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Abstract: For some people with bipolar disorder, excessive self-trust in the manic phase conflicts with trusting themselves over time, and radical shifts in mood and activity can undermine their trustworthiness. Difficulties in trust interface with the ability to construct a narrative. Although the narrative self may be (for anyone) fragmented and disjointed, it can nevertheless provide an unfolding rationale for the shape that one’s life has taken and will take. Many people with bipolar disorder experience themselves as fragmented where neither self-trust nor narrative can appropriately develop. Clinicians play a crucial role in extricating patients from this struggle for meaning in their lives. One aim of therapy may be to develop appropriate self-trust and to enhance patient trustworthiness through construction of a narrative where the patient is able to make sense of her changes to herself and others. Part of this joint task involves helping the patient to construct a narrative that accounts for effects of bipolar illness but is not driven by it. Because explanations of change from one mood or set of desires to another need to be deep enough to facilitate trust relations, the criteria for a narrative self must not be overly demanding of unity and similarity. This aim requires that the clinician be trustworthy with regard to the specific vulnerabilities of patients with bipolar disorder. This paper offers an outline of an approach psychotherapists should take to provide a kind of self-narrative–oriented therapy to help patients with bipolar disorder develop a sense of self that will help them to account for their illness while allowing patients see themselves as something more than just their illness.

Keywords: bipolar disorder, self-trust, fragmented identity, narrative self, agency, illness narrative.

“The fact that a person has bipolar disorder can make ordinary life decisions seem complex, and important life decisions seem overwhelming” (Mondimore 1999, 143). I propose that one of the reasons for difficulties in decision making is a problem with self-trust. As one patient said after finally coming down from a manic phase, “it was a very long time until I recognized my mind again, and much longer until I trusted it” (Goodwin and Jamison 1990, 27). It is true for all of us that consistently acting on poor judgment undermines self-trust over time. However, the bipolar patient may also be coping with delusions, general cognitive problems, and severe mood swings. Marked shifts in mood and activity can diminish others’ trust in the patient as well; thus, both self-trust and trustworthiness are undermined. The illness, not the patient’s character, is the cause, but therapeutic treatment can be of enormous help in developing a character the patient and her family can live with. Part of this joint task involves helping the patient construct a narrative that accounts for effects of bipolar ill-
ness but is not driven by it. This is an ambitious thesis, especially because self-trust and narrativity each are complex and philosophically rich, but my actual aim is modest: to engage readers in thinking creatively about how to address one sort of problem that bipolar patients face.

**What Is Self-Trust?**

First, let me give a general definition of self-trust. (See Govier 1998 for another view.) Self-trust is an epistemological and evaluative attitude we take toward ourselves. Self-trust is both backward- and forward-looking: when I trust myself, I am making a prediction about the quality of my judgments, evaluations, capabilities, and choices. I am basing that prediction on the quality of past experiences and an understanding of myself. It is a positive assessment in that I am looking favorably on myself with respect to some future activity or judgment. This definition suggests that self-trust has the following logical characteristics.

1. Self-trust, like trust in others, is a relational concept. But in self-trust, the relation is self-referential. I trust myself. To put it another way, both conceptually and linguistically, self-trust always takes an object, but the object is (presumably) the same as the subject.

2. The relational quality of self-trust is also a relation between the “I” of the moment and the temporal and historical “I.” Self-trust, therefore, assumes continuity of self across time and that the subject can recognize the outcomes of her actions, as well as the desires, aims, and judgments underpinning those actions, as stemming from her.

3. Self-trust is typically a three-place predicate: I trust myself to do x or not to do x. In other words, typically we trust ourselves with respect to some particular domain, and we may not trust ourselves in other domains. (For example, I trust myself to find my way around in the wilderness, but I do not trust myself when it comes to making good investments.)

4. Self-trust requires self-knowledge. Although self-trust may be delimited, self-knowledge must be broader to provide a framework by which to evaluate ourselves in the various domains of judgment and action. In other words, self-trust requires critical self-reflection.

What I have said so far may suggest that self-trust is purely epistemic. But it is also in the moral domain. Proper self-trust contributes to our ability to live flourishing lives; it strengthens autonomy, affirms our worth, and situates us psychologically and morally as equals among others. Excessive or deficient self-trust can be harmful to others as well as ourselves, because others’ lives are implicated in the choices each of us makes.

