Psychiatry and the Non-Existent Self: A Humean Critique of Psychiatry's Supposed Objectivity

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Psychiatry construes itself as an objective study of the mind, akin to other sciences such as neuroscience or physiology. Unfortunately, this construal conceals the fact that psychiatry is deeply value laden. In this paper, I draw from David Hume's bundle theory of self, and from Rachel Aviv's Strangers to Ourselves, arguing that though mental disorders are portrayed as objective truths about an individual's psychology, they act (partly) as self-narratives which can be rejected or accepted by the diagnosed individual. The case studies of Bapu and Laura concretely illustrate that the self cannot be reduced to a set of neurochemical phenomena, and instead must be understood on the level of illusory narratives used to make sense of the world.

Keywords: Psychiatry, self-narrative, sense-impression, neurotransmitter, personality disorders

Psychiatry is often understood as an objective science of the mind aimed at uncovering and treating the root causes of mental disorders. In line with this construal, the APA dictionary defines psychiatry as "the medical specialty concerned with the study, diagnosis, treatment, and prevention of mental, behavioral, and personality disorders […] based on the premise that biological causes are at the root of mental and emotional problems" (APA, 2024, italics added). Many philosophers have pointed out that this construal of psychiatry is deeply misleading1, because it falsely implies that mental disorders are defined in purely biological terms, and that the concept of 'disorder' is not value laden. In fact, mental disorders are largely defined by a deviation from what society deems 'normal'. Thus, the mental state of the diagnosed patient is labeled as 'abnormal' or 'undesirable,' which necessarily causes a shift in their self-concept. Serife Tekin (2011) supports the latter claim by arguing that mental diagnoses can influence a patient's self-concept by acting as autobiographical and social narratives. In this paper, I take inspiration from David Hume's Bundle Theory of Self to argue that the self is an illusion. Thus, there is no 'correct' self-narrative. I ground my argument in the real lives of individuals with mental disorders by drawing from case-studies in Rachel Aviv's Strangers To Ourselves, accommodating Tekin's insights while accounting for the fact that any self-narrative necessarily abstracts from experience. By acknowledging the illusory nature of the self, the subject embraces the concrete reality of their suffering, without trying to fit it into a pre-defined form.

In part one, I elaborate on Hume's argument for the non-existence of the 'self' as it is traditionally conceived. I argue that the referent of 'I' is an illusion of the mind that takes the form of a self-narrative, which is only 'real' insofar as any other object of the imagination is 'real'. By holding that self-narratives have a similar status as objects of the imagination, I account for their causal influence on the world without assuming that they accurately describe the world.

In part two, I recount Tekin's explanation for how psychiatric diagnoses can influence a patient's self-concept, combining it with the roughly Humean conception of an illusory self that I establish in part one. Then, I explore how my argument applies to case studies from Aviv's Strangers To Ourselves. Specifically, I provide multiple conflicting narratives of the lives of Bapu and Laura. If the self is a narrative (or fiction, so to speak), then there is no correct way of describing it.

Part One: The Non-Existence of the Self

Does the 'self' exist? If so, what is it? As an Empiricist, David Hume is committed to the view that all ideas can ultimately be traced back to sense impressions. Thus, in the beginning of his Treatise of Human Nature, he writes, "every simple idea has a simple impression, which resembles it; and every simple impression a correspondent idea" (Hume, 1896, 8). In other words, every idea we have has been formed by some experience. Nevertheless, we can form ideas of things we have never seen before. The imagination combines simple ideas to construct complex ideas that have never impressed on our senses. However, for an idea to correspond to some reality beyond the imagination, it must be formed by some sense impression. We can think of the mind metaphorically as a collection of images, each of which is a copy of some simple sense impression; for example, there is an image for the impression of pain, or cold, or purpleness, etc. Though every image is a copy of some sense impression, we can form new images which do not correspond to any existent thing by using our imagination to cut up and glue together images of past sense impressions. From this perspective, Hume investigates the notion of personal identity to determine whether some sense impression gives rise to it.

