

Insight and the No-Self in Deep Brain Stimulation

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1. INTRODUCTION

If I tell you that “I don’t feel like myself today,” how might you respond? Will you ask me who is the self that I do not feel like (but want to), or will you ask me what is wrong? Most of us, I contend, will take the latter route. My response is likely predictable as well. I will tell you that I feel tired, or unmotivated, or that something is just *off*. In other words, I will translate my feeling that something is wrong into a statement about my self. But am I actually telling you something about my self, or about the fact that I just feel bad?

In the United States, it is common to discuss feelings and thoughts through the lens of the self. This may be due in part to language – to say “I feel tired” in English, one must use the first person pronoun, “I.” Other languages omit first person pronouns. In Japanese, for example, to express sleepiness one says “*nemui*”, no pronoun required. Indeed, many English speakers learning Japanese mistakenly use the first person pronoun, adding “*watashi wa*” (I am) to *nemui*. Yet the tendency is not just linguistic; it is also phenomenological. Our experience of the world comes through the lens of the self as a subject. *We* are the ones feeling tired, eating an apple, watching the bird in the tree. The sense of self transcends phenomenology, even. The focus on the individual self in America is as much cultural as it is linguistic and phenomenological; having an authentic identity is an ideal of American life.¹ In this sense, when we feel that something is wrong, our idea of how to make it right trades on our beliefs about what feeling right looks like – and in the U.S., feeling right often means feeling like one’s self.

In this paper, I explore one manifestation of this preoccupation with the self. In the field of neuroethics, there has been an explosion of interest in cases of deep brain stimulation (DBS) where patients report feeling “unlike themselves.” These cases have served as an opportunity for ethical theorists to test the viability of their theories of

¹ Taylor, C. (1991). *The Ethics of Authenticity*. Harvard University Press; Elliott, C. (2003). *Better than Well: American Medicine Meets the American Dream*. New York: W.W. Norton and Company.

identity, much as the arrival of enhancement technologies opened a window for theorists of authenticity (more on the precise meanings of these concepts later). While these theoretical reflections are valuable, I call into question the assumption that what is at stake in these cases are patients' identities or their sense of self. My goal is to argue that restoring a sense of self is not necessarily the solution to a patient's claim that "I don't feel like myself," and that clinicians, researchers, caregivers, and ethicists should interrogate the meaning of these statements before defending a particular perspective on which conception of selfhood would prove most helpful.

But first, a clarification of terms is necessary. Our linguistic tools for discussing the self are as imprecise and overlapping as the experiences they aim to capture and the concepts they mean to convey. The word "identity" tends to pick out the types of essential features of an entity that make it the same individual entity over time – that is, those features that render it "identical" to itself over time, rather than morphing into some other, new entity. For example, continuity of memories, beliefs, and desires might be requisite for a continuous human identity. When we speak of the "self", we mean something like the particular features of that unchanging human entity that persists through time – the actual memories, beliefs, and desires that we would offer up if asked to describe our selfhood. It is also possible to describe our "sense of self," or the subjective, first-person experience of being an entity that (seems to) persist through time. The language of "sense of self" is also related to the idea of "authenticity" – if individuals describe themselves as feeling inauthentic, they are generally thought to have lost their sense of self. And finally, there is the widespread belief, which I have just partly attributed to culture, that the self is a real entity and is the grounds of our identity – a belief that may also draw from our experience of our "sense of self."²

In the essay that follows I will be using all of these terms. I will aim not to use them interchangeably, but to clarify when I am talking about identity, when I am describing the self or the sense of self, and when I am referring to our belief in the self. As will become clear, the goal of this paper is not to ask whether we actually have continuous identities and in what our selves consist, but to question the normative use of

² An anonymous reviewer very helpfully suggested that I clarify the language of identity, self, and sense of self, and the description of these terms here derives from their suggestions.

a “sense of self” in bioethical conversations – as if it is something that people *ought* to have. Others have argued against the existence of a continuous self much more persuasively than I can here, and regardless that is not my aim.³

In this paper, I first provide a brief description of different uses of these various concepts of self in bioethical and neuroethical discussions, and I explain how recent cases of DBS contribute to this discussion. Second, I describe several of the bioethical responses to these cases and assess their proposals. Third, I introduce the concept of no-self and explain its normative implications. Fourth, I consider how the concept of no-self might be useful in these DBS cases. Finally, I anticipate possible objections to incorporating Buddhist thought into contemporary bioethical analyses.

