The Problem of Mental Capacity in Self-Harming Egosyntonic Disorder

> Right before I swallowed the pills, I went to see my husband at work. I used to go there and, sort of like, bother him. He was just like, "It's over, that's it." Then I just felt so alone, more alone than I've ever, ever felt. And I just said, I'd just rather be dead than feel this way. And I'd rather feel dead than hurt, and I can't take the hurt anymore. I knew that I didn't know what was going to happen, I took a lot of pills, and I figured it would probably hurt, the way that I would die. But I figured that it would be *over*, instead of every day just living with pain. *Every day*. I couldn't take it anymore.[1]

Kate describes her feelings right before she attempted suicide after her husband had left her. She had a diagnosis of borderline personality disorder (BPD) and history of self-harm. Consider Kate's case alongside the controversial suicide of Kerrie Wooltorton in 2007 by ethylene glycol toxicity. Ms Wooltorton had a history of self-harm and depression; she was diagnosed with 'untreatable' BPD and had previous admissions under the Mental Health Act. In nine previous attempted suicides she had accepted life-saving treatment. Ms Wooltorton had prepared an advance directive three days beforehand. This advance directive was submitted to clinical staff fully conscious and alert, stating that she refused treatment but wished to die where she would not be alone and could be made comfortable. Judging her to be competent, the clinician in charge complied with Ms Wooltorton's wishes. She died the following day.

The Wooltorton case raised all sorts of complex issues around mental capacity assessment[2] and the validity of advance decisions.[3] Sheila McLean nonetheless concluded that the case was 'in essence only about a straightforward refusal of consent by a competent adult person' and however uncomfortable one might be with the outcome, Ms Wooltorton as a capacitous adult had the right to have her treatment refusal respected.[4] But this conclusion ignores the core ethical dilemma behind determining mental capacity in such cases, where chronic self-harming and suicidality are behaviours that are constitutive of an enduring egosyntonic disorder. Egosyntonic disorders mean that the nature of the impairment and its indicative behaviours accord with the individual's selfhood

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[1] Jeffrey Young, et al, *Schema Therapy; A Practitioner's Guide* (Guildford Press 2003) 320 (hereafter Young, et al, *Schema Therapy*).

[2] Anthony David and Navneet Kapur, 'Mentally disordered or lacking capacity? Lessons for managing serious deliberate self harm' (2010) 341 BMJ 587; Genevra Richardson, 'Mental capacity in the shadow of suicide: What can the law do?' (2013) 9 IJLC 87 (hereafter Richardson, 'Mental capacity in the shadow of suicide').

[3] Navneet Kapur, et al, 'Advance Directives and Suicidal Behaviour' (2010) BMJ 341.

[4] Sheila McLean, 'Advance directives and the case of Kerrie Wooltorton' *The BMJ*, 1 October 2009) <http://blogs.bmj.com/bmj/2009/10/01/sheila-mclean-on-advance-directives-and-the-case-of-kerrie-wooltorton/>accessed 3 January 2017

and personal identity. By contrast egodystonic disorders occur where disordered behaviours are viewed as disconnected from and in conflict with the individual's sense of self.

The concept of mental capacity functions as a gatekeeper for the right of personal autonomy, namely the right to make one's own decisions about care and treatment. Under the Mental Capacity Act 2005 in England and Wales (MCA), mental capacity is decided according to a functional test based on the ability to (i) understand; (ii) retain; (iii) use and weigh; and (iv) communicate information that is relevant to a specific decision. In theory, these value-neutral criteria are designed such that assessors refrain from judging the wisdom and goodness of individuals' decisions. These functional criteria are nonetheless problematic: autonomy is presumed to be *individualistic* and *value-neutral* which then precludes explicit engagement with the more substantive evaluative judgements that are needed to articulate what may be incapacitous in the decision-making expressed in self-harming egosyntonic disorders.[5]

In this paper I argue that a relational approach to the question of mental capacity will help clarify the substantive evaluative judgements needed in such problematic cases. Specifically, I suggest that the concept of capacity should operationalise a model of relational autonomy which illuminates the importance of *mutual recognition* in the development of self-narratives that are consistent with autonomy. Section I provides a brief overview of the diagnosis of BPD. Section II critically assesses the authenticity approach as a possible alternative framework for capacity assessment in self-harming egosyntonic disorders and claims that the authenticity approach ultimately remains overdetermined by the clinical diagnostic criteria. Section III explores how relations-to-self conducive to autonomy or heteronomy are inculcated through an intersubjective process of recognition or misrecognition. I examine the subjective and intersubjective possibilities of active resistance and narrative repair in Sections IV, concluding with its implications for capacity assessment in Section V.

I. About Borderline Personality Disorder

Although the diagnosis remains deeply controversial,[6] 'personality disorder' in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) is defined by enduring patterns

[5] Elsewhere I have argued more fully for a relational account of capacity and suggested how more substantive judgements inevitably motivate mental capacity assessments. See Camillia Kong, *Mental Capacity in Relationship: Decision-Making, Dialogue, and Autonomy* (Cambridge University Press, 2017) (hereafter Kong, *Mental Capacity in Relationship*); Camillia Kong, 'Beyond the Balancing Scales: The Importance of Prejudice and Dialogue in *A Local Authority v E and Ors*' (2014) 26 CFLQ 216 (hereafter Kong, 'Beyond the Balancing Scales')

[6] Kate L. Lewis and Brin F. S. Grenyer, 'Borderline Personality or Complex Posttraumatic Stress Disorder? An Update on the Controversy' (2009) 17 Harvard Review of Psychiatry 322; Emanuela S. Gritti, et al,

of experience and behaviour in areas of (i) thinking; (ii) feeling; (iii) interpersonal relationships; and (iv) impulse control. These patterns depart from cultural norms and expectations, are pervasive and inflexible, and generate distress or impairment. Pathological personality traits in BPD fall into more specific impairments in self- and interpersonal functioning. Impairments in self-functioning revolve around issues of identity (such as poorly developed or unstable self-image that is often connected to excessive self-criticism, feelings of emptiness, and dissociative states) and self-direction (such as unstable goals, aspirations, and values). Impairment in interpersonal functioning involves hypersensitivity and fears of abandonment and rejection. Together, these impairments are expressed in emotionally dysregulated, maladaptive behaviours, such as risky behaviour, repeated self-mutilation with non- and parasuicidal intent, and suicide attempts.

