Becoming Yourself: Existential Authenticity and Mental Illness[1]

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Abstract: What does it mean to be true to yourself when you have a mental illness? Can symptoms of a mental illness ever be part of one's authentic self, or does mental illness occlude the authentic expressions of self by definition? Consider a choice that some with mental illness may face: whether to take medication as part of treatment. When effective, medications alter symptomatic moods or behaviors, for instance by neutralizing compulsive, anxious thoughts. But though these symptoms can be undesirable, some agents can nonetheless identify with them as an important part of who they are. For these agents, psychopharmaceuticals that alter or eradicate their symptoms can also alter or eradicate (part of) their selves. Yet for others, the very same concern of maintaining one's self can count in favor of medications. If one feels a mental illness has altered who one is, turning one into 'someone else,' medication allows for a return to one's self. Though it is tempting to determine which sort of state (symptomatic or treated) is "really" authentic, I argue that we should resist privileging either type of self as the authentic self; neither recovery nor illness are categorically authentic states. Additionally, we should take patients' self-reports as starting points to understanding authentic selfhood rather than viewing them as phenomena to be explained away. We should recognize the possibility that mental illness can be part of one's authentic self for some agents, but not for others. To do this, I motivate an existentialist notion of authenticity according to which authentic selfhood is an active, situated, and relational construction; authentic selfhood indicates those self-constructions that the agent freely and responsibly chooses and which are enacted and disclosed in the world. This view allows for an appreciation of differences in authentic selfhood that can help destigmatize mental illnesses.

1. Introduction[2]

What does it mean to be true to yourself when you have a mental illness? Are claims that mental illness or its symptoms are part of who one is only ever "the illness talking," or can one ever

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[1] Originally published as LaGuardia-LoBianco, A. W. (2025). "Becoming Yourself: Existential Authenticity and Mental Illness." Mélissa Fox-Muraton (editor), *Existential Philosophy and Disability: Perspectives, Brill* (coll. New Research in the History of Western Philosophy). Pp. 173-201. doi: https://doi.org/10.1163/9789004730748_009

[2] This project was started, stopped, and restarted over five years, and many people have been instrumental in its development. Among them is Jesse Prinz, who was a supporter of this project when I first presented it at the Annual Conference of the Association for the Advancement of Philosophy and Psychiatry in 2018 and who has been a consistent source of encouragement. Discussions with Dana Francisco Miranda have also improved the paper, particularly in helping it find an existentialist framing. I thank Mélissa Fox-Muraton for encouraging me to submit the paper to this volume and for her excellent comments that helped improve the paper. Finally, I thank all the audiences and organizers at the various conferences at which versions of this paper have been presented for their comments and engagement.

authentically incorporate mental illness into one's sense of self? And if the latter is possible, might treatment or recovery ever be a loss—even a betrayal—of one's self?

This paper takes these questions seriously by examining some of the ways that mental illness may or may not fit into one's identity. It does so partly by examining a choice that some people with mental illnesses may confront: that of taking psychiatric medication as part of treatment. Unlike other forms of treatment such as talk therapy, psychiatric medication may pose what some take as a threat to one's very self. When effective, these medications can alter symptomatic moods or behaviors, for instance by mitigating a pervasively depressed affect. But though such symptoms are often undesirable, some agents can nonetheless identify with them as an important part of who they are. For these agents, psychiatric medication that alters or eradicates their symptoms can also be seen to alter or eradicate (part of) their selves; medication may additionally cause side-effects that make one feel "not themselves" in troubling ways. As the loss of self may be a painful prospect, some may resist medication for this reason. Yet for others, the very same concern of maintaining one's self can count in favor of treatment with psychiatric medication. If one feels a mental illness has altered who one is, turning one into someone else, psychiatric medication can allow for a return to one's self. How should we understand these strikingly divergent attitudes towards taking psychiatric medication for mental illness treatment, and with them, the different ways of relating mental illness to one's self?

A tempting way to answer the question is to determine which sort of state—mentally ill or mentally healthy—must be the authentic one. This approach can be framed in terms of what has been called the self-illness ambiguity, or the boundary between one's self and one's illness (Zadler 2007, Jeppsson 2022). This framework has been proposed as a way to help individuals with mental illness manage their symptoms in a therapeutic context (Zadler 2007) by

determining, either by discovery or construction, where that boundary lays (Jeppsson 2022). One could draw or discover this boundary strictly, excluding all mental illness symptoms from one's self-conception. On such a view, one's 'real' self is the recovered or mentally healthy self. On the other hand, one could identify with their mental illness, or parts of it, in a positive way. Mad Pride and neurodiversity movements offer a re-valuing of mental illnesses and disorders, respectively, as ways of being that should be accepted (Hoffman 2019, Rashed 2019). On this view, the authentic self is the mentally ill self (though proponents of Mad Pride would not necessarily frame the experience as an illness). Following reports of people with mental illness, I argue that philosophers should resist privileging either resolution of the self-illness ambiguity as categorically authentic. Rather, we should take patients' experiences and self-reports as starting points to understanding authenticity and self, rather than viewing them as phenomena to be explained away. That is, we should recognize the possibility that, for some, mental illness is consistent with a given agent's authentic self.

In this paper, I motivate an existentialist view of selfhood and authenticity under conditions of mental illness. I argue that we should understand authenticity as a situated, intersubjective project that involves recognizing the human condition and committing to self-construction in light of it. This self-construction involves interpreting one's situation, making choices and taking responsibility for them, and disclosing being through concrete projects; it is a matter of choosing who to become given the facts of our situation (which may include symptoms of mental illness). This view allows for variations in authentic selfhood as it is a project of individual self-definition. Specifically, it can account for different ways of relating to one's mental illness and by extension, differences in authentic choices for treatment. This position

rightly respects the moral agency of people with mental illnesses and recognizes that each of us determines our authenticity for ourselves (though we don't do so in isolation).

However, this does not mean that *any* interpretation of one's mental illness is automatically authentic. One may worry that rather than actively defining themselves, agents may instead conform to narratives about mental illness or recovery that reify the self, and it would be troubling if these interpretations were considered authentic. To address this worry, I draw on existential notions of bad faith to explain the dangers of conforming to static and reductive narratives of self, specifically, narratives of mental illness and recovery that posit the self as having a pre-given nature. One kind of inauthentic self is that built on such bad faith narratives since they arrest the authentic process of self-construction by positing the self as already defined. Rather than rely on fixed and reifying narratives to define the self, I suggest that authentic selves undertake self-construction as a process that is continually subject to revision and not stuck too deeply or exclusively on any illness or recovery narrative, or indeed, any determination of self.

I first consider two different perspectives that one may take towards their mental illness and argue that a view of authenticity should not privilege either one of them. I then motivate an existentialist view of authenticity as a situated, intersubjective process of self-construction. According to this view, mental illness may be part of a given agent's authentic self depending on their choices of self-construction. I then argue that essentializing narratives of self—such as a reductive biomedical model of mental illness—are in bad faith and thus cannot count as

authentic interpretations of self. Finally, I briefly discuss an implication of this view for the question of responsibility under mental illness.[3]

2. Perspectives on Selfhood and Mental Illness

Among the considerations that factor into the choice of whether to take psychiatric medication for mental illness treatment (including cost, efficacy, side effects, etc.), maintaining or recovering one's sense of self can be of crucial significance. Examining this choice can help illuminate some of the variety of ways in which one can relate to their mental illness.[4] I will consider two such perspectives here—mental illness as a loss of self and mental illness as a part of self—and argue that a philosophical view of authenticity should not privilege either view as 'really' authentic. Instead, it should motivate a pluralistic view according to which there are many possible ways to authentically relate to one's mental illness.