2. THE SENSE OF SELF IN BIOETHICS

In bioethics, questions of how medicine might impact the self gained interest in the 1990’s with the possibility that pharmaceuticals such as Prozac could “transform the whole person” such that “there are almost two different persons”.⁴ When taking Prozac, some patients described the effects of the drug as making them feel more authentic, while for others the changes in personality seemed to effect the emergence of a new, non-identical self. Since then, arguments addressing changes to identity and feelings of authenticity have grown in response to a wide range of treatments, from anxiety disorders to enhancement technologies.⁵

Recently, questions concerned with the self have resurfaced in the context of neural interventions such as deep brain stimulation (DBS), which can affect patients’ personalities and behavior in much the same way as psychopharmaceuticals. Individuals with these interventions have developed manic states, lost their inspiration to work, and

³ Strawson, G. (1997). The Self. *Journal of Consciousness Studies* 5-6:405-428; Strawson, G. (2004). Against Narrativity. *Ratio* 17:0034-0006.

⁴ Kramer, P. (1993). *Listening to Prozac*. Penguin Books.

⁵ Elliott, C. (2003). *Better than Well: American Medicine Meets the American Dream*. New York: W.W. Norton and Company; DeGrazia, D. (2005). *Human Identity and Bioethics*. New York: Cambridge University Press; Bolt, L.L.E. (2007). True to Oneself? Broad and Narrow Ideas on Authenticity in the Enhancement Debate. *Theoretical Medicine and Bioethics* 28:285-300; Bublitz, J.C. and Merkel, R. (2009). Autonomy and Authenticity of Enhanced Personality Traits. *Bioethics* 23(6): 360-374; Levy, N. (2011). Enhancing authenticity. *Journal of Applied Philosophy*. 28(3):308–318.

become more outgoing, with many of these changes resulting in disruption such as marital difficulties or institutionalization.⁶ Some individuals describe these changes in terms related to identity and authenticity: “Now I feel like a machine, I’ve lost my passion. I don’t recognize myself anymore,” “During all these years of illness, I was asleep. Now I am stimulated, stimulated to lead a different life,” and “I feel like an electronic doll.”⁷

These phenomena have prompted debate among ethicists about how to interpret these statements, often by way of proposals of theories that might be used for the ethical analysis of DBS-induced changes. The assumption seems to be that we can use these cases as evidence, either to recommend new theories of identity to ground conversations about authenticity and the self (such as relational or narrative identity), or to support older stalwarts (such as psychological continuity). We can then return to the cases themselves with a clearer sense of what is at stake and with the ideas for how to proceed that the theory has provided.

And, to be sure, these cases do not admit of easy analysis. When a participant says “I don’t recognize myself anymore,” do they mean that they are no longer the self they once were (their identity has changed), or that their sense of self has been impaired? They may even mean something else entirely.

Few commentators interpret these responses along the former route, as actual changes to patients’ identities. The concern is not that the patient has become a new individual. Rather, their claim is that something feels off about their behavior, their interests, or their thoughts. There is an aspect of the unfamiliar or the unwelcome to their

⁶ Leentjens, A.F.G., Visser-Vandewalle, V., Temel, Y. et al. (2004). Manipuleerbare wilsbekwaamheid: een ethisch probleem bij elektrostimulatie van de nucleus subthalamicus voor ernstige ziekte van Parkinson. *Nederlandse Tijdschrift voor Geneeskunde*;148:1394–8; Kraemer, F. (2013). Authenticity or Autonomy? When Deep Brain Stimulation Causes a Dilemma. *Journal of Medical Ethics* 39:757–760; Schupbach, M., Gargiulo, M.L., Welter, L., Mallet, C. et al. (2006). Neurosurgery in Parkinson’s disease: A distressed mind in a repaired body? *Neurology* 66: 1811–1816; Bolt, I. and Schermer, M. (2009). Psychopharmaceutical enhancers: Enhancing identity? *Neuroethics*, 2:103–111; Kraemer, F. (2013). Me, Myself and My Brain Implant: Deep Brain Stimulation Raises Questions of Personal Authenticity and Alienation. *Neuroethics* 6(3):483-497; Klein, E. et al. (2016). Brain-Computer Interface-Based Control of Closed-Loop Brain Stimulation: Attitudes and Ethical Considerations, *Brain-Computer Interfaces*, DOI: 10.1080/2326263X.2016.1207497.

⁷ Schupbach, M. et al. *op. cit.* note 6, p. 1812-1813.

experience. While ethical interpretations of these statements are diverse, as I describe below, they agree that reports of inauthenticity and alienation such as “I don’t feel like myself anymore” are problematic because having a sense of self is ethically important, either in itself or because of how it affects what one can do.

I question this shared assumption that a sense of self is ethically significant. I propose a third approach to making ethical sense of patients’ claims about authenticity that is based in insight about the causes and effects of one’s mental states, not identity. According to this approach: (1) both subjective and objective authenticity claims indicate a barrier to insight about the causes of an individual’s mental states and behavior, (2) insight into the causes and effects of mental states and behavior improves subjective well-being and supports autonomy competency, and (3) insight is intrinsically and instrumentally valuable and ought to be preserved. Importantly, having insight into one’s mental states and behavior does not require a sense of self.

