

**DETERMINING MEDICAL DECISION-MAKING CAPACITY FOR PATIENTS  
WITH DISSOCIATIVE IDENTITY DISORDER:  
A PATIENT-CENTERED APPROACH**

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## **Abstract**

Patients with Dissociative Identity Disorder (DID) pose ethical challenges for clinicians regarding capacity for medical decisions. If such a patient possesses various personality states with potentially different values, opinions, and preferences, this can lead to conflicting choices regarding medical treatments. Yet, only one decision can be carried out, which might lead some clinicians to believe that DID patients cannot possess capacity. In this thesis, I argue against this presumption by demonstrating that there are clinical contexts and situations where, ethically, patients with DID should (and, in some cases, should not) possess capacity. To accomplish this, a patient-centered approach to determining capacity for DID patients is introduced. Such an approach is rooted in the attributes of patient-centered care and the current bioethical consensus that psychiatric patients should not be deemed to lack capacity for treatment decisions solely due to their diagnosis. It also implores clinicians to consider the degree of value-sharing and awareness among a patients' personality states, as well as the decision at hand and the level of risk associated with the decision when making determinations of capacity for DID patients.

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## **List of Abbreviations and Symbols**

AHCD Act	Advanced Health Care Directives Act
DES	Dissociative Experiences Scale
DSM-5	Diagnostic and Statistical Manual of Mental Disorders- 5
DID	Dissociative Identity Disorder
MPT	Multiple Person Thesis
NL	Newfoundland and Labrador
SCID-D-R	Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised
SDM	Substitute Decision-Maker
SPT	Single Person Thesis

## Introduction

If you were to look at me, you'd see a single person, a female in her early forties; but when we look in the mirror we see *us*, fragmented identities living within one body. . . .[W]e are twenty six alters each with our own distinct personality. . . . [W]e have grown from the original six Carol knew of when she was initially diagnosed in 2008. Such is the reality of life with [dissociative identity disorder].<sup>1</sup>

This excerpt was written by "Caitlyn," one of twenty-six different identities residing within the mind of Carol Broad.<sup>2</sup> As she states, Carol suffers from dissociative identity disorder (DID), a psychological disorder primarily characterized by " . . . the presence of two or more distinct personality states."<sup>3</sup>

Imagine now that Carol is diagnosed with a glioblastoma and the likelihood of survival, even with therapy or surgical intervention, is slim. "Caitlyn" appreciates the fact that Carol has limited time left and she does not want to live out her remaining days in hospital attempting treatment that would probably be futile. Therefore, Caitlyn chooses not to undergo any medical treatment because she wants to spend time with loved ones and doing activities she enjoys instead. However, another of Carol's personalities is not willing to accept death and, as a result, wants to try and combat the tumor with aggressive therapy. Therefore, this personality is adamant that medical intervention occur in order to prolong Carol's life as much as possible.

Given that Carol's personalities are in disagreement with one another on a major medical decision, such a scenario raises an intriguing dilemma. Both personalities inhabit

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<sup>1</sup> Carol Broad, "Living with DID," in *Living with the Reality of Dissociative Identity Disorder: Campaigning Voices* ed. Xenia Bowlby and Deborah Briggs (London: Karnac Books Ltd., 2014), 67.

<sup>2</sup> Broad, "Living with DID," 67.

<sup>3</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., Arlington, VA: American Psychiatric Association (2013). Retrieved from <https://dsm-psychiatryonline-org.qe2a-proxy.mun.ca/doi/full/10.1176/appi.books.9780890425596.dsm08>.

the mind of Carol and both seem to be putting forth viewpoints that are valid and in accordance with their expressed beliefs and preferences. However, only one decision can be carried out by Carol's physician or care team. Therefore, what is the appropriate course of action in such a case? Should Carol be deemed capable of making this medical decision?

Let us consider another case. A well-known example of DID is Christine "Chris" Costner Sizemore (born Christine Costner).<sup>4</sup> Chris suffered from severe childhood trauma after witnessing several horrifying events, such as seeing her mother being bloodily injured.<sup>5</sup> She was also physically abused repeatedly while growing up, and she later entered into a relationship with a man who constantly beat her.<sup>6</sup> As a result of her trauma, Chris dissociated into multiple personality states as a means of coping with, and escaping from, her pain and suffering.<sup>7</sup> Severe trauma is the most common trigger of dissociation.<sup>8</sup> At one point, Chris possessed three distinct, contrasting personalities: "Eve White" (a "demure and depressed" woman who preferred to remain at home), "Eve Black" (a "self-indulgent party girl"), and "Jane" (a woman characterized as "pleasant and sensible").<sup>9</sup>

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<sup>4</sup> Bruce Weber, "Chris Costner Sizemore, Patient Behind 'The Three Faces of Eve,' Dies at 89," *The New York Times*, August 5, 2016. <https://www.nytimes.com/2016/08/06/us/chris-costner-sizemore-the-real-patient-behind-the-three-faces-of-eve-dies-at-89.html>.

<sup>5</sup> Weber, "Chris Costner Sizemore."

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Frank W. Putnam, *Diagnosis and Treatment of Multiple Personality Disorder*, (New York: The Guildford Press, 1989), 47.

<sup>9</sup> Weber, "Chris Costner Sizemore;" Adam Bernstein, "Chris Sizemore, Whose Many Personalities were the Real Faces of Eve, Dies at 89," *The Washington Post*, July 29, 2016. [https://www.washingtonpost.com/national/health-science/chris-sizemore-whose-multiple-personality-disorder-was-filmed-as-the-three-faces-of-eve-dies-at-89/2016/07/29/3ed468e2-55b4-11e6-bbf5-957ad17b4385\\_story.html?utm\\_term=.2641d2c9ec16](https://www.washingtonpost.com/national/health-science/chris-sizemore-whose-multiple-personality-disorder-was-filmed-as-the-three-faces-of-eve-dies-at-89/2016/07/29/3ed468e2-55b4-11e6-bbf5-957ad17b4385_story.html?utm_term=.2641d2c9ec16).



The case of Chris Costner highlights the notion that the different personality states of an individual with DID often exist within contrasting psychological states. Considering the above descriptions of Eve White and Jane, for instance, it is implied that Jane does not display signs of psychiatric pathology as compared to Eve White (who displays signs of clinical depression). What is also apparent from this case is that the personality states of an individual with DID can express different preferences and values. As an example, comparing Eve White to Eve Black, it can be inferred that Eve Black values socializing and being active, whereas Eve White prefers to be alone and not interact with others.

Taking these observations into account, hypothetically, if Eve White, Eve Black, and Jane were all presented with a particular medical treatment decision, it would be possible for them to make differing choices. For example, if Chris required treatment for a thyroid nodule and was presented with the options of either an anti-thyroid medication or surgery (a more invasive option),<sup>10</sup> Eve Black may choose the medication option, since surgery would require a recovery period whereas the medication would allow her to continue her lifestyle. However, based on their characteristics, it is not as clear what choice Eve White or Jane would make, so it cannot be assumed that they would agree with Eve Black and consent to the surgery. Moreover, in cases of DID such as Chris Costner's (whereby the personality states have differing psychological states or symptoms), it could be theoretically possible for the decision-making capabilities of the individual personalities to vary in addition to their choices.

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<sup>10</sup> Mayo Clinic, "Thyroid Nodules," 2019. Retrieved from <https://www.mayoclinic.org/diseases-conditions/thyroid-nodules/diagnosis-treatment/drc-20355266>

Why would the above situations be ethically problematic for health care professionals? First, a patient with DID only has one body; therefore, a treatment decision that is accepted and implemented by a physician or care team would directly impact all of the patient's personality states, regardless of their expressed values and whether or not they agree with the decision. Second, if there is more than one personality that appears to be decisionally capable, accepting the decision of one personality as authoritative could unethically undermine the capably expressed wishes of the other personalities and, possibly, their autonomy (if one considers a DID patient's personality states to be autonomous agents). Finally, DID patients are often psychologically traumatized individuals (as seen with Chris Costner). Therefore, automatically deeming them incapable of making their own treatment decisions because of conflicting personalities could cause significant distress, distrust in health care professionals, and even worsen their condition. As a result, a series of questions is raised: how should health care professionals reconcile various personality states when presented with a patient with DID? Are personality states autonomous agents? Do all personality states have decision-making capacity? For which medical decisions should a DID patient possess capacity? What approach to determining a DID patient's capacity ensures that the patient's autonomy is maintained when possible?

This thesis will attempt to answer these questions through introducing and outlining ethical considerations and guidance on determining the medical decision-making capacity of patients with DID. My aim is to introduce a patient-centered approach to determining such capacity by debunking the presumption that DID patients simply cannot possess capacity due to their psychiatric condition, as well as demonstrating that

there are situations and contexts where, ethically, DID patients should and should not possess capacity. This requires a multi-step framework and analysis. Thus, in Chapter One, I will present and discuss the clinical attributes of dissociative identity disorder, including the symptoms of DID and how clinicians assess the severity of dissociation and DID. As well, the concept of decision-making capacity (specifically within the context of medical treatment decisions) will be outlined in detail. Possessing capacity for such decisions would require the following abilities: understanding the necessary information regarding the treatment, appreciating the outcomes of the decision on one's life, reasoning about a treatment decision through weighing benefits and risks, outwardly communicating a decisional choice, and possessing a coherent, stable set of values. Finally, I will also discuss how allowing patients with capacity the freedom to make their own decisions supports their autonomy and welfare.

Determining capacity for DID patients requires an in-depth examination of the nature of personality states, and in Chapter Two, I will outline two competing viewpoints in the literature regarding personality states: the multiple person thesis (personality states are distinct persons) and the single person thesis (personality states are not individual persons, but rather altered psychological states of the subject with DID). In this chapter, I will argue that the single person thesis offers a more plausible interpretation of personality states. To accomplish this, I will demonstrate that a subject with DID is a singular entity through discussion of trait overlap between personality states and the possibility of shared phenomenological and conscious awareness among alter personalities. I will also argue that alter personalities are not autonomous agents, and that a DID subject is a single agent who possesses self-governance that does not rest with

their alter personalities. This will be shown through discussion of dissociation and the therapeutic process of integrating personality states.

Regarding an individual with DID as a singular locus of agency, in Chapter Three, I will argue that the presence of alter personalities can, in some circumstances, impede a patient with DID from executing their agency as an individual that is autonomously capable of their own medical decision-making. I will analyze how each of the requirements and abilities necessary for decision-making capacity presented in Chapter One could be hampered in a patient with DID. As well, I will demonstrate that DID can diminish the moral agency and responsibility of patients with the disorder. It is important to clarify that, in this chapter, I am not suggesting that patients with DID do not possess capacity at all, as capacity is context- and decision-specific. Rather, these hindrances force one to consider which treatment decisions DID patients could and could not possibly make.

Such a consideration will be explored in Chapter Four, as I will present and discuss an ethically-sound approach for determining the decision making capacity of a patient with DID, as well as my recommendations for which treatment decisions DID patients should be allowed to make. This approach takes into account the aforementioned ethical challenges posed by DID and attempts to preserve the autonomy of the patient when possible. I will demonstrate that the following considerations are necessary when determining whether a DID patient has capacity for a particular treatment decision: the degree of awareness between the patient's alter personalities, whether or not there is a designated main personality, the decision itself, and whether the decision at hand is in regards to the patient's psychiatric therapy or a non-psychiatric medical issue.

## Chapter 1: Dissociative Identity Disorder and Decision-Making Capacity

Imagine an elderly female patient afflicted with Alzheimer's disease who is becoming increasingly forgetful and suffers from memory loss.<sup>11</sup> She visits her physician to undergo a pre-operative evaluation for a full hip replacement surgery.<sup>12</sup> As part of the evaluation, the physician informs her about the risks of the surgery, as well as other potential treatment options, and asks her if she understands what they have just told her.<sup>13</sup> The patient does not appear to understand what is being communicated to her as she continuously smiles and repeats the phrase "It'll be okay."<sup>14</sup> The patient's unusual response and apparent lack of understanding causes the physician to wonder if the patient possesses the capacity to decide whether or not to proceed with the surgery.<sup>15</sup>

Clinical situations similar to the one above occur frequently in medical practice, as clinicians are often presented with patients whose capacity to make decisions concerning medical treatment is questionable.<sup>16</sup> As suggested in the aforementioned example, the patient's memory loss due to Alzheimer's disease is hindering her ability to comprehend and process the information being communicated to her. Such cognitive impairment affects a patient's capacity to make decisions<sup>17</sup> (hereafter referred to as decision-making capacity, or capacity). However, psychological disorders and symptoms

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<sup>11</sup> Laura L. Sessums, Hanna Zembruska, and Jeffery L. Jackson, "Does this Patient Have Medical Decision-Making Capacity?," *Journal of the American Medical Association* 306, no. 4 (2011), 420.

<sup>12</sup> Sessums et al., "Does this Patient," 420.

<sup>13</sup> *Ibid.*, 420.

<sup>14</sup> *Ibid.*, 420.

<sup>15</sup> *Ibid.*, 420.

<sup>16</sup> Thomas Grisso and Paul S. Appelbaum, "Comparison of Standards for Assessing Patient's Capacities to Make Treatment Decisions," *The American Journal of Psychiatry* 152, no. 7 (1995), 1033.

<sup>17</sup> Laura Dunn, Milap A. Nowrangi, Barton W. Palmer, Dilip V. Jeste, and Elyn R. Saks, "Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments," *The American Journal of Psychiatry* 163, no. 8 (2006), 1323.

may also affect a patient's decision-making capacity.<sup>18</sup> Assessing capacity with regards to treatment decisions is integral to the care of patients with psychological disorders, as the presence of such a disorder can alter a patient's ability to make sound, informed medical decisions.<sup>19</sup> Dissociative identity disorder (DID) is no exception; however, before discussing how DID affects capacity, it is crucial to introduce and outline the clinical features of DID, as well as the concept of decision-making capacity.

## 1.1 What is Dissociative Identity Disorder?

### 1.1.1 Symptoms of DID

As previously mentioned, one of the most defining features of DID is the presence of multiple personality states.<sup>20</sup> These states are referred to as "alter" personalities (or "alters" for short)<sup>21</sup> and they appear individually from one another and seemingly have control of the person's body during their appearance.<sup>22</sup> To be clear, all of an individual's personality states are considered alter personalities.<sup>23</sup> According to Maiese, "[e]ach of these coexisting personalities seems to be a fully integrated and complex unit with its own memories, [behaviour] patterns, outlook, moods, ambitions, tastes, and habits."<sup>24</sup> Consequently, the continuous shifting between personality states often causes severe disturbances in the person's behaviour, consciousness, memory, affect, cognition,

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<sup>18</sup> Dunn et al., "Assessing Decisional Capacity," 1323.

<sup>19</sup> Manne Sjöstrand, Petter Karlsson, Lars Sandman, Gert Helgesson, Steffan Eriksson, and Niklas Juth, "Conceptions of Decision Making Capacity in Psychiatry: Interviews with Swedish Psychiatrists," *BMC Medical Ethics* 16 (2015), 35.

<sup>20</sup> American Psychiatric Association, *DSM-5*. "Dissociative Disorders."

<sup>21</sup> Paulette Marie Gillig, "Dissociative Identity Disorder: A Controversial Diagnosis," *Psychiatry* 6, no. 3 (2009)

<sup>22</sup> Michelle Maiese, "Dissociative Identity Disorder and Ambivalence," *Philosophical Explorations* 19, no. 3 (2016): 223.

<sup>23</sup> Putnam, *Diagnosis and Treatment*, 106-107.

<sup>24</sup> Maiese, "Dissociative Identity Disorder."

perception, and sensory-motor functioning.<sup>25</sup> A common means by which DID can originate is repeated instances of trauma or abuse, as alter personalities are often formed as a means of escaping extreme pain and suffering.<sup>26</sup> The DSM-5 states that a diagnosis of DID requires the presence of two or more alters.<sup>27</sup> Findings regarding the average number of alters among DID patients are similar across surveys. For example, a survey of 236 cases of DID (referred to as Multiple Personality Disorder at the time of the survey) conducted by Ross et al. revealed that the average number of alters is fifteen,<sup>28</sup> while a similar survey conducted by Putnam indicates the mean number to be thirteen.<sup>29</sup> It is not clear as to what exact factors cause differences in the number of alter personalities among DID patients;<sup>30</sup> however, the type and length of trauma experienced and the age of onset have been suggested.<sup>31</sup>

Alter personalities assume various roles or functions for the patient with DID.<sup>32</sup> Some examples include the following roles: "persecutor" personalities (personalities that express anger and frustration and may engage in self-mutilation or harm), "protector" personalities (" . . . those that protect the body from any perceived external danger" or internal threats, such as thoughts of suicide),<sup>33</sup> "promiscuous" personalities (alters who tend to engage in risky behaviour and are impulsive),<sup>34</sup> "internal self-helpers" (" . . .

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<sup>25</sup> American Psychiatric Association, *DSM-5*, "Dissociative Disorders."

<sup>26</sup> National Alliance on Mental Illness, "Dissociative Disorders," 2019. Retrieved from <https://www.nami.org/Learn-More/Mental-Health-Conditions/Dissociative-Disorders>.

<sup>27</sup> American Psychiatric Association, *DSM-5*, "Dissociative Disorders."

