



ORIGINAL ARTICLE

Interdisciplinary workshop on “mental disorder and self over time”

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1 | INTRODUCTION

How is personal identity affected by changes in the self over the course of time? How does the experience of a severe mental disorder impact on an individual's sense of self and personal identity? Do fluctuations in the self affect culpability for their actions? These questions are of interest to psychiatrists, philosophers, and legal scholars. However, all too often they are studied from within disciplinary silos.

We report on an interdisciplinary workshop that we organized, on “Mental disorder and self over time.” The workshop took place on 1st September, 2015, under the aegis of the European Research Council project “Self-Control and the Person: An inter-disciplinary account.” It followed in the footsteps of the Centre for the Humanities and Health, which aimed to facilitate interdisciplinary engagement of clinicians and philosophers.¹⁻⁵

We designed the workshop to be clinically relevant; approximately half of the 41 participants were clinicians. We aimed to create a collaborative and exploratory atmosphere, bringing together participants from mental health, philosophical, and legal backgrounds. This allowed us to explore issues in the philosophy of personal identity as they relate to the actual experience of mental disorder: to see what lessons clinical experience might have for this area of philosophy and to get

philosophical input on questions of identity and selfhood that arise in clinical practice.

Specific disorders have their own particular patterns, which can affect sense of self and personal identity in different ways. The workshop was divided into six sessions, each focusing on a different disorder: dementia, affective disorders, bipolar, psychotic disorders, borderline personality disorder, and anorexia nervosa. Each of these sessions opened with a 25- to 30-minute talk by someone with clinical experience, as a clinician or service user or both, followed by a 5- to 10-minute response from a philosopher and then discussion.

In this paper, we summarize the talks and responses, giving a flavour of the discussion and drawing some general conclusions. Five detailed papers, each based on one of the presentations given at this workshop, also appear in this issue,⁶⁻¹⁰ and 3 papers on the workshop theme have appeared in the previous philosophy thematic.¹¹⁻¹³ A podcast is available on the website of the Self-Control and the Person group, at <http://www.selfcontrolandtheperson.weebly.com/podcasts>.

2 | SESSION 1: DEMENTIA

Juliette Brown, a psychiatrist specializing in General Adult and Older Adult Psychiatry in the East London NHS Foundation Trust, opened

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the day by asking how the experience of dementia affects an individual's sense of self and personal identity over the course of time. She began by describing some of the apparent effects on selfhood and identity may accompany dementia and argued that, although dementia is often seen as synonymous with loss, the illness can also deliver remarkable insights into the capacity to navigate a fragmented identity, as well as reminding us vividly of the importance of a relational, interactive quality to identity. For those with personal experience of dementia and also within our wider culture, Brown explained dementia represents an archetype of loss of self and identity over time, which brings great sorrow and is rightly often met with horror, sadness, and shock.¹⁴ All of the dementias and the fear of the late stages, with their overwhelming need and dependency, can impede any positive thinking concerning the intervening years and the possibility of living and dying better with dementia.

Dementia forces us to confront the possibility of living with a fragmented identity and the extent to which we all rely on a notion of psychological continuity, presenting ourselves to ourselves as a coherent self over time and creating a fiction around consistency.¹⁵ Brown drew on the ideas of a broad range of thinkers to question this fiction, ranging from Hume's view of identity as no more than a series of perceptions over time to ideas found in postmodern, post-structuralist, and particularly continental psychoanalytic thought that the self we experience is a (necessary) fiction.¹⁶ Dementia demonstrates that we can develop beyond the need or capacity for continuity and coherence.

Moreover, dementia highlights the relational element of selfhood, as we witness the adaptive, socially constructed self diminishing through the disease and a second, experiential self, comes to prominence.¹⁷ Via Levinas and Lacan, we might ethically consider, instead, the relationship between development, mastery, and anxiety in relation to a post-memory, post-language self that evolves in the course of dementia.^{18,19} Brown argued that, if we can move beyond our conventional notions of selfhood, we may be able to face the radical challenge dementia poses to selfhood. Psychodynamic insights might help us to understand the responses of people with dementia and their carers to their new realities and to support people with dementia to face the diagnosis. Perhaps, then we can negotiate the altered sense of self and fragmentation and find creative ways to persist in our relationships with those with dementia.