In the following section, I describe a range of approaches to ethically evaluating patients’ experiences following neural interventions such as DBS. I then draw on the concept of no-self to argue that patients’ claims do not require reference to stable identities via a concept of self for ethical assessment. Finally, I explain how this analysis helps to make sense of — and respond to — patients’ concerns about neural interventions such as DBS.

3. “I JUST DON’T FEEL LIKE MYSELF”: ETHICAL INTERPRETATIONS

In this section I describe a number of the theoretical approaches to patients’ experiences with DBS. These approaches fit roughly into two camps: those that focus on identity and the self (Schechtman, Baylis, and Mackenzie and Walker) and those that focus on authenticity and the sense of self (Kraemer, Erler and Hope, and Wardrope).⁸ A

⁸ Schechtman, M. (1996). *The Constitution of Selves*. Cornell University Press; Schechtman, M. (2010). Philosophical Reflections on Narrative and Deep Brain Stimulation. *Journal of Clinical Ethics* 21(2): 133-139; Baylis, F. (2013). “I Am Who I Am”: On the Perceived Threats to Personal Identity from Deep Brain Stimulation. *Neuroethics* 6:513-526; Mackenzie, C. and Walker, M. (2015). Neurotechnologies, Personal Identity, and the Ethics of Authenticity. *Handbook of Neuroethics*, Jens Clausen, ed. Springer; Erler, A. and Hope, T. (2014). Mental Disorder and the Concept of Authenticity. *Philosophy, Psychiatry, and Psychology* 21(3): 219-232; Wardrope, A. (2014). Authenticity and Autonomy in Deep-Brain Stimulation. *Journal of Medical Ethics* 40:563-566.

number of theorists yoke identity or authenticity to autonomy or agency for normative analysis, premised on a self or a sense of self being requisite for meaningful human choices. As I will explain, they all rely on the assumption that a sense of a unified, continuing self is valuable, regardless of the particular orientation of their theoretical approach.

Marya Schechtman, who is best known for her elucidation of the concept of narrative identity, was one of the first theorists to propose an ethical interpretation of patients' responses to DBS. Schechtman describes a number of cases of psychological and personality changes experienced by patients with DBS for Parkinson's disease, some of which are acute (immediately changing from a depressed to a hyperactive character when the DBS is turned on), and others of which are long term (a general feeling of dissatisfaction with one's new self and difficulty readjusting to familial and social life). She suggests that in both types of cases, DBS can be a threat to narrative identity. According to the narrative theory of identity, to both be a continuous self and to have a sense of this self, one ought to be able to give a roughly logical life story that makes sense of one's past history and experiences in a way that enables one to see what types of implications this may have for the future. This is part of what Schechtman terms the characterization question – rather than asking whether one person is the same person (the reidentification question, which depends on identity), Schechtman proposes considering whether certain behaviors, desires, thoughts, etc. can be attributed to a given person (i.e., how to constitute their self).⁹

Schechtman proposes that DBS is a threat to narrative identity in two ways: (1) it is immediate, giving patients no sense of how or why their personality has changed, and (2) this break makes it difficult for patients to pick up their life story after treatment. In non-narrative terms, patients are faced with an abrupt change in their behavior that can be difficult to attribute to who they understand themselves to be. These threats can be forestalled by encouraging patients to take a broader perspective on the changes wrought

⁹ While Schechtman uses the language of identity, her proposal of the characterization question may be interpreted as a shift from identity to authenticity - whether certain behaviors belong to a given person. Nevertheless, I will preserve her language of identity in this analysis (Schechtman 1996 *op. cit.* note 8, p. 73).

by DBS so as to see them within a larger narrative, in which DBS-induced changes are part of a continuous chain of events.

Beyond patients' difficulties adjusting to life following treatment, Schechtman does not explain why it is ethically significant for individuals to have stable narrative identities – that is, a stable sense of self based in an ability to give an account of one's self. She does suggest that identity is important, and ought not to be threatened, because “identity and agency... have been deep and long-standing parts of Western culture.”¹⁰ Francoise Baylis builds on Schechtman's contribution and clarifies why narrative identity might be valuable. She suggests that the one sense in which DBS could be a real problem for identity is through its effect on agency – if a patient does not think that her actions are a result of her intentions and beliefs, but are an effect of stimulation, she may no longer feel that she contribute to the authoring of her own life. In other words, the very mechanism of DBS – direct brain stimulation – may lead patients to think that they are “not themselves” in that they are not in control of their actions; the DBS unit is. Without this sense of self, patients might lose the motivation to try to shape their lives and contribute to their worlds in meaningful ways.

