Article

The implications of the loss of self-respect for the recovery model in mental healthcare

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Abstract

According to the recovery model, mental healthcare should be aimed towards a conception of recovery articulated by a patient or service user in accord with his or her own specific values. The model thus presupposes and emphasises the agency of the patient and opposes paternalism. Recent philosophical work on the relations between respect, self-respect, self-esteem, shame, and agency suggests, however, two ways in which mental illness itself can undermine self-respect, promote shame and undermine agency, suggesting a tension within the recovery model. I argue, however, that this is a tension rather than a fatal flaw by distinguishing between paternalist and non-paternalist clinical responses to this failure of agency.

Recovery as the goal of mental healthcare.

Over the last two decades, recovery has come to be promoted as a novel and desirable target for mental healthcare. It has become a proud boast that mental healthcare is recovery orientated. Nevertheless, whilst there is agreement that, in this context, it does not mean merely getting better or returning to a previous state of health, there remains disagreement as to what exactly recovery is.

> There is an increasing global commitment to recovery as *the* expectation for people with mental illness. There remains, however, little consensus on what recovery means in relation to mental illness. [Davidson and Roe 2007: 450]
>
> The term 'recovery' appears to have a simple and self-evident meaning, but within the recovery literature it has been variously used to mean an approach, a model, a philosophy, a paradigm, a movement, a vision and, sceptically, a myth. [Roberts and Wolfson 2004: 38]

In this section, I outline a view of recovery I have developed previously [Thornton and Lucas 2010, Thornton 2012, 2017].

In the UK, a policy paper published by the Sainsbury Centre for Mental Health, titled 'Making recovery a reality', begins by summarising some key points of emphasis which, it is suggested, characterise any broadly conceived recovery-based approach. These points include:

> Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
> Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
> Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward.
> Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all'.
> The helping relationship between clinicians and patients moves away from being expert / patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be "on tap, not on top".
> People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.
> Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability. [Shepherd, Boardman and Slade 2008: 0]

The Scottish Recovery Network summarises its views of recovery in similar terms:

> Recovery is about living a satisfying and fulfilling life.
> Recovery is about more than the absence of the symptoms of illness. Some people describe

> themselves as being in recovery whilst still experiencing symptoms.
> There can be lots of ups and downs during the recovery process – some people describe it as a journey.
> For this reason people often talk about being in recovery rather than recovered.
> Some people consider recovery as being 'back to the way things were' or back to 'normal' but for others recovery is more about discovering a new life or a new way of being. [Brown and Kandirikirira 2007: 3]

These lists provide a starting point for setting out a theoretical model of recovery. But there is a further structural constraint. To articulate a recovery model that is distinct from, or contrasts with, for example, a bio-medical model of mental healthcare, it is not enough to say that recovery (construed in some broad way) is a desirable aim of mental health care. One could hold that whilst holding a broadly bio-medical view of health and illness: for example, as pertaining to biological function versus dysfunction. To count as a distinct model of healthcare, it must offer more than just a broad aim but, rather, a theoretical conception of what illness, or health, or something like health is.

(In the UK, the rise of the recovery movement associated with the promotion of the novel view of recovery with which I am here concerned confusingly coincided with greater optimism within biological psychiatry of the efficacy of medicines. Both elements played a role in raising the possibility of recovery in mental healthcare, complicating the historical story.)

The characterisations of recovery in the quotations above suggest the importance of two distinctions. First, there is a distinction of focus between pathology and whatever is its relevant contrast, perhaps health or wellbeing. Second, there is the distinction between what is evaluative or normative and what is merely plainly factual. Together these can be used to sketch a distinct although abstract conception of recovery which genuinely contrasts with a medical model. It is to locate it on the health-focused rather than pathology-focused side of the first distinction and on the values-laden or normative side of the second. The recovery model combines: a) a focus on a conception of wellbeing and b) in normative or evaluative terms.

The latter element, however, merely hints at something of great importance to the recovery model. The normative and evaluative elements enter the picture in a conception of a life worth living as conceived by the patient or service user him- or herself. Healthcare resources are thus deployed in the service of choices and values of the patient whose views are thus central. This contrasts both with a value-free conception of healthcare as aimed at returning patients to statistically normal or biologically functional states but also with paternalistic models of health service provision which are guided by the choices of clinicians on behalf of patients.