<sup>28</sup> Colin A. Ross, G. Ron Norton, and Kay Wozney, "Multiple Personality Disorder: An Analysis of 236 Cases," *Canadian Journal of Psychiatry* 34, no. 5 (1989), 414.

<sup>29</sup> Putnam, *Diagnosis and Treatment*, 123.

<sup>30</sup> *Ibid.*, 123.

<sup>31</sup> *Ibid.*, 123.

<sup>32</sup> *Ibid.*, 106-114.

<sup>33</sup> *Ibid.*, 109.

<sup>34</sup> *Ibid.*, 111.

[those] who provide information and insight into the inner workings of the [personality] system" and can be invaluable during the delivery of therapy).<sup>35</sup>

DID also encompasses "sudden alterations or discontinuities in sense of self and sense of agency."<sup>36</sup> This usually manifests as periods of depersonalization: an out-of-body experience whereby the individual is an external observer of their own actions, speech, and behaviour (accompanied by a feeling of loss of control over one's body).<sup>37</sup> Such discontinuity can also present as derealization, or " . . . a feeling of unreality or detachment from the environment [and one's surroundings]."<sup>38</sup> Depersonalization and derealization often occur in tandem with one another, but they can occur independently.<sup>39</sup> Moreover, many people with DID experience dissociative amnesia.<sup>40</sup> As the *DSM-5* states, dissociative amnesia primarily appears in the following three manners:

1) gaps in remote memory of personal life events (e.g., periods of childhood or adolescence; some important life events, such as the death of a grandparent, getting married, giving birth); 2) lapses in dependable memory (e.g., of what happened today, of well-learned skills such as how to do their job, use a computer read, drive); and 3) discovery of evidence of their everyday actions and tasks that they do not recollect doing (e.g., finding unexplained objects in their shopping bags or among their possessions; finding perplexing writings or drawings that they must have created; discovering injuries; "coming to" in the midst of doing something).<sup>41</sup>

As well, dissociative fugues are frequent among individuals with DID, mainly occurring

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<sup>35</sup> Ibid., 110.

<sup>36</sup> American Psychiatric Association, *DSM-5*, "Dissociative Disorders."

<sup>37</sup> Ibid.

<sup>38</sup> Putnam, *Diagnosis and Treatment*, 16.

<sup>39</sup> Ibid., 16.

<sup>40</sup> American Psychiatric Association, *DSM-5*, "Dissociative Disorders."

<sup>41</sup> Ibid.



as dissociated travel.<sup>42</sup> Such individuals often cannot recall how or when they moved location and find themselves suddenly in a new place (e.g. travelling from home to work; moving around their house, etc.).<sup>43</sup> Finally, individuals with DID can also experience a wide variety of psychiatric and neurological comorbidities.<sup>44</sup> Some prominent examples include anxiety and depression disorders, post-traumatic stress disorder, sleep disorders (e.g. insomnia, sleepwalking, frequent nightmares), non-epileptic seizures, and personality disorders.<sup>45</sup>

### *1.1.2 Assessing Dissociation and DID*

There exist various clinical tools psychiatrists can use to assess the severity of dissociation and dissociative symptoms. One assessment scheme is the Dissociative Experiences Scale (DES).<sup>46</sup> This scheme is used to both determine the types of dissociative experiences patients endure and quantify these experiences by examining how often they occur.<sup>47</sup> The experiences measured on the scale are dissociative amnesia, depersonalization, derealization, and absorption<sup>48</sup> (a phenomenon whereby individuals become immersed in their own internal imagery and neglect attending to external reality or stimuli).<sup>49</sup> Patients are asked to rate the frequency they experience each item on a

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<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

<sup>44</sup> Mayo Clinic, "Dissociative Disorders," 2019, Retrieved from [mayoclinic.org/diseases-conditions/dissociative-disorders/symptoms-causes/syc-20355215](https://www.mayoclinic.org/diseases-conditions/dissociative-disorders/symptoms-causes/syc-20355215).

<sup>45</sup> Ibid.

<sup>46</sup> Bethany L. Brand, Judith G. Armstrong, and Richard L. Loewenstein, "Psychological Assessment of Patients with Dissociative Identity Disorder," *Psychiatric Clinics of North America* 29 (2006), 150.

<sup>47</sup> Eve M. Bernstein, and Frank W. Putnam, "Development, Reliability, and Validity of a Dissociation Scale," *The Journal of Nervous and Mental Disease* 174, no. 12 (1986), 731.

<sup>48</sup> Nirit Soffer-Dudek, Dana Lassri, Nir Soffer Dudek, and Golan Shahar, "Dissociative Absorption: An Empirically Unique, Clinically Relevant, Dissociative Factor," *Consciousness and Cognition* 36 (2015), 338.

<sup>49</sup> Brand et al., "Psychological Assessment," 150.

Likert scale (ranging from 0% of the time to 100% of the time).<sup>50</sup> However, if a patient obtains a high score on the DES, it does not necessarily indicate that they experience severe dissociation or have DID.<sup>51</sup> Brand et al. state that, in certain instances, " . . . patients who are nondissociative and [later] questioned about their responses [on the DES] had not been thinking of truly dissociative experiences or had overrated the frequency with which they occur."<sup>52</sup> As well, patients who are dissociative may underreport the frequency of such experiences on the DES, even though they provide details of "frequent and profound dissociative experiences" during a clinical interview.<sup>53</sup> It has also been shown that conflicting statements in the instructions of the questionnaire can lead to various interpretations and confusion regarding how to answer the items, which has led some to question the validity of the scale.<sup>54</sup>

While the DES can provide an indication of the presence of dissociative experiences, the current "gold standard" assessment tool for dissociation and making determinations of DID is the Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R).<sup>55</sup> Of the existing interview assessment tools, the SCID-D-R is the only one that is based on clinical criteria outlined in the DSM.<sup>56</sup> Dissociation is considered to be a "multidimensional" phenomenon, and clinicians need to take into account multiple factors when making diagnoses of DID and examining dissociation.<sup>57</sup>

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<sup>50</sup> Robert Stern, and Michael McDonald, "Diagnosing Dissociation, Or Why Measuring Multiple Personalities Doesn't Work," *Skeptic Magazine* 18, no. 4 (2013), 41-42.

<sup>51</sup> Ibid., 150.

<sup>52</sup> Ibid., 150.

<sup>53</sup> Ibid., 150.

<sup>54</sup> Stern and McDonald, "Diagnosing Dissociation," 42-43.

<sup>55</sup> Brand et al., "Psychological Assessment," 150.

<sup>56</sup> Ibid., 150.

<sup>57</sup> Ibid., 150.

The SCID-D-R is an ideal clinical tool because it assesses the five primary symptoms of pathological dissociation, namely amnesia, depersonalization, derealization, identity confusion, and identity alteration.<sup>58</sup> Patients are asked a series of questions which require them to provide concrete examples of each symptom, and the clinician " . . . must be convinced that these experiences are dissociative in nature" in order to make a diagnosis of DID.<sup>59</sup> Furthermore, the above dissociative symptoms can be placed on, what Temple refers to as, a "spectrum of severity."<sup>60</sup> At the extreme high end of the spectrum are the "severe dissociative disorders," including DID and other specified dissociative disorder (a diagnosis given to patients who have dissociative symptoms but do not meet all of the necessary *DSM-5* criteria for DID);<sup>61</sup> at the extreme low end are normal, non-pathological instances of dissociation that most of us experience, such as intermittent absorption (e.g. day-dreaming) or "anxiety-induced distraction."<sup>62</sup> This thesis and the arguments contained within are only concerned with patients who have been clinically diagnosed with DID.

As such, regarding severity among cases of DID, the diversity of a patient's alter personalities and the number of times certain alter personalities emerge (as opposed to the total number of alters) determine the severity of the patient's condition.<sup>63</sup> For example, if a patient has more persecutory alter personalities than helper personalities and the

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<sup>58</sup> Ibid., 150.

<sup>59</sup> Ibid., 150.

<sup>60</sup> Melanie J. Temple, "Understanding, Identifying, and Managing Severe Dissociative Disorders in General Psychiatric Settings," *BJPsych Advances* 25, no. 1 (2019), 14.

<sup>61</sup> Temple, "Understanding, Identifying, and Managing," 14;18.

<sup>62</sup> Ibid., 14.

<sup>63</sup> Erdniç Öztürk, and Vedat Şar, "Formation and Functions of Alter Personalities in Dissociative Identity Disorder: A Theoretical and Clinical Elaboration," *Journal of Psychiatry and Clinical Psychology* 6, no. 6 (2016): 00385, 6.

persecutory personalities are manifested more often, the patient would engage in self-mutilation or self-harm more frequently than if their helper personalities were dominant.<sup>64</sup> Thus, such dominance of persecutory alters would clearly indicate a more severe psychological disturbance.<sup>65</sup> Similarly, Kluft notes that clinicians need to focus on the content of a DID patient's alter personality system and not the strict number of alters when examining complexity.<sup>66</sup> For instance, he states that patients can replicate their system of alters during major life changes or stressors, thereby creating a "new and undamaged" version of the system and inactivating the previous system (a process termed "epochal division").<sup>67</sup> In one patient, the same system of alter personalities was replicated five times as the patient moved through different levels of schooling as well as during her divorce.<sup>68</sup> Even though there were numerous alters present, the core active content of her system was still the original, smaller set of alters.<sup>69</sup> However, in another case, a patient who was repeatedly abused for over ten years developed a different alter after every instance of abuse to avoid dealing with the trauma, leading to a highly complex system due to the diversity among the alters.<sup>70</sup>

Before proceeding, it should be stated, though, that DID is a controversial diagnosis within psychiatry. Some psychiatrists are critical of the DSM criteria, as it does not include a clear definition of what constitutes an alter personality, nor any exclusion

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<sup>64</sup> Öztürk and Şar, "Formation and Function of Alter Personalities," 6.

<sup>65</sup> Ibid., 6.

<sup>66</sup> Richard P. Kluft, "Dealing with Alters: A Pragmatic Clinical Perspective," *Psychiatric Clinics of North America* 29, no. 1 (2006), 286;287.

<sup>67</sup> Ibid., 287.

<sup>68</sup> Ibid., 287.

<sup>69</sup> Ibid., 287.

<sup>70</sup> Ibid., 287.

criteria for the disorder.<sup>71</sup> Therefore, such ambiguity has led some to argue that the disorder cannot be accurately diagnosed.<sup>72</sup> This controversy needs to be kept in mind when examining the issue of decision-making capacity in patients who have been given a diagnosis of DID.

## 1.2 Decision-Making Capacity

### *1.2.1 What Constitutes Decision-Making Capacity?*

Having outlined the clinical attributes of dissociation and DID, I now turn to discussing the concept of decision-making capacity. Various scholars have put forth conceptions of the requirements for decision-making capacity. While there exist slight differences among them, there is general agreement regarding certain abilities that one would require to engage in medical decision-making.

One commonly cited requirement is "understanding": the ability to understand and comprehend the information needed to make a particular decision.<sup>73</sup> Regarding medical treatment decisions, Charland states that ". . . in order to be capable of consenting to or refusing a given treatment, a subject must have some basic understanding of the facts involved in that decision."<sup>74</sup> Appelbaum and Grisso concur, as they assert that if a patient is unable to understand the facts and information about a specific treatment, this would preclude them from being able to consent to or refuse the

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<sup>71</sup> See Joel Paris, "The Rise and Fall of Dissociative Identity Disorder," *The Journal of Nervous and Mental Disease* 200, no. 12 (2012), 1076-1079; Harold Merskey, and August Piper, "The Persistence of Folly: Critical Examination of Dissociative Identity Disorder. Part II. The Defence and Decline of Multiple Personality and Dissociative Identity Disorder," *The Canadian Journal of Psychiatry* 49, no. 10 (2004), 678-683.

<sup>72</sup> *Ibid.*, 679-680.

<sup>73</sup> Louis C. Charland, *Stanford Encyclopedia of Philosophy*, s.v. "Decision-Making Capacity," Stanford: Metaphysics Research Lab (2011), <https://plato.stanford.edu/search/searcher.py?query=decision-making+capacity>.

<sup>74</sup> Charland, "Decision-Making Capacity."

treatment in question.<sup>75</sup> This would make sense, given that a patient who consents to a treatment without comprehending the information about the treatment itself would not be giving informed consent, and therefore, ethically, such consent should not be accepted. Appelbaum and Grisso also state that, in general, understanding involves not only the mental capabilities of " . . . reception, storage, and retrieval of information . . .", but also the understanding of causal relations.<sup>76</sup> Pesiah et al. would agree as they view the ability to understand the dynamics of one's social environment and relationships as necessary to making sound decisions.<sup>77</sup> Therefore, understanding can be regarded as the ability to comprehend that one's decisions will have an impact on them, and that one's decisions can also affect those around them.

In keeping with the notion that one's decisions affect them, another cited requirement for decision-making capacity is the ability to appreciate the consequences and outcomes of one's decisions ("appreciation").<sup>78</sup> Appreciation takes understanding a step further by demanding one to consider whether their actions and choices will have a beneficial or detrimental effect. Cairncross et al. view appreciation, in this sense, as " . . . the ability to apply [information] about one's own personal situation and to anticipate the likely outcome of a [decision]."<sup>79</sup> Such a requirement would seem reasonable, as if one is unable to foresee the outcomes or implications of their decisions, then it would not be

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<sup>75</sup> Paul S. Appelbaum and Thomas Grisso, "Assessing Patients' Capacities to Consent to Treatment," *The New England Journal of Medicine* 319, no. 25 (1988), 1636.

<sup>76</sup> Appelbaum and Grisso, "Assessing Patients' Capacities," 1636.

<sup>77</sup> Carmelle Peisah, Orestes Forlenza, and Edmond Chiu, "Ethics, Capacity, and Decision-Making in the Practice of Old Age Psychiatry: An Emerging Dialogue," *Current Opinion in Psychiatry* 22, no. 6 (2009): 520.

<sup>78</sup> Tom L. Beauchamp, and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013), 118.

<sup>79</sup> Molly Cairncross et al., "Assessing Decision Making Capacity in Patients with Communication Impairments," *Cambridge Quarterly of Healthcare Ethics* 25, no. 4 (2016), 692.

possible for them to know whether or not the decisions they make are good for them. Moreover, Charland states that, when one makes decisions, " . . . it is their life . . . and future that are at stake."<sup>80</sup> Therefore, to ensure that one makes decisions that preserve and support their future well-being, one must be able, as Buchanan and Brock assert, " . . . to appreciate the nature and meaning of potential alternatives – what it would be and "feel" like to be in possible future states and to undergo various experiences."<sup>81</sup>

Closely related to appreciation is the ability to engage in reasoning. In the context of decision-making capacity in health care, no definitive, normative criteria for reasoning exist, with one cited reason for this being that if too high of a normative standard were accepted or insisted upon, then many capable patients may be rendered as incapable of making their own treatment decisions.<sup>82</sup> However, there are certain attributes that are generally regarded as important when reasoning a treatment decision.<sup>83</sup> One such attribute is the ability to rationally manipulate information by " . . . [comparing] the benefits and risks of various treatment options."<sup>84</sup> This would require the patient to first ascertain the benefits and risks of a single option and weigh them against other options to reach a decision.<sup>85</sup> As well, Siegel et al. state that reasoning about a treatment decision would involve " . . . [moving] from a particular premise or set of premises to their

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<sup>80</sup> Charland, "Decision-Making Capacity."

<sup>81</sup> Allan Buchanan and Dan W. Brock, "Deciding for Others," *The Milbank Quarterly* 64, Supp. 2: Medical Decision Making for the Demented and Dying (1986), 25.

<sup>82</sup> Charland, "Decision-Making Capacity."

<sup>83</sup> Ibid.

<sup>84</sup> Appelbaum and Grisso, "Assessing Patients' Capacities," 1636.

<sup>85</sup> Ibid., 1636.

conclusion regarding the particular treatment decision in a logical manner."<sup>86</sup> A patient who is capable of this would be able to answer questions such as "How did you decide to accept or reject the recommended treatment?" or "What makes [your] chosen [option] better than [an alternative option]?"<sup>87</sup> To be clear, what is being examined here is a patient's decision-making process and not the "reasonableness of a particular decision," as a patient possesses the freedom to make treatment decisions that are considered unreasonable by their physician or care team.<sup>88</sup> As Appelbaum and Grisso state, ". . . patients should be able to indicate the major factors in their decisions and the importance assigned to them."<sup>89</sup>

One other noted requirement for decision-making capacity is the ability to communicate or outwardly express (verbally or otherwise) one's decisions and preferred choices.<sup>90</sup> With regards to medical treatment decisions, if a patient is unable to indicate their preferred treatment option, it would be impossible for their decision to be implemented or acted upon;<sup>91</sup> therefore, "[t]he ability to communicate choices is accepted almost universally as a sign of competence to consent to treatment . . ."<sup>92</sup> This requirement could also include ". . . the ability to maintain and communicate stable

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<sup>86</sup> Andrew M. Siegel, Anna S. Barnwell, and Dominic A. Sisti, "Assessing Decision-Making Capacity: A Primer for the Development of Hospital Practice Guidelines," *HEC Forum: An Interdisciplinary Journal on Hospitals' Ethical and Legal Issues* 26, no. 2 (2014), 163.

