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Is it me or my delusion?

Harnessing authenticity for an agential view of delusionality

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Abstract
In the *revisionist* part of the book, Bortolotti aims at defending a non-pathologising view of delusions, according to which they not just compromise, but support our agency. By construing delusions as meaningful protective responses, the author attempts to decouple delusionality from pathology. Nevertheless, it is not clear how, according to her approach, delusions could foster agency. Even when seen as a "way of life" and not as psychiatric symptoms, the defensive nature of delusions can undermine the person's sense of agency, for the symptom or defence mechanism never stems only from the person themselves. Notwithstanding the benefits delusions might bring along, they seem to display their own intentionality to the detriment of the agent. Here, I suggest that insights from the authenticity debate in psychiatry could support Bortolotti's revisionist aim and benefit her discussion on identity beliefs. For this purpose, I introduce the concept of *self-illness ambiguity* (Sadler, 2007) and compare de Haan's notion of *existential stance* (2020) and Stanghellini's concept of *position-taking* (Stanghellini et al., 2023) to argue that the person's agency resides in their ability to take a stance on their (psychiatric) condition, especially when struggling with questions of authenticity. Finally, I explore why one cannot just get rid of a delusion and why, when one attempts to, it feels urgent to replace it.

Keywords
Authenticity · Delusions · Position-taking · Protective role · Sense of agency

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1 Not our own strategy

According to Garson (2022) all of psychiatry's history might be viewed as the interplay of two co-existing, albeit contrasting, visions. In Garson's words, either 'madness' (psychiatric conditions[1]) is construed as a strategy, or as a dysfunction.

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[1] In this essay, I refrain from endorsing the current medical terminology. Instead, I privilege a person-centred approach to psychological suffering. For this reason, I favour the term 'psychi-

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Delusional beliefs easily attract attributions of falsity, irrationality, meaninglessness and, for these reasons, are deemed as inherently *dysfunctional* (Miyazono, 2015). Dysfunctions are interpreted as indicators of their *pathological* nature and, given that pathology is often regarded as a constraint on someone's agency, delusions are deemed as a negation of the person's agency.

On the other hand, in the *revisionist* part of her book, Bortolotti (2023) seems to embrace the former way of thinking – *madness-as-strategy*[2] – and attempts to decouple delusionality from pathology by construing delusions as meaningful *protective* responses. Delusions, as the argument unfolds, are not the primary issue; rather, they represent a (imperfect) solution to the underlying problem. By presenting a more desirable and less threatening reality than the actual one, they become "means by which we respond to uncertainty, manage negative emotions and express our identity" (p. 155). For these reasons, Bortolotti argues, "delusionality is an expression of agency" (p. 161).

In sum, Bortolotti shifts away from dysfunction-centred views of delusionality to emphasise its meanings and potential benefits. In this contribution, I build upon Bortolotti's account and propose another perspective on what grants agency to those experiencing delusions. While I endorse Bortolotti's revisionist manoeuvre, I will challenge the primary tenet of function-centred frameworks: I contend that ascribing a protective role to psychiatric symptoms does not enhance the person's sense of agency, rather, it either diminishes or strips it away, for the symptom never stems only from the agential processes of the person themselves. Although this fact holds true for many phenomena (consider the myriad of ongoing bodily processes at this very moment without your slightest awareness of them), it is especially noteworthy here.

The story of patient S.T., as reported by Eagle (2011), serves as an illustrative example. It shows how symptoms may diminish the person's agency precisely by playing a protective role in their life. In other words, the strategy that the symptom demands is not the strategy of the (whole) person, and when the intentionality of the symptom overrides the one of the subject, it does so to the detriment of the person. The same line of reasoning can be extended to delusions, alongside numerous other manifestations of psychological suffering.

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atric condition' over 'psychiatric disorder/illness', and opt for terms such as 'person' or 'individual' rather than 'patient'. Given their ethically-loaded connotations within psychiatric practice (Ritunnano, 2022), I confine the use of the terms 'patient' and 'disorder/illness' to descriptions that already entail a clinical perspective.