Why is paternalism of such concern in mental healthcare? I suggest that three factors play a role. First, the stakes are higher in the case of mental illness because a diagnosis of mental illness can serve as a reason to detain and treat a person against their will. Second, because of that connection, there remains a greater tendency for clinicians simply to assume a paternalist role in mental by contrast with physical healthcare. Third, as Bill Fulford has forcefully argued, even if – as he holds – physical and mental illness are both essentially value-laden, the value-ladenness of the latter is more obvious because the values involved are much more contested [Fulford 1989]. As a matter of contingent fact, there is much more agreement about the contrasts of physical health and illness than mental health and illness. Thus paternalism in mental health care presents a much greater risk of imposing a value on a patient or service user that they do not themselves hold. These three points fit a further key aspect of paternalism to which I will return at the end of the paper and which holds the key to reconciling the aim of the recovery model – in opposing paternalism – with the tension I will unfold below.

To counter paternalism, an essential feature of recovery is thus the authorship of an agenda by patients themselves. One indication of this is the proliferation of 'recovery stories' as part of the promotion of the recovery approach. These explore:

> the personal and existential dimensions of recovery, taking the form of subjective and self-evaluated accounts of how an individual has learned to accommodate to an illness. These accounts have become the founding stories of the recovery movement [e.g. Chamberlin, 1978; Lovejoy, 1984; Deegan, 1988, 1996; Leete, 1989; Unzicker, 1989; Clay, 1994; Coleman, 1999; Ridgeway, 2000], and anthologies of these personal stories have been used by governments and professions as a means of combating stigma and reasserting a focus on personal perspectives [Leibrich, 1999; Lapsley et al, 2002; Ramsay et al, 2002]. [Roberts and Wolfson 2004: 38-9]

Given this anti-paternalist stance, however, much weight has to be placed on the capacities of authorship and agency of those with mental illnesses. Thus Larry Davidson, a foremost proponent of the recovery approach to mental healthcare asserts:

> There can be no recovery without self-determination… Mental illness may pose an obstacle to the person's achievement of the kind of life he or she wishes to have, may make it more difficult to live that life, and, at its most extreme, may even deprive the person of life altogether. In none of these cases, though, does mental illness fundamentally alter the basic nature of human beings, which is that of being self-determined agents, free to choose and pursue the kind of life they as individuals value. *Mental illness does not rob people of their agency, nor does it deprive them of their fundamental civil rights*. [Davidson et al 2009: 40-1 italics added]

By contrast, Kim Hopper warns that the choices made people with mental illnesses may lack authenticity. Their choices may be affected or distorted as a consequence of illness itself or their treatment as a result of that illness.

> Deprivation and disgrace can so corrode one's self worth that aspiration can be distorted, initiative undercut and preferences deformed. Sensitive work will be needed to recover that suppressed sense of injustice and reclaim lost possibility. [Hopper 2007: 877]

In the rest of this paper I will shed light on the threat to authorship and agency raised by mental illness in virtue of its effects on self-respect and shame and thus suggest a tension at the heart of the recovery model.

Respect, self-respect, self-esteem, shame and action

While the concepts of respect, self-respect, self-esteem, shame, and agency are obviously interrelated, the precise nature of the connections is contested, with self-esteem more widely used in psychology and self-respect in philosophy, especially moral philosophy [Roland and Foxx 2003]. In this section I will draw on the literature to set out some of their connections. If the connections are neither completely tight nor uncontentious, that will not undermine the key claim needed here: that loss of self-respect and also feelings of shame can both undermine free agency. Given, however, that some philosophers equate self-respect and self-esteem while others argue for their difference, and given that there is disagreement concerning the absence of which is more closely connected to shame, it will be helpful to spell out a broad frame which can shed light on these differences. The best route to that is, I think, via Stephen Darwall's distinction between two kinds of respect [Darwall 1995]

Darwall takes it for granted that respect for persons plays an important role in moral philosophy. But, he argues, moral philosophical accounts of it have in general failed to draw a key distinction between two kinds of attitude, which he labels 'recognition respect' and 'appraisal respect'.