The commonsense notion of personal identity is that there is some unchanging thing which guarantees that a person stays the same over time. If this is true, then there should be some impression which corresponds to the idea of an unchanging self. Reflecting on his attempt to locate the sense impression of an unchanging self, Hume writes, "[f]or my part, when I enter most intimately into what I call myself, I always stumble on some particular perception or other, of heat or cold, light or shade, love or hatred, pain or pleasure" (134). When we reflect on what we call the 'self,' all that can be found is particular sense-impressions; there is no unchanging impression of the self. Hence, Hume describes the mind as,

> […] a kind of theatre, where several perceptions successively make their appearance; pass, re-pass, glide away, and mingle in an infinite variety of postures and situations. There is properly no simplicity in it at one time, nor identity in different; whatever natural propension we may have to imagine that simplicity and identity (134).

For Hume, the mind is made up of many separate sense impressions without unity or connection. Any illusion of connection between these disparate impressions can be attributed to the imagination's propensity to attribute 'simplicity and identity'. There is no self, but there is an illusion of self, constructed by the imagination.

Fortunately, we needn't accept Hume's entire metaphysics to extract two key insights from his argument. Firstly, as we saw above, there is no unchanging thing which I can point to and identify as myself. My body is constantly changing and so are my thoughts. Secondly, the illusion of self that we refer to with the word 'I', is a construction of the imagination. Thus, the self is not 'real' in the sense that it does not represent anything in the actual world, but it is 'real' as an illusory narrative constructed by the imagination. The latter sense of the word 'real' is important; though they do not represent anything actual, objects of the imagination still have causal effects on the world. Hence the fact that an imagined landscape in an artist's mind can, with some effort, become an existing painting in the real world. To give a crude example, the person whose describes their self in mechanistic terms might act as if they have less autonomy because they understand their behavior as the inevitable result of their brain chemistry. Contrastingly, the person who describes their self in terms of a non-physical soul is likely to view their behavior as fully determined by their will. In other words, they will act as if they are in full control of their behavior, feeling disappointed in themselves for not having the will to act differently. Ultimately, the self can be understood as a fictional narrative that situates the individual's present experience in the context of an imagined past and future. This definition is admittedly vague, but it should become clear in what follows.

Part Two: Diagnosis and Self-Construction

In the introduction, I pointed out that psychiatry is deeply value-laden. Mental disorders are ways of defining what counts as 'abnormal' or 'undesirable' mental states. Now, in saying this, I do not mean to say that mental disorders are—as Psychiatrist Thomas Szasz (1961) famously calls them—(mere) "problems of living". I admit that many mental disorders probably do have underlying biological causes. My point is merely that the existence of a single biological cause is insufficient to explain any mental disorder in its entirety. Additionally, the existence of a biological cause for something is not reason to call that thing a disorder; hence, psychiatry must make normative judgments about what distinguishes a mere 'problem of living' from a genuine disorder.

To see what is missing in a reductionistic biological picture of mental illness, consider the 'chemical imbalance' theory, put forth in 1965 by a scientist at the National Institute of Mental Health, named Joseph Schildkraut. In one of her case studies, Rachel Aviv describes Schildkraut's reasoning process, writing,

Schildkraut proposed that the drugs increased the availability of the neurotransmitters dopamine, norepinephrine, and serotonin—which play a role in the regulation of mood—at receptor sites in the brain. He reasoned backward: if antidepressants worked on those neurotransmitters, then depression may be caused by their deficiency. He presented the theory as a hypothesis—'at best a reductionistic oversimplification of a very complex biological state,' he wrote. (Aviv, 2022, 48)

Aviv goes on to explain that, despite Schildkraut's careful skepticism, the chemical-imbalance theory has become common rhetoric. Hence, people have begun to view the self as a mechanism, as if "brain chemicals were at the root of peoples moods" (48). But there is much more to someone's mood than neurotransmitters in the brain. The claim that our mental states can be entirely explained by brain chemistry implies the obvious falsehood that important life events such as getting married or promoted are irrelevant to explaining changes in a subject's mood. Moreover, explaining a subject's complex mental states in terms of an oversimplified biological reduction delegitimizes the way they understand their lived experience of the world. Tekin writes,

Considering her [the patient's] psychological states merely a function of unbalanced brain chemistry divorced from the environmental, social, and cultural context may lead her to question the perceived reality of her disturbed psychological states, thereby diminishing her self-respect and feelings of agency (Tekin, 359).

