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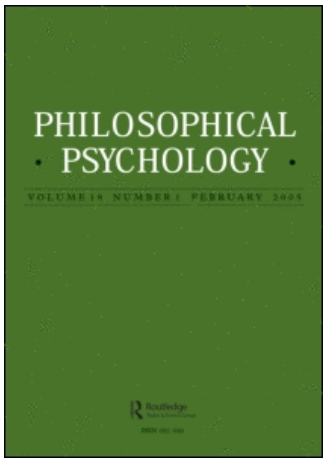

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Self-concept through the diagnostic looking glass: Narratives and mental disorder

Şerife Tekin

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This paper explores how the diagnosis of mental disorder may affect the diagnosed subject's self-concept by supplying an account that emphasizes the influence of autobiographical and social narratives on self-understanding. It focuses primarily on the diagnoses made according to the criteria provided by the Diagnostic Statistical Manual of Mental Disorders (DSM), and suggests that the DSM diagnosis may function as a source of narrative that affects the subject's self-concept. Engaging in this analysis by appealing to autobiographies and memoirs written by people diagnosed with mental disorder, the paper concludes that a DSM diagnosis is a double-edged sword for self-concept. On the one hand, it sets the subject's experience in an established classificatory system which can facilitate self-understanding by providing insight into the subject's condition and guiding her personal growth, as well as treatment and recovery. In this sense, the DSM diagnosis may have positive repercussions on self-development. On the other hand, however, given the DSM's symptom-based approach and its adoption of the Biomedical Disease model, a diagnosis may force the subject to make sense of her condition divorced from other elements in her life that may be affecting her mental-health. It may lead her to frame her experience only as an irreversible imbalance. This form of self-understanding may set limits on the subject's hopes of recovery and may create impediments to her flourishing.

Keywords: Diagnostic Statistical Manual of Mental Disorders (DSM); Looping Effects; Mental Disorder; Narrative; Psychiatry; Self-Concept

1. Introduction

The second half of the twentieth century witnessed a change in the way philosophical problems of selfhood were posed. Until then, the self was often conceived as an independently existing metaphysical entity waiting to be discovered through

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self-knowledge and self-understanding (Locke, 1690/1968; Parfit, 1984; Wiggins, 1967). However, new trends in cognitive science, developmental psychology and neuroscience, not to mention theories of postmodernism, influenced the concept of self. Now, philosophers dwell on what *constitutes* the self, i.e., the social and cultural factors that contribute to one's traits and comprise their identity. Narrative approaches to self are a subset of this ongoing development (e.g., Bruner, 1990; Dennett, 1989; Flanagan, 1994; Hutto, 2007; Schechtman, 1997; Taylor, 1989). These views' assertions concerning the definition of narratives and their contribution to self-understanding and self-constitution are diverse; however, in all of them, it is indicated that narratives are implicated in—if not necessary for—the subjects' self-concept.

This period also witnessed an increase in the number of first-person narratives written by psychiatric patients and a heightened focus on the patients' perspectives (e.g., Sadler, 2005; Stanghellini, 2004).[1] To cite one example, Erving Goffman's motivation in writing his *Asylums* (1961) was to understand the social world of the mental hospital inmate—her world as she experiences it. Instead of employing common measurements such as statistical evidence, Goffman sought out ''the tissue and fabric of patient life'' (1961, p. x) by observing patients' daily lives in the hospital. He excused the statistical limitations of his investigation by indicating that he was portraying patients' situations ''faithfully,'' in a bid to rectify the imbalance in the professional literature, which, at that time, tended to voice primarily the views of mental health professionals.

In this paper, I bring together these developments on the phenomena of self and mental disorder. I argue that the diagnosis of mental disorder, based on the criteria established by the Diagnostic Statistical Manual of Mental Disorders (DSM), acts as a *source of narrative*, affecting the diagnosed subjects' self-conceptions and possibilities for self-development. I then contend that the ethical implications of the diagnosis in the process of self-development are twofold. On the one hand, a DSM diagnosis may have positive ramifications on the subject's self-concept, since it appropriates the subject's experience in an established classificatory system, thus facilitating her self-understanding by shedding light on her experience with the mental disorder.

On the other hand, given the DSM's symptom-based approach to mental disorders, whose classifications list a set of symptoms corresponding to an ''ideal'' of a certain mental disorder, and its adoption of the Biomedical Disease Model, which approaches mental disorder as a type of medical disease—explicable, predictable, and treatable using the biological methods of somatic illness—a narrative driven by a DSM diagnosis may lead the subject to treat her disorderly psychological states or behaviors as the prototype of an illness beyond her control. These characteristics of the DSM may prevent the diagnosed subject from assessing mental distress as an outcome of multiple factors that involve not only her subpersonal physiological processes but also various factors that influence her well-being in the world, such as her socio-economic status, relationships, self-care habits. Such narrative may prevent the subject from developing adaptive cognitive, affective, and social responses to her condition.

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These repercussions, by altering the diagnosed subject's interpretation of the events in her life, as well as her assessment of her feelings, desires, beliefs, values, behaviors, and goals, may transform her sense of self. Considering her 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. Further, assuming her psychological states as beyond her control may disrupt her sense of autonomy and responsibility. Such self-understanding may set limits on the development of moral character, as well as on goals and hopes for the future—thus posing obstacles to recovery.

This is not to say that mental disorders do not have an underlying neurobiological structure or that their symptoms are insignificant; indeed, understanding their neurobiological component and the symptoms they elicit are integral to understanding mental disorders. The criticism targets their non-comprehensive approach to mental disorder; it is necessary to acknowledge the complexity of a phenomenon involving not only biological parameters but also cultural, social, and environmental factors that may escape a purely neurobiological analysis. Further, there are significant problems in the way psychiatric knowledge is disseminated. Although there are missing links in the explanation of mental disorders, while psychiatric knowledge evolves, this is usually not communicated to the patients. Rather, they are often led to believe that their condition is both chronic and static. I do *not* make a conclusive argument about *how* the DSM diagnosis influences the subject's self-concept. However, I illuminate certain limitations of the DSM by appealing to the narratives of the subjects diagnosed with mental disorder, which are indispensable to an investigation of the effect of DSM diagnosis on the subjects' self-conceptions. This exploratory work may aid scholars in addressing particular problems associated with the DSM.

I first develop an account that describes the role narratives play in self-understanding by briefly reviewing the narrative approaches to the self and expanding on Flanagan's account. Next, I employ Ian Hacking's concept of ''looping effects,'' to show how the DSM may be perceived as a source of narrative that contributes to the diagnosed subjects' self-concept. Hacking, with the concept of ''looping effects,'' tells us an ontological story about how the classifications made by professionals guide the individuals so classified and how this influence feeds back into a change in the classifications themselves; whereas I use it in support of my claim that self-conception is epistemically sensitive to how it is narrated. I use the parameters that account for the ''looping effects'' to illustrate how a DSM diagnosis may be altering the subject's self-concept. Then, using the autobiographies of the patients, I consider whether two of the inherent problems of the DSM, i.e., its adoption of the Biomedical Disease Model of mental disorder and its symptom-based approach to mental disorder, may be seen as impediments to self-understanding and moral development. It is important to note that my goal is neither to deny the experience of mental disorders, argue that they are not ''real,'' nor to resort to an anti-psychiatry standpoint. I am interested in exploring how receiving a DSM

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diagnosis affects the possibilities for self-growth, by addressing the importance of narratives in self-understanding and furnishing a self-concept.