Of the former he says:

> There is a kind of respect which can have any of a number of different sorts of things as its object and which consists, most generally, in a disposition to weigh appropriately in one's deliberations some feature of the thing in question and to act accordingly. The law, someone's feelings, and social institutions with their positions and roles are examples of things which can be the object of this sort of respect. Since this kind of respect consists in giving appropriate consideration or recognition to some feature of its object in deliberating about what to do, I shall call it recognition respect. [ibid: 183]

This form of respect applies more broadly than just to persons, though it also applies to persons. Holding the attitude – respecting, in this sense – simply consists in weighing some fact, such as that someone is a person, with their rights and roles, appropriately in deliberation and judgement. The object of this attitude is thus a fact. But given how potentially widely the idea of weighing facts in deliberation could range, to count as respect it must be restricted to weighing appropriately the *moral* propriety of acting in particular ways with respect to some fact.

The second attitude is *appraisal* respect. Darwall introduces it as follows:

> There is another attitude which differs importantly from recognition respect but which we likewise refer to by the term "respect." Unlike recognition respect, its exclusive objects are persons or features which are held to manifest their excellence as persons or as engaged in some specific pursuit. For example, one may have such respect for someone's integrity, for someone's good qualities on the whole, or for someone as a musician. Such respect, then, consists in an attitude of positive appraisal of that person either as a person or as engaged in some particular pursuit. [ibid: 183-4]

This attitude consists in the having of positive regard. It may in turn rationalise and motivate particular actions but whereas recognition respect is a disposition to an intellectual act – the weighing of something in deliberation – appraisal respect can be independent of any particular conception of how to act. A second distinction is that appraisal respect much more readily admits of degree. People merit appraisal respect in virtue of them meeting particular expectations. They can do this to greater and lesser degrees. By contrast, recognition respect turns on the status of someone simply as a person. And hence the distinction between the two attitudes explains the different aspects of respect for persons.

> The distinction between appraisal respect and recognition respect for persons enables us to see that there is no puzzle at all in thinking both that all persons are entitled to respect just by virtue of their being persons and that persons are deserving of more or less respect by virtue of their personal characteristics. [ibid: 192]

It might be assumed that with the distinction in play, the 'personal characteristics' in virtue of which appraisal respect is earned might range over anything another subject might value. In fact, however, Darwall argues that genuine (appraisal) respect is more narrowly bounded. It must relate, in part at least, to excellence of character. Taking the example of a tennis player, he suggests that to be respected as a tennis player, one must demonstrate excellence in tennis playing. But that is not *sufficient* to merit respect as a person, even as a tennis player.

> To begin with, somebody may be an excellent tennis player without being a highly respected one. He may be widely acclaimed as one of the best players in the world and not be widely respected by his fellows— though they may (in the extended recognition sense) respect his return of serve, his vicious backhand, and so on. Human pursuits within which a person may earn respect seem to involve some set of standards for appropriate and inappropriate behavior within that pursuit. In some professions this may be expressly articulated in a 'code of ethics.' In others it will be a more or less informal understanding, such as that of 'honor among thieves.' To earn more respect within such a pursuit it is not enough to exercise the

> skills which define the pursuit. One must also demonstrate some commitment to the (evolving) standards of the profession or pursuit. [ibid: 187]

In other words, while the personal characteristics necessary to perform a role skilfully may modify the excellences of character that merit respect, they do not replace them. They augment them.

The two distinct attitudes that comprise respect for persons also comprise forms of self-respect, since both are attitudes which one can bear to oneself. Thus:

> It is recognition self-respect to which we appeal in such phrases as "have you no self-respect?" hoping thereby to guide behavior. This is not a matter of self-appraisal but a call to recognize the rights and responsibilities of being a person. [ibid: 193]

Similarly, like appraisal *respect*, appraisal *self*-respect is based on the excellences of persons that constitute good character. It is thus, according to Darwall, narrower or more specific than other forms of positive self-appraisal.

> One such attitude is that which we normally refer to as self-esteem. Those features of a person which form the basis for his self-esteem or lack of it are by no means limited to character traits, but include any feature such that one is pleased or downcast by a belief that one has or lacks it. One's self-esteem may suffer from a low of opinion of, for example, one's appearance, temperament, wit, physical capacities, and so forth. [ibid: 194]

In other words, while both self-respect and self-esteem are forms of positive self-appraisal, the self-appraisal which constitutes self-respect is of oneself *as a person*, a being with a will who acts for reasons. I will return to this distinction shortly.

John Rawls offers the following influential account of the connection between self-respect or self-esteem (between which he did not distinguish) and what he calls 'moral shame' which fits well with Darwall's account of appraisal self-respect.

