COMMENTARY

The lack of agency becoming part of the self[†]

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[†]Commentary on…: When the illness speaks. See this issue.

SUMMARY

This brief commentary on Greenberg's article 'When the illness speaks' addresses the problem of agency in mental disorder. Complementing the perspective of the article, it advocates an approach that does not see the causal mechanism of disorder-related behaviour in terms of an exclusive disjunction between the effects of the individual patient's own agency or manifestations of the illness. When reduced agency becomes part of the person's self-conception, passivity no longer means behaviour that is alien to their 'genuine self'. Relatedly, the requirement that the patient's self-conception be validated raises some questions regarding its therapeutic constraints.

KEYWORDS

Borderline personality disorder; agency; mental illness; self-determination; locus of control.

In his clinical reflection, Greenberg (2024, this issue) addresses the question of the causal role we can attribute to mental illness versus the agency of the patient themselves in the explanation of behaviour related to their condition (in Greenberg's example, the suicidal behaviour of a patient with borderline personality disorder). Is it the illness or the person suffering from it speaking and acting? In Greenberg's view, although medical approaches laudably work towards destigmatisation and the lifting of blame from the patient, they present the person as lacking agency. However, conceiving the patient as passive with regard to their disorder-related actions, verbal and other, creates theoretical and practical difficulties. In particular, the sense of agency should be boosted as an essential part of mental health and advancing recovery from the mental disorder.

Greenberg's dilemma

I am in full sympathy with the author's misgivings concerning a purely medical approach on the basis of considerations about agency and would like to augment his argument by some further observations from a philosophical perspective (which he finds useful in thinking about agency, responsibility and the potential to change). The main question for Greenberg is whether it is the patient or the illness causing the given behaviour, whether chalking it up to the latter is justified and serves the clinician's purposes. I would like to complicate this question by blurring the distinction between these two causal sources, the patient and their illness: the latter can become an integral part of the identity of the former, in which case the two can be jointly and inseparably manifested in behaviour.

I see two factors unfavourably converging on a passive conception of the patient. One is the simplifying medicalised view targeted by Greenberg. The other is the individual's own lived experience: the fact that in relation to their condition, patients often do not sufficiently perceive their own agency and causal impact on their lives. These self-perceptions of passiveness and lack of personal control, possibly also enhanced by other people's reactions to the sufferer's condition on the part of their environment, are detrimental to the process of recovery.

Many mental disorders, among them borderline personality disorder, are associated with a reduced sense of personal agency and a more external locus of control (Hope 2018). This is likely to be connected to lower levels of personality organisation, making it a challenge for patients to sustain goal pursuit and achieve desired outcomes. The individual may genuinely feel helpless, incapable of attaining goals, including making changes in their own attitudes and behaviour. A one-sidedly medicalised outlook on their condition strengthens their self-perception of not making significant choices and lacking personal control.

Identity and diminished sense of control

A severely reduced sense of agency and control dampens the likelihood that the patient will help their recovery by taking positive actions and a positive view of their 'current selves' (with positive goals and desires providing incentives for future behaviour) helping their recovery (Janis 2006). Naturally, we have to tread carefully here to avoid bringing back victim-blaming and stigmatisation. The fact that psychological factors, including attitudes and habits of thinking (e.g. pain rumination and shifting responsibility), may have a causal role

in the manifestation and maintenance of the disorder does not make it a matter of the patient's choice and control. It does mean, however, that a sense of lack of agency and external locus of control may contribute to depriving patients of a path to improvement.

This has bearing on the question of the role of the patient's self-understanding in the process of recovery. Recognising and examining the lived experience of the patient can be a major contributor to the management and treatment of various conditions. It has been emphasised by therapists (e.g. in the dialectical behaviour therapy of borderline personality disorder) that the individual's perception of themselves and their illness has to be 'validated' (the patient's experience, feelings and self-interpretation have to be acknowledged), allowing them to rebuild self-esteem and regain some sense of agency and control (Koerner 2011). In recent philosophy of psychopathology, this has been framed in terms of not committing 'epistemic injustice' against patients (Crichton 2017).

Although the principle is plausible and commendable, its execution can meet serious difficulties, even leading to what we might think of as a practical paradox. Persons with mental disorders know some aspects of their own experience that clinicians/doctors do not have access to, and they are entitled to perceive and frame their experience in their own terms; at the same time, certain pathologies often involve characteristic dysfunctional cognitions and emotional episodes. Since these dysfunctional cognitions and emotions are likely to be at the core of the patient's lived experience, they cannot simply be put aside, and it is also crucial from the patient's perspective to address them. It takes a very careful approach to acknowledge and validate lived experience without confirming such cognitions and feelings, confirmation of which may be counterproductive for recovery.

In borderline personality disorder, some typical beliefs or judgements include 'I will always be alone', 'I am an evil person and I need to be punished for it', 'Other people are evil and abuse you', 'I'm powerless and vulnerable and I can't protect myself', 'If other people really get to know me they will reject me' (Arntz 1999). How can the experience of lack of personal agency and control be validated without affirming such underlying dysfunctional beliefs? Relatedly, how can the person's perception of the *causes* of their feelings be validated, when they may not correctly assess their agentic role due to their condition?

When talking about the causal mechanisms of behaviour in mental disorder, both self-determination and its subjective perception need to be taken into consideration. As I observed above, these are not independent of each other. The question of how patients act and how the illness 'makes them' behave cannot be detached from their self-conception. Perhaps we should not assume a 'pre-existing border, in the psychiatric patient's mental life, between that which belongs to the self and that which belongs to the mental illness' (Jeppsson 2022). Diminished agency might be integrated into that self-conception; thus, if we prefer to put it in terms of the self–illness dichotomy, the illness 'acts' through the patient's own agency, effects of the illness being incorporated into the person's 'own', 'genuine' current self-conception, shaping their agency.[a]

Therapeutic efforts need to reckon with the reduced sense of self-determination, which often becomes a part of the person's identity, contributing to lack of motivation to act as an agent. Patients may have built incapacity and passiveness with regard to the illness into their self-conception, as well as having dysfunctional assumptions about the possibility of change, making for an additional obstacle to improvement. Addressing the patient's attitudes to their agency as part of their self-conception, potentially influenced by their condition, might thus be fruitful in the process of recovery.

a. An entire issue of *Philosophical Explorations*, in which Jeppsson's article appeared, is devoted to 'self–illness ambiguity' (2022, Vol. 25, Issue 3).

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