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THERAPEUTIC JURISPRUDENCE: INFORMED CONSENT AS A CLINICAL INDICATION FOR THE CHRONICALLY SUICIDAL PATIENT WITH BORDERLINE PERSONALITY DISORDER

Stephen H. Behnke and Elyn R. Saks***

I. INTRODUCTION

Therapeutic jurisprudence,¹ a recent development in the law, is based upon the idea that the law can, and should, promote the mental health of the citizenry. Therapeutic jurisprudence does not claim that the law should be concerned solely with furthering the therapeutic interests of individuals living within our society. Rather, it states that promoting the psychological well-being of society is a legitimate purpose of the law. A challenge for therapeutic jurisprudence is, therefore, to identify specific areas of the law that provide a realistic opportunity to further this goal.

Identifying areas of the law ripe for a therapeutic jurisprudence analysis requires a reasonable degree of psychological sophistication. For example, an analysis must be able to determine which sector of the population a given law is most likely to affect; to explore the psychological dynamics of that sector; and, given these dynamics, to examine what effect the law is likely to have. Without all three components the analysis will be incomplete.

This Article elaborates on the therapeutic jurisprudence literature in two ways. First, the Article illustrates a therapeutic jurisprudence analysis. Bruce Winick, the foremost proponent of therapeutic

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1. See BRUCE J. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* 327, 328 n.3 (1997) (explaining that therapeutic jurisprudence refers to the need for an assessment of the therapeutic impact of legal rules).

jurisprudence, provides a useful example of a therapeutic jurisprudence analysis by examining the clinical implications of informed consent.² Winick demonstrates how obtaining informed consent may bring about clinical gains by making the patient an active participant in treatment decisions.³ Winick argues that when a patient consciously embraces a treatment goal she⁴ is more likely to achieve that goal, especially when the treater predicts success.⁵ In analyzing the benefits of informed consent, Winick looks to considerable empirical evidence that when people are self-determining, they function more effectively and with a higher degree of commitment and satisfaction.⁶ He points out that treating patients as competent adults enhances the therapeutic alliance.⁷

This Article takes Winick's discussion a step further by exploring how informed consent may be especially beneficial to a particular clinical population—namely, chronically suicidal individuals who meet the criteria for borderline personality disorder (BPD). The Article discusses how a new treatment modality, dialectical behavior therapy (DBT), makes obtaining informed consent an essential aspect of the treatment. The Article shows how patients appear to benefit as a result of incorporating informed consent into DBT, and will speculate about the reasons why doing so is helpful to patients.

This Article elaborates on the therapeutic jurisprudence literature in a second way by raising challenges to the concept of therapeutic jurisprudence. Our hope is that by providing an illustration of therapeutic jurisprudence at work and exploring problems as yet unaddressed by the doctrine of therapeutic jurisprudence, we will contribute to the therapeutic jurisprudence literature. Our ultimate goal is to provide concrete avenues by which the law can promote the mental health and well-being of individuals who struggle with significant psychological and behavioral difficulties.

2. *See id.* at 327.

3. *See id.* at 338-42.

4. This Article discusses the relationship between the legal doctrine of informed consent and a clinical treatment for patients who meet criteria for borderline personality disorder. Because borderline personality disorder is diagnosed primarily among women, the pronouns "she" and "her" are used throughout the Article. *See* MARSHA LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT OF BORDERLINE PERSONALITY DISORDER 55-56 (1993) [hereinafter LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT].

5. *See* WINICK, *supra* note 1, at 330-32.

6. *See id.* at 333-34.

7. *See id.* at 338-42.

II. THE CLINICAL POPULATION: INDIVIDUALS WHO MEET CRITERIA FOR BORDERLINE PERSONALITY DISORDER

In the United States, psychiatric diagnoses are most often made according to the official nosology of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).⁸ The fourth edition of the DSM (DSM-IV) lists psychiatric diagnoses along five "axes."⁹ Each axis indicates some aspect of an individual's illness or life situation.¹⁰ Axis 1 lists clinical disorders.¹¹ Schizophrenia would be an example of a clinical disorder listed on Axis 1.¹² Personality disorders are listed on Axis 2.¹³ Axis 3 names general medical conditions that have psychiatric implications.¹⁴ Hypothyroidism, which can cause depressive symptoms, is an example of a medical condition that would be listed on Axis 3.¹⁵ Axis 4 lists problems in the person's day-to-day life, such as difficulties in gaining access to adequate health care, problems in obtaining employment, and difficulties with the law.¹⁶ Axis 5 contains the "global assessment of functioning," a number on a scale from one to one hundred that places the individual on a hypothetical continuum of mental health according to psychological, social, and occupational functioning.¹⁷

A personality disorder, listed on Axis 2, describes the manner in which a person thinks and feels about himself or herself, the manner in which a person relates to others, and the problems that ensue from that way of experiencing the self and relating to others.¹⁸ Put most simply, a personality disorder refers to the difficulties attendant upon a person's way of being in the world. Personality disorders tend to affect all areas of a person's life, to begin in adolescence or early adulthood, and to result in significant distress, impairment, or both.¹⁹

Individuals who meet the criteria for BPD are some of the most

8. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) [hereinafter DSM-IV].

9. *Id.* at 25.

10. *See id.*

11. *See id.* at 25-26.

12. *See id.* at 26.

13. *See id.* at 26-27.

14. *See id.* at 27-28.

15. *See id.*

16. *See id.* at 29-30.

17. *Id.* at 30. One represents the lower end of the scale, while one hundred represents superior functioning in all aspects of a person's life. *See id.*

18. *See id.* at 630.

19. *See id.* at 629.

challenging patients clinicians treat.²⁰ The difficulty in treating borderline patients stems in large part from their propensity to engage in high-risk behaviors—most notably behaviors that are intentionally self-injurious. As many as four-fifths of borderline individuals have a history of intentionally hurting themselves; often such acts are carried out with the intent to die.²¹ In addition, individuals who meet the criteria for this disorder tend to have highly unstable interpersonal relationships and to engage in behavior that represents a high risk of harm to themselves or to others, such as serious substance abuse or unprotected sex with numerous partners.

The DSM-IV lists nine criteria for BPD.²² To merit the diagnosis of BPD, an individual must meet at least five of the nine criteria.²³ The first of the nine criteria is that the individual engages in “frantic efforts to avoid real or imagined abandonment.”²⁴ The important word is “frantic”; often a borderline individual will become highly anxious, or even suicidal, at the prospect of separation from an important person in her life and will take steps that appear extreme to an outsider in order to avoid the separation. The second criterion is “a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.”²⁵ Borderline individuals may treat new acquaintances like life-long friends. Often such acquaintances are idealized, as if they could do no wrong whatsoever, and then a complete fall-from-grace occurs when they evince the most minor of faux pas, such as not acting sufficiently empathic during a casual conversation.

The third of the nine criteria is an identity disturbance.²⁶ Often, borderline individuals have a markedly unstable sense of who they are. This criterion may materialize as an individual taking on the characteristics, thoughts, and beliefs of whatever group she happens to be with at the moment, only to change such characteristics, thoughts, and beliefs when she moves on to a new group, even if such a move occurs within hours. The fourth criterion is impulsivity in areas that could be

20. See Marsha M. Linehan & Constance A. Kehrer, *Borderline Personality Disorder*, in *CLINICAL HANDBOOK OF PSYCHOLOGICAL DISORDERS: A STEP-BY-STEP TREATMENT MANUAL* 396, 396 (David H. Barlow ed., 2d ed. 1985).

21. See LINEHAN, *COGNITIVE-BEHAVIORAL TREATMENT*, *supra* note 4, at 4.

22. See DSM-IV, *supra* note 8, at 654.

23. See *id.* The DSM is, of course, only one nosology. For other ways of thinking about BPD, see LINEHAN, *COGNITIVE-BEHAVIORAL TREATMENT*, *supra* note 4, at 3-13.

24. DSM-IV, *supra* note 8, at 654.

25. *Id.*

26. See *id.*

dangerous, such as frequent unprotected sex, substance abuse, reckless driving, or binge eating.²⁷ The fifth criterion is "recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior."²⁸

The sixth criterion is a marked emotional instability that results from being highly reactive to internal or external stimuli.²⁹ A borderline individual may become enraged, or deeply sad, in immediate response to a thought or to a perceived slight. The seventh criterion is chronic feelings of emptiness, which are often felt physically.³⁰ A patient may say, for example, that there is a large hole in her stomach, or that there is nothing inside. The eighth criterion is an intense, inappropriate anger and is the single criterion perhaps most associated with BPD.³¹ The ninth and final criterion is a change in thought processes, sometimes with a paranoid flavor, that arises when the individual is under stress.³²

Marsha Linehan groups these nine criteria into five categories.³³ According to Linehan, the DSM criteria can be reorganized on the basis of a pervasive "dysregulation," or lack of regulation.³⁴ Her view is that the essence of BPD is a dysregulation that permeates the borderline individual's life.³⁵ The domains affected therefore include the individual's emotions, manner of relating to others, behavior, ways of thinking, and manner of experiencing the self.³⁶

Emotional dysregulation refers to the emotional instability, the difficulty in controlling and appropriately expressing anger, and the highly reactive quality to emotional responses often seen in borderline individuals.³⁷ Interpersonal dysregulation—the dysregulated manner of relating to others—refers to the highly intense and unstable quality of relationships, as well as to the extreme sensitivity to loss often seen among borderline individuals.³⁸ Behavioral dysregulation refers

27. *See id.*

28. *Id.*

29. *See id.*

30. *See id.*

31. *See id.* Marsha Linehan has offered an alternative explanation for what appears to be the centrality of anger in the psyche of the borderline individual. *See* LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 70-71.