Agnieszka Jaworska, Professor of Philosophy at UC Riverside, took up the issues of discontinuity and fragmentation, asking what we should do about the conflict between the dementia patient's earlier and later self, when there is a mismatch between a patient's advance wishes and their current best interests. She asked what justifies Dworkin's notion of *precedent autonomy*, in which "a competent person's right to autonomy requires that his past decisions about how he is to be treated if he becomes demented be respected even if they contradict the desires he has at a later point."²⁰

Jaworska argued that lack of decision-making capacity may well be insufficient to justify precedent autonomy, given that early or pre-dementia patients are unable to understand what their best interests will be once they start suffering from severe dementia because of the unknown nature of the experience. Nevertheless, she suggested the possibility of a threshold of degeneration so severe in terms of the concerns on which an advanced directive was based that

it might justify implementation of the directive, even though decision-making capacity itself may have actually been lost at a much earlier point.

The discussion centred on the topic of personality change and whether, for example, changes in behaviour constitute alterations of fundamental personality. Participants reflected on the extent to which continuity of identity diminishes and how far this is reflected in others' or the person's own view of themselves.

3 | SESSION 2: AFFECTIVE DISORDERS

Julia Bland, Consultant Medical Psychotherapist at the South London and Maudsley NHS Trust, began her presentation by suggesting that one central question in this area concerns how the formerly ill person now relates to themselves. There is often a fundamental shift, she suggests, from the premorbid state of common sense assumptions about continuity of self along lines that, "I may have good and bad days, but I remain myself throughout my life." The person living through an experience such as psychotic depression (absolutely convinced that the psychiatric nurses are planning to torture them with snakes and spiders, which they believe they richly deserve) is in a new state. When fully recovered, there is a discontinuity between the sick and the well self, which must be accommodated, tolerated, and somehow made sense of.

To explore these questions further, Bland took the audience through a brief history of ideas about the self (including references herein²¹⁻²³). She noted that there has been much emphasis within philosophy on the continuity of psychological features such as memory, beliefs, values, personality, and preferences as facilitating the continuity of the self over time. She then pointed out that a theory of selfhood must, however, also allow for change over time and that this raises the question, "how much of your personality could you lose and still be you?" She noted also that these ideas are challenged from other perspectives including Buddhism, which reifies the dissolution of self as an ideal, raising another question, "Do we overvalue both psychological coherence and self?"

Bland explained that she is persuaded by a theory according to which we have no static selves but are in a constantly fluctuating state of becoming and actively constructing ourselves, in a way that is dependent on the social environment. She also proposed that the idea of an internal dialogue between different parts of the self is extremely apt clinically, giving the example of Freud in "Mourning and Melancholia" describing the hostile attack of the highly critical part (called *super-ego* by Freud) and the struggling self.²⁴

Connecting these ideas to the therapeutic task, Bland moved on to the experience of the self in affective disorder. She noted that at the milder end of low mood, there may be no radical disturbance in the sense of self, unlike the terror of disintegration that is part of psychotic depression. Part of the therapeutic work that can be done, she suggests, facilitates an adjustment to a new identity, which includes a vulnerability to a mood disorder, even if there is no discontinuity in the self. In other contexts, the therapeutic task is to support the repair of a painful "split" in the psyche that might be caused by a childhood trauma, which undermined the development of a coherent self.

In this therapeutic process, Bland suggests that narrative becomes crucial: The central offering is the co-construction of a narrative of the self that makes the terrifying and inexplicable take its place and thus

become bearable. This “dialogical self” is a fluctuating movement around a central core, which we each construct in inner dialogue between parts of ourselves, and outer dialogues with others in social contexts.

In her response, Jillian Craigie, an ethicist at King's College London, focused on a central idea in Bland's presentation that the healthy state is characterized by a continuity and coherence and mental ill health is characterized by a rupture in the self.²⁵ Craigie continued Bland's exploration of this idea by drawing in particular on the work of David Velleman.²⁶

Velleman, rightly in her view, worries about the idea seemingly implicit in coherence models such as Harry Frankfurt's that problematic emotions (those experienced as alien and not reflectively endorsed) should be repressed.²⁷ She notes that Velleman wonders whether this kind of response to incoherence within the self might even contribute to mental ill health. Could our striving for coherence and consistency undermine our mental health?

