I Am Not My Self: Reconceiving Identity in Rehabilitation Medicine

Introduction

Who are you when your body becomes a foreign country, or your mind an island? The mapping of identity starts from a young age and involves several factors, uniting mind and body. But through injury, incident, or intervention this can be abruptly altered. Rehabilitation medicine is concerned with optimising functional ability in individuals, reducing their experience of disability [1]. As a medical discipline, this has frequently been defined narrowly to primarily focus on physical functionality [2]. In recent decades, however, there has been increased interest in the role of rehabilitation medicine in self-identity – and self-identity's role in patients' experiences of rehabilitation [3]. This is typically through the lens of phenomenology and Merleau-Ponty. While this approach allows for the development of serious consideration of identity in rehabilitation medicine, I will draw on a Wittgensteinian view of identity to present a different approach and to elucidate some of the complexities faced by those undergoing rehabilitation, with the overall goal of improving patient experience and outcomes. To further illustrate this, I draw on my own experience listening to the narratives of patients with lower limb amputations.

Self and Rehabilitation

It has long been recognised that to have a truly holistic approach, the self[1] must be considered [4]. This is stressed in the research around neuropsychological rehabilitation, particularly around brain injury[2] [5] [6] [7]. In focusing on identity as a key in both injury and recovery, we shift our focus from a purely biological view to consider the social, psychological and spiritual as well. Moreover, identity can help unite these aspects, recognising the way biological damage along with psychosocial factors contribute to a patient's condition [8]. Talking about identity allows researchers and clinicians to acknowledge the wider impact of illness on patients, such as their biographical disruption, change of sense of self, and altered feelings of security [9]. Such a perspective allows clinicians to tailor their practice or, as Ellis-Hill puts it: 'people do not always want us to "solve a problem"; being heard, sharing experiences and receiving validation is just as important' [10]. One systematic review found there is some positive evidence for the effectiveness of using identity reconstruction as a central part of neuropsychological rehabilitation, although studies are limited [11], with more research needed.

One issue in the literature centres on the problem of incorporating identity into clinical rehabilitation practice owing to the difficulty of conceptualisation [12]. Discussion of the self in Western philosophy often begins with Descartes' immortal utterance of the cogito: 'I am thinking therefore I exist' [13, p. 36]. This is derived from Descartes' doubts in his senses such that they should not be trusted as leading to knowledge. However, in asserting this he observes 'it was necessary that I, who was thinking this, was something' [13, p. 36], thus leading to his assertion that the self is distinct from the body and resides in the intellect, forming the sole thing one cannot coherently doubt. In an empirical age, this dualism does not abide with our materialist sensibilities. Moreover, physical damage is recognised as the root of identity changes in rehabilitation. Yet the notion the self is important has persisted. Although there is a reluctance to pin down a specific view of the self in rehabilitation, with many taking a "hyphenated" view which encompasses many schemas [3], a phenomenological approach has proved popular [14] [15] [16] [17]. Derived primarily from Merleau-Ponty [18], this view takes experience as subjective perception, with a quality known only to the proprietor, but which is

[1] Note that in the literature the words "self", "identity", and "self-identity", amongst others, are all used. For some these are interchangeable [32] while others make some delineations [12] [3]. In this essay, I will primarily use "the self" as emblematic for many of these different phrases, based on the ways they are used. By this I mean the idea of the self (or identity etc.) as some*thing* that you can have.

[2] This essay will look at other areas of rehabilitation, although it should be acknowledged that all of the rehabilitation literature used is primarily about neuropsychological conditions.

inherently situated within a body. Consequently, it is not so much that humans have a body but that they are their body, as a key facet of their personhood. In contrast to Descartes, this view stresses the realness of the physical and its unity with the intellectual: 'The world is not what I think, but what I live through. I am open to the world, I have no doubt that I am in communication with it, but I do not possess it; it is inexhaustible' [18, pp. xviii-xix]. This means the body is both an object in the world and a subject through which the world is experienced [17].

But Why the Self at All?

