

# Deep brain stimulation, authenticity and value: further reflections

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3 *Deep Brain Stimulation, Authenticity and Value*

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6 *Further Reflections*

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9 QA SVEN NYHOLM and ELIZABETH O'NEILL

10  
11 **Abstract:** In this article, we engage in dialogue with Jonathan Pugh, Hannah Maslen, and  
12 Julian Savulescu about how to best interpret the potential impacts of deep brain stimulation  
13 on the self. We consider whether ordinary peoples' convictions about the true self should  
14 be interpreted in essentialist or existentialist ways. Like Pugh, Maslen, and Savulescu,  
15 we argue that it is useful to understand the notion of the true self as having both essentialist  
16 and existentialist components. We also consider two ideas from existentialist philosophy—  
17 Jean-Paul Sartre and Simone de Beauvoir's ideas about "bad faith" and "ambiguity"—to  
18 argue that there can be value to patients in regarding themselves as having a certain amount  
19 of freedom to choose what aspects of themselves should be considered representative of  
20 their true selves. Lastly, we consider the case of an anorexia nervosa patient who shifts  
21 between conflicting mind-sets. We argue that mind-sets in which it is easier for the patient  
22 and his or her family to share values can plausibly be considered to be more representative  
23 of the patient's true self, if this promotes a well-functioning relationship between the patient  
24 and the family. However, we also argue that families are well advised to give patients room  
25 to determine what such shared values mean to them, as it can be alienating for patients if they  
26 feel that others try to impose values from the outside.

26 **Keywords:** deep brain stimulation; authenticity; the true self; essentialism; existentialism;  
27 values; anorexia nervosa

28 When patients and their families express concerns about the impact that deep  
29 brain stimulation (DBS) can have on the self, are these concerns always primarily  
30 about psychological continuity over time, or are they sometimes concerns about  
31 something else? Moreover, should we take it for granted that DBS either has a bad  
32 effect on the self or else is neutral, having no effect on the self? In our previous  
33 article on this topic in the *Cambridge Quarterly of Healthcare Ethics*, we argued that  
34 neuroethical discussions of DBS should be concerned not only with continuity  
35 over time, but also with the impact of DBS on what patients and their families  
36 think of as the patient's "true self." We also argued that sometimes, the effect of an  
37 intervention such as DBS is neither bad nor neutral with respect to the self; rather, it  
38 can also be positive, by helping to rehabilitate or make manifest the patient's true  
39 self. In such cases, the patient can be understood as achieving greater "authenticity"  
40 with the help of DBS.<sup>1</sup>

41 In their article in this issue, Jonathan Pugh, Hannah Maslen, and Julian Savulescu  
42 move the conversation on DBS and authenticity forward, partly by highlighting  
43 and discussing a number of issues that we did not comment on in our previous  
44 article.<sup>2</sup> We are delighted to have this opportunity to engage in a dialogue with  
45 them about how best to interpret and analyze the idea of authenticity and the true  
46 self in relation to its importance for DBS patients and their families.

47 Pugh, Maslen, and Savulescu, address a number of theoretical points before  
48 returning to the sorts of practical cases that motivate the debate about DBS and  
49 authenticity. They emphasize a general distinction between "essentialist" and  
50 "existentialist" understandings of authenticity and the practical implications

1 of this distinction. They also discuss the question of what it is to value some-  
2 thing. They do so because, like us, they think that people's values are closely  
3 related to what they and others will perceive as representative of their true  
4 selves.

5 Here, we will follow their lead. We will first discuss the essentialism/existentialism  
6 distinction as a way of deepening the analysis of peoples' intuitions and beliefs  
7 about the authentic or true self. We will consider a certain type of unavoidable  
8 ambiguity at the heart of the human condition that this distinction suggests. Like  
9 them, we will also discuss the relation between peoples' values and what they  
10 regard as their true selves. Most importantly, however, we will return to a practical  
11 case that Pugh, Maslen, and Savulescu also discuss: namely, the type of case in  
12 which DBS patients (or other patients) are shifting between different mind-sets,  
13 and the question therefore arises if any of these mind-sets is more representative  
14 of the patient's true self.