BPD and its symptoms present a conundrum on two fronts. First, the *enduring persistence of the unstable self* reveals BPD selfhood rests on a paradox: on one hand, individuals can switch between, or even experience concurrent psychological states of emptiness, dissociation and emotively charged self-punishment. On the other hand, this instability remains enduring and 'stable', so that such instability *constitutively defines* BPD selfhood and personal identity. Second, maladaptive coping behaviours of BPD appear to be *consistent* expressions of the unstable self. Reasons behind intentional self-mutilation include the expression of anger, self-punishment, distraction from emotional distress, and a desire to regain normal feelings.[7] Indeed, self-punishment and anger towards oneself (rather than towards others) are often the predominant motives behind non-suicidal self-mutilation,[8] whilst the desire to decrease one's burden on others largely motivates suicide attempts in BPD.[9] The self-punitive intentions behind self-mutilating, suicidal behaviour in BPD appear to be entirely consistent expressions of individuals' personal identity based on self-abnegating narratives and values. Further complications emerge when considering the overwhelming evidence that the emergence of BPD is closely connected to trauma and adverse childhood experiences of abuse, physical and/or emotional neglect, and invalidation.[10]

'Diagnostic Agreement Between Clinicians and Clients: The Convergent and Discriminant Validity of the SWAP-200 and MCMI-III Personality Disorder Scales' (2016) 30 Journal of Personality Disorder 796.

[7] M. Z. Brown, et al, 'Reasons for suicide attempts and nonsuicidal self-injury in women with borderline personality disorder' (2002) 111 Journal of Abnormal Psychology 198 (hereafter Brown et al, 'Reasons for suicide attempts')

[8] Ibid 200; O. Guralnik and D. Simeon, 'Psychodynamic theory and treatment of impulsive self-mutilating behaviors', in D. Simeon and E. Hollander (eds.), *Self-mutilating behaviors: Assessment and treatment* (American Psychiatric Press 2001) 175-97

[9] Brown et al, 'Reasons for suicide attempts' (n 7) 200

[10] Bessel van der Kolk, et al, 'Childhood Origins of Self-Destructive Behavior' (1991) 148 American journal of Psychiatry 1665; Marsha Linehan, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (Guildford 1993) (hereafter Linehan, *Cognitive-Behavioral Treatment*); Gemma L. Gladstone, et al, 'Implications of childhood trauma for depressed women: an analysis of pathways from childhood sexual abuse

II. The Authenticity Approach to Capacity

Functional tests of capacity, such as the approach adopted in the MCA, are designed to presume capacity in the first instance and thereby safeguard the self-determination of individuals with impairments. Although the inquest found that the clinical staff had assessed her decision-making competence appropriately, determining capacity in situations like the Wooltorton case is not straightforward precisely because self-mutilating, suicidal behaviours are constitutive of disordered borderline selfhood. The functional route towards capacity is insufficiently equipped to cope with egosyntonic disorders of this kind on two levels. First, it is questionable that an entirely functional focus is achievable if self-harm is a constitutive feature of the diagnosis[11]: consider by analogy the problematic question of capacity amongst those with eating disorders such as anorexia nervosa (AN). AN is constitutively defined by an overriding fear of weight gain and refusals of treatment or food are core symptoms of the disorder. Medico-juridical practitioners consequently struggle to assess capacity about AN treatment refusals without appealing to the diagnostic criteria for eating disorders ('by definition, an eating disorder entails a refusal of treatment and food'). By the same logic, individuals with BPD may be unable to make capacitous choices related to self-harm and suicide because such behaviours are constitutive features of how the disorder manifests itself ('by definition, BPD entails self-harming and suicidal behaviour'). The reasoning behind capacity adjudications in both cases would collapse into status-based assessments, meaning the functional approach itself may fail by its own standards when assessing the capacity of self-harming behaviours that constitutively define the diagnostic criteria.[12]

Second and more fundamentally, whether a functional approach can accurately pinpoint what might be incapacitious about decision-making in self-harming egosyntonic disorders is doubtful. The case of AN is again helpful here. Jacinta Tan et al revealed that individuals with AN often pass functional tests of capacity (like the MacCAT-T) with flying colours, displaying relevant knowledge about their disorder and making decisions in a rational, logically consistent manner.[13]

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to deliberate self-harm and revictimization' (2004) 161 Am J Psychiatry 1417; Paul Soloff, et al, 'Childhood abuse as a risk factor for suicidal behavior in borderline personality disorder' (2002) 16 Journal of Personality Disorders 201

[11] Indeed, BPD is the only personality disorder which includes self-injurious or suicidal behaviour amongst its diagnostic criteria: Michele Berk, et al, 'Beyond threats: Risk Factors for suicide in borderline personality disorder' (2009) 8 *Current Psychiatry* 33

[12] Kong, 'Beyond the Balancing Scales' (n 5) 232

[13] Jacinta O. A. Tan, et al, 'Competence to make treatment decisions in anorexia nervosa: thinking processes and values' (2006) 13 *Philos Psychiatr Psychol* 267 (hereafter Tan, et al, 'Competence to make treatment decisions', page numbers refer to PMC version https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2121578/#__ffn_sectitle, accessed 23 March 2017)