For both Schechtman and Baylis, the concern with DBS is not that patients have actually become different people, but that the mechanism by which DBS operates is one that people are not used to incorporating into the account of self that grounds their sense of self, a sense which is required for their ability to act as agents in the world. Both these positions assume that patients' statements say something meaningful about their sense of self and that a sense of self is a prerequisite for agency. Selfhood (here described as identity) and agency are valuable to the extent that they are Western cultural values (being one's self and acting on one's own).¹¹

Catriona Mackenzie and Mary Walker provide a more substantive defense of the value of specific forms of selfhood. They argue that a feminist relational theory of identity, described as an intersubjective shaping, can be enabling or damaging to one's autonomy competencies.¹² If an identity (that is, an account of one's self) is enabling, it is

¹⁰ Schechtman 2010, *op. cit.* note 8, p.134

¹¹ This interpretation of the cultural grounding of identity and authenticity is also found in Charles Taylor (1991) and Carl Elliott (2003).

¹² Meyers, D. (1989). *Self, Society and Personal Choice*. New York: Columbia University Press.

because it fosters the capacities needed for developing an autonomous self-narrative. If it is damaging, it is because relationships or broader social structures limit the range of narratives available to a person, which thwarts the exercise of autonomy competencies.¹³ For instance, if one conceives of oneself as a confident, self-assured person then this will support the ability to make reflective and responsible decisions. By contrast, if only subordinate or deferential identities are available given a person's social position, their autonomy will be constrained.

Felicitas Kraemer takes a different tack from these analyses focused on selfhood. She offers that patients' statements are evidence of the felt mental states of authenticity and alienation. These states have explicit normative dimensions: authenticity is something we ought to strive for and alienation is something we ought to avoid.¹⁴ These are not necessarily pleasurable states - she interprets authenticity as self-realization and in this sense it can be negative, if one finds one's self to be unsatisfactory; her analysis is not strictly consequentialist. Indeed, patients might feel *too* happy and this could lead them to feel inauthentic, or not like themselves. Because her approach is not based on the subjective value of patients' good feelings, it also trades on a conception of authenticity as an intrinsically valuable ideal in Western social and moral thought.

Alexandre Erler and Tony Hope also speak in terms of authenticity: the purpose of authenticity is to guide self-development in the face of inner conflict. While they reflect on authenticity's intrinsic value by referencing Charles Taylor's argument that being authentic is a proper goal for self-development in Western culture, they argue that the language of authenticity is useful because it provides guidance to patients.¹⁵ Authenticity suggests that there is a true self, the core characteristics of which are discoverable through introspection – thus the language of authenticity suggests the existence of selfhood, or the true self. They argue that the true self is the only plausible ground for a theoretical account of authenticity. This true self need not be unchanging but

¹³ Mackenzie and Walker 2015, *op. cit.* 8, p. 387.

¹⁴ Synofzik and Schlaepfer take a similarly skeptical approach to claims about DBS threatening personality. They rely on a naturalistic definition of the self to propose that: “the ethically decisive question is not whether DBS alters personality or not, but whether it does so in a good or bad way from the patient's very own perspective” (Synofzik and Schlaepfer 2008, 1514).

¹⁵ Taylor 1991, *op. cit.* note 1.

responds to life experience, education, and self-development, thus encouraging patients' reflection.

Alistair Wardrope also defends authenticity. He utilizes John Christman's definition of autonomy as comprised of both competency and authenticity to argue that authenticity is not just necessary for autonomy, it is a constitutive part of it.¹⁶ For Wardrope, authenticity is a form of hierarchical or reflective endorsement of our values and emotions – thus as with Erler and Hope, he interprets authenticity less as a “sense of self” and more as reflective awareness of the constituent parts of one's selfhood. He invokes both J.S. Mill (“A person whose desires and impulses are his own—are the expression of his own nature, as [...] developed and modified by his own culture—is said to have a character” and Immanuel Kant via Christine Korsgaard (“normativity flows from our practical conceptions of our own identity”) to make this point.¹⁷ In short, autonomy as free self-rule makes little sense if there is no identifiable “self” behind one's action, and autonomy is ethically significant as the source of moral action. Authenticity, then, is normative to the extent that being able to give an account of one's self is a requirement for being an autonomous agent.

Despite their unsettled uses of terminology and their diverse arguments about the value of the self, these varied ethical approaches to patients' claims about DBS all rely on some version of the assumption that being able to give an account of one's self (i.e., selfhood) or feeling like oneself (i.e., authenticity) is valuable. When this value is not intrinsic – derived from the thought that one ought to be a continuous self – it is based on the assumption that being able to give an account of one's self or having a sense of self is necessary for being an autonomous, moral agent.