15 In particular, Pugh, Maslen, and Savulescu focus on patients with anorexia  
16 nervosa (AN), because such patients are sometimes unstable in their mind-sets.<sup>3</sup>  
17 Suppose that in one mind-set an AN patient believes that his or her condition is a  
18 health problem that should be treated. But the patient then sometimes shifts back  
19 to a mind-set in which he or she places a higher value on being extremely thin  
20 than on being "healthy" by common medical standards. Such cases raise two  
21 distinct and difficult types of questions. First, are there any general reasons for the  
22 patient or a third party to regard one mind-set as more representative of the per-  
23 son's authentic or true self? Second, under what conditions, if any, would a third  
24 party be warranted in intervening to encourage the mind-set that that third party  
25 thinks is more authentic?

26 When we discussed this type of case of shifting, conflicting mind-sets in our  
27 earlier article, we made a suggestion about how family members—and also the  
28 patients themselves—might go about deciding which mind-set is more represen-  
29 tative of the patient's true self. Our suggestion was that a mind-set in which the  
30 patient is inclined toward values that are widely endorsed and viewed as sensible  
31 or legitimate, even by those who do not share them, is, *ceteris paribus*, a better can-  
32 didate for being representative of the patient's true self than an alternative mind-  
33 set in which the patient is inclined toward values without that feature. Pugh, Maslen,  
34 and Savulescu reasonably request further explanation for why such mind-sets  
35 should be considered more representative of the person's true self. We will address  
36 this question here.

37 The reason we offer has to do with what will be a main theme of the second half  
38 of these further reflections having to do with the social roles that values play in  
39 our lives. However, we want to be very clear about the restricted nature of our  
40 claim on this topic. Our point that the shared status of some values can shed light  
41 on authenticity applies primarily to circumstances in which a patient experiences  
42 shifting mind-sets that prevent appeals to stable values to resolve authenticity  
43 questions. Furthermore, even in those cases, using information about more easily  
44 shared values to identify the more authentic mind-set does not necessarily pro-  
45 vide either the patient or a third party with an overriding reason to think that this  
46 mind-set should be pursued. Manifesting a characteristic that one interprets as  
47 representative of one's true self is a value, but there are other important values—  
48 for example, the value of respecting a person's personal autonomy—that also matter  
49 greatly. This point will be further developed later.

1 **Essentialism and Existentialism, Part 1: Internal Coherence and Synchronic**  
2 **versus Diachronic Self-Concepts**

3 In our earlier article, we made the following six observations about the notion  
4 of the true self: (1) The concept permeates human thinking, and, therefore, will  
5 affect how stakeholders interpret the results of DBS. (2) The true self is a syn-  
6 chronic notion that permits us to describe effects of DBS on the self, which the  
7 diachronic concept of personal identity does not. (3) The extent to which the true  
8 self is expressed can be a matter of degree. (4) The degree to which persons feel  
9 that their true self is expressed can be influenced by their modes of function-  
10 ing, which can be affected by DBS. (5) In some cases, radical transformation  
11 can make the true self more fully expressed. (6) Which features are considered  
12 characteristic of a person's true self depends, in an important sense, on which  
13 features that person values.<sup>4</sup>

14 As Pugh, Maslen, and Savulescu note, in focusing on these six points, there was  
15 an issue that we did not comment on in our discussion; namely, whether we had  
16 in mind an "essentialist" or "existentialist" conception of the true self. To address  
17 this question here, we should first be clear about our aim. Our previous article  
18 addressed the true self as a concept that tends to concern ordinary people, includ-  
19 ing patients, and which, therefore, is worth considering in DBS decisions. We did  
20 not directly engage with the question as to whether there is a true self that exists  
21 independent of peoples' concept of it.<sup>5</sup> Consequently, our present interest in ques-  
22 tions about essentialist and existentialist conceptions of the true self is primarily in  
23 whether people tend to conceptualize the true self in existentialist or essentialist  
24 ways, and whether there might be any practical benefits associated with either,  
25 or both of these ways, of conceptualizing the self.

26 Pugh, Maslen, and Savulescu argue that our points (2) and (6) suggest an  
27 existentialist understanding of the notion of the true self. What does that mean?  
28 According to an *existentialist* view of the true self, which characteristics are part of  
29 one's true self is a matter of the choices people make and the agency they exercise.  
30 Thus understood, being one's true self is a matter of "self-creation." By contrast,  
31 an *essentialist* interpretation of the true self sees it as a static set of characteristics  
32 to be discovered.<sup>6</sup> We did not set out to present an existentialist interpretation of how  
33 people think about the true self in our previous article. However, we do think that  
34 there are some ideas within existentialist philosophy that are useful in this overall  
35 discussion. In the next section, we briefly discuss some such ideas; but here, our  
36 focus is on the discussion by Pugh, Maslen, and Savulescu.