By the lights of a purely functional test, many AN patients at risk of death would be found to have capacity to refuse life-preserving treatment as a result.[14] Tracking the problematic nature of AN decision-making therefore requires going beyond the functional test, towards an examination of concepts such as personal identity, values, and authenticity. Even in cases where ambivalence towards or conflict with the eating disorder is expressed, treatment is typically difficult because it involves challenging core parts of an individual's perceived identity and values, making it tantamount to becoming a different person altogether.[15]

To determine the decision-making capacity of AN patients, Tan et al appeal to a distinction between 'pathological' and 'non-pathological' values, 'pathological' values denoting those which arise from a mental disorder, such as the overriding importance of thinness above all else or a preference to risk death or disability rather than weight gain.[16] The concept of mental disorder further distinguishes pathological values from eccentric, unreasonable values, making 'authenticity' equivalent to the autonomous, non-disordered self. Though proponents of this view are rightly hesitant to argue that authenticity is necessarily coextensive with capacity,[17] the concept has nonetheless been deployed to illustrate how the ideal of autonomy should be *independent* of mental disorder, where authentic views, in other words, are those 'that she would have (or did have) if she did not suffer from the mental disorder.'[18] Consequently, '[i]f value or value system can be determined to arise from a mental disorder then it is 'pathological'.[19] Particular decisions determined by pathological values diverge from the 'authentic', non-disordered person and may therefore fail to demonstrate decision-making competence.

Aspects of this research are applicable to issues of self-mutilating and suicidal behaviour in BPD. Tan et al rightly highlight ambiguities about the authenticity of egosyntonic disorder, a point which tends to be overlooked in a purely functional approach to capacity. Moreover, attending to these ambiguities would lend itself towards a more scalar rather than binary view of decision-making capacity, offering greater leeway for the provision of positive support that fits somewhere between

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[14] Though the law certainly does not necessarily defer to this position: *A Local Authority v E and Ors (Medical treatment: Anorexia)* [2012] EWHC 1639 (COP), [2012] MHLO 55; *The NHS Trust v L* [2012] EWHC 2741 (COP), [2012] MHLO 159

[15] Tony Hope, et al, 'Anorexia Nervosa and the Language of Authenticity' (2011) 41 Hastings Center Report 19, 25 (hereafter Hope, et al, 'Anorexia Nervosa')

[16] Tan, et al, 'Competence to make treatment decisions' (n 12)

[17] Hope, et al, 'Anorexia Nervosa' (n 14) 28

[18] Tan, et al, 'Competence to make treatment decisions' (n 12) 20

[19] Ibid p. 21

coercive treatment and strict non-intervention.[20] This grey area is important given the significant mortality rates of individuals diagnosed with AN and BPD.[21]

Yet an authenticity approach to capacity raises its own problems on several fronts. First, the distinction between pathological and non-pathological values hinges on a strict adherence to how mental disorder is clinically defined, thus committing itself to questionable assumptions about the scientific objectivity of diagnoses. As mentioned earlier, the BPD diagnosis is both deeply controversial and stigmatising: not only is its criteria contested by both clinicians and patients,[22] but it contains implicit, value-laden views about gender, untreatability, and intentionality of behaviour (i.e. 'attention-seeking' and 'manipulative', 'difficult', 'irresponsible', 'psychological vampires').[23] In other words, BPD carries the burden of being perceived as an untreatable disorder on one hand, yet as expressing fully intentional, controllable behaviours that individuals can and should be accountable for on the other. To pathologise certain behaviours and presume its inauthentic source overlooks implicit assumptions within the BPD diagnosis which demand further critical scrutiny.[24]

Second, the complex phenomenology behind the egosyntonicity of BPD cannot be captured if the authentic self is separated from the disordered self. It may be the case that we might question whether the disordered self is indeed authentic, particularly in cases of extreme ambivalence or value conflict. But egosytonicity becomes a difficult issue when the disordered self is subjectively perceived to be the authentic self: the self may not disown the values that are, from the outside, viewed as pathological, disordered, or self-destructive. Indeed, disordered behaviour may be an appropriate response to the way one sees the world, fully consistent with one's identity.[25] If we no longer rely on the clinical diagnostic criteria, the pathological / non-pathological distinction must

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20 Kong, *Mental Capacity in Relationship*, ch. 5; Richardson, 'Mental capacity in the shadow of suicide' (n 2)

21 According to Klaus Lieb et al, '10% of [BPD] patients commit suicide, a rate almost 50 times higher than in the general population', 'Borderline Personality Disorder' (2004) 364 The Lancet 453; Maurizio Pompili, et al, 'Suicide in borderline personality disorder; A meta-analysis' (2005) 59 Nordic Journal of Psychiatry 319; J. Arcelus, et al, 'Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders: a meta-analysis of 36 studies' (2011) 68 Arch Gen Psychiatry 742

22 Linehan, *Cognitive-Behavioral Therapy* (n 10) 3-26; Nicolas Rüsch, et al, 'Self-Stigma in Women With Borderline Personality Disorder and Women With Social Phobia' (2006) 194 Journal of Nervous & Mental Disease 766; M. Crowe, 'Never good enough – part 1: shame or borderline personality disorder?' (2004) 11 *Journal of Psychiatric and Mental Health Nursing*, 327

23 Nancy Nyquist Potter, *Mapping the Edges and the In-between: A Critical Analysis of Borderline Personality Disorder* (Oxford University Press 2009) (hereafter Potter, *Mapping the Edges*); Clare Shaw and Gillian Proctor, 'Women at the Margins: A Critique of the Diagnosis of Borderline Personality Disorder' 2005 (15) Feminism and Psychology 483; Len Bowers, *Dangerous and Severe Personality Disorder; Response and Role of the Psychiatric Team* (Routledge 2002)

24 Potter, *Mapping the Edges* (n 23)

25 Cf. *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60

rely on what it means to be authentic / inauthentic. Yet this becomes a circular argument if authenticity depends on whether or not one has a mental disorder.[26] It thus becomes unclear what the pathological / non-pathological distinction brings to the table to improve mental capacity adjudications of egosyntonic self-harming and suicidal behaviour in BPD. Indeed, it seems to collapse into a status-based test, failing in similar ways to that of the functional test.