2. Narratives and the Self

In the current literature, we see two different approaches to the role narratives play in our lives. One suggests that narratives enable us to exercise our imagination in unique ways. According to this weaker claim, the narrative activity helps us to understand reasons for actions and to understand ourselves and others (e.g., Currie, 2007; Gallagher, 2000, 2007; Hutto, 2007). The second, stronger claim suggests that narratives constitute the core of self-constitution, and that human species might appropriately be named *Homo narrans*, rather than *Homo sapiens* (e.g., Dennett, 1989, 1991; Flanagan, 1994; McAdams, 1993; MacIntyre, 1981; Schechtman, 1997).

In considering the diagnosis of mental disorder as a form of narrative, I find myself closer to the first approach. I believe that narratives play a crucial role in understanding ourselves and others, as well as establishing a self-concept. I avoid making excessive claims about the influence of narratives on the self by acknowledging that narratives are *not* the only players in self-understanding and self-constitution; there are other dimensions of human experience not mediated through language, but which are essential to self-constitution.[2] In my analysis, I spell out how the narratives may contribute to a subject's self-concept and exert an influence on the possibilities for self-development. In order to accomplish this task, I make use of Flanagan's account—without commitment to his stronger claims—as it develops a framework for us to understand how narratives may be affecting the self.[3] Taking his arguments one step further, I point out the ethical implications of the narratives' influence on self-understanding, thereby setting the stage for my discussion about the role the DSM diagnoses play in the subject's self-concept.

Initially, it is important to explain how I use the concept of ''narrative.'' I follow Hutto's account, according to which, narratives are ''complex representations that relate and describe the course of some unique series of events, however humble, in a coherent but selective arrangement'' (Hutto, 2007, p. 1).[4] According to this definition, narratives can be viewed as sense-making tools. They help describe and organize thoughts and deeds, aiding the appropriation of experiences in a context, thus enabling the person to make sense of the series of events in her life.

According to Flanagan (1994, p.135), ''personal identity is grounded on'' *narrative connectedness from the first point perspective*, i.e., in order to be construed as having a personal identity, the subject must be able to ''to tell a coherent story'' (Flanagan, 1994, p. 136) about her life. In this strong view, narrative accounts of a self-experience, delivered through autobiographical narratives and the narratives provided by society contribute to self-knowledge and comprise personal identity, because they help the subject make sense of her actions, behaviors, psychological states, emotions, and other self-experiences in the world. For Flanagan, autobiographical narrative—the subject's active engagement in self-representation—links

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personal memories to current conditions and future expectations; affording continuity and coherence to her experiences. Social narratives such as those provided by the subject's parents actively shape the character from early childhood on: ''the construction and maintenance of the self involves many players'' (Flanagan, 1994, p. 141). In this sense, the self is ''multiply authored'':

> We modify and adjust our self-conception unconsciously and effortlessly in response to social feedback, as well as consciously, with effort, and with mixed success in response to our judgment of fit between who we are and who we aspire to be. (Flanagan, 1994, p. 141)

Thus, in Flanagan's view, self-understanding and self-constitution (whether conscious or unconscious) occur in a complex interplay between one's autobiographical narrative and the social narrative provided by society. Social feedback leads to an alteration in the subject's self-perception, allowing the subject to discover and create the meaning of her beliefs, desires, emotions, goals, and hopes in the broader social framework.

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3. Narratives and Self-Concept: Ethical Implications

Flanagan does not elaborate on *how* the subject develops a self-concept in response to the various narratives, on account of which I will draw a rough sketch. 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.[5] Such a response shapes the subject's autobiographical narrative as it influences her reassessment of her psychological states, activities, actions, temper, behavior, character traits, etc. If the social narrative is dominant and compelling, if it is coherent, consistent and comes from an individual or a group of individuals considered authority by the person, she may accept the narrative—sometimes with little critical reflection—and integrate it into her autobiographical narrative. Alternatively, she may reject the social narrative and shape her autobiographical narrative independently, or create a counter-narrative to it.

Metaphysical, epistemic, and ethical issues are at work here, as the process is complex: the (autobiographical and social) narratives may not always reflect the *truth* about the subject's experience; yet they may influence her self-understanding. Therefore, there are ethical implications of, say, feeding the subject ''false'' narratives. In that regard, it is possible to talk about ''harmful'' narratives and to define what constitutes ''good'' narratives. Despite its emphasis on the necessity of narratives in the constitution of a normatively acceptable self, Flanagan's view does not touch upon these questions.[6] For my purposes in this paper, I offer an account of the self that focuses on how narratives influence the self-concept and the ethical implications of such influence on self-development.

Autobiographical and social narratives affect the subject's self-perception, independent of their epistemic and ethical status. They may not always be true to the

psychological and historical facts of the subject's life as it is experienced by her and witnessed by others; they may be logically inconsistent, restrictive, self-deprecating, and set limits on hopes, desires and plans for the future. The subject may accept these narratives or reject them to create a counter-narrative. Yet, each may be used as a tool for self-understanding, and hence, for self-concept.

What renders this view philosophically interesting is the ethical implications associated with it. If the narratives aid self-understanding, modify the person's psychological states, moral concerns, choices, decisions, goals, and plans for the future, thus facilitating the development of self-concept, then the kind of narrative accounting for the person's experience does matter. My concomitant ethical argument emphasizes the importance of ''good'' narratives in the furnishing of self-concept. Here, I evaluate the ''good''ness of a narrative in terms of its influence on the person's moral development. ''Good'' narratives positively contribute to the subject's moral development; they are *at least* (1) responsive to the historical and psychological facts of the subject's life that are observable and verifiable; (2) comprehensive in their interpretation of the historical and psychological facts of the subject's life; and (3) resourceful in offering insight into the subject's experiences. Narratives fulfilling these criteria help the subject achieve a realistic understanding of her psychological states, temperament, actions and decisions, help her evaluate her strengths and weaknesses in interpersonal relationships, assess her talents and abilities with respect to what she wants to accomplish, and develop appropriate responses to her limitations. Otherwise, a narrative would be ''restrictive'' in the form of limiting the range of responses a subject may generate with regards to her experiences. While the criteria identified here for ''good'' narrative are neither exhaustive nor complete, they provide a framework within which we can discuss the ways a narrative may positively guide personal development. The following example may help situate these remarks.

Imagine we have a high school student, Peter. Peter is introverted and spends a great deal of time alone. In classes, he is quiet and does not participate in discussions unless solicited. He has low grades in classes that call for strong communication and verbal expression skills, such as literature. Unfortunately, since both of his parents are drama teachers, they define success in terms of good communication skills and high grades in literature. Consequently, they repeatedly state that Peter is a failure—he cannot comment on a story he read in class and he will never succeed at anything. In conversations with others, they note that Peter is anti-social at school; he never gets invited to birthday parties, etc., alluding to his lack of communication skills. Yet Peter has excellent mathematical skills: he has high grades and solves complex geometry problems quickly. But his parents ignore his analytic thinking skills and provide him a narrative focused on his so-called shortcomings.

