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Alienation, Quality of Life, and DBS for Depression

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Introduction

Lawrence et al. (2018)'s results are a timely contribution to the growing empirical neuroethics literature on deep brain stimulation (DBS). We found their report of a near-universal belief among participants that the hypothetical resolution of their depression symptoms via DBS “would be an unmitigated good” particularly useful. The authors rightly point out that some empirical studies of DBS complicate this picture—including those reporting patient experiences of *alienation* or *self-estrangement* (Kraemer 2013, Gilbert et al. 2017). We offer conceptual clarification of the idea of alienation and apply it in the context of DBS for depression.

Kraemer (2013, 483) claims that upon undergoing DBS, some “patients no longer feel like themselves,” while others “experience their state of mind as authentic under treatment and retrospectively regard their former lives without stimulation as alienated” (see also Gilbert et al 2017 for a similar finding, but de Haan et. al. 2017 for a contrary one). Kraemer (2013, 483) offers an initial conception according to which alienation is a “felt mental state” consisting in *not feeling like oneself*, making it the opposite of *authenticity*. Gilbert et. al. (2017) employ what we take to be an equivalent notion, *self-estrangement*.

Here, we join Kraemer and Gilbert et. al. in focusing on *experiences* of alienation. On our view, an individual experiences alienation from some aspect of herself (or her life conditions) when she *fails to identify with* that aspect and experiences awareness of this fact.

When an individual experiences alienation, it is typically alienation *from* something. In other words, feelings of alienation typically have *objects*. Therefore, a key question for ongoing work in this area is: If DBS does in fact itself contribute to alienation, from *which kinds of things* does it alienate the patient? Answering this question empirically will require distinguishing different potential objects of alienation. Without taking a position on the empirical question of whether DBS does in fact cause alienation, we sketch different *possible* objects of alienation in order to inform future research.

Self-Alienation

One case-type involves an individual apparently reporting alienation from herself in a general way, as is captured by the phrase “I don’t recognize myself anymore” used by one patient receiving DBS for Parkinson’s disease (Schüpbach et al. 2006, in Kraemer 2013, 488). But such feelings can also be more targeted. One could also fail to identify with one’s own agency, as this same patient may have, reporting “feel[ing] like a machine” (Ibid.). Kraemer gives the example of another patient receiving DBS for Parkinson’s disease who views their body as being in a different state (health) than their mind: “My body is cured, but my mind is still sick” (Ibid., 489). It is of course crucial to clarify statements like these with further empirical research to determine if patients do mean to be expressing what they have been interpreted to be (Gilbert et al. 2018). For our purposes, however, the point is just that such forms of alienation are conceivable; we leave open the issue of the association of such experience with DBS.

More broadly, it is plausible that an individual could in principle be alienated from nearly *any* mental state (perception, emotion, motivation, belief, judgment, etc.) or collection thereof. Any such state could, conceivably, be experienced by a person as not characteristic of herself, and therefore as alien to her.

Beyond Self-Alienation

Interestingly, Kraemer (2013, 487) also includes among possible objects of alienation one’s work and personal relationships. One might, for example, cease to enjoy a previously fulfilling career, or no longer find a particular friendship appealing. Importantly, to be alienated in these ways is not to be alienated from *oneself*, but from the physical and social environment that constitutes one’s *life conditions* (and in the case of personal relationships, from *other people*). Therefore, we argue that what Kraemer and de Haan refer to as alienation may be more properly called *self*-alienation, and that there are forms of alienation beyond self-alienation. It is therefore a pressing issue which of these possible objects DBS may in fact be associated with alienation from, and with what frequency and magnitude.

We have made the case that there is plurality in the possible objects of alienation. Is there also a plurality in *modes* of alienation—*distinct ways* of being alienated from the same kind of thing? If we distinguish between *lack of identification* and *active disavowal*, then it seems so. In addition, Gilbert et. al. (2017) distinguish between *deteriorative* self-estrangement and *restorative* self-estrangement. The former involves feelings of estrangement that have a negative impact on an individual and/or her self-conception, the latter such feelings that have a *positive* impact. The idea that alienation could be positive is not without precedent (see Kraemer 2013), but objections have been raised to the idea that such a phenomenon would actually count as alienation (de Haan 2017).

Alienation and Depression

Having drawn these distinctions, we are now in a position to evaluate how the concept of alienation applies to cases of clinical depression and to argue why these patients may be a rich source of empirical insight on the potential relationship between DBS and feelings of

alienation. Consider some relevant diagnostic features of major depressive disorder (American Psychiatric Association, 2013):

- Anhedonia (“feels sad, empty, hopeless”)
- Loss of interest or dysphoria (“Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day”)
- Less interest in hobbies and a sense of “not caring anymore”
- Social withdrawal
- “Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) nearly every day”

While it is an open question whether *all* of these features can be properly conceptualized in terms of alienation, many are just the kind of phenomena that seemed to be plausible candidates earlier in our analysis. Loss of interest in daily activities might be understood as a failure to identify with pursuits that one previously found engaging, and social withdrawal seems plausibly to involve alienation from others. This suggests that patients with depression may have significant first-personal insight into the nature and varieties of alienation. Having potentially experienced different forms of alienation as a consequence of their condition, they may be in a strong epistemic position to elucidate further the kinds of conceptual questions that we have discussed here.

If that is right, patients undergoing DBS for depression would likely be in yet a stronger epistemic position. Such patients’ pre-DBS lived experience of different forms of alienation might allow them to identify and shed light on similarities and differences in the forms of alienation that DBS occasions, if any. It would be important to examine the experiences of patients whose symptoms improve and those whose do not to in order to differentiate which feelings of alienation, if any, are more likely due to DBS itself as opposed to symptom improvement.

While here we focus on patients undergoing DBS for depression, we suspect that other patient populations are likely to be similarly well-situated on questions about alienation. Patients with obsessive-compulsive disorder, for example, may well experience symptoms like compulsions and intrusive thoughts as alienating in the sense we have outlined here. Similarly, some patients with movement disorders might experience alienation from their bodies due to symptoms such as uncontrollable tremors or gait freezing. A more complete understanding of the relationship between DBS and alienation will likely require further engagement with patients like these as well.

Conclusion: Alienation and Quality of Life

The question of whether DBS might sometimes cause feelings of alienation is increasingly recognized as an ethically important one. We think it is particularly significant due to the relationship between alienation and *quality of life* (often referred to as *well-being* or *welfare* in the philosophical literature). According to a plausible criterion formulated by Railton (1986), contributions to quality of life require *non-alienation*. Railton maintains that

something can non-instrumentally benefit an individual's quality of life only if it is or would under suitable conditions be "compelling or attractive" to them, in such a way as to "engage" them (1986, 9). Because something's being compelling, attractive, or engaging in this way is typically incompatible with its being alienating, accepting Railton's criterion implies that alienation is a threat to an individual's quality of life. To become alienated from experiences, pursuits, and personal relationships that one previously found engaging may deprive one of important benefits to quality of life.

Kraemer (2013, 483) calls for "further research" on alienation "in order to gain a deeper philosophical understanding, and to develop the best evaluative criterion for the behavior of DBS patients." We renew that call here, and we suggest DBS for depression as a one important setting for such work. Qualitative investigation of the experience of patients receiving DBS for depression, both pre- and post-intervention, would be highly informative for theorizing about alienation, its various forms, and their potential effects on quality of life. This in turn has the potential to yield more sophisticated measures of these phenomena—an important precondition for further advancements in neuroethical reflection on these technologies (Gilbert et al. 2018).

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