Because self-trust is part of what we need to live a flourishing life, it can be considered one of the virtues. The person who trusts herself believes, ‘I am not going to let myself down; I can count on myself.’ ‘Counting on oneself’ is a matter of disposition, and a disposition is an enduring trait, one developed over time. For example, when we talk of someone with a cheerful disposition, we mean that that person has a tendency to maintain cheerfulness when confronted with difficulties and so on. Both epistemologically and morally, then, self-trust is an enduring trait that is crucial to living a fully flourishing life.

**How Is Self-Trust Different for Bipolar People?**

Bipolar disorder is a mood disorder, the manic phase of which is described as euphoria, exuberance, or a belief that ‘no task is too difficult’ (Mondimore 1999, 9). One way to understand the self-trust of a patient in a manic phase is that she has an excess of it. Exuberance and excessive self-trust do not lead her to suspect that something is wrong (Mondimore 1999, 10). Instead, the manic person trusts her feelings, beliefs, desires, and goals.

An inability critically to assess one’s present state and to evaluate the merits of current desires and interests seems a hallmark of mania. Excessive self-trust itself is assessed as unproblematic, and the patient sees no reason to doubt herself. She trusts her excessive self-trust, to put it rather oddly. Excessive self-trust is often counterbalanced with diminished self-trust when depressed. Fear that she cannot trust herself to accomplish goals, a belief that she has nothing important to contribute, doubts about her ability to make good or worthwhile decisions, plague the depressed patient (Mondimore 1999, 213). Then, this debilitating lack of self-trust vanishes again at the onset of mania or hypomania.

In other words, the sense of moral imperative and certainty of moral and other beliefs is dependent on mood—and those mood changes are not...
under the control of the patient (Goodwin and Jamison 1990, 27). So the values the patient holds, and the moral landscape she takes herself to be moving within, changes depending on mood states (cf Jamison 1996; Moore et al 1994). The bipolar patient may feel she has a moral compass with no magnetic north, so to speak. Does she value fidelity in relationships? Gentleness in disputes? Financial security and responsibility? It depends on whether she is manic, depressed, or in remission. Under these circumstances, it is not surprising that a patient would say:

And always, when will it happen again? Which of my feelings are real? Which of the me’s is me? The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? (Goodwin and Jamison 1990, 18)

As this query indicates, the long-term result of the extremes of self-trust that correlate with mood swings is that of even deeper self-doubt. Trying to identify herself as the same person, with constant values, beliefs, and goals, becomes increasingly difficult over time. That is, if a patient takes a narrative view of himself or herself, the story may be devastating.

I am not arguing that vacillating extremes of self-trust constitute a character flaw. In fact, I think it is incorrect to cast problems of self-trust for bipolar patients in typical moral terms. Part of what makes it possible for one person to develop a virtue that another cannot is a matter of what Thomas Nagel (1979) calls ‘constitutive luck.’ The bipolar patient has constitutive bad luck when it comes to virtues of trust. However, if a patient is to manage her illness, she must be able to situate herself and her illness within a larger context of actions, goals, and values so that self-trust and trusting relations with others are not radically undermined. Because identity and self-trust rest on temporal judgments of ourselves over time, the bipolar patient’s sense of self requires some kind of temporal framework in which to make sense of her experiences. The clinician can assist the bipolar patient in articulating and delineating the problems and possibilities for healthy self-trust by locating the patient’s shifting state/traits questions of identity in a narrative framework.

**What Is the Relationship of the Narrative Self to Self-Trust?**

So far, I have argued that self-trust is invaluable to living a flourishing life and that proper self-trust rests on a more or less correct view of oneself. But the self-trust of bipolar patients is distorted, and the extremes need to be diminished. In this section, I explain how damaged self-trust, over time, can erode a person’s narrative self as well, such that a bipolar patient is caught in a double-bind: if she resists situating herself in a narrative, she may succeed in diminishing the anguish of self-doubts—but it will be at the expense of seeing herself as a coherent and morally responsible self over time. Or, if she does try to situate herself in a larger narrative, she finds herself faced with both the inconsistencies of desire and action that her illness brings and a sense of fragmentation or alienation from her alternating state-selves. Thus, managing bipolar illness so that patients can experience a degree of flourishing involves minimizing the extremes of self-trust while at the same time helping the patient to produce a narrative she and her loved ones can live with.