32. *See* DSM-IV, *supra* note 8, at 654.

33. *See* LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 11-13.

34. *Id.* at 11.

35. *See id.*

36. *See id.*

37. *See id.*

38. *See id.*

to the impulsive and suicidal behaviors characteristic of BPD.³⁹ Cognitive dysregulation—dysregulation in ways of thinking—represents brief, often stress-related forms of distorted thinking, such as the feeling that others want to injure or are out “to get” you.⁴⁰ Finally, self-dysregulation refers to a profound sense of inner-emptiness or to the highly variable manner in which a borderline individual may experience who she is or who she ought to be.⁴¹

Individuals who meet the criteria for BPD struggle with unstable, unpredictable, and often highly distressing thoughts, behaviors, relationships, experiences of self, and emotions. In severe cases of BPD it would not be too strong to describe an individual as volatile, or even highly volatile, along one or more of these dimensions. Providers and consumers of mental health services would agree that the lives and interactions of individuals who meet the criteria for BPD are characterized by an intensity that can often be extreme.

III. CHRONIC SUICIDALITY AND BORDERLINE PERSONALITY DISORDER: INDICATED AND NON-INDICATED INTERVENTIONS

One common feature of individuals who meet the criteria for BPD is suicidal behavior. Indeed, suicidal behavior is one of the nine criteria listed by DSM-IV as characteristic of BPD.⁴² Often the suicidal feelings experienced by borderline individuals are chronic. Individuals who meet borderline criteria may become suicidal in response to what appear to be minor life events. Events which represent rejection, however slight, such as a therapist's inability to return a phone call immediately or a therapist's vacation, are particularly difficult. Suicidal thoughts and feelings may become part of the fabric of a borderline individual's life.⁴³ Indeed, suicidality may take on an existential quality, as if the pain in one's life is so great that it leaves

39. *See id.*

40. *See id.*

41. *See id.*

42. *See* DSM-IV, *supra* note 8, at 654. Marsha M. Linehan, one of the most prolific writers on BPD and the psychologist who developed dialectical behavior therapy—the only therapy shown to be effective in treating borderline individuals—realized after working with individuals who chronically engage in suicidal behavior that the population and the borderline population largely overlap. *See* LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 13-15.

43. *See* Donald A. Schwartz, *The Suicidal Character*, 51 PSYCHIATRIC Q. 64, 64-70 (1979) [hereinafter Schwartz, *Suicidal Character*]; *see also* Donald A. Schwartz et al., *Treatment of the Suicidal Character*, 28 AM. J. PSYCHOTHERAPY 194, 199 (1974) [hereinafter Schwartz et al., *Treatment*] (adhering to the proposition that suicidality may become part of an individual's life).

one to ask each day, literally, whether to be or not to be.

The suicidality seen among borderline individuals stands in contrast to the suicidality often experienced by other clinical populations. While suicidality experienced by borderline individuals may take on a chronic, existential quality, suicidality is more often experienced in other populations as the result of an acute psychiatric state such as psychosis, major depression, or anxiety. The quality of the suicidality may therefore depend upon whether the suicidality is an aspect of a personality disorder that would be diagnosed along Axis 2, or whether the individual suffers from an Axis 1 disorder. In the latter case, the suicidality is likely to pass when the psychosis, depression, or anxiety subsides.⁴⁴

The distinction between the manner in which suicidality is experienced has important implications for clinical treatment. Suicidality that is secondary to an acute psychiatric state is generally treated by keeping the individual in a safe and secure environment until the clinical picture has stabilized.⁴⁵ Often a locked psychiatric facility is the setting of choice. Indeed, commitment laws are designed in large part to address the individual who is acutely suicidal but whose suicidality will pass when the clinical syndrome giving rise to the suicidality is addressed and treated. Treatment of acute suicidality usually can take place in a matter of days, at which point the individual is released back into the community.

Chronic suicidality experienced by borderline individuals, however, requires treatment of a different kind,⁴⁶ for reasons that are not immediately obvious. One way to treat chronically suicidal individuals, for example, would be prolonged hospitalization.⁴⁷ If, after all, locked psychiatric facilities are the treatment of choice for suicidality, then that treatment should presumably continue as long as the suicidal thoughts and feelings are present. Thus, civil commitment could continue almost indefinitely for this group of patients, because the suicidal thoughts and feelings may persist for years.

44. Individuals who suffer from chronic suicidality may, of course, experience acute suicidality that arises from an Axis 1 syndrome.

45. See PAUL S. APPELBAUM & THOMAS G. GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 35 (2d ed. 1991); see also *SUICIDE: GUIDELINES FOR ASSESSMENT, MANAGEMENT, AND TREATMENT* 179 (Bruce Bongar ed., 1992) (discussing theory, research, special populations, assessment, treatment, prevention, training, and legal issues of suicide).

46. See Thomas G. Gutheil, *Medicolegal Pitfalls in the Treatment of Borderline Patients*, 142 AM. J. PSYCHIATRY 9, 12 (1985) [hereinafter Gutheil, *Medicolegal Pitfalls*].

47. See APPELBAUM & GUTHEIL, *supra* note 45, at 41.

An objection to this line of reasoning could be made on the grounds that chronic suicidality is not real suicidality. Chronically suicidal patients remain suicidal for lengthy periods of time—sometimes for years—without actually killing themselves. As a consequence, the objection goes, we ought to treat such patients differently from the way we treat acutely suicidal patients, because their risk of *actually* committing suicide is lower. The problem with this objection, however, is that chronically suicidal patients with BPD do commit suicide, at rates far above those found in the general population.⁴⁸ Indeed, the rates of suicide among patients suffering from BPD have been found to be between 4 and 9.5%.⁴⁹ Studies have shown that the rate of suicide among borderline individuals is equal to the rate among individuals suffering from other psychiatric disorders that also represent a high risk of suicide.⁵⁰ Rates of suicide among the general population, on the other hand, are approximately 12 out of every 100,000 persons per year.⁵¹ From both a clinical and societal perspective, borderline patients cannot be refused hospitalization solely on the grounds that the likelihood of suicide is slight.⁵²

A clinical observation that speaks against hospitalization is that placing a chronically suicidal individual in a locked unit often appears to exacerbate the patient's situation. That is to say, it appears that these patients actually get worse when placed in a psychiatric hospital. The reasons for this are unclear. Some suggest that the inviting characteristics of an inpatient setting may reward suicidal behavior, while at the same time making it more difficult for the patient to deal with the life situations generating the stress and anxiety that lie

48. See generally Paul H. Soloff et al., *Risk Factors for Suicidal Behavior in Borderline Personality Disorder*, 151 AM. J. PSYCHIATRY 1316 (1994) (comparing the suicide rates between borderline patients and the general population).

49. See Harrison G. Pope, Jr., et al., *The Validity of DSM-III Borderline Personality Disorder: A Phenomenologic, Family History, Treatment Response, and Long-term Follow-up Study*, 40 ARCHIVES GEN. PSYCHIATRY 23, 27 (1983); Michael H. Stone et al., *Natural History of Borderline Patients Treated by Intensive Hospitalization*, 10 PSYCHIATRIC CLINICS N. AM. 185, 190 (1987).

50. See Gunnar Kullgren et al., *An Empirical Study of Borderline Personality Disorder and Psychiatric Suicides*, 174 J. NERVOUS & MENTAL DISEASES 328, 329 (1986).

51. See David C. Clark & Jan Fawcett, *An Empirically Based Model of Suicide Risk Assessment for Patients with Affective Disorder*, in SUICIDE AND CLINICAL PRACTICE 16 (Douglas Jacobs ed., 1992).

52. Clinicians will sometimes ignore this fact and argue that suicidality among this population is not real or is only an attempt to manipulate caregivers, family, or friends.

behind the intensification of suicidal thoughts and feelings.

In fact, the mothering behavior [of the hospital setting] may enhance suicide risk, since it creates a secondary gain for suicidal behaviors [T]he maintenance of focus on the patient's suicidality can act as an obstruction to his coming to deal with the problems underlying his suicidality and his life problems in general. Constant preoccupation with suicide may actually act to increase the risk of it.⁵³

Marsha Linehan has argued forcefully that psychiatric hospitalization is clinically contraindicated for many patients in this population; much of her work is centered upon keeping chronically suicidal patients out of the hospital.⁵⁴ Paul Appelbaum and Thomas Gutheil likewise observe:

A specific population requiring consideration is the group of chronically, as opposed to acutely, suicidal patients. This type of patient offers a unique challenge to the diagnostician in the emergency setting, since actual suicide is a perpetual risk, yet hospitalization tends to promote regression and should often be actively resisted.⁵⁵

Chronically suicidal, borderline patients, therefore present a medico-legal Catch-22: their suicidality is indeed real, but the law's usual response to suicidality—inpatient hospitalization—appears to work against their clinical best interests. What are treaters able to do?