> [S]omeone is liable to moral shame when he prizes as excellences of his person those virtues that his plan of life requires and is framed to encourage. He regards the virtues, or some of them anyway, as properties that his associates want in him and that he wants in himself. To possess these excellences and to express them in his actions are among his regulative aims and are felt to be a condition of his being valued and esteemed by those with whom he cares to associate. Actions and traits that manifest or betray the absence of these attributes in his person are likely then to occasion shame, and so is the awareness or recollection of these defects. [Rawls 1995: 129]

This conceptual articulation of the link between shame and a lack of appraisal self-respect has been criticised. John Deigh points out that shame is commonly felt over trivial things that do not seem connected to 'excellences of character'. He gives the example of a young French girl who felt shame on her first day of school because her name 'Mlle Péterat' carried a connotation 'which might be rendered in English by calling her Miss Fartwell' [Deigh 1995: 141] As Deigh points out: 'The morphemes of one's surname do not make one better or worse suited for pursuing the aims and ideals around which one has organized one's life' [ibid: 141]. Further, shame is ascribed to small children.

> Shaming is a familiar practice in their upbringing; "Shame on you" and "You ought to be ashamed of yourself" are familiar admonishments. And, setting aside the question of the advisability of such responses to a child's misdemeanors, we do not think them nonsensical or incongruous in view of the child's emotional capacities. Furthermore, close observers of small children do not hesitate to ascribe shame to them. [ibid: 142]

In such cases, it seems ridiculous to ascribe an explicit self-conception of ambition to excellences of character up to which the child, for example, has failed to live. Shame, Deigh argues, need not

presuppose the rational reconstruction Rawls offers. In sum, it may apply more broadly than cases of explicit failure of (appraisal) self-respect of the form Rawls sets out.

One way to reconcile this difference is to think that the archetype of shame is the one that Rawls describes and thus to think that the one ascribed in the case of young children, or to more trivial aspects of one's person but not one's character, is an extension of the archetypal or paradigmatic case. There are other species of the genus shame, though connected neither directly to a subject's explicit conception of broader virtues (excellences of character) nor more narrowly to moral properties but rather more broadly to some conception of what is personally important. As Gabriele Taylor asserts:

> Shame can be seen as a moral emotion, then, not because sometimes or even often it is felt when the person believes himself to have done something morally wrong, but rather because the capacity for feeling shame is so closely related to the possession of self-respect and thereby to the agent's values. [Taylor 1995: 163]

With that broad outline of the nature of self-respect – and its connection to respect and self-esteem – and a standard Rawlsian account of its link to shame in place, I can now look to a further connection reflected in the literature. Failure of self-respect and shame both undermine agency of the sort that underpins the recovery approach in mental health. In other words, failures of self-respect – and possibly self-esteem – are not just unfortunate symptoms of mental illness but threaten the very idea of the current central aim in mental healthcare.

The links between both self-respect and shame and agency are explored by Paul Benson using, first, the example of the 1944 film *Gaslight* in which Ingrid Bergman plays a character married to an man who plans to reduce her to a state of confusion and disorientation such that she will not be able to block his plans to steal a jewel she has inherited. He does this by keeping her isolated, persuading her that she is losing her memory and generally confusing her by a variety of means which include turning down the titular gaslight (hence the phrase 'gaslighting'). The net effect is *not* to undermine those abilities that are taken in 'proceduralist' accounts to underpin agency and autonomy such as Harry Frankfurt nested hierarchy of first order desires and second order endorsements of those desires [Frankfurt 1971]. As Benson says:

> It is possible that Bergman [ie her character] has retained whatever procedurally definable abilities have been held to suffice for freedom. She can act intentionally. She is not frozen in space, nor are her bodily movements 'mere behavior.' Her will may not be afflicted with unconscious, compulsive, or otherwise ungovernable motives. And the privileged region of her will which, on any given theory, is allegiance or engagement as a free agent in her will, may be intact and functional, properly coupled to her behavior… Despite the possibility that Bergman can reflectively regulate or authorize her conduct, she is nevertheless not a free agent. She is quite disengaged from her actions. [Benson 1994: 655]

This case suggests a way in which a person's autonomy can be undermined by undermining their self-respect, not that Benson puts it quite this way. The victim of gaslighting doubts her competence to make reasonable evaluations because of her, in fact fictitious, mental instability and thus doubts her capacity as an agent. She thus lacks recognitional self-respect by falsely thinking she is incapable of full autonomous agency.

