



Others' Contributions to an Individual's Narrative Identity Matter

Sara Goering, Timothy Brown & Jenan Alsarraf

To cite this article: Sara Goering, Timothy Brown & Jenan Alsarraf (2017) Others' Contributions to an Individual's Narrative Identity Matter, AJOB Neuroscience, 8:3, 176-178, DOI: [10.1080/21507740.2017.1366586](https://doi.org/10.1080/21507740.2017.1366586)

To link to this article: <https://doi.org/10.1080/21507740.2017.1366586>



Published online: 23 Oct 2017.



Submit your article to this journal [↗](#)



Article views: 49



View Crossmark data [↗](#)

transformative experience, it is implausible to suppose that we can accurately predict how an intervention or illness will shape a patient's narrative identity.

Oliver Sacks's (1998) account of "Witty Ticky Ray" provides a particularly noteworthy instance of how medical intervention can constitute an existentially transformative experience. When Sacks first met Ray, as a result of his Tourette's syndrome, Ray was "almost incapacitated by multiple tics of extreme violence coming in volleys every few seconds" (97). Though treatment with Haldol helped control Ray's syndrome, Ray found that on Haldol, "he no longer had [the] wild and creative surges" (101) that made him a brilliant drum player. Much like HD, Ray found a balance, taking Haldol during the week to control his Tourette's syndrome but abstaining during the weekends to enable his creative side. Unlike HD, Ray sees himself as living two fundamentally different lives: "there are now two Rays . . . There is the sober citizen . . . and there is 'witty ticky Ray,' frivolous, frenetic, inspired" (101). Ray's story is not merely an example of the lability of narrative identity and the resultant inability to predict an individual's postintervention identity. Ray's story further highlights the fact that narrative unity is among the very values that can change as a result of illness and intervention.

Jecker and Ko offer an account of narrative identity that they hope can improve the quality of clinical decision-making. We have argued that because construction of narrative identity is fundamentally retrospective, considerations related to narrative identity can only help improve clinical decision making if we can reliably predict a patient's post-illness/post-intervention identity. But

because illness and intervention can be transformative experiences that fundamentally reshape a patient's values, we cannot reliably predict how an illness or intervention will shape a patient's narrative identity. Ray's choice to abandon a unified narrative drives home the magnitude of this skeptical conclusion. We cannot even assume that, post intervention, a patient will continue to value having a unified narrative. ■

ORCID

Emily Cox  <http://orcid.org/0000-0002-2620-025X>

REFERENCES

- Carel, H., I. J. Kidd, and R. Pettigrew. 2016. Illness as transformative experience. *Lancet* 388(10050): 1152.
- Charon, R. 2008. *Narrative medicine*. New York, NY: Oxford University Press.
- Jecker, N. S., and A. L. Ko. 2017. Is that the same person? Case studies in neurosurgery. *AJOB Neuroscience* 8(3): 160–170.
- MacIntyre, A. C. 1984. *After virtue: A study in moral theory*. Notre Dame, IN: University of Notre Dame Press.
- Paul, L. A. 2014. *Transformative experience*. New York, NY: Oxford University Press.
- Sacks, O. 1998. *The man who mistook his wife for a hat: And other clinical tales*. New York, NY: Touchstone.
- Schechtman, M. 1996. *The constitution of selves*. Ithaca, NY: Cornell University Press.

Others' Contributions to an Individual's Narrative Identity Matter

Sara Goering, University of Washington

Timothy Brown, University of Washington

Jenan Alsarraf, University of Washington

Jecker and Ko (2017) argue that issues of narrative identity (rather than merely numerical identity) better capture the things people care about when they wonder how they will fare following a neurosurgical procedure, and we generally agree. But the authors' focus on individual narrative identity—told from a person's own point of view—fails to capture the significance of the social/relational nature of narrative identity, and therefore leaves out some of the key

matters of concern that have been raised in regard to the possible psychosocial side effects of neurosurgery and/or implantable neural technology. In particular, the authors fail to appreciate how individuals who go through significant changes in aspects of their narrative identity following neurosurgery may not be able to identify the changes in themselves. Further, we suggest that narrative repair may not be the most appropriate response to changes in

Address correspondence to Sara Goering, Center for Sensorimotor Neural Engineering and Department of Philosophy, University of Washington, Box 353350, Seattle, WA 98195, USA. E-mail: sgoering@u.washington.edu

narrative identity related to neurosurgery if the individual has a device that can be altered or adjusted.