Thus, if we think of the chemical imbalance theory as a self-narrative, then it starts to become clear how a subject's adopting it could cause changes in their behavior. The narrative that a subject's mood is the result of biological factors outside of their control is patently untrue, and yet when it occupies the subject's imagination it can become a 'self-fulfilling prophesy' of sorts. The narrative changes the subject's behavior by causing them to view their behavior as outside of their control.2 To use the metaphor from the end of section one, self-narratives can influence reality in the same way that an artist's imagination manifests itself in their art. This metaphor gets the general point across, but let me be more precise.

How can a psychiatric diagnosis influence a patient's self-narrative, and consequently, their self-concept? First, the word 'narrative' must be defined. On Tekin's view, narratives are,

…self-making tools [that] help describe and organize thoughts and deeds, aiding the appropriation of experiences in a context, thus enabling a person to make sense of the series of events in her life (Tekin, 360).

This is roughly how I have been using the word narrative. In my own words, a self-narrative is a collage of sense-impressions that the subject takes to be a rough representation of their past experiences and an anticipation of their future experiences. The subject then understands their present self as sandwiched between an imagined past and future. Though the subject takes their self-narrative to repre-

sent their past and future experiences, they actually fail to represent anything at all, since the past and future only exist in the imagination. The main difference between my account and Tekin's is my commitment to this view. While I follow the Humean route of viewing the self as an illusion (or, in my words, a fiction), Tekin holds both that a self-exists, and that it is partly constituted by self-narratives. These disagreements don't prevent us from converging on an understanding of how self-narratives are constructed. Tekin writes that,

The social narratives representing the subject's psychological states, such as her beliefs, desires, feelings, as well as activities, choices, temper, behavior and character traits create a response in the form of acceptance or rejection of the narrative, or something in between.

Thus, the subject builds their self-narrative from the social narratives which represent them. They can either reject the social narrative and form a new self-narrative based on that rejection, or they can accept the narrative and integrate it into their illusory sense of self. There are numerous case studies in Aviv's Stranger To Ourselves which lend support to this account of self-construction, but I focus on "Bapu" and "Laura."

Bapu

Bapu's family was Brahmin, the highest social caste in India. She married to a man named Rajamani, with whom she had two children, a boy named Karthik and a girl named Bhargavi. They lived in a wealthy neighborhood in Chennai, India. On the surface, Bapu's life represented India's societal ideal of domesticity. On a deeper level, Bapu was unsettled and unhappy; her husband treated her badly and she hated her in-laws. She wrote, "My husband considers me an enemy if he doesn't get my body or my money" (Aviv, 71).

Disillusioned with her family life, Bapu turned to religion, reciting prayers for hours on end and devoting herself to Krishna, the Hindu god of tenderness and compassion. She went to an Ashram, where a priest named Nambudiri led recitations of holy texts. Nambudiri was a Sannyasin, "an ascetic who has given away his belongings and renounced the material world by holding his own funeral […], treated as the apogee of Hindu spirituality—they are said to have complete insight" (71, italics added). Additionally, Bapu wrote two books of poetry, which a scholar identified as "divine work" (73). In 1970, she moved to Kanchi monastery, a sacred sight in South India.

Eventually, Bapu began to display 'unusual' behavior. One day, she was caught "wandering at large" by police, who cited the British colonial law which allowed them to detain anyone they have "reason to believe has mental illness" (75-76). The police brought her back to her family in Chennai. Aviv writes,

[…] Bapu seemed displaced, as if the house no longer belonged to her. She lingered in the hallways without entering rooms. She seemed to have crossed some sort of threshold, beyond which domestic duties, like packing her husband's lunch or tying Bhargavi's ponytail ribbons, no longer held any meaning (76).

Bapu soon left home again, but not for long, as she would repeatedly be found in unusual places in a dazed state, and afterwards brought back home. Eventually, one of Bapu's family members recommended that she go to a psychiatrist. She was diagnosed with schizophrenia, and prescribed chlorpromazine, a drug advertised as a "civilizing force that would tame a patient's wildness" (83). For a period of time, she was held in an asylum which "resembled a military barracks, with nearly two thousand beds and a concrete wall surrounding the grounds" (78).