<sup>87</sup> Siegel et al., "Assessing Decision-Making Capacity," 163.

<sup>88</sup> *Ibid.*, 163.; It should be noted that health care professionals often struggle to accept and implement competently expressed choices that they deem to be unreasonable or are doing harm to the patient. For a striking case study demonstrating this, see: Daryl Pullman and Kathleen Hodgkinson, "The Curious Case of the De-ICD: Negotiating the Dynamics of Autonomy and Paternalism in Complex Clinical Relationships," *The American Journal of Bioethics* 16, no. 8 (2016), 3-10.

<sup>89</sup> Appelbaum and Grisso, "Assessing Patients' Capacities," 1636.

<sup>90</sup> *Ibid.*, 1635.

<sup>91</sup> *Ibid.*, 1635.

<sup>92</sup> *Ibid.*, 1635.



choices long enough for them to be implemented."<sup>93</sup> Appelbaum and Grisso state that while patients can change their minds and have sufficient reasons for doing so that would not preclude them from being capable of making treatment decisions,

. . . repeated reversals of intent, particularly if they can be linked to a diagnosable psychiatric disorder and can prevent the implementation of any consistent approach, may suggest the presence of substantial impairment.<sup>94</sup>

Many scholars also believe that possessing a set of values is necessary for decision-making capacity. For example, Buchanan and Brock assert that values and a conception of what is good are necessary for an individual " . . . to evaluate particular [decisional] outcomes as benefits or harms, goods or evils, and to assign different relative weight or importance to them."<sup>95</sup> This viewpoint echoes the previous discussion regarding appreciation, as one's values allow them " . . . to draw inferences about the consequences of making a certain choice and to compare alternative outcomes based on how they further one's good or promote one's ends."<sup>96</sup> Wicclair adds that while one's values may not be fully developed or detailed, some degree of consistency and coherency is necessary.<sup>97</sup> Lo concurs and asserts that, for medical treatment decisions, total inconsistency in values would cause a patient to " . . . change their minds back and forth repeatedly without any changes in external circumstances, [making it] impossible to carry out plans for medical care."<sup>98</sup> Consequently, a lack of consistent values would undermine the aforementioned requirement of being able to effectively communicate a decisional

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<sup>93</sup> Ibid., 1635.

<sup>94</sup> Ibid., 1635.

<sup>95</sup> Buchanan and Brock, "Deciding for Others," 26.

<sup>96</sup> Ibid., 25.

<sup>97</sup> Mark Wicclair, "Patient Decision-Making Capacity and Risk," *Bioethics* 5, no. 2 (1991), 92.

<sup>98</sup> Bernard Lo, "Assessing Decision-Making Capacity," *The Journal of Law, Medicine, and Ethics* 18, no. 3 (1990), 195.

choice.<sup>99</sup> As well, since individuals can have multiple values and certain decisions may not necessarily align with all of their values, consistency would allow a patient to set priorities and assign weight to certain values.<sup>100</sup> This would promote a person's ability to rationally reason through a decision, as their values would guide and shape how they view the benefits and risks and ultimately decide if they are willing to accept the outcome of the decision.

### *1.2.2 Ethical Importance of Decision-Making Capacity for Health Care Patients*

Tannjso states that, within health care, " . . . a strong presumption exists for allowing adult [patients], who can make their own decisions about their need for health and social care, to have their own say [with regards to their care]."<sup>101</sup> Why would allowing patients with capacity the free will to make their own decisions be ethically important? In his work *On Liberty*, Mill puts forth the argument that such an allowance serves to support an individual's welfare.<sup>102</sup> He states that the interest a person has in their own welfare and life is not shared to the same extent by others.<sup>103</sup> Beyond this, Mill also asserts that " . . . with respect to [their] own feelings and circumstances, the most ordinary [person] has means of knowledge immeasurably surpassing those that can be possessed by anyone else."<sup>104</sup> Applying these points within a health care context, while a physician or care team can sympathize with a patient and hold their well-being in high regard, ultimately, it is the patient's life and health that are at stake when making treatment

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<sup>99</sup> Lo, "Assessing Decision-Making Capacity," 195.

<sup>100</sup> Ibid., 195-196.

<sup>101</sup> Torbjorn Tannsjö, *Coercive Care: Ethics of Choice in Health and Medicine* (London: Routledge, 1999), 16, ProQuest Ebook Central.

<sup>102</sup> John Stuart Mill, *On Liberty*, ed. David Bromwich and George Kateb (New Haven: Yale University Press, 2003), 140, ProQuest Ebook Central.

<sup>103</sup> Mill, *On Liberty*, 140.

<sup>104</sup> Ibid., 140.

decisions, not the lives of the health care professionals, and it is the patient who must bear the outcomes of a decision.<sup>105</sup> Only the patient possesses a " . . . knowledge of [their] particular subjective aims and values that are likely to be affected by whatever decision is made."<sup>106</sup> Since the patient has the greatest stake in a medical treatment decision (i.e. their life), allowing a patient with capacity to choose their course of treatment affords them the ability to make the choice that is most in line with their values and what they deem to be important to them. In turn, this respects the patient's autonomy and self-determination.<sup>107</sup> As Beauchamp and Childress state, respecting a patient's autonomy means " . . . [acknowledging] their right to hold views, to make choices, and to take actions based on their values and beliefs."<sup>108</sup> Patients have an " . . . interest in making important decisions about [their] own [lives]," and since capably expressed choices and decisions are based on the values of the patient making the decision, allowing such patients to exercise their capacity also enables them to exercise their autonomy.<sup>109</sup>

However, it is regarded as ethically acceptable or appropriate to intervene in treatment decisions where a patient has been deemed to lack decision-making capacity for those particular decisions.<sup>110</sup> Bassford states that if a patient cannot comprehend the nature of a decision or its consequences or outcomes, they are unable to self-govern their

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<sup>105</sup> Buchanan and Brock, "Deciding for Others," 26.

<sup>106</sup> Ibid., 26.

<sup>107</sup> Pesiah et al., "Ethics, Capacity, and Decision Making," 519; Buchanan and Brock, "Deciding for Others," 29.

<sup>108</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 7th ed., 106.

<sup>109</sup> Buchanan and Brock, "Deciding for Others," 29.

<sup>110</sup> David A. Greaves, "Can Compulsory Removal Ever be Justified for Adults who are Mentally Competent?," *Journal of Medical Ethics* 17, no. 4 (1991), 191.; Jayne Breeze, "Can Paternalism be Justified in Mental Health Care?," *Journal of Advanced Nursing* 28, no. 2 (1998), 264.

decision-making in this instance.<sup>111</sup> Patient autonomy and paternalistic intervention are regarded as "reciprocal," meaning that as a patient's autonomous capabilities to make a particular decision decrease, the need to make the decision on behalf of the patient increases, and vice versa.<sup>112</sup> Carter adds that if an agent is unable to " . . . use relevant concepts, . . . recognize relevant information . . . , appreciate the consequences of [a] proposed [action], and . . . be intellectually capable of deliberation," their "action rights" (rights that permit individuals to perform or carry out actions) are limited in circumstances where the action in question requires these abilities.<sup>113</sup> The abilities noted by Carter correspond directly with the aforementioned requirements of medical decision-making capacity, implying that, in circumstances where patients who do not meet the capacity requirements, they can be denied decision-making capacity. In accordance with promoting patient welfare, not allowing patients without capacity to make treatment decisions serves to "[protect] [patients] . . . from the harmful consequences . . . of their own choices," as incompetently made choices " . . . may fail to serve [their] good or well-being."<sup>114</sup>

As alluded to by Bassford and Carter, it is necessary to note that decision-making capacity is not "global," meaning that an individual cannot be " . . . deemed capable or incapable of making all decisions . . . ."<sup>115</sup> Capacity is determined in light of the particular task or decisional domain at hand, and it " . . . cannot be extrapolated from one task [or

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<sup>111</sup> H.A. Bassford, "The Justification of Medical Paternalism," *Social Science and Medicine* 16, no. 6 (1982), 737.

<sup>112</sup> Mark S. Komrad, "A Defense of Medical Paternalism: Maximising Patients' Autonomy," *Journal of Medical Ethics* 9 (1983), 39;43.

<sup>113</sup> Rosemary Carter, "Justifying Paternalism," *Canadian Journal of Philosophy* 7, no. 1 (1977), 143.

<sup>114</sup> Buchanan and Brock, "Deciding for Others," 29.

<sup>115</sup> Pesiah et al., "Ethics, Capacity, and Decision Making," 519.

domain] to another."<sup>116</sup> For example, the capacity task for consenting to research would be different from that of appointing a power of attorney or making financial decisions.<sup>117</sup> Moreover, decision-making capacity can vary within a specific type of decision.<sup>118</sup> For example, medical treatment decisions can differ widely in terms of the complexity of the decision, ranging from somewhat simple decisions (e.g. choosing to have a blood test) to more difficult, arduous decisions (e.g. deciding whether or not to undergo risky surgery). Therefore, physicians may deem a patient capable of making certain treatment decisions but not others.<sup>119</sup> As well, a patient could presumably lack capacity for a treatment decision simply because they lack sufficient information or understanding of the decision at hand. However, through discussion with the patient, a physician or care team can provide this information or clarity to help the patient become capable of making the treatment decision. Such a notion of helping a patient become capable is not directly addressed in the forthcoming arguments of this thesis. When a patient does not have capacity for a particular decision, a substitute decision-maker is identified to make decisions on behalf of the patient.<sup>120</sup> Decisions made for an individual when intervening on the grounds of absence of capacity must be guided by, as Rawls notes, " . . . what is known about the [person's] more permanent aims and preferences."<sup>121</sup> Such consideration of a patient's values and preferences serves to promote the patient's

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<sup>116</sup> Ibid., 519.

<sup>117</sup> Ibid., 519.

<sup>118</sup> Ibid., 519.

<sup>119</sup> Ibid., 519.

<sup>120</sup> Lo, "Assessing Decision-Making Capacity," 195.

<sup>121</sup> John Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press, 1971), 250, EBSCOhost eBook Collection.

autonomy through making the decision that would most likely be the decision that the patient themselves would make if they were capable of doing so.<sup>122</sup>

Lo indicates various ways that physicians can promote the decision-making capacity of particular patient groups at risk of being deemed incapable of making decisions, such as elderly patients and patients with psychiatric symptoms and/or cognitive impairment, in order to promote self-governance over their decision-making.<sup>123</sup> In particular, he asserts that physicians need to recognize and acknowledge that capacity is fluid and can change throughout a patient's lifetime and treatment process.<sup>124</sup> For example, illnesses that may impair cognitive function and hinder capacity may improve over time or be cured;<sup>125</sup> therefore, a previously incapable patient may need their capacity re-evaluated upon improvement.<sup>126</sup> As well, certain psychiatric symptoms may worsen when a patient is hospitalized or placed in unfamiliar settings, so physicians should be aware of this before assuming a patient with psychiatric symptoms lacks capacity.<sup>127</sup> Pesiah et al. would concur, as they assert that " . . . incapacity is no longer diagnosis bound . . ." and it is inappropriate to assume incapacity solely due to a diagnosis of a psychiatric or mental disorder.<sup>128</sup> Sjöstrand et al. maintain that it is possible, in some cases, for a patient's capacity to be retained during severe mental illness.<sup>129</sup> Considering these points, it would be reasonable to opine that assuming incapacity based only on mental illness would not only unethically undermine a potentially capable patient's

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<sup>122</sup> Lo, "Assessing Decision-Making Capacity," 195.

<sup>123</sup> Ibid., 196-197.

<sup>124</sup> Ibid., 196.

<sup>125</sup> Ibid., 196.

<sup>126</sup> Ibid., 196.

<sup>127</sup> Ibid., 196.

<sup>128</sup> Pesiah et al., "Ethics, Capacity, and Decision Making," 519.

<sup>129</sup> Sjöstrand et al., "Conceptions of Decision Making Capacity in Psychiatry," 35.

autonomy, but also may result in potential distress or cause them to distrust their physician and, by extension, the health care system itself. Lo states that vulnerable patients are more likely to be fearful of strangers and discussing treatments with individuals whom they do not know well, so acting in ways that foster trust and comfort is imperative to providing care to these patients.<sup>130</sup>

Having examined the concepts of DID and decision-making capacity in detail, I now turn to outlining two contrasting viewpoints regarding the nature of a DID patient, namely the single person thesis and multiple person thesis. In Chapter Two, I will defend the position that the single person thesis offers a more plausible interpretation of an individual with DID.

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<sup>130</sup> Ibid., 196.

## Chapter 2: A Defence of the Single Person Thesis

In 1886, Robert Louis Stevenson published his novel *The Strange Case of Dr. Jekyll and Mr. Hyde*.<sup>131</sup> This novel tells the story of Dr. Henry Jekyll, a respected and successful intellectual who, unbeknownst to those around him, possesses a dark, evil side to his personality.<sup>132</sup> At times, Jekyll accedes to this evilness by committing atrocious acts, but he does so covertly to avoid damaging his social status.<sup>133</sup> However, through experimentation, he develops a concoction that enables him to " . . . free [the] evil in him" by transforming into a man named Edward Hyde.<sup>134</sup> Unlike Jekyll, Hyde is purely evil with no moral compass.<sup>135</sup> Today, the eponymous term "Jekyll and Hyde" " . . . has become a synonym for multiple personality in scientific and lay literature."<sup>136</sup>

One could theoretically interpret Jekyll and Hyde as separate entities from one another, as their outwardly opposing traits, moral characters, and values place them " . . . constantly at war with each other";<sup>137</sup> however, one could also regard Hyde as a fragment of Jekyll's personality, as in the novel, Jekyll describes Hyde as " . . . a second form and countenance substituted, none the less natural to me because [he] [is] the expression, and [bears] the stamp, of lower elements in my soul."<sup>138</sup> Therefore, in this view, Jekyll and Hyde may not be so distinct from one another, as Hyde is a manifestation of the evilness that resides within Jekyll. While Jekyll and Hyde is not a case of dissociative identity

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<sup>131</sup> *Encyclopaedia Britannica*, 15th ed., s.v. "The Strange Case of Dr. Jekyll and Mr. Hyde," <https://www.britannica.com/topic/The-Strange-Case-of-Dr-Jekyll-and-Mr-Hyde>.

<sup>132</sup> Shubh Singh and Subho Chakrabarti, "A Study in Dualism: The Strange Case of Dr. Jekyll and Mr. Hyde," *Indian Journal of Psychiatry* 50, no. 3 (2008), 221.

<sup>133</sup> Singh and Chakrabati, "A Study in Dualism," 221.

<sup>134</sup> *Ibid.*, 221.

<sup>135</sup> *Ibid.*, 221.

<sup>136</sup> *Ibid.*, 221.

<sup>137</sup> *Ibid.*, 222.

<sup>138</sup> *Ibid.*, 222.



disorder (DID) *per se*, these conflicting interpretations regarding the connection (or lack thereof) between Jekyll and Hyde mirror two existing theories that attempt to explain the nature of someone with DID: the single person thesis and the multiple person thesis.

The single person thesis states that the alter personalities of an individual with DID are altered states of the patient and fragments of the individual's personality (similar to interpreting Hyde as a fragment of Jekyll's identity).<sup>139</sup> In this view, the individual is a single person, whose alter personalities are " . . . [states] [of] one person in which only the person's concept of self has been replaced, distorted, and diminished."<sup>140</sup> However, similar to the notion that Jekyll and Hyde are distinct entities, the multiple person thesis posits that alter personalities are separate persons because they each possess " . . . [a] distinct [sense] of themselves, [a] distinct [centre] of self-consciousness, and [a] different body [image]."<sup>141</sup> According to the theory, this distinctness is due to an "epistemic or phenomenological barrier" that prevents the personalities from accessing each others' consciousness.<sup>142</sup> Such a barrier affords personality states independent agency from one another, and, thus, " . . . if there are two or more centers of consciousness . . . or loci of agency, then there are two or more persons in a single body."<sup>143</sup>

Before I discuss how DID impacts medical decision-making capacity and present an approach to determining a DID patient's capacity for medical treatment decisions, it is necessary to adopt either the single person thesis (SPT) or multiple person thesis (MPT),

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<sup>139</sup> Jeanette Kennett and Steve Matthews, "Identity, Control, and Responsibility: The Case of Dissociative Identity Disorder," *Philosophical Psychology* 15, no. 4 (2002), 511.; Steve Matthews, "Establishing Personal Identity in Cases of DID," *Philosophy, Psychiatry, and Psychology* 10, no. 2 (2003), 144.

<sup>140</sup> Kennett and Matthews, "Identity Control and Responsibility," 512.

<sup>141</sup> Michelle Maiese, "Dissociative Identity Disorder, Ambivalence, and Responsibility," *European Journal of Philosophy* 25, no. 3 (2017), 765-766.

<sup>142</sup> *Ibid.*, 765-766.