First, consider accounts in which mental illness is interpreted as a loss of self which medication may restore. Andrew Solomon writes of his experience with depression:

> [A] loss of feeling, a numbness, had infected all my relations. I didn't care about love; about my work; about family; about friends. My writing slowed, then stopped…This gave me a feeling that I was losing my self, and that scared me. (2002, p. 45)

Solomon expresses what many with mental illness may experience, especially when symptoms come on suddenly. A profound change in one's passions, loves, comforts, habits—the collections

[3] I will use "mental illness" throughout to conform to discussions in the philosophy of psychiatry while acknowledging that some reject this label in favor of "madness," "difference," or other non-pathological terms. I will use "patient" instead of "service user" to avoid the capitalist connotations, despite the limitations of the former.
[4] I focus on psychiatric medication rather than other forms of treatment (like talk therapy) as the former seems to pose more serious implications for selfhood and authenticity for many agents. Additionally, I identify two different perspectives for the for the sake of argumentative clarity; in reality, there are many varieties in how one may relate to their mental illness, and this perspective may not remain constant for a given individual.

of ingredients that make up who one takes themself to be—can intelligibly be interpreted as a loss of self. Psychiatrist Peter Kramer discusses the other side of this theme through the reports of his patients who tried Prozac to treat their various symptoms.[5] He writes:

> An indication of the power of medication to reshape a person's identity is contained in the sentence [Kramer's patient] Tess used when, eight months after first stopping Prozac, she telephoned me to ask whether she might resume the medication. She said, "I am not myself." I found this statement remarkable. After all, Tess had existed in one mental state for twenty or thirty years; she then briefly felt different on medications. Now that the old mental state was threatening to re-emerge—the one she had experienced almost all her adult life—her response was "I am not myself." (1993, 18-19)

Stitching these themes together, we can identify a narrative that posits mental illness as taking away a self that psychiatric medication can restore (even if that restored self was not experienced prior to using medication, as was the case with Tess). I take this to be the socially dominant view of mental illness and selfhood, in which mental illness occludes or changes the authentic self and psychiatric medication offers a way to return to one's authentic self.

Notice that the judgments of authentic selfhood is not simply a function of time or unfamiliarity. Each respective new experience (of symptoms or relief from them) could conceivably last the same amount of time, and the fact that one set of behaviors is unfamiliar does not preclude identification with it (Kramer repeatedly notes the alarmingly quick and radical changes witnessed in his patients).[6] Kramer describes Tess as undergoing a "redefinition of self" on Prozac and requesting to resume the medication to maintain this newfound sense of self (1993, 19). Prozac thus represented a pharmaceutical shift from 'merely' healing to radically transforming the self (Kramer 1993, 13).

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[5] I recognize that there is a limitation, even potential harm, in using a psychiatrist's testimony about patient experiences. Still, I think Kramer offers a worthwhile perspective as someone who has witnessed the various effects of psychiatric medication, but I use his testimony sparingly here.

[6] There is a parallel here with individuals who come out of the closet and embrace their sexual identity: though doing so is initially unfamiliar to them, it may feel the most authentic. I think James Martin for this general point.

Though an alternative perspective on psychiatric medication as a threat to self is perhaps less common in mainstream narratives of mental illness, I argue that it is, *prima facie*, no less legitimate. Consider Lauren Slater's remarkable account of her experience taking Prozac to treat depression and obsessive-compulsive disorder:

> My personality…had always consisted of suppressed energies and curiosities, but also of depressions, echoing intensities, drivenness that tipped into pain. With the exception of the counting and touching obsessions, which I was only too happy to be rid of, I missed these things, or parts of them anyway, for they were as familiar to me as a dense fog and drizzle, which has its own sort of lonely beauty, as does a desert or the most mournful of music. (1998, 44)

After a reduction of symptoms on the medication, she continues:

> I was thinking of stopping the Prozac altogether, torn between my desire for my old self and my enthusiasm for the new. I was concerned that Prozac, and the health it spawned, could take away not only my creativity but my very identity…I was a different person now, both more and less like me, fulfilling one possibility while swerving from another. There is a loss in that swerving. (1998, 49)

Slater recounts the ambiguity between the "new and old" selves, but also expresses a significant feeling of loss over "her very identity" and the creativity that helped constitute it. Though she does appeal to the familiarity of her years-long symptoms in describing her fear of loss, she frames this in terms of her very self. Arguably, then, she is not just talking about the comfort of known behaviors, but of how she prefers to interface with the world. The fact that Slater distinguishes symptoms she identified with and those she did not supports the idea that she was engaged in the process of identity construction rather than passively influenced by her illness. Had her identification with her symptoms just been "the illness talking," she presumably would have thoroughly identified with all of her conditions. But as she does not, she instead demonstrates active self-authorship in the navigation of her mental illnesses and choice of treatment.

While some construct their selves by embracing their symptoms, others found an identity by rejecting the pathological framing of their experiences. This latter approach is represented by Mad Pride movements. As Mohammed Abouelleil Rashed writes:

> Mad Pride discourse rejects the language of 'illness' and 'disorder,' reclaims the term 'mad,' and replaces its negative connotations with more positive understandings. It reverses the customary understanding of madness as illness in favor of the view that madness can be grounds for identity and culture. (2019, 151)

Though the key insight of the movement is in reframing traditionally pathologized experiences as the basis for a positive social identity, Mad Pride is not a monolithic view, and there are various strains within the discourse. For instance, some interpret their hallucinations "as helpful influences in their lives, guiding and encouraging them and/or ensuring that they never feel alone," while "the state we call 'mania' allows [others] to feel more spiritually connected" (Cutler 2019, 189). Rashed notes that some proponents of Mad Pride may still recognize the negative aspects of their madness (2019, 151); for instance, some with hallucinations may interpret them in terms of their connection to past trauma, and "while these experiences may not be framed as positive or enjoyable, they are still seen as valuable and helpful because they may alert the individual to unresolved trauma" (Cutler 2019, 189). Further, Ginger Hoffman distinguishes Mad Pride views that regard "mental differences" as illnesses and those that reject that they are pathological; both views still share a normative claim about accepting these differences (2019, 301-302). So, we see some variety in the ways mental illness can be neutrally, or even positively, incorporated into one's identity.

Though many individuals do identify with their mental illness in various ways, the plausibility of an authentic self built partly on one's mental illness may seem tenuous because these symptoms can impact several features on which our identities are based, including emotions, cognitions, behaviors, moods, temperaments, etc. In other words, instead of arguing

that mental illness *should* not be part of a self-conception, one may argue that mental illness *cannot* be part of a self-conception since it may affect the very capacities needed for the construction of selfhood, thus calling the legitimacy of such "selves" into question.[7] As Tamara Kayali Browne notes, "depression…directly impacts an individual's thoughts, feelings and behaviours—the very stuff that the self is made of" (2018, 47). We could generalize this point to other mental illnesses, and one could then take a step further and argue that mental illness acts like an exogenous blight that worms its way into a person's behaviors, thoughts, and values, thereby corrupting or obscuring the "real" self. On a view like this, it is easy to suspect that any identification with mental illness is "just the illness talking," that is, that any identification is itself part of the symptomatic character of that mental illness, perhaps even further evidence of it! So, the possibility that mental illness can be *legitimately* part of an authentic self rather than a mistake attributable to the illness itself may seem to require defense. One way to frame this problem is in terms of the self-illness ambiguity, in which service users are encouraged to identify the 'boundary' between their illness and their self for therapeutic aims (Sadler 2007). As Sofia M.I. Jeppsson puts it, patients may "want to know where [their] selves end and [their] illnesses start, both for therapeutic reasons and to escape guilt, shame, and blame" (2022, 294).