In close connection with Bland's ideas about the self, Craigie described how Velleman pushes back against monolithic notions of a true self that must be sustained over time, urging us embrace multidimensionality and complexity in our understanding of self. This presents a model of developmental achievement that does not involve the resolution of inconsistency, as many philosophers would have us believe is the ideal.

The discussion that followed revolved around question whether the proposed discontinuity in the self in affective disorder was a difference in kind or simply in degree, relative to ordinary experience. Bland was asked whether any particular philosophers had helped her in this area and suggested that different ideas were helpful in different contexts but that no particular theorist stood out.

4 | SESSION 3: BIPOLAR DISORDER

Clare Dolman, journalist and part-time PhD student at the Institute of Psychiatry, Psychology & Neuroscience, KCL, spoke from both a personal and a researcher's perspective on various aspects of bipolar disorder and identity: The effect of diagnosis, the relationship between the self in manic, depressive, and euthymic episodes, and the impact of the passage of time on memory and identity in bipolar disorder.

Dolman said that her first hospitalization and diagnosis caused a massive shift in identity, from being an ambitious and driven person to being a “mentally ill person” who would need to take medication the rest of her life to stay “sane” and who could not talk about it because of the stigma. The disorder affected how she saw her past and future. She reassessed important events and periods of her life in the light of the diagnosis. She was no longer sure she could become the sort of person she had imagined she would be: a high flying career woman and, even more importantly, a mother.

Dolman also explored how bipolar disorder fundamentally impacts identity. One of the definitions of the word “identity” is “the state or fact of remaining the same one, as under varying aspects or conditions.” But bipolar disorder, by its very nature, involves widely discrepant views of the self during mania, depression, and normal functioning, ranging from inflated self-esteem and grandiosity to feelings of worthlessness. In particular, people with bipolar disorder see themselves differently during manic episodes

than they do when they recall the episode from a euthymic state.²⁸ This leads to a conundrum: They take pills to stop themselves from turning into “a different person”—one who they may think is more quick-witted and energetic, more gregarious and attractive, but also less sensitive to other people's feelings, who can behave incredibly badly and generally become very irritating. Does the lithium keep them who they truly are or does it subdue a version of themselves, and a more creative one at that?^{29,30}

Bipolar disorder also impacts on the relationship between memory and identity. Dolman is particularly interested in how the passage of time affects one's perception of self. We all construct our memories, which cumulatively contribute to our developing sense of identity. But people with bipolar disorder may interpret a formative moment differently depending on whether they are manic, depressive, or euthymic when they recall it. So the process of constructing self through memory will be more complex for with bipolar disorder, as their minds accommodate traces of several different interpretations of every event, each loaded with emotional salience, which go on accumulating over time.

Finally, Dolman noted that her psychiatrist did not believe manic depressives (as bipolar disorder was then called) needed anything but medication to return them to “normal.” However, she thinks therapy can be extremely helpful—even essential—for people who receive a diagnosis of bipolar disorder. As well as taking the medication, they need to come to terms with the need to take it, and it helps if they can somehow assimilate the condition into their identity and make it a positive as well as a negative.

Wayne Martin, Professor of Philosophy at the University of Essex, talked about how bipolar disorder can help us to understand personal identity, a key topic in philosophy. He distinguished between 2 framings of personal identity. On the *forensic* version, personal identity is a fact of the matter. We care about it because we use forensic identity to impute guilt for earlier actions, to enforce contracts on later selves, and to establish the legitimacy of advance directives. Theories of what underlines forensic identity include bodily continuity and memory. On an *existential* understanding, personal identity is a task to be accomplished or a status. We care about it because an existential identity is a psychological need and a social requirement. On this understanding, achieving personal identity is a kind of work.

Martin identified problems for existential identity. The Problem of the Starting Point is that personal identity requires that I do some work (“integration”) but how can I do that work unless identity is already accomplished? The Problem of the End Point is that working towards personal identity presupposes some standards of success or failure, but what are these? He argued that we can get clues to the answers from bipolar disorder. Regarding the Problem of the Starting Point, personal identity is incipient in identity-implicating moods and attunements, such as feelings of guilt and regret. Regarding the Problem of the End Point, achieving personal identity requires making sense of the episodes as parts of a whole.

