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## **Changing Minds and Mental Health Transcript**

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## Changing Minds and Mental Health

Professor Gwen Adshead

What happens when people change their minds? In this lecture, I will offer a historical perspective on changing minds, starting with a discussion of the role of medicine in changing minds. I will discuss the move from changing behaviour to changing thinking, and changing stories; and how modern mental health services use such ideas.

### Introduction

The phrase 'changing your mind' is so familiar that we do not always appreciate what a complex concept is being communicated therein. Changing one's mind has social, commercial, political and religious implications, depending on context. We can think of advertising as a form of mind changing process; we have contemporary anxieties about how militant and extremist narratives can change vulnerable minds; what we used to call 'brain washing', but is also called 'grooming' or 'radicalisation'.

In this first of three talks, I want to look at the history of how humans have thought about the process of changing minds. I will explore the similarities and differences between changing minds as a form of self-improvement, and changing minds as a cure for mental illness. These processes ran in parallel for centuries until the late nineteenth and early twentieth centuries, when it appears that the goal of self-improvement became more closely allied with an idea of having improved 'health' more generally. In short, I want to discuss how the Self became an object of improvement in medical terms.

In this lecture, I will attempt to offer a historical perspective on this issue; or more accurately a 'tour d'horizon'. Although it is sometimes said that one should never begin a talk with an apology, I feel I must do so here, not one but two apologies; first, in the original sense of an explanation and the second in the more usual sense of a regret. My explanation is that to understand how the mind/self became an object of change, it is necessary to look at how and why people have sought to do this in the past; a history of the concept of self-improvement. I will try and illustrate this with images that reflect this; and I am grateful to Professor Joanna Woodall of the Courtauld Institute for generously sharing ideas and expertise about how the Self became an object in portraiture. I am also grateful to Dr Morris Nitsun, psychologist, psychotherapist and artist, for the use of images of some of his most recent portraits.

My regret is that there is really too much material here for an hour talk, and many readers will rightly feel that important topics of deep academic study have been mentioned only superficially. I plead guilty to this charge and can only offer in mitigation that my intention is to provide a historical overview only, which I hope will point the interested reader to more in depth discussions by real experts. I want to acknowledge the help I have had from reading both Roy Porter's and Andrew Scull's histories of psychiatry; Barbara Gold Taylor's account of the rise and fall of the asylum Friern Barnet; and Professor Dan McAdams' study of personality and personality change (McAdams, 2015).

### The Mind and the Self

To begin this discussion, I want to ask what we mean by 'mind'; and whether this has any relationship with words like 'self', 'identity' and 'personality'. Within the Abrahamic traditions, the heart, mind, soul and will were historically discussed as separate; there has of course been a huge and extensive debates about the relationship between 'mind' and 'brain'; but this is a different topic (to which I will return in my second lecture).

At this point, I want also to introduce the subject of what we mean by 'change'; how we recognise the process of change, and how we evaluate the outcome of any change process. 'Change' implies difference and movement; its metaphors are those of perspective and relationship between time and place, and perspectives on time and place. For every change of mind or Self, there is a statement like this: "I used to think/feel/see....but now, I ...."

There is an everyday sense of change which is value neutral: when something changes, in theory the outcome may be worse or better for you as subsequent events and decisions unfold. However, in relation to changing one's mind, there is some assumption that people want to change their minds for the better; that change is a willed choice that results in positive change. The medical or therapeutic view of 'mind changing' certainly assumes that people change from some negative mental view to a 'better' positive view, although it is not always clear who gets to evaluate change or decide whether such change is actually 'better'. In modern psychiatric practice, services try to help people 'recover' from an abnormal mental state, as if 'normal' function has been lost. When people seek psychological therapy, there is an implied search for a 'better' self-functioning.

How should we best understand the relationship between mind and the self, the personality and identity? One possible way to think about these different words is that they all refer to both an individual experience of thoughts, feelings and interpretations; *and* a social or relational experience in the interpersonal space between people. Dan McAdams, a sociologist in Chicago, has suggested that we may think of the personality as having

three layers: that of the social actor; the individual agent; and the author of the story of our identity in the social world (McAdams, 2015). Changing our minds may involve a change at all three of these levels; although the ways that the change take place may all differ significantly. For example, we might take medication to change emotional reactivity; but use talking therapies to change the way we interpret social interactions.