<sup>143</sup> *Ibid.*, 766.

as these theories have vastly different implications for judging the decision-making capacity of a patient with DID. For instance, if the MPT is favoured, then assessing the capacity of a patient would be difficult as the person (i.e. personality) who is consented for a particular treatment option would not necessarily be the person who bears the consequences of the treatment decision or whose capacity was assessed to begin with. Under the MPT, each alter personality would require an assessment of their capacity because it would be possible for them to capably exercise their individual agencies to make their own treatment choices. Conversely, if one adopts the SPT, the patient, as a singular person, only has one center of agency. The term "center of agency" refers to the autonomous agency of a singular being. Therefore, instead of assessing capacity for each personality, it would have to be determined whether or not the presence of alter personalities has sufficiently disrupted the patient's agency enough to preclude them from possessing capacity for their own treatment decisions. In this chapter, I discuss the overlap that exists between alter personalities, as well as the phenomena of dissociation and integration, in defending the position that the SPT, as opposed to the MPT, provides a more plausible interpretation of an individual with DID and their alter personalities.

## 2.1 Overlap between Alter Personalities

As previously mentioned, the MPT states that there exists an epistemic and phenomenological barrier between alter personalities; however, alter personalities share more than the MPT would lead one to believe. This section will discuss the overlap between alter personalities and, in turn, demonstrate that the existence of such a rigid barrier is a somewhat inaccurate analysis.

First, there is evidence that the semantic memory of a patient with DID overlaps across personality states and remains stable.<sup>144</sup> Semantic memory includes the memory of concepts and ideas that are not linked to personal experience.<sup>145</sup> This includes factual information, common knowledge (e.g. colours, letters of the alphabet, etc.), and procedures (e.g. how to get dressed, how to cook a meal, etc.).<sup>146</sup> Such overlap would indicate that personality states have access to the same reservoir of semantic knowledge and information, as when the individual undergoes a switch of personality states their ability to survive and carry out day-to-day tasks is maintained.<sup>147</sup> Similarly, the capacities and skills of the individual alters are not unique to one particular alter.<sup>148</sup> An example of this is the case of Kim Noble.<sup>149</sup> Kim was exposed to painting as a means of therapy, and, subsequently, fourteen of Kim's alter personalities started to paint.<sup>150</sup> In this case, what is suggested is that once Kim started to paint, this ability became accessible to all of her alter personalities and was not exclusive to a particular alter. This supports Braude's notion of a central repository of capacities that are shared by all alter personalities and from which an individual's personality states can draw upon.<sup>151</sup> Such ability sharing contradicts the MPT, because, unlike alter personalities, distinct persons develop skills and attributes independently of one another, and just because one person possesses a

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<sup>144</sup> Maiese, "Dissociative Identity Disorder and Ambivalence," 226.

<sup>145</sup> Kim Ann Zimmerman, "Semantic Memory: Definition & Examples," *LiveScience*, January 29, 2014. <https://www.livescience.com/42920-semantic-memory.html>.

<sup>146</sup> Zimmerman, "Semantic Memory."

<sup>147</sup> *Ibid.*, 226.

<sup>148</sup> Stephen E. Braude, *First Person Plural: Multiple Personality and the Philosophy of Mind* (London: Routledge, 1991), 170.

<sup>149</sup> Kim Noble, "The Art of Kim Noble," in *Living with the Reality of Dissociative Identity Disorder: Campaigning Voices* ed. Xenia Bowlby and Deborah Briggs (London: Karnac Books Ltd., 2014), 6.

<sup>150</sup> Noble, "The Art of Kim Noble," 6.

<sup>151</sup> Braude, *First Person Plural*, 172

particular skill does not mean that everyone will acquire the same skill. As an example, hypothetically, if I know how to swim and my brother does not, then my brother, as a separate person from me, will not know how to swim simply because I have the ability to do so.

However, consider the following case of DID. Born in Milan, Italy, Elena possessed two alters, dubbed the "French personality" and "Italian personality" by her clinician because of the language difference between the alters.<sup>152</sup> The "Italian personality" only spoke Elena's first language of Italian;<sup>153</sup> however, the "French personality" could only speak French, and even when reading Italian-language texts, this alter would believe that she was reading a text written in French.<sup>154</sup> On the surface, this would suggest that alter personalities can acquire different language skills independently of one another: an observation a proponent of the MPT might use to argue that alter personalities possess independent centers of agency.

Even though they speak different languages, Elena's alters are similar in that they are each limited to the utilization of one language, and the ability to speak both Italian and French was acquired by Elena prior to dissociation (which occurred in her early twenties).<sup>155</sup> Deeley states that alter personalities cannot possess abilities or capacities that are not available to the host individual in question.<sup>156</sup> Elena's alters exemplify this point, as they could only speak languages to which Elena had been exposed and learned.

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<sup>152</sup> Adriano Schimmenti, "Elena: A Case of Dissociative Identity Disorder from the 1920s," *Bulletin of the Menninger Clinic* 81, no. 3 (2017), 288.

<sup>153</sup> Schimmenti, "Elena," 288.

<sup>154</sup> *Ibid.*, 288.

<sup>155</sup> *Ibid.*, 287.

<sup>156</sup> Peter Q. Deeley, "Social, Cognitive, and Neural Constraints on Subjectivity and Agency: Implications for Dissociative Identity Disorder," *Philosophy, Psychiatry, and Psychology* 10, no.2 (2003), 164.

Thus, I would argue that if alter personalities were distinct persons with their own loci of agency, they would be able to develop and hone abilities according to own free will and not be limited to the abilities possessed by the host individual. As I will elaborate upon later, this would indicate that alter personalities are not truly autonomous agents (as suggested by the MPT). Moreover, the case of Elena demonstrates Braude's point that " . . . the traits and abilities manifested by or latent in the pre-dissociative personality begin to get distributed throughout the [alter personalities]."<sup>157</sup> Such distribution strongly suggests that the SPT is more plausible than the MPT, as it indicates not only the sharing of abilities or capacities between alter personalities, but also that personality states are fragments of a singular person.

Furthermore, although personality states assume specific roles or functions for the individual with DID, " . . . the functional specificity of alters does not require [them] to have traits or abilities shared with no other alters (or split-off completely from the rest of the individual's activities)."<sup>158</sup> Task-specific alters are commonplace among individuals with DID.<sup>159</sup> As an example, Miller states that one of her patients possesses a young alter personality who emerges when the need to use a computer or technology arises, especially at the patient's workplace.<sup>160</sup> Braude notes that a task-specific alter who, for instance, shops for groceries, would require the abilities of reading lists and labels, making mathematical calculations, comparing sizes and prices, and interacting with

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<sup>157</sup> Braude, *First Person Plural*, 57; See also Stephen E. Braude, "Multiple Personality and Moral Responsibility," *Philosophy, Psychiatry, and Psychology* 3, no. 1 (1996), 51.

<sup>158</sup> *Ibid.*, 170.

<sup>159</sup> Putnam, *Diagnosis and Treatment*, 106.

<sup>160</sup> Alison Miller, *Becoming Yourself: Overcoming Mind Control and Ritual Abuse*, (New York: Routledge, 2014), 30, ProQuest Ebook Central.

others;<sup>161</sup> however, such capacities are not limited to grocery shopping, as, for example, many other tasks and functions involve communicating and engaging with other individuals (e.g. carrying out projects in the workplace, caring for one's children, etc.), so other alters can also possess these abilities to carry out their functions for the individual.<sup>162</sup> Thus, it is not specific capacities that distinguish alter personalities from one another, but rather the combination of traits they exhibit from the central repository, and

. . . the functional specificity of [alter] personalities actually discourages the appeal to distinct subsystems lacking a deeper unity, since the capacities . . . that distinguish different alters are overlapping and interlocking parts of a *single individual's* full range of dispositions.<sup>163</sup>

A final consideration is that alter personalities can observe the actions of other alters, or hear the voice of another alter, which contradicts the MPT in that there can be shared phenomenological awareness among alter personalities.<sup>164</sup> This is referred to as co-consciousness.<sup>165</sup> Brown states that co-consciousness often involves an "interior dialogue" or communication among the manifested alter personality and the other alters who observe the actions or "outward behaviour" of the manifested alter.<sup>166</sup> There are many examples of co-consciousness and its phenomena in the medical literature. For instance, Ribáry et al. cite a case they call the "Phottae system," whereby a female patient's twenty alter personalities can "hear" each other's thoughts and are in constant

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<sup>161</sup> Braude, *First Person Plural*, 170.

<sup>162</sup> Ibid., 171.

<sup>163</sup> Ibid., 186-187.

<sup>164</sup> Ibid., 227.

<sup>165</sup> Bernard W. Kobes, "Unity of Consciousness and Bi-Level Externalism," *Mind & Language* 15, no. 5 (2000), 535-536.

<sup>166</sup> Mark T. Brown, "Multiple Personality and Personal Identity," *Philosophical Psychology* 14, no. 4 (2001), 439.

communication with one another.<sup>167</sup> Another case involves the personality system of a twenty-three year-old female patient, which the patient characterizes as a "large community of housemates" due to frequent "verbal interactions" among the alters.<sup>168</sup> The existence of co-consciousness makes sense for two reasons. First, as mentioned in the DSM-5, individuals with DID experience episodes of depersonalization, which involves observance of their own actions and speech.<sup>169</sup> Second, as demonstrated in the examples above, it is possible for alter personalities to be aware of, and recognize, each other's existence as alter personalities within one body: a phenomenon referred to as "mutual awareness."<sup>170</sup>

## 2.2 The Nature of Dissociation

Beyond the possibility of shared abilities and awareness among alter personalities, the SPT can be supported by the phenomenon of dissociation itself. Only the SPT provides justification for, what Maiese terms, ". . . the adaptive function of alter-formation."<sup>171</sup> Alter personalities are generally created in response to ". . . a single pre-dissociative individual's experience of trauma [and their] desire or need to cope with it."<sup>172</sup> An individual's set of alter personalities are unique and adaptive to *that* individual, as how the individual dissociates (i.e. what kind of alters are generated and how many are created) is dependent upon their specific traumas and conflicts, as well as what the

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<sup>167</sup> Gergő Ribáry, László Lajtai, Zsolt Demetrovics, and Aniko Maraz, "Multiplicity: An Explorative Interview Study on Personal Experiences of People with Multiple Selves," *Frontiers in Psychology* 8 (2017): Article 938, 5-6.

<sup>168</sup> Ribáry et al., "Multiplicity," 4.

<sup>169</sup> American Psychiatric Association, *DSM-5*, "Dissociative Disorders."

<sup>170</sup> Mathew Nguyen, Michael Shapiro, and Jorge Avila, "Obtaining Informed Consent from a 45-Year-Old Woman with Dissociative Identity Disorder," *Australian and New Zealand Journal of Psychiatry* 47, no. 11 (2013), 1092.

<sup>171</sup> Maiese, "Dissociative Identity Disorder," 767.

<sup>172</sup> Braude, *First Person Plural*, 174.

individual needs to shield themselves from their trauma.<sup>173</sup> Hence, this supports the SPT, as it is evident that alter personalities arise from a singular self, and any future proliferation of alters can be plausibly attributed to " . . . the same *pre-dissociative synthesizing self* that orchestrated (and needed to orchestrate) the initial dissociations."<sup>174</sup> Also referred to as the "original personality"<sup>175</sup> or "trauma-self,"<sup>176</sup> the pre-dissociative self is the identity of the individual that experienced trauma prior to the onset of dissociation, and it remains hidden but it can be accessed through the course of therapy.<sup>177</sup> In summary,

. . . since [the] traumas presumably all happened to the same subject, and since the conflicts and needs to which the traumas lead seem to make sense *only* with respect to a single agent, the subsequent dissociative coping strategies (and ongoing attempts to sustain them) likewise seem to make sense only with respect to a single agent.<sup>178</sup>

Furthermore, Maiese asserts that the underpinning logic of dissociation lends itself to interpret an individual with DID as a singular person.<sup>179</sup> Theoretically, if *x* becomes dissociated from *y*, then some sort of division or barrier now exists between *x* and *y*.<sup>180</sup> Translating this to DID, when an individual dissociates their psychologically traumatizing mental states from conscious awareness (i.e. their alter personalities), emotions, memories, and feelings associated with their trauma cannot be consciously

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<sup>173</sup> Ibid., 174, 175.

<sup>174</sup> Ibid., 174; emphasis added.

<sup>175</sup> Richard P. Kluft, "An Introduction to Multiple Personality Disorder," *Psychiatric Annals* 14, no. 1 (1984), 23.

<sup>176</sup> Erdniç Öztürk, and Vedat Şar, "The Trauma-Self and Its Resistances in Psychotherapy," *Journal of Psychiatry and Clinical Psychology* 6, no. 6: 00386 (2016), 1-2.

<sup>177</sup> Putnam, *Diagnosis and Treatment*, 114.

<sup>178</sup> Ibid., 175.

<sup>179</sup> Maiese, "Dissociative Identity Disorder," 767.

<sup>180</sup> Ibid., 767.



accessed.<sup>181</sup> According to Maiese, " . . . what [becomes] dissociated, [then], . . . are [states] that the subject already has registered [as traumatizing], and it is impossible for a subject to block conscious awareness of states that [they] already [have] registered unless these are [their] own mental states."<sup>182</sup> Since alter personalities are not consciously aware of the subject's traumatized mental states, they would not be capable of doing the dissociating;<sup>183</sup> thus, this presupposes that dissociation is carried out by the traumatized pre-dissociative self (a singular person), which supports the SPT.<sup>184</sup>

Moreover, the concept of dissociation raises an intriguing question: does an individual who dissociates into multiple alter personalities possess control over the dissociative process? Scholarly opinion is divided on this issue. For example, van der Hart asserts that dissociation into alter personalities is automatic or reflexive.<sup>185</sup> On the other hand, both Sarbin and Spanos state that alter personality formation is a goal-directed response to coping with the particular social circumstances and environment in which an individual finds themselves.<sup>186</sup> Segall agrees with Sarbin's and Spanos's claim, but adds that the switching between alter personalities could be an automatic process "with meaning," in that it " . . . [reflects] changing organismic and social stimulus

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<sup>181</sup> Ibid., 766.

<sup>182</sup> Maiese, "Dissociative Identity Disorder and Ambivalence," 228.

<sup>183</sup> Ibid., 228.

<sup>184</sup> Ibid., 228.

<sup>185</sup> Onno van der Hart, "Discussion of: Metaphors of Agency and Mechanisms in Dissociation," *Dissociation* 9, no. 3 (1996), 165.

<sup>186</sup> Theodore R. Sarbin, "On the Belief that One Body May Be Host to Two or More Personalities," *International Journal of Clinical and Experimental Hypnosis* 43, no. 2 (1995), 168.; Nicholas Spanos, "Multiple Identity Enactments and Multiple Personality Disorder: A Sociocognitive Perspective," *Psychological Bulletin* 116, no. 1 (1994), 160.

conditions and [promotes] (or [is] at least "intended" to promote) sociobiological adaptation."<sup>187</sup>

I would state that given the aforementioned "adaptive function" of alter formation,<sup>188</sup> it would be reasonable to posit the existence of some degree of control over the nature of one's alters to ensure that the specific coping needs of the individual are met. The adaptive function would be in line with Sarbin's and Spanos's commentary regarding dissociation as a means of coping with one's social environment, as one's social circumstances are unique to them as well, and the created alters would have to allow the individual to cope within *their own* environment. While I am sympathetic to Segall's notion that switching may be automatic and reflexive, as one's social stimuli and other events may change suddenly and could necessitate a swift emergence of another alter better suited for that circumstance, it is plausible that alter formation is not completely random or reflexive (as suggested by van der Hart) given their specificity.

If an individual does have some control over the nature of their alters, since not every individual who experiences trauma uses dissociation as a coping mechanism,<sup>189</sup> I also argue that it would be possible for an individual with DID to possess some degree of self-motivation to dissociate, and such motivation could only plausibly be possessed by the pre-dissociative self. Given that, as previously mentioned, alter personalities do not register the individual's psychologically damaging mental states, it would appear that alters would have no clear reason to want to engage in dissociation. Therefore, to assert

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<sup>187</sup> Seth Robert Segall, "Metaphors of Agency and Mechanism in Dissociation," *Dissociation* 9, no. 3 (1996), 157.

<sup>188</sup> Maiese, "Dissociative Identity Disorder," 767; See also Putnam, *Diagnosis and Treatment*, 11.

<sup>189</sup> Anne P. DePrince and Jennifer J. Freyd, "Trauma Induced Dissociation," in *Handbook of PTSD: Science and Practice*, ed. Matthew J. Friedman, Terence M. Keane, and Patricia A. Resick (New York: The Guilford Press, 2007), 139.

that alter personalities are the sources of dissociation would be illogical because any impetus to dissociate would have to come from an entity that seeks to dissociate itself from traumatic memories, emotions, and experiences. As Kluft states, it is the original personality (i.e. pre-dissociative self) who " . . . [splits] off the first new personality in order to help the body survive a severe stress,"<sup>190</sup> and Putnam adds that this entity continues the proliferation of alters.<sup>191</sup> Since alter personalities are derived from, and created by, the pre-dissociative self (a singular agent), the phenomenon of dissociation plausibly indicates the superiority of the SPT over the MPT.

### 2.3 Integration as a Challenge to the Multiple Person Thesis

A commonly employed treatment for DID is integration:<sup>192</sup> a psychotherapeutic process utilized to gradually reverse pathological dissociation through combining (or "integrating") an individual's alter personalities.<sup>193</sup> Integration involves "psychic restructuring," whereby the " . . . separate elements of each alter [are synthesized] into a more unified global personality . . ."<sup>194</sup> As I will outline below, integration poses two salient contradictions to the MPT.