[2] Garson's madness-as-strategy and madness-as-dysfunction overlap, respectively, with what I will define *function-centred* and *dysfunction-centred* frameworks. However, regarding the former paradigm, I emphasise the extensive use of the concept of 'protective role' and associated notions to account for the working of a psychiatric symptom within the person's psychological life. In this context, the symptom is described as performing a certain *function* or role, whose purpose is protective in nature. This paradigm has not escaped the question of agency. Notably, emphasis is placed on a framework that traps the agent in a position that is subservient to the symptom. In other words, according to this narrative, the symptom exerts control over the individual, using the person as a medium to reach certain goals.

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S.T., a 26-year-old man, was plagued with the obsessive thought that he was homosexual. To counteract the insidious symptom, he would engage in all sorts of compulsions, such as imagining a homosexual scene to 'test' his reaction. His symptom first arose when his girlfriend pressured him to become formally engaged. Eagle describes S.T. as afflicted by an inner conflict between his desire for and fear of commitment, and suggests that the symptom 'intervenes' as an attempted solution to the aforementioned conflict, thus playing a *protective role* in the patient's (psychological) life. Eventually, tired of his procrastination, S.T.'s girlfriend left him. Despite feelings of loss and rejection, his symptoms were dramatically reduced. Two years later, he was asked for commitment again, and the obsessions returned in full force. Eagle concludes:

> "I do not begin to adequately understand the mechanism or process that can generate a symptom that is experienced as unbidden, unintended, and involuntary and yet can be *purposive* (i.e., *designed to protect* S.T.) [emphasis added]". (2011, p. 71)

One might inquire – how did S.T. *relate* to his symptom? Could appreciating the purposive nature of his ego-dystonic obsessions, over which he lacked control, have altered his feelings of helplessness? Bortolotti herself concedes that emphasising the purposeful aspect of delusions won't help individuals restore their sense of control and agency. In reviewing Garson's work, she maintains:

> "In the history of madness-as-strategy that Garson reconstructs, madness is not the means by which we can pursue the goals with which we identify; it is the means by which we are made to chase an inscrutable end […]. When madness is seen as a strategy, it is not our own strategy". (2022)

According to the madness-as-strategy paradigm, painful obsessions would intrude on the patient's mind to help him resolve a conflict concerning intimacy. Paradoxically enough, S.T. himself, as a subject deprived of his agency, had no say concerning his relationship issues. Bortolotti concludes:

> "The hope is that a new version of the madness-as-strategy account will emerge and lead us into a future where the coping mechanisms we adopt are more robustly under our control". (2022)

2 Agency: Taking a stance amidst ambiguity

In the remainder of this contribution, I confront Bortolotti's hopeful outlook and embark on the challenge of outlining what (a partial aspect of) this new account would look like. I suggest that insights from the authenticity debate in psychiatry could support Bortolotti's revisionist aim and benefit her discussion on identity beliefs.

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2.1 Pursuing authenticity: An existential endeavour

Individuals living with psychiatric conditions face an *existential* endeavour, for they confront the delicate matter of distinguishing between aspects which are felt as fundamentally belonging to their authentic self, and those that are perceived as foreign. Sadler referred to this phenomenon as *self-illness ambiguity* (2007).

As a 'phenomenology of authenticity' is still in its early stages, in what follows I direct my attention on individuals experiencing anorexia nervosa, as reported by Hope et al. (2011). This focus serves as an analogy supporting my main argument, centred around delusions.