Broadly defined, a narrative account is one where events are presented in a manner that shows connectedness and coherence and provides a sense of movement and direction through time (Draucker and Hessmiller 2002, 218). Clive Baldwin (2005) argues that we constitute ourselves through story-telling, where our individual narratives cohere by being part of the larger web of (others’) narratives. Our lives are narrative in the sense that no time-slice is completely intelligible outside of the context of our lives before and after that time-slice (Schechtman 1996, 97). But, as Phillips argues, “a self is constructed of not one but multiple narratives, some short, some long, some subdivisions of others, many contradicting one another, some coherent and some less coherent” (2003, 315). So, even without the presence of psychopathology, a person’s narrative may be discontinuous and messy. Gillett also points out that a person’s narrative can get ‘broken’ by things such as chemical imbalances or genetic predisposi-
tions; “the more other-involving narrative skills we have developed the more we will be able to see the position from a different view or from somewhere else” (1999, 137).

I highlight three components of narrative that are taken to be crucial to narrativity of the self, two structural and the third evaluative. First, an effective narrative needs to emphasize the human agency in actions—that is, it should provide a way to characterize actions that are goal-directed and self-chosen (Bruner 2003). Second, an effective narrative will provide a way to explain “reportable events”—those unique events that violate canonical human behavior and require explanation (Draucker and Hessmiller 2002, 219–21). Valerie Hardcastle argues that the affective ties and emotionally experiencing self that we select as most important to our storytelling entail that it is especially important to attend to those reportable events that are affectively troubling in a person’s narrative (2003; cf. also Hutto 2007, 4, n. 3). Third, an effective narrative maps the trajectory and the gaps between internal states of motive, intention, desire, and belief and the everyday actions performed. In other words, an effective narrative situates the narrator as an actor whose desires and actions are, to some degree, being evaluated at a second-order level and whose gaps between the two are critically reflected upon. This reflective stance is one that we must learn to engage in, because our everyday experience of living narratively is prereflective (cf. Phillips 2003). When a patient is unable to create a reflective distance about her lived experience, that patient experiences herself as a person in this state or that state but not within a full trajectory of her life course (Phillips 2003, 315).

A difficulty many bipolar patients face is that, when they try to create a narrative of their ongoing lives, they cannot fulfill the requirements of a good narrative. They cannot see their goals and actions as a reflection of their agency, because their illness is the determining factor of their choices. And they cannot adequately explain ‘reportable events’—such as buying twelve snake bite kits—in a way that makes sense of bizarre or irresponsible actions to either themselves or their listeners. Their narrative account of themselves over time lacks the connectedness and coherence that we take to provide explanatory power. As Marya Schechtman notes, “we expect a person’s beliefs, desires, values, emotions, actions, and experiences to hang together in a way that makes what she says, does, and feels psychologically intelligible” (1996, 97). But, as I discuss below, those with bipolar disorder may not be able to accomplish that skill without help. Second-order reflection on the relationship between desires and goals may be confounding or shaming and seem not to be easily incorporated into one sensible narrative. Lacking both self-trust and a clear narrative account of their lives, many bipolar patients cannot get a foothold. They have trouble locating themselves within one narrative and, when they try to piece it together, they perceive a person lacking agency who should not trust herself.

Narratives, however, are not simply created out of private experience; they intersect with cultural patterns of meaning and interpretation. One kind of narrative is the illness narrative and bipolar patients, when they begin to reconstruct their sense of self after diagnosis (or a recent manic phase), are likely to try to fit themselves into this form. Frank (1995) discusses three types of illness narrative—the restitution narrative, where illness is a transitory interruption and health is ultimately restored; the quest narrative, where a search for meaning in illness is sought and found; and the chaos narrative, where the person’s life will not get better. “The chaos story depicts life experiences that are without coherent sequence or sense of causality” (Draucker and Hessmiller 2002, 234). My hunch is that many bipolar patients, finding neither the restitution form nor the quest form of narrative a viable alternative, feel stuck with the chaos narrative—in which they narrate their lives as hopelessly out of control, senseless, and fragmented, with little hope of improvement. They may be able to identify reportable events (say, a costly shopping spree), and even situate those events in the context of other events (say, the consequences of the spree), but cannot identify the agentic or causal elements beyond the illness itself to piece together a picture of their lives that is not paradoxically both chaotic and deterministic.
FROM CHAOS NARRATIVES TO HINGE NARRATIVES

For most of us, the mental life of our narrative selves congeals into forms that move with us, building a future out of the past, by accommodating our desires and beliefs in such a way that we can integrate our experiences in to a conscious narrative (Gillett 1999, 75). For some, however, the narrative that congeals is oppressive or entrapping, or there may be several congealed forms that cannot readily come together to form one meaningful narrative in which the narrator can locate herself.

