

Towards Humanism in Psychiatry

JONATHAN GLOVER

THE TANNER LECTURES ON HUMAN VALUES

Delivered at

Princeton University
February 12–14, 2003

JONATHAN GLOVER is a professor of ethics and director of the Centre of Medical Law and Ethics at King's College London. He was educated at Corpus Christi College, Oxford, and was a fellow in philosophy at New College, Oxford, for thirty years. He chaired a European Commission Working Party on Assisted Reproduction, authored a report for the Office of Technology Assessment of the United State Congress on the social and ethical implications of the Human Genome Project, and was joint director of a project on Women, Equality, and Reproductive Technology in the Third World at the United Nations University. His numerous publications include *Responsibility* (1970); *Causing Death and Saving Lives* (1977); *What Sort of People Should There Be?* (1984); *I: the Philosophy and Psychology of Personal Identity* (1988); and *Humanity: A Moral History of the Twentieth Century* (2000).

These two lectures are an attempt to outline some of the features of a “humanist” psychiatry. The title “towards humanism in psychiatry” is not meant to suggest that humanism is entirely alien to current psychiatry. It indicates only that these lectures aim to encourage psychiatry to go in a certain direction.

Humanism, as understood here, is contrasted with a purely biological or medical approach to psychiatry. But there is no necessary conflict between the version of humanism advocated here and biological psychiatry. It should be uncontroversial that medical and biological approaches have added enormously to our understanding of mental disorder and to its alleviation. But it should be equally uncontroversial that some relevant aspects of people may elude description in purely biological or medical terms. Biological psychiatry and the psychiatric humanism defended here are partners, not rivals. If once there was a war between the two, now we all support the peace settlement. (But, as in Northern Ireland, there are times when the peace can seem fragile.)

The humanism in psychiatry advocated here has two main features. There is an emphasis on the interpretation of people (the topic of this lecture). A humanist psychiatry also emphasizes human values and how they inform a conception of the good human life (one of the topics of the next lecture).

I. INTERPRETATION

Psychiatric humanism emphasizes the interpretation of people. The interpretation aims at understanding how things seem and feel to the person. There are reasons to think such interpretation may sometimes help towards curing psychiatric disorder. But it may also be of value in itself, independent of any contribution to a cure. One bad thing about having psychiatric illness can be a sense of loneliness associated with not being understood by other people.

The kind of interpretation meant is not the diagnostic kind, where symptoms suggest a particular disorder. The standard diagnostic categories have their uses. It is hard to see research making much progress

unless there were some agreement on criteria for classifying disorders. But, as a tool for understanding, they also have their limitations. A person can exhibit a kaleidoscope of symptoms from a number of supposedly different disorders before (perhaps) settling down roughly within one diagnosis. This can make the categories seem like the colonial boundaries in Africa, lines drawn from outside, sometimes uniting very different tribes in one territory, sometimes dividing a single tribe between different territories. Here the diagnostic categories will be used, but with a tinge of scepticism.

In developing the kinds of interpretation that may help break down the psychological isolation of people with psychiatric illnesses, we should take seriously how they see themselves. For this we need to think about first-person accounts of psychiatric illness. To use a first-person account is not to make wild extrapolations from a single instance. The aim is more particular. It is to understand experiences from the inside and to understand the ideas and metaphors someone with psychiatric illness uses to describe and make sense of his or her own life.

This lecture is about the possibility of such an interpretative psychiatry. It considers interpretation in two directions. There are questions about how things said and done by people with psychiatric disorders should be interpreted. And, as part of this, there are questions about how people with psychiatric disorders interpret the world. Perhaps inevitably, the lecture sets out more a programme than a set of answers.

PART I. INTERPRETING STRANGENESS

I. "STRANGENESS" AND "PERSONAL CHEMISTRY"

There is no doubt that some people with psychiatric disorders at times strike others as strange. They may behave in ways that seem unintelligible. They may look strange or have an odd posture or gait. They may laugh at unexpected times, or stare, or say things in ways that make it hard to have a conversation with them. At such times, it is hard to get through to them: they seem unreachable.

Sometimes this inaccessibility has baffled their families and friends and also psychiatrists. Eugen Bleuler, the inventor of the word "schizophrenia," said that people with the disorder were stranger to him than

the birds in his garden. Karl Jaspers said it was possible to have empathy for those with mood disorders, but not for those with schizophrenia: “We may think we understand dispositions furthest from our own, but when faced with such people, we feel a gulf which defies description.”¹

Since those hit by schizophrenia are not birds in the garden but people, their problems may be compounded by our inability to reach them. To psychiatric disorder may be added loneliness and isolation. Understanding them more intuitively, “from the inside,” matters independently of any contribution to developing a cure. It is also a serious intellectual challenge, to psychiatry, to psychology, and to philosophy. So far, our theories about knowledge of other minds have not much helped us here.

The way people do or don’t bond is often thought of as a matter of their “personal chemistry” with each other. Psychiatric disorder can bring a generalized disruption of this personal chemistry. There are two (not mutually exclusive) possible explanations. There may be disruption of a person’s skills at sending signals and at interpreting other people’s signals. Or the problem may come from the affected person having an inner life so unusual as to be almost unimaginable.

The first explanation suggests a possible remedy. Standing too close, talking too loudly, not noticing the reactions to bizarre clothing or to sudden, inappropriate laughter, and being oblivious to someone else’s signals about having to go are all communication failures that can increase the impression of strangeness. They suggest a poor sense of the small change of everyday life. But sending the right signals and the related ability to read the signals sent back are skills that can be taught. Some women with postnatal depression do not bond well with their babies. There is evidence that if these mothers attend a massage class that also teaches them to read the baby’s body language, they and their babies bond much better.² Some psychiatric “strangeness” may be amenable to a similar approach.

The other explanation, that the affected person may have a very different inner life, raises much deeper difficulties. It is the one I want to discuss here. The causal accounts of biological psychiatry, for instance, in terms of abnormalities of brain chemistry, often transform our

¹ Karl Jaspers: *General Psychopathology*, translated by J. Hoenig and Marian W. Hamilton (Baltimore, 1997), vol. 2, pp. 577–82.

² K. Ozonawa et al., “Benefits of Infant Massage for Mothers with Postnatal Depression,” *Journal of Affective Disorders* 63 (2001): 201–7.

understanding of a disorder and sometimes contribute to it being either cured or contained. But in themselves they give us no intuitive understanding of how the disorder feels from the inside.

One source of intuitive understanding is first-person descriptions. There is an increasing flow of writings by people who have either recovered from psychiatric disorders or still have them. Equally helpful can be what they say in conversation. I have a friend who has Asperger's syndrome. She has unusually good personal chemistry with people affected by more severe autism. I once asked her if she could describe the intuitive understanding that she has but that most of us lack. She said she shared with more severely autistic people a difficulty in reading faces and invited me to imagine how my world would change if people had no faces.

Other hints of the effects of psychiatric disorder on people's feelings and ways of seeing things come from paintings by psychiatric patients. These often have a peculiarity that is hard to describe but that recurs again and again. Examples of this tormented strangeness can be seen in the early twentieth century paintings collected at Heidelberg by the art historian and psychiatrist Dr. Hans Prinzhorn.³ At a very different level, the extraordinary power of Vincent Van Gogh's self-portraits is inseparable from the way they convey the same lack of inner peace. To say this is not to reduce them to a set of psychiatric specimens. They are portraits of a terribly tormented man by a tormented painter of genius. And his final painting, the wheat field with crows, may be the most powerful expression ever given to a certain nightmarish view of the world. It is seen as being in violent motion and, at the same time, as claustrophobically oppressive. The greatness of the painting comes partly from its making a suicidal state of mind intelligible from the inside.

Paintings do something to convey the troubled inner climate of various psychiatric disorders. But we also stand in need of verbal answers to some questions about the effect of those conditions on the inner life. For instance, what is going on in the mind of someone who has delusions?

2. DELUSIONS AND THEIR IDENTIFICATION

It is not easy to define "delusion." It is common to think of delusions as false beliefs, irrationally based and stubbornly held. But a delusive be-

³ *Beyond Reason: Art and Psychosis—Works from the Prinzhorn Collection*, Hayward Gallery, London, 1996.

lief may happen to be true: some paranoid people *are* persecuted. The important thing is whether the belief is arrived at by means that should track reality. But since we all have only bounded rationality, the formation of beliefs by means suboptimal for tracking reality does not mark off the deluded person from the rest of us.⁴ We need to think in terms of degrees of irrationality. Perhaps we should think of delusional beliefs as combining two factors. They are formed on a basis that provides extremely poor tracking of reality, and they are clung to with great stubbornness.

But what about fanatical believers in dubious religious or political systems? Psychiatric delusions are only a minority of stubbornly held irrational beliefs. Marking them off may require some distinction between beliefs held as a result of indoctrination or other cultural factors and beliefs held as a result of some personal cognitive malfunctioning. Here it is not necessary to attempt a watertight definition. I shall assume only that there is enough agreement in central cases to justify the assumption that delusional beliefs do exist.

There are problems of how far a delusional belief is really held. There is “double bookkeeping”: the person may say, “The staff here are poisoning my food” and then happily go off to lunch. Apparent statements of belief may be undermined by a mocking demeanour or a manic cackle.

A psychiatrist’s patient claimed to have had a baby at Buckingham Palace. This belief, if persisted in by someone with no royal connections, seems to be a delusion. But, when she says, “I had a baby at Buckingham Palace,” there are several possible interpretations, not necessarily involving belief. She could be toying with the idea that it is true or else acting out a fantasy about being a princess. It could be something said to mislead or annoy the psychiatrist. It could be some kind of joke, possibly a political one with some satirical point. Things said by people seeing psychiatrists can have the ambiguities of comments by Shakespearean clowns or fools.