We therefore need an approach to mental capacity that can capture the phenomenology of egosyntonic disorder, yet avoids overdetermination by the diagnostic criteria. In the next section I argue that mental capacity in such cases needs to attend to the *social and relational process* of how autonomous or heteronomous selfhood develops in the first place. This analytical focus will help clarify the self-understanding and self-narratives that are consonant with autonomy, giving it two advantages over a narrow focus on authenticity or pathological values: firstly, this approach looks at *how* autonomy competencies develop *irrespective of pathology*; secondly, *cohesive, integrated* self-narratives (which egosyntonic disorders often reveal) will not necessarily reflect the possession of autonomy competencies. Instead, the *substantive content* of these self-narratives will indicate whether certain ways of valuing oneself have been internalised.

III. Relational Autonomy and Mutual Recognition

The concept of mental capacity assumes the value of autonomy as a core pillar of medical law and clinical practice. This emphasis on individual autonomy has its critics (as we see in this volume): Jonathan Herring, for example, questions why autonomy rather than care should be the lens through which interpersonal obligations are viewed. Others, such as Charles Foster, believe that values such as dignity rather than autonomy often bear the normative burden in ethically fraught medico-juridical scenarios. The tragic outcome of the Wooltorton case provides obvious reasons why one might question the preeminent weight accorded to the autonomy ideal in mental capacity law and medical law more generally. However, these worries do not warrant a complete dismissal of autonomy though they do highlight the need for significant refinements as to how the concept is operationalised in medical law cases involving potentially fatal egosyntonic disorders.

Bioethical theory and medico-juridical practice tend to take as their point of departure the liberal conception of autonomy defined as personal independence, where the self is sovereign over one's body and mind.[27] Deference to an individual's choices, preferences, and wishes is required so long as certain criteria are met: (i) *procedural conditions*: one's choices reflect a consistent

26 Hope, et al, 'Anorexia Nervosa' acknowledges that this argument would be circular and rightly scale back the claims that disordered personal identity would be inauthentic. However, how this coheres with Tan's claims in 'Competence to make treatment decisions' (particularly the version published on PMC) is unclear, where the pathological / non-pathological values distinction lends itself to circular reasoning.

27 JS Mill, *On Liberty* (Penguin 1974) 69, mentioned by MacDonald J in *Kings College Hospital NHS Foundation Trust v C & V* [2015] EWCOP 80.

hierarchical order (that first-order choices cohere with higher-order desires and values) and (ii) *authenticity conditions*: an individual's values accord with her sense of personal identity and selfhood (that one takes 'ownership' of one's higher order preferences). But we have seen so far, those with egosyntonic disorders often meet both conditions: individuals with BPD may engage in repetitive self-mutilating behaviour (such as cutting) and this not only accords with their higher order preferences (i.e. relief of pain or distress, desire to self-punish) but likewise conforms to their core personal identity (i.e. as deserving punishment due to one's worthlessness). Alternatively, an attempt to isolate what is potentially 'authentic' in the BPD self is difficult without understanding what has gone awry in the *development* of personal identity. For many with BPD, traumatic, abusive childhood experiences have affected their self-constitution, with self-destructive coping mechanisms and decisions manifesting themselves later in life. An individual's disordered motivational structure and self-understanding can hinge on relational, socialising influences. Closer scrutiny of these influences will add much needed nuance to the issue of whether self-mutilating or suicidal behaviours reflect capacitious, and indeed, autonomous decision-making.

Feminist models of relational autonomy have particular relevance here. Theories of relational autonomy focus precisely on the question of how pernicious socialisation can affect the development or expression of personal identity and key autonomy competencies, either in a causal or constitutive sense.[28] Autonomy competencies are socially acquired rather than the result of monological introspection and include an 'ingrained disposition to consult the self, a capacity to discern the import of felt self-referential responses as well as independent beliefs, values, and goals, and a capacity to devise and carry out conduct congruent with the self', particularly in determining whether certain situational constraints are appropriate or addressing discord within oneself.[29] Based on this definition, integration or consistency between one's sense of self and one's values in of itself isn't the main focus. What matters, rather, is the *process* behind our self-constitution – namely the complex interaction between social / relational context and individual dispositional traits – which may or may not encourage and establish autonomy competencies in our personal identity.[30] The process behind self-constitution will involve both passive and active factors that contribute to or obstruct the development of key autonomy skills.