Several of these authors reflect on this value via the role of the self in Western culture; given the scope of the literature that is drawn from to advance these diverse arguments, the influence of thinkers from particular backgrounds is certainly felt more strongly than others. Yet this is not just to say that this assumption must be mistaken because it is parochial. Rather, it is to point out that beyond culture, the analytic ground for relying on theories of selfhood to interpret patients' experiences ethically is not as

¹⁶ Christman, J. (2004). Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves. *Philosophy Studies* 117:143–64

¹⁷ Wardrope 2013, *op. cit.* note 8, p. 564.

strong as we might like. In the next section, I consider whether the assumption that the self is of value for the ethical discussion on DBS is justified.

4. BUDDHIST NO-SELF

Why think that we are properly “selves” in the first place? As suggested by Schechtman and Erler, this is a cultural idea as much as a philosophical one. To be one’s true self is “one of the constitutive ideals of modern culture.”¹⁸ As an ideal, it takes on normative dimensions: “many people today have the sense that an authentic life is somehow a higher life, a more fulfilled life; they feel that if they do not discover a path that is true to themselves, to their own talents and desires and aspirations, they are missing out on what life could be.”¹⁹ However, while this accounts for the tendency to frame some concerns through the lens of selfhood, it does not justify the assumption that the self exists. It surely does not justify its assumption in ethical analysis, for while many people may *believe* in the self, it neither follows that this belief is true such that selfhood ought to be protected nor that this belief ought to be reinforced even if it is false.

Skepticism about the self is a core element of Buddhist philosophy and practice across varied traditions.²⁰ While details of the theory of no-self differ, main similarities include the ideas that the self is not metaphysically real but is a conceptual construction and that reifying this conventional concept of the self as a metaphysical entity results in harm and confusion, given that the constructed self is both impermanent and causally ineffective.²¹ In the words of HH the Dalai Lama, “Any reification of a concept, even one

¹⁸ Taylor 1991, *op. cit.* note 1, p. 18-25.

¹⁹ Elliott 2003, *op. cit.* note 1, p. 34.

²⁰ These traditions include Vasubandhu’s Abhidharma Buddhism (Collins, S. (1982). *Selfless Persons: Imagery and Thought in Theravāda Buddhism*. New York: Cambridge University Press) and Japanese Zen Buddhism (Kopf, G. (2001). *Beyond Personal Identity: Dōgen, Nishida, and a Phenomenology of No-Self*. Curzon; Pawle, R. (2009). *The Ego in the Psychology of Zen: Understanding Reports of Japanese Zen Masters on the Experience of No-Self*. In: *Self and No-Self: Continuing the Dialogue Between Buddhism and Psychotherapy*, Mathers, D., Miller, M.E., and Ando, O. eds. New York: Routledge.). There are also formulations of the concept in the Kyoto School Philosophy of Nishida Kitarō. No-Self is commonly referred to in Pāli or Sanskrit terms: *anattā* and *anātman* respectively (Krummel, J. (2005). *Praxis of the Middle: Self and No-Self in Early Buddhism*. *International Philosophical Quarterly* 45(4): 180.). In Japanese it is *muga*.

²¹ Giles, J. (1993). *The No-Self Theory: Hume, Buddhism, and Personal Identity*. *Philosophy East and West* 43(2): 175-200. As with the self in European and North American philosophy, the

related to a positive characterization of our fundamental nature, is potentially harmful, for it breeds intolerance and a tendency towards dogmatism.”²² Importantly, this does not necessarily mean that there is no such thing as subjectivity or first-person experience. The no-self view does not reject that there is something it is like to be *you*; rather, it proposes that your experience from your own particular perspective does not mean that your self is an actual entity in the world with objective characteristics, just that your experience of the world is always perceived through the same lens. In other words, the no-self view is not a “no-subjective-experience” view. The phenomenology of subjective experience comes through your particular lens on the world. While this lens is unique, it is merely that – a lens – and does not exist as a thing in the world that can itself be experienced. To put this in the clarificatory language of the introduction, the Buddhist claim is that the “sense of self” is not a good enough reason to ground the belief in the self as the grounds of our identity – as a real entity that persists continuously through time.