The narrative provided by Peter's parents about his success (or failure) may define Peter's interpretation of his actions in class, his relation to other students, his performance and personality traits, thus contributing to his self-understanding. In spite of the positive narrative provided by his math teacher pertaining to his

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success in math, he may acknowledge his parents' narrative rather than his math teacher's, due to their authoritative presence in his life.

In the light of the definition provided above, the narrative supplied by Peter's parents is *not* a ''good'' one: (1) the narrative is non-responsive to historical and psychological facts about Peter's experience that are observable and verifiable (e.g., his strength in math is not considered a measure of his accomplishments); (2) it is non-comprehensive in that it does not allow for various ways of evaluating Peter's success (e.g., it focuses on Peter's lack of social skills in evaluating his success as opposed to focusing on a wider range of his talents); and (3) it is not a resourceful narrative, because it does not offer Peter insight into the reasons for his shyness and lack of communication skills. These characteristics of the narrative constrain his choices for self-improvement. In a ''good'' narrative, Peter's shyness may have been plotted in broader context; it may have been explained, say, as an indication of his dissatisfaction with his social environment due to a lack of friends with whom he shared similar interests, such as mathematics. Such a narrative would have been resourceful, encouraging Peter to seek social activities that he enjoyed and overcome his shyness.

Notwithstanding these limitations, Peter *responds* to this narrative in a myriad of ways as he creates his personal narrative and forms his self-concept. At one extreme, Peter may accept his parents' narrative without critical reflection and believe that he is a failure. This uncritical acceptance may occur partly because the narrative is a strong one; after all, it comes from his parents. At the other end of the spectrum, Peter, in order to prove his parents wrong, may reject their narrative. He may work on improving his communication skills and overcoming his shyness by observing his friends with refined social skills and pushing himself to act like them. Thereby, he may improve his communication skills and become a participating adult. In either scenario, the outcome elucidates the main argument: regardless of how true the narrative is to reality, it affects the subject's self-concept. Narrative influence has ethical implications.

The ethical dimension of the effect of narratives locates their influence on self-concept in a context of moral relevance; whether the narrative is ''good'' does matter to us as narratives play a role in identity constitution. In the light of the example, let me summarize the characteristics of a good narrative: (1) the responsiveness of the narratives to the historical and psychological facts of the subject's life ensures that the interpretation of the subject's experience is grounded on the facts; rather than being, say, a mere product of wishful thinking, or deprecatory attitude of the creator of the narrative; (2) a comprehensive interpretation of the subject's experiences may help her attain a clear-sighted self-knowledge by evaluating the different dimensions of her experience and build responsive relationships with others by encouraging her to develop a sense of responsibility;[7] and (3) if narratives are resourceful in offering an insight into the subject's experiences, they may open avenues enabling the subject to lead an autonomous, responsible, and fulfilling life. In other words, a good narrative, by offering a meaningful understanding of the subject's experiences, allows her to develop a variety of responses to the historical and psychological facts of her life,

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thereby contributing to self-development, maintenance of mental health, well-being, and success in interpersonal relationships.

Despite their prominence, narrative approaches to self are not without critics; Galen Strawson is one of them. Strawson distinguishes the descriptive narrativity thesis—individuals *do* live their lives in narrative form—from the ethical narrativity thesis—individuals *should* live their lives in narrative form. He argues against both (Strawson, 2004).[8] His criticisms are outside the concerns addressed in this paper, since the view I defend neither proposes that individuals live their lives in narrative form, nor that they should. Rather, I argue that narratives are instrumental in the formation of self-concept.

4. DSM Diagnosis as a Narrative Source

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The DSM lists the diagnostic criteria for mental disorders and is used by clinicians, researchers, health insurance companies, psychiatric drug regulation agencies, pharmaceutical companies, and policy makers. It functions not only as a tool for clinicians to determine and communicate a patient's diagnosis and develop a suitable method of treatment, but also as a guide for clients to make sense of their mental discomfort. Further, some insurance companies, particularly in North America, require a DSM diagnosis in order to provide insurance for expenses incurred during treatment. The DSM is also used in mental health research and clinical trials. In this work I address another crucial role that the DSM plays, when considered from the perspective of the diagnosed subject experiencing psychological distress and seeking relief to her condition. The DSM diagnosis affects the subject's self-understanding by validating her experiences at a personal and social level.

I emphasize the function of the DSM as a narrative source, by relating the influence of DSM diagnoses on self-concept to the ethical implications of the narratives' influence on self-understanding. In this probe, I appeal to memoirs written by patients in order to exemplify how the DSM diagnoses function as a source of narrative affecting the subject's sense of self. It is important to note that reference to memoirs is not an attempt to provide conclusive data on the effect of DSM diagnoses on self-concept. Neither do I claim that the DSM diagnoses influence each diagnosed subject similarly. Rather, my goal is to explore how psychiatric diagnoses may change the subject's self-concept. I exemplify these claims by using patients' own writings.[9]

I claim that the DSM diagnoses function as a source of narrative, which contributes to the subject's self-understanding. Consistent with the framework for narratives constructed in section 2, a DSM diagnosis systematizes the subject's experience with mental distress, offering a conceptual schema within which an explanation for her otherwise puzzling feelings, moods, temper, behavior, and thoughts can be found; contributing to her knowledge about her psychological states. The diagnosis presents guidelines for the subject's understanding of her mental distress and influences her autobiographical and social narrative.

The DSM diagnosis may alter an autobiographical narrative in various ways. For example, upon being diagnosed with Major Depressive Disorder (APA, 1994, p. 327), the subject may redefine her past experiences based on the descriptive framework established by the diagnostic schema, reassess the psychological and historical facts of her life in light of the theory underlying her diagnosis, start to reevaluate certain events of her past as earlier symptoms of her mental disorder, and so on. After being diagnosed, she may make better sense of, say, her increasing sadness, significant weight loss, insomnia, and suicidal thoughts exacerbated by feelings of hopelessness and despair in her early adulthood. This understanding may lead her to reassess her failure in her first job as an outcome of mental disorder, instead of, say, incompetence. The alteration in the subject's autobiographical narrative may generate changes in her future plans, hopes, desires, anticipations, expectations, habits, as well as her relationships with others. She may, for instance, blame a failed relationship on her depression.

Consider the effect of being diagnosed with Major Depressive Disorder on autobiographical narrative in the following passage from Daphne Merkin's ''A journey through darkness'':

> I do know that by the age of 5 or 6, in my corduroy overalls, racing around in Keds, I had begun to be apprehensive about what lay in wait for me. I felt that events had not conspired in my favor, for many reasons, including the fact that in my family there were too many children and too little attention to go around. What attention there was came mostly from an abusive nanny who scared me into total compliance and a mercurial mother whose interest was often unkindly. By age 8, I was wholly unwilling to attend school, out of some combination of fear and separation anxiety. (It seems to me now, many years later, that I was expressing early on a chronic depressive's wish to stay home, on the inside, instead of taking on the outside, loomingly hostile world in the form of classmates and teachers.) By 10 I had been hospitalized because I cried all the time, although I don't know if the word ''depression'' was ever actually used. (Merkin, 2009)

The diagnosis of Major Depressive Disorder helps Merkin make sense of the mental distress of her early childhood. It serves to reevaluate what happened then and functions as a form of explanation in her autobiographical narrative. The diagnosis of depression makes her experiences palpable and understandable.