To bolster our first point, consider this claim from de Haan et al. (2017), noting that in a study of Parkinson's patients who received deep brain stimulation (DBS) (from Pham et al. 2015), recipients became

more impulsive, more self-centered, less persistent and less conscious [of how they are] three months after surgery. Relatives also reported that patients showed a 'lack of premeditation': patients were considered to be 'less thoughtful, more impulsive, and likely to act on the spur of the moment without regarding the consequences'. *The patients themselves did not report such changes.* (de Haan et al. 2017, quoting Pham et al. 2015; our emphasis)

If individuals who undergo neurosurgery and/or receive DBS undergo significant changes in their thoughts and behavior but cannot themselves recognize those changes as such, their capacity to continue or retell their narrative (to "survive" the surgery, on the individual narrative identity approach) may be relatively robust. Our capacity to develop post hoc rationalizations that purport to explain our choices or behavior is well documented (Haidt 2001). But looking in from the outside, the individual's friends and family may identify significant differences in their loved one who behaves abnormally. The capacity to articulate an individual narrative, then, doesn't seem like quite enough to capture what's at stake with personality or behavior changes postsurgery. (This is not so much a claim about whether or not the individual "survives" narratively, but about the ability to recognize a "diminishment" of their narrative identity.)

In the case of Walter, for instance, the authors suggest that he survives the surgery but with a diminished sense of narrative identity, because although he has "adequate" control over the flow of his actions from his thoughts and choices, he loses some degree of control at certain times and in relation to certain desires. He leads a life—is author of his life in many respects—but he is a passive subject to his new and unusual sexual desires. Interestingly, the authors suggest that Walter may not be fully aware that his urges come from effects of the neurosurgery rather than from his own choices, a situation they describe as "lacking brain proprioception at times" (161).

So what follows from this concern about the individual's inability to recognize changes in her behavior or personality? It means that we need a more robustly social or relational account of narrative identity. Following Baylis (2013), we recommend using a relational account of identity, one in which others play a role in shaping our narratives and in "holding" us in our identities (Lindemann 2014). On this account, the process of identity formation is ongoing and dynamic. People's identities are somewhere in the equilibrium between self-ascription and ascription by others (Baylis 2013, 518); "my identity is not in my body or my brain, but in the negotiated spaces between my body and brain, and the bodies and brains of others" (Baylis 2013, 517). We rely, in other words, on our friends

to help define us, and to hold us in our identities. If our self-narratives seem to go awry following surgery, and others cannot explain our behavior, they may rightly push back against our shifting first-person narratives. As Baylis notes, someone may have both a preferred and a performed narrative, and these may not match up entirely, but the individual will in fact be "the person at the intersection of who he wants to be, and who others will minimally let him be" (518).

If Walter cannot recognize that his new behavior is causally linked to his neurosurgery, perhaps he will create a new narrative that fits this altered behavior. He might feel somewhat conflicted (he hides the new behavior from his wife as much as he can), but as he experiences it, he may think of it as his own. Does he then "own" his behavior (i.e., understand it as flowing from his choices)? If so, it becomes part of his self-told narrative in Jecker and Ko's view (even if this particular narrative is not one widely shared). But we think his ability to articulate his experience isn't enough for it to constitute his identity. In this situation, surely what we would want is for family members or others who realize how strangely he is behaving to try to get help for him, to figure out what accounts for this surprising and unsettling new behavior. We would hope that Walter would be sensitive to their concerns, especially if his behavior is harmful to them. For patients with a DBS that causes significant changes in behavior, an adjustment of the settings may be the appropriate intervention. Narratively surviving the surgery from the first-person perspective isn't all that matters.

Some neurosurgical patients will, of course, recognize changes in their own behavior. In some respects, Jecker and Ko seem to understand Walter in this way (we find their treatment of his case somewhat ambiguous). They suggest that, at least for some part of the day, he experiences a disconnect between his preferred narrative and his performed narrative. He doesn't maintain desired control over his performed narrative, even if it is "adequate" for narrative survival.