Arguments for Buddhist no-self are both metaphysical and epistemological.²³ The metaphysical argument is that there is no reason to infer the ontological reality of a self from our phenomenological experience of our sense of self. Our experience is mistaken all the time, as when the perceived water we see in the road on a hot day turns out to be an illusion. The epistemological argument is that we know the self neither through perception nor through introspection – when we carefully investigate our inner and outer

concept of no-self is contentious in Buddhist philosophy as well (Albahari, M. (2002). *Against No-Ātman Theories of Anattā*. *Asian Philosophy*. 12(1):5-20; Siderits, M., Thompson, E., Zahavi, D. eds. (2011). *Self, No Self? Perspectives from Analytical, Phenomenological, and Indian Traditions*. Oxford University Press). For brevity of argument, this summary glosses over questions of which Buddhist philosophies are emergentist, reductionist, or eliminativist about the self (Ganeri, J. (2012). *Buddhist No-Self: An Analysis and Critique*. In: *Hindu and Buddhist Ideas in Dialogue: Self and No-Self*. Kuznetsova I and Ganeri J, eds. Routledge).

²² His Holiness the Dalai Lama. (2002). *Understanding Our Fundamental Nature*. In: *Visions of Compassion: Western Scientists and Tibetan Buddhists Examine Human Nature*. Davidson R and Harrington A, eds. Oxford University Press: 66-80.

²³ David Hume’s skepticism about the self resembles these arguments (Olson, O.T. (1998). *There is No Problem of the Self*. *Journal of Consciousness Studies* 5(5-6): 645-657.). Hume proposes that when we introspect, we do not find any single stable self, but rather a succession of causally related mental events – a “bundle of perceptions.” This is a close analogue to the Buddhist view, although Hume does not draw any explicitly ethical conclusions. Derek Parfit also expresses similar skepticism about the self (Parfit, D. (1984). *Reasons and Persons*. Oxford: Oxford University Press), as does Galen Strawson (*op. cit.* note 3).

experience, we do not find an independent entity corresponding to our sense of self.²⁴ I am glossing over detailed arguments here, but suffice to say that beyond metaphysical and epistemological arguments for the nonexistence of the self, the normative valence of the no-self account in Buddhism is clear – belief in the concept of self can cause harm both to oneself and to those whom are affected by one’s actions. Belief in a self leads one to try to preserve and protect what cannot be protected: an impermanent, constructed entity. Reification of the self also promotes the false idea that ethics is a matter of being a good person, rather than being a causally effective source of positive change.

In the place of the common assumption that the self is a continuous, unifying entity, Buddhist scholars propose that what is called the self is really a set of five aggregates: physical matter, sensation, perception/cognition, mental dispositions, and consciousness or mind. These five aggregates are constantly changing, such that the self is not a stable entity but a process or stream of different elements that are causally connected.²⁵ Continuity of the self is only apparent, conventional, or constructed.

This does not mean that actors lack awareness of the source of their actions and mental states. Many Buddhist practices aim for the cultivation of attentive insight into one’s nature as defined by the five aggregates. These five aggregates can be described as a collection of habits, an explanation that clarifies the significance of insight.²⁶ What we experience as a sense of self is an abstraction from the mental, physical, attitudinal, and affective habits that have been cultivated through patterns of cause and effect.²⁷ Accurate knowledge of the ground of our experience is not the sense of self, but attentive awareness of no-self. In other words, it is insight into the patterns of cause and effect in the five aggregates.

This insight is the source of awareness, understood as correct perception of one’s nature, and well-being. To have insight is to be aware that what we assume is the self is

²⁴ Chadha, M. (2016). No-Self and the Phenomenology of Agency. *Phenomenology and Cognitive Science*. Published online first, DOI: 10.1007/s11097-016-9455-1

²⁵ Dreyfus, G. (2002). Is Compassion an Emotion? A Cross-Cultural Exploration of Mental Typologies. In: *Visions of Compassion: Western Scientists and Tibetan Buddhists Examine Human Nature*. Davidson R and Harrington A, eds. Oxford University Press: 31-45.

²⁶ Carlisle, C. (2006). Becoming and Un-Becoming: The Theory and Practice of Anatta. *Contemporary Buddhism* 7(1):75-89.

²⁷ Loy, D. (2008). Awareness Bound and Unbound: Realizing the Nature of Attention. *Philosophy East and West* 58(2):223-243.

really an impermanent bundle of perceptions that ground our actions and reactions, leading us (for example) to experience aversion to things we perceive to be disgusting and to feel drawn towards situations we identify as pleasurable. From insight into this no-self, one can assess which habits (of behavior, cognition, feeling, etc.) have beneficial effects and deserve a positive response and which habits have detrimental effects and require a negative response. For instance, while I might think of myself as someone who just does not like trying challenging experiences, such as biking in the rain, I might identify the source of this reaction as my perception that certain situations merit fear. If I can recognize when this fear response is appropriate and when it is overactive, I can reflectively regain agency over my decision to engage in some actions and not others. This ability to reflect on the benefit of one's responses without reference to selfhood or a sense of self can enhance one's well-being and improve one's capacities as a source of positive change.