The DSM diagnosis also affects social narratives surrounding the subject, allowing others around her to reconceptualize her actions, behaviors, temper, and personality traits in the explanatory paradigm offered by the diagnosis. A good illustration of this point, which also signifies the ethical implications of DSM diagnoses, can be found in Ruth White's narrative about her diagnoses. In 2003 she receives a diagnosis of Attention Deficit and Hyperactivity Disorder (ADHD), then, one year later, following a breakdown, she receives a Bipolar Disorder diagnosis. In the section where she discusses how the change in the diagnosis affected her, she tells us about her friend's interpretation of the change in the diagnosis she received:

> It was too difficult, too, for many of those same friends . . . to accept this new diagnosis. They questioned whether I was not simply stressed out from the many

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> changes that had been going on in my life: a new job, a new city, my partner's move, and my new single-motherhood status. Ironically some of my friends thought that I was just being overmedicalized and overmedicated. That angered me . . . . For my friends to think that I was basically being emotionally lazy hurt me deeply. I knew that if I had called to say that I had cancer, the response would have been significantly different. I would have received empathy instead of being challenged on the validity of my diagnosis. (White, 2008, p. 49)

White's points are telling. The change in her diagnosis makes her friends question the perceived reality of her experience of the mental disorder. We learn from the rest of her narrative that this affects how White perceives her puzzled psychological states, her coping, as well as her friendships, and her professional performance. Taken together, these influences on the subject's autobiographical narrative and social narratives affect the various dimensions of the subject's life, eventually affecting her self-perception (or misperception).

An important question surfaces here. If the DSM is primarily a list of the descriptions of psychiatric diagnoses that guide clinicians and patients in treatment, how does its influence rise above the treatment of the subject's condition? The answer lies in the way the diagnostic knowledge is disseminated and perceived. I use Hacking's concept of ''looping effects'' in order to explain how the dissemination of psychiatric knowledge extends the leverage of DSM diagnosis from being a tool for treatment to altering the subject's self-concept by influencing her autobiographical and social narratives (Hacking, 1986, 1996, 2007a, 2007b).[10]

5. The Looping Effects of the DSM Diagnoses

Hacking's concept of ''looping effects'' accounts for the dynamics of the interaction that takes place between certain classifications made by human sciences and individuals grouped under these classifications. Human sciences study phenomena that bear direct and significant relevance to certain individuals and their quality of life. As an outcome of various forms of scientific scrutiny, individuals are sorted amidst a broader social context. These classifications expound patterns of human conduct to enable meaningful interpretations, predictions, and interventions. In Hacking's view, the act of classifying may affect the individuals classified, because they interact with their classification. In other words, the classification made by human sciences, affecting how individuals understand themselves and their personal concerns as well as how other people recognize these individuals, may transform their self-awareness, self-understanding, and how they come across to the society. Consequently, the changes individuals undergo upon being classified may alter the initial classifications made by human sciences (Hacking, 1996, 2007a).[11]

Hacking's most illustrative example is multiple personality. He draws our attention to how the symptoms people displayed upon being diagnosed with multiple personality disorder have changed over time, as the hypotheses about the condition leaked into popular knowledge with the combined effect of curious psychiatrists,

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TV show producers, alliances of patients, and so on. The changes in symptoms have, in turn, altered the classification of multiple personality (Hacking, 1996, 2007a).

In his most recent works, Hacking elaborates on a framework to explain how "looping" works.[12] The parameters in this schema include (1) *institutions*, (2) *knowledge*, (3) *experts*, (4) *classification*, and (5) *classified people*. The interaction between these elements leads to looping: the *experts* in human sciences, who work within certain *institutions* that guarantee their legitimacy, authenticity, and status as experts, become interested in studying the kinds of people under a given *classification*; possibly to help them or advise them on how to control their behavior. These experts generate *knowledge* about the kinds of people they study, judge the validity of this knowledge and use it in their practice, and create certain *classifications* or refine the existing ones. Such *knowledge* includes presumptions about the people studied, which are taught, disseminated, refined, and applied within the context of the *institutions*. For instance, it may entail de facto assumptions, e.g., multiple personality patients were subjected to sexual abuse as children. This *knowledge* is disseminated into society, leading many to hold certain beliefs about multiple personality (Hacking, 2007a, p. 297). The interaction between the five elements creates a looping effect, which in turn concerns the subject.

I plot the repercussions of the DSM diagnoses on the self-concept in a framework that elucidates "looping effects." Namely, I use the "looping" phenomenon to explore how the diagnoses of mental disorder function as a narrative source and affect the subject's autobiographical and social narratives. We have *people* subjected to *DSM classifications*, suffering from mental distress, seeking help. We have *experts* including researchers who create DSM classifications to define the symptoms of particular mental disorders; psychiatrists following DSM guidelines who diagnose people and provide treatment plans; scientists who undertake research to provide etiological explanations of the roots of mental disorders; social workers who aid patients' medication management. These *experts* work within the *institutions* that legitimize them, including American Psychiatric Association (APA), the community of American psychiatrists; National Institute for Mental Health (NIMH), the largest research organization in the world specializing in mental illness funded by the federal government of the United States; various pharmaceutical companies and insurance firms that recognize DSM diagnoses and provide coverage for treatment. *Experts* collectively generate *knowledge* about mental disorders, which contributes to the creation process of DSM classifications, clinical research experiments, and the development of treatment methods, such as drug therapy. This *knowledg*e is then disseminated through the publications promoted by these institutions, including information booklets, websites, books; the DSM manual itself; drug companies' advertisements for drugs, etc. *People* who receive a DSM diagnosis acquire *knowledge* about their condition through *experts*, including their psychiatrists and media publications. This acquired *knowledge* molds their self-perception and self-understanding, leading to changes in their autobiographical and social narratives. Thus, a *subject*, upon receiving a *diagnosis*, gains *knowledge* about her diagnosis produced by various *experts* who work in various *institutions* and thereby forms

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or transforms her self-concept. The interactions between these five paradigms shed light on how DSM diagnoses function as sources of autobiographical and social narratives.

In short, DSM diagnoses form what I call a *culture of psychiatric diagnosis* that affects self-understanding, the components of which include the DSM diagnostic criteria (*classification*), patients (*classified persons*), psychiatrists and researchers (*experts*), APA, NIMH, various psychiatric institutions, pharmaceutical companies and insurance firms that recognize DSM diagnoses and provide coverage to treatment (*institutions*), along with empirical research documented in field publications and breakthrough research that is not yet incorporated into official diagnostic systems but is available to popular media (knowledge). The components of the *diagnostic culture* together provide the narrative fodder, which affects the subject's self-concept by influencing the subject's autobiographical and social narratives, thereby altering and shaping the subject's self-perception as well as her possibilities.

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6. Ethical Concerns around the *DSM Culture*

This section addresses my worries about whether the *DSM diagnosis* functions as a "good" narrative, i.e., whether it is (1) responsive to the historical and psychological facts of the subject's life that are observable and verifiable; (2) comprehensive in its interpretation of the subject's experiences with mental distress; and (3) resourceful in offering insight into the subject's experience. I address these concerns by reviewing two main characteristics of the DSM and the criticisms they received. Ultimately I unfold the ethical implications of DSM-based narratives.