Jeppsson frames two approaches to resolving the ambiguity: a "Realist Solution" of discovering a preexisting boundary between self and illness, and a "Constructivist Solution," in which the patient determines for themself where to draw this boundary (2022, 294).[8] Jeppsson

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[7] Though there are reasons to resist this conclusion other than the ones I give below. See Phillips (2003) on mental illness and narrative self.

[8] This distinction mirrors the competing self-discovery and self-creation views of authenticity (Levy 2011). Levy argues that "enhancements" like psychiatric medication can be compatible with authenticity whatever the correct view of authenticity: "For those who advocate authenticity as self-creation, enhancements can be one tool with which we reinvent ourselves. For those who advocate self-discovery, enhancements can be tools whereby we bring our outer selves into line with who we most deeply are. In utilizing them, agents might be heeding an inner voice that calls them to transformation, rather than shutting their ears to its call" (Levy 2011, 317).

argues for a constructivist approach on the grounds that there is a lack of support for a realist solution. First, introspective attempts to find the "pre-existing border between self and illness" will just result in a regress of questions about the source of one's own thoughts that draws one no closer to the presumed boundary (e.g. 'maybe everyone doesn't actually hate me; maybe that belief is just caused by my depression. But what if my depression is making me question that belief in the first place?...') (2022, 299). Further, attempts to pin down a general boundary between self and illness (such as deep self views) cannot categorically exclude mental illness symptoms from the self without merely stipulating that symptoms "*simply cannot* be part of a person's self" (Jeppsson 2022, 303). So, a constructivist approach in which service users are encouraged to determine for themselves where to draw the boundary between self and illness—how to write the story of their own lives—are both more accurate and therapeutically useful. Such an approach should respect patients' own interpretation of their symptoms, but also recognize that certain interpretations will be "most conducive to recovery," for a given individual (Jeppsson 2022, 305). So, Jeppsson identifies an additional instrumental value in the constructivist approach: it has the flexibility to help patients identify the interpretation that is most helpful for their treatment.

I largely agree with Jeppsson and will endorse an existentialist version of a constructivist approach that prioritizes the agent's own interpretation of their selfhood in the following section. But I point out that the framing of the self-illness ambiguity already implies a view of self that is conceptually prior to and independent of the symptoms of mental illness. In this framing, the question becomes whether to accept some amount or degree of symptoms through the boundary and into one's self-conception. Of course, on the constructivist view, one could choose to eliminate the theoretical boundary and entirely embrace one's mental illness as part of one's self.

But even in this case, the framing of the issue already seems to beg the question about authentic selfhood by positing mental illness as something *prima facie* separable from self that can be 'let in' by choice. Mental illness is represented, again, as a separate entity that poses questions for authentic selfhood. This is quite different from an approach to selfhood that asks, of my various experiences, which values, behaviors, emotions, beliefs, etc., I choose to incorporate into a self-conception and ultimately enact through my choices—which, I will argue, may be a truer representation of how authentic selfhood is constructed. Additionally, I am not evaluating personal conceptions of authenticity and selfhood on clinical grounds, in terms of which interpretation may be most useful for a given agent's recovery—indeed, on my view, the most authentic self for some may not involve recovery at all.

A further suspicion about the desirability of identifying with mental illness is seen in one criticism of Mad Pride discourse. In objection to the notion that mental illness can constitute a positive social identity, as Mad Pride movements hold, Alison Jost writes: "*Most* mental illnesses, for *most* people, are inherently negative…No matter how destigmatized our society becomes, mental illnesses will always cause suffering. They are not simply *different* ways of processing information or emotion; they are *disorders* in the capacities for processing information or emotion" (2019, 1). Jost suggests that the "inherent" suffering and disabling nature of mental illnesses means it is not simply another neutral way of being. By implication, they should not be incorporated into a positive social identity. And if that is right, "how can one advance a positive framing of that which appears to be inherently negative?" (Rashed 2019, 151).[9]

[9] Rashed argues against Jost-style arguments by showing how mental illness can be understood on a social model of disability wherein symptoms are not inherently negative but are exacerbated by social conditions (2019). I offer a different response above.

I suggest that there is a latent resistance to any identification with mental illnesses that runs through criticisms of this type, a resistance that involves, among other things, a discomfort with the pain and suffering that mental illnesses represent. As Jost rightly notes, mental illnesses are painful, often profoundly so, and our societies generally regards symptoms as requiring treatment. A self that incorporates that pain into its orientation to the world may be viewed as perverse, and not only because it seems to challenge the typical medical response to mental illness. The suggestion can yield discomfort, even fear, especially in loved ones of those with mental illness. We just want to see those we love happy, without pain and struggle, and the suggestion that this pain may be embraced or voluntarily internalized into one's self-conception may seem a tragic capitulation to a destructive ailment. Further, a life predicated on pain in any way may be seen as a philosophical paradox: why would anyone *want* to embrace that pain as part of their very identity? Such an understanding of one's authentic self must either rest on a mistake ("it's the illness talking") or else be illegitimate because perverse. Thus, resistance to the legitimacy or desirability of personal identities that incorporate mental illness may by partly explained by a profound discomfort with the idea that suffering can be part of some lives as more than a transition to cure.

But as much as we may be uncomfortable with it, we do have to make sense of our suffering, and not always just so it can be eased or resolved. Sometimes it must be made sense of because it is *there;* it has happened or is happening and has thus become part of a person's history. This fact is well understood in discussions of trauma. Undergoing trauma can change a person, sometimes in irreversible ways. Recovery often involves learning to incorporate those painful effects of trauma into the new self that emerges, rather than the impossible attempt to erase the past (Brison 2002, chapter 3). Many of us already do fold negative, painful, and

traumatic experiences into our sense of self out of the necessity of facing reality.[10] So too with mental illnesses, and the pain felt therein: experiencing mental illness can shape one's character, values, goals, choices, what one cares about—for better or worse, painfully or otherwise. For many people with mental illnesses, symptoms are experienced as ways of moving through the world before they are ever registered as symptoms; these traits may already make up their selves. Additionally, the values and traits that are inculcated by our societies and families, the oppression or privilege we may face, and the traumas and joys we live through all contribute, in various ways, to the shaping of our selves. Authentic selfhood that somehow sought to transcend these conditions to some painless pure sense of self is like a voice without an accent—impossible and insensitive to the grounded conditions of human life. And if that is right, we either need a principled reason for arguing that mental illness and the pain it can cause are unlike other such factors that can validly be part of one's self, or we should admit that mental illness and its pain can be legitimate parts of one's identity (for some). To suggest that mental illness categorically *cannot* be authentically incorporated into one's identity has the unpalatable implication that every agent who does so is mistaken, deluded by their own condition, while also begging the question against authentic mental illness identities; to suggest that it *should not* be so incorporated seems unrealistic at best and sanist at worst, as it erases the recognition of such identities.[11] Ultimately, there seems to be no good reason to rule out identities built on painful

[10] As one of my students noted, being a former POW is a very painful identity, yet an identity all the same.
[11] Clearly there is a political point to be made here about the recognition of those who identify with madness (Rashed 2019, Cutler 2019). That is, while I am sympathetic to the Mad Pride position, I am not explicitly arguing for it here. As I'll argue, whether a given mental illness *should* be incorporated into one's self is a question that can only be answered by the agent themself.

experiences as legitimate, and a good reason to recognize them since they are already a reality for many.[12]

Where does this leave us in terms of authentic selfhood and mental illness? Though it is tempting to explain away either perspective (of mental illness as a loss of self or a part of self, respectively), I suggest that we should avoid a philosophical position that privileges either type of self as somehow 'really' authentic. Such a privileging approach would mean that some individuals are wrong about their authentic self, which seems an objectionable declaration about a group that so often receives dominant social messages about how they should relate to their own experiences (Cutler 2019). Some may see their mental illness as an alienating force; others may view their mental differences as a positive part of their selves; still others may see no incompatibility between the pain of symptoms and a basis for identity. Rather, we should take these divergent accounts of how one can interpret their own experience as starting points for untangling what it means to be authentic when one has a mental illness. Instead of seeking a general answer to the question of authenticity under mental illness, we should take this variety of experiences as motivation for a view that sees individual agents as the arbiters of their authenticity, which may or may not involve mental illness symptoms.