The key concept here is that our minds are not purely personal to us, but have a social aspect by which we communicate with others in our social groups (Frith 2007). Knowing and reflecting on our own minds allows us to reflect and know about other people's minds; a process that is sometimes called 'mentalising' or keeping 'mind in mind' (Allen, 2006). Similarly, the Self has an inner aspect (Wordsworth's 'Inner Eye'), and an outer aspect that is seen by others. The history of the metaphor of 'sight' for self-knowledge i.e. how the Eye can stand for 'I' is one of the many themes in this lecture that would merit an hours lecture in its own right.

I suggest that in both psychological and philosophical terms, this idea of 'changing minds' for the better is much more complicated than it first appears. If our minds are social, the social structures and discourse will influence what we call 'better' outcomes when it comes to changing minds. In philosophical terms, it is hard to see how we can think things that we also think are not true or real; and taking in information that might suggest that our view is wrong in some way is not a comfortable process, which many resist. Our minds are arguably not singular entities, but active processes that function at several levels, not all of which are conscious (Kahneman, 2011).

Finally, from a medical perspective, psychiatry (which is still a young medical science) has focussed on behaviours rather than minds that generate behaviours. This has meant that the philosophy and psychology of self-knowledge and self-improvement has been divorced from historical accounts of mental illness, and the modern development of psychiatry as a medical speciality. The Self has been kept separate from Psychiatry for reasons that are not completely clear, but may reflect stigma and fear.

### **Early accounts of the Self and the mind**

If minds are to be changed, much depends on the understanding that a person has of their mind. Probably everyone has a philosophy of mind (even if they do not give it such a formal title) by which they understand their self-experience, in relation to themselves, their bodies and to others.

Is the mind the type of 'thing' that can be disordered, damaged or dysfunctional? How could that be? The question of the nature of mind has been the subject of philosophy since well before the Common Era; we may think here of what Karl Jaspers called the Axial Age and what Karen Armstrong has described as 'The Great Transformation' (Armstrong 2006). In this period (around the 9th century BCE) there were significant and similar developments in Indian, Chinese, Jewish and Greek thought about how minds can self-reflect, and the importance of compassion for the social mind. Although there is debate about the extent to which these schools of thought in different places are really similar, and the potential influences of communication in trade and markets; nevertheless, it does appear that philosophical traditions emerged that explored how minds can change for the better, at both an individual and social level.

Some Buddhist traditions (e.g. as described in the Pali canon) encouraged people to become more skilful at becoming aware of their here-and-now experience; and letting go of any aspects of mind that were a hindrance to awareness. There was considerable debate within this literature about whether the Self was an illusion or a type of 'diamond' at the heart of reality. Injunctions to know yourself and examine your life were also part of the Mediterranean classical tradition, and the myth of Narcissus offered a warning about the tragic fate of people who failed to recognise themselves. The Narcissus myth describes an early use of mirroring and reflection in an external contact as a means of self-knowledge.

Siedentop (2014) has argued that Christianity gave rise to the modern concept of the individual in terms of agency, choice and responsibility. In the pre-classical and classical era, only the free had minds that made choices; slaves, women, children and lunatics were not people who could exert agency or choice. Christian teaching claimed that all people were free and equal in God's eyes; and so all had agency and choice in terms of self-reflection, sinning and repentance. Whatever the strength of Siedentop's argument, there is no doubt that Christian writers had a significant influence on discussions of the Self and the nature of Mind. One famous example is St Augustine, writing in the 4C AD on the nature of time:

*It is in thee, my mind, that I measure times. Interrupt me not, that is, interrupt not thyself with the tumults of thy impressions. (Confessions, Book XI)*

Processes of self-examination and reflection were an important part of both early Christian and Stoic thinking. There was an assumption that humans wanted to pursue the good life as a form of self-enhancement (Taylor, 1989). This 'goodness' was generally modelled on Christian accounts of Self, which encouraged the 'letting go' of the quotidian Self, which was held to be sinful and the cause of the Soul's distance from the Divine. The Self was sometimes seen as having a Higher aspect (which sought after God) and lower aspect (which was part of our animal heritage); and conflict could arise between the Higher and Lower nature. Choices and intentions could be complex and conflicted.