Even assuming belief, there is a range of possibilities. Perhaps the deluded person does, in a quite literal way, hold the belief. But there are also various kinds of partial or nonliteral “belief.” One woman’s later description of a delusion linked to vomiting was explicit about the “belief” not being literal: “I got the idea that in taking food I was in a sense eating the body of my youngest child. I did not believe this to be the literal

⁴ Herbert Simon: *Reason in Human Affairs* (Oxford, 1983), pp. 19–23.

case, but the aversion to food was strong because of this association.”⁵ There is a continuum of degrees of belief to be understood.

PART II. TWO MODELS OF DELUSIONS

3. THE VARIETY OF DELUSIONS AND OF EXPLANATIONS

Consider cases where there is reason to think the person in some way really holds the belief, and where this clearly counts as being deluded. How are we to understand what is going on?

Delusions are not all of a kind, and different types may need different explanations. Hearing “voices” may have different causes from delusions of alien control, where the person ascribes some of his or her actions to the will of some other person. “Thought insertion,” where the person believes that “this thought is in my mind, but it is put there by someone else,” may need a different explanation from Cotard’s delusion: “I am dead.” Some delusions are localized to a narrowly specific topic: those with Capgras delusion think that a close friend or relation has been replaced by an impostor with an identical appearance. (Sometimes brain injuries involve delusions confined to a specific narrow topic.) Other delusions involve a ramified system of beliefs through which the whole world is seen. Some delusions are long-lasting, while others have an unstable, fleeting existence. One cluster of delusions (thought insertion, Cotard’s delusion, delusions of alien control, and others) involves defects or distortions of awareness of oneself and/or one’s own agency, while others (delusions of persecution) are not self-referential in the same immediate way. Different delusions may involve different perceptual or cognitive failures or distortions. And a single delusion may be multiply caused. The content of a delusion may need a different explanation from its origin or its maintenance.

Many attempts to explain the origin of delusions appeal to one or both of two models. The first model, which emphasizes misinterpretation of evidence, is often called “poor reality testing.” The second model

⁵ Anonymous, “An Autobiography of a Schizophrenic Experience,” *Journal of Abnormal and Social Psychology* 51 (1955): 677–90.

sees delusions as a rational interpretation of highly abnormal experiences.

4. DELUSIONS AS “POOR REALITY TESTING”

If delusions are partly defined as beliefs with a basis that tracks reality badly, to *explain* them by “poor reality testing” is in danger of being tautological. To have content, the explanation has to cite fairly specific perceptual or cognitive failures or distortions. One possibility is that delusions result from highly exaggerated versions of cognitive distortions to which we are all prone.

“Normal” people weigh evidence in ways that are systematically skewed. For instance, when people are given a description of someone’s personality (shy, meek, tidy, etc.) and asked to guess the probability of his being a farmer or a librarian, they tend to go by whether the personality fits one of their stereotypes. They ignore the fact that there are many more farmers than there are librarians.⁶ There are the distorting effects of irrelevant factors. These include salience (famous cases or cases close to the person making the judgment are given excessive weight) and anchoring (the first case is given excessive weight). There is also “confirmation bias”: the tendency to accept evidence that confirms previous assumptions more readily than evidence against them. People underinterpret evidence, not noticing its overall pattern: “not seeing the wood for the trees.” Conversely, there is “jumping to conclusions.” People overinterpret evidence, projecting onto it nonexistent patterns⁷ or projecting a causal link onto a mere conjunction.⁸

Where “poor reality testing” seems an appropriate description, there is a question about whether this is to be explained in terms of cognitive mechanisms functioning in a distorting way or in terms of the person not choosing to test beliefs properly against reality. But for the moment let us stay with the account in terms of unmotivated cognitive distortion.

⁶ Amos Tversky and Daniel Kahneman, “Judgment under Uncertainty: Heuristics and Biases,” *Science* (1974), reprinted in *Judgment under Uncertainty: Heuristics and Biases*, ed. Daniel Kahneman, Paul Slovic, and Amos Tversky (Cambridge, 1982), pp. 3–20.

⁷ Philippa A. Garety and David R. Hemsley, *Delusions: Investigations into the Psychology of Delusional Reasoning*, Maudsley Monographs No. 36 (Hove, 1997), chapter 7, pp. 86–106.

⁸ Amos Tversky and Daniel Kahneman, “Causal Schemas in Judgments under Uncertainty,” in *Judgment under Uncertainty*, ed. Kahneman, Slovic, and Tversky, pp. 117–28.

Exaggerated versions of the “standard” cognitive distortions could play a role in generating or maintaining delusions. (Though many cases do not fit comfortably here. The person who thinks she is being persecuted by spectacle-wearing doctors and nurses, who use their glasses to refract too much light into her eyes,⁹ has not just somewhat overestimated the probability of this happening.) Perhaps salience and anchoring sometimes play a part in generating or maintaining delusions. The tendency to project dubious causal and other interpretations onto the world is a candidate for a role in paranoia. There is evidence that people with delusions are more willing than others to jump to conclusions, even about matters not relevant to their delusions.¹⁰ But the ramified and bizarre content of many delusions (why persecution by means of light? why with spectacles?) suggests something more wrong than would result from even strong versions of the standard cognitive distortions.

5. DELUSIONS AS RATIONAL RESPONSES TO STRANGE EXPERIENCES

The second model does not postulate cognitive irrationality and distortion. Instead, the suggestion is that some neurological or neurochemical failure generates bizarre experiences and that delusional beliefs are a rational attempt to make sense of them.¹¹ This idea has been applied to various kinds of delusion, including hearing “voices,” delusions of alien control, thought insertion, and Capgras delusion.

On this model, the “voices” people hear are the result of a breakdown in one or more of the brain mechanisms that enable us to distinguish real sounds from imagined ones. A powerful version of this model has been proposed by Christopher D. Frith.¹² He says that certain schizophrenic symptoms have in common that they reflect a disorder of self-awareness. He postulates a breakdown in the system of “metarepresen-

⁹ Anonymous, “An Autobiography of a Schizophrenic Experience.”

¹⁰ Garety and Hemsley, *Delusions*.

¹¹ B. A. Maher, “Anomalous Experience and Delusional Thinking: The Logic of Explanations,” in *Delusional Beliefs*, ed. T. F. Oltmanns and B. A. Maher (New York, 1988), pp. 15–33.

¹² Christopher D. Frith, *The Cognitive Neuropsychology of Schizophrenia* (Hove, 1992).

tation” by means of which we are normally aware of our goals and intentions. Delusions of alien control involve a failure to understand that my action was brought about by my own intention. People who hear “voices” ascribe the products of their own imagination to external speakers. And those with thought insertion fail to recognize that they themselves are the authors of certain thoughts that rise up in their own minds.

On this view, bizarre experiences are generated by failures in the brain’s self-monitoring mechanisms. These mechanisms normally give rise to the sense of agency. When I decide to drink some water, this intention is monitored so that awareness of it accompanies my lifting the glass to my lips. But, if the monitoring fails, I find myself lifting the glass while being unaware of any intention to do so. The idea of being controlled by someone else is one possible explanation of my apparently unintended action.

This account is also applied to thought insertion. Having a thought is seen as a kind of performance as a result of an instruction that is monitored. Breakdown of the monitoring system could then generate an awareness of a thought being not in the usual way under one’s control. And the passivity would once again create an impression of the thought coming from “outside.”¹³

6. SOME LIMITATIONS OF THE TWO MODELS

Both models draw attention to factors that may well play a role in delusions. But each of them gives the impression of telling only part of the story. And even if we combine the strange experiences of the second model with some of the cognitive biases and distortions of the first, important features of delusions are left unexplained.

For instance, why are delusions so specific? And why, when the person who has a delusion starts to question it, does checking only seem to

¹³ There are obvious problems about a thought being preceded by an instruction to have it. A subtle attempt to deal with these problems is John Campbell, “Schizophrenia, the Space of Reasons and Thinking as a Motor Process,” *Monist* 82 (1999): 609–25. The view of delusions as disorders of self-monitoring has been developed in a variety of theories. I am aware of having given only a very schematic account of an approach that has been refined by Frith and others. For a recent version, see G. Lynn Stephens and George Graham, *When Self-Consciousness Breaks: Alien Voices and Inserted Thoughts* (Cambridge, Mass., 2000).

generate new experiences apparently confirming it? (“Then I began to have the feeling that other people were watching me. And, as periodically happened throughout the early stages, I said to myself that the whole thing was absurd, but when I looked again the people really were watching me.”)¹⁴ And, when a delusion is given up, why does another often emerge to replace it? These questions suggest a “wellspring” model, in which delusions rich in detail keep bubbling up to the surface of the mind. To say the wellspring must be some kind of unconscious mental activity is not to explain it. (Though there may be some link with whatever unconscious processes generate dreams, also often startlingly specific.) It is hardly news to say that there are processes here of which we understand almost nothing.

There are other questions. Why are many delusions clung on to so hard? And—the issue taken up here—there is their bizarreness. The content of delusions is often extreme, as in the thoughts that other people are robots, or that the whole world depends on me, or that my best friend has been replaced by an impostor. Being so bizarre, these beliefs suggest something more radically wrong than unusual experiences or cognitive biases. And the belief of those with Cotard’s syndrome that they are dead goes beyond the bizarre to the paradoxical or impossible.

PART III. THE BIZARRENESS OF DELUSIONS

7. TAGGING ERRORS

People’s accounts of their delusions are sometimes so strange as to be almost unintelligible. Philosophers such as Ludwig Wittgenstein, W. V. O. Quine, and Donald Davidson in different ways have stressed the links between meaning and belief. If my interpretation of what you say makes your beliefs unintelligible or highly irrational, or else largely false, there is a real question of whether I have interpreted your words correctly. If a different account of what you mean can make it all more intelligible or more rational, or can make much more of what you believe true, should not that account be preferred?