In this way, he is rather similar to a person who wants to lose weight but continues to eat doughnuts. She has "adequate control" over her actions—she gets herself to work and takes care of the dog—but she can't seem to stop eating too many doughnuts. Does control over narrative identity help here? Perhaps she can articulate the difficulty in resisting a good doughnut, even though she would prefer to be the kind of person who wasn't as prone to their call. Being able to tell a story that articulates the urge to eat doughnuts is not the same as having adequate control or overcoming the urge to eat doughnuts. And if her doughnut indulgences pose a serious health risk, drive a wedge between her and her family, or stand in the way of her becoming who she wants to be, she will need to do more than take control of her narrative. So too, if Walter is able to craft a story about his inability to resist his sexual urges, that doesn't address what matters to him (and his family) regarding his narrative survival. They want not just a continuous story, but one that holds Walter appropriately, one that maintains him. Survival isn't just about spinning a

narrative but about making it one that fits the relational person it describes.

As Baylis rightly points out, we survive all kinds of changes to our bodies and our thinking, both chosen and unchosen. People survive accidents that alter their embodiment, and they survive ugly divorces they would never choose. Sometimes we cannot control the circumstances that require us to shift our narratives of identity, and we rely on our loved ones to help us create our new narratives. But in the case of unchosen alterations to our identities due to neurosurgeries or implanted devices, we have other options to try if we want to hold a person in her identity.

While Jecker and Ko conclude that we should meet patients where they are—"in the middle of life stories that have been disrupted by disease, and that may benefit from narrative repair"—we think that sometimes what is called for is not merely narrative repair, but perhaps also readjustment of a neural system (like a DBS) that itself changes a person's narrative in problematic ways the person may or may not recognize. In this, we agree with De Haan et al. (2017) that we need to understand "the possibility that DBS can have side-effects on personality in order to recognize when such changes call for an adjustment of the DBS

settings—rather than a re-adjustment of patients and/or their loved ones." It's not clear from the Jecker and Ko piece how we would do that. ■

REFERENCES

- Baylis, F. 2013. 'I am who I am': On the perceived threats to personal identity from deep brain stimulation. *Neuroethics* 6:513–26.
- De Haan, S., E. Rietveld, M. Stokhof, and D. Denys. 2017. Becoming more oneself? Changes in personality following DBS treatment for psychiatric disorders: Experiences of OCD patients and general considerations. *PLoS ONE* 12(4): e0175748. <https://doi.org/10.1371/journal.pone.0175748>
- Haidt, J. 2001. The emotional dog and its rational tail: A social intuitionist approach to moral judgment. *Psychological Review* 108:814–34.
- Jecker, N. S., and A. L. Ko. 2017. Is that the same person? Case studies in neurosurgery. *AJOB Neuroscience* 8(3): 160–170.
- Lindemann, H. 2014. *Holding and letting go: The social practices of personal identities*. New York, NY: Oxford University Press.
- Pham, U., A-K. Solbaak, M. Skogseid, et al. 2015. Personality changes after deep brain stimulation in Parkinson's disease. *Parkinson's Disease* 2015 [Epub]. doi:10.1155/2015/490507.

"I Just Wanna Get My Self, or My Story, Back Again": Narrative Identity, Neurosurgical Intervention, and the Temporary Change Argument

Russell DiSilvestro, California State University–Sacramento

Chong Choe-Smith, California State University–Sacramento

Timothy Houk, University of California–Davis

When dealing with identity—whether numerical or narrative—a neglected type of argument might be called a "temporary change" argument. The argument earns its name from the fact that it examines cases where an individual appears to undergo "change" in some way—perhaps trivial, perhaps dramatic—but then, over time, this change appears to be reversed, and hence was merely "temporary."

This type of argument has been advanced in articles (e.g., DiSilvestro 2008) and a book (DiSilvestro, 2010) recently reviewed in *American Journal of Bioethics* (Jordan 2012) to contrast various accounts of our numerical identity

and moral status. But the argument's name is not proprietary, and its structure is not new. Those pieces merely expand upon standard reversible changes (like sleep, anesthesia, and temporary coma) to describe various hypothetical cases of neurological and neurosurgical changes that dramatically affect the personality of an individual before being eventually reversed. But those pieces never brought the temporary change argument into conversation with accounts of narrative identity. Jecker and Ko's valuable target article (2017) provides an excellent chance to do so.

Preliminarily, we should note a tension in how Jecker and Ko relate narrative identity to numerical identity.

Address correspondence to Russell DiSilvestro, Department of Philosophy, California State University-Sacramento, Mendocino Hall, Room 3000, 6000 J Street, Sacramento, CA 95819-6033, USA. E-mail: rdisilv@csus.edu