Bipolar patients, in particular, may struggle with fitting themselves into the crucial components of narrative I discussed in Section 3. Partly this is because of their illness, but partly it is because of a restricted notion of narrative. This is why Baldwin argues that:

[i]f we are not careful, our conceptualization and operationalization of narrativity and what it means to be a narrative being may result in the narrative dispossession of those with severe mental illness. (2005, 1023)

Baldwin argues that clinicians need to provide ways for patients to accommodate episodes of severe mental illness into their narrating (2005, 1025). By not imposing a restrictive sense of narrative on patients, clinicians can begin to assist their patients in reclaiming some semblance of narrative self. Working in the spaces between theoretical narrative expectations and real patients’ narrative chaos is one way that clinicians exhibit trustworthiness to their patients.

When our experiential ‘raw material’ is not signposted in typical forms of narrative, and when we ourselves are uncertain about what to make of our experience, we may face the dual problems of lack of self-trust and a disruption in our narrative self. To learn the skills necessary to produce well-enough-integrated narratives, we (all of us) need a loving, nurturing environment (Gillett 1999, 133). This is crucial in the development of patient self-trust, because corrections in self-trust will have to come partly from others who the patient can believe are trustworthy. Being a trustworthy clinician is also vital in helping the patient map into narrative form her disparate experiences in various states, where to do this successfully involves being able to trust the clinician’s perceptions of who the patient is over a broader expanse of time. As Tim Thornton argues, the narrative structure of a person’s story comes about through the experience of embodiment, and when patients are uncertain about how to unify disparate actions and reportable events from their past, clinicians can function in their third-person capacity to substantiate that such-and-such actions can be ascribed to this embodied subject (2003). The third-person perspective of an embodied patient/subject is necessary but not sufficient in assisting patient construction of a narrative self.

A crucial part the clinician can play, then, is in sharing and nurturing the skills necessary for constructing a narrative the patient and her loved ones can live with (Gillett 1999, 137). Gillett suggests that helping the patient develop other-involving narrative skills will help the patient to see himself not only from within himself but also as others see him. Seeing the position one was in (or has now gotten oneself into) helps one to dissipate “mismatches between where one puts oneself and where one finds oneself” (Gillett 1999, 137). This suggests that the clinician needs to introduce patients to a repertoire of narratives other than the chaos narrative—in ways the patient can locate herself.

I propose a form of narrative that bipolar patients can draw upon instead of a chaos narrative. I am naming this the ‘hinge narrative’ to capture the sense of being at a swinging door that can be opened or closed to varying degrees and that does not move by itself but rather is moved upon. The idea of a hinge narrative comes from Gillett (1999), who names the problem of the border between the chaos of mania and the creative edge that is under the control of the patient ‘the hinge zone.’ The hinge zone is that psychophysiological space between the bustling marketplace of signifiers and the chaos of unconstrained activity (Gillett 1999, 186). A hinge narrative allows for the fact that self-trust is never wholly independent of how others see us and that any narrative we construct must take into account not only our own conflictual desires but the ways in which our
desires and aims may conflict with those we love. It accounts for the lure of mania and the reality that the bipolar patient may want to keep the door to creativity open and so must learn to control the hinge movement. A hinge narrative also draws on a metaphor of looser and more flexible, rather than fully bolted-down and secure, connections between parts of a ‘whole.’ Rather than aiming at full coherence and integration of a unified narrative self, the hinge narrative is suggestive of the ways that our experiences of ourselves over time are not always smooth and sustained, but are sometimes deliberately linked through hinges we ourselves create.