First, the DSM adopts the Biomedical Disease model of mental disorder, according to which, mental disorder is a biomedical disease like diabetes, which needs to be treated physiologically, like other illnesses in general medicine. Although the creators of the DSM are committed to attaining an etiological understanding of mental disorders, as in other illnesses, these ideals are not met in the current schema. In fact, this expectation is conceptually problematic as the concept of mental disorder lacks cogency and there is not a specific dysfunctional organ that may be associated with the mental distress the person is experiencing. In this sense, Biomedical Disease model is reductionist in its attempts to understand and respond to psychological suffering and disability in purely physiological terms.

Second, in the DSM's symptom-based model, the classifications reflect the "ideal" of a certain mental disorder, providing a list of symptoms that the subject may display. "Making a DSM diagnosis" entails selecting those disorders from the DSM manual that best reflect the signs and symptoms afflicting the subject evaluated. Thus, even if the actual experiences of the individuals do not entirely correspond to the ideals of mental disorders epitomized in these classifications, psychiatrists base their treatment plans on them.

Instead of repeating these criticisms, I explore how the DSM diagnoses, due to these two problems, may diminish the range of responses available to individuals that are subject to diagnosis. In the Biomedical Disease Model of mental disorder,

psychiatry is perceived as a branch of medicine, alongside specialties like Infectious Diseases. While the diagnoses in these branches of medicine are based on the etiology of the diseases, the DSM diagnoses of mental disorder are based on outwardly observable symptoms—behavioral traits, peculiar affects or desires, patterns of thought, so forth. Researchers in the field, however, hope that it will be eventually possible to identify the causes of the malfunctioning of particular organs which give rise to symptoms of mental disorder and base diagnosis on causes rather than symptoms.

Despite the lack of etiological information about mental disorders, the assumption that they are purely physiological leads many psychiatrists to resort to prescription of medication. Further, this knowledge, despite being subject to ongoing scientific research, is disseminated as fact. To give one example, on the NIMH website, depression is described as ''a serious medical illness.'' Psychiatrists often use analogies between medical diseases and mental disorders when communicating with their patients. Consider the following:

> I was originally reluctant to try pills for something that seemed so intrinsic to who I was—the state of mind in which I lived, so to speak—until one of my first psychiatrists compared my emotional state to an ulcer. ''You can't speak to an ulcer,'' he said. ''You can't reason with it. First you cure the ulcer, then you go on to talk about the way you feel.'' (Merkin, 2009)

The analogy Merkin's doctor employs is problematic; there are significant differences between the disease diagnoses and mental disorder diagnoses that remain unacknowledged by the followers of the Biomedical Model. For instance, when a patient sees an Infectious Diseases specialist with complaints of chest pain, fever, chills, fatigue, and weight loss, the specialist may suspect tuberculosis. To confirm this hypothesis, the doctor may run blood tests and identify in the body *Mycobacterium tuberculosis*, the organism known to cause tuberculosis. The doctor may then prescribe antibiotics known to kill *Mycobacterium tuberculosis*. The process is different in mental disorder diagnosis in that the psychiatrist cannot conduct a test to identify the bacteria causing, say depression, or a body-scan to detect the malfunctioning of a particular organ. Psychiatrists upon consulting the DSM and seeing that the patient's symptoms fit the description of a certain mental disorder, offer a diagnosis. Even though the mental disorder diagnosis cannot be validated in the way tuberculosis can be, i.e., based on the results of a blood test, psychiatrists often accompany their diagnosis with a statement about the physiological causes of depression and how helpful physiological treatment methods can be. They may, for instance, prescribe a mood-altering drug to help with the symptoms.

I address three problems with the above characteristics of the DSM diagnosis and the culture of psychiatric diagnoses which render the DSM diagnosis incongruent with the first two characteristics of a good narrative: (1) The symptom-based approach to diagnosis abstracts mental disorder from the person with mental disorder; (2) the Biomedical Disease Model of mental disorder often considers that a unique cause or a determinate set of causes lead to a particular disorder, but the

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determining factors are complex and not readily measurable; and (3) even though many psychiatrists are aware that hypotheses about the etiological roots of mental disorders are unverified and that psychiatric knowledge is not as empirically justified as medical knowledge, they tend not to inform patients of this. These three problems make the DSM diagnosis function as a narrative that is (a) non-responsive to the historical and psychological facts of one's life that are observable and verifiable; and (b) non-comprehensive in its interpretation of individual's mental distress. Let me expand on them in turn.

(1) The symptom-based approach may render a DSM-based narrative non-responsive and non-comprehensive. It may be non-responsive to the historical and psychological facts of the subject's life due to its focus on the subject's symptoms, not on the subject as a person situated in a context of historical, environmental, social, and cultural factors. Further, a DSM-based narrative may offer a non-comprehensive account of the subject's mental distress by preventing both the subject and the psychiatrist from approaching mental distress as an outcome of multiple factors that involve not only the subject's subpersonal physiological processes but also her socio-economic status, relationships, circumstances, self-care habits, etc.

Consider this example: psychiatrists have developed the Structured Clinical Interview for DSM-IV (SCID), which is tied to the DSM-IV's catalogue of mental illnesses. The questions in the SCID are used to determine whether the person meets a particular diagnosis in the DSM. It includes questions such as ''did you have trouble concentrating?'' to determine whether his thinking and concentrating abilities have diminished. Reaching a diagnosis through a checklist of such questions may be misleading. For instance, extreme agitation and disturbed sleeping patterns, while included in the symptoms of Major Depression, may simply equal excessive coffee consumption. This crucial point may be missed if other symptoms also overlap with Major Depressive Disorder, leading to misdiagnoses, a wrong treatment plan, or the person's misunderstanding of the causes of her mental distress.

A good illustration of this is found in psychotherapist Gary Greenberg's essay ''Manufacturing depression: A journey into the economy of melancholy,'' in which he talks about his depression and treatment. Below is an account of a conversation he had with his psychiatrist, while the latter was filling out a form for the Hamilton Depression Rating Scale (HAM-D), a 21-question multiple-choice questionnaire used by clinicians to rate the severity of major depression:

> He [the psychiatrist] opens the binder again and asks me how my week was. Papakostas has a way of making HAM-D into a reasonable facsimile of an actual conversation. So, when he asks me for an example of what I feel self-critical about (item 2), I open the spigot a little, telling him I worry that my insistence on working at my therapy practice part time, my giving up a plum teaching job, my indulgence in writing and other less savory vices, my seemingly endless desire for free time—that these reflect a hedonism and irresponsibility that have led me to squander my gifts. Papakostas waits a beat, then nods and says, ''in the past week, Greg, have you had any thoughts that life is not worth living.'' It's time for item 3. Papakastos is so unfailingly kind—and I want him to care, I want him to tell me

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> that I am not really feckless—that I cannot be mad at him for sticking to the script, let alone correct him about my name. He's not doing it because he's a bad man, or a disingenuous one, or a shill for the drug companies. On the contrary. He does it because he wants to help me, because he thinks I'm suffering, and because he's a doctor and this is what he knows how to do: to find the targets and send in the bullets, then to ask questions and circle the numbers and decide if those bullets really are doing their job. We are not here to talk about me, at least not about the homunculus we call a self. We're trying instead to figure out what's going on in my head—in the gray, primordial core where thought and feeling, according to the latest psychiatric fashion—arise. (Greenberg, 2007, p. 39)