John Campbell has pointed out that, if there is a rationality con-

¹⁴ E. F. Torrey: *Surviving Schizophrenia*, 3rd ed. (New York, 1995), p. 53, quoted in Ian Gold and Jakob Hohwy, “Rationality and Schizophrenic Delusion,” in *Pathologies of Belief*, ed. Max Coltheart and Martin Davies (Oxford, 2000), p. 161.

straint of this kind on how we should interpret people, this raises a problem for the interpretation of delusions.¹⁵ Can someone who says he is dead, despite walking and talking, really understand the meaning of his own claim? Can someone who claims that her husband has been replaced by an impostor, and does nothing to test this by discussing past shared experiences, really understand the meaning of what she says? In his discussion of this question, Campbell quotes a person with schizophrenia who said that his words bear two meanings: the meanings they ordinarily have and the meanings he is trying to use them to express. There is no obvious answer to the general question of whether deluded people have a proper grasp of the meaning of their claims. Perhaps “grasping the meaning” admits of degrees. But there is a psychological phenomenon that may help intuitive understanding of how they might feel impelled to say such bizarre things.

Sometimes, in a dream or when imagining something, we make mistakes that can be seen as either mistakes of naming or mistakes of representation. I dream I am having a conversation with Mahatma Gandhi, but the image of the face is that of Jawaharlal Nehru. Was I dreaming of Gandhi but making a mistake about his face, or was I dreaming of Nehru but getting his name wrong? I may simply know the answer to this: “It *was* Gandhi—I just got the face wrong.” The dream is mine, and my sense of what was going on overrides the visual discrepancy. There is a system of labels or tagging bound up with the intentional object of my mental state. If the person was tagged as Gandhi, then that is what my image meant even if I did get the face wrong. (It is said that Warden Spooner, after preaching a sermon in New College Chapel, corrected himself: “Every time I said ‘Aristotle,’ I should of course have said ‘Saint Paul.’” Even an eccentric preacher is the authority on what he meant to talk about.)

Normally we cannot explain what this tagging consists in by citing a feature of the experience. There is no equivalent of the caption that might appear below someone’s face on television. (“It may be Nehru’s face, but underneath it *says* it is Gandhi.”) Tagging seems to involve no conscious interpretation of any sign. Whatever goes on in the process of tagging is unconscious. All we are aware of is the end result: our conviction that this is Gandhi.

¹⁵ John Campbell, “Rationality, Meaning and the Analysis of Delusion,” *Philosophy, Psychiatry and Psychology* 8 (2001): 89–100.

Items can be tagged in many different ways. Two possible tags are obvious candidates for involvement in psychiatric disorder. One is the tagging of things as familiar or strange. If this exists, its breakdown would be a plausible element in Capgras delusion. The other is the tagging of items as being or not being part of me. Its failure could contribute to Cotard's delusion.

The idea of things being tagged as "me" or "not me" is given some support by attempts to describe the peculiarly vivid awareness of "being me" that people sometimes have. In *The Idiot*, Fyodor Dostoyevsky draws on his own experience in describing the intensity of Prince Mishkin's consciousness just before the onset of an epileptic fit. It was "purely and simply an intense heightening of self-awareness...and, at the same time, the most direct sense of one's own existence taken to the highest degree."¹⁶ It is striking that Dostoyevsky does not specify any visual, tactile, emotional, or other feature of the experience: any feature equivalent to the taste of Marcel Proust's madeleine dipped in tea that could serve as a vehicle for this direct sense of one's own existence. The absence of such a vehicle is what one might expect if the pre-epileptic experience is caused by some kind of boosted functioning of a tagging process that is unconscious.

Gerard Manley Hopkins clearly had moments of heightened awareness of self. In describing this awareness, he emphasized its distinctiveness. He also emphasized its incommunicability: something that would be expected if it came from unconscious tagging rather than from interpreting some visual or emotional feature of the experience. He said, "...when I consider my self-being, my consciousness and feeling of myself, that taste of myself, of *I* and *me* above and in all things, which is more distinctive than the taste of ale or alum, more distinctive than the smell of walnutleaf or camphor, and is incommunicable by any means to another man (as when I was a child I used to ask myself: What must it be to be someone else?). Nothing else in nature comes near this unspeakable stress of pitch, distinctiveness, and selving, this self-being of my own."¹⁷

Perhaps a "me/not me" tagging system, working too hard, generates these indescribable yet intense and conviction-laden experiences. If so, some other malfunctioning of the same system might begin to explain someone's intense conviction of no longer existing, together with the

¹⁶ Fyodor Dostoyevsky, *The Idiot*, translated by Alan Myers (Oxford, 1992), p. 237.

¹⁷ Gerard Manley Hopkins, *Comments on the Spiritual Exercises of St. Ignatius Loyola*.

inability to articulate reasons for it. But this conjecture, even if true, contributes to the explanation of only those delusions that relate directly to the sense of self. A “familiar/strange” tagging system may contribute to Cotard’s delusion, and tagging errors could be implicated in some other delusions. But it is not obvious that such errors have very widespread application. A more general account is needed.

8. DELUSIONS AS A REFLECTION OF AN EPISTEMOLOGICAL STANCE

Few philosophers would be surprised by the thought that there is an overlap between philosophy and psychiatry. Perhaps less attractive is the thought that there is an overlap between philosophy and madness. But one of the striking features of people on psychiatric wards is how much their conversation is about topics also discussed in philosophy journals: Is the physical world the only world? Does it exist outside my mind? Could other people be unconscious robots? Is there a God? Do we have free will? Is telepathy possible? The atmosphere of the discussion is different, but the topics overlap.

One thing people on psychiatric wards have in common with philosophers is an awareness that the commonsense interpretation of the world is not the only one. It can seem that people on psychiatric wards take seriously forms of scepticism that philosophers discuss only academically. One of the most interesting recent discussions of delusions, by Louis Sass, links the clinical phenomena with philosophical discussions of scepticism.¹⁸ He looks afresh at the much discussed case of the German judge Daniel Paul Schreber, who in 1903 published a notably articulate account of his psychiatric illness.¹⁹ Schreber had a ramified delusional system in which he heard voices and sometimes saw two suns. He was threatened by rays. He had a unique relationship with God, who depended on him and who contacted him through “nerves.” Schreber had the solipsistic view that the world and other people depended in various ways on his own mind. Some events were miracles that depended on him, while other people often had only a problematic

¹⁸ Louis A. Sass, *The Paradoxes of Delusion: Wittgenstein, Schreber and the Schizophrenic Mind* (Ithaca, 1994).

¹⁹ Daniel Paul Schreber, *Memoirs of My Nervous Illness*, translated and edited by Ida MacAlpine and Richard A. Hunter (New York, 2000).

existence: "The human forms I saw during the journey and on the platform in Dresden I took to be 'fleeting-improvised-men' produced by miracle."²⁰ But at times his grip on his own existence as the person who had his experiences seemed precarious, with the experiences described impersonally, as though they occurred but did not belong to anyone.

Louis Sass takes up the strand of solipsism in Schreber and compares it with Wittgenstein's discussion of solipsism. Wittgenstein suggested that solipsistic thoughts are more likely to arise when a person is passive. When we walk around, knocking things over and picking them up, we are more likely to be aware of objects' independent reality than when we are sitting still and staring. Schreber's delusions were embedded in a life that fitted Wittgenstein's view. Apart from brief and reluctant walks, Schreber liked to sit motionless all day at the same place in the garden.

But, more importantly, Wittgenstein makes conceptual points about the paradoxes of solipsism. Arguments for solipsism are usually conceptual rather than empirical. It is not that the evidence suggests that nothing exists independent of my mind. It is rather that it seems impossible to show that anything does have such independent existence. A similar line is taken about the idea of people other than me having experiences. Wittgenstein's response is that if you make it impossible for others to have experiences, it becomes empty to say that they belong to you: "If as a matter of logic you exclude other people's having something, it loses its sense to say that you have it."²¹ Sass links this up with the way Schreber's impersonal descriptions of experiences suggest only a weak sense of himself as the person having them.

Sass's application of Wittgenstein suggests a new use for philosophical discussions of the implications of deviant beliefs. These implications may suggest possible experienced consequences for deluded people who actually hold those beliefs. Perhaps this applies especially to people with a distorted sense of themselves and of their own agency. But it may be possible to build on Sass's approach by asking about more general links between philosophical beliefs and psychiatric disorder. Since people with these disorders are often interested in philosophy, are their delusions perhaps linked to the adoption of some epistemological stance?

²⁰ Ibid., p. 115.

²¹ Ludwig Wittgenstein, *Philosophical Investigations*, translated by G. E. M. Anscombe (Oxford, 1953), part I, section 398.

9. HOLISM AND PLAUSIBILITY CONSTRAINTS

One familiar thought in philosophy is that our beliefs form a system that functions in a holistic way. Suppose something I expect does not happen. I expected that the medicine the doctor prescribed would cure my illness. But it did not. I need to change in some way the beliefs that generated this expectation. Perhaps the doctor is not as good as I thought and got the diagnosis wrong. But there are alternative revisions I can make. The prescription may have been made up wrongly. Perhaps the diagnosis was right, but I have an unusual resistance to medicine that works for most people. Or, if I decide the diagnosis was wrong, I can give up more than just my faith in this doctor. I can abandon scientific medicine. Or, at the extreme, I can give up my belief in the scientific method as a reliable way of finding out about the world. The falsification of a prediction leaves me a lot of free play about which revisions to make to my system of beliefs and about how extensive they should be.

Of course, some of these revisions are more plausible than others. We need to find the right balance between holding onto a belief system so loosely that all of it is destroyed by some slight evidence against any part of it and clinging to it so tenaciously that no evidence is ever allowed to modify any of it.

There are striking cases of how evidence can be explained away by those following the second, more conservative, strategy. Confronted by the fossil evidence for evolution, Philip Gosse argued that, to test our faith, God had arranged fossils to look as if evolution had happened.