An observation shared by clinicians of widely divergent theoretical orientations is that the therapeutic alliance represents a powerful clinical tool in the treatment of chronically suicidal, borderline individuals.⁵⁶ Although the therapeutic relationship is considered central in all treatments, it appears to take on a special role when treating individuals who struggle with borderline psychopathology. Often the nature of the treater-patient relationship takes center stage when a

53. Schwartz, *Suicidal Character*, *supra* note 43, at 199-200.

54. See LINEHAN, *COGNITIVE-BEHAVIORAL TREATMENT*, *supra* note 4, at 510-14.

55. APPELBAUM & GUTHEIL, *supra* note 45, at 65; see generally Henry J. Friedman, *Some Problems of Inpatient Management with Borderline Patients*, 126 AM. J. PSYCHIATRY 299 (1969) (discussing behavioral regression of borderline patients in a hospital setting).

56. See APPELBAUM & GUTHEIL, *supra* note 45, at 65; Mark Goldblatt & Alan Schatzberg, *Medication and the Suicidal Patient*, in *SUICIDE AND CLINICAL PRACTICE* 23, 27 (Douglas Jacobs ed., 1992); Gutheil, *Medicolegal Pitfalls*, *supra* note 46, at 13; Thomas G. Gutheil, *Suicide and Suit: Liability After Self-destruction*, in *SUICIDE AND CLINICAL PRACTICE* 147, 160 (Douglas Jacobs ed., 1992) [hereinafter Gutheil, *Suicide and Suit*].

clinician is attempting to address the suicidal thoughts and feelings experienced by a client in this population.

The essential quality of the therapeutic relationship is collaboration in the truest sense of the word. Collaboration derives from Latin and means "to work together," as opposed to work against or to work on.⁵⁷ Collaboration implies two individuals working side-by-side toward a mutually agreed-upon end. In a collaborative treatment relationship, both treater and patient view themselves as autonomous agents, making conscious choices that will eventually result in greater psychological health for the patient. Clinicians across theoretical spectrums have agreed that a collaborative working relationship is the keystone of a successful treatment and is pivotal when dealing with the intense suicidal thoughts and feelings of a chronically suicidal individual.⁵⁸

From a therapeutic standpoint, one essential characteristic of a collaborative relationship is that the patient is an equal partner, one whose values, goals, and visions of the outcome are valued as much as those of the treater. The experience of autonomy in the treatment relationship entails an experience of ownership; choices are one's very own choices. Choices that are one's own, however, are also choices for which one is responsible. Thus, responsibility is the necessary counterpart of autonomy. From a clinical perspective, this equation makes sense. A patient will not feel responsible for choices that she does not perceive to be her own autonomous choices. A sense of autonomy is a necessary—perhaps not a sufficient, but certainly a necessary—ingredient for assuming responsibility. A sense of autonomy and the willingness to assume responsibility go hand-in-hand.

The literature on BPD has underscored the value of enhancing patient autonomy as part of the treatment. Marsha Linehan has written eloquently about this element in working with borderline patients.⁵⁹ Linehan refers to a "dialectical dilemma" in the treatment of borderline individuals: that of "active passivity" versus "apparent competence."⁶⁰

Linehan defines "active passivity" as the tendency of borderline

57. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 371 (3d ed. 1992).

58. See, e.g., WINICK, *supra* note 1, at 328-42.

59. See LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 107.

60. *Id.* at 84-85.

individuals to approach problems in a passive manner in an attempt to get others to solve problems for them.⁶¹ Thus, the patient actively seeks help from her external environment to solve problems that she passively addresses herself. Active passivity is distinct from learned helplessness; while learned helplessness represents a surrender to problems that the individual perceives cannot be resolved, active passivity entails an active effort to bring about change through the agency of others.⁶² According to Linehan, active passivity is a learned behavior: a deficit in active problem-solving skills, combined with a sense of personal inadequacy and a history of failure despite having made one's best efforts, may result in an individual who continually attempts to have others solve her problems for her.⁶³ In this context intentional self-injury may be the most effective manner for a borderline patient to marshal forces on her behalf in the face of a problem that she views as insurmountable. Self-injury is often interpreted by others as manipulative because it is designed to achieve an end other than—if only in addition to—the apparent goal of hurting oneself.

Linehan defines "apparent competence" as the tendency of borderline individuals *sometimes* to act competently when addressing problems encountered in day-to-day living.⁶⁴ At other times, however, the individual will not be able to meet successfully the challenge of a problem that is no more difficult.⁶⁵ Apparent competency leads to a highly uneven quality to the individual's life, insofar as she is able, for example, to deal with problems at work in an adequate or even superior fashion, yet unable to deal with the most straightforward problems or challenges in her personal life. Linehan offers a number of explanations for borderline individuals being "stable in [their] instability."⁶⁶ First, competency expressed in one domain of the borderline individual's life does not generalize to other domains.⁶⁷ Second, the borderline individual has severe deficits in her capacity to regulate moods. Because her behavior is highly mood-dependent,

61. *See id.* at 78.

62. *See id.* at 79.

63. *See id.*

64. *See id.*

65. *See id.* at 80-84.

66. THEODORE MILLON, DISORDERS OF PERSONALITY, DSM-III: AXIS II 341 (1981) (quoting M. Schmideberg, *The Borderline Patient*, in 1 AMERICAN HANDBOOK OF PSYCHIATRY 399 (S. Arieti ed., 1959)).

67. *See* LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 81.

shifts in mood bring about dramatic shifts in the capacity to behave in an organized and effective manner.⁶⁸ Like the borderline individual's active passivity, her apparent competence may be interpreted as manipulative because she often appears to have competencies far exceeding those she actually possesses.⁶⁹

Active passivity and apparent competence pose particular problems for the borderline patient's experience of herself as an autonomous and hence responsible agent. The problems arise because her competence in dealing with problems encountered in everyday life is fleeting and unstable. While her apparent competence serves to communicate to others that she is capable of successfully addressing difficulties on her own, the competence depends on her emotional state and the interpersonal context. When these change, she may find herself faced with problems that she perceives as utterly insurmountable. Now, desperate for help, she finds herself mindful of her history of failure in negotiating precisely such challenges, yet unable to ask directly for the help she needs. The borderline individual may then turn to indirect ways of communicating her desperation, ways that may include intentionally self-injurious behavior. Such behavior communicates both to others and to the borderline individual herself that she is unable to cope with the current state of affairs. Such behaviors do little, however, to change that state of affairs in any helpful way.

The apparent competence and active passivity of borderline individuals tempt treaters to step in and either attempt to solve the patient's problems for her or, at the very least, to absolve the borderline patient from responsibility for engaging in unacceptable conduct. Lured by a wish to take care of the patient and to keep the patient safe, treaters may well consider that hospitalization is a sensible and effective treatment intervention. Nevertheless, hospitalization may profoundly deprive a patient of the capacity to exercise her auton-

68. *See id.* at 82.

69. One could argue that a more appropriate term would be "apparent *in*-competence," insofar as the individual is truly competent at certain times and in certain situations, thus indicating that she actually does possess the competencies in question. To phrase the matter in this fashion, however, would miss the point that the borderline patient experiences her competence as transient; it simply does not feel real to her many times and in many situations. Because competence is, in large part, a state of mind, and because the psychological states of borderline patients fluctuate dramatically, it seems more clinically appropriate to use the term "apparent competence," thereby indicating that, from a psychological standpoint, borderline individuals experience their competence as the exception rather than as the rule.

omy. And it is precisely the sense of autonomy that is so vital to the treatment of borderline individuals.

From a clinical perspective, the hope is that as the patient assumes a greater responsibility for herself and for her actions, her sense of herself as an autonomous agent will grow. As the patient increasingly experiences herself as an autonomous agent, her sense of responsibility will increase, thus setting in motion a therapeutically indicated synergy. If the patient is never pushed in the direction of taking greater responsibility for who she is and what she does, it is unlikely that she will begin to experience her own sense of agency in the world. Instead, she will likely remain in the grip of active passivity and apparent competence; that is, she is likely to remain borderline.

Thomas Gutheil has described the dilemma facing the clinician who must make treatment decisions about the chronically suicidal borderline patient.⁷⁰ Gutheil points out that hospitalization may entail the treater assuming the very responsibility that the borderline patient must learn to bear.⁷¹ Gutheil also recognizes, however, that failure to hospitalize a suicidal patient asking for help is problematic.⁷² He describes the situation by first acknowledging that not admitting a chronically suicidal patient to a psychiatric unit

may strike the lay person as callous or uncaring. For example, clinicians are quite familiar with the seemingly desperate patient who should, on clinical grounds, be refused hospital admission to avert regression and to foster the assumption of personal responsibility. This example captures the way in which a short-term risk (i.e., that the patient will actually kill himself or herself, even by accident, in a context that appears to relate this event to the "rejection" by the hospital) is weighed against a long-term advantage (i.e., modification of character problems) that must of necessity remain only a potential until the patient actually improves. To put this in crudest possible terms, the evaluator's choice, largely by hindsight, appears to lie between two outcomes: a concrete dead body and the rather abstract notion of personal growth.⁷³

The dilemma Gutheil underscores is that clinical interests may

70. See Gutheil, *Medicolegal Pitfalls*, *supra* note 46, at 12-13.

71. See *id.* at 12.

72. See *id.* at 12-13.

73. *Id.* at 12.

call for keeping such a patient out of the hospital, while concerns about professional liability appear to call for the opposite.⁷⁴ Therapeutic jurisprudence would ask whether the law could address this apparent paradox so that the clinician is given incentives to act in a manner consistent with the patient's clinical interests. Put another way, therapeutic jurisprudence asks whether the law could help to bring into explicit harmony the value of providing the patient good clinical care and the value of ensuring that the treater take seriously her medico-legal responsibilities in caring for suicidal patients. In attempting to resolve this dilemma, therapeutic jurisprudence could look to the doctrine of informed consent.