3. Existential Authenticity

In this section, I motivate an existential view of authenticity according to which authenticity is an active, situated, and intersubjective project of self-construction which may be useful for

[12] I do not wish to romanticize the very real suffering that arises from mental illnesses, nor to suggest that any given experience should or should not be part of one's self. I am not making an ethical claim regarding what sort of identity one should or should not have—as I'll argue, such a decision can only be made by the individual.

individuals navigating questions of selfhood, authenticity, and mental illness. On a view of authenticity as self-construction, authentic selfhood is something we create for ourselves, not something that exists and must be discovered prior to our choices (Levy 2011). An existential version of self-construction emphasizes this process of self-construction amid the human condition of freedom, choice, and responsibility, but also acknowledges that each of us is concretely situated and shaped by the conditions of our facticity (aspects of our bodies, our pasts, the time and place we were born, our families, our societies, etc.). It thus respects agents' authority over their own authenticity while recognizing that authenticity is a process embedded in the world and with others. In the following section, I will also argue that existentialism is particularly well suited to address bad faith identities that reify the self—a potent threat under dominant biomedical models of mental illness.

Simone de Beauvoir describes what she calls the "ambiguity" of the human condition (1948/1976, 7). An array of contradictions, human experience is marked by both subjectivity and objectivity, transcendence and immanence, agency and passivity. We find ourselves faced with certain immutable facts: there are limits to what I can change about my body, my past is fixed, I've found myself thrust into a particular socio-political milieu whose history long predates me, etc. Yet we are also the sorts of beings that can reflect on and interpret our situations, choose what to value and how to treat others, and disclose our being in the world through actions we decide. We are not predetermined to *be* anything, and thus bear the incredible burden of creating ourselves. Yet this creation can only happen amid the existing realities of our situations, in a world where other people must also create themselves. For Beauvoir, the human challenge is to confront our ambiguity without collapsing into either pole of freedom or facticity; to embrace our ambiguity rather than trying to flee from it (1948/1976, 9).

Existentialism emphasizes that individuals are always concretely situated in the world. Beauvoir writes that "[t]here is no way for a man [sic] to escape this world," as our given contexts provide the conditions through which we exercise choice (1948/1976, 67). This does not amount to a picture of radical freedom in which we choose every aspect of ourselves, freed from any biological or social constraints (as Jean-Paul Sartre's [1946] conception of freedom sometimes suggests). Though the challenge of exercising our freedom responsibly is upon all of us, Beauvoir rightly recognizes that a radical notion of freedom is unrealistic: "every human situation" is limited to a greater or lesser degree (Beauvoir 1948/1976, 38). In the most restrictive of oppressive circumstances where there is literally no possibility of external resistance, it may be possible for agents to realize "a perfect assertion of their freedom" only *within* those restrictions (Beauvoir 1948/1976, 38). But this narrow form of freedom is unacceptable, and Beauvoir places great importance on using our freedom to fight against oppression and create a world where everyone can exercise their freedom fully (1948/1976).

Importantly, Beauvoir recognizes that my ability to exercise my freedom depends on the freedom of others. This is because I can only determine what I care about and what projects I want to pursue in a world that is imbued with meaning from others' projects. The material out of which I create meaning—including available concepts, narratives, and possibilities—is given to me in my interactions with others within a culture and society.[13] Values that others enact in the world become possibilities for me and vice versa (Beauvoir 1948/1976, 72). By seeing someone act with moral courage or devote themself to artistic endeavors, for instance, I may decide that I

[13] As will be discussed in section 3, the downside of socially shared meaning is that the available sources of meaning may be significantly constrained by dominant narratives. As Kathryn Norlock puts a version of this tension, others provide us with sources of meaning but also potentially constrain them: "The recognition of others provides us with options, sources of control, and assists us in integrating our self-narratives; the denial of recognition can leave us trapped within ourselves" (Norlock 2008, 153).

want to commit myself to those values, commitments that may go on to shape my life significantly and go on to inspire others. Further, my personal projects only have a chance of being realized when others are also free to pursue their own projects. For instance, students depend on teachers and teachers depend on students to realize their respective goals; "No project can be defined except by its interference with other projects" (Beauvoir 1948/1976, 71). Freedom is not an isolated affair of pure will. My freedom requires the freedom of others, which is why it is so crucial to protect the freedom of all (Beauvoir 1948/1976, 72).

Taken together, the existentialist picture of authenticity is that of a situated, intersubjective project of recognizing the ambiguity of the human condition and committing to self-construction in light of it. This self-construction involves interpreting one's situation, making choices and taking responsibility for them, and committing to values that are disclosed through concrete projects. And all of this must happen with a respect for and promotion of others' freedom in order to fully recognize the human condition for what it is—and so, to be authentic.

How does an existential understanding of authenticity apply to questions of selfhood under conditions of mental illness? Whatever its complex set of causes, mental illness is clearly part of some individuals' facticity, an aspect of their embodied reality that can shape their experiences in various ways and that admits of greater or lesser degrees of change or control.[14] If a project of authenticity is possible at all, it must be possible *given* the constraints of facticity and the setting of situatedness, for these are the only conditions humans have in which to make choices. We are already shaped by our individual facticities, but we are also the sort of creatures

[14] Sartre (1956) even uses disability as an example in his discussion of the body: "…for we are a choice, and for us, to be is to choose ourselves. Even this disability from which I suffer I have assumed by the very fact that I live…This means that I choose the way in which I constitute my disability (as "unbearable," "humiliating," "to be hidden," "to be revealed at all," "an object of pride," "The justification for my failures," etc.) (432)."

that try to make sense of these facts: we create who we are out of what we are given. We can choose to be otherwise, not in the sense that we can radically alter our facticity, but rather in that who we choose to become—what projects we pursue—is not deterministically bound by it. We may not be able to alter every aspect of our lives; one cannot will themself out of mental illness by brute force, though there are measures they can take to cope with it. But we need not collapse our sense of self entirely into what is given to us.[15] 'Transcendence' here does not mean defeating one's facticity and creating oneself *ex nihilo*, but rather fashioning a way of being that is *beyond* mere facticity; one's facticity becomes an object of interpretation, and one's possibilities are informed by but not deterministically tethered to what is given. The question of authenticity under conditions of mental illness, then, is a question of how to relate to that aspect of one's facticity, and what to do (and who to become) in light of this interpretation.[16]

In many instances of mental illness, individuals have some choice in how to interpret their symptoms and some control in how to respond to them. Of course, some severe symptoms might preclude both introspection and action at given points in time: one may only be able to reflect on their symptoms when not in a psychotic or manic state, for instance. And social and environmental factors dictate the resources available to treat or cope with one's condition.[17] But

[15] There is a parallel here to feminist discussions of moral luck and responsibility. Claudia Card (1996) and Lisa Tessman (2005) each argue that oppression is a form of constitutive moral luck in that it can shape a victim's character through moral damage—the interference with developing virtues or the development of vices. Yet both argue that even if victims are not backwards-looking responsible for the state of their characters (they are not blameworthy for the damage they've incurred), they can still take a forward-looking responsibility *for* who they are and what they will do. In this way, constitutive moral luck does not erase responsibility, but rather situates it and informs it.

