Affectivity and Identity in the Treatment of mood Disorders

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1. Mood disorders and the "real self"

It is not uncommon to hear patients who suffer from depression complain that they are not themselves. Given that their lives during a depressive episode may be profoundly changed, it is often easy to agree. But what does it mean to agree here? "Not being themselves" in this context refers to qualitative changes that have occurred in their way of being, including changes in personality and self-understanding. I will use the term "self" to refer to periods of a distinguishable personality pattern in a person's life, without further discussion of their metaphysical status or the criteria for a distinction between different selves.[1]

Given the person with a mood disorder who considers herself not really "herself" any more, what happens when she takes medication and the symptoms disappear? I will now assume for the sake of simplicity (but incorrectly)[2] that patients generally consider their illness self S2 as alien to their usual self S1. Three different possible reactions to medication can thus be distinguished: (i) First, there are those who just seem go back from S2 to their usual self S1 that represents what they "really" are. They may have some side effects from the medication, but do not consider these to be relevant. (ii) Then there are those who perceive the effects of medication as changing their personality. In this case, S1 is what they remember being before S2. However, instead of regaining their "real self" through medication, they are now left with S3, which despite many similarities to S1 still seems alien to them. This can happen in the treatment of bipolar disorder with lithium, as well as in the treatment of depression with some antidepressants (e.g. Jamison 1995, Elfenbein 1995). (iii) Finally, there are those cases in which patients again perceive the resulting S3 as different from S1, but now see S1 as comparatively lacking. From the standpoint of S3, they judge S1 as alien, while S3 is now considered to be their "real self". This phenomenon has sometimes been observed in the treatment of depression, usually with SSRIs, and famously depicted in Peter Kramer's bestseller *Listening to Prozac* (also Elfenbein 1995 and Thompson 1995).

How should the difference between these cases be understood? The first case seems straightforward – a "mental illness" has interrupted the person's usual way of being and behaving; once this disruption is under control, she can go on living her life as usual. The second case, again, does not seem mysterious. Psychotropic medication has a pervasive influence on the patient's nervous system. Its use may be necessary for keeping the "mental illness" at bay, however, it is not surprising that a person under its influence may not feel entirely the same way about herself as before. However, the third case seems puzzling. How is it possible that a person can regard as her "real self" what she has only experienced under the influence of medication, and moreover only for a very brief time? The worry behind this question seems to be above all a worry about authenticity – can a person under these circumstances authentically identify with S3? In order to bring into focus what is at issue here, I will now explore one specific important aspect that is often reported to differ between S1 and S3.

2. Medication and moral sensibilities

It has long been known that changes in mood can go together with changes in moral sensibilities. Moral scrupulosity is a frequent characteristic of depression, and there is typically some moral carelessness in persons who experience mania. There is also evidence that some kinds of anti-depressant medication (e.g. Prozac) may affect not only mood, but also moral sensibilities, and promote shifts towards greater moral indifference (cp. Kramer 1997, Sobo 1999, 2001, Elfenbein 1995). That is, during the use of medication, the person seems to be more morally indifferent than before.

Such malleability of moral sensibilities is an interesting phenomenon, especially in the context of discussions of personal identity. Given that moral commitments are generally acknowledged to be an important part of a person's identity, how will such changes affect those who experience them? Empirically, reactions among patients who experience such changes seem to fall into two categories:

(i) Some patients are rather disturbed when they notice these changes, and struggle to keep up their previous moral standards. Their current moral sensibilities as S3 appear to them inadequate when compared with S1. Despite experiencing a certain degree of moral indifference now, the patients still think that they were morally right when they perceived the moral demands of situations differently. Interestingly, just being cognitively aware of this experiential difference seems not to be enough. While using the medication, patients seem not to be able to fully make up cognitively for the experiential difference and act as they would think right. As a consequence, they may choose to rather go back to a state of depression than compromise their moral standards (Sobo 2001).

(ii) Alternatively, other patients may also be aware of similar changes, but not be worried by them. Instead, they consider their current moral sensibilities as more adequate than their previous ones. That is, the more rigid moral standards of S1 are now regarded as obsolete for S3. Not only do these patients not experience the urgency of certain moral demands any more, but they also explicitly discount their validity now, despite being well aware that previously they had thought otherwise about them (Kramer 1997, Elfenbein 1995).

3. Medication and the inauthentic self

When confronted with such changes in personality that have been brought about through medication, the first impulse seems to be to consider them as alien. That is, the patient herself would be considered as suffering from some kind of self-deception if she insists on identifying with S3. Different reasons can be given for this attitude: Some critics would assume that any interference which is not due

[1] I do not want to discuss here whether such "selves" are e.g. Parfitian selves (Parfit 1989). What I want to draw attention to resembles what Taylor refers to as "identity" (Taylor 1992), or what Quante calls "personality" (Quante 1999 and 2001).

[2] For positive accounts of the experience of depression, cp. Martin 1999 or Graham 1990.

to internal or "natural" causes has to be alien to the "real self"; others would only accept changes as authentic when they come about as a result of a process of rational reasoning; others would claim that authenticity depends on the exercise of autonomous choice in a very strong sense (to name but the most popular options).