First, integration challenges the notion that there exists a rigid barrier between the consciousnesses of alter personalities (as put forth by the MPT). When alter personalities

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<sup>190</sup> Kluft, "An Introduction," 23.

<sup>191</sup> Putnam, *Diagnosis and Treatment*, 114.

<sup>192</sup> For specific case study examples of integration therapy for DID, see: Debra Rothschild, "On Becoming One-Self: Reflections on the Concept of Integration as Seen Through a Case of Dissociative Identity Disorder," *Psychoanalytic Dialogues* 19, no. 2 (2009), 175-187; Karen Baker, "From 'It's Not Me' to 'It Was Me, After All': A Case Presentation of a Patient Diagnosed with Dissociative Identity Disorder," *Psychoanalytic Social Work* 17, no. 2 (2010), 79-98; Carl P. Ellerman, "The Phenomenological Treatment of Dissociative Identity Disorder," *Journal of Contemporary Psychotherapy* 28, no. 1 (1998), 69-79.

<sup>193</sup> Catherine G. Fine, "The Tactical-Integration Model for the Treatment of Dissociative Identity Disorder and Allied Dissociative Disorders," *American Journal of Psychotherapy* 53, no. 3 (1999), 362.

<sup>194</sup> Putnam, *Diagnosis and Treatment*, 301

integrate, they can exist in a hybrid state referred to as "co-presence," which occurs when full integration of an individual's set of alters is either partial or incomplete.<sup>195</sup> However, what is fascinating about co-presence is that, considering hypothetical alter personalities A and B (and hybrid personality AB), " . . . the experiences and psychological characteristics of AB can apparently be a composite of the distinctive inner lives of A and B – a kind of cognitive cocktail."<sup>196</sup> In order to combine experiences and inner conscious states, alter personalities would have to be able to access each other's consciousness. Therefore, in my view, to posit a phenomenological barrier between alter personalities would seem somewhat illogical because if alter personalities possess separate, impenetrable centers of consciousness, co-presence would be impossible to achieve. Moreover, the ultimate goal of integration is to combine an individual's full range of alter personalities into one single personality.<sup>197</sup> Since this process would involve alter personalities combining their conscious states to create one composite state, it is improbable that they could be considered independent persons, as a person cannot integrate their consciousness with another's in such a manner.

Second, I argue that integration calls into question the notion that alter personalities can be considered autonomous agents each in themselves (as the MPT suggests through the claim that alter personalities are distinct loci of agency). To be an autonomous agent, " . . . one must be capable of self-control, self-determination, and self-governance."<sup>198</sup> Since integration involves morphing personalities together, as well as the

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<sup>195</sup> Braude, *First Person Plural*, 54.

<sup>196</sup> *Ibid.*, 54.

<sup>197</sup> Fine, "The Tactical-Integration Model," 362.

<sup>198</sup> Maiese, "Dissociative Identity Disorder," 770.

elimination of certain personalities,<sup>199</sup> this would imply that alter personalities themselves do not possess the self-control or self-determination to maintain their own fundamental characteristics or existence. Therefore, in light of this, alter personalities should not be considered autonomous agents.

While an alter personality appears to possess control over the individual's body during their manifestation,<sup>200</sup> I argue that the individual's locus of autonomous agency is actually their pre-dissociative self. As previously discussed, it is plausible that dissociation is, to a degree, autonomous, and it is carried out by the pre-dissociative self. It would follow, then, that integration is controlled by the pre-dissociative self, as integration permanently alters or removes the safe havens the pre-dissociative self has generated to block out the individual's traumatic past (i.e. the alter personalities), and this self would have to be willing and ready to lose these personalities. This is supported by Öztürk and Şar, as they state that it is the pre-dissociative or trauma-self that determines the patient's attitude toward integration.<sup>201</sup> Therefore, in my opinion, since the pre-dissociative self possesses control to bring alter personalities into existence as well as terminate their existence, they are the entity that houses the individual's self-governance. And since alter personalities originate or are derived from the pre-dissociative self,<sup>202</sup> the self-control displayed by them could also stem from the pre-dissociative self. As a result, in my opinion, alter personalities would not be autonomous entities of their own accord, but rather vehicles through which the individual's autonomy is expressed. Therefore, this

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<sup>199</sup> Braude, *First Person Plural*, 54.

<sup>200</sup> Ibid., 55.

<sup>201</sup> Öztürk and Şar, "The Trauma-Self," 3.

<sup>202</sup> Putnam, "Diagnosis and Treatment," 114.

would indicate the existence of one, singular center of autonomous agency in an individual with DID, which supports the SPT. Considering that this thesis is examining the medical decision-making capacity of patients with DID, if alter personalities can express or channel the individual's autonomy, this raises questions regarding how physicians should proceed when alters differ in their choices regarding treatments and how to determine which alters' choices should be accepted. These questions will be explored in Chapter Four.

A proponent of the MPT could argue that alter personalities sometimes display deception to avoid integrating by not emerging or manifesting,<sup>203</sup> which could suggest some level of self-governance. However, a more plausible explanation is that such resistance can be attributed to the pre-dissociative self resisting integration. Öztürk and Şar state that " . . . resistances of the trauma-self . . . [prevent] the patient from actively participating in therapeutic work."<sup>204</sup> Like the individual's autonomy, the individual's alter personalities would only channel this resistance. Such channelling has been noted in the psychiatric literature, as alter personalities reflect the view or perspective of the pre-dissociative self towards the individual's trauma, thereby rendering the pre-dissociative or trauma-self as the "psychological centrum of the [individual]."<sup>205</sup> Thus, this centrality and channeling would support the existence of a singular locus of agency in an individual with DID (and, in turn, the SPT).

Now that I have demonstrated that an individual with DID can be regarded as a singular person with one locus of agency, in Chapter Three, I will assess the decision-

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<sup>203</sup> Ibid., 55.

<sup>204</sup> Öztürk and Şar, "The Trauma-Self," 3.

<sup>205</sup> Ibid., 1;3.

making capacity and agency of such an individual *as a whole*. In turn, I will assert that the presence of alter personalities can impede a person with DID from executing agency as a being that is capable of, and responsible for, their own decision-making.

### **Chapter 3: Possible Impediments to Medical Decision-Making Capacity and Agency of a Person with Dissociative Identity Disorder**

Consider the following hypothetical scenario: Cindy is a middle-aged woman with dissociative identity disorder (DID) and possesses three alter personalities who frequently switch between one another. She is at the hospital for an appointment with a rheumatologist because she has been diagnosed with chronic osteoarthritis in her knee and is exploring potential treatment options. At the start of the consultation, the rheumatologist speaks with the personality "Laura," who happens to be the personality that was manifested at the time when Cindy received the diagnosis. Laura seems to favour knee replacement surgery as the preferred option, as she wants to be able to walk pain-free and return to her active day-to-day lifestyle without risk of a future flare-up. However, halfway through the consultation, the alter personality "Emily" emerges. Emily is aware of the diagnosis, but tells the rheumatologist that she has a fear of general anaesthesia and, because of the anxiety it causes her, she would prefer a non-surgical option at all costs. As the physician continues to outline the options she is eligible for, Cindy begins to look dazed and confused as her final alter "Anna" emerges, who, unaware that she has arthritis or a physician's appointment, questions why she is in the hospital and asks what is wrong with her.

In this case, the alter personalities Laura and Emily seem assured in their expressed opinions and they each give plausible reasons for why they would choose their preferred option; yet, the fact that their choices conflict, combined with the presence of Anna who is ignorant to the diagnosis altogether, would first force the physician to question whether Cindy has the capacity to make this decision. Other similar cases would



present the same challenge; thus, at this point I will turn to assessing the medical decision-making capacity of an individual with DID.

In the previous chapter, a series of arguments were presented supporting the notion that an individual with DID is a singular person with one centre of agency (i.e. the single person thesis), and that alter personalities should not be considered autonomous, self-governing agents in and of themselves. As well, I stated that adopting this position enables one to examine the decision-making capacity of a person with DID in light of their whole being to determine if the presence of alter personalities would compromise their capacity and agency. Thus, viewing an individual with DID through this lens, in this chapter, I will demonstrate that the presence of alter personalities could, in certain circumstances, impede or diminish the *overall* medical decision-making capacity and agency of a person with DID. While Maiese makes a similar claim regarding the impediment of an individual's agency due to dissociation into alter personalities, she situates her argument within the context of determining if such an impediment absolves a person with DID from moral or legal culpability for any committed crimes.<sup>206</sup> Other scholars have also put forth varying positions on the issue of agency and culpability regarding individuals with DID.<sup>207</sup> However, I will, instead, contextualize this

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<sup>206</sup> Maiese, "Dissociative Identity Disorder, Ambivalence, and Responsibility," 770; 778-780.

<sup>207</sup> Engaging in the debate regarding whether DID absolves culpability for crimes is beyond the scope of this thesis. For commentary arguing that a person with DID should be culpable, see: Jennifer Radden, *Divided Minds and Successive Selves: Ethical Issues in Disorders of Identity and Personality* (Cambridge, MA: The MIT Press, 1996), 125-142; Walter Sinnott-Armstrong and Stephen Behnke, "Responsibility in Cases of Multiple Personality Disorder," *Philosophical Perspectives* 14 (Action and Freedom) (2000), 301-323.; For responses challenging these authors specific arguments, see (respectfully): Ishtiyaque Haji, "Multiple Selves and Culpability" *Legal Theory* 3, no. 3 (1997), 249-272; Steve Matthews, "Blaming Agents and Excusing Persons: The Case of DID," *Philosophy, Psychiatry, and Psychology* 10, no. 2 (2003), 169-174; for a specific case study of determining whether a person with DID possesses civil competence and is responsible for their behaviour, see: Yu-Ju Lin, Ming-Hsein Hseih, and Shi-Kai Liu, "Dissociative State and Competence," *Journal of the Formosan Medical Association* 106, no. 10 (2007), 878-882.

impediment solely within the concept of medical decision-making capacity, and, in turn, demonstrate how each of the requirements or attributes for capacity regarding medical decisions (as outlined in Chapter One) could be hampered in such a person.

### 3.1 Appreciation and Expressing a Choice

#### *3.1.1 Moral Responsibility and Appreciation*

According to Glannon, if an individual possesses " . . . the capacity for beliefs about the foreseeable consequences of [their] actions . . .," they are morally responsible for those actions.<sup>208</sup> In other words, he states that one would have to be able to ascertain the consequences of a particular action *prior* to committing it in order to be held morally accountable for the outcomes of the act in question.<sup>209</sup> This claim seems logical, as, hypothetically, a child who steals their sibling's toy, but is unaware that stealing is generally considered to be a wrongful act, would not be held accountable for their behaviour because, prior to the act of stealing, it would not have been possible for them to evaluate the ramifications and consequences of such an act; however, if the child steals the toy again, they are morally responsible for that action, since prior to stealing the toy they were aware that it is wrong to steal.

Considering Glannon's assertion, there are certain domains of decision-making for which one can be held morally responsible, notably medical decision-making. The medical treatment decisions a patient makes for themselves or those made for a patient by a substitute decision-maker generate outcomes that could significantly affect the patient's welfare; thus, it is reasonable to state that engaging in morally responsible medical

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<sup>208</sup> Walter Glannon, "Moral Responsibility and Personal Identity," *American Philosophical Quarterly* 35, no. 3 (1998), 233.

<sup>209</sup> Glannon, "Moral Responsibility," 233.

decision-making would require the ability to draw possible conclusions about the effects or implications of treatment decisions or choices on the patient before executing them. This correlates directly with the aforementioned notion of appreciation, of which an integral facet is the ability to anticipate the implications of one's decisions. Thus, the following question is raised: could a person with DID possess this ability and, in turn, be morally responsible for their medical decision-making?

Maiese asserts that " . . . in [certain] cases of DID, there may be so many memory gaps and disruptions in the connectedness between mental states that it is difficult for [some individuals] to foresee what they will do or assess the long-term consequences of their actions."<sup>210</sup> Such disruptions could be due to amnesia regarding conscious experiences between alter personalities (a common feature of DID as previously mentioned).<sup>211</sup> As well, alter personalities can exist in different amnesiac states of awareness, including "asymmetrical awareness"<sup>212</sup> (one alter is aware of another's actions and thoughts but not vice versa) and "two-way amnesia"<sup>213</sup> (one's alters are not aware of each other's existence). Braude notes that persons with DID only occupy, or act through, one alter personality at a time.<sup>214</sup> Therefore, depending on which alter personality is manifested and the degree of awareness between a patient's alter personalities, it may be difficult (or impossible) for a patient with DID to foresee (i.e. appreciate) the implications of a treatment decision for all of their alter personalities if they are unaware of how the outcomes of such a decision would affect them in all of their personality states.

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<sup>210</sup> Maiese, "Dissociative Identity Disorder,"

<sup>211</sup> American Psychiatric Association, *DSM-5*. "Dissociative Disorders."

<sup>212</sup> Braude, *First Person Plural*, 42.

<sup>213</sup> Nguyen et al., "Obtaining Consent," 1092.

<sup>214</sup> Braude, *First Person Plural*, 42.

Therefore, this impediment would diminish a person's ability to make sound decisions for themselves (as a whole). As Braude states, individuals with DID who cannot foresee the implications of their actions are not morally responsible agents because " . . . if each [alter personality's] evaluative capacities are inadequate, . . . then it may be that the [person] as a whole cannot judge [their] actions in a suitably integrated and comprehensive way."<sup>215</sup>

However, as discussed in Chapter Two, in some cases of DID, alter personalities mutually share conscious awareness and can observe the actions of other alters through depersonalization. In such cases, individuals could, theoretically, possess insight into how they act or think while occupying their range of alter personalities and, echoing Braude's point, evaluate the causal effects of a treatment decision in a more holistic and "comprehensive" manner. Thus, it should be noted that if a person with DID possesses such insight, the ability to appreciate the implications of medical treatment decisions on their entire being (and engage in morally responsible medical decision-making) would not be so hampered. Even though this ability can be impeded in persons with DID, such an impediment should not be automatically assumed solely on the basis of a diagnosis of DID.

### *3.1.2 Value (In)consistency, Appreciation, and Expressing a Choice*

In some cases of DID, such as was illustrated in the hypothetical scenario just presented, there could be inconsistency among alter personalities' expressed values, which, in turn, would diminish their capacity for appreciation and expressing a decisional choice with regards to medical decision-making capacity.

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<sup>215</sup> Braude, "Multiple Personality and Moral Responsibility," 51.

As discussed in Chapter One, each alter personality generally serves a specific function for an individual with DID. According to Braude, since alter personalities emerge from the pre-dissociative self, the functional "specialization" of alters results from the distribution of " . . . traits and abilities manifested by or latent in the pre-dissociative [self] . . . throughout the members of the personality system."<sup>216</sup> Therefore, since traits and abilities can be distributed among alter personalities, it would also make sense for a person's values to be divided among their alters. In order for an alter personality to be able to carry out its function or role, it would have to prioritize values that would be important or beneficial to their particular role. As an example, Oliver possesses the alter personalities "John" and "Sam." If John is a promiscuous alter and Sam is a protector alter, then in carrying out these roles, Sam would have to prioritize and value Oliver's personal safety and security, whereas John would be inclined to take risks. The competing values of personal security and risk-taking could both be plausibly possessed by Oliver as a whole, as persons without DID can possess contrasting values that are weighted depending on the situation or circumstances at hand. For instance, one might accept an invitation to go jet-skiing (an activity that carries a risk of bodily injury) but, on another occasion, prioritize their safety by declining to go skydiving since that activity is above the threshold of risk to which they are willing to consent.

However, in a person with DID, inconsistency between the expressed prioritized values of their alter personalities would be problematic, as one's alters could make vastly different choices regarding a particular medical treatment decision. While this may appear to be, on the surface, qualitatively similar to other patients who may struggle with

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<sup>216</sup> Braude, *First Person Plural*, 57.

changing their minds repeatedly (such as those with other psychiatric disorders), the ramifications of clashing values between a patient's alter personalities could be quite detrimental. An example demonstrating this is the case of a twenty-three year old female with DID.<sup>217</sup> She possesses two alter personalities, Sarah and Jamie, who frequently switch throughout the day.<sup>218</sup> At one point, the individual in question was sexually assaulted while occupying the alter Sarah, and Sarah disappeared for six years.<sup>219</sup> During this time, Jamie decided to begin a course of hormone therapy and this decision was implemented without any external intervention.<sup>220</sup> Sarah returned to discover the physical changes that were occurring to her body, and she was bothered and distressed by these changes and that such a decision had been made in her absence.<sup>221</sup> In this case, the patient (while occupying the alter personality Jamie) clearly lacked the ability to, as Maiese states, " . . . [make] all-things considered judgments . . . in light of a conception of how a particular action [fit] into [their] life as a whole"<sup>222</sup> (with the particular action here being decision-making). In this case, the patient is consciously aware of both of her alter personalities while occupying either Jamie or Sarah (although Sarah was absent or dormant during the decision). However, value incoherence among alter personalities can also be observed in patients with alters who display degrees of unawareness between them. For example, in the case of a twenty-year-old Korean patient (whose alters display asymmetrical awareness), the patients' alters include (among others) a violent personality who is described by the system as a "thirsty killer," and a diametrically opposed alter who

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<sup>217</sup> Ribáry et al., "Multiplicity: An Explorative Interview," 4.