[16] The introduction of facticity along with freedom may help navigate the general debate over whether an authentic self is discovered or created (Levy 2011). Someone who realizes they are trans or queer may feel they have made a discovery about who they really are, rather than have constructed or chosen that self. On an existential view, the fact of being trans or queer may be part of that person's facticity—it is a 'discovery' or realization of reality—but the way one interprets and relates to it is a choice they must make, and this can range anywhere from denial to embrace. In this sense, we create ourselves partly out of what is given to us, constructing a self out of (some of) our discoveries, but this does not mean that authenticity is *purely* a matter of discovery.

[17] Such facts may also bear on responsibility (Ciurra 2019).

these variables do not suggest that people with mental illnesses are globally unable to undertake the task of authentic self-construction, as we've seen (though the practice may be increasingly difficult with more severe symptoms). And in general, a project of authenticity is not a single, definitive event, but a practice that is continually revised and renewed.[18]

We've already seen some of the ways an individual may interpret their mental illness. One may embrace their experiences as positive aspects of their identities and reject their pathological associations, as some Mad Pride proponents do; or, symptoms may be a painful but important part of their histories, as for Slater. For others, symptoms may represent an alien departure from the self they want to be, as was the case for Solomon. Still others may interpret symptoms as part of their reality that they accept and manage, but that are only a peripheral feature of their self. Interpreting one's experiences/symptoms may not yield a positive, prideful identification; it may mean accepting symptoms that one would prefer not to have, a reluctant recognition that these symptoms shape one's orientation to the world, like it or not, or a commitment to one's projects *despite* their condition. And of course, one may hold multiple,

[18] One may object that this existentialist view of authenticity is heavily reliant on reflection and introspection, abilities that may not be equally available to all people, and which would thus result in some people lacking authenticity. In fact, one may add, authenticity is achieved by just *being ourselves* without thinking so much about who we are! (For instance, Tamara Kayali Browne [2018] offers a view of authenticity focused on the phenomenological feeling of being authentic along with feeling in control, which does not rely on reflection.) I proffer my view, first, because I do think this introspective reckoning *is* part of the inquiry into authenticity and mental illness for many people and is therefore speaking to an important part of their experiences (as Browne found in her interviews with women with depression [2018, 49]). Second, I am not restricting the form that this interpretation can take; it may not be as explicit as described above, as if consciously putting one's experiences under an interpretive microscope, but may also come about in the wonderings of everyday life. Third, interpretive reflection can happen in moments separate from enaction; it's not that one is constantly hyper-consciously thinking of who they are and what they are doing when they are doing it (which may indeed seem incongruent with authenticity) but may reach these conclusions that then inform their actions. Alternatively, enaction may *reveal* one's values and interpretations to oneself. Fourth, reflection is not conceived as a constant activity, so conditions that may disrupt local reflections (manic episodes or panic attacks, for instance) do not necessarily preclude global reflections. Finally, I'm willing to take on some emphasis on reflection in the spirit of existentialism in general, for the imagined alternative of unreflectively 'autopiloting' through life hardly seems authentic, either, and it would seem a flaw of the view if it predicted that *everyone* is always authentic!

even contradictory interpretations of their mental illness, and one's interpretations can change over time (Browne 2018, 25). In her interviews with women with depression, Browne notes:

> Some women stated that sometimes they make a conscious distinction between what belongs to the self and what belongs to the illness based on personal preference. [Some women have] chosen what constitutes part of their self and what does not, acknowledging that the views they espouse do not necessarily reflect some underlying truth but are rather a reflection of what they would rather own and disown. (2018, 50)

Browne's findings support the notion that there is a component of active self-making for at least some individuals with mental illness. Notably, this is not an impossible fashioning of a self out of nothing, but an active and self-aware process of interpretating and choosing how one wants to see themself given the realities they face.

This complicated duet between what we are and what we could be is part of the composition of authenticity. And it applies to the question of how psychiatric medication bears on selfhood, to recall our opening question.[19] For instance, though some medications may bring about an unfamiliar way of moving through the world (e.g. more confidence and less fear), as Kramer describes the experience of some of his patients, the agent must make sense of this new experience. It may be a welcome change, as in the case of Tess above, or an ambiguous one, as for Slater.[20] And interpretations may be more subtle than this; one may deny that they are a completely different person when medicated yet still see medication as bearing on their self. Their fundamental values, dispositions, and emotions may all remain basically the same, as well as their pasts, the relationships that help constitute them, their projects, etc. But medication may just attenuate certain psychological experiences rather than radically alter them. A moderately

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[19] Neil Levy notes that medication may be a way to realize one's authenticity whether authenticity is interpreted as self-creation or self-discovery, as it may be "one tool with which we reinvent ourselves…[or the means] whereby we bring our outer selves into line with who we most deeply are" (2011, 317). Though I deny that self-creation and self-discovery are mutually exclusive options, I agree with Levy's general point that medication is compatible with both views of authenticity.

[20] Though in the next section, I'll argue that claims that medication "made me a whole new person" may be used in bad faith insofar as they are biologically essentializing.

depressed person may view their illness as their self in a minor key, and medication a way to transcribe those same "notes" into a relative major key.[21] Absent the process of reflecting on who one chooses to be given what one is, there can be no 'right answer' about the 'real self,' and thus no correct choice concerning medication and authenticity.

It is worth clarifying the distinction between, on the one hand, the emotions, cognitions, and behaviors that constitute symptoms, and an agent's interpretations of them on the other. At the most painful end of the spectrum, the consuming anxieties, swallowing depression and suicidality, horrifying delusions, and more that can make up experiences of mental illness become objects of interpretation, experiences that are made sense of in the context of a life in one way or another. In her discussion of self-forgiveness, Kathryn Norlock notes that parts of ourselves are outside of our control, for instance, intrusive memories (especially associated with post-traumatic stress disorder) or the ineluctable pull to beat oneself up for a past wrong (2008 142, 153). Similarly, it would be foolish to suggest that one is in control of every aspect of their mental illness (indeed, *no one* is entirely in control of all aspects of their psychology, healthy or otherwise). But this fact does not answer the questions of how to interpret these experiences or what attitude to take towards them. I suspect some critics of Mad Pride may overlook this active component of interpretation or fail to recognize that there are multiple ways to relate to these experiences that are quite intelligible. I note that this is a feature of self-making in general: we suffer, and our human condition compels us to situate that suffering and decide how we will carry it forward. My suggestion is that authenticity under mental illness is no different in this respect, and involves (among other things), choosing how to interpret and relate to those symptoms.

[21] An alternative metaphor: the medicated and unmedicated selves may be like different musical modes; the same 'notes' are there, but their different arrangements, tonal centers, and relationships reveal different aesthetic valences.