IV. THE DOCTRINE OF INFORMED CONSENT

Informed consent is a doctrine with legal, ethical, and interpersonal dimensions.⁷⁵ From a legal perspective, informed consent refers to a set of rules by which a practitioner must abide.⁷⁶ Failure to adhere to these rules may result in legal sanctions.⁷⁷ From an ethical perspective, informed consent underscores the value of individual autonomy, a value that both flows out of and protects human dignity.⁷⁸ From an interpersonal perspective, informed consent refers to a central aspect of the relationship between a treater and patient.⁷⁹

The legal doctrine of informed consent has developed in the United States over the past several decades.⁸⁰ Most of this evolution has taken place in the past thirty years.⁸¹ Those who practiced medicine as recently as the 1950s would not recognize the current doctrine. The most significant development in the doctrine arose from court cases that shifted the emphasis from simply obtaining consent to ensuring that the consent was *informed*.⁸²

74. It could be argued—correctly, we believe—that the best protection against liability is for the treater to do whatever is in the patient's best clinical interest. As Gutheil points out, however, the reality of a dead body carries such anxiety about professional repercussions that a treater will often seek to avoid such an outcome at all costs, at least as long as the patient remains in his or her care. *See id.* at 12-13.

75. *See* PAUL S. APPELBAUM ET AL., *INFORMED CONSENT: LEGAL THEORY & CLINICAL PRACTICE* 12-13 (1987).

76. *See id.* at 3.

77. *See id.*

78. *See id.*

79. *See id.*

80. *See id.* at 38-41.

81. *See id.*

82. *See id.* at 38-39.

Up through the 1950s cases involving informed consent were analyzed primarily in terms of whether a patient had consented to treatment.⁸³ Consent was important because its absence gave rise to an action in battery, should the treatment entail a touching.⁸⁴ Many cases addressed what actions, or inactions, could reasonably imply consent.⁸⁵ The primary focus, however, remained on whether a patient had consented to the treatment.⁸⁶ The value behind the doctrine was that of a patient's right to be free from unwanted bodily intrusion.

In the early 1960s, the courts shifted the emphasis of their analyses.⁸⁷ While an unconsented to touching remained actionable, an important focus became whether the consent was informed.⁸⁸ An informed decision was held to be a decision made after certain information had been provided; the important information included the nature and purpose of the treatment, the risks and benefits of the treatment, the alternatives to treatment, and the risks and benefits of the alternatives, including no treatment at all.⁸⁹

The shift of concern from consent to the informed nature of decision making represented an important shift in the values behind the doctrine. While the doctrine previously embodied the value of a patient's right to be free from an unwanted touching—a privacy interest—the emphasis became whether the patient was sufficiently informed to make an autonomous decision about the nature and course of treatment. The shift from an emphasis on protecting the individual's bodily integrity to emphasizing the individual's autonomy had enormous ethical implications.

The ethical doctrine of informed consent states that an individual has an inherent dignity to his or her humanity.⁹⁰ This dignity implies a right to make decisions about the nature, course, and purpose of one's own life. The individual making the decision must be informed about relevant aspects of the decision, must understand those aspects, and, based upon such information and understanding, must voluntarily decide to accept or forgo treatment. The ethical doctrine of informed consent is grounded firmly in the value of indi-

83. *See id.* at 36.

84. *See id.*

85. *See id.* at 36-37.

86. *See id.* at 37.

87. *See id.* at 40.

88. *See id.* at 40-41.

89. *See id.* at 14.

90. *See id.* at 22.

vidual autonomy. As the Massachusetts Supreme Judicial Court has said, "[e]ven if the patient's choice will not achieve the restoration of the patient's health . . . , that choice must be respected. The patient has the right to be wrong in the choice of treatment."⁹¹

The interpersonal dimension of informed consent speaks to the quality of the relationship between treater and patient. Treaters are in positions of enormous power and can behave in a manner that enhances or denigrates patient autonomy and dignity. While information, understanding, and voluntary acceptance of a treatment are essential elements of informed consent, they fail to capture that the doctrine is fundamentally an interpersonal doctrine. That is to say, informed consent takes place in the context of an interpersonal relationship, and the quality of that relationship will inevitably speak to the quality of the consent. The interpersonal aspect of the doctrine of informed consent is sometimes discussed under the rubric of "the alliance."⁹² The legal, ethical, and interpersonal dimensions of informed consent provide the rich understanding necessary to explore the relationship between informed consent and the clinically indicated treatment of the chronically suicidal borderline patient.

V. COMPETENCE, INFORMED CONSENT, AND DIALECTICAL BEHAVIORAL THERAPY

Every competent adult has the right to informed consent concerning his or her medical treatment. The right to informed consent entails three components: that the adult is competent to consent, is informed about the relevant aspects of the treatment and alternatives to the treatment, and voluntarily consents to the treatment.⁹³ The notion of competency is that the individual is able to understand, consider rationally, and indicate a choice concerning the available treatments. A competent adult is informed when all relevant information is available, information that includes the risks and benefits of a treatment, the risks and benefits of alternative treatments, and the risks and benefits of no treatment at all. Consent entails the freedom to choose, free from external constraints or undue duress. Thus, an adult who is capable of understanding relevant information about medical treatment and communicating a treatment choice has the right to have information about what choices are available and to ac-

91. *Rogers v. Commissioner of the Dep't of Mental Health*, 458 N.E.2d 308, 316 n.15 (Mass. 1983).

92. Gutheil, *Medicolegal Pitfalls*, *supra* note 46, at 13.

93. See APPELBAUM ET AL., *supra* note 75, at 57.

cept or reject the treatment offered. The right of a competent adult to informed consent is founded upon the value of individual autonomy.⁹⁴

Thomas Gutheil has written about assessing the competence of a chronically suicidal patient with BPD.⁹⁵ Gutheil's assessment of competence entails determining whether the individual is aware of her own psychological processes, able to identify an appropriate individual to whom those processes can be communicated when they threaten the individual's safety, and capable of communicating those processes to such an identified individual.⁹⁶

Gutheil provides several examples of how competence to engage in treatment is assessed in a clinical interview by asking questions that speak to the relevant capacities.

- Do you realize I can't help you if you don't level with me?
- Do you understand the only way I'll know what's on your mind is if you tell me?
- Do you know what to do if things turn bad on you when you are outside the hospital?
- Do you know what to do if you feel the impulse to hurt yourself getting stronger?
- Do you have some plans as to what to do if you find your suicidal feelings coming back while you are on this pass?
- Do you know whom to call and do you have the number for the hospital (or the emergency room, the clinician, the ambulance service, etc.)?⁹⁷

As the questions indicate, Gutheil focuses on whether the individual has the capacity to identify problematic internal states, to identify appropriate individuals capable of providing emergent care, and to communicate the problematic internal state to the identified individual or individuals. The problematic states for the chronically suicidal individual are those psychological states in which she is more likely to act impulsively⁹⁸ than upon organized and planned thought. The appropriate treaters are those individuals trained to assess and treat suicidal thoughts and feelings. The ability to communicate en-

94. *See id.*

95. *See* Gutheil, *Medicolegal Pitfalls*, *supra* note 46, at 12-13.

96. *See* Gutheil, *Suicide and Suit*, *supra* note 56, at 159-61.

97. *Id.* at 160-61.

98. *See* John G. Gunderson & Margaret T. Singer, *Defining Borderline Patients: An Overview*, 132 AM. J. PSYCHIATRY 1, 4-5 (1975).

tails the ability to put the suicidal thoughts and feelings into words, rather than to act on them in a self-destructive fashion.

Gutheil underscores the inherent unpredictability of knowing when the patient will experience suicidal thoughts, feelings, and impulses.⁹⁹ As a consequence, his assessment of the patient's competence also entails determining whether the patient has the capacity to make a plan for a contingent event.¹⁰⁰ Gutheil urges the clinician to share this uncertainty with the patient. "By . . . inviting the patient to share the risk of the situation facing the dyad, the therapist brings the uncertainty into the realm of therapeutic work, rather than feeling, oppositionally, that his task is to outguess the patient or foretell the future, feats outside the realm of the possible."¹⁰¹ The patient's competence depends on how well she can manage the unpredictability of her shifting internal states.

Assessing the competence of a chronically suicidal individual to engage in treatment is the first step to determine whether that individual can consent to a course of treatment. If the individual is deemed not competent in the manner described above, or if an adequate assessment cannot be conducted, the treatment of choice will be inpatient hospitalization, for two reasons. First, the patient is stating that she is incapable of assessing her own internal states, of identifying appropriate individuals to whom suicidal thoughts and feelings could be communicated, or of actually communicating her suicidality to those individuals. Inpatient hospitalization may also be indicated because the therapeutic alliance is not sufficiently developed to make possible the assessment of competency to engage in the treatment. That is to say, patient and treater do not know or trust one another well enough to allow the treater to determine what the patient's true capacities are. In such a case, where competency cannot be assessed, the patient should be placed on a psychiatric unit until an adequate assessment can be conducted.