37 As they note, there is some reason to think that the folk concept of the true self  
38 is essentialist to a significant extent, in the sense that people typically think of the  
39 characteristics that constitute the true self as "deeply inherent within the person."<sup>7</sup>  
40 This is consistent with a more general phenomenon of folk essentialism.<sup>8</sup> However,  
41 it is worth considering whether there are also existentialist aspects to ordinary  
42 peoples' conception of the true self, in the sense that people view the true self  
43 as partially determined by the free choices and the agency of the human person.  
44 Very likely, most people have intuitions and beliefs about the true self that point  
45 in conflicting directions.

46 Pugh, Maslen, and Savulescu prefer a combined view, "the dual-basis framework,"  
47 that understands being one's true self in an authentic way to involve both discov-  
48 ery and choice about who one wants to be.<sup>9</sup> We are in broad agreement with those

1 authors here. Rather than viewing essentialism and existentialism as opposing  
2 interpretations of the true self, we find it useful to view the true self as partially  
3 discovered, but also potentially something over which people have some control.  
4 Whether people manage to manifest what they take to be their true self surely  
5 depends on multiple factors, both in and outside of their control. We believe that  
6 it is possible to take this sort of view without abandoning the six points we made  
7 in our earlier article.

8 With regard to point (2) from our previous article in particular, Pugh, Maslen  
9 and Savulescu argue that there may be a tension between our claim that the true  
10 self is a synchronic notion and the task of determining which features of a person  
11 are aspects of their true self, which often entails considering enduring aspects of  
12 the self. Moreover, as they and also Alexandre Erler and Tony Hope point out, one  
13 reason patients are frequently concerned with the true self is that they are in  
14 pursuit of practical guidance.<sup>10</sup> Pugh, Maslen, and Savulescu suggest that our  
15 view may face a problem that Erler and Hope take existentialists to face: namely,  
16 failing to provide choice-independent guidance about which characteristics are  
17 more representative of the true self. We recognize this as an important concern,  
18 and will discuss it presently. First, we briefly elaborate on our characterization of  
19 the true self as a synchronic notion.

20 Our discussion of synchronicity was motivated by the idea that patients' con-  
21 cerns about authenticity need not be solely rooted in a desire to maintain past  
22 characteristics. As an example, we mentioned that although it might be more in  
23 keeping with the past for a patient with severe OCD to continue having obsessions  
24 and compulsions, it might seem to that patient that his or her true self might be  
25 better realized if upon DBS treatment, the patient manages to finally get his or her  
26 obsessions and compulsions under control.<sup>11</sup>

27 Part of our point about synchronicity was that at any given moment of assess-  
28 ment, regardless of personal history or future, persons can always be thought of as  
29 exhibiting their true selves to some more or less fully realized degree. Moreover,  
30 *judgments* about authenticity and the true self are also made at particular moments  
31 in time; and, such judgments about the characteristics that constitute an individual's  
32 true self may change. Lastly, whether the mere persistence of a given characteristic  
33 over time makes it more likely to be counted as part of the true self ultimately  
34 depends on the particular conceptualization of the true self endorsed by whoever  
35 is making a judgment, and whether it is manifest.<sup>12</sup>

36 Pugh, Maslen, and Savulescu propose an alternative interpretation of the true  
37 self. They say that on this account, one can appeal to a person's values over time  
38 to resolve questions about which characteristics are authentic. However, we are  
39 skeptical that this proposal offers benefits that a synchronic interpretation of the  
40 concept of the true self could not. So what is their account? They write, "the true  
41 self is best construed as being constituted by the cohering elements of the indi-  
42 vidual's nexus of values and their rational beliefs."<sup>13</sup> In effect, these authors offer  
43 a procedural account of authenticity, according to which people can change their  
44 manifest characteristics authentically if this change is intelligible and justifiable in  
45 accordance their existing set of values and rational beliefs.<sup>14</sup>

46 Such a coherence-based account implies, as the authors themselves note, that it  
47 is possible for a person to undergo radical transformational changes authentically,  
48 provided that it is coherence that supplies rational guidance for each change that  
49 the agent makes. This does place constraints on the possible ways that a person

1 can change at any given moment, since this depends on the person's existing suite  
2 of values and beliefs, but it also means that in principle there are no essential,  
3 unchangeable aspects of one's values, beliefs, and characteristics. As a consequence,  
4 in principle there are also no essential, unchangeable aspects of the true self.