As portrayed by Greenberg's ironic comments, there is a tendency to focus on the mental disorder, not the person with the mental disorder. Going through a checklist of symptoms reinforces this tendency, as mental disorder is abstracted from the person experiencing it. Such first-hand anecdotes help us understand how non-comprehensive the symptom-based approach to diagnosis may be in its interpretation of the patient's experience. Here, Greenberg—a psychotherapist and a patient at once as well as a critical thinker—is able to notice the problems associated with the process of diagnosis. However, what happens if the subject diagnosed is not on the same level of awareness and knowledge about the problems involved in the diagnostic process? Given the already diminished psychological capacities of the subject with mental distress and the psychiatrist's position of authority with respect to his knowledge on the subject's psychological states, the exchanges similar to that of Greenberg and his psychiatrist's may lead to serious problems in the diagnosed subject's interpretation of her symptoms. She may be led to divorce the symptoms she is displaying from the other aspects of her life that may be affecting her mental health. The danger is that, upon being given the DSM diagnosis, regardless of how limited its interpretation of her condition or how non-responsive it actually is to her condition, the subject may misinterpret her experiences.

(2) The reductionism of the Biomedical Disease Model of mental disorder renders a DSM-based narrative non-comprehensive. As in the case of diseases, the presence of a unique cause or a determinate set of causes that lead to a particular disorder is a recurrent assumption of this model, e.g., low levels of chemical neurotransmitter serotonin cause depression. However, this offers a limited account of mental distress. Undoubtedly, physiological structures play a role in mental health. However, the phenomenon is complex: there may be several factors that lead to mental distress. Linking ''depression'' to low serotonin levels is akin to linking ''fear'' to adrenalin levels. Adrenalin levels play a role in the feeling of ''fear,'' but we cannot suggest that adrenalin levels ''cause'' fear. The same holds true for serotonin and depression.

It is hard to identify a single cause or a single set of causes resulting in depression. Rather, there is a cluster of factors, some of which are readily measurable and verifiable and others, which are not. These may include socio-economic status, lack of social support system in their circle, a disease, major loss in the family, so forth. Neglecting the involvement of a set of divergent factors in mental health and

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assumption of a single biological cause make the Biomedical Disease Model of mental illness reductionistic. This may lead the subject to ignore the broader context that includes the psychological and historical facts of her personal history as well as the social, cultural, and interpersonal dynamics in which she finds herself. Thinking of her mental distress as an incurable biological disease may constitute obstacles to hopes of recovery and influence life choices, values, decisions, and interpersonal relationships. It may threaten her agency, leading her to believe that her behaviors and emotions are not in her control. In short, a purely biological account of her condition may constrain the range of her responses to her condition.

Further, the limited interpretation may lead the subject to deem her biology as the primary reason for her disorder and develop a solipsistic approach to her interpersonal relationships. Learning not to trust her feelings or emotions, say, as they are ''disordered,'' she may blame herself or her biology when an interpersonal relationship fails, which may diminish the range and number of social, emotional and personal relations that connect her to others, the social world, and her own humanity. When a person is diagnosed, to a certain extent, she receives a filtered version of the story about her mental distress. In the short run, it may be a relief to discover that the mental distress is not a character flaw but a chemical imbalance. However, such reasoning may shrink her psychological resources in the coping process.

(3) Even though psychiatrists are aware that hypotheses on the etiological roots of mental disorders require verification and that psychiatric knowledge is not as empirically justified as medical knowledge, they tend not to inform their patients of this. This may result in the DSM diagnosis functioning as a non-comprehensive narrative; non-responsive to the actual picture of the diagnostic process and what is known about mental disorders, yet affecting a person's knowledge and beliefs about her disorder. Many psychiatrists do not, say, qualify a diagnosis by informing their clients that psychiatric knowledge evolves—due to the ongoing nature of research on a patient's disorder of diagnosis, it may be invalid in 5, 10, maybe 50 years. Rather, the diagnosis is often announced as an unchangeable fact.

One could argue that the DSM is *only* a classificatory guide systematizing mental disorders and that it is not designed to offer a conclusive and unchangeable account of the subject's condition. This is true; even its creators acknowledge certain challenges it is facing. For instance, Allen J. Frances, Chair of the DSM-IV Task Force, states that the notion of mental disorder is unclear and whether we can develop a definitional criterion to guide our diagnoses is questionable (cited in Sadler, Wiggins, & Schwartz, 1994, p. 7). Further, the multi-axial system incorporated into psychiatry with the publication of the DSM-III encouraged the assessment of patients from clinical *and* phenomenological perspectives. This system was incorporated to address the problems raised above, such as the non-comprehensiveness of DSM diagnoses. In the multi-axial model, the DSM-IV divides each psychiatric diagnosis into five levels (axes) targeting and addressing different aspects of mental disorders. *Axis I* lists

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major clinical disorder, such as depression and bipolar disorder; *Axis II* lists the underlying personality conditions of the subject diagnosed; *Axis III* addresses the medical conditions, which may play a role in the development, continuance, or exacerbation of Axis I and II Disorders; while *Axis IV* lists the psychosocial and environmental factors encountered by the patient within previous 12 months that may have contributed to the development, recurrence, or exacerbation of a mental disorder (APA, 1994, pp. 25–31).

Both Frances's acknowledgment of the uncertainty regarding the definition of mental disorder and the introduction of the multi-axial system to the DSM schema indicate that positive steps are taken to improve the DSM categories. However, I am concerned that the critical framework inherent to academic psychiatry may not always be reflected in clinical practice. That patients are not always informed about the uncertainties around the definition of mental disorders or that environmental factors, for instance, may play a role in their mental disorder have serious ethical implications since the DSM is not merely a theoretical inquiry into the nature of mental disorders. The diagnosis of mental disorder is crucially important for the treatment of the subject and her sense of self. Hence, the dissemination of inaccurate knowledge via the components of the *diagnostic culture* may have serious implications on the subject's identity constitution by offering a "restrictive" narrative to the subject's mental disorder.

One may argue that the DSM diagnoses fulfill my third criterion for a good narrative—that they are resourceful in offering insight into one's experience for they facilitate self-understanding. Giving direction to treatment and recovery, DSM diagnoses may be deemed resourceful, i.e., the diagnosis may encourage the subject to reach out to others with the same diagnosis, engendering in her a sense of belonging to a community of people sharing a common problem. This may provide a social framework by means of which the subject can define her identity and develop new psychological traits aiding her recuperation and subsequent functioning in the world.

For instance, given the potential epistemic utility of depression, the subject may gain valuable insights through her diagnosis, which may help build a better life. George Graham, in his "Melancholic epistemology" (1990) refers to J.S. Mill's experience with depression as a young man, how, by delving into his depression, he reached a deeper understanding of himself. Mill thus recognizes the importance of aesthetic enjoyment for him and renews his hopes about his ability to change his character. In his case, Graham suggests, depression works as a "recognitional epiphany in which he discovered certain truths and used them to shape his life" (1990, p. 417).

A similar case may be made for psychiatric diagnoses, where, by framing the subject's otherwise unintelligible psychical experience, a diagnosis may provide insight into the inner workings of the disorder, insofar as the diagnosis is thorough; which is not necessarily the case with DSM classifications. To illustrate, I draw upon two more examples.