A project of authenticity includes interpreting symptoms, but additionally, one must decide how to *respond* to that aspect of their facticity. How will an individual disclose their being in the world given their interpretation of their facticity? What will they concretely choose? The process of authenticity also involves disclosing one's being through ongoing commitments to projects *given* one's facticity. But this shouldn't be interpreted as a radical choice to enact mental illness symptoms or not—to, say, "turn off" chronic anxiety, depression, or behaviors association with autism spectrum disorder. Such an interpretation would represent an unrealistic appreciation for facticity and the way it influences our selves. Norlock illustrates this consideration in her discussion of culpability for self-inflicted harms:

> The choices of eating disorder patients to deprive themselves of food stem from recognized illnesses, but the further choices involved in keeping their behaviors, their self-hatred, and their deprivations secret are more robust. When they take the form of ending relationships, deceiving others, or declining opportunities for meaningful work, those who self-inflict incur costs for which their current and future selves may hold them accountable. (2008, 150)

Mental illnesses may hamper or influence certain choices (like the choice to eat, described above), yet individuals must still make other choices given their situations, and this includes their psychological situations. So, the interpretation given to symptoms is not only important regarding the view of one's self, but it also bears on what one actually *does.*

I've motivated a view of existential authenticity in which authenticity is an active, situated, intersubjective project of self-construction. The upshots of this view are that it gives authority to agents who are often denied the ability to self-define while insisting that authenticity is not a solitary effort. It also acknowledges a diversity of possible authentic selves. However, one may wonder if *all* interpretations of mental illness are equally authentic, or whether there must be some restrictions on authenticity. In the next section, I argue that one such restriction

concerns narratives that essentialize the self in bad faith: authentic selves cannot be based on biological essentialism and a corresponding medicalized vision of cure.[22]

4. Bad Faith

In her discussion of the "crisis of adolescence" and the dawning of individual subjectivity, Beauvoir identifies several characteristic responses (1948/1976, 42). Among them is the serious person: one who, instead of embracing their own subjectivity, clings to what they view as absolute, ready-made values—serious values—given to them by society (1948/1976, 49-56). Capitalism, patriarchy, religion, etc., offer stock values to which the serious person conforms ("he is no longer a man, but a father, a boss, a member of the Christian Church or the Communist Party" [Beauvoir 1948/1976, 52]). According to Beauvoir, the serious person is in bad faith because they have denied their subjectivity (an aspect of ambiguity). They have failed to recognize that the only thing that gives these values importance is their and others' choice to value them, not some objective, impersonal bestowal of value. And in so doing they have cast themselves as having a reified nature: as some *thing* that is and must be a pre-given way, which can lead to a denial of the choices one does have.[23]

What is wrong with reifying oneself in this way? For Beauvoir, the immediate worry is that it is dishonest. An attitude that denies the ambiguity of one's human condition is in bad

[22] I focus on these this narrative because it is predominant in Western cultures, but there are other narratives about mental illness that could potentially be interpreted in bad faith, such as the denial of mental illness altogether, or the view that one reductively *is* one's mental illness by nature.

[23] As Lewis Gordon describes the problem, positing that humans have a nature involves assuming that there is some necessary way they must be because of the beings they are: "As a consequence, the question of what human beings choose to be isn't important. What is important is determining the ways human beings are already predisposed to act" (1995, 25).

faith. In the case of the serious person, it is a denial of one's freedom and responsibility (though one may also deny one's facticity in bad faith). To illustrate this point further, notice that there is a subtle distinction between recognizing one's facticity and positing a reified nature. Facticity refers to the conditions of one's situation: "I was assigned female at birth," "I was adopted," "I have been diagnosed with a mental illness." As discussed, these facts certainly can shape our experiences. But that something is true *of* me does not determine its meaning *for* me since that meaning cannot be found outside my interaction with this fact about myself. Alternatively, to appeal to a nature is to risk reifying the self, to make oneself a thing for which choices are dictated and no interpretation is necessary. If meaning is already given, there is no meaning to be created. Denying a reified nature need not entail a denial of facticity, though; rather, it can signal an endeavor to honestly accept the facts of one's life without reducing oneself to them, and thereby denying the choices one makes.

Consider an example to illustrate the distinction between facticity and reified nature. Among the Italian American culture in New York that was the backdrop of part of my upbringing, one hears many self-endorsed declarations about what an Italian American *is*: loud, appreciative of food, rude (or forthright), family-centered, stubborn, quick to anger, and generally excessive. Now, plenty of these things may be part of some individuals' facticity by some combination of genetics, upbringing, and cultural influence. But this set of norms do not just collectively dictate what an Italian American should be; it can also provide a script for how such a person in fact acts. One can relieve (some of) the burdens of freedom and responsibility by relying on that script, referring to the character description to guide one's choices.[24] Like an actor who cannot escape the type of role that made them famous, these choices are taken as

[24] There is a further question about whether such performative 'script following' may *become* authentic, though I don't have space to consider it here.

prescribed rather than freely undertaken: one typecasts oneself. There is a subtle but important distinction between acknowledging that one's irascible temperament is partly due to factors of genetics or upbringing and claiming it is "just in my blood," for instance. The former allows for a range of interpretations; the latter reifies oneself and leaves little room for interpretation (if that's just *who one is,* there is not much more to say).[25] This example is not meant to deny the importance of culture in authenticity; we are embedded in a society of shared narratives from which we construct a self. Yet at the same time, the way we *use* some of these narratives can be inauthentic. They can offer an easy way to avoid choosing oneself because one already has a self to be.[26]

In addition to the dishonesty of denying ambiguity, Beauvoir is concerned with potential for bad faith to support oppression. Certainly, one can 'cling' to harmful values like racism or ableism; the content of one's bad faith can be dangerous. But further, bad faith teaches its bearer to avoid taking responsibility for their actions—if my temperament is "just in my blood," then there's nothing I could have done to mitigate it and nothing I should do now to repair its effects.[27] This sense of passivity, of being fed one's lines rather than composing them, may have a ring of "just following orders" that acutely concerned Beauvoir. Additionally, the serious form of bad faith represents a failure to interrogate the values one holds. If one clings to absolute values to escape anguish, then these values may become more important than the people that their instantiations hurt (Beauvoir 1948/1976, 53). And all of this can translate into a complicity

[25] This is not to suggest that the only way to be authentic is to alter one's facticity; again, the attitude one takes towards one's facticity and the enactments pursued therein are what matter here.
[26] To be clear, one is still choosing themselves by these very interpretations, but they are denying that this is what they are doing. This is what makes this a situation of bad faith.
[27] Even if I can't stop myself from getting angry, I can leave the room before I do so.

in or even collusion with oppression. So, the stakes of bad faith are both materially and existentially high.

What does all this have to do with mental illness? Because meaning is created in a shared social world, individuals grappling with a sense of self may come across available social narratives about mental illness. And some of the narratives around mental illness run the risk of portraying individuals with mental illness as a "type" of person with a reified nature. I will consider one such set of narratives here, which Angela K. Thachuk identifies as "biomedical models of mental illness" (2011, 144). I will argue that such narratives can potentially be interpreted in bad faith when they pose a reductive and reified view of the self; in such cases, they can be used inauthentically. To be clear, I do not claim that these narratives are *always* in bad faith or inauthentic, nor that they cannot be interpreted in helpful, authentic ways. My concern is that such narratives are susceptible to a bad faith interpretation, not that they are necessarily interpreted this way. Additionally, there are other such narratives about mental illness that may pose similar risks, though I focus on biomedical models as one such example.