In the next section, I explain how insight into the no-self has implications for the ethical analysis of neural interventions.

5. THE NO-SELF AND NEURAL INTERVENTIONS

According to the no-self account, the self is not ultimately real – the belief in selfhood based in the subjective sense of self is unfounded. Widely used terms such as the first person pronoun and the word “self” are conventions, the use of which is determined by mutual agreement, not ontological reality.²⁸ In the words of Jonardon Ganeri, “‘I’ is a referring expression without a referent.”²⁹

This theory of no-self is not radically dissimilar from theories of narrative identity discussed above. The two theories agree that selfhood is a constructed concept that is conventionally used to make sense of one's experiences and actions and that such a self must be dynamic and relational, determined by social and political expectations and categories as much as by direct experience. They also agree that being able to make meaning out of one's experiences improves well-being. Yet where narrative identity suggests that the constructed self is the source of meaning and the locus of well-being,

²⁸ Giles 1993, *op. cit.* note 21.

²⁹ Ganeri 2012, *op. cit.* note 21, p.73.

Buddhist no-self proposes that these goods are more readily available when the concept of self is set aside. That is, even though the narrative self is dynamic and changing, it is still premised on the fact that it is valuable to construct one's world in terms of selfhood, where the self has its own characteristics as an independent entity. For narrative theorists, those characteristics are important; recognizing them allows us to engage in the work of constituting the self. They want to say that belief in selfhood and having a sense of self are valuable; I suggest that this is precisely what the no-self theorists would dispute.

What are patients saying when they report that "I don't feel like myself," "I feel like a different person," or "I feel like an electronic doll"? According to narrative identity theorists, patients are reporting what they intuitively feel – an inability to incorporate a neural intervention into their life story. The narrative theorist may propose working with a patient and those close to her to see their lives as continuations of the lives they were living before (as with Schechtman) or to restore the emotional and critically reflective capacities required for narrative self-revision (as with Mackenzie and Walker).

I contend that the Buddhist no-self theorist will be more skeptical about the referent of patients' referring expressions. As Monima Chadha argues, in many experiences we do not have a conscious sense of agency or authorship of our actions – it is only in some special cases that an unpleasant feeling is identified as a *lack* of the feeling of authorship or agency.³⁰ People immersed in certain physical and artistic activities – running or playing music, for example – often report having no sense of self, yet they can act fluidly and expertly. Even when engaged in intentional planning and imagination of our futures, we do not consciously do so from the sense of "I am a person who would..." Rather, we think, "It seems natural to..." or, "It is important to..." This is not to say that there is no difference between these first-person experiences and the objective understanding of others' experiences. There is still an immediate phenomenal character to these experiences – the feeling of running or playing music. The point is just that there is no need to invoke a metaphysical self in order to appreciate the *sense* of running in these experiences.

While there is no persistent, positive sense of self, unwelcome feelings may be interpreted as a negative sense of its absence. As David Loy suggests, "the need to feel

³⁰ Chadha 2016, *op. cit.* note 24.

more real, and the perpetual failure to achieve it, haunts the sense of self as a sense of lack.”³¹ The goal of insight is to become aware of the causal source of one’s discomfort and to determine a more comfortable response, not to construct a concept that makes sense of the discomfort. When patients say, “I don’t feel like myself,” they might just mean that “something feels wrong.” If a patient reports feelings of alienation, a no-self theorist might suggest that the patient works with her care team and her intimates to gain insight into the cause of the feeling. Perhaps an activity she used to enjoy, like her work, no longer gives her pleasure. The solution may be to explore new activities as sources of pleasure, or to recognize different ways of feeling pleasure. A sense of alienation is a symptom of her discomfort, but a sense of self is superfluous to resolving her concerns.

This does not mean that the no-self theorist is skeptical about whether patients’ subjective experiences are really as pleasant or unpleasant as they claim. Rather, it is skeptical about the assumption that communication always entails a superficial interpretation of the meaning of the words and expressions that patients use. If a patient says “I don’t feel like myself,” the Buddhist response is not to dismiss it as ignorant or immature. The no-self response to such a statement would not be, “but you don’t really mean ‘self,’ do you?” Rather, the response would be “Let’s try to understand these feelings. Can you describe them in more detail to me? When and how do they arise?” In this way, a no-self theorist can tease out the source of the discomfort with care, rather than skepticism or superiority.