Under this view, then, the body is the thing through which the self becomes known, and through which the self is, in part, constructed. While this is appealing, why must we consider there is an ethereal "self" to been known or constructed? Is this not continuing the Cartesian view of a separate cogito? We are drawn into thinking that, because we think there is no person without a self, the self must be identifiable as separate from the person. This confusion is one which Wittgenstein identifies in his *Philosophical Investigations*. For Wittgenstein, the construction of the self arises from mistaken philosophical analysis [19](§413) in which we are misled by the grammar of phrases like "I am in pain" to believe this signifies an inner self by whom the pain is experienced [19](§404-410). We take the "I" not as a replacement for my name or my whole person, but a self who experiences that pain and about whom we refer when we talk of a person's identity.

This is further elicited in Bennett and Hacker's *Philosophical Foundations of Neuroscience* which describes the notion of the self as 'an aberration' resulting from the confusion of tacitly inserting a space into reflexive pronouns such as "myself", "yourself", "ourselves" to make "my self", "your self", and "our selves". Consequently, 'having opened up an illicit space, we then fall into it' [20, p. 382]. Such a misunderstanding entices us to believe that there is a 'mysterious object' called a self 'whose nature must be investigated' [20, p. 382]. We create a psychological Ego, to be defined, rather than accept that 'to speak of myself is not to speak of a self which I have, but simply to speak of the human being that I am' [16, p. 382]. When thinking about a person there is no separate "self" to be considered: they are them and they are themselves, accepting what we see before us as the entire person.

This might appear similar to the Merleau-Pontian phenomenological view owing to its stress on unity between body and self. However, in speaking of the ways in which the body can be understood, and the positioning of the body-as-subject being experienced differently to the body as object, Merleau-Ponty is still falling into the trap of creating a self, separate from the experiential. Instead, when introspecting, or examining another, 'We can find thoughts, intentions, and the body in action, but not the bearer of thoughts, the author of intentions, or the owner of the body' [21, p. 158]. The self is never found because it was never there to be found. We must therefore limit ourselves in what we seek to study in the person before us, to consider expressions of self as about what is happening in one's life and one's attitude towards life [22]. In our rush define the "self" we should step back and question whether we are wrong to try and define a *thing* at all.

Significance for Rehabilitation

This argument is not simply a philosophical difference but has real application and relevance for rehabilitation researchers and, more importantly, for patients. Firstly, there is the value of conceptual clarity. This is something which researchers frequently cite as an important area of development in research [23] [12][3]. However, this is not about policing the ways in which patients express themselves. The colloquial expressions around the self can still carry meaning for an individual and can be helpful as metaphors for conveying a person's experience. For example, one interviewee in a study talked

[3] Some researchers try to get around the complexity of defining the self by speaking of "sense of self" (see [12]). "Identity" is another term used. However, without sufficient clarity, these terms become proxies, always edging close to the idea that there is a self to define or to have a sense of, or that an identity is something we possess.

about their brain injury as a death of their self [24]. This is certainly expressing something about the reality that person was living – the profound changes they had undergone, the chasm between their current experiences and their past interactions. However, what is ruled out are philosophical, psychological and neuroscientific claims based on this way of speaking [20, p. 384] such that in talking about the self the person is taken as making a claim about a thing which exists. Their experience and emotions ought to be taken seriously, not any potential metaphysical attribution. It is not about correcting ways patients express themselves but ensuring it is not philosophically over-interpreted.

Secondly, beyond conceptual clarity, this view of identity as resting not in a self but in a person, whole and complete, is a profoundly hopeful one within rehabilitation, making this a practical as well as philosophical argument. When a person experiences a significant illness or injury it is not that their previous self is lost, broken, damaged, changed; instead, their circumstances have changed, or their reactions to circumstances, or their physicality. This is not to down-play its significance but to iterate a sense of continuity. If you have an idea of the self as a "thing", you can realistically talk about it being lost or broken, much like a prized possession. The change the person has undergone is then located *within them* and is framed as a defect, or places their previous way of being as out of reach. Consequently, the picture which is created is not just incorrect but also negative and lacking hope. As Whiffin and Ellis-Hill ask: 'How many clinicians have said the words "they will never be the same" to a family member by a hospital bedside?' [25, p. 125]. If we take this within the model of self-as-thing you are telling the family some fundamental essence of their relative's existence has altered.