Other cases come not from religion but from politics. In 1939, the Central Committee of the British Communist Party had to discuss the Nazi-Soviet pact and a resulting order from Moscow that they were to withdraw support from the war against Adolf Hitler. The order was to work for Britain's defeat. Many members had joined because the Party seemed to provide serious opposition to Hitler. The new policy required them to go against their deepest political instincts. But many of them had also adopted as a fixed point in their system of beliefs that the Soviet Union could do no wrong. The transcripts of the debate show them agonizing as they tried to retain this fixed point in their system by skewing other beliefs. Some bending and squeezing would make it easier to see the Soviet Union as right. Suppose democracy and fascism were not importantly different. Or suppose the British Empire was as bad as Nazi

Germany. Or Germany was so weak as not to be a threat, or Britain and France were worse aggressors than Nazi Germany. None of these claims was plausible, but each was adopted by some members of the Central Committee in the effort to defend the fixed point in their system.²²

Gosse on evolution and this response to the Nazi-Soviet pact are extreme cases of evidence being stretched and squeezed in consequence of the holism of a belief system, in which some other belief is put beyond question. In these cases the implausibility seems obvious. Something similar can be said of many delusions.

Perhaps the person who has Capgras delusion has the neurological deficit that Frith and others describe, so that the expected emotional response is missing when a familiar person appears. But more than this must be missing. If you are someone I usually warm to, but today you walk into the room and I feel no emotional response, there is probably an explanation of my unresponsiveness. Perhaps I have a hangover. Perhaps today you are using some perfume I do not like. Perhaps things said last time have left a chilliness. If none of these explanations seems true, I will go on looking. But one explanation I will not be tempted by is that you have been replaced by an identical impostor. As a convincing story it ranks below the school excuse that “the dog ate my homework.” Capgras delusion carries with it the loss not only of an emotional response but also of a sense of plausibility.

Delusions in general carry with them a loss of the normal plausibility constraints on belief. (It is often by their bizarre nature that we identify them as delusions.) What are these normal plausibility constraints? When is it reasonable to give up a deeply entrenched belief because of some new evidence against it, and when is it reasonable to use the entrenched belief as a reason for scepticism about the evidence? When is it reasonable to accept someone’s testimony about something and when is it not? Is a simple and elegant theory that fits nearly all the evidence to be preferred to a complex and untidy account that fits all the current evidence? How much evidence is needed to turn a hypothesis into a fact?

One hope has been that science and philosophy, partly by extrapolating from obvious cases, might be able to explain what plausibility is. Perhaps they might even generate methodological rules to steer people towards the more plausible interpretations of the world. Such an en-

²² Francis King and George Matthews (eds.), *About Turn: The British Communist Party and the Second World War: The Verbatim Record of the Central Committee Meetings of 25 September and 2–3 October 1939* (London, 1990).

quiry might highlight misguided epistemological stances underlying delusions.

If epistemology and philosophy of science gave this clear guidance, we would have a map of the plausibility constraints on beliefs. We might then be able to see whether a deluded person lacks the whole map or only certain parts of it. But those parts of philosophy disappoint this hope. Books on philosophy of science are not rulebooks for scientists trying to choose between hypotheses. There is the case, argued by Jerry Fodor and others, that the holistic nature of our central cognitive processing excludes the possibility of such rulebooks.

Our minds are finite, and we have to answer questions in a limited time. So we consider only aspects of a problem and limit both the cognitive strategies we use and the possible answers we are willing to accept. Does this bounded rationality have an underlying coherence, supporting the exclusions we make against other possible ones? Or do we separate the plausible from the implausible by many different strategies, each justified by having been found to work roughly but quickly in a context that is irreducibly specific and local?

Some implausibility detectors appeal to very general parts of our system of belief. Doubts about a claimed miracle may appeal to the general reliability of scientific laws. And, as in this case, different general belief systems often change the probability rating of a contentious claim.

But other implausibility detectors seem to be highly specific. At the ticket office at Paddington Station, I ask the price of a ticket to Oxford. The man behind the glass says it is 407 pounds, but when purchased on a Tuesday it comes with a lettuce as a free gift. The resulting mental alarm bells have not been triggered by a commitment to the scientific worldview. The warning comes from specific beliefs about the likely costs of tickets and the kind of promotional offers made by the rail company. If the man then asks to borrow the pair of socks I am wearing, the plausibility rating of his testimony plummets even closer towards zero. One of the reasons why it is hard to say whether certain scenes in Dostoyevsky or in Franz Kafka are closer to dreams or to madness is because both dreams and madness escape the normal plausibility constraints.

A possible clue to the experience of being deluded comes from dreams. They also combine rational thinking with toleration of the bizarre. Dostoyevsky talks of how, after waking, we remember the ingenuity with which we outwitted our enemies: "you guessed that they were perfectly aware of your trick and were just pretending not to know

your hiding-place; but again you outwitted and cheated them, all this you remember clearly.” He goes on: “But why was it that your reason was able to reconcile itself to the obvious absurdities and impossibilities with which your dream was crammed? One of your killers turned into a woman before your very eyes, then from a woman into a sly and hideous little dwarf—and you accepted it at once as an established fact, with barely a hesitation, and this at the very moment when your reason, on the other hand, was at a pitch of intensity and demonstrating extraordinary power, shrewdness, perception, and logic?”²³

Logic and reasoning can persist, split off in dreams from the (lost) normal plausibility constraints. If this separation is possible in dreams, it is less surprising if it also occurs in madness. And there are contexts outside either dreams or madness in which it is useful to note how reasoning and intellectual analysis function separately from (at least some of) the plausibility constraints.

For instance, in epistemology, the standard form of philosophical reasoning about beliefs is the Socratic one. A belief is challenged first by questions designed to make the person formulate it more explicitly and perhaps to give reasons for it. Then unwelcome logical consequences are drawn out from the belief or from its supporting reasons. Epistemology works by spelling out the costs of different systems of belief. Unwelcome consequences are an implicit invitation to abandon or modify a belief. But the fact that they are unwelcome is not itself generated by logic, but by an intuitive sense of what is plausible. Logic alone is enough to exclude inconsistent belief systems, but not enough to choose between consistent ones. An epistemologist with no intuitive sense of plausibility or implausibility could still produce a map of the costs of belief systems but would have no way of deciding which costs were acceptable or unacceptable. Something extra is needed. And that “something extra” may be relevant to delusions.

10. PLAUSIBILITY CONSTRAINTS AND EMOTIONAL CHEMISTRY

The inconclusiveness of an epistemology without any intuitive plausibility weightings is paralleled by the “frame problem” in artificial intelligence. If an intelligent machine is designed to perform a simple task

²³ Dostoyevsky, *The Idiot*, p. 477.

such as fetching a package, and given access to whatever information it wants about all the alternative strategies, it may never actually start the job. Without any way of excluding irrelevant information or questions, it will have an indefinitely large number of preliminary calculations to carry out. After several years it may still be working on such calculations as that going out of the door will not have any effect on the number of geese in Canada or on the price of vodka in Poland.²⁴ Difficulties in the project of designing a satisfactory relevance detector for such a machine have given support to the suggestion that, in people, emotional responses may function as relevance-prompts. There may be no general intellectual strategy for a relevance search. Instead we may notice a lot of what is relevant by its “feel.”²⁵

The work of Antonio Damasio has brought the cognitive role of emotional responses into prominence. He describes the case of “Elliot,” who had undergone surgery to remove a brain tumour.²⁶ After the operation, he seemed incapable of completing tasks to time. The job might be to read and classify some documents: “he might spend a whole afternoon deliberating on which principle of categorization should be applied: Should it be date, size of document, pertinence to the case or another?” Elliot seems to be the frame problem come to life in a human being. His neurological condition left his intellectual abilities unimpaired, except that he was unable to plan activities over time and was unable to take decisions. He was also emotionally blank. He said that he no longer felt the emotional responses that used to come before his illness and operation. Damasio links the emotional blankness with the inability to take decisions: “I began to think that the cold-bloodedness of Elliot’s reasoning prevented him from assigning different values to different options, and made his decision-making landscape hopelessly flat.”²⁷

Something similar may be true of the plausibility constraints on beliefs. The “something extra” needed in addition to logic may not be some abstract heuristic device. It may instead depend on the emotional

²⁴ Daniel Dennett, “Cognitive Wheels: The Frame Problem of AI,” in *Minds, Machines and Evolution*, ed. Chris Hookway (Cambridge, 1984), pp. 129–51; and in Daniel Dennett, *Brainchildren: Essays in Designing Minds* (Cambridge, Mass., 1998), pp. 181–205.

²⁵ Ronald de Sousa, “The Rationality of Emotions,” *Dialogue* 18 (1979); and in Amelie Oksenberg Rorty (ed.), *Explaining Emotions* (Berkeley, 1980).

²⁶ Antonio R. Damasio, *Descartes’ Error* (London, 1996), chapter 3, pp. 34–51.

²⁷ *Ibid.*, pp. 36 and 51.

“feel” of an idea. (Not on the great emotions of love, hatred, anger, and fear but on such “calm passions” as “there is something fishy about this,” “that sounds really cool,” “it has a good feel to it,” “I don’t like the sound of that,” or “there is something not quite kosher about this proposal.”)

The conjecture I want to put forward is that the loss of plausibility constraints in people with delusions is linked to their problems of “personal chemistry” in everyday life. Their intuitive and emotional “feel” for other people often has been severely reduced or disrupted. And one of the symptoms of schizophrenia is having great difficulty in taking decisions. The indecisiveness is reminiscent of Elliot, as described by Antonio Damasio. The indecisiveness of schizophrenia too perhaps comes from an emotional blankness that makes it hard to assign values to different options. The evaluative weight given to things by people with delusions is often bizarre. K. W. M. Fulford speaks of “evaluative delusions.” He cites a patient who had forgotten to give his children their pocket money and thought this was “the worst sin in the world,” that he was “worthless as a father,” and that his children would be better off if he were dead.²⁸ If disrupted emotional intuition makes it hard to assign weight to options, it could also make it hard to assign plausibility to beliefs.