This applies to third-person authenticity claims as well as to first-person claims. A spouse may object to DBS, saying that, “I just don’t recognize my partner anymore” (following Baylis, they may equally say this about a partner who has picked up a new hobby or made a new group of friends). According to the no-self theory, this does not necessarily mean “my partner has become a new person,” but: “I find this change unpleasant.” If the partner has insight into the source of the change – perhaps she has begun traveling alone because it stimulates her curiosity and her creativity – she can work with her partner to understand this beneficial causal relationship. If her partner suspects that she *lacks* insight, he may encourage her to question her behavior – why do you think you are acting this way? While narrative theories are correct that making meaning is an

³¹ Loy 2008, *op. cit.* note 27.

interpersonal project, there is no need to posit a self as the locus of meaning, only a need to identify a viable causal explanation.

6. POTENTIAL OBJECTIONS

Before concluding, I consider three potential objections to my proposal that the no-self theory is useful in considering cases of patients feeling unlike themselves with DBS.

First, there is the objection that while the no-self theory proposes an ideal to be achieved by long-term Buddhist practitioners, it is not a theory for everyday people, such as people who require DBS for medical reasons. This is a larger question about whether the no-self theory is an ideal theory, meant to apply only to aspiring and actual Bodhisattvas, or whether it is a broader statement about the non-existence of the self and its normative implications. This question is the focus of much discussion in Buddhist philosophy, and I do not believe it is something that I can resolve here. However, what I do suggest is that the no-self theory does not seem to be aspirational in the way that an ideal theory would need to be. It does not propose that if one practices, then that person will achieve no-self. Rather, the idea is that the self does not exist for anyone, but we think and act as if it does. By engaging in Buddhist practice, one is not working to bring something new into existence, but to realize (to recognize) what already exists: the truth of no-self. The question then becomes whether the clinical response to patients ought to reinforce the language of the self, or work to identify the grounds of patients' distress. This brings me to the second objection.

The second objection is that while the no-self theory may be helpful for some patients, theories of narrative identity will be helpful for others. On this view, persons have diverse methods for understanding their experiences, and each will use different means to achieve balance after a disruptive event like DBS surgery. Ethical responses to patients ought to meet them where they are in terms of self-understanding, and not respond through a theory that may not resonate with them. On this point, I agree. The above argument is not meant to imply that the language of the self will necessarily be misguided in all cases – for some patients, reconstructing a narrative sense of self may be the best way to gain insight into the relationships between causes and effects in their own

life. Yet while this language may be useful for some patients, it is just that – an occasionally useful language, like a metaphor through which to understand a difficult situation – and ought not be posited as the ethical locus of patients’ concerns. This is not to say that all ethicists propose interpreting patients’ statements solely in terms of a sense of self; rather it is to point out that the ethical discussion thus far has focused on the sense of self to the exclusion of other normative frameworks.

Part of what makes the conversation about how to respond to patients’ concerns following DBS difficult is the connection between ethical theories and ethical practice, given the complexities of the clinical domain. In the clinical context, the goal is to respond to patients’ concerns, not to assess whether different theories are correct. Yet in the broader ethical discussion removed from immediate clinical realities, patients’ concerns often become opportunities to identify the strengths or limitations of particular theories. My argument here is meant to show two things: first, that the clinical approaches suggested by various proponents of self-based theories are not the only possible responses to patients’ concerns, and second, that there are normative reasons to question the use of self-based theories alone to develop these approaches.

Third and finally, some might object that the no-self theory is most relevant in Buddhist cultures, but that the centrality of the self in Western, and especially American, culture requires that we begin our theorizing from the value of the self. Yet this is surely not a philosophical response. If we agree that ethical justification of particular practices requires something broader than cultural description, then we ought to pay attention when our justifications rely on the fact that a given concept is an important part of a particular culture. My argument here is an attempt to show how a non-Western theory can challenge the assumptions within Western theories and develop an ethical analysis that is wider in scope and on firmer ground.

7. CONCLUSION

In conclusion, neural interventions need not be understood as threats to either authenticity or identity, but, as with any sudden addition of a new causal element into a system of relationships, they can be the source of negative effects by obstructing individuals’ insight into the source of their feelings and actions and impairing their

abilities to act towards their own and others' well-being. In such circumstances, patients need not necessarily work to reconstruct a sense of self, but should be encouraged to identify relationships between this new causal element and their habits, sensations, thoughts, and so on, and to assess the effects of these relationships on their own and others' well-being.

The theory of no-self makes sense of individuals' reports of inauthenticity without relying on the self. Essentially, the Buddhist proposal highlights that if "who we really are" or the "true self" is a cultural concept and not an ontological entity, then in ethical conversations it can be utilized normatively for divergent ends. An unwanted intervention threatens the true self, but an endorsed intervention supports it. Neither claim says anything about whether the intervention itself is good or bad, desirable or undesirable. The language of the self becomes a placeholder for missing argumentation. By rejecting the assumption that the self is valuable, ethicists can respond to patients' distress without continuing the metaphysically and ethically problematic reification of the conventional self.