Passive determinants of autonomy denote the socialising influences and narratives one cannot control. More specifically, an intersubjective process called *mutual recognition* makes our

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28 I explore the debate between causal and constitutive accounts in Kong, *Mental Capacity in Relationship* ch. 3

29 Diana T. Meyers, *Self, Society, and Personal Choice* (Columbia University Press 1984) 83-4.

30 Diana T. Meyers, 'Intersectional Identity and the Authentic Self?: Opposites Attract!' in Catriona Mackenzie and Natalie Stoljar (eds) *Relational Autonomy; Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford University Press 2000) 154.

autonomy 'vulnerable to disruptions in one's relationships to others'.[31] Through mutual recognition, attitudes of others come to mediate our own *intrapersonal*, relations-to-self and frame our choices accordingly.[32] We internalise modes of mutual recognition or misrecognition within the developmental process. Some relations-to-self are prone towards indecisive, doubtful, punitive, or hateful attitudes towards oneself; other intrapersonal attitudes reveal more *nurturing* relation-to-self, constituted by a positive vision of one's identity and agency. Three modes of recognition are significant in cultivating nurturing relations-to-self that are amenable to autonomy.[33]

First, respectful recognitional bonds are expressed when others treat us as worthy of respectful treatment, as individuals whose reasons deserve consideration. When internalised as *self-respect*, we likewise regard ourselves as persons of worth and valid reasons, and object to others' arbitrary disregard for our physical integrity, reasons, and personal characteristics. Degrading treatment by others, once internalised, will manifest itself in the intrapersonal acceptance of others' disregard as deserved (i.e. an appropriate response in keeping with one's sense of self). Or even if one objects, one will lack the internal resources to mount resistance in situations where such treatment has fallen short of respect.

Second, mutual recognition based on trust becomes internalised as *self-trust*. This intrapersonal attitude implies an open, confident relationship with conative aspects of our agency, such as our perceptions, emotions, desires, and impulses. Self-trust develops when those around us treat our particular conative expressions as legitimate and valuable. Relational contexts and socialising narratives that validate our conative responses help nurture an *intrapersonal* framework of safety and compassion towards ourselves – we become attuned to and openly explore these facets of our identity. Without experiencing recognitional bonds founded on trust, our relationship to the conative dimensions of our own agency can go awry in two ways: we can disown or distrust them – and thereby become uncertain about the crucial role these play in our practical actions and choices – or they can become underdeveloped, dysregulated, and inflexible – where an orientation of psychological rigidity rather than reflexivity towards our conative responses characterises our agency.

Finally, mutual recognition that affirms the positive contributions of our activities, goals, and role to a defined group or community becomes internalised as an intrapersonal attitude of *self-esteem*. We gain a sense of our intrinsic value and belonging. By contrast, a sense of interpersonal disconnection, displacement, and personal insignificance pervades where self-esteem is lacking.

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31 Joel Anderson and Axel Honneth, 'Autonomy, Vulnerability, Recognition, and Justice' in John Christman and Joel Anderson (eds) *Autonomy and the Challenges to Liberalism* (Cambridge University Press 2005) 130

32 Ibid 131

33 I adapt the recognitional framework of Axel Honneth to the context of impairment. See Honneth, *The Struggle for Recognition: The Moral Grammar of Social Conflicts* (MIT Press 1996)

Studies have shown repeatedly that individuals with BPD have little or no experience of these modes of mutual recognition required to acquire autonomy competencies. Trauma, abuse, and adverse childhood experiences are prevalent amongst those later diagnosed with BPD. These experiences typically include a family context that is: (i) unsafe and unstable (particularly in cases of abuse, neglect, or abandonment); (ii) depriving (in terms of parental nurturing, guidance, or protection); (iii) harshly punitive and rejecting (highly critical, unforgiving, and punishing); and (iv) subjugating (in that the needs and emotions of the child are suppressed through active discouragement or withdrawal).[34]

Such a family environment embodies modes of *misrecognition*, as illustrated well in the therapeutic dialogue between Kate (from the beginning of the paper) and Jeffrey Young (the founder of Schema Therapy). Kate was physically and sexually abused by her brother and she was blamed for, rather than protected from, his behaviour when she told her parents. Kate's lack of self-respect put her in a double-bind – she could neither defend herself against her mother's cutting criticisms of her nor even think she was *deserving* of such a defense: 'That's what prevents me from sticking up for myself and taking care of myself, because I just don't feel like I have the right. And I don't think that anyone has the right to want to take care of me, because I don't deserve it.'[35] She had little opportunity to develop self-trust, given that her conative responses to situations were repeatedly invalidated to the point that they would incite punitive, volatile recriminations. For example, Kate's mother frequently berated her for being 'miserable'. 'She told me she didn't like me, that I was just hopeless, that I was just so miserable she couldn't stand it. […] I just believed it, because it was true.'[36] Kate also lacked self-esteem – her activities were met with ambivalence and lack of care, and any sense of intrinsic belonging or subjective value was absent. When asked about the origin of her feelings of 'being no good or worthless', Kate stated, 'I've just always felt them, just from my family life, just not really feeling that I was important, or like I made a difference, or that I was significant in my family. […] [T]hey just never listened to me, never acknowledged me. I could do whatever I wanted, whenever I wanted.'[37]

Ultimately, individuals with BPD have failed to experience the intersubjective, recognitional bonds of respect, trust, and esteem which help cultivate nurturing intrapersonal relation-to-self. Misrecognition becomes part and parcel of one's way of relating to oneself. Due to emotional deprivation and abuse, many individuals believe they have no right to express their needs and feelings, and deserve punishment when they do so.[38] BPD individuals internalise and identify with self-abnegating narratives, viewing themselves as inherently worthless and

34 Young, et al, *Schema Therapy* (n 1) 312-3.

35 Ibid 318

36 Ibid 317.

37 Ibid 316.

38 Ibid 345.

irredeemably bad. Kate described herself as 'not really a whole person, whatever a whole person is, I don't even know. I just know that I look at other people, and I just don't see myself equal to anybody.'[39] Like Kerrie Wooltorton, she engaged in self-mutilating behaviour, culminating with an attempted suicide via drug overdose. Describing that incident, Kate stated, 'I just felt that I was no good, that I was worthless. […] I was just nobody.'[40]

The broader relational, social context therefore determines whether a certain manner of valuing oneself has been inculcated. In ideal circumstances, this culminates in nurturing relations-to-self which function as the necessary scaffolding on which our autonomy competencies can be developed and exercised.[41] Such attention to the socialising process behind developing autonomy competencies points to a key difference from both functional and authenticity approaches to capacity. Both latter approaches remain relatively neutral towards the question of *which* self-conceptions can be seen as expressing autonomous – and therefore – capacitous decisions. But even if authenticity is coextensive with non-pathological values, it remains unclear why a person's skewed valuing cannot fulfil this criterion, particularly if one feels fully 'responsible' for one's values and decisions are consistent with one's sense of self. This is especially the case if clinical opinion is split as to whether one suffers from a mental disorder or not. By contrast, a relational approach to autonomy posits that not all self-narratives can be said to be consonant with autonomy. Different modes of recognition capture the more passive process of constituting an autonomous or heteronomous self and likewise provide crucial content by which *normatively acceptable* intrapersonal narratives can be judged.