Benson mentions a second relevant case. Shame, too, can undermine agency even when it does not directly undermine the features of a 'proceduralist' account of agency and autonomy (though it can do that too).

> But shame can also diminish freedom when it involves a collapse of the person's sense of worthiness to act. Like the gaslighted woman, the ashamed person can become dissociated from his reflective or evaluative capacities because his apparent dishonor or disgrace undercuts his view of himself as a competent agent. As before, this sort of disorientation

> need not impede the person's capacities to authorize his will as his own... [Similarly] Slaves who internalized the debased public images of themselves as nonpersons felt barred from entering into relations or practices fit only for persons. [ibid: 658]

Here shame seems to be connected to a lack of appraisal self-respect: a feeling of unworthiness to act.

Having now sketched a distinction between two sorts of respect, and hence of self-respect and the potential connection between a lack of self-respect and the undermining of free action, I can now return to the challenge of the recovery model of mental healthcare.

Self-respect and mental illness

Earlier I quoted Larry Davidson's assertion that mental illness does not 'fundamentally alter the basic nature of human beings, which is that of being self-determined agents, free to choose and pursue the kind of life they as individuals value. Mental illness does not rob people of their agency' [Davidson et al 2009: 40-1]. I contrasted this with Kim Hopper's claim that 'Deprivation and disgrace can so corrode one's self worth that aspiration can be distorted, initiative undercut and preferences deformed' [Hopper 2007: 877]. The detour via the recent philosophy of self-respect helps to shed light on the nature of the conflict here. *If* mental illness can corrode both recognition and appraisal self-respect then that alone can undermine autonomy and free-agency. But can it?

In this final section I will sketch two routes from mental illness to a loss of recognition self-respect and then draw some conclusions for recovery.

The first route is a directly from the pathology itself. Some mental illnesses directly impact on emotions. As Matthew Ratcliffe describes in his book length description of the phenomenology of depression, depression often involves an experience of guilt.

> Depression experiences often involve feelings of all-enveloping, irrevocable guilt. These cause considerable suffering and are sometimes singled out as the most troubling symptom. Rowe (1978) quotes several interviewees with depression diagnoses who complain of profound guilt. One states that the depression itself is 'a sign that I'm not what I should be' (p.39). Another describes the experience as follows: 'I feel I am suffering more than a murderer is suffering. In the end a murderer forgets and it all goes away from him. […] I know I'm not the only one that suffers from depression, but it's my guilt—it's worse than the depression' (p.173). Talk of 'guilt' usually features alongside a host of related themes, including 'inadequacy', 'shame', and 'damnation'. 'Self-hatred' is very common (e.g. Rowe, 1978, p.215), as is worthlessness (e.g. Styron, 2001, p.3). Several DQ [depression questionnaire] respondents similarly describe a feeling of being guilty, of a kind that does not attach to anything specific and permeates one's relationship with the world as a whole:
> #16. When I am depressed everything seems so bad. It seems as if there is nothing good in the world and that all the bad is because of me somehow.
> #179 [When depressed] I hate myself. The reason my life is so awful at these times is because I am a terrible, wicked, failure of a person. I'm not a proper human being, I am a failed human being. Everything that goes wrong in my life is directly my fault; I caused it by not doing things I should have done, or doing things I shouldn't have done. I am a waste of a human life. No-one knows just what a horrible useless nothing of a person I really am, because I hide it from people—if they ever found out the truth, they will all hate me and I will never have a single friend in the world ever again. [Ratcliffe 2015: 135]

Such experiences play a role akin to the case of gaslighting described above in that they undermine a proper self-appraisal of the subject as a competent agent. The illness of depression itself undermines the subject's self-respect. Such a connection most obviously applies in the case of mental illnesses that involve emotional dysregulation such as major depression, PTSD and C-PTSD, Borderline Personality Disorder, and substance abuse. But it might also apply in cases of delusions of value. Bill

Fulford describes the case of Mr H who having failed to give his children pocket money thought this a deeply wicked omission, a sign of his own worthless and that his family would be better off were he dead [Fulford 1989: 206].

A second route goes from having a mental illness to a loss of self-respect via the internalisation of social stigma towards such illness. In their paper 'The paradox of self-stigma and mental illness', Patrick Corrigan and Amy Watson argue that '[P]ersons with mental illness, living in a culture steeped in stigmatizing images, may accept these notions and suffer diminished self-esteem and self-efficacy as a result' [Corrigan and Watson 2002: 35]. They quote a first person testimony.