If the patient is deemed competent, the treater may offer a course of treatment. To do so, the treater must first obtain the patient's informed consent. It must be made clear that one facet of the treatment entails keeping the patient out of the hospital and that this aspect of the treatment entails a risk—the risk of death. Other risks

99. See Gutheil, *Medicolegal Pitfalls*, *supra* note 46, at 12-13.

100. See Gutheil, *Suicide and Suit*, *supra* note 56, at 160-61.

101. Gutheil, *Medicolegal Pitfalls*, *supra* note 46, at 13; see Gutheil et al., *Malpractice Prevention Through the Sharing of Uncertainty: Informed Consent and the Therapeutic Alliance*, 311 NEW ENG. J. MED. 49, 50 (1984).

and benefits of the treatment will need to be explained as well, but the risk of death must be a central feature to the informed consent of the chronically suicidal borderline patient.

A treatment that has been found effective for chronically parasuicidal¹⁰² patients with BPD is dialectical behavior therapy (DBT). DBT is a cognitive-behavioral outpatient treatment designed specifically for this population.¹⁰³ DBT shares many of the aspects of traditional cognitive-behavioral therapy. Common to cognitive therapies, DBT focuses on disordered patterns of thinking. Common to behavioral therapies, DBT makes treatment goals clear at the outset of the therapy and measures in concrete and certain ways the progress patients make toward those goals.

DBT embodies the doctrine of informed consent in both theory and practice. To explore why, the doctrine of informed consent may be broken down into four components:

- (1) The value of individual autonomy that underlies the doctrine and the manner in which furthering this value by obtaining informed consent takes place in the context of an interpersonal relationship.
- (2) The assessment of competence that precedes obtaining informed consent.
- (3) The nature of the information that must be shared for the consent to be informed.
- (4) The patient's actual consent to the treatment offered.

There is a particularly good fit between DBT and informed consent along each of these four dimensions.

VI. INDIVIDUAL AUTONOMY AND THE THERAPEUTIC RELATIONSHIP

DBT is based upon a collaborative relationship between therapist and patient. In the words of Marsha Linehan, the psychologist who developed DBT, "[a]t times, this relationship is the only thing that keeps [borderline patients] alive."¹⁰⁴ Linehan's emphasis on the quality of the relationship permeates the treatment:

102. Linehan defines parasuicidal behavior as "any intentional, acute self-injurious behavior with or without suicidal intent, including both suicide attempts and self-mutilative behaviors." Marsha M. Linehan et al., *Cognitive-Behavioral Treatment of Chronically Parasuicidal Borderline Patients*, 48 ARCHIVES GEN. PSYCHIATRY 1060, 1060 (1991).

103. See *id.*

104. LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 21.

The therapist must work to establish a strong, positive interpersonal relationship with the patient right from the beginning With a highly suicidal patient, the relationship with the therapist is at times what keeps her alive when all else fails DBT works on the premise that the experience of being genuinely accepted and cared for and about is of value in its own right, apart from any changes that the patient makes as a result of the therapy. Not much in DBT can be done before this relationship is developed.¹⁰⁵

Linehan's final statement is particularly telling. The relationship is the basis out of which the healing power of the treatment develops.

The nature of the therapeutic relationship Linehan envisions supports the patient's autonomy. Linehan is explicit about the goal of DBT: a life worth living.¹⁰⁶ She is equally explicit about why: "Borderline patients' frequent voiced dissatisfaction with their lives are valid. They are indeed in a living hell. If patients' complaints and descriptions of their own lives are taken at all seriously, this assumption is self-evident. Given this fact, the only solution is to change their lives."¹⁰⁷

Linehan is clear that what makes life worth living depends upon the patient's own values, not upon those of the therapist:¹⁰⁸

[F]lexibility and respect for the patient's own wishes, goals, and ideas about "how to get from here to there" are needed. Thus, the therapist should avoid being judgmental about the patient's choice of goals and/or commitments. The therapist should be careful not to impose his or her own goals or treatment procedures on the patient when such goals or procedures are not dictated by DBT or the therapist's own limits. Although it is tempting to present arbitrary therapist choices or preferences as necessary, such a tendency must somehow be averted or corrected when noticed.¹⁰⁹

The therapeutic relationship in DBT is based upon a respect for the patient's own "wishes, goals, and ideas" about what constitutes a life worth living.¹¹⁰

Consistent with a respect for the patient's values and choices,

105. *Id.* at 98.

106. *See id.* at 100.

107. *Id.*

108. *See id.* at 286.

109. *Id.*

110. *Id.*

Linehan believes that a therapist practicing DBT must be willing to recognize, acknowledge, and admit his or her mistakes.¹¹¹ Linehan sees these characteristics as central to the therapeutic relationship.¹¹² She elaborates on this idea by explaining that therapists must be willing to repair a relationship that has been damaged by their mistakes because "in such a complex and difficult therapeutic endeavor, mistakes are inevitable; what the therapist does afterwards is a better index of good therapy."¹¹³ By placing the burden on the therapist to admit and repair mistakes for which he or she is responsible, Linehan highlights the equality of patient and therapist. It is precisely this equality that best demonstrates the treatment's respect for the patient's autonomy.

Linehan further underscores the importance of treating the patient as an equal partner by noting how easily therapists fall into the trap of pathologizing the patient when the therapy goes awry.¹¹⁴ Linehan remarks how this trap is especially inviting for therapists who work with borderline patients. "I suspect that many therapeutic failures in commitment that have been laid at the feet of borderline patients could more properly be laid at the feet of their therapists."¹¹⁵ The danger is sufficiently great that a foundation of DBT is the premise that patients cannot fail in therapy. According to Linehan, "when patients drop out of therapy, fail to progress, or actually get worse while in DBT, the therapy, the therapist, or both have failed. If the therapy has been applied according to protocol, and the patients still do not improve, then the failure is attributable to the therapy itself."¹¹⁶ By not automatically attributing therapeutic stalemates or failures to the patient's pathology, the dialectical behavior therapist assumes equal responsibility for the therapeutic relationship.

The equality of therapist and patient is especially evident at the beginning of the therapy. First, during the initial sessions a therapist and patient decide whether they can work together. The assignment of patient to therapist is not assumed final. Second, the therapist and patient must each agree to several conditions before the treatment can actually begin. The patient agrees to make every effort to stay in therapy for a specified period of time, usually one year at the outset;

111. *See id.* at 110-11.

112. *See id.*

113. *Id.* at 110.

114. *See id.* at 111.

115. *Id.* at 285.

116. *Id.* at 108.

to attend therapy sessions; to reduce parasuicidal behaviors; to reduce behaviors that interfere with therapy; to participate in necessary adjunctive aspects of the therapy; and to abide by fee arrangements. The therapist agrees to make every reasonable effort to conduct the therapy in a competent manner; to conduct the therapy in an ethical manner; to respect the integrity and rights of the patient; to protect the patient's confidentiality; to attend all sessions; and to obtain consultation as needed. The fact that the therapy cannot go forward until both therapist and patient agree to work together, and agree on certain conditions of how the therapy will proceed, further elaborates the egalitarian, collaborative nature of DBT.

Linehan is clear that the collaborative nature of the relationship does not detract from the patient's primary responsibility in determining the course of the therapy and of her life.¹¹⁷ A central assumption upon which Linehan bases DBT is that

a borderline patient has to change her own behavioral responses and alter her environment for her life to change [T]he therapist cannot save the patient. Although it may be true that the patient cannot change on her own and that she needs help, the lion's share of the work nonetheless will be done by the patient.¹¹⁸

Linehan points out that placing primary responsibility upon the patient to change her own life entails serious risks—literally of life or death—that the therapist must accept if the treatment is to be successful.¹¹⁹ If the therapist cannot accept such a risk and strives to keep the patient alive at all costs, a patient will inevitably fail to achieve the goal of a life worth living. "Acceptance of the possibility that the patient may commit suicide is an essential requisite for conducting DBT. The other alternative, however—in which the patient stays alive, but within a life filled with intolerable emotional pain—is not viewed as tenable."¹²⁰ Linehan places the risks incumbent upon the therapist in stark relief.¹²¹ The important point is that the risks are taken in the service of the patient's growth toward the goal of the therapy: a life worth living, as the patient herself envisions that life.

Obtaining informed consent takes place within the context of a collaborative therapeutic relationship that fosters the patient's

117. *See id.* at 107.

118. *Id.*

119. *See id.*

120. *Id.* at 108.

121. *See id.*

autonomy. Put another way, obtaining informed consent is an interpersonal event that holds the potential to further, or inhibit, the patient's choices about the life she would like to live. Ideally, informed consent fosters these choices.