5 This certainly strikes us as an interesting proposal. We agree that coherence can  
6 be important for understanding which values, beliefs, and characteristics are best  
7 counted as part of someone's true self. Furthermore, we see that a coherence view  
8 of the true self can provide guidance also in cases in which a person counts a long-  
9 standing, disvalued characteristic, such as OCD, as not being part of his or her  
10 true self. However, we think that the supposed diachronic nature of this account  
11 is unnecessary for obtaining this practical guidance.

12 The action guidance here is supplied solely by the procedural aim of obtaining  
13 coherence among one's own values, beliefs, and characteristics, given a starting  
14 set of the same. Whether such features have endured or are quite new does not  
15 really matter for helping someone ascertain which of two possible features is more  
16 authentic in the sense of cohering with the person's earlier positions. The person  
17 needs only to refer to his or her existing features, ascertain how coherence can be  
18 promoted, and then choose one of the actions that would promote coherence; for  
19 example, jettisoning an existing characteristic or adopting a new value. What  
20 matters for action guidance here is not continuity over time as such, but rather the  
21 more "logical" feature of coherence among the different states of mind that people  
22 can transition between. Therefore, we conclude that having a diachronic view of  
23 authenticity is not strictly required for action guidance. A purely synchronic version  
24 of Pugh, Maslen, and Savulescu's coherence account illustrates this.

25 That being said, we suspect that in most cases in which people feel that their  
26 conceptions of their true self have provided them with practical guidance, it is  
27 probably something more substantial and content related than coherence among  
28 their mental states that gave them this sense. Most likely, people who feel that they  
29 achieve guidance by a conception of their true self will typically find that they are  
30 able to pinpoint some aspect of themselves with which they strongly associate or  
31 are moved by some value that they truly wish to live by. Many people do want to  
32 be "true to themselves," and this can mean trying to be consistent; however, often-  
33 times it is likely to mean something more substantial related to what they think they  
34 are like or what they aspire to be.

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## **Essentialism and Existentialism, Part 2: The Neuroethics of Ambiguity**

38 Taking a wider and more general perspective, and setting aside for the moment Pugh,  
39 Maslen, and Savulescu's discussion, might it be helpful for patients to think of their  
40 true selves in a partly existentialist way? It is true that there are many real constraints  
41 on which characteristics people can actually manifest. On the other hand, people also  
42 have substantial control over which characteristics they exhibit. As far as making  
43 choices based on authenticity, agents may not obtain much practical guidance about  
44 how to be authentic if they think that the features that define their true self are *com-*  
45 *pletely* up to them. However, we believe that it may promote both autonomy and well-  
46 being if people believe that they have some choice and control over which of the  
47 characteristics that they do, or could, manifest are authentically their own.

48 This brings us to some basic ideas from the work of existentialist philoso-  
49 phers Jean-Paul Sartre and Simone de Beauvoir that we propose as being relevant.

1 Beginning with Sartre, the concept of “bad faith,” which he discusses in the sec-  
2 ond chapter of his *Being and Nothingness*, is important in this context.<sup>15</sup> Briefly  
3 stated, this is the idea that if we believe that we have a very strongly fixed essence  
4 and that all the norms and rules we think of ourselves as subject to are all absolute  
5 and non-fungible, then we are subject to a sort of self-deception: “bad faith.”  
6 We then fail to recognize a freedom that we possess as human beings to shape  
7 ourselves and our situation. We deceive ourselves—according to this idea of bad  
8 faith—if we think that human society and culture have to be exactly as they are  
9 and that we have an essence about which we can do nothing.

10 Also important from existentialist philosophy is what Simone de Beauvoir calls  
11 the “ethics of ambiguity.”<sup>16</sup> the idea that our human condition is deeply ambiguous  
12 in nature. On the one hand, we are constrained by biology and shaped by society  
13 and culture, but on the other, we also possess freedom to shape ourselves and to  
14 transcend constraints and boundaries imposed on us from both the inside and  
15 the outside. According to de Beauvoir, we need, as human beings, to accept this  
16 unavoidable ambiguity as being part of the human condition. To be “honest”  
17 with ourselves, to live in an “authentic” way, any sensible person, according to her  
18 analysis, needs to accept and embrace this ambiguity. These ideas from Sartre and  
19 de Beauvoir underscore the point that there may be value in conceptualizing  
20 authenticity and true self as partly under one’s own control.