> I perceived myself, quite accurately unfortunately, as having a serious mental illness and therefore as having been relegated to what I called "the social garbage heap." … I tortured myself with the persistent and repetitive thought that people I would encounter, even total strangers, did not like me and wished that mentally ill people like me did not exist. Thus, I would do things such as standing away from others at bus stops and hiding and cringing in the far corners of subway cars. Thinking of myself as garbage, I would even leave the sidewalk in what I thought of as exhibiting the proper deference to those above me in social class. The latter group, of course, included all other human beings. [Gallo 1994: 407–408].

Since social stigma attaches widely across different forms of mental illness, this connection to a loss of self-respect and hence diminishment of free agency is not limited to illnesses of emotional dysregulation.

What then of the prospects for a recovery model of mental healthcare? As I stressed in the first section, such a model is designed to counter historic psychiatric paternalism and to place the perspectives and values of those with mental illnesses at the heart of healthcare. But it does this by making the goal of healthcare the support of a flourishing life, whether or not accompanied by ongoing mental illness symptoms, identified by the subject him- or herself. It thus presupposes the agency and capacity for authorship of a conception of flourishing by the subject. The problem, however, is that mental illness can undermine self-respect and hence agency and the capacity for authorship in the way flagged in this and the previous section.

As I have described, Larry Davidson, a proponent of the recovery model, denies this. He claims that mental illness never robs people of their agency. But such a claim seems mere wishful thinking in the light of the connections explored here. If so, as Kim Hopper suggests, 'sensitive work' is required to compensate in order to preserve the anti-paternalist aims of the recovery model. 'Sensitive' because the imposition by a clinician of what are deemed to be the best interests of the patient would run counter to the ethos of the model. But it is surely better to acknowledge this tension at the heart of the current orthodox approach to mental healthcare than to deny some of the more damaging but all too frequent consequences of mental illness.

Tension or fatal flaw?

I have argued that there is a tension in the recovery model in that it presupposes agency in the specific case of people who suffer illnesses that can undermine agency via a failure of self-respect and by instilling shame. Why, however, think of this as a mere tension rather than a fatal flaw in the recovery model (as one referee of this paper suggested)?

The answer turns on a nuance of the notion of paternalism hinted at earlier and to which I now return. Probably the most famous model of medical ethics, Beauchamp and Childress's four principles approach, attempts to capture a tension between two prima facie virtues or reasons for action: respect for beneficence and respect for the autonomy of the patient [Beauchamp and Childress 2001]. These can conflict and, depending on the context, either can be the more important. Thus, according to this framework, it *can* be ethically correct to override someone's autonomy in order to do them (other) good. I think that this is correct. It accords with an aspect of moral reason particularism: context is all [Dancy 1993, Thornton 2006]. This does not, however,

imply that *paternalism* is sometimes correct. Paternalism is not the mere trumping of a person's autonomy – for good particularist reasons – it is also the reason why that is done. Paternalism is status driven: the clinician as father.

I take it that the ethos of the recovery model in mental healthcare is anti-paternalist in this sense. The grounding of the judgement that the authorship of a recovery narrative or agenda by someone with a mental illness may have been impaired by the illness, and is thus not authentic, is not that it is wrong by the standards of the clinician *simpliciter* but that it is wrong, in the clinician's (and other relevant parties') views, in virtue of the subject's own non-illness limited desires. The difference between the two cases is that, in the former paternalist case, clinical views set the standard for correctness. In the latter, they attempt to track the subject's real wishes. One visible sign of the difference is the different kinds of evidence (such as advanced directives or family testimony) relevant in either case.

Hence the tension set out in this paper is a tension rather than a fatal flaw because paternalism can still be countered despite it. Kim Hopper uses the phrase 'sensitive work' to suggests a hermeneutic task, unfolding over time, of attempting to recover authentic wishes. Elsewhere, I have argued that narratives have a role in this [Thornton 2017]. Narrative coherence as perceived by the subject provides one test of the diachronic self-understanding of a patient recovering from severe mental illness. If the final test of a suggestion for a goal for recovery of a patient by a clinician is its adoption into the patient's own narrative, that suggests that it is neither a paternalist imposition of a brutely external value nor the distorted effect of the lack of self-respect and shame that is often a product of mental illness.

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