A reoccurring theme in Aviv's account of Bapu's life is the conflict between two self-narratives, one of enlightenment, and one of schizophrenia. Consider the following descriptions of Bapu's story:

(1) Bapu was unhappy with her life long before she was diagnosed with schizophrenia. Her husband and in-laws treated her badly; she was forced into the role of 'domestic housewife'. But she rejected that narrative and began constructing a new self-narrative centered around the Hindu god Krishnu. Her hours of devotion were

rewarded with an ability to transcend to a higher plane of existence. This ability for transcendence was mistaken for schizophrenia, and she was punished for her deviation from societal norms.

(2) Bapu was wealthy, and had a large family; in many ways, her life was idealistic. Unfortunately, she began displaying unusual behavior, claiming to have contacted an unobservable Hindu god. This behavior was symptomatic of an underlying mental disorder. Hence, she was diagnosed with schizophrenia and placed in a mental hospital to heal.

The description in (1) seems to align with how Bapu herself might have described her story. Contrarily, the description in (2) is the narrative that society imposed upon Bapu. But which narrative is 'correct,' and which should Bapu adopt as part of her self-narrative? I return to this question in the conclusion. For now, consider Laura's story.

Laura

Though she came from a drastically different background, Laura's story is not dissimilar to Bapu's; by the standards of the societies in which they grew up, both Laura and Bapu had ideal lives. Laura grew up with her parents and her three younger sisters in the wealthy community of Greenwich, Connecticut. Her parents had high expectations of her, but "She didn't want to pursue what she called the 'good-girl model of life,' fulfilling the prim ideals of Greenwich society" (177). When her parents found out that Laura had intentionally cut herself, they took her to a family therapist, who referred her to a psychiatrist that diagnosed her with bipolar disorder.

Later in her life, Laura attended Harvard university, where she continued to feel disconnected from the world, like an actor in a play. She wondered "whether the surface of people can ever harmonize with what's inside their minds" and asked, "why do I have these extra layers of thought that others don't have and that pull me farther and farther away from being human?" (179). After returning from her first semester at Harvard, Laura made an appointment at the prestigious 'McLean hospital,' where a psychiatrist "confirmed her early diagnosis, calling it Bipolar II, a less severe form of the disorder" (181). Laura embraced this diagnosis, writing "it was like being told: its not your fault. You are not lazy, you are not irresponsible" (181).

Laura enjoyed getting diagnosed with mental disorders and taking prescription medications to deal with her symptoms, and her doctors enabled her. Aviv writes, "They kept tinkering with her drugs, as if they could eventually bring her to an emotional state that corresponded with all the advantages she'd been given" (183). Aviv points out that Laura's doctors were driven by the same societal expectations as Laura, making it difficult for them to understand why a wealthy Harvard student achieving a high level of professional success would feel unhappy.

Despite her 'tinkering with drugs,' Laura remained deeply depressed.3 Eventually, she attempted to commit suicide by overdosing on her prescription medications. Later, she would go on to read a book by Robert Whitaker, in which he argued that "psychiatric medications, taken in heavy doses over the course of a lifetime, may be turning some episodic disorders, which might have otherwise resolved on their own, into chronic disabilities" (192). Whitaker's book inspired Laura to learn about the history of psychiatry, and she came to understand that the 'chemical-imbalance' theory, which she took for granted, is deeply flawed. Hence, Laura began on a long journey of trying to ween herself off of her prescription medications. She struggled with the realization that her previous self-narrative was based on a theory that is patently false. Aviv writes, "'Bipolar was a path I was on,' she told me. 'And all of a sudden I wasn't on that path anymore.' She felt like she was stepping into a void" (196).

Again, let us imagine two different descriptions of this story, (3) and (4).

(3) Laura's supposed 'advantages' were both a blessing and a curse. She was wealthy and went a prestigious school, but she did not want the

life that had been laid out for her. The societal expectations imposed upon Laura made her feel depressed and lonely, but she lived up to them by necessity. Failing to understand how someone in Laura's position would reasonably come to be dissatisfied with life, doctors diagnosed her with bipolar disorder, assuming that her discontent was caused by something biological. This diagnosis was a mistake, and it led Laura down a dark path.