IV. Narrative Repair

Alongside this passive process is a more active dimension of autonomous self-constitution, where individuals reflexively adjust and claim responsibility for the ways in which relational, social influences have shaped one's cognitive and motivational structure. Thus, one does not automatically submit to such influences, but responds to them so that the self is dynamic rather than fixed and rigid. This becomes particularly important in the case of BPD. The diagnostic criteria suggest that individuals struggle with unstable, empty selfhood, even as the lens through which they view themselves is often highly rigid and self-abnegating, with inflexible expectations about their and others' behaviour. This implies difficulty engaging with the more active dimension of autonomous self-constitution.

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39 Ibid 315.

40 Ibid 316.

41 I discuss this in some depth in Kong, 'Nurture before responsibility: Self-in-relation competence and self-harm', PPP (forthcoming).

For example, Kate describes to Young that 'I know I'm just supposed to be myself, but this is just really hard for me' due to this sense of expectation of what *others* expect her to do or be like, such as 'intelligent and articulate', 'without too much emotion'.[42] She states explicitly,

> I don't know what it is that I am. I think I'm just a miserable person deep down. That's just what I think. […] I start to emulate people, and just sort of like change myself, and I can be whoever and whatever I want. But what I've found is that it's just made me feel worse, more empty […] because I don't know what *I* expect. I don't know what *I* want. I don't know what's important to *me*. I don't know. I'm 27 years old and I have no clue.[43]

Instability in one's personal identity and phenomenological experience of selfhood (i.e. feelings of emptiness and confusion about one's identity, as Kate describes; dissociative experiences in the midst of self-harming behaviour) can be attributable partly to the challenge of actively constituting an autonomous self. The simultaneous emptiness and rigidity of BPD selfhood means the process of developing a dynamic yet stable practical identity cannot be carried out in isolation, through one's own monological introspection.[44] Individuals' core sense of themselves can be heavily invested in self-abnegating narratives: no matter how harmful or inconsistent with autonomy these may be, they are still familiar. The alternative – i.e. the dialogical process of constituting one's identity through unfamiliar narratives and perspectives – is often daunting and terrifying.

Where nurturing relations-to-self are lacking, the burdens of overturning the pernicious narratives which distort our self-understanding will therefore demand 'narrative repair' – a process of dialogical engagement with others who can help us identify and reflect on these distortions, create distance between our sense of self and dominant, self-abnegating narratives, and highlight intrapsychical tensions so as to encourage a practical identity which actively resists harmful socialisation.[45] In other words, this process attempts to undo the internalisation of misrecognition so that harmful self-constituting narratives become *egodystonic* – alien to ourselves and external to our practical identity.

Narrative repair as active resistance forms a crucial part of Schema Therapy approaches for treating BPD, for example. Through therapeutic dialogue and experiential work, individuals are encouraged to confront and undo their identification with the self-punitive mode of their identity. The self-punitive voice comes to be known as the 'Punitive Parent', thus distancing it from the self.

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[42] Young, et al, *Schema Therapy* (n 1) 319.

[43] Ibid.

[44] Indeed, this is the case for all individuals engaged in the active process of self-constitution. But the need for supportive others is especially so in cases where self-abnegating narratives are pervasive.

[45] Hilde Lindemann Nelson, *Damaged Identities, Narrative Repair* (Cornell University Press 2001).

For example, Young enjoins Kate to visualise herself as 'Angry Kate', and coaches her to respond to her father and challenge his mistreatment of her:

> Kate: (*to father in image*) I'm just tired of [my brother] taking everything out on me, and beating me, and having you yell at me.
> Young: (*coaching Kate*) 'It's not fair.'
> Kate: (*Repeats*.) It's not fair.
> Young: (*still coaching*) 'And that's why I want to destroy my room. Because I'm so angry at you for doing this.'
> Kate: I just want you all to die.[46]

But the process of externalising the internalised 'Punitive Parent' from one's sense of self is difficult, as evident in Kate's feelings following this challenge:

> Young: OK, that's good that you said that, Kate. Now, are you feeling bad about yourself or saying it, or does it feel like a relief?
> Kate: No. (*Cries*.) It's wrong.
> Young: Can you be the part of you that feels that's wrong right now? Is that your father now, telling you that?
> Kate: (*Nods yes*.) […] 'It's wrong for you to think those things and to feel those thing, and to be angry, and to want me dead, to want us dead. We take care of you.'[47]

This exchange demonstrates in concrete terms how the punitive voice starts to become uncoupled with, and externalised from the BPD individual through dialogical prompts. Kate initially says 'it's wrong' for her to be angry, but Young encourages her to identify that voice with something outside herself – calling it the Punitive Parent – in order to cultivate strategies of protection and resistance against harmful, abusive narratives. Importantly, the dialogue continues by bringing in an external, nurturing narrative which counters the Punitive Parent voice. In these visualisation strategies, the Schema therapist is brought into the image or scenario to actively *intervene, speak up for*, and *protect* the BPD individual. Young asks Kate to bring him into the image to speak to her father, to protect her from him in the scene:

> Young: Now I'm going to speak up for you to the Punitive Father: 'Look, it's not wrong for Kate to be angry with you. You don't give her the normal amount of attention and caring that a father gives, and your wife is no better. She doesn't give her the attention, either. No wonder

[46] Young, et al, *Schema Therapy* (n 1) 343.