DBT breathes life into the values behind the doctrine of informed consent by:

- (1) highlighting the importance of the therapeutic relationship;
- (2) setting a goal—a life worth living—that the patient will define with her own values, wishes, and ideals;
- (3) the therapist's nurturing the patient's goals in a non-judgmental way;
- (4) refusing to blame the patient when the therapy goes awry;
- (5) the therapist's willingness to recognize, acknowledge, and repair mistakes;
- (6) allowing therapy to commence only when therapist and patient have mutually agreed they can work together;
- (7) having both therapist and patient agree to conditions upon which the therapy will proceed;
- (8) ultimately holding the patient responsible for achieving her goal of a life worth living, however she chooses to define such a life.

While certain therapies contain one or more of these elements, DBT makes each an explicit aspect of the treatment. Striking is that the centrality of these elements to DBT is based primarily upon their therapeutic efficacy. At the same time, they bring alive the values underlying the legal doctrine of informed consent.

VI. ASSESSING COMPETENCE TO ENGAGE IN THE TREATMENT

Individuals are generally assumed competent to consent to treatment. This assumption holds until evidence to the contrary arises, at which time it may be necessary to assess an individual's competence. Competence may be assessed in a variety of ways that range from requiring very little of the patient's capacities to those that demand a significant showing of cognitive ability. As examples, the questions asked to determine competence may be whether the patient is simply able to make a decision; whether the patient can understand the information presented; whether the patient can manipulate the information presented in a rational manner; and whether the

patient can make a reasonable decision about the treatment offered.¹²² Borderline patients are generally competent by each of these standards.

Far more complex with a chronically suicidal borderline patient is assessing the individual's competence to engage in treatment. Assessing competence to engage in treatment will require determining whether the individual is aware of her own psychological processes, including the propensity to act on impulse; whether the individual is able to identify an appropriate individual to whom those processes can be communicated when they threaten the individual's safety; and whether the individual is actually capable of communicating those processes to such an identified individual.

Because the mental status of borderline individuals is prone to change in response to external events, as well as in response to the individual's own psychological processes, it is important that the competency of these individuals be assessed in an ongoing manner. Dialectical behavior theory builds into the treatment mechanisms that allow the therapist to assess the patient's competence to engage in treatment on a regular basis. The assessment of this competence takes place in two ways: through the use of "diary cards" and through phone contact between the therapist and patient.

Diary cards are written forms that the patient brings to therapy each week. The cards provide a forum for the patient to report on a variety of thoughts, feelings, and behaviors that have occurred since the previous treatment session. Specific behaviors asked about include the frequency and intensity of substance abuse, as well as any self-harming behaviors. In addition, the patient indicates the degree and intensity of thoughts and urges to harm herself. Finally, the patient indicates whether she was able to use techniques learned in the therapy to cope with these behaviors, thoughts, and feelings. The diary card is the first item on the agenda for each individual therapy session. Dialectical behavior therapists review the card in order to determine what material will receive priority as a topic of discussion during a given hour.

Diary cards serve a number of purposes, the primary of which is therapeutic. The information on the cards is a benchmark for the patient's mental state during the past week. In addition, the cards provide concrete information for the therapist about what the patient thought, felt, and did since their last meeting.

122. See APPELBAUM ET AL., *supra* note 75, at 84-89.

The process of having the patient fill out and present a diary card to the therapist each session is relevant to her competence to engage in treatment in two ways. First, practice makes patients better at reporting. The diary card is a way for the patient to learn how to read and report her own internal states. In this regard, competence to engage in treatment is an acquired skill. Patients can improve. Second, through the diary cards the therapist has the patient's first-hand report about her thoughts, feelings, and behaviors during a specified period of time. While the therapist cannot assume that the diary cards are a completely veridical account of what occurred, the diary card does give the therapist the opportunity to determine how the patient responded to certain internal states. As an example, the protocol for handling diary cards requires that a report of any intentional self-harm, or intense suicidal thoughts or urges, be addressed on a priority basis during that particular session. As a consequence, the therapist is able to assess immediately the patient's capacity for handling such thoughts, urges, or behavior in an appropriate fashion simply by discussing what the patient did.

Telephone calls are a second such mechanism. Telephone contact with the individual therapist is a central part of DBT. Dialectical behavior therapists explain to patients the centrality of telephone contacts at the outset of the therapy. A dialectical behavior therapist will actively explore with a patient unable or unwilling to make telephone calls what can be done to increase her participation in this aspect of the treatment.

Two reasons speak to why telephone contact is another way for the therapist both to assess the borderline patient's competence to engage in treatment, as well as to increase that competence. First, according to Linehan, a therapeutic reason underlying the value of telephone contact is that

many suicidal and borderline individuals have enormous difficulty asking for help effectively. Some are inhibited from asking for help directly by fear, shame, or beliefs that they are undeserving or their needs are invalid; they may instead engage in parasuicidal behavior or other crisis behaviors as a "cry for help." Other patients have no difficulty asking for help, but do so in a demanding or abusive manner, act in a way that makes potential benefactors feel manipulated, or use other ineffective strategies.¹²³

123. LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 104.

Telephone contact affords the therapist the opportunity both to assess the patient's competence to identify and appropriately communicate her internal states, as well as to assist the patient in improving these capacities.

Second, the content of the telephone calls has a highly specific structure. DBT permits telephone contact in two situations, one of which is germane to the patient's competence to engage in treatment: "when the patient is in a crisis or is facing a problem she cannot solve on her own."¹²⁴ In such a case the therapist will use the telephone contact to focus on helping the patient apply the techniques she has learned in the therapy to the crisis or problem.

The idea is that the patient may know how to use skills in a situation of low stress—a therapy session—but have enormous difficulty applying those skills to situations encountered in everyday life. Thus, the patient is encouraged to call the therapist when the patient is in a situation she experiences as highly stressful and when she is likely to engage in self-injurious behavior. During such a phone call, the therapist acts something like a coach, exhorting and encouraging the patient to use what she has learned in therapy to deal with the crisis at hand. Consistent with this end, Linehan is clear that therapists are not to engage in psychotherapy during telephone contacts; rather, therapists are to assist patients in addressing whatever problem precipitated the call.¹²⁵

The structure and purpose of phone calls provides the therapist an excellent opportunity to assess how the patient handles a crisis situation. Many therapists must assess in an office a borderline patient's competence to engage in treatment, far removed both in space and in time from any problem the patient may actually encounter. DBT, in contrast, provides—as a central part of the treatment—a mechanism for the therapist to assess the patient during what the patient experiences as a crisis. Put another way, through the use of telephone contacts, DBT brings therapist and patient together in the very moment the patient is having the most difficulty and thus provides the therapist a first-hand opportunity to examine the degree to which the patient is competent to engage in treatment.

Diary cards and telephone contacts are central features of DBT. Each has important therapeutic benefits. Each also is highly relevant to the question of informed consent. Their significance lies in how

124. *Id.* at 500.

125. *See id.* at 500-01.

diary cards and telephone contacts allow the therapist to assess whether the patient is competent to engage in the treatment; that is, whether the patient can monitor, report, and appropriately communicate difficult and potentially life-threatening internal states. The protocol of DBT allows this assessment to occur in an ongoing manner and so takes into consideration the fluctuating nature of the borderline individual's mental and emotional states. The assessment of competence sets the stage for another ongoing process, that of obtaining informed consent to the treatment. Obtaining informed consent consists of informing the patient about relevant aspects of the treatment and of obtaining the patient's consent.

VII. INFORMING THE PATIENT

An essential component of obtaining informed consent is providing the patient information about the nature, purpose, risks, and benefits of the therapy. DBT builds the provision of such information directly into the initial part of the treatment. During the first several sessions, the treatment is explained in detail. The explanations consist of the most rudimentary details about the therapy—for example, how often sessions occur, how long they last, and how matters such as payment and missed sessions are handled.

On a deeper level, the patient is oriented to the philosophy that underlies the treatment. Linehan identifies six themes to the philosophy of DBT that must be shared before the patient has been adequately informed.¹²⁶ Patients are told:

- (1) The treatment is supportive, insofar as its aim is to decrease self-injurious behavior and increase satisfaction with life;
- (2) The treatment is behavioral, insofar as its focus is carefully to analyze behavior, to increase positive behaviors, and to decrease maladaptive behaviors;
- (3) The treatment is cognitive, insofar as it will help the patient examine and change problematic beliefs, expectations, and assumptions;
- (4) The treatment is skill-oriented, insofar as it helps the patient to improve skills for dealing with everyday life;
- (5) The treatment balances acceptance and change, insofar as it helps the patient both to tolerate painful feelings and to

126. *See id.* at 442-43.

change problematic ways of relating to her world;

(6) The treatment is based upon a collaborative relationship.¹²⁷

By beginning the treatment in this manner, Linehan informs the patient of the treatment's technical aspects, as well as of the theory that underlies DBT's technique.¹²⁸

Another aspect of orienting the patient to the treatment is agreeing on treatment goals. For the first part of the treatment, the goals are ordered in hierarchical fashion. These goals are to reduce parasuicidal and life-threatening behaviors, to reduce behaviors that interfere with therapy, and to reduce behaviors that interfere with the patient's quality of life. Again, agreement on these goals is necessary before the treatment can proceed. Thus, the patient is explicitly informed about the goals of treatment before the work can begin. As the treatment progresses, new goals are identified and agreed to. Goals beyond those initially agreed to include addressing post-traumatic stress symptoms and decreasing problems in living.