Discussion focused on the surprising inapplicability of a “two-person” model, where the patient is considered to be different persons in the manic and depressive phases. Although it is superficially appealing, sufferers feel emotions like shame and regret about episodes once they have passed, which suggests a continued sense of identity between the different phases. It was suggested that bipolar patients

have to accept that the person during the episode is them in some respects—to own their episodes and accept that they could do those things—and that the notion of “taking responsibility” could bear more philosophical scrutiny.

5 | SESSION 4: PSYCHOSIS

Eduardo Iacoponi, Consultant Psychiatrist at the South London and Maudsley NHS, explained why his main experience with patients suffering from psychosis is not actually of change but of an absence of and perhaps even a resistance to change. In the majority of cases, he sees patients without being invited. After attempting to establish basic facts to ascertain the presence and type of psychiatric problem, his therapeutic mission is to help to eliminate symptoms, to achieve functional and occupational recovery.

A typical clinical encounter pits friends, relatives, and clinicians against the patient. Friends and relatives see the patient's identity as disrupted, while clinicians immediately present their primary objective as ridding the patient of the psychosis, which is judged as wholly negative. By contrast, the patients do not accept this view and cling to their psychotic beliefs, asserting that they have always been as they are now. Thus, Iacoponi associates psychosis with a lack of change, a clinging to essential aspects of identity, and wonders whether part of psychosis might actually be a desperate resistance to change.

To illustrate these ideas, Iacoponi described some case studies. One patient thinks she is the mother of Christ; another that her brain is being monitored by an international atomic agency; a third that his relatives were impostors who were fiddling with the internet and poisoning his food. The patient who believes herself to be monitored says that, despite the fear this causes, the worst and most intolerable possible outcome would be to find her beliefs to be mistaken.

In Iacoponi's third case study, the patient eventually retreats into himself and becomes passive and accommodating, appearing to lose all interest in external activities. Most challenging, perhaps, are such patients who, ultimately, overwhelmed by “negative symptoms,” fall into a lack of the energy, which could maintain the hope of change. He drew a comparison with the nymph Daphne in the Ovid's tale of Daphne and Apollo, who asks to be transformed into a tree, so as to resist Apollo and remain a virgin. Perhaps, he speculated, to talk about identity over time in psychosis, we need to think of more than one identity, and of the relationship between a core and essential identity that must remain, and an external, malleable one that will adapt and protect according to need.

In response, Tania Gergel, a philosopher at the Centre for Mental Health, Ethics and Law at King's, suggested that contemporary philosophical notions of selfhood and personal identity are a poor fit when it comes to accommodating the radical transformations of identity, which occur with psychotic disorders. Reflecting on Iacoponi's case studies, she focused on the way in which psychotic delusions come on fairly suddenly, with no major explanation beyond pathology and cause, in effect, almost a complete fracturing between the pre- and post-psychosis self. Core delusional beliefs alone are valued and become the key element of identity. Interaction with others becomes, essentially, a combative relationship, in

which the need to prove the legitimacy of this new reality is all that matters.

Within the context of the reductionist notion of personal identity, in which our continuing identity simply is constituted by the psychological connectedness between ourselves at the different moments of our lives,^{31,32} or the narrativist view of identity as some type of teleological coherence drawing the various moments of our lives together,^{33,34} it is hard to see where the psychotic “fracturing” of identity could fit in. If we stick to such models, we may simply have to concede that, for Iacoponi's patients, especially those in whom the psychosis is most refractory, the onset of psychosis constitutes the loss of self. More worryingly, perhaps, in legal or ethical terms, such a view may lead us to see psychosis as the loss or diminution of personhood. To find, therefore, some way in which identity and personhood can be maintained within psychotic disorders, it seems that we need an alternative or adapted conceptual model of identity over time.

A key topic within the discussion was the tension between identity as the individual with psychosis sees themselves and their identity or loss of identity as it is perceived by others. If we try to find some way to accommodate the changes by concentrating on “character,” as opposed to selfhood, what do we do with the “person” as they are known by others? Despite the certainty of the individual, is the psychotic self itself “disordered,” and how do family, friends, and clinicians navigate the way in which their views of the individual are now seen, primarily, as a threat?