<sup>218</sup> Ibid., 4.

<sup>219</sup> Ibid., 4.

<sup>220</sup> Ibid., 4.

<sup>221</sup> Ibid., 4.

<sup>222</sup> Maiese, "Dissociative Identity Disorder," 772.

is nurturing, caring, and motherly.<sup>223</sup> For those with asymmetrical awareness, depending on whether or not the alter making the decision is aware of the conscious states and thoughts of the other alters, the person as a whole may not be able to make medical decisions that are inclusive of the values and preferences of all of their personalities. In cases of total unawareness, such inclusive decision-making would be impossible due to the absence of conscious awareness among alters.

Therefore, in the context of capacity, value inconsistency may impede the patient's ability to foresee the implications of a particular treatment choice on their entire being, as it is possible that each alter would make treatment decisions according to only *their* values (as seen in the case of Jamie and Sarah). What the patient considers to be an acceptable or reasonable treatment while occupying one alter may not correlate with their wishes or opinions while occupying another alter. As well, in certain circumstances (especially involving patients with degrees of unawareness between alter personalities), a patient may have no way of knowing how they would react to a particular treatment option in their various personality states. Thus, in a patient with DID, an inability of individual alter personalities to appreciate the significance or impact of a treatment choice on the entire personality system would certainly diminish the patient's overall capacity to engage in sound medical decision-making.

Moreover, if a person's alter personalities can make contrasting treatment choices due to different prioritized values, their ability to effectively communicate or express such a choice would be hampered as well. As stated in Chapter One, if one is to

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<sup>223</sup> Ilbin Kim, Daeho Kim, and Hyun -Jin Jung, "Dissociative Identity Disorders in Korea: Two Recent Cases." *Psychiatry Investigation* 13, no. 2 (2016), 251.

effectively communicate their preferred treatment option, their choice would have to remain stable long enough for it to be implemented or carried out by a physician or care team. Since a person's alter personalities can frequently switch between one another, the person's expressed choice could change multiple times if there is incongruence between the preferences for a particular treatment option among their alters. This parallels Lo's remarks from Chapter One regarding how the presence of inconsistent values would cause patients in general to repeatedly change their minds regarding their medical decisions.<sup>224</sup> Since Lo states that such inconsistency would undermine a patient's ability to communicate a decisional choice,<sup>225</sup> it can be inferred that this ability would also be impeded in individuals with DID who express incongruent values or preferences throughout their alter personalities.

However, note that in Chapter Two, I discussed Braude's notion of how an alter personality's abilities are not necessarily unique to that alter (as alters can share abilities). Similarly, it could be possible for alters to share values since some personalities' can have overlapping or shared functions.<sup>226</sup> This is apparent in the aforementioned case of Kim Noble.<sup>227</sup> Kim is a mother to daughter Aimee, and some of her alter personalities, such as "Bonny," "Hayley," and "Patricia," act in tandem as caregivers to Aimee.<sup>228</sup> Kim (through these alters) successfully fought for custody of Aimee when the courts took her away at birth, thinking that Kim was psychologically unfit to care for a child.<sup>229</sup> In Kim's case,

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<sup>224</sup> Lo, "Assessing Decision-Making Capacity," 195.

<sup>225</sup> Ibid., 195.

<sup>226</sup> Putnam, *Diagnosis and Treatment*, 106.

<sup>227</sup> Amanda Mitchison, "Kim Noble: The Woman with 100 Personalities," *The Guardian*, September 30, 2011. <https://www.theguardian.com/lifeandstyle/2011/sep/30/kim-noble-woman-with-100-personalities>.

<sup>228</sup> Mitchison, "Kim Noble."

<sup>229</sup> Ibid.



these personalities express her desire to be a parent and, as parental personalities, one could reasonably assume they would make decisions that serve to protect Aimee and ensure that Aimee's well-being is secured (what any good parent would highly value). Therefore, Kim's caregiving personalities would most likely agree on decisions and choices with regards to parenting due to these shared values, thereby suggesting that it would be theoretically possible, in other DID cases, for alter personalities to agree on certain types of decisions if their values coincide. Thus, in the context of capacity for medical decisions, depending on the treatment decision at hand, the ability for the person to express a singular decisional choice may not be so impeded. And if alters who share values are mutually aware of each other's thoughts and conscious states, then the person (as a whole) may be able to appreciate the significance of a particular treatment option on their system of alter personalities and choose an option that would be in line with their alters' common values. As will be elaborated upon in Chapter Four, physicians would need to determine this ability on a case-by-case basis, taking into account the degree of value sharing and conscious awareness among alter personalities, as well as the treatment decision being made.

### *3.2 Understanding and Reasoning*

In addition to appreciation and expressing a choice, the abilities of "understanding" and "reasoning" (as necessary for medical decision-making capacity) could be impeded in a person with DID. First, in cases where one's alter personalities are not consciously aware of each other's experiences, situational or contextual information needed to make a treatment decision may only reside with one personality. For example, hypothetically, Sally is a female patient with DID whose two alter personalities "Jane"

and "Lucy" exist in a state of two-way amnesia. She has been diagnosed with breast cancer and, during a consultation with her physician, "Jane" receives information regarding possible treatment options. Since Jane and Lucy cannot access one another's conscious thoughts and experiences, only Jane would be able to make an informed decision regarding the treatment since she possesses the knowledge about the treatment information. Thus, Sally's overall ability to understand and comprehend the necessary treatment information is diminished since Lucy does not possess this information. As well, an episode of dissociative amnesia (in the form of a lapse in dependable memory)<sup>230</sup> experienced by one alter could cause them to lose or forget information acquired during a previous manifestation. Using the same example, if Jane is unable to retain the treatment options and information presented to her and recall it at a later time, then she too would not possess the required information to make a decision regarding Sally's treatment, thereby impeding Sally's capacity requirement of understanding.

As previously mentioned, the concept of understanding with regards to medical decision-making capacity also requires a patient to comprehend that their decisions will have an impact on them.<sup>231</sup> This ability could be impeded in persons with DID. If one's alter personalities are mutually unaware of each other's existence, then it would follow that any treatment decision a single alter makes would be made in ignorance of any impact the decision will have on their other alters. In such a case, the person would be constricted to an awareness of the impact on the alter they are occupying when making

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<sup>230</sup> American Psychiatric Association, *DSM-5*, "Dissociative Disorders."

<sup>231</sup> Appelbaum and Grisso, "Assessing Patients' Capacities," 1636.

the decision, thereby impeding their ability to understand that a medical treatment decision could affect their *entire* well-being and welfare.

However, in cases of mutual conscious awareness between alter personalities, these impediments to understanding may not be so severe, as more than one (or even the full range) of a person's alters could receive and retain the necessary knowledge or information to make a treatment decision. As well, if a person's alters are conscious of the existence and thoughts of each other, the person (as a whole) would be able to make a more informed treatment choice if they are aware that they would be impacted (possibly in drastically different ways) by a treatment choice in various personality states. Though it would not be guaranteed that such a patient would be able to make an informed decision while occupying *every* alter, it is theoretically possible; therefore, it should not be automatically assumed that an individual with DID is incapable of understanding and processing the required information for a medical decision.

Nevertheless, if a person with DID is not able to possess and comprehend the required treatment information for a specific decision in all of their personality states, it would seem logical that lacking such information would impede their overall ability to reason through the benefits and risks of various treatment options (depending on the alter personality they are occupying at the time of the decision). However, assessing the benefits and risks of treatment options would require more than just factual treatment information. Rovane states that rational agents are capable of ranking, and resolving inconsistencies among, their beliefs and values.<sup>232</sup> It would make sense that to judge

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<sup>232</sup> Carole Rovane, *The Bounds of Agency: An Essay in Revisionary Metaphysics* (Princeton, NJ: Princeton University Press, 1997), 140.

whether or not a treatment would be beneficial, a patient would need to possess this ability. Recall Buchanan's and Brock's assertion that patients need a set of values or a conception of what is good to determine whether a treatment is beneficial or harmful to their well-being,<sup>233</sup> and Lo's remarks regarding how coherency among a patient's values would allow a patient to assign importance or weight to certain values when making medical decisions.<sup>234</sup> With regards to persons with DID, as previously shown, it is possible for alter personalities to possess competing values, and those values may not align in some circumstances. Therefore, in these cases, the person (as a whole) may not possess a consistent set of expressed values across their alter personality system.

Consequently, such a lack of consistency would impede a person with DID (as a whole) from being able to rationally reason through the benefits and risks of treatment options, as they may possess a different perception of whether or not a treatment would support their well-being depending on the alter personality manifested at the time of the decision. Moreover, it could also render an individual with DID incapable of providing consistent justification for why they would choose a particular treatment option over another or what makes a certain option better than another (clear indications that a patient is able to rationally reason through a treatment decision as outlined by Siegel et al.<sup>235</sup>). Therefore, it is possible that the requirement of reasoning for capacity could be diminished in some patients with DID.

In summary, while not every patient with DID would have their capacity for medical decisions impeded, it is possible that some patients will display a severe

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<sup>233</sup> Buchanan and Brock, "Deciding for Others," 26.

<sup>234</sup> Lo, "Assessing Decision-Making Capacity," 195.

<sup>235</sup> Siegel et al. "Assessing Decision-Making Capacity," 163.

diminishment of capacity. If medical decision-making capacity is somewhat specific depending on the particular patient, for what medical decisions should patients with DID have capacity? Are there decisions or situations where such patients lack capacity? How can physicians and care teams promote and preserve the autonomy of a patient with DID when possible? These questions will be explored in Chapter Four where I will present a patient-centered approach to determining what medical decisions could (and should) be made by DID patients.

#### **Chapter 4: A Patient-Centered Approach for Determining Capacity**

Thus far, I have demonstrated that a person with dissociative identity disorder (DID) is a singular person with one center of agency and alter personalities are vehicles which channel their autonomous agency that is rooted in their pre-dissociative self. I have also outlined how, regarding the requirements for medical decision-making capacity, this capacity, as well as the agency to make and be morally responsible for medical treatment decisions, may be impeded or diminished (but not necessarily) in patients with DID. I will now discuss my recommendation for a patient-centered approach in terms of determining which medical treatment decisions, and under which circumstances, patients with DID could (and could not) be ethically entitled to make for themselves.

Before this discussion, however, it is necessary to first highlight the reasons why I utilize the term "patient-centered." First, as I alluded to in the previous chapter, assessing medical decision-making capacity for this patient group is, to a degree, patient-specific. A DID patient's alter personalities can exhibit varying types of awareness between them, and the patient's values may or may not be shared among their alters due to the functional specificity of each alter. Therefore, depending on how these phenomena are manifested in a patient with DID, medical decision-making capacity may or may not be impeded, which would necessitate assessing such capacity on a somewhat individual basis. This would be consistent with the objectives of "patient-centered care," which " . . . [puts] the particular patient, not the average patient, at the center of care planning . . . " and requires health

care professionals to " . . . [have] the flexibility to respond differently to different patients."<sup>236</sup>

Moreover, the language of "patient-centered" implies that such an approach places utmost importance on the patient themselves. Indeed, patient-centered care emphasizes patient welfare, as well as respecting the patient's values, preferences, and beliefs.<sup>237</sup> As previously discussed, allowing patients who are capable of making their own treatment decisions the freedom to do so respects the patient's autonomy, their decisional choices, and the values that guide those choices. Since patients with DID are autonomous agents (plausibly singular agents), and because capacity is both context- and decision-specific (as previously asserted by Pesiah et al.<sup>238</sup>), automatically discounting their autonomy by deeming them to not possess capacity for their medical decisions would constitute unethically undermining their free will. As well, this would undermine the patients' potential ability to make medical treatment choices that, in accordance with their beliefs and values, would be beneficial to them. Thus, in this sense, viewing DID patients and their welfare through a patient-centered lens would call on physicians and care teams to recognize situations where such patients could have capacity and uphold their autonomy. This would be in line with Lo's aforementioned remarks regarding the importance of health care professionals promoting the self-governance of patients with mental and cognitive disorders.<sup>239</sup>

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<sup>236</sup> Carolyn Ells, Matthew R. Hunt, and Jane Chambers-Evers, "Relational Autonomy as an Essential Component of Patient-Centered Care," *International Journal of Feminist Approaches to Bioethics* 4, no. 2 (2011), 80.

<sup>237</sup> NEJM Catalyst, "What is Patient Centered Care?," January 1, 2017, <https://catalyst.nejm.org/what-is-patient-centered-care/>.

<sup>238</sup> Pesiah et al., "Ethics, Capacity, and Decision-Making," 519.

<sup>239</sup> See Lo, "Assessing Decision-Making Capacity," 196-197.

Although, considering the aforementioned points regarding the interrelatedness of capacity and autonomy<sup>240</sup> and the reciprocal relationship between patient autonomy and intervention in treatment decisions,<sup>241</sup> as well as Buchanan's and Brock's statements from Chapter One,<sup>242</sup> promoting a DID patient's welfare would also require not allowing DID patients to make decisions they have been deemed incapable of making (due to significant impairment of capacity by the nature of their alter personalities) in order to prevent a possible infliction of harm upon them due to their incompetently made choices. As will be discussed in this chapter, a "patient-centered" approach that is based on promoting patient welfare provides leeway to ascertain a patient with DID as either capable or incapable of making a certain treatment decision, depending on the decision itself, as well as the degree of value sharing and conscious awareness among the patient's alter personalities. Such a way of viewing the decision-making capacity of DID patients would be coherent with current scholarly opinion on capacity and patients with mental disorders in general as I discussed in Chapter One.

It is important to clarify that the purpose of this chapter is not to generate every possible or hypothetical clinical decision and determine if a particular DID patient could have decision-making capacity for that decision, nor is it to provide determinations of capacity based on every possible configuration of awareness, value-sharing, or value-incongruence between alter personalities. These tasks would be nearly impossible to successfully accomplish. Instead, my aim is to build on the discussion from Chapter Three and provide general guidance and suggestions regarding certain situations when it

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<sup>240</sup> See Bassford, "The Justification of Medical Paternalism," 737.

<sup>241</sup> See Komrad, "A Defense of Medical Paternalism," 39;43.

<sup>242</sup> See Buchanan and Brock, "Deciding for Others," 26.



might be ethically (and even legally) appropriate to deem such patients as capable or incapable of making a particular medical decision.

#### 4.1 Decision to Pursue or Refuse Integration as Psychotherapy

##### *4.1.1 An Argument for Decision-Making Capacity*

As stated in Chapter Two, integration is a therapy for DID which attempts to combine a person's alter personalities into one personality state. In my opinion, it is possible for all patients with DID (while occupying any of their alter personalities) to possess capacity to consent (or refuse) to undergo integration.

First, in cases of DID where the patient's alter personalities are mutually aware of each other's existence and conscious states, I argue that only the patient would be able to appreciate or comprehend the significance and importance of alter personalities to their being. While a psychiatrist or therapist would be able to understand the function or role of each alter to a patient with DID through observation,<sup>243</sup> only the patient would be able to fully comprehend the (more subjective) significance or importance of each alter to their overall welfare and how they would react to, or be affected by, a disruption or change to their alter personality system (since they are the person that lives day-to-day as a collection of alters). Kluft states that certain patients are able to cope with possessing a collection of alter personalities and would prefer to live this way.<sup>244</sup> For example, Nicky Robertson accepts his alters and likens them to "beads" that, together, make up the

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<sup>243</sup> Putnam, *Diagnosis and Treatment*, 104-105.

<sup>244</sup> Richard P. Kluft, "Clinical Approaches to the Integration of Personalities," in *Clinical Perspectives on Multiple Personality Disorder*, ed. Richard P. Kluft, and Catherine G. Fine (Washington D.C.: American Psychiatric Press, 1993), 107.

"necklace" that is his whole identity.<sup>245</sup> Other patients are not so accepting, such as one nurse who writes that having DID made her feel a multitude of negative emotions, such as "shame," "despair," and "panic."<sup>246</sup> Integration and the loss of a patient's alters would certainly constitute a major change to the patient's personality system and way of life; therefore, it could be stated that a patient with mutually aware alters would possess the appreciation requirement of capacity, in that they would be able to appreciate the impact that integration would have on their entire being.

Considering Öztürk's and Şar's points from Chapter Two,<sup>247</sup> the attitude of the patient's pre-dissociative self towards integration would determine whether or not this impact is positive or negative, as it is the self that would have to accept (or reject) either a change in the nature of, or losing altogether, the alter personalities it initially created to block out the patient's traumatic memories and experiences. And since the attitude of this self to integrate would be channelled by the patient's alter personalities,<sup>248</sup> each of the patient's alters would plausibly express the same viewpoint regarding whether or not to integrate. Thus, irrespective of the degree of awareness among a patient's alters, due to this cohesion, any DID patient (as a whole) could rationally reason through the benefits and risks of integration and, in turn, express a consistent choice of whether or not to integrate across their alter personality system (which would satisfy the medical decision-making capacity requirements of reasoning and expressing a choice as stated in Chapter

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<sup>245</sup> Nicky Robertson, "Spiritual Aspects of DID," in *Living with the Reality of Dissociative Identity Disorder: Campaigning Voices* ed. Xenia Bowlby and Deborah Briggs (London: Karnac Books Ltd., 2014), 19.