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In her memoir, psychiatrist Kay Jamison chronicles her diagnosis:

> He [the psychiatrist] made it unambivalently clear that he thought I had manic-depressive illness and that I was going to be on lithium, probably indefinitely. The thought was very frightening to me—much less was known then, than is known now about the illness and its prognosis—but all the same I was relieved: relieved to hear a diagnosis that I knew in my mind of minds to be true. Still, I flailed against the sentence I felt he had handed me. He listened patiently. He listened to all of my convoluted, alternative explanations for my breakdown—the stress of a stressed marriage, the stress of joining the psychiatry faculty, the stress of overwork—and he remained firm in his diagnosis and recommendations for treatment. I was bitterly resentful, but somehow greatly relieved. (Jamison, 1995, p. 87)

Consider the ambiguity here. On the one hand, Jamison's diagnosis lends certainty to otherwise unintelligible symptoms and offers a plan to alleviate them. The desire to attain a clear understanding of her psychological states is consistent with Daniel Gilbert's recent work, which shows that certainty, on average, is preferable to uncertainty, even when people are presented with an unpleasant certainty. Gilbert suggests that when people receive bad news about a situation, they live out their disappointment for a while but then change their attitudes and behavior to remedy the situation, by, for instance, ''raising consciousness'' and ''lowering standards.'' The biggest trouble with uncertainty, for Gilbert, is the inability to reconcile with circumstances whose terms are unknown to us. ''An uncertain future leaves us stranded in an unhappy present with nothing to do but wait'' (Gilbert, 2009). The diagnosis of bipolar disorder, despite being an unpleasant certainty, may have taken away Jamison's discomfort with the uncertainty of her psychological states and may have increased her awareness to her condition.

On the other hand, the psychiatrist's consideration of her condition as purely biological and his additional comments, including the ongoing necessity to use of lithium, discounts the diagnosis as a source of ''good'' narrative. That is, the narrative provided by the psychiatrist is non-responsive to the publicly observable historical and psychological facts of Jamison's life, which include the additional stress factors she is facing. These factors are not acknowledged in the diagnosis process, prompting a non-comprehensive account. Further, the research on the nature of bipolar disorder is still work-in-progress; the suggestion that she will have to be on Lithium indefinitely does not reflect that the psychiatric knowledge about bipolar disorder and its treatment is continuously changing. In Jamison's case, Lithium helps her mood swings and in fact she is a big advocate of the effectiveness of the drug; however, we do know that there are numerous psychiatric patients diagnosed with bipolar disorder, who did not benefit from Lithium.[13] In Jamison's case, the diagnosis and drug therapy seem to have provided resources for her to understand and deal with the difficulties of her disorder but this cannot be generalized to all patients. The purely biomedical account offered by Jamison's doctor narrative may not always resourcefully offer insight into the subjects' experience, as they may start to consider themselves victims of their biological constitution instead of engaging

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with the nature of their psychological states and trying to decipher their symptoms in the broader context of their lives. The manic and depressive states of the bipolar disorder, for instance, are very sensitive to the subject's personal circumstances. Striving to understand the social and environmental triggers may help avoid appealing to a one-sided biological explanation, thereby enhancing the subjects' hopes of recovery.

Consider another example: Elyn Saks, a law professor, initially receives psychoanalytic treatment. Her condition is later identified as schizophrenia, under the classifications provided by the DSM. Regarding the DSM definition of schizophrenia, Saks writes:

> I had discovered the DSM . . . I read it cover to cover. Knowledge had always been my salvation, but with my immersion into the DSM, I began to understand that there were some truths that were too difficult and frightening to know . . . . And now, here it was, in writing: The Diagnosis. What did it mean? Schizophrenia is a brain disease which entails a profound loss of connection to reality. It is often accompanied with delusions, which are fixed yet false beliefs—such as you have killed thousands of people—and hallucinations, which are false sensory perceptions—such as you have just seen a man with a knife. Often speech and reason can become disorganized to the point of incoherence. The prognosis: I would largely lose the capacity to take care of myself. I wasn't expected to have a career, or even a job that might bring in a pay check. I wouldn't be able to form attachments, or keep friendships, or find someone to love me, or have a family of my own—in short I'd never have a *life* . . . . I'd always been optimistic that when and if the mystery of me was solved, it could be fixed; now I was being told that whatever had gone wrong inside my head was permanent, and from all indications, unfixable. Repeatedly, I ran up against words like "debilitating," "baffling," "chronic," "catastrophic," "devastating" and "loss." For the rest of my life. *The rest of my life*. It felt more like a death sentence than a medical diagnosis. (Saks, 2007, pp. 167–168)

Saks acknowledges the component of truth in the DSM diagnosis but the use of value-laden expressions in the DSM's description of schizophrenia, such as "baffling," "debilitating," and "catastrophic" make it a "restrictive" narrative. It molds the way a person may view her psychological states. The subject may have hallucinations, but whether this is "catastrophic" and "debilitating" requires agreement on what this experience means to her. Such agreement can only be reached in a non-paternalistic therapeutic setting where the psychiatrist respects the person's agency, and treat her concerns more than just a "symptom of her illness."

One may find it problematic that I critique the DSM diagnoses for their relative comprehensiveness and responsiveness but do not inquire into the relative truthfulness and accuracy of first person accounts. In response, I would note that, first, the problems I address in the DSM have been discussed by many scholars. The novelty in my analysis is the attempt to evaluate how these problems affect the diagnosed subjects' sense of self. Second, skepticism about whether these particular first person narratives may reveal the truth can be applied to any form

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of self-representation. Indeed, one may question whether in our daily interactions with other people we ''truly'' represent what we actually are. But a careful analysis of first person narratives surprisingly reveals many commonalities between experiences of different subjects, diagnosed with different disorders, thereby suggesting the need to set aside extreme skepticism.

One may ask if there is a solution to these problems. Namely, one may inquire whether there can be a DSM conducive to a ''good'' narrative or whether the very idea of a diagnostic scheme—however responsive, comprehensive, and resourceful it may be—is itself problematic. It is beyond the extent of this paper to offer a conclusive account of how the DSM should be framed but I suggest that the elimination of diagnostic categories does not offer a solution, as receiving a psychiatric diagnosis may be beneficial for the reasons I addressed above. A diagnostic schema that excludes the abovementioned problems of the DSM may prove useful in addressing mental disorders. Tellingly, significant attempts to improve the DSM schema are underway; among which is the incorporation of the multi-axial system into the DSM. Further, there are noteworthy recommendations made by philosopher-minded psychiatrists to include the patients' and their families' perspectives in the diagnostic review process (Sadler & Fulford, 2004). However, as we approach the scheduled publication date of the DSM-V, the APA continues to be target to criticisms. For instance, Robert Spitzer, the head of the DSM-III task force, has criticized the APA for mandating the members of the DSM-V taskforce sign a non-disclosure agreement, averring that transparency is necessary for the DSM-V to be credible (Carey, 2010). The merits of DSM-V are yet to be reevaluated. In the meantime, a concerted effort must be made to recognize and communicate to patients the DSM's limitations. This may temper the severity of the problems associated with the dissemination of inaccurate psychiatric knowledge.