Importantly, the authors refrained from imposing any specific conceptual framework regarding authenticity. One major finding was that anorexia nervosa constitutes a genuine struggle and no individual reflecting on their experiences expressed 'satisfaction' with it. While it may seem trivial, it is in fact noteworthy to explore the connection between rejecting the 'eating disorder' and resisting efforts to overcome it. One participant's report exemplifies this dilemma:

> "[…] I had nothing in my life but the eating disorder, I didn't know whether I wanted to get rid of it, even though if I didn't get rid of it then I would have died." (Participant 12)

For these participants, a conflict lies at the heart of their concerns regarding authenticity – persisting with starvation could lead to death, yet eating and gaining weight feels like dying. Dealing with anorexia nervosa thus becomes deeply entrenched with the participants' feelings, thoughts, perception and behaviour, as is the case with every psychiatric condition. Ultimately, these conditions pertain to *persons*, as they affect one's experience in its totality. As a consequence, one may ask, what does my psychiatric condition say about me?

> "Quite often, people with anorexia, they don't say,"I have anorexia," they say, "I am anorexic." […] it becomes who you are, it defines who you are, as opposed to just an illness that you have." (Participant 17)

Several participants reported experiencing an internal division, as if there were two parts to the self, two voices within their mind. Some felt that one of these bits was authentic, representing the real self, while the other was deemed inauthentic.

> "It feels like there's two of you inside – like there's another half of you, which is my anorexia, and then there's the real K [own name] […] I truly believe that, that if there wasn't any me left, if there was none of me inside of me, then I would have let it kill me by now." (Participant 36)

As Sadler (2007) would contend, the blending of identities is always partial, with a core "me" persisting, as evidenced in cases where the true self served as a necessary condition for surviving, for remaining alive. Indeed, experiencing a portion of

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oneself as ego-dystonic, or inauthentic, is yet a different experience from feeling that one's very being is disordered.

What were the participants engaged in, in order to distinguish their most authentic characteristics from their inauthentic aspects? What were they pursuing when confronted with the endeavour of forcing themselves to externalise their condition, and to convince themselves it was not a part of them, albeit feeling otherwise? Ultimately, what were the participants committed to, when they contended that they did not *have* an illness, but rather they *were* and *had become* anorexic persons? At varying degrees of awareness, they were pursuing authenticity. When faced with existential ambiguity, the person takes a stance on their condition and their place in the world.

2.2 For an agential view of delusionality

According to Fuchs (2012), our ability to relate to ourselves and our situation, that is, our *stance-taking* capacity, forms the very prerequisite for the emergence of psychiatric conditions. Our nature as self-conscious, meaning-making organisms, aware of the passing of time and the reality of death, capable of making moral judgements and being evaluated by other beings like us, implies an *existential vulnerability* (Haan, 2020). In what follows, I argue that, despite being a precondition for our psychiatric vulnerability, our capacity to take a stance is what enables us to relate to and even (partly) shape the manifestation and course of our condition. This capacity is, fundamentally, an expression of agency.

As argued above, psychiatric conditions open up questions of profound ambiguity - "If I experience X, is it because of the illness, the medication, or is it 'just me'?" (Karp, 2006); "To what extent does the disorder define who I am?" (Haan, 2020). It is precisely due to this condition of ambiguity that the individual is called upon to take a stance and relate to their experiences in a certain way, that is, *their* way.

Indeed, as de Haan (2020) shows, the person grappling with psychiatric conditions may (at least in certain phases) assume an active stance with the potential to modulate 1) their conceptualisation of the condition and its diagnosis. Some may interpret it as an alien entity, while others may construe it as an integral facet of their most authentic being; 2) their approach to treatment, as patients may scrutinise the implications of pharmacological interventions on their sense of self; 3) their relation to the cultural background and their significant others, as these factors shape perceptions and responses to the condition; 4) their contemplation of suicide, which emerges amidst seemingly uncontrollable factors, and appears as a locus of control.

She refers to these ways of relating to one's condition as *existential stance* (2020), a notion which resembles Jaspers' concept of the 'patient's attitude toward his illness' (Stanghellini et al., 2013) and Husserl's notion of *Stellungnahme*, 'position-taking' (Stanghellini et al., 2023). However, a fundamental distinction emerges be-

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tween these accounts. While de Haan conceives psychiatric 'disorders' as capable of massively affecting the patients' agency, Stanghellini harnesses the Husserlian notion of 'position-taking' to illustrate how the reverse can also hold true: the person's ability to take a stance affects the unfolding of her symptoms and shapes (at least partially) the expression and trajectory of her condition. In other words, Stanghellini maintains that personhood and agency are reciprocally intertwined.