<sup>246</sup> Anonymous, "Living and Working with MPD," *Journal of Psychosocial Nursing and Mental Health Services* 32, no. 8 (1994), 19.

<sup>247</sup> Öztürk and Şar, "The Trauma-Self," 3.

<sup>248</sup> *Ibid.*, 3.

One). For instance, if the pre-dissociative self is accepting of integration, the patient would regard the therapy as worth the risks of integration. Considering the concept and aims of integration,<sup>249</sup> such risks could include losing alter personalities altogether, learning how to function and live as a single personality, and dealing with past trauma as the boundaries between the alter personalities and past memories and experiences erode (a feature of DID therapy<sup>250</sup>). On the contrary, if the pre-dissociative self is ambivalent towards integration, then the patient (through their alters) would view the disruptions to their personality system as detrimental to their welfare and not be willing to consent to the above risks. Therefore, in accordance with the medical decision-making capacity requirement of "understanding," the alter personalities of any DID patient would be able to understand that the decision to attempt integration is life-changing and would have an enormous impact on the patient's day-to-day life and welfare. Moreover, any uncertainty towards integration and reluctance to accept the aforementioned risks expressed by a patient's alter personalities is indicative of some uncertainty possessed by the pre-dissociative self;<sup>251</sup> thus, in order for consent to the therapy to be deemed acceptable, the patient's alters should display clear acceptance to integrate, as to disregard such uncertainty could constitute unethically undermining the wishes of the patient's autonomously capable pre-dissociative self.

Regarding the appreciation requirement of capacity, patients whose alters are not consciously aware of one another or patients who possess incoherency among their alters' awareness of other alters (asymmetrical amnesia) would not necessarily have the ability

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<sup>249</sup> See Fine, "The Tactical Integration Model," 362; Putnam, *Diagnosis and Treatment*, 301.

<sup>250</sup> See Putnam, "Dealing with Alters," 287.

<sup>251</sup> *Ibid.* 3.

to appreciate the significance of the decision to integrate on their whole being when making the decision, since they would be only occupying one alter at the time of the decision. Despite this, given the aforementioned commentary on how a patient's alter personalities reflect the attitude of their pre-dissociative or trauma-self towards therapy,<sup>252</sup> the choice to integrate would plausibly be consistent across a patient's alter personalities. As a result, this inability may not impede such a patient's capacity for this decision. Moreover, considering that the decision to integrate (or not) affects the fundamental psychological composition and welfare of all patients with DID, in my opinion, one would be ethically justified in respecting the autonomous agency of the pre-dissociative self and, in turn, accepting the choice regarding integration expressed by any DID patient as one that is capably made. Since many DID patients have experienced extreme abuse and are psychologically traumatized, physicians need to exercise care in ensuring that they " . . . avoid inflicting further pain . . ." upon the patient;<sup>253</sup> therefore, respecting a patient's capacity and autonomy for this decision would certainly promote the patient's welfare.

On a somewhat simpler note, it could also be argued that because integration is regarded as an autonomously executed behaviour by the patient, forcing integration upon a patient through forced therapy would be therapeutically ineffective. Forced integration via hypnosis and verbally persuading the patients' alters to integrate while the patient is in a hypnotic trance has been attempted by psychiatrists, notably Brandsma and Ludwig.<sup>254</sup>

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<sup>252</sup> Öztürk and Şar, "The Trauma-Self," 3.

<sup>253</sup> Cornelia B. Wilbur, "Treatment of Multiple Personality." *Psychiatric Annals* 14, no. 1 (1984), 27.

<sup>254</sup> Jeffrey M. Brandsma, and Arnold M. Ludwig, "A Case of Multiple Personality: Diagnosis and Therapy," *International Journal of Clinical and Experimental Hypnosis* 22, no. 3 (1974), 230.

However, many clinicians believe such techniques to be ineffective, as forcing integration results in the creation of a highly unstable integrated personality or a failure to integrate altogether.<sup>255</sup> Therefore, in order to achieve the therapeutic goals of integration, the decision to integrate should lie with the patient themselves. Furthermore, attempting to force integration therapy upon a patient would be highly unethical for two reasons. First, not allowing the patient to make this decision for themselves by attempting to coercively initiate integration while the patient in a suggestible state (i.e. hypnosis) would undermine the autonomous capability of the pre-dissociative self to choose whether or not to integrate, as well as the demonstrated sufficient decision-making capacity of the person as a whole regarding this decision. Second, given that patients with DID are often psychologically troubled individuals, a psychiatrist or care team may " . . . intensify the strife that they are supposed to stifle" if they attempt to impose integration upon a patient, as the patient may be re-traumatized if they feel that their welfare and alter personalities are threatened and not respected by their health care professionals.<sup>256</sup> Recall Lo's aforementioned point regarding the need for health care providers to establish trust with vulnerable patients, including those with mental disorders, as well as foster comfort through reassuring such patients that their needs will be met.<sup>257</sup> Both of these attributes of ethically sound care of mental health patients would certainly be undermined through imposing a patient to attempt integration, and, as Putnam states, "[t]here may be a significant disruption in the therapeutic alliance following a forced [integration]."<sup>258</sup>

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<sup>255</sup> Putnam, *Diagnosis and Treatment*, 303-304.

<sup>256</sup> *Ibid.*, 304.

<sup>257</sup> Lo, "Assessing Decision-Making Capacity," 196.

<sup>258</sup> Putnam, *Diagnosis and Treatment*, 304.

#### 4.1.2 Potential Illegality of Involuntary Psychiatric Detainment for DID Patients

A final consideration is the potential illegality of detaining a patient with DID as an involuntary patient in a psychiatric unit. Spring notes that, among persons with DID in the United Kingdom, there is concern regarding the clauses in the UK *Mental Health Act* which give law enforcement personnel the grounds to move an individual to a "place of safety" if they "reasonably think" that the individual is "mentally ill" and moving them will " . . . keep [them] and other people safe."<sup>259</sup> Most often, this involves detainment for psychiatric assessment and possible further detainment in a hospital as an involuntary patient.<sup>260</sup> Such concern would lead one to examine whether an individual with DID could be legally detained due to their condition, and I argue that this could be legally problematic under mental health legislation in Newfoundland and Labrador (NL). I have chosen to utilize this legislation as a framework for analysis, as the legislation in NL is fairly standard and comparable to legislation in other developed nations. Also, as a bona fide resident of NL, I am interested in how our legislation would impact DID patients in this province.

Under Section 17(b)(ii) of the Newfoundland and Labrador *Mental Health Care and Treatment Act*, two of the criteria that must be met for a patient with a mental disorder in this province to be involuntarily admitted into a psychiatric unit are as follows:

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<sup>259</sup> Carolyn Spring, "Caring for Yourself: Aspects to Consider from the Mental Health Act and Mental Capacity Act," *Positive Outcomes for Dissociative Survivors*, March 17, 2016, Retrieved from <https://information.pods-online.org.uk/caring-for-yourself-aspects-to-consider-from-the-mental-health-act-and-mental-capacity-act/>.

<sup>260</sup> Spring, "Caring for Yourself."

1. [They] [are] likely to cause harm to [themselves] or to others or to suffer substantial mental or physical deterioration or serious physical impairment if [they] [are] not admitted to and detained in a psychiatric unit as an involuntary patient.
2. [They] [are] unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding [their] need for treatment or care and supervision . . . .<sup>261</sup>

Considering the first stipulation of the second clause regarding appreciation of the mental disorder in question, patients whose alters are consciously aware of each other would be able to acknowledge they have DID and that they house a collection of alters because of this disorder;<sup>262</sup> however, this may not be the case for patients whose alters are unaware of each other's existence. Each alter would only recognize their own existence and, as a result, the patient (while occupying any of their alters) may not consider themselves as having DID and other personality states. An example of this is the historical case of Norma, whose alter personalities were unable to integrate because they did not recognize the existence of each other nor believed they existed.<sup>263</sup> Therefore, for patients whose alters display asymmetrical awareness or are unaware of each other's existence, depending on the alter they are occupying at any given moment, the patient may not be able to understand the nature of the disorder and, in such cases, this clause may hold up.

In the previous section, I established that the decision to pursue integration therapy is one that could be capably made by all patients with DID. Regarding the first

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<sup>261</sup> Quoted from Section 17(b)(ii) of the *Mental Health Care and Treatment Act* (2014). [https://www.assembly.nl.ca/legislation/sr/statutes/m09-1.htm#16\\_](https://www.assembly.nl.ca/legislation/sr/statutes/m09-1.htm#16_).

<sup>262</sup> For an example of this, see: Carol Broad, "Living with DID," in *Living with the Reality of Dissociative Identity Disorder: Campaigning Voices* ed. Xenia Bowlby and Deborah Briggs (London: Karnac Books Ltd., 2014), 67.

<sup>263</sup> Robert W. Riber, *The Bifurcation of the Self: The History and Theory of Dissociation and its Disorders* (New York: Springer Science+Business Media, Inc., 2006), SpringerLink, 165.

clause of Section 17(b)(ii), patients with DID who decide not to pursue integration therapy for DID would not necessarily be harming themselves. The notion of "harm" is both broad and vague in terms of its meaning, and it is beyond the scope of this chapter to outline and defend a conception of harm; however, if one accepts, for instance, Feinberg's well-known philosophical viewpoint (i.e. to cause harm is to setback one's or another's interests),<sup>264</sup> a patient who decides not to integrate would not be harming themselves as this decision would *support* the attitude to not pursue integration that is possessed by their autonomously capable pre-dissociative self. Considering harm in the psychological sense, as previously stated, choosing not to integrate would promote the psychological and emotional welfare of the patient if the pre-dissociative self is not ready to do so; therefore, such a decision would not harm the patient in this sense, and, by extension, not cause "mental deterioration" as their mental stability would be maintained. Involuntary detainment would inflict undue psychological harm due to the potential distress and anxiety this act would induce in the patient.<sup>265</sup> Moreover, DID does not necessarily cause physical harm, deterioration, or impairment, as patients with DID can function day-to-day and carry out successful lives.<sup>266</sup> Detainment on the basis of harm may be legally justifiable, though, on a case-by-case basis when factoring in a particular patient's life circumstances and if they are causing significant harm to others. Nevertheless, solely choosing to live with DID would not be grounds for psychiatric detainment under the

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<sup>264</sup> Joel Feinberg, *The Moral Limits of the Criminal Law*, vol. 1 (Oxford, Oxford University Press, 1984), 31-32.

<sup>265</sup> Putnam, *Diagnosis and Treatment*, 304.

<sup>266</sup> For an example of this, see Kim Noble's story about becoming a successful painter and artist: Kim Noble, "About," <http://www.kimnobleartist.com/about.html>.



aforementioned first clause, and any attempt to do so would be both unethical and illegal under this legislation.

## 4.2 Non-Psychotherapeutic Treatment Decisions

Similar to all other patient groups, patients with DID can be afflicted with non-psychiatric pathologies and many will likely encounter medical treatment decisions other than choosing whether or not to integrate their alter personalities. Recall that a patient-centered approach prioritizes seeking out possible means of deeming patients with DID as capable of making their own treatment decisions, so this section will outline possible ways that such patients could possess decision-making capacity for non-psychotherapeutic treatment decisions.

### 4.2.1 Possessing a Main Alter Personality

Physicians and care teams should determine if the patient possesses a "main"<sup>267</sup> or "host"<sup>268</sup> alter personality. Many individuals with DID possess a dominant personality that is manifested most often and takes on a larger functional role than their other alters.<sup>269</sup> Putnam notes that in many cases, the host personality is often "compulsively good" and "conscience-stricken,"<sup>270</sup> with an example being a fifty-five year-old patient who states that she feels most comfortable and at ease when occupying her main alter (who also identifies as a fifty-five year old female).<sup>271</sup> It is not clear from the literature whether the patient chooses their main alter personality or whether it just emerges as the

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<sup>267</sup> Victor S. Alpher, "Assessment of Ego Functioning in Multiple Personality Disorder," *Journal of Personality Assessment* 56, no. 3 (1991), 375.

<sup>268</sup> Putnam, *Diagnosis and Treatment*, 107.

<sup>269</sup> *Ibid.*, 107.

<sup>270</sup> *Ibid.*, 107.

<sup>271</sup> Muhammad Awais Rehan et al., "A Strange Case of Dissociative Identity Disorder: Are There Any Triggers?," *Cureus* 10, no. 7 (2018): e2957, 2.

more dominant alter. However, because dissociation is considered an adaptive response and patients have some control over the dissociative process to ensure they are able to cope in their surroundings,<sup>272</sup> I think it is reasonable to posit that an alter could be chosen or designated as a main alter as part of ensuring that the patient's specific coping and survival needs are met. Main alter personalities can assume a variety of different forms. For example, "Matthew" is the dominant alter in a system containing alters who have names of fictional characters (e.g. Han Solo; Luke Skywalker), and the alters refer to themselves as the "space system";<sup>273</sup> "Autumn" refers to herself as the "core" functional personality of her system, and the other alters are mainly child personalities who call Autumn "mommy";<sup>274</sup> "Nadine" is considered the "major" alter of the personality system to which she belongs and she speaks on behalf of the other alters.<sup>275</sup>

With regards to medical decision-making, consider first the above case of Autumn. Hypothetically, the person who houses Autumn and the other alters is confronted with a medical decision concerning whether or not to undergo high-risk brain surgery. Since child alters think and act like children regardless of the age of the individual who houses them,<sup>276</sup> a physician would be justified in deeming Autumn to have decision-making authority since standard ethical and legal medical practice regards

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<sup>272</sup> See Sarbin, "On the Belief"; Spanos, "Multiple Identity Enactments."

<sup>273</sup> Ribáry, "Multiplicity: An Explorative Interview Study," 4.

<sup>274</sup> Monica Robins, "Pieces of Me: One Woman's Story of Living with Multiple Identities," *WKYC3 News*, May 24, 2018. <https://www.wkyc.com/article/news/health/pieces-of-me-one-womans-story-of-living-with-multiple-identities/95-557622057>.

<sup>275</sup> René J. Muller, "A Patient with Dissociative Identity Disorder 'Switches' in the Emergency Room," *Psychiatric Times* 15, no. 11 (1998). Retrieved from <https://www.psychiatristimes.com/dissociative-identity-disorder/patient-dissociative-identity-disorder-switches-emergency-room>.

<sup>276</sup> For evidence of this, see: Lisa Capretto, "Cameron West, Man Who Had 24 Personalities, Shares what Life is Like Today," *The Huffington Post*, January 23, 2014. [https://www.huffpost.com/entry/cameron-west-multiple-personalities-oprah\\_n\\_4591462?guccounter=1](https://www.huffpost.com/entry/cameron-west-multiple-personalities-oprah_n_4591462?guccounter=1); Rob Spring, "Back to Normal? Surviving Life with Dissociation," in *Living with the Reality of Dissociative Identity Disorder: Campaigning Voices* ed. Xenia Bowlby and Deborah Briggs (London: Karnac Books Ltd., 2014), 84-86.

children as having limited autonomous capability of giving consent to their own medical treatment.<sup>277</sup> In this case, it would be ethically sound to accept the decision made by the main alter Autumn, provided the patient is deemed to possess the aforementioned requirements for medical decision-making capacity while occupying Autumn. If so, this person's physician could assert that decisions made by Autumn are to be regarded as authoritative and note on the person's health record that only decisions made by Autumn are to be accepted and carried out.

However, what would be an appropriate approach in cases like Matthew or Nadine above (i.e. the patient's main and other alters are aware of one another but the alters are all adult personalities)? In my opinion, it is not unreasonable to posit that such a patient (while occupying their less predominant alters) might accept a treatment choice that they knowingly made while occupying their main alter. The patient would have to endure and live with the consequences of the decision for the longest period of time while occupying their main alter; therefore, it seems ethically plausible to accept a decision made by the patient during the manifestation of the main alter, as it is during this manifestation that the patient's overall welfare would be most at stake. One could argue that affording decision-making authority to the main alter personality would resemble cultures where men are regarded as authoritative and make decisions for their wives, thus undermining the autonomous capability of their wives to make their own decisions. However, a key difference between these situations is that, in the case of the man and wife, one agent (i.e. the man) is making decisions for another agent (i.e. his wife); in the

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<sup>277</sup> See Beauchamp and Childress, *Principles of Biomedical Ethics*, 105; P. Bradley, "Issues of Consent and the Primary-School Medical," *Journal of Medical Ethics* 26 (2000), 469.

case of a patient with DID, there is only one agent involved (this singularity was established in Chapter Two). As previously mentioned, given the "adaptive function" of alter formation,<sup>278</sup> it is plausible that the patient's pre-dissociative self (as the singular locus of agency) can choose which alter becomes the main alter and, as apparent from the discussion in Chapter Two, channel the patient's agency through the main alter. Therefore, from a viewpoint of autonomy, accepting the decision of the main alter would constitute respecting the autonomous agency of the patient to make decisions they believe would contribute to their welfare. Although, ethically, a physician would have to determine whether or not the patient possesses the aforementioned requirements for decision-making capacity while occupying their main alter before accepting decisions; however, if a patient has a self-recognized main alter personality, the patient's decision made through this alter should be accepted if at all possible.