[47] Ibid.

> she's angry. No wonder she hates all of you. What do you do to make her care bout you? What do you do to make your daughter love you and feel close to you? All you do is get angry with her and blame you and feel close to you? All you do is get angry with her and blame her for things. Even when her brother beats her, you still blame her. Do you expect her to love you for that and be happy? Is that fair?'[48]

When Kate is asked about how she feels about Young saying those things on her behalf, she refers to her guilt and fear that once he leaves the image she is going to be beaten up by her brother 'for sticking up for myself'.[49] Young then asks Kate to visualise a kind of wall or barrier to protect herself from her brother in the image, encouraging her to replicate the protective interventions Young uses against her father.

If certain core attitudes towards oneself are externalised, one might ask whether this process of narrative repair exacerbates rather than ameliorates the instability of selfhood that is characteristic of BPD: does this not create a vacuum of values which would amplify the sense of emptiness of BPD selfhood? Importantly, alongside these strategies of externalisation is the promotion of recognitional 'counterstories'; stories of narrative repair reflect the modes of recognition that are necessary to encourage nurturing relations-to-self and promote autonomy competencies. These include the encouragement of individuals' exploration of their conative responses, needs, and values. For example, Kate describes the significance and meaning of the moment she discovered her favourite colour:

> Kate: I was so excited […] because I had a favorite color. And it was something that I actually pointed to.
> Young: And you knew it was *you*.
> Kate: Yes. (*Cries*.) I was 27 years old and that was it. This is the color that I really like, not because somebody says it's the color I should like, or somebody that I want to be like likes it, it's just – to *me* – it's very pleasing. So I was real proud of myself (*laughs*).
> Young: That's wonderful. So you were able to find the part of yourself that's real, as oppose to the part that's trying to be what everyone else wants you to be. […]
> Kate: And it's funny, but, whenever I see that color, I just want to hang on to it, because it's something that I know that I like and it's important to me. Because there are so few things that I know that I like and that I want.[50]

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[48] Ibid 343.

[49] Ibid 344.

[50] Ibid 369-70.

This passage illustrates well how actively engaging in the process of narrative repair through intersubjective dialogue premised on recognitional bonds helps strengthen one's subjective autonomy competencies: alternative tracks of self-understanding are revealed and one's conative responses – such as one's favourite colour – experience subjective validation and trust. We eventually gain a clearer, more determined stance towards the social values and norms that are consistent with ourselves, and begin to assert our agency in the process of self-constitution. These emotions and preferences then become potential topics of examination through intersubjective dialogue. Previously self-consistent narratives and social norms are subject to critical reflection with others, where we examine our beliefs about ourselves with others, actively confront contradictory commitments, and address value conflict in our lives.

This does not mean all contradictions within oneself are resolved: the ideal of integration is not necessarily the goal of constituting the autonomous self since individuals with self-abnegating egosyntonic disorders may well embody such an ideal. Integration in and of itself fails to track the complex interaction between external obstacles (i.e. socialising narratives, modes of misrecognition) and internal impediments (i.e. self-abnegating attitudes and beliefs, inflexibility, timidity) which prevent the development of autonomy competencies. Rather, the focus is on cultivating an open, flexible practical orientation, both *intrapersonally* and *interpersonally*, so that we become more sensitive and understanding of discord within ourselves as well as more attuned and proactive towards the socialising narratives surrounding us.

V. Back to the Question of Capacity

This discussion has two implications on assessments of mental capacity: first, the concept of capacity must presume and operationalise a more nuanced interpretation of autonomy, especially if it is to understand how the relational and environmental context contributes to the development of egosyntonic, self-mutilating behaviours as evidenced in disorders such as BPD. Second, even as capacity assessments in medico-juridical practice themselves are outside the intersubjective process of autonomous self-constitution, they are nonetheless well placed to identify the potential need for a process of narrative repair in the first instance.

First, individuals' self-conception premised on self-abnegation or self-hatred would not be considered an appropriate expression of autonomy competencies from the theoretical standpoint I have discussed thus far: it would instead alert us to the absence of crucial recognitional mechanisms that are necessary for the development of autonomy. Attunement to this developmental aspect enables us to acknowledge ways in which *authentic* selves can also be steeped in self-abnegation and self-hatred; or to state it differently, how highly negative self-constituting narratives may be *authentic* (or *egosyntonic*) but not necessarily expressive of *autonomy*. On one hand, this enables us to accommodate more evaluative judgements about the narratives which lie behind the self-constitution of egosyntonic, self-mutilating and suicidal behaviours: the narrative that one deserves

to be punished due to some inherent worthlessness might be authentic, but capacity assessors should rightly hesitate about *endorsing and validating* those narratives through capacity adjudications. On the other hand, a more nuanced view of relational autonomy enables a more scalar rather than either-or view of capacity: individuals may experience strong intrapersonal integration but embody heteronomy; equally, their ability to exercise self-determination in discrete parts of their lives may deserve respect and recognition. Some degree of practical judgement is needed to resolve the question of capacity as a result. A functional approach may well conclude that BPD individuals choosing to engage in self-mutilating or suicidal behaviour reflects decision-making capacity – as the clinicians had in the Wooltorton case. But if a relational concept of autonomy is operationalised in capacity, then the criteria would require further understanding of the individual's 'practical orientation' towards the decision – more specifically, how this choice reflects certain subjective narratives and a particular understanding of the self.