Thachuk characterizes biomedical models of mental illness as follows:

> [B]iomedical theories claim that certain (theoretically if not actually) detectable brain states lie at the root of mental illness. These theories generally attribute mental illness to a deficiency or excess of neurotransmitters, to hormonal imbalances, or to genetic predispositions….Mental illnesses are not so much problems of the mind as they are diseases of the brain. Brain-based psychiatry assumes that the causal foundations of mental illness can be objectively identified and scientifically understood. (2011, 145-6)

While such views can recognize the role of social and environmental factors in mental illness, in practice, the causal explanation of mental illness is still largely attributed to biology (Thachuk 2011, 147). Indeed, such views are so predominant as to inform the assumptions and practices of psychiatry itself as well as public views of mental illness (2011, 148).

Thachuk acknowledges that biomedical models of mental illness have had some positive effects, notably, legitimizing as illnesses behaviors that have historically been attributed to immoral character (2011, 149). But she argues that the costs of these models are significant and serve to increase stigma against mental illness. On the "objective" evidence of brain scans of individuals with mental illness, she notes:

> [T]hese images present these brain states as static and homogenous entities, when in truth they are quite fluid and diverse in their manifestation and in individual experiences of them…These visualizations work to ingrain clear demarcations between …ostensibly different kinds of people…while these technologies make stigmatized behaviors more intelligible, they potentially create the impression that the brain responsible for these behaviors is fundamentally broken, and that the person enacting these behaviors is of a distinct and aberrant kind. (2011, 151-2).

Empirical verification is a double-edged sword.[28] The risk of legitimizing an illness is reifying its bearer into a biologically "broken" brain. One can already see the potential reification at play: Western societies disposed to favor biological narratives may comfortably take on physically explanations of mental illness. The result can be a reductive view of mental illness and the person who bears it as a fundamentally "broken brain." And because such explanations are so socially entrenched, individuals are at risk of being viewed as nothing more than their biology.

There is a worrying parallel here to the deployment of essentializing narratives to reinforce gender, racial, and other oppressions. Members of minoritized groups are routinely treated as having essential—and inferior—natures: white women are seen as emotional and irrational, Black women as angry and promiscuous, Black men as violent. These are not only false and harmful stereotypes that seek to justify dehumanizing treatment.[29] They also represent an attempt to reduce and reify these groups into an aberrant *type* of people, thereby precluding

[28] Even taking things like brain scans as definitive causal evidence is presumptuous; as Thachuk notes, mental illness may cause brain changes, not the other way around (2011, 152).

[29] One could object that this is one salient difference between oppressive essentializing and biomedical models of mental illness, as there is at least some evidence for some biological underpinnings of mental illness.

any need for group and individual self-definition. Thachuk's argument against biomedical models of mental illness seems to encompass a similar concern. When individuals with mental illness—already a stereotyped and stigmatized group—are artificially boiled down to their brain states, this reification may become a further tool of their oppression by positing this group as necessarily of a different and inferior kind.

If the reductive cause of mental illness is taken to be an aberrant biology, then the response will be straightforwardly biological as well. And on this view, that response can only be *cure.* Kramer argues that this perspective on psychiatric medication is consistent with the pervasive social narrative that "biology is destiny" (1993, xiii); we are neurobiological creatures who can be neurochemically restored to our true selves. He writes: "what my patients generally said was that they had learned something about themselves from Prozac…they believed Prozac revealed what in them was biologically determined and what merely (experience being 'mere' compared to cellular physiology) experiential" (Kramer 1993, xv). This remarkable assessment supposes a biomedical model: mental illness is caused by a broken biology that psychopharmaceutical treatments correct, restoring the patient to who they always, by biological determinism, were. And the implication seems to be that we are determined to be psychologically healthy: the self on psychiatric drugs is viewed as the *real* self because these drugs "undo" illness, which, after all, is seen as only a biological malfunction.

Taken together, we see one dominant narrative about what mental illness is and how it should be treated.[30] This narrative involves two related claims: the cause of mental illness is

[30] Note that this is consistent with the perspective discussed in section 1, of mental illness as a loss of self and medication as a restoration of self. This is because there is an authentic way to take up that perspective that is not essentializing; the difference is in how one relates to one's symptoms and the interpretation one gives to their treatment. Similarly, receiving a diagnosis need not be essentializing if one uses that diagnosis as a way of interpreting one's experience that does not reduce oneself to their neurochemical makeup.

fundamentally biological, reducible to, for instance, neurotransmitter activity; and the psychopharmaceutical cure of mental illness proves the "destiny" of biology by revealing one's true self.[31] This narrative, I claim, *can* be interpreted in bad faith when it is used as a script to determine one's self. Indeed, because it offers an encompassing explanation for behavior, this type of narrative may be especially vulnerable to bad faith interpretations (though again, this doesn't mean it is necessarily in bad faith).

How might biomedical models of mental illness be applied to one's sense of self in bad faith? The biological determinism of these narratives can cast the individual as reducible to and defined by their brain chemistry. Like Beauvoir's serious person, the individual who adopts this narrative in this way finds a ready-made script for their actions that could be used to deny their own choices ("That's just my brain chemistry being weird," "I need more serotonin"). The point is not that there is never any truth to such biochemical claims (nor that our biochemistry never influences our behaviors), but rather that their influence can be overextended and used to deny the choices that one *is* making (including the choice to deny this interpretive choice!). Especially when a reductive biomedical model of mental illness is pushed on individuals (particularly by doctors imbued with epistemic authority [Kidd and Carel 2014]), it can be even easier to unreflectively adopt this pre-given blueprint for one's self. This adoption is only in bad faith when one "treats [their] choice as having already been made in order to evade it" (Gordon 1995, 18). Here, the choice is that of how to interpret one's mental illness (whether that involves biomedical explanations or not). Biomedical models can offer a ready-made interpretation for one's selfhood, behaviors, and actions. It can thus be used to evade these interpretative and agentive choices in bad faith.

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[31] This second claim implies that medication should have the same positive effect on every patient, which is clearly not the case. I thank to Mélissa Fox-Muraton for this point.

The worry is not that there is a biological component factored into one's interpretation of self—as this interpretation need not be inauthentic—but rather that the interpretation may not be treated as the choice that it is. Instead, it is clung to as a pre-given determination of who an individual is (a biochemical object) to the denial of however else they may choose to see themselves. In turn, any questions of selfhood may be taken as automatically answered by this narrative: mental illness is a biological blight that medication cures, restoring one's biological destiny. When taken up this way, this view can foreclose alternative interpretations of one's situation, collapsing the process of self-construction into the appropriation of a pre-given trope.[32] If the project of the human condition is, as Beauvoir argues, that of continuously negotiating our ambiguous situation of facticity and freedom, then narratives that deny this ambiguity by positing the self as determined once-and-for-all and independent of choice are also denying the human condition. They are thus inauthentic.

I've argued that biomedical models of mental illness present one possible bad faith narrative when interpreted in a certain way. But I do not mean to suggest that there is no authentic way to interpret such narratives.[33] Indeed, many with mental illness may interpret biomedical narratives as helpful and empowering ways to make sense of their experiences and authentically self-define. For instance, someone with panic disorder may take comfort in recognizing the physiological underpinnings of a panic attack; someone with autism spectrum disorder may be empowered with the knowledge that their response to certain situations is not evidence of a defect, but just attributable to their neurology. And in all cases, these explanations

[32] Hilde Lindemann Nelson (2011) and Diana Tietjens Meyers (2004) both note that overly rigid or fixed narratives can interfere with the creative capacity for autobiographical identities, particularly a "master narrative" of the privileged class (Nelson's term). The biomedical model of mental illness represents one such master narrative, though I don't have space to fully support this claim.