6 | SESSION 5: BORDERLINE PERSONALITY DISORDER

Angel Santos, Consultant Psychiatrist and trained psychotherapist from the South London and Maudsley NHS Trust, contrasted the discontinuity that arises from psychosis with the general disorder and chaos of self that is associated with personality disorders, especially Borderline Personality Disorder. Borderline Personality Disorder is characterized by a self that does not develop properly; by extreme emotional sensitivity, which can be compared to the physical sensitivity of a person with burns; and by rapid changes in mood, which patients feel no control over.

From a psychoanalytic point of view, there are theories of Borderline Personality Disorder, Kernberg's analysis based on object-relationship theory³⁵ and Fonagy's theory of mentalization.³⁶⁻³⁸ While they place different emphases on nature vs nurture and innate aggressive impulses vs learned deficits in mental processes, both place identity disturbance—and the inability to create, maintain, and use benign images of self and others—central to the disorder. In both theories, emotional instability, impulsivity, and other symptoms are secondary, a result of the sufferer's experience of an incongruent and unstable self.

However, there is not much empirical work on identity disturbance and the concept is very diffuse. When Weston and Wilkinson-Ryan developed a questionnaire to probe the construct, based on the theoretical literature and their clinical experience, it had 35 items all examples of what psychiatrists consider to be indications of identity disturbance.³⁹ They included contradictory beliefs and

behaviours, personality changes, value changes, feeling empty inside, and confusion over sexual orientation.

From his clinical experience, Santos made the following observations about diagnosis and identity. For some patients, a BPD diagnosis provides a new and useful sense of identity, helping them to make sense of their experiences and giving them a sense of hope. For others, identifying with the sick role is not useful and they resent it. Many patients already have a diagnosis of bipolar disorder or post-traumatic stress disorder; they have located their disturbance outside of the self, in a chemical imbalance or an event, which caused everything to go wrong. It can be hard for them to accept that their problem is internal. The psychiatrist wants to help them change their narrative, to get them to accept how their experiences have led to their behaviour and to try to give them a sense that they can be helped. If the source of the problem is inside the self, then maybe there is something they can do about it. However, in that case the patients need to face the experience of loss and of lost years: "If I can change now, why couldn't I do it ten or twenty years ago?"

Natalie Gold, Senior Research Fellow at King's College London, explained how, in the non-clinical population, impulsivity can be seen as being caused by a focus on *me-now* at the expense of the self over time. BPD seems at first sight to be a pathological version of this, as the diagnostic criteria include a disordered sense of self and potentially self-damaging impulsivity.⁴⁰ The philosophical framework of intertemporal agency offers a connection between the subjective feelings of disorder and the objective behaviours.

However, the relationship between philosophical theories of identity and the disrupted self of BPD patients is not so simple. Amongst the 35 items identified by Weston and Wilkinson-Ryan,³⁹ we can find several senses in which the BPD patient's self is disrupted. BPD patients can have a sense of not being the same person over time, changing intentions, the sense of being different selves with different people, feelings of emptiness, and hatred of themselves. As we go through this list, we get increasingly far from philosophical accounts of the changing self over time, and hating oneself even seems to presume the existence of a persisting self. Some of the items look like discontinuities of self, but others look like they are better described as disunities. What is the relationship between disunity and discontinuity? Might disunity be a type of or cause of discontinuity?

In discussion, we distinguished the philosophical project of personal identity as articulating what individuates a person over time (or being the same person) from psychiatric accounts of the development of identity understood as a set of affiliations (having a sense of identity). These are different sets of problems: In principle, there could be someone who has exactly the same commitments and values as me, but that would still be a different individual. However, the projects are connected because a severe strain on identity in the psychiatric sense can cause strain on metaphysical identity.

7 | SESSION 6: ANOREXIA NERVOSA

Lorna Richards, Consultant Psychiatrist, St Ann's Eating Disorders Service, North London, argued that treating anorexia nervosa purely as an illness distracts from "the messy stuff inside," around issues of identity and values. The most common time of onset is during adolescence

and young adulthood, when patients do not yet have a robust adult sense of self and are still trying to work out who they are and who they want to be. Richards explained how anorexia shields them from confusion and offers identity during a time of identity crisis, allowing an unwell anorexic self to emerge in place of the authentic self.