The Wittgensteinian view is also in line with the social model of disability: the patient is not a defective version of who they once were, but they are in a different set of circumstances which poses new challenges, new ways people react, and new barriers owing to the way the world is set up and their interaction to it[4]. Of course, this is notwithstanding the various critiques levelled at the original social model of disability, like its denial of the body's role [26], but to highlight the importance of social relations to a person's experience of their 'embodied vulnerability' [27]. A patient I met on a ward had had a mid-knee left leg amputation five months previously and was really struggling to come to terms with it. She was still in pain, fearful of losing her other leg, and frequently tearful. She was worried about caring for her son and what it would mean for her work. With the loss of her leg, she felt like so much had been taken, including many activities from which she gained a sense of identity. However, rather than seeing this as some*thing* lost or altered, a self she no longer possesses, an identity changed, we should view this as an altered way of being in the world, a new relationship to it. What this woman needed was not to construct a new model of selfhood, but assistance in adjusting to her different embodied relationship with the world.

Narrative and Social Identity

These social relations are very important in this view of personhood. In this view an identity is not something you "have" as this is too readily confused with being a possession, but it is something you live. You *are* your identity; you *are* yourself. In being lived, it is dynamic, it can be impacted by various circumstances and changes. Consider the following sentences:

1. I have changed.
2. Everything has changed.

To centre discussions around the former is to place the locus of change as entirely within the person, seemingly attributing blame. The latter encompasses the experiences and interaction of others around the person as they can be the cause of change, as much as the illness itself. Once again, this is not to police the language used colloquially, but to allow for critical assessment of the language with is used.

[4] See Michael Oliver's seminal work on this topic [30] and statements such as: 'disability is the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities' [31, p. 22].

To believe you, as a person, are fundamentally changed is deeply alienating. Glintborg warns against reifying a diagnosis of brain injury such that it becomes the person's full identity and subjugates their humanity [23, p. 27]. Echoing this, I would warn of the dangers of reifying the self, estranging patients from their continued humanity, and focussing discussions on what is lost, not on persistence. On a separate occasion, I spoke to a man with a recent above-knee amputation and, while he undoubtedly had concerns about the impact it would have on his life, he was still keen to talk about his hopes for the future and the desire to be a good husband, father, and grandfather. The way he was seen in these social roles would change, and this will require some sense-making, but I would deny this is the same as "identity reconstruction"[5], but rather as changes enough within themselves, without being taken as an indication of an essential alteration.

Much of the literature around self-identity in rehabilitation utilises narrative as a key tool [10] [23] [28]. It is here I can find some common ground, although rather than seeing narrative as a means for expressing a new 'inner subjective experience' [12], it is constitutive of our senses of personhood. Holmes, for example, rejects the idea of a pre-existing self in favour of one which forms through telling: an 'autobiographical self' [29, p. 179]. In speaking of his hopes for the future, and the things he had done in the past, the man was not just telling me about himself, but developing that understanding of who he was and how he relates to the world. This is not just a cerebral activity, but one which relates to the body as well. Narrative gave a sense of bodily capabilities, such as how he used to run marathons, and conveyed his pain. Through narrative, though, these are not isolated, but connected, incorporating how he sees himself as a person, and how he believes others see him.

Conclusion

Merleau-Ponty's writing is of benefit to rehabilitation medicine because it brings to the fore the idea of an embodied self, reinforcing the physical aspects which construct a person's place in the world. When considering a person whose physicality has changed their place in the world – be that through a stroke, brain injury, or an amputation – this connection between self and physicality seems an important one. However, I have argued that, through isolating the "self", even in an embodied sense, we are creating a false perception of reality. Instead, when a person says "I have changed" what we can appreciate is "things have changed", thus reducing the blame on them. Through a Wittgensteinian rejection of the reified notion of the self, we can appreciate the wholeness of a person, regardless of their illness or disability. There has been no fundamental shift inside them. In this we can also see the importance of narrative: not the reporting of some internal sense of self but the creation of personhood, as an expression of an attitude.

[5] Ownsworth and Haslam, for example, say: 'Self-continuity is often achieved in the course of re-connecting with one's values, activities (e.g., hobbies), and social networks and roles (e.g., as a parent); many of which are closely tied to one's self-understanding… identity reconstruction ultimately involves coming to terms with an altered lifestyle and change in future goals' [11]. While I acknowledge these changes as significant, I deny the suggestion that these changes in relations are an indicator of anything deeper than just that.

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