[33] I thank Mélissa Fox-Muraton for suggesting I explore the points in this paragraph.

can be just one component of the complex and evolving story of their selves (though a prominent and important one for some).[34]

Additionally, to claim that biomedical models of mental illness can potentially be taken up in bad faith is not to deny there is ever any biological component to mental illness. Recall the distinction between facticity and reifying nature. One can acknowledge some biological aspect of their condition (say, if they respond well to medication or have a family history of schizophrenia) without reducing their self-interpretation to nothing more than a spark of neurochemical signals. The point of existential authenticity is not to deny the immutable facts of our situation, but to recognize that we must choose how to interpret these situations and respond to them through our choices and actions. There is a difference between recognizing my biological reality as a truth that can be incorporated into my interpretation of selfhood and using that reality to attempt to flee self-definition entirely. I suggest the difference represents a project of authenticity, a project that is ultimately up to the individual to decide for herself.

5. Conclusion: Authenticity and Responsibility

In this paper, I've motivated a view of existential authenticity that hopefully offers a way to navigate questions of selfhood, authenticity, and mental illness by centering individuals' power to define themselves. But it holds further implications for other entailments of selfhood: specifically, this view bears on responsibility. If authentic selfhood is a process of self-construction, and since existentialism views this process as intimately bound up with

[34] Jeppsson notes the dangers of "[hanging] my entire identity on [a] single peg," whether that is a particular diagnosis, the label of 'mad' or 'mentally ill,' or indeed, *any* identity (even non-pathological ones) (2002, 307). Such an encapsulating identification leaves one vulnerable to the loss of that identity (say, if one's DSM diagnosis changes). The same problem can be interpreted through an existentialist lens: the problem with exclusively relying on any one identity is that it is likely dishonest (no person can be encapsulated into *one* aspect of identity) and there is a risk of clinging to that identity to the exclusion of other possibilities, which would be in bad faith.

responsibility, then who one chooses to be is related to the responsibilities they assume. For instance, if one incorporates their mental illness into their self, they may be reluctant to excuse certain symptomatic behaviors. Browne found that this was the case for some of the women she interviewed: "at times they were unsure whether they were really entitled to feel guilt-free for behaviours which they have been told or read are symptoms of depression or mania and whether the biomedical explanation was simply providing them with an escape from responsibility" (2018, 49).[35] If authenticity values the agent's interpretation of their situation and the choices made therein, then it should also give some consideration to their *own* sense of their responsibility with regard to their symptoms. The question of whether mental illness undermines responsibility should consider, among other things (and perhaps defeasibly), how that agent relates to her mental illness and what she takes responsibility for in light of it.[36]

Selfhood and authenticity are as messy as the people who worry about them. Though it may be dissatisfying to still lack *the* answer about authenticity—some definitive solution to how I should be and what I should do—that uncertainty is exactly the point. There is no such answer outside of the work of living, interpreting, interacting with others, and deciding how to disclose our being in the world. This is why the work of authenticity is never done: *any i*dentity is always a potential trap into the restrictions of bad faith. It is temptingly easy to encase oneself into a safe pre-defined identity, and difficult to practice authenticity with the requisite honesty and flexibility. The conditions of mental illness are in some ways not unique in problematizing

[35] Tellingly, the biomedical model of mental illness was identified as a bad faith scapegoat.
[36] This can be part of what Ciurria calls "specific considerations" of that help determine the responsibility of a person with mental illness; these concern "the role of the disorder in the person's psychological profile and its relation to the person's environment" (2019, 339). Additionally, there are "generic considerations" about the mental disorder in question (Ciurria 2019, 339).

authenticity and selfhood. Yet in other ways, they cut right to the heart of why we are concerned about who we are at all.

6. Works Cited

1. Beauvoir, Simone de. (1948, 1976). The Ethics of Ambiguity. Trans. Bernard Frechtman. Citadel Press.
2. Brison, Susan J. (2002). Aftermath: Violence and the Remaking of a Self. Princeton, NJ: Princeton University Press.
3. Browne, Tamara Kayali. (2018). *Depression and the Self: Meaning, Control, and Authenticity.* Cambridge University Press.
4. Card, Claudia. (1996). The Unnatural Lottery: Character and Moral Luck. Philadelphia, PA: Temple University Press.
5. Carel, Havi and Kidd, Ian James. (2014). Epistemic Injustice in Healthcare: A Philosophical Analysis. Medicine, Health Care and Philosophy, 17: 529-540. DOI 10.1007/s11019-014-9560-2
6. Ciurria, Michelle. Mental Illness, Agency, and Responsibility. 2019, The Bloomsbury Companion to the Philosophy of Psychiatry. Serife Tekin, Robyn Bluhm 325-345
7. Cutler, Emily Sheera. (2019). Listening to Those with Lived Experience. In: Steingard, S. (eds) *Critical Psychiatry.* pp. 179-206. Springer, Cham. https://doi.org/10.1007/978-3-030-02732-2_8
8. Gordon, Lewis. (1995). Bad Faith and Antiblack Racism. Atlantic Highlands, NJ: Humanities Press.

9. Hoffman, Ginger A. (2019). Public Mental Health Without the Health? Challenges and Contributions from the Mad Pride and Neurodiversity Paradigms. *Developments in Neuroethics and Bioethics,* 2 (289-326). https://doi.org/10.1016/bs.dnb.2019.07.003
10. Jeppsson, Sofia M.I. 2022: Solving the self-illness ambiguity: the case for construction over discovery. *Philosophical Explorations* 25(3) 294-313
11. Jost, Alison. 2009. "Mad Pride and the Medical Model." Hastings Center Report, 39(4): c3.
12. Kramer, Peter D. 1993. *Listening to Prozac.* Viking Penguin.
13. Levy, Neil. 2011. Enhancing Authenticity. Journal of Applied Philosophy, 28(3): 308-318. doi: 10.1111/j.1468-5930.2011.00532.x
14. Meyers, Diana Tietjens. (2004). "Narrative and Moral Life." In Being Yourself: Essays on Identity, Action, and Social Life. 159-182.
15. Nelson, Hilde Lindemann. (2001) Damaged Identities: Narrative Repair. Ithica, NY: Cornell University
16. Norlock, Kathryn. (2008). "Self-forgiveness." In *Forgiveness from a Feminist Perspective.* pp. 137-158. Rowman and Littlefield.
17. Phillips, James. 2003. "Psychopathology and the Narrative Self." Philosophy, Psychiatry, & Psychology (10)4: 313-328.
18. Rashed, Mohammed Abouelleil. 2019. "In Defense of Madness: The Problem of Disability." *Journal of Medicine and Philosophy.* 44: 150-174.
19. Sadler, John Z. (2007). The Psychiatric Significance of the Personal Self. *Psychiatry,* 70(2): 113-129.

20. Sartre, Jean-Paul. (1946). “Existentialism is a Humanism.” Trans. (P. Mairet, Trans.). In W. Kaufman (Ed.), Existentialism from Dostoyevsky to Sartre. (pp. 287-311). London, UK: Meridian Publishing Company.
21. ---. (1956). Being and Nothingness: A Phenomenological Essay on Ontology. Trans. Hazel Barnes. New York: Washington Square Press.
22. Slater, Lauren (1998). Prozac Diary. Penguin Books.
23. Solomon, Andrew. (2002). The Noonday Demon. An Anatomy of Depression. London: Vintage.
24. Tessman, Lisa. (2005). Burdened Virtues: Virtue Ethics for Liberatory Struggles. Oxford University Press.
25. Thachuk, Angela K. (2011). “Stigma and the Politics of Biomedical Models of Mental Illness.” International Journal of Feminist Approaches to Bioethics (4)1: 140-163.