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OPEN PEER COMMENTARIES

The Role of Self-Illness Ambiguity and Self-Medication Ambiguity in Clinical Decision-Making

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INTRODUCTION

In their target article, Moore and colleagues (2022) offer a valuable overview of the various ambivalence-related phenomena that may impede swift clinical decision-making. They argue that patients "having mixed feelings or internal conflict, being pulled in different directions, plagued by uncertainty or indecision" can thus have significant implications for treatment. As they remark, Moore and colleagues do not address the specific complexities that may occur in decision making for patients with psychiatric illnesses. In this comment we propose to partly fill this gap by supplementing Moore et al.'s taxonomy with the phenomena of *self-illness ambiguity* and *self-medication ambiguity* in the context of psychiatric disorders. These ambiguities are similar to the ambivalence-related cases that Moore et al. discuss to the extent that they too concern "internal conflict, being pulled in different directions" and may thus present an obstacle in clinical decision-making.

Below we first introduce self-illness and self-medication ambiguity and provide some examples of how these ambiguities could affect clinical decision making. We then explain how such self-ambiguities differ from ambivalence. Finally, following Moore et al.'s acknowledgement that different forms of ambivalence may require different interventions or means to resolve, we address several ways to deal with self-ambiguities in clinical decision-making contexts.

SELF-ILLNESS AND SELF-MEDICATION AMBIGUITY

Psychiatric disorders impact how you feel, perceive, think, and/or act: experiences that pertain to who you are. The same goes for psychotropic medication. How then do you know whether certain thoughts or feelings are genuine expressions of yourself, or whether they are colored by your psychiatric illness, or by the medication you take (De Haan 2020a)? As Karp (2007) aptly summarizes the problem: "If I experience X, is it because of the illness, the medication, or is it 'just me'?." Such ambiguities have been reported with regard to various mental illnesses (see Dings and Glas 2020 for an overview) and may impact decisions regarding psychiatric *and* somatic treatment.

For example, consider Mrs. B who has a history of recurring depressions and is currently experiencing a depressive episode. She does not want a certain treatment. To what extent can she rely on her considerations, as these might be colored by her depression? Would she make the same decision if she were not currently depressed? How to distinguish between Mrs. B and the effect of her depression? Or consider Mr. J who has suffered from Obsessive-Compulsive Disorder (OCD) for most of his life. He is now treated with Deep Brain Stimulation and is very happy with the results, but his partner less so: she doesn't recognize him anymore and finds his behavior to be over the top. Is the "new" Mr. J himself without the burden of OCD, or is this a (hypo)manic state, a possible side-effect of DBS (De Haan 2017; Dings and De Bruin 2016)? Because of the early onset of his OCD, Mr. J cannot compare his current experiences with a pre-OCD self. Similar considerations play a role with regard to psychotropic medication. Patients may be reluctant to start with medication out of fear that it will change them too much. Or patients may stop taking medication because they indeed feel less

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themselves, because the medication flattens their emotions, or makes them less sharp, and more subdued. Or they may continue taking their medication because they are worse off when not taking them (relapsing in a depression for instance), but they continue to have this nagging experience of wondering how they could be without it. In all these ways, patients' stances toward their illness and/or medication influences their treatment choices (De Haan 2017).

DISTINGUISHING SELF-AMBIGUITY FROM AMBIVALENCE

Self-ambiguity is not the same as ambivalence. The first thing to note is that most discussions on ambivalence operate with a *dichotomous* framework. For example, Harry Frankfurt (and many of those drawing on his work) employs the dichotomous terms "internality" and "externality" to refer to the different ways in which the "moving principles" of our actions may be experienced (Frankfurt 1998). If "that which moves us" is internal, then it is fully endorsed, it may feel as part of ourselves and is possibly identified with. An external moving principle is not experienced as part of ourselves, leading to cases such as the unwilling addict who feels that what is moving him to take the drugs is an external force. On this view, ambivalence is construed as a state of mind with two competing yet incompatible moving principles which are *both internal*. As Frankfurt (1998, 165) puts it: "In the absence of wholeheartedness, the person is not merely in conflict with forces 'outside' him; rather, he himself is divided."

There are two main problems with the dichotomy between internality and externality. First of all, this dichotomy does not cover all of human experience (Dings 2020). In particular, it leaves out instances of self-ambiguity: the gray areas, the cases in which it is not clear what does and does not belong to me. Similar to ambivalence, people who experience self-ambiguity have "mixed feelings" and can be "plagued by uncertainty or indecision." But whereas ambivalence on this view stems from incompatible *internal* moving principles this does not apply to self-ambiguity. What happens in self-ambiguity is rather that the patient might *wonder whether it is them or X that makes them desire, feel or do Y*. For present purposes, the "Y" may be a decision that is relevant to the patient's treatment. The X is the ambiguating factor; the thing that makes it unclear whether it is themselves or X that is making them desire, feel or do Y. There are numerous potentially ambiguating factors, coming from all domains of everyday life (Dings and De Bruin 2022), but in the context of clinical decision-making for patients with psychiatric problems it is particularly self-illness and self-medication ambiguities that are relevant.

Secondly, the dichotomy between internal and external seems problematic if one assumes that we are relational, situated beings who are shaped by our interactions with others from the moment we are born, or rather conceived (De Haan 2020b). A simple distinction between "internal" as authentic and "external" as a threat to being oneself does not seem to do justice to our relational nature, nor to the fundamental ways in which our interactions with others shape us in positive, self-constitutive ways.

As Moore and colleagues point out, clinicians should ideally accommodate the choice that reflects the "authentic preferences" of the patient. This may be difficult in general, but it can be further complicated if one also needs to take one's psychiatric problems into account. For how does the "authentic me" relate to the disorder? Some consider the disorder to constitute a meaningful part of who they are, others regard it as a meaningless infliction that they just happen to suffer from (De Haan, 2022). It is also typically not clear when certain ways of acting, of feeling and thinking amount to being "disordered" in the first place. Where does my shyness stop and where does my anxiety disorder start (De Haan 2020a)? The question what does and does not "belong" to me is not an easy one: does my sensitivity belong to me, my perfectionism, my depressive tendencies.? How one answers these questions is a highly individual matter and may also depend on the psychiatric disorder at stake. Yet one's answers do influence how to go about making important (clinical) decisions: which of your tendencies do you try to "bracket" or ignore and which inclinations do you instead take seriously? Furthermore, how one relates to one's illness is not a static given, but will likely change over time. This goes for medication too.

RECOMMENDATIONS FOR DEALING WITH SELF-AMBIGUITIES IN CLINICAL DECISION-MAKING

How to deal with these complicated issues in the context of clinical decision-making? Simply denying all psychiatric patients the capacity for informed consent is clearly no solution. And here too Moore et al.'s warning not to confuse disagreement with incapacity and agreement with capacity is very relevant. In order to support patients to make the choices that best

reflect their own values and preferences clinicians need to be able to put a patient's current views in a wider perspective. It helps if the clinician already has a long-term relationship with the patient, especially in case of psychiatric problems that are clustered in episodes. Would the patient have made the same decision in a better period? As Moore and colleagues also recommend for some ambivalence-related problems, in this case too it makes sense to include patients' loved ones; partners, family members, good friends. They can support patients in putting the role of the psychiatric problems and/or medication in perspective. Another party that could help in the decision making process are experts by experience. It is typically in interactions with others that we establish which course of action fits with who we are and who we want to be. Especially when one is stuck in a decision-making process isolated navel-gazing is less helpful than conversations with (important) others (De Haan 2020a).

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