I I. BELIEFS AND THEIR WEIGHT

Consider two ways in which the normal plausibility constraints may fail. Discussion of plausibility often makes use of the metaphor of weight. How weighty is a certain argument? How much weight should be given to this testimony? Bad cognitive strategies assign to a belief (or to some evidence or to an argument) either too much or too little weight.

A. The Disproportionate Heaviness of Beliefs

A particular belief may be given great weight. In everyday life, there are many beliefs we cannot seriously think of giving up. They are beliefs so heavy that we cannot pick them up and move them. Three of them are that I have no more than two hands, that trees do not make jokes, and

²⁸ K. W. M. Fulford, “Value, Illness and Failure of Action: Framework for a Philosophical Psychopathology of Delusions,” in *Philosophical Psychopathology*, ed. George Graham and G. Lynn Stephens (Cambridge, Mass., 1994), pp. 212–13.

that chairs do not leap away to avoid being sat on. If I start to experience these things, I will wonder whether I am dreaming, drugged, or having a psychiatric breakdown. It is right to give this weight to these beliefs, as they have vast empirical support.

But sometimes a belief may be given too much (sometimes *much* too much) weight. The belief of the British Communist leaders in 1939 that the Soviet Union could do no wrong was a clear nonpsychiatric example. In people with psychiatric disorders, the belief that “I am dead” may be treated as being too heavy to move in the way “trees don’t make jokes” is. One possible explanation of this heaviness could be some distortion of a tagging system whose normal mode of operation gives certainty without supplying evidence open to conscious scrutiny.

B. The Unbearable Lightness of Thinking

When people think about philosophy, nihilism can be a temptation. There are so many alternative ways of thinking about the world (and so many arguments about them to evaluate) that it can seem impossible to choose between them. None of them seems to have any more weight than any other. Far from being too heavy to move, their lightness makes them seem both unreal and absurdly easy to pick up. A student in a philosophy examination who feels this lightness may choose any opinion more or less at random.

Something like this could happen to people whose psychiatric disorder has disrupted their emotional and intuitive feel for people or for plausibility. When thinking is as “light” as this, someone may just “choose” any old version of the world, without feeling a real commitment to it. For this to happen sometimes in people with psychiatric delusions would fit with “double bookkeeping.” It would also fit with the sense of mockery, the sense of the person not really being serious about the belief, that sometimes comes across.

12. THE THREE CONJECTURES

The approach to delusions offered here centres round three conjectures. The first is that the heaviness of some delusive beliefs may derive from an origin in unconscious tagging, which, even when working normally, delivers apparent certainty without providing reasons or evidence open

to being looked at. The second is that the adoption and persistence of delusive beliefs may depend on loss of the normal feel for what is plausible. The third is that the loss of plausibility constraints may itself be part of psychiatric disorder's frequent disruption of emotional intuition. These are all empirical claims, whose acceptance would depend on empirical testing. They are offered as conjectures, in the hope that conjectures can advance knowledge. Even if, as Karl Popper taught us, this is most often by inviting refutation.

II. IDENTITY

PART I. HUMANIST PSYCHIATRY AND THE IDEA OF A GOOD HUMAN LIFE

Humanism in psychiatry has two central themes. One, considered in the last lecture, is the interpretation of people. This will be continued here with an emphasis on the metaphors people use to interpret and shape their own lives. The second theme, at the centre of this lecture, is human values and a conception of a good human life.

A humanist psychiatry is not in conflict with a medical approach but may sometimes supplement it. Some aims of a humanist psychiatry are medical, but some are not. One aim is to improve people's damaged or impaired capacity for living a good human life. The impaired capacity may result from a psychiatric illness, but it may not. Some of the "Personality Disorders" come to mind. The boundaries of psychiatric illness are not altogether clear. But having a rigid or obsessional personality is at most only dubiously to have an illness. It may be just someone's nature. But, if it impairs someone's capacity for relationships, a humanist psychiatry might try to help those who want to overcome their "natural" personalities.

I. ANTIDEPRESSANTS AND THE BOUNDARIES OF MEDICAL TREATMENT

Some thoughtful psychiatrists notice a shift in their own aims when prescribing antidepressants. Peter Kramer raises this in the context of

his treatment of his patient "Tess."¹ Her alcoholic father died when she was twelve. Her mother went into permanent depression. Tess took over care of her and of the nine younger children until they grew up. At seventeen, partly to give her brothers and sisters a base, she married an older man, an abusive alcoholic. The marriage collapsed. Tess was a successful businesswoman and also looked after her mother. She had a strong sense of guilt and responded, perhaps too much, to the claims of others. She thought she put off men, and had unhappy involvements with abusive married men. She had all the symptoms of clinical depression. Dr. Kramer prescribed medication.

The symptoms faded. Tess no longer met the criteria for clinical depression. She thought she was better: "I am myself again." Dr. Kramer was less sure. In her work, she was uncharacteristically upset by some negotiations. She cried when asked about her boyfriend. Wanting a more robust return to her predepression personality, Dr. Kramer suggested Prozac: "My goal was not to transform Tess but to restore her."

But on Prozac Tess did seem transformed: more relaxed and energetic, and with more self-esteem. She laughed more and had a new ease with people. She no longer cried over her old boyfriend and often dated other men. Tess was more at ease in the negotiations. She felt less guilt about her mother and stopped living so close to her. She was less self-sacrificing. She felt relief at this "loss of seriousness."

Tess was able to come off Prozac and continued to do well. But later she asked to go back on Prozac. She was no longer either depressed or driven by guilt. But she felt that Prozac had given her stability. She had lost a little ease and confidence and said, "I'm not myself." Dr. Kramer wondered if he should be giving medication to someone who was not depressed. He could claim to be guarding against a relapse into illness but knew he would really be treating her temperament or personality. He prescribed Prozac, and she recovered her ease and assurance.

On his own account, Peter Kramer's treatment of Tess went beyond treating her illness to acting on her underlying temperament. He was concerned about crossing the boundary of medicine. But, subject to conditions about Tess's understanding what was at stake and reaching her own autonomous decision, the prescription could be justified within humanist psychiatry. The aim was to overcome psychological obstacles to a good life. Peter Kramer's worries suggest a degree of commitment

¹ Peter D. Kramer, *Listening to Prozac* (New York, 1993).

to the medical model, but his policy here suggests the pull of the humanist model.

2. THE IDEA OF A GOOD HUMAN LIFE

Humanist psychiatry may include the aim of improving someone's psychological capacity for living a good human life. But what is it to have a good human life? Or, in Aristotle's terms, what is human flourishing?

Obviously, these huge questions should not be answered by giving a single blueprint of how everyone should live. What counts as flourishing may vary with age, gender, place, and time. A modern American teenaged boy will not flourish exactly as Proust's grandmother did. But, subject to this obvious and necessary pluralism, there still may be things to say about the good human life that are not vacuous. Some features of good lives may fall into clusters. One hope underlying humanist psychiatry is that some clusters may be more central and important than others.

It is a familiar thought that a battery chicken or a caged bird cannot flourish because such lives deny their natures. Part of the good life for a bird is to use its wings and fly. Are there similar aspects of human nature that set some of the contours of the good human life?

Although the attempt to give a species-specific account of human flourishing goes back to Aristotle, the most influential modern version is Darwinian. Evolutionary psychology suggests that natural selection "designed" our physical and psychological systems to perform certain functions. One possible account of human flourishing would be in terms of our physical and psychological systems performing the functions for which evolution designed them. One worry about such an account is that it seems to ignore the way human culture allows us to move away from our biological origins. If reproduction was the original function of sex, can this approach avoid an echo of the bad old days of seeking to "cure" gays and lesbians? Do we really want to say that gays and lesbians have less flourishing lives?

An alternative way of thinking about the good life is to try to ground it in shared human values. These values can be explored by seeing how people respond to living in different ways. The most powerful first-person accounts are often about ways of life that do *not* fit with human needs: accounts of being forcibly separated from one's children, of

solitary confinement, of mindless work or loveless childhoods. Another way of seeking shared human values uses thought experiments devised by philosophers. These lack the vividness and intensity of real first-person accounts, but they allow reflection on possibilities more extreme than are found in real life.

Take the "experience machine" devised by Robert Nozick as a counterexample to (a certain version of) utilitarianism. Jeremy Bentham, explaining what he meant by "happiness," said it was "pleasure and the absence of pain." For his utilitarianism, the good life is a matter of the kind of experiences you have. Nozick assumes a futuristic neurophysiology. His experience machine can stimulate the brain directly, in ways that give any kind of desired experience. It could have many alternative pleasure-maximizing programmes, geared to things different people like. If you would get most pleasure from being a great scientist, you can be put on the Albert Einstein cassette. And so on. There could even be some pain, just the right amount to heighten the pleasure by contrast. Nozick's question is: would you agree to go on the machine for the rest of your life? On Bentham's account of the good life, people should accept such an offer. Yet Nozick believes the great majority of people would not do so. He concludes that there must be aspects of the good life that go beyond enjoyable experiences.

Conversations about this suggest that people resist the experience machine for reasons deeper than the possible unreliability of the technology. They often come up spontaneously with the things Nozick himself thought the experience machine left out. We want actually to do things, not just to have experiences as if we were doing them. We care about the kind of person we are: we want to be something more than a passive recipient of experiences. And we want to explore and to try to understand a reality transcending ourselves. Exploring a constructed surrogate is not the same. Convergence on these values supports a degree of optimism about a shared human nature, and the possibility (at this deep and general level) of discovering some shared views of the good life. (Of course it is an empirical question how far Nozick and the people I have talked to really are representative of the human race in general.)

Here I am going to conjecture without proof and suggest some plausible features of the good human life, features that might emerge from a widespread Socratic search for shared human values. There is no claim that absolutely everyone would share these values. The hope is that they

would be sufficiently widely shared to give substance to the idea of the good human life. (My optimism does not go so far as to suggest unanimity.)

People sometimes say, when explaining why an endless sequence of pleasurable experiences would not satisfy them, that they want their life to add up to something, to mean something. One thing they may have in mind is making a contribution to a project outside themselves, often seen as larger than they are. They are working for the church; they are defending their country or the integrity of the legal system; they are bringing up their children or looking for the cure for AIDS.