One may argue that this line of reasoning cannot be applied to delusionality – individuals experiencing psychotic episodes may not retain the same ability to adopt a stance. This raises a question which once again concerns ambiguity: how do subjects perceive themselves, as "disordered selves" or as "person with schizophrenia"? (Stanghellini & Rosfort, 2015). Emphasising the *passive* role of individuals as recipients of their condition, de Haan suggests that in cases of full delusions, the perspective that would allow individuals to maintain their grip on reality, the "as if" perspective (Fuchs, 2017), is lost. In such instances, de Haan contends, "the disorder has confiscated their existential stance, so to speak" (2020, p. 131). However, this perspective offers only a partial understanding.

I contend that the scenario I have outlined, wherein individuals struggle to pursue authenticity in the midst of ambiguity, can be extended to Bortolotti's analysis of delusionality. Indeed, Bortolotti's examination of *identity beliefs* suggests that contending with delusions entails confronting our deepest conceptions of ourselves and the world. She argues that delusions and one's sense of self are deeply intertwined: on one hand, identity contributes to delusions, as their formation and maintenance are influenced by our self-conceptions and group affiliations; on the other hand, once adopted, delusions contribute to our identity, integrating with other beliefs and influencing our emotional and behavioural responses. Thus, delusions act as personal identity beliefs, shaping one's self-definition. Consequently, ambiguity issues may arise in this context as well.

The issue at stake in the authenticity debate can be framed as follows: how do I relate to my symptoms and how do my symptoms relate to me? (Haan, 2023). I propose that there are multiple ways in which this aspect of *self-relatedness* can unfold (Glas, 2023). Exploring such dimensions can illuminate the various ways agency manifests itself. In reviewing these ways, we will see that the story is much more complex than this uni-directional influence from symptom to agency or from agency to symptom. Let us distinguish between three distinct levels[3]. First, symptoms may be conceived as being intentionally produced by the person. Second, symptoms arise independently of the person's volition. Sometimes, they are experienced as unwanted and devoid of meaning, and annihilates the person's agency. However, there are instances where symptoms may be perceived as purposive and the person experiences a sense of agency emerging as a result of them. This level still centres on symptoms' inherent intentionality. Third, while it may still be the case that the symptom is not intentionally produced, in the sense that they seem to happen to the individual - whether unwanted or with a purposiveness that is not

[3] I would like to thank an anonymous reviewer for their helpful suggestion.

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explicitly endorsed by the person, the symptom is nonetheless actively engaged with from the person's perspective (Glas, 2023). This stance-taking engenders a different form of agency: individuals position themselves in relation to their distressing experiences, which they may or may not have any control over, imprinting their own intentionality, hence shaping their condition.

By endorsing a function-centred perspective, Bortolotti emphasises the second level described; the person's symptom appears to be designed to help. Such a perspective is indubitably capable of retrieving meaningfulness and conferring purpose to the person's life. However, cases such as the one of S.T. shows us that, when the symptom overrides the ability to choose between strategies, it sharply constrains the agency of the person involved. Purposefulness and harm can coexist (Ritunnano et al., 2022) and yet the individual does not 'have a say' as to the symptoms' (often extremely distressing) inscrutable plan.

Let us consider the story of Harry, as reported by Ritunnano et al. (2022). This case may illuminate the distinction between the three levels proposed above and highlight the importance of the third one.

> "Mr Harry is a 33-year-old gentleman who has been complaining of being the target of a worldwide conspiracy for the past 5 years. He explains that one day, he was in his room and he was picking his nose. The cameras in his room recorded it and this was uploaded to the internet; now everyone in the world, especially those in the USA, are talking about it. […]. When asked further about the challenges of conducting a life under the control of others, Harry replied: 'If I went out one day and I realised that people weren't expecting me to be there, it would be a real shock again […] If I found out that they are not watching me and reading my mind, I would feel alone and crazy like everyone else. To feel like I have everyone following me around, whether it's negative or positive, that alone is a force of power […] knowing that you can influence people's minds in the right way, I feel like Jesus (of course I'm not) but why not believe?' " (2022, p. 110 abridged).