Patients describe how anorexia becomes integral to their selves, not necessarily all encompassing, but a part of themselves.^{41,42} Richards explained how anorexia affects patients' values, their personalities, and their ways of thinking. There is a general societal tendency to associate negative values with fatness, but anorexics go beyond this, thinking that being fat is a failure and makes them unlovable; they put paramount importance on being thin, seeing their anorexia as indicating their superior willpower. They identify with the disorder, which is part of a broader personality style, and have difficulty envisaging their future self without anorexia. They worry that getting well would completely change them, turning them into different people. It would be a leap into the unknown, since many have never experienced a self without disorder. So, although patients may want to be free of eating problems, they do not necessarily want to be free of the disorder itself. Richards said that these issues are exacerbated by the pro-ana sub-culture, which promotes anorexia as a lifestyle choice. Patients are looking for an identity and the culture provides a tribal identity, which legitimizes their anorexia.

According to Richards, the therapist has to try to get patients to see their anorexia as in battle with the healthy part of themselves, to get them to try to change. This requires them to tease apart the true self and the anorexic self.⁴³

Jonathan Glover, Professor of Philosophy at King's College London, responded by taking up the question of how we identify authentic values. He argued that we cannot just discount values because they are pathological or caused by illness. Nor is it enough that anorexia is not conducive to things that are important for human beings. Other acceptable lifestyle choices, such as mountaineering, involve a high risk of death. Instead, Glover gave possible approaches for identifying authentic values.

The first was stability, or the tendency of the value to persist in the long term, over time. To discover which values are stable, we can use the "thank-you test": If you do not want something (or some treatment) at the time but are grateful afterwards, then that suggests your previous values were not stable and therefore not authentic. However, whilst Glover argued that the thank-you test is important evidence of instability he noted that it must be used with caution because of the possibility of abuse. For instance, someone's later values can be changed by torture and brainwashing, as happened to Winston Smith in Orwell's 1984.

The second approach was to distinguish between shallow and deep values. According to Glover, shallow values are not rooted in experience but are often assumed to please other people. In anorexia, one story is that patients are pushed into the disorder by controlling parents.⁴⁴ Pro-ana websites can help to sustain the disorder. Glover argued that this causal story suggests that the values associated with anorexia are not genuine values; the feminine ideal is rather shallow and too other-directed to base a life around. He suggested that we can also identify whether someone is living according to deep values by asking how value conflicts are settled; whether it is just that the strongest desire at the

moment wins out or whether the person asks deeper questions about where the desire comes from and whether it really leads to a satisfying life. For Glover, part of the role of a therapist is to help self-creation.

We discussed the idea that patients should externalize the condition, and whether encouraging them to do so is problematic. Richards said that externalization works really well for some patients but has the opposite effect on others.

8 | CONCLUSION

The day's discussions focused on a broad range of conditions and a diversity of challenges in relation to the question of self over time within these various disorders. Despite this diversity, the centrality and importance of questions concerning selfhood to the issues that face individuals who suffer from these disorders clearly emerged from the day's discussions. A number of the clinicians, both those who spoke and those who attended, commented that, although questions relating to identity and self are not a usual part of their clinical practice, they had found the day's discussions to be useful and illuminating in terms of possibilities for understanding and engaging their patient population. For the philosophers present, in-depth discussions about identity and self within different mental disorders stimulated a reconsideration of philosophical notions of personal identity.

What constitutes continuity and coherence of the self, and the difficulties in relation to self various forms of mental disorder, emerged as key theme. It seems that both philosophical and general conceptions of psychological continuity and coherence as central to the persistence of selfhood and identity play a major role in our current understanding and treatment of those who experience mental disorders. At the same time, each of the disorders under discussion appears to involve fundamental transitions and challenges to these dominant ideas of selfhood and identity, both in the eyes of the person themselves and those around them. We may well need, therefore, to expand or find alternatives to our current ways of conceptualizing selfhood and its persistence in an individual over time, if we are to deal with such transitions and challenges and to avoid consigning those who experience mental disorder to fragmentation, diminution, or loss of personal identity.

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