Theories of mind have often been divided into dualist and non-dual accounts in terms of the relationship between body and mind or the material and non-material. Many thinkers of the Axial Era developed non dual accounts of

mind, while dualist accounts were developed in the classical era of Plato and Aristotle. In the modern era, Descartes is most famously associated with dualist thinking; although he famously described the relationship between body and mind as being like a ship and its captain i.e. the relationship is strong, complex and interactive:

*"I am not merely present in my body as a sailor is present in a ship, but that I am very closely joined to it, and as it were intermingled with it, so I and the body form a unit." (Descartes Meditations p 56)*

## **The Self in conflict**

The classical Western account defines the 'self' as the 'entire person of the individual', which is a unitary phenomenon (Johnson, 1985: 92-93). However, Plato's account of the Soul drew on Socrates' account of justice as a means of drawing together disparate groups who may be in conflict within a city. On this account, there must be a part of the soul ('psyche', equivalent to our sense of Mind) that promotes justice and reason over other parts of the soul that are activated only by appetite or strong feeling. Early Christian accounts of the Self drew on Jewish philosophy that suggested that the self was plural and therefore could be in struggle with itself. St Paul of Tarsus, one of the earliest Christian writers, describes the paradoxical experience of not doing that which he wants to do; but apparently willingly doing something he does not want to do. The influence of both Platonic and Judeo-Christian thought persisted into modern accounts of mind, especially as later described by Sigmund Freud in his tripartite account of the mind as being ego, super-ego and id.

Modern Anglo-European accounts of the Self were developed in modern European culture, especially in poetry, drama and literature. Shakespeare in particular provides many modern accounts of the experience of a mind in conflict with itself, or a mind that is deceived about what it really wants. In *King Lear*, Lear is described as one who '*hath ever but slenderly known himself*'; and Hamlet's inner conflict is the stuff of one of Shakespeare's most famous soliloquies. What is also of interest is the strong distinction Shakespeare makes between this type of self-conflict and 'madness', where there is apparently loss of the capacity to think at all. Famously in *Macbeth*, the doctor comments that some kinds of '*minds diseased*' need not a doctor but a 'divine' or religious minister.

## **Portraits and the Self**

Portraiture has been a way that for people's personal identities to be fixed as an image of themselves; and thus remembered and communicated to others after they are dead. Early portraits were created for funerals; the earliest portrait is thought to be 26000 years old. Portraits in stone or metal were popular in Ancient Greece and Rome, and were often life like; unlike later idealised portraits that which were intended to depict the Self in heroic postures that implied a virtuous identity (Woodall, 1997).

Later portraits were intended to convey evidence of social status or membership of a social group. An early portrait is that of Giovanni and Giovanna Arnolfini, painted in 1434 by Jan van Eyck (who can be seen in the mirror that cleverly placed at the back of the picture, so he is also painting a portrait of himself). Renaissance philosophy encouraged the development of portraiture that revealed the character and personality of the sitter, not just their status: over one hundred years after van Eyck's portrait of the Arnolfinis, Lavinia Fontana painted a portrait of a young girl with no status or rank; but a memorable face and expression. She was called Antonietta Gonzales and she suffered from hypertrichosis: a condition in which the sufferer grows hair all over their bodies including their faces. Antonietta and her family were welcomed at court and the portrait was painted in 1595 while she was visiting the court at Parma.

Modern portraits have moved away from naturalistic depictions of people to more expressionistic forms that communicate the inner Self or personhood. Recent portraits by Morris Nitsun use colour and paintwork to communicate the experience of the person depicted. The work of interpretation is left largely to the imagination of the person looking at the portrait; the modern portrait painter may leave very few direct clues about the personality of the sitter. Although paint portraits are still a social status symbol, they are also more intended as psychological communications about the state of mind of the person in them. In contrast, the self-photograph ('Selfie') is now a formal communication about happiness and success; no sad or reflective Selfies are on display.

### **• The Disordered Self and the Disordered Mind**

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The early accounts of mind and self-reflection seemed to have no connection with early accounts of mental illness, which were based on theories of diabolic or demonic possession that 'drove out' the capacity for reason (Scull, 2015). The Hippocratic writings in the 5th century BCE were the first to identify mental illness as being a disease and not a sign of divine or diabolic action. They first described a range of disorders as disturbance of the balance of different internal 'humors', which controlled different aspects of bodily function. The humoral theory of illness was widely followed by physicians in the Islamic world as well as Europe for over 400 years.

Although superseded by understanding of anatomy, physiology and biochemistry, the humoral tradition was modern in its emphasis on the close relationship of mind and body, and on the importance of a homeostatic balance between different bodily systems. For example, one of the early humoral 'disorders' was 'melancholia', which was a disorder of low mood brought on by an excess of 'black bile'. Contemporary accounts of mood disturbance now emphasise the causal role of the deficiency of certain neurochemicals or the dysregulation of neurotransmitter release or metabolism: in essence, a similar account based on disturbance of homeostasis.

The early doctors saw madness as being the province of medicine i.e. it was due to disease and could be subject to therapeutic interventions. Then (as now) there was a preoccupation with the risk that mentally ill people might pose; Spruit (1998) describes Roman laws that required family members to control their mentally ill members and prevent them from causing harm to others. There was no apparent attempt to link philosophical discussions of the nature of Self or Mind; it was 'madness' (as disease of the Mind) had no relationship with the accounts of the Soul or Mind that were being actively discussed by philosophers, especially those from the Classical or Christian tradition.