21 DBS raises questions about authenticity in part because it can seemingly con-  
22 fer on the patient and the medical team an ability to alter what the patient can be  
23 and do. In effect, it also has the potential to change how the patient views his or  
24 her true self, and what values, beliefs, and characteristics that patient views as  
25 authentic. This is suggested by Pugh, Maslen, and Savulescu’s earlier discussions  
26 of DBS as a treatment for AN. In our opinion, technology—including advanced  
27 medical technologies like DBS—has the potential to widen and deepen the free-  
28 dom people have to shape ourselves and to take control of who and what we are  
29 as human beings and as individuals.<sup>17</sup> Technology can affect which features we  
30 are capable of exhibiting, the centrality and role of particular characteristics in  
31 relation to other characteristics, and how we view those characteristics. When  
32 such freedom-enhancing technologies are under human control, there is further  
33 reason for including existentialist elements in our philosophical interpretations  
34 of what it is for a person—a DBS patient or any other person—to realize what  
35 that person regards as his or her true self.

36 Notably, some bioconservatives worry about precisely this aspect of tech-  
37 nologies that can be used for self-shaping. Bioconservatives are theorists who  
38 oppose the use of modern technology to manipulate or “enhance” human  
39 beings. Michael Sandel, for example, worries that if human beings go too far in  
40 shaping themselves using biomedical and other kinds of technologies, we will  
41 be left in a situation where we have control over almost all aspects of our own  
42 nature. In such a situation, there is “nothing to affirm or behold outside our own  
43 will.”<sup>18</sup> It is better, Sandel thinks, to leave certain aspects of our own nature  
44 untouched. We should accept these aspects of ourselves as simply “given,” and  
45 not created by human agency.

46 Whether or not Sandel intends his discussion in that way, his argument suggests  
47 that he too endorses—if only implicitly—something similar to what de Beauvoir  
48 calls the “ethics of ambiguity”: that human life is a mix of things that we have to  
49 accept as given as well as things that we can influence or control. Sandel may find

1 it alarming that neurotechnologies such as DBS have the potential to shift the  
2 balance among the different aspects of our ambiguous human existence; how-  
3 ever, to the extent that such shifts can help to promote patients' autonomy and  
4 well-being, we think that the technological developments that produce them  
5 should potentially be welcomed.

6 To summarize the main points of this section: the way we are, including how we  
7 perceive our "true selves," depends on multiple factors, which encompass every-  
8 thing from biology to society/culture to the choices we make and the agency we  
9 exercise. It would be a form of "bad faith" to deny our freedom to influence and  
10 shape ourselves and our human situation; however, human existence is "ambigu-  
11 ous" at its core: we have to accept some aspects of ourselves, whereas other aspects  
12 are under our control. As a result, we suspect that there is practical value in con-  
13 ceptualizing the true self as having both existentialist and essentialist components.  
14 However, the relationship between what is simply "given" and what we can influ-  
15 ence is not static. New and developing technologies—including medical technolo-  
16 gies such as DBS—shift the boundaries and constraints of the human condition.  
17 This adds an additional level of complexity to the question of authenticity.

#### 18 19 **Authenticity and the Case of the AN Patient with Conflicting, Shifting Mind-Sets**

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21 As mentioned, in our earlier article we discussed a topic that Pugh, Maslen, and  
22 Savulescu had also discussed in their previous work on DBS and authenticity;  
23 namely, the possibility of using DBS to treat AN. One important issue in their dis-  
24 cussion, which we also picked up in ours, was that AN patients may shift between  
25 different mind-sets, where the values they endorse in one mind-set appear differ-  
26 ent from the values they endorse in another mind-set. Tony Hope et al. report that  
27 they sometimes find this situation in their clinical work with AN patients.<sup>19</sup> The  
28 question here was whether there is a particular mind-set in which an AN patient  
29 can be said to better be able to manifest her true self.

30 Patients may sometimes enter into a mind-set in which they view AN as a prob-  
31 lem for which they need help. But the same patient may then shift to an alternative  
32 mind-set in which her values seem to change, and in which she values extremely  
33 thinness more than anything else. Drawing on Jacinta Tan and colleagues' discus-  
34 sion of what they call "pathological values," we made a suggestion about how  
35 patients and their families might think about this circumstance.<sup>20</sup> Tan et al. suggest  
36 that the sorts of values a patient exhibits in the latter sort of mind-set are so closely  
37 tied in with the patient's illness that they can be regarded as "pathological," and,  
38 for that reason, less authentic than values not associated with the patient's AN.  
39 Our suggestion was somewhat different.