Another requirement for consent to be informed is that the patient be apprised of the risks and benefits of the treatment. As Linehan sees it, the benefit of DBT is a life worth living.¹²⁹ She is clear that, left untreated, most borderline patients lead lives that are unbearable. Linehan is equally explicit with patients about the risks of treatment.¹³⁰ She likens engaging DBT to climbing an aluminum ladder, placed in the basement of a house, in the midst of burning coals.¹³¹ The patient's choice is to remain standing on the coals, or to begin climbing the ladder.¹³² Unfortunately, because the ladder is aluminum, it is also red-hot and scorches the patient as she begins to make her way out of the basement.¹³³ Linehan uses this metaphor in part to capture the painful feelings patients will experience as they engage in the treatment.¹³⁴ While the goal is to climb out of the basement, achieving the goal will almost certainly entail excruciating pain.

The most serious risk of DBT is the risk of death. Linehan is

127. *See id.*

128. *See id.* at 438-48.

129. *See id.* at 100.

130. Marsha M. Linehan, Address on Dialectical Behavior Therapy: Treating the Difficult-to-Manage Borderline Client (June 1997).

131. *See id.*

132. *See id.*

133. *See id.*

134. *See id.*

succinct in how she balances this risk against the treatment's benefit: "[a]cceptance of the possibility that the patient may commit suicide is an essential requisite for conducting DBT. The other alternative, however—in which the patient stays alive, but within a life filled with intolerable emotional pain—is not viewed as tenable."¹³⁵ Linehan sees the willingness to take risks as an essential attribute of a dialectical behavior therapist.¹³⁶ Such willingness is necessary if the therapist is to help the patient not revert to a more familiar, albeit more dangerous and painful, way of life.

Perhaps the risk experienced by therapists most acutely—a risk that implicates what mental health professionals experience as the risk of life or death—will arise from Linehan's position on inpatient hospitalization. Linehan sees inpatient hospitalization to be clinically contraindicated for the vast majority of borderline individuals.¹³⁷ As a consequence, she makes clear that a goal of DBT is to keep patients out of the hospital.¹³⁸

Linehan's clinical reasons for her bias against inpatient hospitalization are shared with individuals entering therapy.¹³⁹ Patients are thus informed about DBT's posture in this regard. The bias against inpatient hospitalizations is sufficiently strong that patients who are brought to emergency rooms are exhorted to educate emergency personnel about the reasons they should not be placed on a locked psychiatric unit.

Linehan also takes care to inform patients that other treatments are available and may be more helpful than DBT.¹⁴⁰ She is particularly attentive to how patients may come to a dialectical behavior therapist in a mental state that makes them prone to accept a treatment without a careful consideration of its realistic benefits and without being aware that other treatments may be available.¹⁴¹

It is sometimes so easy to focus on getting a commitment from the patient that the therapist forgets to consider carefully whether his or her treatment can actually help the patient as much as or better than available alternative treatments When individuals come to treatment in crisis, ready and willing to commit to anything, it is particularly

135. LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 108.

136. *See id.* at 107-08.

137. *See id.* at 510-11.

138. *See id.*

139. *See id.* at 438-48.

140. *See id.* at 445.

141. *See id.*

easy to rush into treating them without giving this the careful consideration such a commitment warrants. Facile promises of therapy can readily inspire hope in a desperate patient, but for just this reason they may be extremely difficult to break without serious damage to the patient. In most cases, the therapist should not promise continuing treatment during the first session. I usually tell a potential patient that we will use the first two or three sessions to assess whether we can work together and whether the person's problems are the type that I am able to treat. Between sessions, I consider whether I am able and willing to offer potentially effective treatment for this particular individual; if so, a firm commitment is made If not, I help the person find alternative treatment.¹⁴²

By actually helping the patient find an alternative treatment, Linehan takes the idea of informing the patient about such treatments a step further. In doing so, she brings to life the idea behind the doctrine of informed consent. Put another way, Linehan goes further than simply providing a patient information about other treatments—she makes those treatments real by actively helping a patient to find them.

Informing the patient is a necessary element of informed consent. Built into DBT are mechanisms for informing the patient about the nature, purposes, risks, and benefits of the treatment, as well as about other available treatments. Behind these mechanisms lies an underlying theme that patients who come to DBT are often desperate and so must not be promised more than the therapy can realistically deliver. In these ways, DBT supports the value behind the doctrine of informed consent, that of providing the relevant information in a manner that allows the patient to exercise an autonomous choice.

VIII. CONSENT

Consent speaks to the patient's decision to accept or refuse the treatment offered. Adequate consent requires that the patient voluntarily embrace the treatment, free from undue coercion. For DBT, consent to treatment takes the form of a commitment that the patient makes to begin the therapy. This commitment must be explicit and must come after the patient has been informed about the therapy.¹⁴³

142. *Id.*

143. *See infra* Part VI.

Consent to treatment, in the form of a commitment, has been shown to be significantly related to future performance.¹⁴⁴ Thus, in addition to fulfilling a necessary legal requirement, consent to treatment carries potential therapeutic benefits as well.

Linehan is explicit and unwavering in her position that patients must commit to treatment goals and to the six patient agreements before any actual treatment takes place.¹⁴⁵

Until the necessary verbal commitments are made, the therapist should not proceed to discuss any other topic. There should be no investigations of the patient's past to get clues about her "resistance"; no discussions of the patient's emotional misery or life chaos to get a better understanding of why she simply can't commit right now This point is crucial because the patients sometimes balk at one or more of the DBT commitments

. . . . Starting therapy without the requisite patient commitment is like being a train engineer who is in such a hurry to get the train passengers somewhere that he or she starts the engine car out of the station before the passenger cars are securely fastened. No matter how fast that engine goes, those passengers left in the station are not going to reach their destination any faster. Borderline patients typically have great difficulty making a commitment to work on reducing parasuicide and suicide risk.¹⁴⁶

Linehan's metaphor—that of a train leaving the station without its most important passenger—highlights the centrality of the therapist attending to the patient's values, goals, and readiness for treatment.

Linehan's view of commitment to treatment is complex. Three aspects of the manner in which patients are asked to commit to treatment merit discussion: first, that the level of commitment varies according to how far the patient has progressed in treatment; second, that commitments are usually not fully present in the sense that even having made a commitment, a patient will tend to waiver in the strength of that commitment; and third, that commitment is an ongo-

144. See LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 284; see generally Sharon M. Hall et al., *Commitment to Abstinence and Acute Stress in Relapse to Alcohol, Opiates, and Nicotine*, 58 J. CONSULTING CLINICAL PSYCHOL. 175 (1990) (discussing commitment levels of patients).

145. See LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 444-45.

146. *Id.* at 445.

ing process. These three aspects of patient consent to treatment serve to acknowledge that consent to treatment is not a single, binary event. Rather, what a treatment requires from a patient may vary significantly as the treatment goes forward.

First, Linehan sees different commitments as necessary at different points in the treatment.¹⁴⁷ At the initial stages, the commitment is straightforward: the patient commits to participate in DBT with a given therapist for a given amount of time, to keep the six patient agreements, to reduce self-injurious behavior, and to build a more worthwhile life.¹⁴⁸ As the treatment moves on, a greater commitment is required.¹⁴⁹ The patient is asked to collaborate in specific treatment procedures that target particular thoughts, feelings, and behaviors. At yet a third level, the patient is asked to commit to attempting to apply techniques learned in the therapy to new situations.¹⁵⁰ Thus, as the focus of the therapy changes according to progress the patient has made, the patient is asked to make additional, explicit commitments to the work.

Second, Linehan recognizes that commitments made rarely continue without wavering in strength.¹⁵¹ For this reason, she exhorts therapists to assess continually the level of commitment to the treatment.¹⁵² When the patient's commitment is extremely weak—perhaps nonexistent—DBT requires that the commitment to treatment be renewed before the work can continue. Thus, commitment to treatment must continually be remade.

Third, Linehan views commitment to treatment as an ongoing process.¹⁵³ This view is consistent with commentators who view informed consent as a process, rather than as an event. The process of commitment in DBT has as its basis the propensity of patients to waiver in their level of commitment.¹⁵⁴ According to Linehan, the process of commitment and recommitment is expectable, and she makes clear that this process is a central aspect of the therapy.¹⁵⁵

Throughout treatment, the therapist can expect that the pa-

147. *See id.* at 284-85.

148. *See id.*

149. *See id.*

150. *See id.*

151. *See id.*

152. *See id.*

153. *See id.*

154. *See* APPELBAUM ET AL., *supra* note 75, at 151.

155. *See* LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT, *supra* note 4, at 284-85.

tient will need reminding of the commitments she has made, as well as assistance in refining, expanding, and remaking behavioral commitments (sometimes over and over). In some cases, a patient and I have had to go back to the original commitment several times within a single (very difficult) session, making and remaking it. On other occasions, one or more whole sessions may be needed to readdress issues of commitment to change, to DBT, or to particular procedures. A failure in commitment should be one of the first things assessed (but not assumed) when a problem in therapy arises Once recommitment is made, both can proceed with addressing the problem at hand.¹⁵⁶

Put more succinctly, “[c]ommitments made must be remade.”¹⁵⁷

A patient's consent is the final stage of a process whereby the patient makes an autonomous choice to engage in treatment. That process can be broken down into three prior stages: establishing a relationship structured to foster the patient's autonomy, assessing the patient's competence to engage in the treatment, and providing information necessary for the patient to make an informed choice about whether to accept the treatment offered. DBT is the only treatment that has demonstrated efficacy in treating borderline patients who engage in intentionally self-injurious behavior.¹⁵⁸ DBT is also a treatment that has built directly into its protocol aspects that address each element of informed consent. In a word, there appears to be an especially good fit between the values behind the legal doctrine of informed consent and the therapeutic elements that make DBT a beneficial treatment for borderline individuals.