Others have a more personal version of life having meaning, centred less on an external project and more on their own hopes in life. The focus may be on their relationships, on their autonomy, or on being creative. The personal concern may focus on values related to their own identity. Self-expression matters: having a life that expresses who they are. They may care about the kind of pattern that emerges in their life, the kind of person they are. People also value a degree of self-creation: wanting the sort of person they are to be partly under their own control.

3. SELF-CREATION

Here I am going to concentrate on the personal version of life having meaning, and particularly on the cluster of values to do with identity. Among the identity-related values, I am going to focus on self-creation. Even if few of us spend our lives, in the spirit of Friedrich Nietzsche, as full-time landscape gardeners of the self, many of us have some rough sense of the sort of person we want to be. And we often have a very clear sense of certain kinds of person we do *not* want to be. We also care about having some control over the sort of person we are. We do not have total control, but to some extent we are able to shape what we are like.

Not all self-creation is self-conscious. Through major decisions about our life, we influence unintentionally the sort of person we become. Who we marry or live with, the friends we choose, the job we take, and the place where we live all mould us in often unpredictable ways. And there is the process Aristotle noticed. He thought that being, for instance, a self-indulgent person is one's own fault, the result of many freely chosen acts of self-indulgence. Actions repeated turn into habits. And habits harden into character.

Then there is the minimally self-conscious kind of self-creation described by Sigmund Freud. The I (or Ego) tries to bring the blind and conflicting unconscious impulses of the It (or Id) under some kind of coherent conscious control. But Freud insists that the unconscious desires can be strong enough to limit this: “often a rider, if he is not to be parted from his horse, is obliged to guide it where it wants to go.”² In his view, psychoanalysis, by giving understanding of the unconscious desires, helps us control them. He thought of this as a work of reclamation, like draining the Zuyder Zee.³

Conscious self-creation can be in response to the pull of some moral commitment. But it need not be moral. A way of life may just express something deep about me. William James wrote about times of feeling most deeply and intensely active and alive: “At such moments there is a voice inside which speaks and says: ‘This is the real me!’”⁴

This description of the voice inside brings out how self-creation is interwoven with self-discovery. We cannot always choose what will prompt the thought about the real me. There may be aspects of our nature, perhaps laid down early, that we are virtually obliged to accept. This suggests a limitation to Aristotle’s thought about being responsible for our own character. What we are like depends partly on physical and chemical states of the brain, on our childhood experiences, and on the culture we live in. At most we only partly create ourselves. The position I start from may make a particular self-creative project unattainable.

There are two different ways in which our self-creation is not fully ours. One is that how we are makes some transformations too hard. To some extent we have to guide the horse where it wants to go. The other is that the desires and values guiding our self-creation are not simply chosen by us. They too depend, at least partly, on factors outside our control. We are both rider and horse. Parents, early experiences, and chance encounters may influence not only the kind of horse but also the kind of rider we are.

Self-creation has a peculiarly problematic relation to some of the major psychiatric disorders, because they can change the central core of a

² Sigmund Freud, *The Ego and the Id*, translated by Joan Riviere, revised by James Strachey (New York, 1962), chapter 2.

³ Sigmund Freud, *New Introductory Lectures on Psychoanalysis*, translated by James Strachey (New York, 1965), Lecture 31.

⁴ *The Letters of William James*, ed. Henry James (London, 1920), vol. 1, p. 199.

person. They raise acutely the problem of the boundary between the person and the illness.

PART II. IS IT THE PERSON OR THE ILLNESS?

4. THE PERSON AND THE ILLNESS IN DEMENTIA

When a medical condition brings about a radical transformation of someone's character, we are inclined to say: "It is not him but his illness." Whether or not we accept this thought affects the relationship. Aggression that seems to reflect the person is resented. If it reflects only the illness we may be more detached. But the boundary between the person and the illness is often elusive. Sometimes it is possible to wonder whether the contrast has any meaning at all.

For the first time in his life, a man with fronto-temporal dementia acts in aggressive and antisocial ways. He develops a new obsession with pornography. He is sometimes uncontrolled and threatening. Once he tries to strangle his wife with a cord. Those who have to live with his behaviour may see it as caused by changes in his brain, over which he has no control. They may suggest (with varying degrees of literalness) that the person's very identity has been affected: "He isn't the man I married."⁵

Even where someone with severe dementia acts most of the time in quite uncharacteristic ways, the question of how much of the original person is left may be complicated. People are more than their deliberate actions. As Iris Murdoch wrote, "When we apprehend and assess other people we do not consider only their solutions to specifiable practical problems, we consider something more elusive...their total vision of life, as shown by their mode of speech or silence, their choice of words, their assessment of others, their conception of their own lives, what they think attractive or praiseworthy, what they think funny...what, making two points in the two metaphors, one may call the texture of a man's being or the nature of his personal vision."⁶

Towards the end of her life, Iris Murdoch herself developed Alz-

⁵ Tony Hope, "Personal Identity and Psychiatric Illness," in *Philosophy, Psychology and Psychiatry*, ed. A. Phillips Griffiths (Cambridge, 1994), pp. 131-43.

⁶ Iris Murdoch, "Vision and Choice in Morality," in *Existentialists and Mystics: Writings on Philosophy and Literature*, ed. Peter Conradi (New York, 1999), pp. 80-81.

heimer's disease. Her husband, John Bayley, described its severity: "The power of concentration has gone, along with the ability to form coherent sentences, and to remember where she is or has been. She does not know she has written twenty-seven remarkable novels, as well as her books on philosophy; received honorary doctorates from the major universities; become a Dame of the British Empire."⁷ She started to ask many anxious, repetitive questions that faded out in mid-sentence. John Bayley found her questions often hard to interpret: "At such times I feel my own mind and memory faltering, as if required to perform a function too far outside their own beat and practice."

But sometimes Iris Murdoch was able to say something grimly appropriate, as that she was "sailing into the darkness." Even under these adverse conditions, John Bayley found that they still had a kind of communication: "like underwater sonar, each bouncing pulsations off the other, and listening for an echo." And he noted the need "to feel that the unique individuality of one's spouse has not been lost in the common symptoms of a clinical condition." He was able to say, "Iris remains her old self in many ways." His account suggests that those ways had to do with the "something more elusive" about which she herself had written: the texture of her being, and especially what she thought funny.

Speaking of times when he could not understand what she tried to convey, John Bayley said, "The continuity of joking can very often rescue such moments. Humour seems to survive anything. A burst of laughter, snatches of doggerel, song, teasing nonsense rituals once lovingly exchanged, awake an abruptly happy response, and a sudden beaming smile.... Only a joke survives, the last thing that finds its way into consciousness when the brain is atrophied."

Even in quite severe dementia, there is often something of the original person. But the blankness may become more prominent. At a late stage of her illness, Iris Murdoch would pick up from the street old sweet wrappings, matchsticks, and cigarette ends. Indoors, she made and rearranged piles of clothes, books, stones, cups, and shoes. Sometimes she was "silently scouring the house, or on the rampage downstairs, drumming on the front door and shouting to the outside world '*Help me—help!*'"⁸

Before the illness, Iris Murdoch would not have thought of any of

⁷ John Bayley, *Iris, a Memoir* (London, 1998), pp. 34–45. The following quotations in the text are also from this source.

⁸ John Bayley, *Iris and the Friends* (London, 1999), p. 232.

this as distinctively her own. None of it comes from any conscious project of self-creation. And it did not even come about in the less conscious Aristotelian way, through the ossifying of freely chosen actions into habits and then character. It came about through the decay of brain cells. This lack of any element of self-creation is the main reason for seeing the behaviour as reflecting the illness rather than the person. In self-creation the person we become partly reflects our own values. But we do not do things knowing they will bring on dementia. This disaster comes “from outside” in the sense that it is not under our present or even past control. It seems right that the piles of stones, cups, and shoes reflect the illness rather than the real Iris Murdoch.

5. THE QUESTION OF THE PERSON AND THE ILLNESS IN SCHIZOPHRENIA

The boundary between the person and the illness is harder to draw in schizophrenia. Dementia mainly (though not always) comes on late in life. This makes it easier to see the demented period as a coda: something after the main period of a person’s life. But the radical personality changes of schizophrenia usually come on relatively young.

The boundary question hardly arises in acute schizophrenic crisis. Then little coherent personality may show through the torrent of words, the delusions, or the suspicious hostility. Most of this has all too clearly more to do with the illness than with the distinctive features of the person. It is in the periods of relative stability that the boundary question is real. Sometimes the person may seem much as before the illness. But often there is a transformation. Someone friendly and humorous, lively and alert, may have become strangely unreachable: taciturn, sullen, uninterested in others, perhaps aggressive, and doing little beyond half-watching television. This new burnt-out personality may last a lifetime, either uninterrupted or alternating with acute episodes. Friends and family may have conflicting responses to the aggression they are sometimes shown. Should they react with exasperation or detachment? Does the aggression reflect the person or the illness?

Jay Neugeboren discusses this in his account of Robert, his younger brother with schizophrenia. Neugeboren would sometimes break down after painful visits to his brother in hospital. For a time, he got through the visits by thinking there were two Roberts. There was one he grew

up with and one now in hospital: "It was as if, I would say, the brother I grew up with had died." This made things easier because it reduced blame or disappointment: "I could spend time with him without making him feel that he had, by becoming a mental patient, somehow failed me, or himself, or life."⁹

To see the original person as having died is an extreme. But there is a strong case for the thought that the schizophrenic personality expresses the illness rather than the person's real self. The reasons are partly conceptual and partly moral.

The conceptual case starts by accepting that the strangeness and narrowing passivity are caused by the illness. As a thought experiment, imagine a treatment that, without other side-effects, restored people in this negative state to how they were before the illness. This would be a cure for schizophrenia. It would then be natural to see the second personality as a temporary product of the illness. The hostility or aggression displayed during the illness would be put aside as not reflecting the person's real self. But, if that would be the approach if there were a cure, why should the status of the schizophrenic personality be so different now? What counts as a feature of an illness is surely independent of whether a cure is available.