40 If the patient and the patient's family want to assess which mind-set best repre-  
41 sents the patient's true self, we proposed that one consideration that could guide  
42 such assessments is whether the values of one mind-set (and not the other) are  
43 viewed as sensible or legitimate even by those who do not hold them. In other  
44 words, these are values about which people think there can be reasonable discus-  
45 sions and disagreements. In such a case, we suggested that the patient and the  
46 family might have reason to think that the mind-set featuring values with that  
47 particular feature is more authentic than the mind-set featuring values without  
48 it.<sup>21</sup> We can label the values that are viewed as sensible or legitimate even by those  
49 who do not hold them "tolerable values."



1 Patients with AN who experience shifting mind-sets sometimes have values  
2 in one mind-set that fall squarely outside of the range of what their family and  
3 others with whom they interact consider tolerable. For example, Tan et al. note  
4 that AN patients sometimes start valuing achieving extreme thinness as the  
5 highest value in life, including their own safety. According to our suggestion,  
6 if an AN patient shifts between such a mind-set and one where he or she places  
7 a more typical degree of value on thinness, that patient and the patient's family  
8 would have reason to regard the mind-set in which thinness is valued over  
9 health—even at the cost of death—as being less representative of the patient's  
10 true self. As noted by Pugh, Maslen, and Savulescu, this idea has some appeal  
11 inasmuch as it supplies guidance about authenticity; however, in our earlier  
12 work we did not elaborate on the reasons substantiating this suggestion. In the  
13 next section we offer more in defense of our proposal by turning to another topic  
14 discussed at some length by Pugh, Maslen, and Savulescu; namely, the question  
15 of what it is to value something.

16 First we will very briefly return to their suggestion that self-discovery is  
17 achieved through the creation of coherence among one's different mental states  
18 and attitudes. The just-described AN-patient could become more coherent overall  
19 by remaining in the mind-set that Tan et al. call "pathological": the mind-set in  
20 which they have the sort of unhealthy values and attitudes some AN patients are  
21 drawn to. But the patient could also become more coherent by trying to remain in  
22 the mind-set in which their values are more "tolerable" for others and "healthy."  
23 Therefore, the idea that we achieve authenticity by being more coherent seems to  
24 offer no clear reason why it might make sense to view a more tolerable and healthy  
25 mind-set as more authentic than a mind-set that strikes many people as pathological.  
26 This is another important reason why we think, as mentioned, that it makes sense  
27 to look for more substantial and value-based reasons for making judgments about  
28 when a patient manages to best manifest his or her true self.

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### **Valuing and the Social Role of Values**

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According to Pugh, Maslen, and Savulescu, to better understand the way in which people's values relate to what it is for them to manifest their true selves, we need to reflect on what is involved in valuing something. As these authors point out, we had little to say about the nature of valuing in our previous article. Here, we want to emphasize the importance of the role that values play in social interactions. In our view, the social role of values has practical implications for authenticity. In particular, we believe that it has implications for the sort of case described previously, in which patients have shifting mind-sets, and the values they incline toward in some mind-sets are more "tolerable" than those that they incline towards in others.

Importantly, it is the case that people often seek to associate with others who share their values. Shared values help to organize and structure peoples' interpersonal interactions, which in turn influence their future actions, beliefs, values, and manifested characteristics. In short, human beings characteristically associate, unite, or commune with others on the basis of shared values.

Notably, this phenomenon plays an important role in influential accounts of how human morality originated historically. Several theories of the evolution of morality posit that it was a need to cooperate that provided the conditions in

1 which humans acquired capacities for morality.<sup>22</sup> Interactions with others are  
2 made possible by shared values governing how such interactions should proceed.  
3 For example, cooperation generally requires agreement on shared goals and shared  
4 expectations about how individuals are to behave in important situations.<sup>23</sup> One  
5 explanation for how humans came to evolve a capacity for values, particularly  
6 moral values, rather than merely desires, is that such values and other components  
7 of moral psychology played an integral role in supplying both the motivation to  
8 comply with norms and the ability to signal reliability as a potential partner.<sup>24</sup>