As to the first level, Harry does not seem to intentionally produce his system of delusional beliefs. Instead, one can appreciate how his first delusion seems to meaningfully arise from an everyday moment where he might have felt watched or experienced shame. In this context, the delusion not only has a meaning, but also gives meaning (Ritunnano & Bortolotti, 2022). The second level appears to describe how symptoms exert control over the person. However, precisely because of the role that the delusions perform in Harry's life – expressing a sense of connection with others – he might experience some sense of agency. And yet, the strategy implied by the delusion is not Harry's strategy. The third level takes into consideration how the person relates to her symptoms in the first place, engendering a distinct form of agency. Harry's insight on his condition is noteworthy; he *feels* like Jesus, and

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though he admits he's not, he asks himself: why not believe? Harry could have related to his delusional system in a variety of ways. For instance, Stanghellini and colleagues (2023) provide a case series of these numerous "attempts at healing" (p. 11) – feelings of centrality to compensate one's sense of isolation, or identification with an external organism to compensate one's loss of vitality, to name just a few. Ultimately, Harry relates to his experiences in a certain way, that is, *his* way.

2.3 "Never take away anything, if you have nothing better to offer"

In conclusion, I explore why one cannot 'just' get rid of a delusion and why, when one attempts to, it feels urgent to replace it.

According to the medical model, if a condition is perceived as disordered, it logically follows that efforts should be made to eradicate it. I contend that attending to the challenges surrounding ambiguity and authenticity has the potential to revise the objective of therapeutic interventions – eliminating one's own psychiatric condition may not always be desirable. The task of psychotherapy thus evolves beyond symptom eradication to assisting the patient in their own endeavour: to disentangle, to *disambiguate*, to pursue authenticity in the midst of ambiguity.

However, the patient must possess adequate resources to actually tolerate the debilitating stress associated with such transformation. Surrendering adaptation strategies that have accompanied someone for an entire existence may feel like a groundless experience. Two reports from the anorexia study exemplify this struggle (Hope et al., 2011). One participant expressed:

> "I don't think it [anorexia nervosa] does feel alien. I think it is part, it feels like it's part of me, but I like to now believe that it's not part of me […] but then at the same time I can see that I don't want it to be part of me and the only way to get rid of it is to really hate it […]" (Participant 38)

Anorexia did not feel alien to her, and because of this familiarity, she wanted to hold on to it. The only way to get rid of it, she asserts, would be to hate it. Another participant was confronted with the following question: if given the opportunity to eradicate it, would you choose to do so? She echoed a similar torment and asked herself: "Who would I be if I didn't, if I wasn't that?" (Hope et al., 2011). Despite the suffering involved, anorexia became to her a comforting, familiar space she was hesitant to let go.

Bortolotti has captured a pivotal aspect of delusions: their inherent unshakeability, despite their implausibility, stems from their contribution to our sense of self. While they may not support our epistemic need of representing the world around us, they do fulfil psychological needs, such as the desire for uniqueness, connection to a bigger entity, and control over reality. The same underlying factor that prevents one from 'just' getting rid of a delusion is also the reason why

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one cannot easily rid oneself of anorexia nervosa – a tight intertwining with one's identity may at times make it hard to discern self and illness. When identity beliefs and delusionality converge, experiences of profound ambiguity may emerge. Thus, "changing them requires changing ourselves" and "giving them up requires something akin to a conversion" (Bortolotti, 2023, p. 83). In essence, if certain aspects become integral components of our identity, and relinquishing them would entail losing a part of ourselves, then letting go of these aspects may require renouncing a part of ourselves.

In the words of Yalom: "Never take away anything, if you have nothing better to offer" (Yalom, 1989, p. 154).

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