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7. Conclusion

In this paper, I explored how DSM diagnoses may affect the diagnosed subject's responses to her mental distress by offering an account that emphasizes the ethical importance of the influence of autobiographical and social narratives on self-understanding and self-concept. Suggesting that a DSM diagnosis may function as a source of narrative, I concluded that DSM diagnosis is a double-edged sword for the subject's self-concept and mental health. On the one hand, it sets the subject's experience in an established classificatory system which can facilitate self-understanding by providing insight into subject's condition and giving a direction to treatment and recovery. In this sense, the DSM diagnosis may have positive ramifications on the processes of recovery and may positively affect the subject's self-perception. On the other hand, however, given DSM's symptom-based approach and its adoption of the Biomedical Disease model, a diagnosis may force the subject to make sense of her distress divorced from other elements in her life that may be

affecting her mental health and may guide her to frame her experience only as a neurobiological imbalance that is unchangeable. This form of self-understanding may set limits on the subject's hopes of recovery and may bar her flourishing. By providing a descriptive account of how the narrative framings of life experiences may alter an individual's self-perception and shape the range and number of social, emotional and personal relations that connect her to others, the social world, and her own humanity, I hope to induce the implementation of corrective measures to fix the longstanding problems associated with the DSM.

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Notes

[1] Gail Hornstein has compiled a bibliography of first-person narratives of mental disorder, which includes more than 700 psychiatric patients' accounts of their experience (Hornstein, 2009).

[2] For further discussion of similar arguments, see Woody (2003) and Zahavi (2007).

[3] Flanagan suggests that even though personal identity can be grounded in a thin thread of biological and psychological continuity, it is the narrative connectedness that ''constitutes a normatively acceptable self'' (Flanagan, 1993, p. 149). Flanagan suggests that the idea that the narrative structure of the self is natural because human lives are experienced in time, memories are very powerful to deem narrativity necessary and that human beings are prospectors, i.e., they plan their futures based on their past and present. Flanagan addresses important aspects of our self-experience that provides support for the influence of narratives on our identity. Nonetheless, I do not want to go as far as claiming that narrative connectedness is *necessary* for moral acceptability. Thus, avoiding this stronger claim, I explain how the narratives influence self-concept.

[4] As Hutto makes it clear, there are a number of working definitions and there is no agreed upon criterion for identifying narratives (Hutto, 2007, p. 1). Hutto's emphasis on the discursive nature of narratives makes his definition comply with the other working definitions in the literature (e.g., Bruner, 1990, p. 43; Lamarque & Olsen, 1994, p. 225; Prince, 1982, p. 4).

[5] Social narratives do not only raise an *explicit* cognitive response in the individual but may also affect the *implicit* cognitive processes—processes inaccessible to consciousness, but that influence judgments, feelings or behavior (Wilson, 2002). Timothy Wilson, distinguishing between explicit and implicit learning suggests that people are able to learn new information unconsciously (Wilson, 2002, p. 25). A similar form of implicit learning may be in force when people hear the social narratives about themselves; they may implicitly shape their character under the influence of the narratives. However, in this paper, I will not deliberate on this.

[6] Flanagan in his later works, appealing to David Jopling's criticisms, acknowledges the necessity to address the important issues concerning the truth and accuracy of personal narratives (Fireman, McVay, & Flanagan, 2003; Jopling, 2000).

[7] Given that narratives are selective representations of the series of events, one may question the degree of comprehensiveness required for a good narrative as well as the possibility of its attainability. Here, by comprehensive interpretation I refer to an account that presents different dimensions of the states of affairs that is being interpreted. It is important to emphasize that a ''good'' narrative is a moral ideal in terms of its contribution to one's moral development. A narrative that does not provide a balanced account of the subject experiences, but a narrow-ranged interpretation, may lead to self-misunderstandings and self-deprecating mindsets.

[8] Contrary to what Strawson asserts, there is no single 'narrativity thesis.' The approaches of the philosophers he refers to (e.g., Bruner, 1987; Dennett, 1988; Sacks, 1985; Schechtman, 1997; Taylor, 1989) are diverse.

[9] Seminal work has been done on labeling theory, i.e., the impact of the negative stereotypes and cultural biases against mental disorder on the treatment and the interpersonal lives of those so diagnosed (e.g., Doherty, 1975; Fink & Tasman, 1992; Goffmann, 1961; Scheff, 1964, 1976). To cite one example, Thomas Scheff's (1964) study ''The societal reaction to deviance: Ascriptive elements in the psychiatric screening of mental patients in a midwestern state,'' explores the role the folk conceptions of mental illness plays in the assessment of an individual as ''ill'' by the medical and legal communities. Scheff points out that once an individual is entered into the system by the society, the presumption of the system is that she is insane until proven otherwise. Scheff also emphasizes that the features of mental illness are a response of the individual to being labeled as deviant. His standpoint is among the forms of antipsychiatry standpoint. His work has been a helpful contribution to some arguments developed in this paper. However, I distance myself from Scheff and other labeling theorists in two respects: (1) I do not assume an 'antipsychiatry standpoint' as I believe that an antipsychiatry stance may miss out accounting for the psychological distress of the subject with a mental disorder by falling into a debate about whether mental illnesses or their symptoms are 'real' or 'constructed', and (2) by grounding my analysis of the effects of receiving a DSM diagnosis to a background that explores the ontological status of selfhood, I put more emphasis on the identity-shaping implications of a psychiatric diagnosis and draw attention to how pervasive its effects may potentially be. It is also worth noting some recent work done in this area. Bruce Winick (1995, 2005) focuses on the rights of patients within the mental hospital. In particular, he explores the topics including voluntary and involuntary hospitalization, the right to treatment, the right to refuse treatment, patients' right to different forms of treatment, e.g., psychotherapy, in addition to psychotropic treatment that are needed to prepare patients for the resumption of life within the community with a high level of functioning. The empirical data and enquiry on therapeutic jurisprudence provided by Winick are indispensable in any work focusing on the subjects who are diagnosed with mental disorder. Since this paper primarily deals with the self-concept of the diagnosed subjects, not their rights as patients, I will leave out a detailed discussion of Winick's contribution to the field.

[10] Different versions of the idea that the classification and people classified interact can be found in philosophers such as Stuart Hampshire and Charles Taylor but Hacking's ideas are better known and more widely discussed (Hampshire, 1971; Taylor, 1989).

[11] Hacking develops the concept of ''looping'' in conjunction with the notion of ''making up people.'' In his view, a scientific classification may ''make up a person,'' i.e., may bring into being a new kind of person ''conceived of, and experienced as a way to be a person'' (Hacking, 2007a, pp. 285–287). The process of ''making up people'' is explained by the concept of ''looping effects.''

[12] In his earlier works, Hacking attributes ''looping effects'' to what he calls ''human kinds''—a term he generates by taking the notion of ''natural kinds'' as a point of departure—alluding to phenomena studied by human sciences. In his later writings, he abandons the notion of ''natural kinds''; since there are so many radically incompatible theories of natural kinds

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in circulation that, for him, the concept has become obsolete. Corollary to this change, he no longer employs the term "human kinds" (Hacking 2007a, 2007b). Instead, he proposes a framework for analysis to understand the *kinds of people* studied by human sciences and explains how the looping effects are generated.

[13] For some examples, see Hornstein, 2009.

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