9 Setting aside the more distant origins of human valuing, the importance of  
10 shared values in amicable social interactions is an apparent aspect of everyday  
11 life. Friends and romantic partners tend to share basic values, and often these  
12 shared values can be thought of as part of the basis of their relationships. In  
13 contrast, disagreement about values, especially values that an agent considers  
14 moral, can incline people to distance themselves from those with whom they  
15 disagree.<sup>25</sup> This is not a new observation – Cicero, for example, argued that what  
16 draws potential friends together is the perception of good qualities in each other.  
17 A lasting friendship, Cicero argues, is based on “mutual goodwill and affection”  
18 along with “agreement in all things, both human and divine;” that is, the sharing  
19 of values.<sup>26</sup> Moreover, less personal relationships can also be based on shared  
20 values and interests in a similar way. Notably, this can be so even when the values  
21 in question may strike some as rather self-centered, such as those related to  
22 “self-tracking” technologies. Social scientists studying the so-called “quantified  
23 self” movement have noticed that people who track and monitor themselves  
24 and their own health using self-tracking technologies are often motivated to  
25 seek out others with similar interests, both online and offline, such as at confer-  
**AQ3** ences and other social meetups.<sup>27</sup>

27 Therefore, whether in close personal relationships, or in ones that are less close,  
28 shared values help to bring people together and sustain their relationships. With  
29 that observation in place, we return now to the issue of patients with shifting mind-  
30 sets. Recall that our proposal is that if patients (e.g., AN patients) are unstable in  
31 their mind-sets in a particular way, they and their families have reason to regard the  
32 mind-sets in which they share values as being more representative of their true  
33 selves. We propose that the just-described social role that values play supplies a  
34 reason for patients and their families to regard such a mind-set in that way; specifi-  
35 cally, that this mind-set is more likely to enable well-functioning relationships. If a  
36 medical technology such as DBS can help a patient to remain in a mind-set in which  
37 that person shares important values with the other people in his or her life, then DBS  
38 will also help support the patient’s mutual relationships.<sup>28</sup>

39 To make this more concrete, consider an unstable AN patient who sometimes  
40 enters into a mind-set in which she values extreme thinness more than her own  
41 safety, and in which anyone whom she perceives as “fat” will be viewed as unwor-  
42 thy. When the patient enters into such a mind-set, her family is likely to feel alien-  
43 ated, just as the patient is likely to also feel alienated from the family, given their  
44 very different mind-sets. In contrast, when the patient shifts toward a mind-set in  
45 which she distances herself from these ideas about extreme thinness, it is likely to  
46 be much easier for the patient and the family to come together on the basis of  
47 shared values. Hence for the sake of their relationship, there is reason for the AN  
48 patient and the patient’s family to see the latter mind-set as being more represen-  
49 tative of the patient’s true self.

1 **Valuing Wholeheartedly, and Individuality**

2 However, as mentioned, the problem of shifting mind-sets raises not just one,  
3 but at least two difficult questions. First, there is the question just discussed  
4 about determining which mind-set is to be considered more authentic. But there is  
5 also a second, more practical question, determining under what conditions a  
6 third party would be warranted in actively encouraging a patient to pursue the  
7 mind-set that the third party believes is more authentic. This issue is briefly  
8 considered next.

9  
10 Even if one takes the idea of a person's "true self" to be very important—indeed,  
11 important enough for us to reflect on what principles ought to guide judgments  
12 about people's true selves—the value of manifesting what is considered a person's  
13 true self is certainly not the only value that matters in healthcare or other contexts.  
14 Values such as whether something is a medical benefit or if it respects personal  
15 autonomy, also need to be taken into account.<sup>29</sup> Whether a person is able to man-  
16 ifest what we, or that person, consider to be that person's true self is not the be-all  
17 and end-all of treatment decisions when considering whether or not to use a tech-  
18 nology such as DBS to treat a certain condition. Even in circumstances in which we  
19 think that it can make sense to ask which of shifting mind-sets best represents a  
20 person's true self, and even if there can be good reasons for making judgments  
21 about this issue in certain ways, we do not believe that this value should take pri-  
22 ority over other values in treatment decisions. Although this is an issue of concern  
23 to many people, it is also important to underscore that this is not the only value  
24 that matters in these contexts, and a determination of which mind-set is more  
25 authentic need not determine the conclusion about which mind-set should be  
26 chosen.

