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.

1. 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,
gehärmte. 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 winterwähriges Laub, unser dunkeles 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.