So let me return to Kate's attempted suicide at the beginning of this paper. It might be true that capacity assessments are by their very nature hampered by urgent time constraints, discrete and relatively unsituated judgements. Especially in emergency situations, a clinician with little or no history of the patient often assesses capacity. At the very least, any assessment of Kate's decision to refuse life-preserving treatment would require some very basic attunement to her self-constituting narratives, to be reflexively aware about how the phenomenology of egosyntonic disorders like BPD eludes conventional definitions of liberal autonomy and authenticity. In no way does this imply that capacity assessors in medico-juridical practice should automatically discount her view and coercively treat her against her wishes in the name of her best interests. It might mean some follow up clarification of how her decisional capacities and her self-mutilating or suicidal behaviour reflect certain socially acquired self-abnegating but intrapersonally consistent narratives.[51] This more nuanced understanding of autonomy should help us move towards a more complex understanding of the decisional pitfalls of individuals with self-harming egosyntonic disorders**.**

Second, individuals' active confrontation of self-abnegating narratives through narrative repair requires a surrounding community that helps support their resistance; these communities are themselves 'a social achievement and not a social given.'[52] Many individuals with BPD, let alone mental disorder more generally, have not been fortunate enough to experience the type of narrative repair discussed in the previous section. Capacity assessors are unable to carry out the intensive process of narrative repair, simply due to the intrinsic constraints of their task. But, as I have argued elsewhere,[53] capacity assessments can nonetheless provide an important check on those who can and should be engaged in this process in two ways. Because it isn't a social given, assessors can, firstly,

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[51] As was demonstrated well by the judgment by Macdonald J in the 'sparkly case', *King's College Hospital NHS Foundation Trust v C and Anor* [2015] EWCOP 80

[52] Miranda Fricker, *Epistemic Justice: Power and the Ethics of Knowing* (Oxford University Press 2009) 54.

[53] Kong, *Mental Capacity in Relationship* ch 6 and 7

detect when narrative repair might be necessary and appropriate, and identify when one has been disadvantaged from developing a supportive community of resistance.[54] Moreover, the very language of the assessment could help *initiate* that process of narrative repair, so as to ensure that the reasoning behind the assessment of capacity is itself consistent with recognitional mechanisms intended to cultivate nurturing relations-to-self. When done effectively, capacity assessment can itself function as part of an autonomy-enhancing normative framework for the medico-juridical treatment of individuals with self-harming egosyntonic disorders like BPD.

One might argue that this relational approach represents an overly substantive approach which would result in unwarranted paternalistic interventions in the lives of, not just those with BPD, but anyone with self-abnegating narratives. The straightforward response would be to simply uphold the MCA's diagnostic threshold which stipulates impairment of the mind must be present to trigger the functional test of capacity. But this would be a weak and unsatisfactory evasion of this objection. From one direction, I think it is necessary to bite the bullet that the line between disorder and non-disorder will become more fluid with such an approach – and this is important if we are to be serious about the safeguards, supports, and positive duties that are necessary to *promotion* of autonomy rather than the mere *respect* of autonomy, particularly to enable the decisional capacity of individuals with impairments. From another direction, it is important to draw critical attention to the contentious value-neutral presumptions of the functional test of capacity: the problematic egosyntonic nature of self-harm and suicidality in BPD provides a clear example of shortcomings from such an approach, ranging from the absence of sufficiently evaluative criteria to track what is disordered about such behaviour, to an illusory eschewal of status-based judgements. Equally, there should be caution in uncritically endorsing overly substantive claims about the nature of disorder, as seen in the temptation to conflate pathology with inauthenticity in the authenticity approach to capacity. The relational approach tries to achieve the right balance, injecting just enough content to the criteria of capacity so as to distinguish between self-conceptions which reflect socially acquired autonomy competencies, and those which have internalised narratives of misrecognition. Capacity as a concept should not be value-neutral about the types of narratives that are consonant with autonomy and should demand critical reflection on those intrapersonal narratives that are implicitly endorsed in the practice of capacity assessment.

Conclusion

This chapter has argued that the complex phenomenology of self-harming, egosyntonic disorders, such as BPD, demands a more nuanced approach to mental capacity. Individualistic and procedural assumptions in our current functional model of mental capacity fail to pinpoint why decision-making capacity is problematic in such cases, whilst authenticity-based accounts tend to

[54] For example, Bodey J's recommendations in *A Local Authority v A & Anor* [2010] EWHC 1549 (Fam)

rest on circular accounts of authenticity and mental disorder. Both struggle because there is a reluctance to engage in some of the more knotty evaluative content around what it means to be a *capacitious and autonomous self*. Instead, we should not shy away from the more *substantive* criteria of capacity which is embedded in a more relational approach, where we consider the normative content of relations-to-self that are characteristic of autonomy or heteronomy, irrespective of diagnostic criteria and psychopathology.

Moreover, this relational approach signals to capacity assessors when narrative repair might be necessary to overturn deeply self-abnegating narratives which can motivate self-mutilation and suicide attempts. Capacity assessment involves an overwhelming focus on the individual undergoing assessment, where it is up to *that person* to prove or disprove her decision-making capacity. But a relational approach pushes against this impulse, suggesting that the social and care environment has a significant role to play in enabling and supporting how we *become* capacitous decision-makers who value and respect ourselves in particular ways. Attentiveness to the complex development of autonomous, self-nurturing narratives may be a key ingredient to providing positive support to those self-harming egosyntonic disorders. The reasons behind suicidal behaviours in these disorders are complex and multilayered, and indeed, there are cases where interventions may not be ethically warranted. But it is important to ensure capacity assessors are equipped with as many resources which attend to these complexities, with a framework which enables a deeper understanding of individual narratives and the *sources* of such narratives, to make the best types of judgements in such difficult cases.