applicable law required that the patient's closest relative make a decision on behalf of the patient. If there was more than one relative who was this close — in this case, the patient had two daughters — they all must agree on a decision, or the decision would be made by the hospital ethics committee. This patient had two daughters with equal decision-making authority. Very unfortunately, the daughters totally disagreed on what their father would have wanted. Worse, over time, neither was willing to budge an inch.

After some time had passed, they met with a new attending physician, who said, on hearing of their differing views, that it didn't much matter to him, because he was unwilling to withhold treatment, and would only be willing to agree to a DNR order. He said this adamantly, responding spontaneously with what he felt. The sisters responded: instantly, they became wholly united. They were like a married couple who argue until someone calls the police, and then present a united front. The sisters demanded that the attending withhold all further treatments, and, in time, with their insistence, he did.

Helping Patients Not Feel Alone

When careproviders are spontaneous, put patients' interests first even when it "hurts," and start from wherever patients are at, they can foster a unique and even inspiring patient/careprovider relationship. Patients, as all persons, can do better when they have an ally. Careproviders who work in prisons, like the second author, may be the only ally that some inmates will have. In hospitals, patients may have their loved ones, and if ethics consultants can help patients have a loved one as an ally, it may be preferable to trying to take on that role themselves.

This is illustrated in the following case from the experience of EH: a patient increasingly insisted on staying at home, even though his health was deteriorating due to a progressive but treatable medical condition. The patient's wife tried repeatedly — and ever more fervently — to persuade and then cajole him to leave the house to see his doctor and get the care he needed. Finally, the wife called the patient's doctor, and the doctor called for an ethics consultation. The ethics consultant saw the need to take strong action, which might cause the patient to be seen — against his wishes — and receive treatment. At that point, the treatment was not yet lifesaving.

The ethics consultant told the patient's wife that rather than confront her husband and continue to alienate him, she should be his ally and be by his side. The ethics consultant suggested to the patient's careprovider that he should take on the role of "the enforcer," which the careprovider was willing to do. Thus, the careprovider called the patient and told him that he was, after all, the patient's physician and could not simply sit idle, knowing that if he did, his patient might die. The careprovider said that he could, if necessary, insist the patient come in to see him. The patient's wife was relieved (and actually ecstatic). She'd been married to her husband for 38 years, and taking on the role of confronter, persuader, and enforcer had been devastating to their relationship. With this change, she became her husband's ally. Paradoxically, after the patient's wife indicated that she would support her husband in whatever he wanted to do, the patient, feeling her support, softened and became willing to go in to see his doctor — which he did, without actual coercion.

In general, to apply this same approach further, ethics consultants might encourage patients (or, when a patient cannot speak for him- or herself, patients' loved ones) to bring another person whom they know and trust with them to an ethics consult, especially when they may face a larger group in an ethics committee meeting. When patients or loved ones can't bring an ally, ethics consultants should attempt to fill this role. Consultants might help to establish such a bond through the use of humor. The humor must not be insensitive to the seriousness of the situation in any way. Perhaps this bonding could be conveyed by just a soft smile.

Starting Where Patients Are At

When patients request a treatment that careproviders consider futile, ethics consultants may do best by first allying themselves with the patient's interests. An example from the experience of EH is that of a patient who had cancer and had had three trials of chemotherapy, all of which had failed. Even so, the patient still

wanted to "try." The staff members, to a person, felt that "it was time for the patient and his wife to accept that it was time for him to die." The patient wanted, however, to try "anything," and the more the staff opposed him, the more he and his wife dug in. The ethics consultant was called in. Although he agreed with the staff, he believed it would be optimal to start from where this couple was at, and so he took an initiative on their behalf.

He sought out and found an expert who did research on this very type of cancer. The doctor said that he would be willing to give the patient an experimental drug, but that it might have several undesirable side-effects, and that it had only about one chance in 100 of significantly prolonging the patient's life. The staff criticized the ethics consultant for taking this initiative, but the patient and his wife considered the consultant the finest ally they ever had. Finally, though, the patient decided to decline the treatment. He said that having had the ethics consultant as a partner is what had enabled him to feel strong enough to be able to make this decision.

In a similar kind of case, parents wanted their child's careproviders to give the child an herbal alternative treatment although he had brain death. The comments of Arthur Applbaum and colleagues, who wrote up the case, are radical and illuminating; they state, "If another course of treatment is necessary to assure the patient that every effort has been made, it would be reasonable to agree, even though the extra effort is on strict biological criteria one step beyond reasonable."[33] They add, "it would be decent to acquiesce; …it is both insulting and unnecessary for medical authorities or institutions to insist that [parents of a child who meets brain death criteria] are mistaken; and . . . a sensitive physician ought to be able to find a decent interval between shock and denial."[34]

These views, much like CH's approaches, push the margins of conventional care. It may be, for some patients and parents — as well as for inmates — pushing the boundaries may sometimes not only be reasonable, but, as Applbaum and colleagues suggest, *minimally decent.*

CONCLUSION

Some inmates have done terrible things. In some cases, they have done these things because they were dissociating, used alcohol or drugs, or had denial. They may also be unconscionably ruthless, and this may be, in part, due to genetic and/or environmental contributions. Careproviders who know of these possibilities may help inmates-patients want to change. Knowing these things may help careproviders overcome feelings of horror at what the inmates have done, so that they can more effectively treat inmates. Acquiring the capacity to not be judgmental may be absolutely necessary when careproviders hope to establish a unique and possibly unprecedented relationship with inmates. Such relationships may be the only possible means to move inmates to want to change.