The moral case for seeing the schizophrenic personality as reflecting the illness rather than the person is linked to the desire not to give up on the possibility of a cure, a kind of keeping faith with the original person. There is the hope that the original version of the person may not be totally lost. On the analogy of a television where the picture has been replaced by visual chaos, there is the hope that, if only we could get the neurological or neurochemical tuning right, the original picture might be restored.

And, as with dementia, the new personality is the product of the illness rather than of any self-creative process. It does not reflect the choices or values of the person before the onset. It seems unfair that people's personalities have been so distorted by factors outside their control. Refusal to see the new personality as really reflecting them is a recognition of this. And blaming the person for things that express the new personality seems particularly unfair.

But there is also a substantial case for accepting the schizophrenic

⁹ Jay Neugeboren, *Imagining Robert: My Brother, Madness and Survival* (New York, 1997), pp. 252–53.

personality as what is now the person's real self. Perhaps the personality of the eighteen-year-old before the onset of the illness is irretrievably lost. At the very least it may have been hidden for decades. Refusal to recognize the new personality leaves the person as he is now in a kind of limbo, perhaps for the rest of his life. Jay Neugeboren recognizes this: "The sad truth is that who he is—his identity as Robert Neugeboren and nobody else, a human being forever in process, forever growing, changing, and evolving—is made up, to this point in time, largely of what most of us have come to call his illness. And if he gives that up... and does not hold on to his illness and its history as a legitimate, real, and unique part of his ongoing self—what of him, at fifty-two years old, will be left?"¹⁰

The dilemma is acute. Is the schizophrenic personality an authentic expression of the person? To say "yes" seems to ignore how it was forced on the person by the illness. To say "no" seems to locate the authentic person in a distant past and to deny recognition to the only person actually here.

How should those close to someone with schizophrenia react to bursts of unprovoked hostility and aggression? Are reactive attitudes such as anger and resentment appropriate? Of course these attitudes are not entirely under our control. But, to the extent that we can choose, either alternative is troubling. To have these responses seems unfair, for all the reasons that make it doubtful that the behaviour reflects the person rather than the illness. But to inhibit the reactive attitudes, especially where the actions that trigger them are typical of the new personality, may be to exclude the person from serious emotional relationships.

6. VERSIONS OF AUTHENTICATION

The question "Is he really like that or is it just his illness?" reflects a contrast between an aberration and something central or deep in a person. But the metaphors of centrality and depth are vague. What kinds of psychological changes support the view that something reflects not the person but the illness? What kinds of psychological continuity support the alternative view? What constitutes a person's individuality? What kinds of psychological variations make each person unique? The ques-

¹⁰ *Ibid.*, p. 303.

tion “Is this the real person?” is not as simple as “Is this banknote genuine or a forgery?” The criteria of authentication in the psychiatric case are multiple and possibly conflicting.

There are at least four different tests for authenticating someone’s present character or personality as “really them”:

1. *The Original Person Test*

2. *The Predominant Person Test*

The names of these two tests are self-explanatory. Take the person greatly changed by schizophrenia, but whose new character and personality have been stable for many years. Does the new personality reflect the real person? The original person test gives the answer “no.” The predominant person test gives the answer “yes.”

3. *The Endorsement Test*

In humanist psychiatry, the person’s own values are central. So the person’s own feelings about what he or she is really like, or wants to be like, have a central place. Taken off Prozac, Peter Kramer’s patient Tess said, “I’m not myself.” Her own endorsement of how she was on Prozac and this rejection of her other state have to be taken seriously.

Not any endorsement is sufficient. People with mood disorders sometimes see-saw backwards and forwards between two states, giving different accounts of what is “myself” in the different phases. What is needed is what can be called “deep endorsement”: a relatively stable endorsement, which reflects the person’s deeper values, rather than the shallow, breathless endorsement given only in a manic phase. This requirement makes the endorsement needed sometimes hard to obtain or to be sure about. The problem is parallel to that raised by mood swings for the authenticity of someone’s expressed wish not to be kept alive.

4. *The Autobiographical Test*

The autobiographical test authenticates the current character or personality to the extent that there is a coherent autobiographical story of its emergence. How I am now does not have to be like how I was. But there has to be an account of the evolution of one out of the other.

The demand for an autobiographical story may seem to exclude

nothing. Surely any change in character or personality *can* be recounted as a first-person story? (“He forced me to undergo surgery, in which several bits of my brain were removed, and since then he has given me daily injections of this drug. Now I do nothing at all except look forward to the next injection.”) A merely passive story does not authenticate the new personality. Authentication needs an active, self-creative autobiographical story, at least in the minimal Aristotelian sense in which my new character or personality grows out of actions I choose to perform.

Some un-self-conscious Aristotelian self-creation is the minimum version of authentication by the autobiographical test. More substantial forms of self-creation (if, for instance, I set out to become the kind of person I am now) provide stronger authentication. And if the project reflects my deepest values, this support from the endorsement test further strengthens the authentication.

All four tests are relevant. But there is a case for giving priority to the autobiographical and endorsement tests. This comes from the point of asking the question about “the real me.” In humanist psychiatry, a large part of the point of this question comes from the value people place on self-creation, on being shaped by their own values. This supports being guided by those values, as in the endorsement test. And it supports the autobiographical test, which has a degree of self-creation built into it. Taken together, these two tests can be described as the “self-creative tests.”

PART III. THE USES OF THE SELF-CREATIVE TESTS

7. SCHIZOPHRENIA AND SELF-CREATION

The relation between schizophrenia and the person can look very different from the inside.

Simon Champ has described something of his history of changing conceptions of himself, his illness, and the relations between them.¹¹ At first, his energies were consumed by the fight against his symptoms. He accepted the “schizophrenic” label: “my illness was central to my identity.” Later he came to see schizophrenia as something more positive,

¹¹ Simon Champ, “A Most Precious Thread,” in *From the Ashes of Experience: Reflections on Madness, Survival, Growth*, ed. Phil Barker, Peter Campbell, and Ben Davidson (London, 1999), pp. 113–26. The following quotations in the text are from this source.

while still identifying with it. He would challenge people about it: "Hi, I'm Simon and I'm schizophrenic." But over time he gained more control over his symptoms: "I was recovering my personhood and saw the illness as influencing rather than defining me."

Champ started to campaign on behalf of people like himself. And he reacted against the passivity of "suffering" from schizophrenia: "I had only really made progress in my own recovery when I stopped seeing myself as a 'victim' and relinquished more passive roles in my treatment." But he still had to overcome a negative self-image absorbed from society: "many places inside me were still darkened by my internalization of society's treatment and attitudes to people who had experienced a mental illness.... As I worked through the anger I felt at the treatment I had received, I felt a renewed sense of hope for my own life."

Champ reflected on his sense of his own identity, previously linked to ideas about employment and about masculinity. His sense of worth need not depend on paid work: he could make other contributions. He also changed his ideas about manhood, coming to see that "real men do indeed cry."

Simon Champ's escape from passivity was based on self-interpretation and self-creation. He describes how coming to terms with his illness has involved a deep communication with himself: "a communication that has given me the most precious thread, a thread that has linked my evolving sense of self, a thread of self-reclamation, a thread of movement toward a whole and integrated sense of self, away from the early fragmentation and confusion I felt as I first experienced schizophrenia."

Untreated schizophrenia is the shipwreck of a person's life, at times a madness in which it is hard to see how any schizophrenics could be at peace with themselves. The success of biological psychiatry is measured by the degree of relief that can be brought to the terrible symptoms of such illnesses: the medications that eliminate or contain the paranoia, the incoherent thought, the paralysing passivity, or the tormenting "voices." Understandably, this relief is often put before more elusive humanist aims.

But Champ's account lends some support to a humanist psychiatry that goes beyond a purely medical approach. The "support" here is in showing what can be possible, not in showing that many other cases are the same. Not everyone will have Champ's self-reflective capacities. In some the grip of the illness may be too strong for the escape from

passivity to start. Any general extrapolation from a single case would be ludicrously flimsy.

Champ's use of the word "self-reclamation" has echoes of Freud's metaphor of reclaiming the Zuyder Zee. Psychiatric treatment can be thought of as having two goals: the medical goal of containing or eliminating the symptoms of illness and the humanist goal of restoring autonomy, including the capacity for self-reclamation. Restoring the person's autonomy will often require the removal or at least containment of the symptoms of illness. It is not easy to be autonomous when passive and withdrawn or when shouted at by menacing "voices." Attacking the symptoms often has to start without the person's own active involvement. He may be too deluded or too indifferent to take self-creative decisions. But, if the symptoms can be driven back far enough to make his involvement possible, there can then be the further aim of restoring autonomy and self-creation. And then, as perhaps in Champ's case, the self-reclamation may contribute to dealing with the symptoms. The medical and the humanist goals are interwoven.

Medication for the symptoms may still be needed. But the restoration of autonomy may need other kinds of help too. These can include encouraging the person to talk and a willingness to listen to what he says. (The aim is not just any old talk, but the long, recurring Socratic conversation that goes deep inside the person. Though, to start with, any old talk may be better than nothing.) Other help may include encouraging such activities as Champ's campaigning for people like himself.

Autonomy cannot be organised by other people. There can only be encouragement and the giving of opportunities. And perhaps no one kind of encouragement works for everyone. But for autonomy to be restored the person has to move away from the purely passive role, as Champ did. Powers of autonomy and self-creation grow through being exercised.