(4) Laura was lucky to have been born into a wealthy family. She lived an ideal life, going to Harvard and achieving a high degree of professional success. Unfortunately, Laura was unable to feel a sense of satisfaction from her success because she suffered from a severe mental disorder called Bipolar II. Her condition proved resistant to treatment, and the doctors were unable to find the right combination of drugs to balance her brain chemistry.

Conclusory Remarks

Bapu and Laura share many similarities; they both struggled with conflicting narratives, and they both rejected the narrative imposed upon them by society. Narratives (1) and (3) describe Laura and Bapu's stories as 'problems of living,' whereas narratives (2) and (4) describe their stories in terms of mental disorders and chemical imbalances. But which narratives are correct? And which narratives should Laura and Bapu integrate into their self-narrative? I argue that, since the self is part of the imagination, there is no such thing as a 'true' narrative. Additionally, the idea of a true self-narrative can cause serious harm in the context of psychiatric treatment. Ultimately, it is up to the individual to decide which self-narratives they accept, and which they reject, but they should never mistake the self-narrative for their lived-experience in the world.

Here, the reader might notice a problem; how can the 'individual' choose between different narratives if the individual is just a fiction, or an illusory self? Aren't we stuck in a self-narrative, unable to escape into an unbiased perspective on experience? I remain agnostic on the question of taking an unbiased perspective on experience. However, though narratives may be a necessary and, hence, unavoidable aspect of experience, they certainly do not constitute the whole of experience. In fact, Narratives necessarily fail to capture the entirety of any given experience, because each experience is composed of a nearly infinite number of sense impressions, whilst a narrative can only contain a limited number of sense impressions. Furthermore, narratives are composed of unobservable connections—such as 'simplicity and identity'—between sense impressions, which do not represent things at all; they are objects of the imagination. If we assume that it is possible to take an unbiased perspective on the narratives that we use to understand ourselves and others, then the subject can refuse all narratives as if suspended before a landscape of possibilities. On the other hand, if we assume (perhaps more realistically) that it is impossible to escape all self-narratives, then the subject must always view themselves from the vantage point of some narrative. This does not mean that the subject lacks the autonomy to adopt a new narrative, thereby moving to a new vantage point and viewing the landscape from an entirely different perspective. However, the subject should proceed with caution; self-narratives have a causal influence on the subject's behavior; their behavior, in turn, affects the world; consequently, the self-narrative an individual accepts can either improve or decrease their quality of life, which makes the question of narrative-choice a moral question.

When a subject is diagnosed with a mental disorder, they have the choice of either accepting the narrative associated with that mental disorder and integrating it into their sense of self, or rejecting that narrative. If the subject decides to embrace the narrative that their suffering is caused solely by a chemical imbalance in their brain, then they risk denying the reality of their lived-experience by

accepting a patent falsehood. Psychiatry exacerbates this problem by framing itself as an objective science of the mind which explains the true cause of our suffering. Consider the term 'insight', which psychiatrists use to evaluate the truth of people's self-narrative. Aviv explains that,

Insight is assessed every time psychiatric patients are hospitalized, and it looms large in decisions about whether to treat them against their will. But the concept largely ignores how the 'correct attitude' depends on culture, race, ethnicity, and faith (Aviv, 22).

If, as I have argued, the self is an illusion of the imagination, then the concept of insight is entirely nonsensical. The authority psychiatry demands as a supposedly objective science makes this concept of insight especially dangerous, since patients are likely to accept the narrative that comes with whatever diagnoses they are given. We also see the concept of insight outside of psychiatry. Recall how the Sannyasin of Hinduism—mentioned in the section on Bapu—are said to have complete insight. Any claim to an objectively true self-narrative is morally problematic. Consider how Bapu developed an arguably unhealthy obsession with detachment because she thought it would lead her to enlightenment, or how Laura spent years 'tinkering with drugs' in an attempt to align herself with societal expectations that made her unhappy. Perhaps, had Bapu and Laura realized that there is no 'true' self to be found, they would have avoided a great deal of suffering.

In sum, despite our best efforts, human experiences do not fit into neat little boxes. If we realize that the self is an illusion and stop trying to force our experiences into a coherent narrative, we can acknowledge the indescribable nature of the world and develop a closer relationship with our suffering. On the other hand, if we grasp to the illusion of self, we limit our own autonomy. Hence, we should be suspicious of psychiatry's supposed objectivity. There is no 'correct' self-narrative.

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