How is it possible that persons nevertheless come to identify with S3 as their "real self"? First of all, the influence of medication could be understood as *intoxication*. That is, while patients are under the influence of the medication, they are presumably not in a state in which they can judge these matters correctly. While it may seem to them that they have the ability to judge their former moral convictions as invalid, they are in fact mistaken, and just unable to acknowledge their impairment.

Another possibility is the *hedonist explanation*, based on the assumption that people prefer feeling better to feeling worse. Accordingly, patients may endorse S3 because it suddenly turns out to be much nicer to live that way. However, while understandable, just feeling good will not be enough to warrant the endorsement of S3. In other words, endorsing S3 is ultimately a sign of moral weakness and not of authentic choice; it means to give in to the temptation of hedonism.

Alternatively, there is the *explanation from social values*: S3 may be endorsed because it is correlated with enhanced fulfillment of certain social norms. Given the current cultural stereotypes, it is no wonder that it is Prozac, a medication that seems to bring about carefree, outgoing, assertive and socially adaptive behavior, that is particularly often involved in cases of endorsement of S3. Once the medication has enabled patients to receive social rewards, so the critic, the formerly accepted restrictive moral norms may now seem insignificant. Identification with S3 and rejection of S1 would again turn out to rely on the wrong kind of motives and not support the claim that this is an authentic endorsement of S3.[3]

4. The possibility of authenticity

Is there any reason to assume that the critics may be mistaken in their diagnosis of S3 as inauthentic? As I want to argue, there is. The main worry in the criticisms in the previous section is concerned with the nature of the patients' rejection of formerly held moral values. This is indeed a puzzling phenomenon, but I do not think the de-authorization of the patients' self-understanding is warranted by the given arguments.

First of all, there is little indication that the intoxication model correctly represents the effects of anti-depressant medication. The medication brightens patients' mood and has some circumscribed side-effects, but does not usually lead to any significant impairment. (Also, neurophysiologically, these anti-depressants do not target those transmitters usually involved in substances of abuse.) The observable changes at least will not be sufficient to establish the presence of an "intoxication" that could justify discounting their judgments.

What about the hedonist and social values explanations? Both assume that the nature of the value change is of a kind that justifies regarding it as inauthentic. However, taking their criticism seriously would entail that authentic selves are extraordinarily hard to come by in ordinary life, as apparently many people are similarly motivated.[4] I would want to argue that the kind of authenticity that is at issue when the role of medication is concerned does not usually seem to imply a highly demanding understanding of authenticity. At least for many of the critics, their worry is rather linked more specifically to the sudden appearance switch in value orientation, and the apparent causal role of medication in it. But is this really sufficient for a de-authorization of the personal identification with S3? Sudden onset of value changes can be found at other times, e.g. in religious conversions. Should we discount these as well, despite their considerable significance for those who experience them? The main issue here is probably that these changes are due to the use of some specifiable chemical agent. However, given that the intoxication model is inadequate, what does the problem consist in? After all, chemicals influence everybody's way of perceiving the world; human psychological life is dependent on the action of exactly such chemicals. Establishing a significant difference between medication and the usual brain chemicals that is relevant for the question of authenticity would require more argument than has been provided.

What is perhaps most irritating in these cases, especially for philosophers, is the apparently non-rational way in which values are changed. However, it is important to note that these changes are not to be understood in terms of chemical brain washing: None of the patients wakes up and finds that overnight a completely different set of beliefs has been installed. Instead, it is their affective experience that has changed, and with it the comparative salience of morally relevant features in their experience. Apparently, changes in affective experience can shape a person's general moral outlook to a significant degree. Interestingly, such experience seems to present itself to the person as having a certain intrinsic authority, so that following its demands may be perceived as justified in virtue of its affective characteristics (and it will not e.g. be seen as giving in to a temptation).[5] Nevertheless, accepting the evaluative authority of affective experience does not seem to be an automatism. Persons under the influence of anti-depressant medication are still able to reflect rationally and may even come to the conclusion that their current experience does not do justice to their moral convictions.

In the absence of serious impairments, it does not seem justified to discount the patients' endorsement of S3 as inauthentic. The identification with S3 is apparently viable in the patients' lives (Kramer 1997, Elfenbein 1995). If the same value changes had occurred independently of the use of medication, de-authorization of the perspective of these fully competent persons would not have seemed warranted. One may perhaps doubt the value of their specific form of life, but one should be aware that this makes them no different from many other cases. If what we mean by authenticity is not something that succeeds only rarely and requires extraordinary efforts, then the specific causal role of medication does not seem to provide sufficient reason against the possibility of authenticity in this case. In being so visibly dependent on the presence of affective factors, this case is perhaps just a particularly clear example of what is more generally involved in the endorsement of value.

[3] For other accounts of similar worries, see also Kramer 1997 and the *Hastings Center Report* 2000.

[4] Arguably, some of the critics who take depressives to have special insight would agree.

[5] This is also supported by observations in more extreme cases of depression and mania. While the episode lasts, patients with depression will frequently explain why they are indeed as morally blameworthy as they feel, and patients with mania are usually convinced that acting on their impulses is fully justified. After the episode is over, both will usually revert to their former understanding of values. – For some neuroscientific evidence of the specific role of affective factors in moral reasoning see also the results of the recent fMRI study by Greene et al. 2001.

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