Picture the door as only the bottom half of a door, but one that swings in either direction. The hinge is what enables the patient to move within the zone of creativity, narrativity, and self-trust while staying (somewhat) connected to others. The door and hinge together are the discursive field that allows for narrative production (there are many doors and hinges). The aim for the patient and clinician is to get the hinge zone under the control of the patient so that he is not swinging wildly into chaos or not swinging at all (medicated while losing creativity or sinking into depression); the hinge zone is that place that allows for the free play of creativity. It is important to note that, because it is only a half-door, it is open both socially and physically so that the patient is never fully ‘enclosed.’ The door will be subject to the wind (chemical imbalances) and to others who may push on it—sometimes in ways the patient does not wish. A hinge narrative, then, is one that intersects with the narratives of others, but is tailored to address the unique needs of those with bipolar disorder whose experience of themselves as subject to swings into mania makes it difficult for them to construct a narrative in which they see themselves as trusted and trustworthy. A hinge narrative is flexible and dynamic without being disconnected from the discursive field. As Gillett reminds us, the subject—in this case, the patient—is not fixed but active (Gillett 1999, 122), and the challenge is to harness just enough of the dynamic between self-fragments, other discursive subjects, and the things of everyday life such that the patient and clinician can make sense and meaning of the patient’s experiences.

Creating a Hinge Narrative

Bipolar disorder can propel people into situations they would otherwise be able to avoid and cause them to do things they otherwise would not do (Mondimore 1999, 170). On the other hand, many bipolar patients do not want entirely to lose the zest and creativity that comes from mania. The issue is, in part, one of maintaining a degree of choice and control such that the patient can see herself as an agent who can, in general, trust herself over time. Clinicians can work with their patients to create a hinge narrative that brings together these elements. A hinge narrative “ought to be true from a biomedical standpoint” (Brody 1987, 17) and it should include the idea that “people must behave in certain ways to get better.” An effective hinge narrative is, in part, “a rehearsal for the part one must perform in the future” (17).

I outline three steps toward such a narrative. First a background condition: the most important tool for treatment and to prevent relapse is to take one’s medications. In learning to trust himself and thereby begin to construct a narrative he and others can live with, then, psychopharmacology may well be the first step.

However, patients may be distrustful of medications, especially if they place a value on creativity and believe that their creativity will be hampered with meds. Gillett points out that the creative process involves a kind of thinking that “leaps from point to point” (1999, 181). This freedom from normal analytic rules of discourse is crucial to—even constitutive of—creativity. The manic person, making trains of association, is prompted to pursue projects that result in creative output. And manic creativity should not be viewed ipso facto as destructive. Still, one can only be creative if one can stay in control of the play of associations. Therefore, managing bipolar illness requires medication—but preserving creativity may involve some constraints on medication. So here is the first point: in creating a hinge narrative, patients
need to be affirmed as creative persons who have a “hinge zone.” A hinge narrative allows patients to retain the sense of ‘sweep’ in degrees of creativity and energy they experience. At the same time, it provides a sense of agency in that the patient is encouraged to see how her choices and values, over time, provide the degree of the sweep. Additionally, clinicians can help the patient to see herself ‘over here’ as related to the person ‘over there’ through the metaphor of a hinged or swinging door.

The second issue in creating a hinge narrative is to address problems in self-trust. Creating any narrative requires discussions about autobiography, personal relationships, choices and goals, moral commitments, and so on (Gillett 1999, 196; cf. Hope 1994). These discussions, however, can be difficult when the patient sees her goals and desires as state-dependent and does not trust her own judgments. The goal is to develop appropriate self-trust while allowing for creativity and self-expression. Completely buttoned-down and controlled agency may result in self-trust but be too constrained to foster growth, experimentation, and discovery.

One therapeutic goal might be to identify positive domains of self-trust and explore why the patient can trust herself in these areas. Then, the clinician and patient could work toward expanding the domains of self-trust. For example, a particularly difficult area for bipolar patients is in learning to read their moods and knowing which ones to trust. A trusted clinician, as well as trusted family members or friends, can help “by acting as an objective observer of mood changes” (Mondimore 1999, 228). (This is not to say that others cannot make mistakes in their assessments: Mondimore describes a couple, the husband of which saw his bipolar wife’s enthusiasm for returning to school as an indication that she was getting manic again, whereas Mondimore thought that the wife had assessed herself accurately and that Peter was overreacting [1999, 241-3]).