27 In addition, when a third party advocates for one mind-set over another, there  
28 is a risk of threatening the patient's perception of his or her own authenticity.  
29 Although we have emphasized the importance of shared values for relationships,  
30 and proposed that they can be a contributor to one's sense of authenticity, people  
31 often react poorly if they feel that values are being imposed on them by others.  
32 If people are to feel that they are being their own true selves authentically,  
33 as they live in accordance with certain values, they need to be given room to  
34 form their own ideas and conceptions of what it is for them to live by these  
35 values in a way with which they are comfortable.

36 Therefore, even if families and patients are able to agree that a mind-set in which  
37 the patient's values are closer to the family's is more representative of the patient's  
38 true self, families nevertheless need to avoid imposing upon the patient overly  
39 restrictive ideas about what these values imply about how the patient should live  
40 his or her life. Just as not being able to share values can be alienating, so too can  
41 having to live by somebody else's conception of those values. Pugh, Maslen, and  
42 Savulescu note that John Stuart Mill was surely right in maintaining that many  
43 people value developing their own individuality.

44 What makes it possible for people who are different in certain ways to share  
45 values is that, in practice, many values come both in a more general form, allow-  
46 ing different people to share them, and in more fully specified forms, which are  
47 the ways people interpret them within the context of their lives. In order to take on  
48 some common human value and make it our own, we typically need to form our  
49 own conception of what it means to live by that value within the specific context

1 of our individual life. This is how values can be put into more concrete practice  
2 within a person's life: general ideals need to be interpreted, specified, and applied  
3 to specific conditions before individuals can live by them.

4 How does this relate to authenticity, and to what persons will associate with  
5 their true self? An important implication is that for people to feel that they are  
6 authentically being their "true selves" when acting in accordance with some value  
7 shared by others, they will most likely need to have a conception of what this  
8 value means to them and how it fits with their personal situation. When we inter-  
9 pret the degree to which other people are being "their true self," we are likely to do  
10 so using our own ideas about how to live by certain values.<sup>30</sup> But for these others  
11 to feel that they are being their true selves in acting in accordance with some value,  
12 it needs to be one that they endorse and with which they agree. Only then are they  
13 likely to feel that their adherence to the value is truly "authentic."

14

15

### 16 **Concluding Summary**

17

18 To summarize these further reflections, we have noted that our earlier article did  
19 not take a position on whether we should accept an essentialist or an existentialist  
20 understanding of the true self. At that time, we were more focused on ordinary  
21 people's tendency to postulate a true self than on whether or not there really is  
22 such a thing as a true self. However, we agree with Pugh, Maslen, and Savulescu  
23 that it makes good sense to discuss this distinction between essentialism and exist-  
24 tentialism as a way of deepening the analysis of "authenticity" and the "true self"  
25 as concepts that concern people in relation to interventions such as DBS. Also,  
26 as we argued, we also believe that there are interesting ideas in the existentialist  
27 literature and other related sources that are relevant in this neuroethical context.

28 Just as Simone de Beauvoir argues that the human condition is marked by a  
29 deep "ambiguity," neuroethical discussions of DBS's impact on the self should be  
30 attentive to the fact that multiple and potentially contradictory factors typically  
31 conspire to influence what patients and their families perceive as most representa-  
32 tive of the patient's true self. And as technologies such as DBS and similar medical  
33 technologies become more advanced, it would also be what existentialists call  
34 "bad faith" to think that human beings have a fixed essence that cannot be altered,  
35 even if we should also recognize that there still are many factors in a person's life  
36 that are outside of their control.

37 We also agree with Pugh, Maslen, and Savulescu that the analysis of DBS  
38 and authenticity can be deepened by paying close attention to what is typically  
39 involved in having values that we try to live by. Whereas these authors mainly  
40 focus on how values can be integrated into an overall coherent psychology, our  
41 focus here was on two slightly different components: first, the social role of values  
42 within human life; and, second, the crucial need for people to develop their own  
43 understandings of what it means for them to live by the values that they endorse  
44 within their particular personal situation.

45 By reflecting on these aspects, we will have a better understanding of what sorts  
46 of arguments might be brought to bear on cases in which patients shift between dif-  
47 ferent mind-sets. Some of these mind-sets endorse values that can be easily shared  
48 with other people; whereas other mind-sets endorse harder to share values.  
49 The social role of values supports viewing more "tolerable" mind-sets as the mind-  
sets that patients and their families have reason to see as best expressing the patient's

1 true self. However, like other people, patients need to be given space to formulate  
2 their own view on how these values relate to their lives. Only then, can patients  
3 truly make these values their own, and only in living in accordance with these  
4 values are they most likely to feel that their true self is authentically manifested.

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