#### *4.2.2 Value-Sharing Among Alter Personalities*

In Chapter Three, I discussed how shared values between a patient's alter personalities can result in an increased overall capacity to appreciate the implications of a treatment decision on the patient's entire being, as well as greater consistency among their alters' expressed choice of treatment and assessment of the benefits and risks of various treatment options. This indicates that the level of value-sharing among alter personalities can significantly affect determinations of decision-making capacity for treatment decisions. As a result, an intriguing question is raised: what degree of value-overlap would be necessary to possess capacity for a treatment decision?

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<sup>278</sup> See Maiese, "Dissociative Identity Disorder," 767; Putnam, *Diagnosis and Treatment*, 11-12.

Beauchamp and Childress state that risk and the "... evidence for determining [capacity] ..." are positively correlated.<sup>279</sup> In other words, as the risks associated with a medical decision increase/decrease, the required evidence for determining capacity with regards to that decision should increase/decrease as well.<sup>280</sup> For example, they assert that the attributes required to consent to participating in medical research should be more stringent than objecting to participation.<sup>281</sup> This would make sense, as participating in research carries a greater level of risk and potential for harm to the patient than not participating; therefore, the requirements for patient capacity to choose participation would need to be greater than choosing not to participate in order to ensure that such a decision is informed. Since value-sharing among alter personalities would be an integral component or attribute of determining medical decision-making capacity for patients with DID, it is plausible to apply Beauchamp's and Childress's assertion to this patient group and state that the degree of value-overlap needed for a treatment decision would depend on the degree of risk posed by the decision. As such, decisions with a lower/higher level of risk and potential for harm would require a lower/higher degree of value-sharing between a patient's alters; thus, I would argue that patients with DID could be capable, in some cases, of making both low-risk and high-risk treatment decisions because, as previously discussed through overlapping and shared functions of alter personalities,<sup>282</sup> a patient's alters can share values.

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<sup>279</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 120.

<sup>280</sup> *Ibid.*, 120.

<sup>281</sup> *Ibid.*, 120.

<sup>282</sup> See Putnam, *Diagnosis and Treatment*, 106.

Hypothetically, consider the following treatment decisions which vary widely in terms of the amount of associated risk: deciding to obtain a bandage for a minor burn, and deciding whether or not to undergo a leg amputation for a severe infection. It is clear that deciding to amputate carries much greater risks (e.g. physical rehabilitation with an artificial limb; long recovery time). However, this decision is also much more value-laden, as bandaging is a common treatment (even outside of a hospital setting) that most patients would probably accept, whereas amputation could significantly affect all aspects of one's life and, as a result, it is highly personal choice, and one may or may not be willing to accept the risks associated with amputation based on their values. For example, if one wants to eventually pursue an active lifestyle, then having the amputation and artificial limb insertion could relieve their pain from the infection and allow them to do so; therefore, the risks of the surgery would not outweigh the benefit of a lifestyle improvement. However, if a patient does not want to be an in-patient or push themselves through the rehabilitation required by surgery, these risks would probably not be acceptable to the patient.

Suppose that Patient A is presented with the bandage decision and Patient B is presented with the amputation decision. Both patients are adults with DID and, in each case, their alter personalities are adult personalities who are consciously aware of one another's existence and thoughts (but there is no main alter). Considering Patient A, their decision is low-risk and could plausibly be made with a low level of value coherence. Therefore, provided that the knowledge regarding the burn as well as the need for a bandage is shared among their alters, any of Patient A's alters could make this decision, regardless of the level of value-sharing. Regarding Patient B, the level of value-sharing

would need to be greater due to the higher level of risk associated with the outcomes. As mentioned in Chapter Three, a patient may judge the risks of a decision differently in their various alter personality states due to the values possessed by those alters, so value-sharing would be necessary to ensure that the decision would support the overall welfare of the patient.

In this case, if Patient B is aware that all of their alters uphold the same values, any alter would be able to soundly consent to the decision. For example, if all of the patient's alters possess the value of gaining an active lifestyle, the patient (while occupying any alter) could consent to the amputation, as they would be aware that this decision is in line with their alters' shared value and would be able to appreciate that this choice would have a positive impact on them in all of their personality states. Moreover, the patient (as a whole) would express a consistent choice across their range of alter personalities, and would be able to rationally reason through the decision in the same manner across their personality states, all of which are crucial components of medical decision-making capacity. To clarify, I am not invoking or arguing for a standard here, nor am I insisting that this is the sole means by which capacity should be ascertained. Instead, I am only arguing that if a clinical situation similar to that of the above scenario arises, this DID patient should be deemed to have capacity for the medical treatment decision at hand.

However, in general, medical treatment decisions do not always align with all of a patient's values, as such decisions often require weighting certain values as more important than others and preserving the values and preferences that are deemed to be

important.<sup>283</sup> Therefore, it may not be guaranteed that Patient B would choose the amputation option while occupying all of their alter personality states due to the differing roles of their alters and possible differing values expressed by those roles.<sup>284</sup> In this case, since Patient B (a singular agent) is consciously aware of how they would react to the decision in each personality state, they could theoretically opt to weight the value of an active lifestyle if they judge this value as important to their welfare. Therefore, if this is the case, Patient B (and other similar patients) could again soundly choose amputation, as, effectively, they would be able to judge which value(s) are important to them and choose the option according what they deem would be in line with their weighted value(s). Possessing these abilities would indicate that Patient B (as a whole) would have the capacity to logically reason through the risks (and benefits) of the decision and provide clear rational justification for why they would choose amputation, both of which would be integral components for capacity for this decision. It should be noted that the number of alter personalities a patient possesses does not factor into my arguments above, as patients whose alters are aware of one another would still possess this awareness and ability to weight values because of this awareness regardless of the size of their personality system.

Possessing shared values and such weighting becomes important when patients whose alter personalities are not consciously aware of each other or display degrees of asymmetrical awareness are faced with higher-risk treatment decisions. It is worth explaining, first, that if there is an externally-observed main alter, it would be ethically

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<sup>283</sup> Lo, "Assessing Decision-Making Capacity," 195.

<sup>284</sup> See Putnam, *Diagnosis and Treatment*, 106-114.



questionable to afford authority to the values or preferences of that specific alter, as the patient would probably not accept treatment decisions made by a personality state they do not know exists except for when they are occupying that sole state. Parallels have been noted in the case literature on DID and legal culpability, as a person's alter personalities who are unaware that another alter committed a crime do not acknowledge or accept that this action occurred.<sup>285</sup> In such cases of DID, I think that deeming this alter as authoritative would constitute arbitrarily prioritizing one of the patient's values (or one set of values) over another, as to the patient, there would be no self-recognized main alter personality. Thus, if a physician or health care team presented a treatment decision made by such a personality to the patient's other alters, the patient would probably be confused as they would have no recollection of making this choice (caused by "selective amnesia" for this decision),<sup>286</sup> and it may cause distress to the patient if they think their health care team is paternalistically imposing a choice on them. Moreover, such patients would not be able to self-judge the values or preferences of their range of alters, so it would not be possible for them to knowingly make a treatment decision in light of any shared values among their alters or in consideration of how their alters would react to the decision.

Even though such patients may not be able to ascertain the values and opinions of their range of alters, it would be possible for health care professionals to do so, and, in some cases, high-risk treatment choices could still be made in accordance with the shared or common values of a patient's alters. Hypothetically, if Patient C (whose alters are not

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<sup>285</sup> For examples, see Stephen H. Behnke, "Assessing the Criminal Responsibility of Individuals with Multiple Personality Disorder: Legal Cases, Legal Theory," *Journal of the American Academy of Psychiatry and the Law* 25, no. 3 (1997), 397.; Sarah K. Fields, "Multiple Personality Disorder and the Legal System," *Journal of Urban and Contemporary Law* 46, no. 1 (1994), 276-277; 281-282.

<sup>286</sup> See Putnam, *Diagnosis and Treatment*, 13.

aware of each other's existence) is faced with the above amputation decision, the health care team could present the decision separately to each of Patient C's alters and the patient could be allowed to make the decision while occupying each alter according to the values expressed by that alter. If there is significant overlap in terms of the decision and the values which shape that decision between Patient C's alters, then, similar to Patient B's case, these predominant values could be weighted and the decision could be accepted as it would be in line with the weighted values. Therefore, in accordance with Buchanan's and Brock's aforementioned arguments,<sup>287</sup> even though the patient themselves did not actively make or reason through the decision it would still be ethically sound, as the patient's autonomous agency is afforded respect because their weighted values and preferences are dictating the decisional choice and the rationale behind it. However, the patient's alters would have to remember the information regarding the treatment between manifestations (as such a high-risk decision would probably take time and have to be decided over more than one manifestation of each alter), and it would probably only be practical to do this in cases where there is a small number of alters. Nevertheless, this act would be possible for some cases, so in accordance with a patient-centered approach (which prioritizes DID patients' autonomy), physicians and care teams should attempt this if at all possible.

#### 4.3 Possible Situations Where DID Patients May Not Possess Capacity

As part of the patient-centered approach, in some cases, it may be ethical to deem DID patients as not capable of making their own treatment choices if the patient is unable to sufficiently meet the requirements of medical decision-making capacity. Here, I

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<sup>287</sup> See Buchanan and Brock, "Deciding for Others," 29.

propose two situations where this could be possible for *non-integration* treatment decisions.

In the previous section, I discussed a scenario where significant value-sharing would be a crucial indicator of decisional capacity and could enable patients with DID to make both low- and high-risk treatment choices. However, as outlined in Chapter One, the diversity or incoherency in the roles of the manifested alter personalities indicates the severity of the patient's condition.<sup>288</sup> Since the roles or functions of the manifested alters would be plausible indicators of the values possessed by those alters (as discussed in Chapter Three), incoherency among the patient's expressed values would *ipso facto* indicate a more severe condition. Thus, consistent with the rationale employed in the previous section, I argue that in instances where there is total or highly significant value-*incongruence* between a patient's alters, the severity of the patient's condition could result in a severe enough diminishment of medical decision-making capacity to preclude them from making treatment decisions if this incongruence leads to complete and irresolvable disagreement of choice. This could especially occur with patients whose alters are not aware of one another's existence (either a large or small personality system), as such patients would have no way of resolving disagreement or discord among their alters' opinions and values due to such lack of awareness. In these cases, all of the aforementioned capacity requirements (appreciation, understanding, reasoning, and expressing a choice) could be sufficiently impeded to preclude capacity. First, regarding appreciation, the patient (as a whole) would not be able to ascertain the implications of a particular treatment choice on their entire being at the time of the decision, as they would

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<sup>288</sup> See Öztürk and Şar, "Formation and Functions of Alter Personalities," 6.

only be able to determine the implications for the alter making the decision. As a result, they would not be able to understand that there are other alters who could be affected by the decision. Moreover, due to total value-incongruence, the patient would likely arrive at different decisional choices due to contrasting assessments and reasoning of the benefits and risks of various treatment options, and it would not be guaranteed that a significant majority of those decisional choices would be the same. Thus, there is a high probability that the choices expressed by the patient (across their range of alter personalities) would be incoherent. Taking into account the aforementioned current opinion on justifiable intervention in patients' medical decision-making,<sup>289</sup> since the core attributes of medical decision-making capacity would be severely impeded in these circumstances, such patients could reasonably be precluded from possessing capacity.

Furthermore, patients who possess a significantly small number of alter personalities, such as two, who are mutually aware of each other's conscious states but express conflicting choices due to value-incoherence, would not be able to make sound treatment decisions. Recall the case of Sarah and Jamie as discussed in Chapter Three. This case demonstrates that, with such a low number of alters, implementing a decision that goes against just one alter's wishes would be unethical, as it would cause the patient distress and anxiety due to the fact that they would be occupying each of their alters more frequently than if they possessed a larger number of rotating alters. In a case such as this one, if a patient is not able make a decision they would accept in both personality states,

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<sup>289</sup> See Greaves, "Can Compulsory Removal," 191.; Breeze, "Can Paternalism be Justified," 264; Carter, "Justified Paternalism," 143.

no alter's wishes or preferences should be prioritized and deemed authoritative, and they should be precluded from making their own medical treatment decisions.

In the above situations, these particular DID patients would require a substitute decision-maker (SDM) due to their incapacity. If a patient who belongs to one of the above groups is a Newfoundland and Labrador resident, this would entail following the legislation outlined in Section 10 of the *Advanced Health Care Directives Act (AHCD Act)* to determine an appropriate SDM.<sup>290</sup> However, SDMs for such patients would be faced with a peculiar problem. Ethically, a SDM should, according to Beauchamp and Childress, make decisions in line with the patient's expressed values and " . . . determine the highest probable net benefit among the available [treatment] options, assigning different weights to interests the patient has in each option balanced against their inherent risks, burdens, or costs."<sup>291</sup> It would be difficult to assign weight to certain preferences or interests (based on what the patient would value most if they had capacity) if the patient expresses highly contrasting and conflicting values in each personality state. In other words, a SDM may not be able to determine what the patient (as a singular whole) would value most and what option would be most in line with this value if there is significant value-incongruence between alter personalities. Therefore, how could treatment decisions be made in these circumstances?

With regards to SDMs and patients in Newfoundland and Labrador, Section 12(1)(c) of the *AHCD Act* states that in cases where a SDM does not possess knowledge of the patient's preferences or wishes for a particular decision, they are required to act in

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<sup>290</sup> Government of NL, *Advanced Health Care Directives Act* (2014), <https://www.assembly.nl.ca/Legislation/sr/statutes/a04-1.htm>.

<sup>291</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 228.

accordance with what they " . . . reasonably [believe] to be in the best interests of the [patient]." <sup>292</sup> This clause could apply to a SDM for a DID patient in either of the aforementioned groups, since the patient's treatment preference and the value(s) that shape their preference would essentially be indeterminable. However, without knowledge of what the patient values most (or would value most if they possessed capacity), in these cases, what could a SDM utilize to make a best interest judgement? Contextual and situational factors regarding the patient's life may indicate potential important interests that the patient could possess, which in turn could help guide a SDM's decisional choices.

For example, hypothetically, "Linda" is a female DID patient and switches frequently between the alter personalities "Ruby" and "Debbie," who are not aware of each other's existence. Linda is a mother to an infant, and while Debbie acts as the caregiver and provider for the child, Ruby wants to live a carefree lifestyle and expresses that she not ready to be a mother. Linda (as Debbie) has also begun breastfeeding her child, yet she is faced with a medical decision regarding two equally effective drugs, one of which poses a much higher risk of toxicity to her infant if ingested through breast milk. Linda's physician first discusses the decision with both Ruby and Debbie in an attempt to explore their viewpoints on the decision. However, due to the highly conflicting attitudes between Debbie and Ruby toward parenthood, the physician is not convinced that Linda (as a whole) fully understands that this decision will greatly impact her infant and appreciates the significance of this decision on both her infant and the caregiver personality Debbie. As a result, Linda is deemed to not possess capacity for this decision and a SDM is appointed. In this case, even though Ruby does not appear to value being a

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<sup>292</sup> *Advanced Health Care Directives Act* (2014).

parent, Linda does possess this value as it is clearly demonstrated through Debbie. As a parent, it is quite plausible that Linda (as Debbie) would have a significant interest in protecting the health and well-being of her child, and most reasonable people would probably agree that the safety and security of one's child is of utmost importance. Therefore, it would be ethically appropriate for the SDM to weight Linda's interest in protecting her child and choose the lower-risk drug, as this decision reduces the risks to the child and accedes to Linda's parental interest. Such weighting of patient's interests and associated risks of various options upholds both the *AHCD Act* and Beauchamp's and Childress's assertions regarding the ethical responsibility of SDMs.

It is clear that determining whether a patient with DID possesses decision-making capacity for a treatment decision necessitates taking into account the following factors: the particular decision at hand, the level of risk associated with the decision, the amount of value-sharing among the patient's alter personalities, and the degree and type of awareness that exists between the patient's alters. As I have demonstrated in this chapter, there are many possible clinical situations and treatment decisions where patients with DID could (and, with regards to integration, should) ethically possess capacity; however, there are circumstances where it would be highly questionable to deem such patients as decisionally capable, especially when assessing patients with severe value-incongruence and conflict between their alter personalities. Therefore, assessment would need to be done on a case-by-case basis, and physicians and care teams could consider the points and arguments I have presented in this chapter as a solid starting place.

## **Conclusion**

Considering this thesis as a whole, I have demonstrated that medical decision-making capacity determination for patients with DID is a complex, multi-layered task; however, to do so in an ethical, patient-centered manner (i.e. one that is in line with current thought on the treatment of vulnerable patients) would require approaching this issue from a position where patient autonomy and self-governance over medical decision-making is afforded if at all possible. As previously stated, it is imperative that vulnerable patients (including those with DID) know that their health care professionals have their welfare and wishes at heart, and to demonstrate this would require not automatically deeming them incapable of their own treatment decisions. With regards to DID patients and medical decision-making capacity specifically, it is my hope that this thesis will shed some light on this important issue and introduce arguments and suggestions that will generate further exploration, analysis, and discussion in order to continue advancing the ethical care and treatment of this unique patient population.



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