IX. THERAPEUTIC JURISPRUDENCE RECONSIDERED

This Article has examined how the principles underlying DBT and the values underlying the doctrine of informed consent converge. This convergence demonstrates that a body of law can serve a particular population's therapeutic interests. To put the matter another way, we have engaged in a detailed therapeutic jurisprudence analysis that relies not just on common sense and speculation, but on outcome studies as well. Informed consent is not merely a good idea for borderline patients—it is an integral part of the only treatment that

156. *Id.* at 285.

157. *Id.* at 291.

158. *See id.* at 4-5.

has been shown to be effective for patients who struggle with this disorder. As straightforward as this analysis may seem, it raises a number of interesting and important questions for the entire enterprise of therapeutic jurisprudence. We draw eight lessons from our analysis.

The first lesson is that the therapeutic or anti-therapeutic implications of a law are often overlooked. Aside from Gutheil and Winick,¹⁵⁹ few have examined the clinical effect of informed consent on patients. Fewer still have explored the legal implications that flow from discovering that hospitalization is contrary to the therapeutic interests of a certain class of patients. Therapeutic jurisprudence serves as a call to examine and explore how laws affect a specific population. When laws affect a population identified as having clinical needs, the relevance of such a project is evident; therapeutic jurisprudence nonetheless demands that the clinical implications of *all* laws be studied.

The second lesson of our analysis is that therapeutic jurisprudence has been able to show that the therapeutic and autonomy interests of patients often coincide. Winick, for example, has demonstrated that a right to refuse treatment both promotes the patient autonomy and enhances the likelihood of a positive treatment outcome.¹⁶⁰ In the case of DBT, we have shown that promoting patient autonomy is not merely a benefit of the therapy—it is a treatment *goal* toward which much of the therapy's technique and theory is directed. Society should be especially pleased when autonomy benefits and treatment benefits coincide, and one accomplishment of therapeutic jurisprudence to date has been to show when and how this occurs.

The third lesson is that therapeutic jurisprudence must face the difficult issue of who gets to decide which rules are therapeutic. To take Winick's example again, allowing a right to refuse treatment—thereby promoting the value of choice—best serves patients' interests. It is not at all clear, however, whether most psychiatrists would agree with this assessment. It may well be that many psychiatrists would force a chronically ill patient to accept an anti psychotic medication, even at the expense the patient's self-respect. These psychiatrists might point out that while patients invested in treatment are more likely to benefit, society is nevertheless able to force compli-

159. See Gutheil, *Medicolegal Pitfalls*, *supra* note 46; Gutheil, *Suicide and Suit*, *supra* note 56; Winick, *supra* note 1.

160. See Winick, *supra* note 1, at 328.

ance on unwilling patients, thereby ensuring that such patients do receive medications with demonstrated efficacy.

The question then becomes: "Who determines what is therapeutic?" On the one hand, the community of mental health professionals may argue that its expertise lies precisely in deciding what constitutes mental health and mental illness, so mental health professionals should be the arbiters in this regard. After all, this community would point out, mental health professionals are the experts in deciding what goes into the DSM-IV, the most widely used nosology of mental illness in the United States.

Other groups will likely counter that therapeutic benefits extend far beyond the expertise covered in mental health training. Philosophers and clerics, for example, might choose to argue that much goes into the idea of therapeutic over and above clinical definitions of mental health and mental illness. When multiple definitions of "therapeutic" coincide, as occurs when promoting autonomy and providing good clinical treatment go hand-in-hand, this problem is mostly hidden. When, however, definitions of "therapeutic" diverge, therapeutic jurisprudence must offer some way of determining who will be the arbiter of what lies in the patient's best therapeutic interests.

The fourth lesson of our analysis is that even if we do decide which group will determine what is therapeutic, members within the group may disagree, and the law may not be in a good position to adjudicate the dispute. This problem is evident in how the law assesses social science evidence; numerous commentators have pointed out how poorly the law is equipped to weigh competing claims, all of which are allegedly grounded in scientific methodology.¹⁶¹ In our example above consider what would happen should dialectical behavior therapists say one thing is therapeutically indicated, while clinicians from another theoretical perspective—perhaps psychoanalysis—claim that something quite different is in the patient's therapeutic interests. The problem is exacerbated because, as Chris Slobogin has noted, the questions raised by therapeutic jurisprudence are peculiarly difficult to study by accepted research methods.¹⁶² The questions are large, with many variables, and ethical constraints limit what research can actually be done. How to address this problem poses a

161. See, e.g., Samuel R. Gross, *Overruled: Jury Neutrality in Capital Cases*, 21 STAN. LAW. 11, 11-12 (1986).

162. See Christopher Slobogin, 1 *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, PSYCHOL., PUB. POL'Y, & L. 193, 207-08 (1995).

significant challenge to therapeutic jurisprudence.

The fifth lesson is that we need to be concerned with the therapeutic interests of *all* individuals affected by a certain law. In the mental health law context we may care most about the therapeutic benefits of a law or policy for patients. At the same time, however, we need to consider other actors in the system and their incentives for acting in one way or another in order to *achieve* those therapeutic benefits. In our example therapists struggle with strong counter-transference feelings, often entailing anxieties that they will be sued following an untoward event. These anxieties may lead clinicians to place patients on locked units when doing so is neither necessary nor clinically indicated. Thus, anxiety may provoke a clinician into a course of action that impairs both a patient's therapeutic and autonomy interests. Therapeutic jurisprudence requires an examination not only of how a law or policy will affect patients; it requires an examination of how a law or policy will affect other actors, such as treaters, as well.

The sixth lesson of our analysis flows from the fifth. Therapists have therapeutic interests no less than patients. The law's current structure may be such that the anxiety experienced by treaters is quelled by committing a potentially self-injurious patient to the hospital, even though hospitalization may not be the treatment of choice for the patient. If we focus on what is clinically indicated for patients, we may find that these interests conflict with what is clinically indicated for therapists. This dilemma thus raises a normative question: whose therapeutic interests should prevail when there is a conflict? To take another example, many different actors populate the child custody context. Therapeutic jurisprudence needs to address how the clinical benefits of these actors are to be weighed against one another. Perhaps a slight decrement to a child's well-being would result in a significant and lasting increment to a parent's well-being. Therapeutic jurisprudence must provide a way to determine whose interests count, how those interests are weighed against one another, and who will decide these questions.

The seventh lesson of our analysis is that, even should we be able to identify where the therapeutic interests lie, to decide how to weigh the interests of various actors against one another, and to determine who is the arbiter of these questions, therapeutic jurisprudence still faces the problem of how to weigh therapeutic values against other values. Therapeutic jurisprudence has not yet provided a way of choosing among competing values or of balancing other values

against therapeutic values. Take, as an example, the question of what to do when an individual with multiple personality disorder commits a crime. Perhaps it could be satisfactorily demonstrated that absolving this person of criminal responsibility is in her best therapeutic interest. Nevertheless, exoneration from criminal responsibility may not serve the goals of the criminal justice system.

Therapeutic jurisprudence has not yet provided a way to reconcile this kind of conflict. If therapeutic jurisprudence says only that the law may legitimately consider therapeutic interests, it has not gotten terribly far. Legal scholarship is *essentially* normative, and good legal scholarship provides a way to address difficult questions raised by competing values. A future task of therapeutic jurisprudence is therefore to indicate how therapeutic interests are balanced against other legitimate interests. In a word, the task is to define what is *jurisprudential* about therapeutic jurisprudence—an issue that has yet to be satisfactorily explored.

The final lesson in therapeutic jurisprudence refers to a condition that plagues much of legal scholarship—a condition that makes bringing law professors, law practitioners, and mental health professionals together so vitally important. The point is that knowing what is therapeutic is not enough to design a system that implements therapeutic interests. To take an example from our exercise, it may benefit patients enormously to change laws that govern the involuntary admission of patients to psychiatric wards. But unless advocates of therapeutic jurisprudence are good lobbyists, or unless we can develop a persuasive legal theory to achieve that end through the courts, our insights may come to naught. While therapeutic jurisprudence promises a law reform agenda, more actors than legal and psychiatric scholars will be needed to carry out that agenda.

X. CONCLUSION

We have drawn eight lessons from our exercise in therapeutic jurisprudence. The lessons fall into two broad categories, the first of which concerns therapeutic questions and the second of which concerns jurisprudential questions. Therapeutic questions speak to the limits on our ability to discern what is therapeutic and to implement what we have learned. Jurisprudential questions concern the very nature of how we define “therapeutic,” the challenge of balancing therapeutic interests against other values society holds dear, the challenge of balancing the therapeutic interests of actors within a system who may have conflicting interests, and the problem of deciding

who is the final arbiter of these and other questions. By addressing these questions this new movement in the law may properly be called *therapeutic jurisprudence*, as well as therapeutic *jurisprudence*.