Simon Champ's account shows how the self-creative, autobiographical approach can make other ways of posing the question about the real self seem too crude. From outside, the question may seem to be "Is the person's real self seen in the personality he had before the illness or in the present, changed personality?" But, from the inside, Champ's self-creative project has complex links with himself at different stages: "you do not simply patch up the self you were before developing schizophrenia...you have to actually recreate a concept of who you are that inte-

grates the experience of schizophrenia.” Although the new created self is not just a reproduction of the original self, there is a kind of continuity with it. He describes the peace of mind he now has. It is “as if I’ve come home to myself, a self changed, a self I last felt at 17, and yet now I’m 40. All those years of experiences separate me from the teenager I was, but somewhere inside I’m complete again, as I used to be then.”

8. OUR LANDSCAPE: DEPRESSION AND TEMPERAMENT

Rainer Maria Rilke’s *Tenth Elegy* starts with thoughts of jubilation on emerging from an emotionally dark time. But the jubilation includes celebrating the dark times themselves:

How dear you will be to me then, you nights of anguish.
Inconsolable sisters, why didn’t I kneel to you, submissive,
And lose myself in your dishevelled hair?

By looking through our bitter times towards their end
We squander our sorrows. But they are a season of us,
Yes, our winter foliage, our dark evergreen. Not only a season,
But also our landscape, settlement and fortress,
Our depths and our home.¹²

Just as those with schizophrenia may care about integrating the experience of the illness into their conception of themselves, so people prone to depression may want to recognise their “dark evergreen,” to accept times of depression as a “season of us.” A season could be a passing mood. But something more permanent—temperament—is Rilke’s “landscape.”

In humanist psychiatry, even temperament may be open to modification, as in the effect of Prozac on Peter Kramer’s patient Tess. But some are sceptical about how radical a transformation of personality Prozac actually brings about. Lauren Slater, in her account of Prozac in

¹² O wie werdet ihr dann, Nächte, mir lieb sein,
gehärmt. Dass ich euch knieender nicht, untröstliche Schwestern,
hinnahm, nicht in euer gelöstes
Haar mich gelöster ergab. Wir, Vergeuder der Schmerzen.
Wie wir sie absehn voraus, in die traurige Dauer,
ob sie nicht enden vielleicht. Sie aber sind ja
unser winterwähiges Laub, unser dunkles Sinngrün,
eine der Zeiten des heimlichen Jares-, nicht nur
Zeit-, sind Stelle, Siedelung, Lager, Boden, Wohnort.

her own life, wonders how far the idea of radical change would survive long-term study of the patients.¹³ At first, Prozac did transform her, but then its powers faded, “the stilts shrinking to fine high heels on my best days, on my worst days to stunted flats.”

Slater also asks whether the transformed self might have been present within the original self. Reports of patients about their previous personality may be coloured by their present depression. Before Prozac, Slater herself would have described her early years in terms of the roots of her depression. But Prozac has brought back many more positive memories that give a quite different colour to her past: “In altering my present sense of who I am, Prozac has demanded a revisioning of my history, and this revisioning is perhaps the most stunning side effect of all.”¹⁴ She finds it hard to choose between two ways of seeing what Prozac does: either as transforming the self or as restoring the original self.

It is striking that Lauren Slater’s account from the inside, like Simon Champ’s account of schizophrenia, centres on changes in her conception of herself. If the “revisioning” of her history leads her to decide that Prozac has restored her, the original person test will authenticate her present self. But, even if she settles for the “transformation” account, her present self can still be authenticated by the autobiographical test. Her active autobiographical story and her endorsement are what count. For either kind of authentication, her self-interpretation is crucial. The landscape, settlement, and fortress are ours only if *we* feel they are our depths and our home.

9. OUR HOME: MANIC-DEPRESSION

But how we feel about them is not always stable. In manic-depression, people’s oscillations of mood may affect their view of where their depths and their home are to be found.

Manic-depression is a severe disorder, with even the manic stages sometimes leading to gargantuan spending sprees or other fantastic things that turn life upside down. The nightmare psychotic episodes

¹³ Lauren Slater, *Prozac Diary* (London, 2000), pp. 186–200.

¹⁴ *Ibid.*, p. 191.

and bouts of depression sometimes prompt suicide. Treatments such as lithium can often restrain the severity of the mood swings, allowing some escape from the oscillation between despair and an out of control wildness. But the price of the escape can present poignant choices.

Dr. Kay Redfield Jamison is a psychologist who has co-authored the standard textbook on manic-depressive illness. She knows it as a doctor and has experienced it from inside. Her autobiography gives a striking personal account of this illness and its dilemmas. For Kay Jamison, the medication (lithium) is essential. There are terrible costs of leaving the illness uncontrolled. There would be intoxicating experiences, but “when the black tiredness inevitably followed, I would be subdued back into the recognition that I had a bad disease, one that could destroy all pleasure and hope and competence.” She saw “how draining and preoccupying it had become just to keep my mind bobbing above water.”¹⁵ The choice was not about whether to have medication but about the dose.

Long-term use of lithium can be seen as changing temperament. To the extent that the effects of a particular dose are stable, choosing a dose for the long term can be to choose a temperament. Such a choice needs reflection in the light of having experienced the alternatives. The question is what you most deeply care about. Kay Jamison reflects on her different states on different doses of lithium.

Higher doses make episodes of mania and depression less likely, but they do so at a cost. Jamison had found some of her manias exhilarating. In one psychotic episode, she had the experience of flying through space, past the ravishingly coloured rings of Saturn. Long afterwards, she missed that experience. Not everyone finds the manic phases so exhilarating. Some consider them almost as troubling as the depressions. But Jamison found it hard to adapt to normality. “The intensity, glory, and absolute assuredness of my mind’s flight made it very difficult to believe, once I was better, that the illness was one I should willingly give up.”

The higher dose controlled her moods rigidly. But a lower dose, like buildings designed for earthquakes, “allowed my mind and emotions to sway a bit.” This made her emotions more even and predictable,

¹⁵ Kay Redfield Jamison, *An Unquiet Mind: A Memoir of Moods and Madness* (London, 1996), pp. 161–69. The following quotations in the text are also from this source, pp. 91–97, 217–18.

through being more resilient to stress. The lower dose also brought greater clarity of thinking and intensity of experience: "It was as though I had taken bandages off my eyes after many years of partial blindness.... I realized that my steps were literally bouncier than they had been and that I was taking in sights and sounds that previously had been filtered through thick layers of gauze."

The greater flexibility of the way the lower dose controlled her moods, together with the clarity of thinking and intensity of experience, suggests that it is in the lower-dose temperament that Jamison has found her depths and her home. And she does say that the clarity and intensity now recovered "had once formed the core of my normal temperament."

But the question is complex. Jamison does use the metaphor of home, but to express a reaction against both illness and medication. Soon after starting on lithium, she was reading Kenneth Grahame's *Wind in the Willows*. She got to where Mole, smelling his old home after a long time away, is desperate to find it again. Having found it, Mole sits before the fire, seeing how much he had missed the warmth and security of the "friendly things which had long been unconsciously a part of him." Reading this, Jamison broke down: "I missed my home, my mind, my life of books and 'friendly things,' my world where most things were in their place, and where nothing awful could come in to wreck havoc.... I longed for the days that I had known before madness and medication had insinuated their way into every aspect of my existence."

This felt pull of the world before madness and medication must make it hard to identify with having the illness, even when it is combined with a lower dose of medication. But this too is not the whole story. At the end of her book, she asks whether, given the choice, she would choose to have manic-depression. If lithium were not available, she would simply answer "no": the depressions are just too awful. But, with lithium, there is a case for the illness. She has felt more deeply, experienced things more intensely, thought on a different level, loved more and laughed more, all through the intensity given to things by her illness. In a phrase Rilke would have liked, she has "appreciated more the springs, for all the winters." So perhaps, after all, she does see the controlled version of the illness as her depths and her home. In the end she says, "Strangely enough I think I would choose to have it."

10. OUR DEPTHS

“Our depths and our home.” Finally, a few words about the other metaphor, of depth.

(Here I am conscious of cheating slightly. The word Rilke uses is “Boden.” Literally, this means “ground” or “bottom,” as in “the bottom of the sea.” To use the word “bottom” when talking of people has irrelevant associations. The translation could have read “our ground and our home.” I preferred to exploit the bottom of the sea associations and chose “depths.” The idea of our bitter times as being part of the depths of a person seemed true to Rilke’s intentions. But what I am now going to say about depth starts from this English word rather than from what Rilke actually said.)

When we see the physical world in depth, we make use of having two eyes. The brain decodes the slightly discrepant pictures from the two eyes to get information about the relative distance of things. Knowledge of depth is extracted from the incompatibilities.

This can be a metaphor for aspects of psychiatry. It is a field in which there are truths that at first can seem incompatible. We create ourselves, to some extent; yet what we are like is also quite severely constrained by factors outside our control. Psychiatric illness can have such strange features that “domesticated” accounts of it often falsify it; yet it is essential not to forget the extent of the shared human condition on both sides of the boundary. A major psychiatric disorder is a tragedy to be prevented if possible; yet it may be something the person who has it would not change, “our winter foliage, our dark evergreen.”

On each of these issues there are tensions between what comes before and what comes after the word “yet.” But there are no deeply incompatible truths: paradoxes exist to be resolved. Each side of the opposition may be part of the truth: psychiatric disorder can make people in some ways radically strange without obliterating all of the human features they share with others. The philosophical interest is greater when the tension goes deeper. How far is self-creation compatible with the constraints of temperament and of environment? How can we take with sufficient seriousness the testimony of someone who is not sorry to have schizophrenia without falling into the shallowness of belittling how terrible it is? These are deep questions for a philosophical account of psychiatry and the conditions it treats. In each, we have to start from the

two perspectives, and it is only by combining whatever is ultimately defensible in both that we will go deeper.

Seeing things from apparently incompatible standpoints provides a metaphor for psychiatry as a whole. We will never understand psychiatric illness unless we see it, as modern psychiatry does—especially in the Anglophone world—in the clear morning light of scientific empiricism. But there is also the strangely elongated twilight perspective—the Russian perspective—of Dostoyevsky. It is binocular vision again. To see to the depths of people with psychiatric disorder we need both.