In helping the patient to learn to better read her own moods, as well as in judgments about other things, clinicians must retain a delicate balance between reminding the patient when she ought not trust herself, on the one hand, and entrenching debilitating self-doubts, on the other. Self-oriented therapy, which focuses on setting priorities and reality testing, is recognized by many clinicians to be an important aspect of therapy, but it is central to therapy with patients who have bipolar disorder.

While expanding domains of self-trust, some safeguards may need to be put in place. A patient may trust herself more overall if she arranges a power of attorney or a legal guardian to prevent enormous sums of money being removed when she is in a manic phase (Mondimore 1999, 246). Safeguards function as one of the hinges, giving the patient room to develop other domains of self-trust while staying fastened in problematic areas.

A third task in creating a hinge narrative is to work together with the patient to evaluate the patient’s beliefs and desires from a second-order level. This evaluation process is vital to the development both of appropriate self-trust and to a narrative the patient and others can live with. The evaluation of first-order beliefs, desires, and goals is central to being human in that it allows us to reason and love, to know and to be wise, to exercise our autonomy and to work cooperatively with others (Lehrer 1997, 1–3). For bipolar patients, the evaluation of values and beliefs at the second-order level should be done in the context of their larger commitments and hopes, and it is best done with the clinician over time and after medications have stabilized.

However, a central problem for many bipolar patients is that they may experience themselves as having two sets of desires, one when they are manic and another when they look at their manic activities from a more normal state. And evaluating desires from a second-order level presupposes that there is one narrative (or one overarching objective set of values) by which the patient can adjudicate between the two separate sets of desires. A patient may be reluctant to choose one set of desires over another, because he may see certain desires as integral to the life and kind of person he is but yet is not descriptive of the whole (Gillett 1999, 194). When this occurs, a clinician might suggest that the patient include a desire to avoid scenarios where certain vital goals would be threatened by worsenings of his illness (Gillett 1999, 195). The patient may need to do
some prioritizing, but the goal is not necessarily to gather all ‘appropriate’ desires into one neat narrative. Instead, the patient may want to construct a future-oriented narrative with multiple pathways, the parameters of which are that none is likely to lead to scenarios that exacerbate the illness or debilitating self-doubt.

**Conclusion**

This paper proposes a self-narrative–oriented psychotherapy for patients with bipolar disorder. I have argued that patients with bipolar disorder are struggling to make sense of who they “really” are: when they are manic, they are one way; when depressed, another, and when euthymic, something else again. These changing mood states often involve conflicting values, such that when manic, the patient may value a certain aspect of himself (e.g., enhanced sexuality or creativity), which others may not value, or which he himself—when euthymic—may view with distrust. I have tried to show how psychotherapists can begin to engage patients with respect to these difficulties by helping patients to create new ‘hinge narratives’—ways in which patients can be open to some of their manic- or depression-driven experiences while putting those experiences in the context of their larger life. Such narratives allow patients to make sense of living with bipolar disorder while avoiding the two extremes of denying that they have the illness or feeling completely trapped by it. These patients need psychotherapy to help them develop a sense of self that will help them both to account for their illness while allowing them to see themselves as something more than just their illness.

Some caveats are in order. First, my ideas about creating a hinge narrative should not be construed as a ‘stage theory.’ Each of the three components is intertwined with the others and will need to be worked on simultaneously. Second, I concede that, like all metaphors, this one has its limits. Still, it gives us a way to think about some of the issues that bipolar patients face without insisting on complete unity and coherence of the self, and without asking those patients to give up some of what they most value. Third, although self-trust is crucial to a good and healthy narrative self, it is not the only important factor. (Having the cognitive and moral capacity to take responsibility for one’s voluntary actions is also important, for example.) Finally, I acknowledge that this work is speculative in a way that scientific research is not. Philosophical work is, by nature, theoretical, and my suggestions will need to be explored in clinical settings to evaluate their merits. What I hope to have provided is enough analysis to prompt deeper research both psychiatric and philosophical.

**Note**

1. To say that the self is constituted through narrative raises the problem of who the author is who is doing the narrating, but that issue is beyond the scope of this paper. Furthermore, some thinkers challenge the very idea of the narrative self, arguing that it is a fiction. Cf. Galen Strawson’s “Against Narrativity” (2004).

**References**