We have described three approaches that may be particularly effective: spontaneity; standing up for inmates and putting their interests above all else; and starting where inmates are at. The last may be hardest, because it may require careproviders to overtly support attitudes and rationalizations they abhor. The murderer Richard Loeb, mentioned above, may provide an example of what we mean. During his trial, Loeb said he had no mental illness, and clearly knew right from wrong. This may have increased the risk he would receive the death penalty. A careprovider who wanted to start where inmates are at could use his or her imagination and might take the initiative to note Loeb's honesty, or perhaps his courage and his strength in making that statement.

These approaches may help careproviders who want to push the boundaries of what they will do for their patients who are the hardest to reach.

NOTES

1. Although no treatment has proved effective, this does not mean that no treatment will ever be found. S.C. Yudofsky, *Fatal Flaws* (Washington, D.C.: American Psychiatric Publishing, 2005), 206.

2. It may be, for example, that in response to the feeling of being trusted, people, including recalcitrant inmates, have a sudden surge of oxytocin that enhances their capacity to relate, despite previously acquired negative cognitions that have — and would, in other cases — normally oppose this. P.J. Zak, "The Neurobiology of Trust," *Scientific American* 298, no. 6 (June 2008): 88-92.

3. F.R. Schrieber, *Sybil* (New York: Warner Books, 1973); *Sybil*, Lorimar Productions, 1976; *Sybil*, Norman Stephens Productions, 2007.

4. "The heterogeneous dissociative disorders are often hidden and unrecognized. . . ." K. McDonald, "Dissociative Disorders Unclear? Think 'Rainbows from Pain Blows'," *Current Psychiatry* 7, no. 5 (2008): 73-85, p. 73, citing B. Foote et al., "Prevalence of Dissociative Disorders in Psychiatric Outpatients," *American Journal of Psychiatry* 16 (2004): 2271-6.

5. Michael Stone also found that approximately one-fourth of these 145 serial killers had had head injuries and periods of unconsciousness. J. Arehart-Treichel, "Multiple Factors at Root of Antisocial Behavior," *Psychiatric News* 45, no. 15 (1 August 2008): 4-18, p. 18. See, e.g., also J.B. Kotch et al., "Importance of Early Neglect for Childhood Aggression," *Pediatrics* 121 (2008): 725-31.

6. G.N. Pachas, "Understanding Drug Addiction and Substance Abuse," *Psychiatry Report* 2, no. 1 (Spring 2008): 5-19, 8.

7. Ibid., 7, citing G. Di Chiara and A. Imperato, "Drugs Abused by Humans Preferentially Increase Synaptic Dopamine Concentrations in the Mesolimbic System," *Proceedings of the National Academy of Sciences USA* 85 (1988): 5274-8.

8. G. Grass, *Peeling the Onion* (New York: Harcourt, 2007), 36.

9. Ibid., 91.

10. Ibid.

11. Ibid.

12. Ibid.

13. Ibid., 132.

14. Ibid., 28.

15. Ibid., 96.

16. S. Baatz, *For the Thrill of It/Leopold, Loeb and the Murder that Shocked Chicago* (New York: Harcourt, 2008), 140-1. Quoted from the notes of W.A. White (Loeb, National Archives in Washington DC, fol. 6, Trial transcript, fols. 1295-6, 1534-5).

17. E.A. Poe, "The Cask of Amontillado," in *Tales of Edgar Allan Poe* (New York: Pennyroyal Press, 1991), 51-9, 51. Even this murderer may have felt a pang of guilt: "My heart felt sick. It was the dampness of the catacombs," (p. 59).

18. L. Pirandello, *Six Characters in Search of an Author*, trans. E. Bentley (New York: Signet, 1998), 57.

19. W. Bernet et al., "Bad Nature, Bad Nurture, and Testimony Regarding MAOA and SLC6A4," *Journal of Forensic Science* 52, no. 6 (November 2007): 1362-71, 1365.

20. D.N. Stern, *The Present Moment in Psychotherapy and Everyday Life* (New York: W.W. Norton, 2004), 157.

21. Ibid., 165.

22. Ibid., 166-7.

23. Ibid., 172.

24. Ibid., 172-3.

25. Ibid., 179.

26. Ibid., 185.

27. P. Wood, *Secrets of the People Whisperer* (New York: MJF Books, 2005), at 21.

28. J.P. McCullough, Jr., *Treatment for Chronic Depression* (New York: Guilford Press, 2000), 8.

29. Ibid., 17.

30. Ibid.

31. The psychiatrist was Eric Lavender, speaking with J.P. McCullough, Jr., during a presentation, "Treating the Chronically Depressed Patient Using the Cognitive-Behavioral Analysis System of Psychotherapy," at the American Psychiatric Association Annual Meeting, Washington, D.C., 5 May 2008.

32. L.L. Havens and S.N. Ghaemi, "Existential Despair and Bipolar Disorder," *American Journal of Psychotherapy* 59, no. 2 (2005): 137-47, 138.

33. A.J. Applbaum et al., "A Family's Request for Complimentary Medicine After Brain Death," *Journal of the American Medical Association* 299, no. 18 (14 May 2008): 2188-93, 2189.

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