Demonic possession regained some ground again in the Middle ages as an explanation for madness, which led to religious houses being early asylums for the mentally ill; St Mary of Bethlehem was known to be admitting patients with mental illness as early as 1403. People placed in these first 'mad houses' had not only lost their personal Selfhood, they also lost social identity and relationships. Admission to a madhouse meant social exclusion, and loss of Self.

Over the next few centuries, there were few developments in the study of mental illness or the brain. It is likely that many of those deemed to have mental illnesses had organic conditions that gave rise to disturbances of conscious awareness and odd neurological symptoms, which were then seen as madness. Thomas Willis and then Thomas Sydenham in the eighteenth century made studies of the anatomy and function of the brain and nervous system. Sydenham in particular made a distinction between the 'internal' and 'external' man in terms of the experience of pain (Valadas, 2011). This was the first recognition that the experience of pain might be psychological and not just physiological; a finding that would be recognised four hundred years later as crucial for understanding the human experience of pain.

- The seventeenth and eighteenth centuries saw the development of the madhouse as places where mentally ill relatives could be left to be cared for by others. These were no longer always linked with religious houses, but nor were they always 'hospitals'. These madhouses were not medical establishments, and doctors were rarely involved in their running. They were however big business and money could be made by the enterprising. Some madhouses did offer medical attention; and some offered 'treatments' that were terrifying and unhelpful. Although these 'treatments' were intended to 'restore' the Mind to its pre-morbid health state (if possible), it was generally assumed that minds once lost could be lost for ever.

The eighteenth century also saw the development of a new kind of mental disturbance; one that maintained social status but reflected kind of 'fragile' temperament. This 'English malady' was linked with the rise of capitalism and commodities trading during this period and was a reflection of the competing theories of madness of the time. Some schools of thought emphasised the inherent degeneracy of mental illness, while others argued for different materialist accounts, such as phrenology, animal magnetism, life forces, chronic infections.

These materialist accounts of mind that emphasised the role of the brain and body were used to justify the role of physicians in the treatment of mental illness, and to move the care of the mentally ill away from religious or lay establishments. Medical doctors argued that their professional skill was needed to restore balance and reason to the sick person, because mental illness was not related to moral deficiency or religious failure. Medical treatment for the mentally ill did not improve them as people, it cured them of disease. Although the 'mad doctors' may well have had beneficent interests towards their patients, the disease model of mental illness had the potential to make doctors who ran madhouses considerable amounts of money.

There were other debates that were relevant to psychiatry and the treatment of the mentally ill; specifically debates about slavery and the right of women. These debates were linked to concepts of personhood, and the possession of both philosophical agency and moral and legal rights. Persons with minds that make choices could not also be possessions; and attacks on the emancipation of women and slaves were seen as attacks on the minds of women and people with coloured skin. These debates had implications for the rights of people with mental illnesses; and would be revisited in the years after the Second World War in the context of the civil rights movement.

## **The development of psychiatry and psychology**

The term 'psychiatry' was first used in Germany in 1808 by Reil (Marneros, 2008) to describe the treatment of the mentally ill. By the late 19<sup>th</sup> century, the unitary 'Self' was synonymous with 'Mind', which had now become an object of medical discourse. Like the liver or a limb, the Mind could be injured, diseased or even lost; insanity was equated with disorders of the self (Berríos & Markova p 16). There are some interesting portraits of people with mental illness from this period; Gericault painted a number of portraits of people suffering from monomania (apparently at the request of his own psychiatrist, a Dr Georget). These portraits are sensitive and personal, evoking sympathy rather than fear.

In 1890, William James published his Principles of Psychology in which he distinguishes an empirical 'me' which can be an object of study and a pure 'I' which is separate. He also described thought a 'stream of consciousness' rather than a chain of thoughts; suggesting that no one can have the same thought twice. James was (and is) a massively influential philosopher and psychologist; although contemporary of Freud's, his work did not have an impact on psychiatric thinking or practice.

Sigmund Freud published his 'Interpretation of Dreams' in 1895, and went on to describe a theory of the Self

that was strongly influenced by classical ideas; specifically a self-made up of different parts, which could be in conflict. He pioneered the use of the therapeutic relationship as a medium for psychological change; and was the first to encourage close attention to the language of *how* people speak, as well as the content of what they say.

Freud's influence was at one time so great the poet W.H Auden called his work '*a whole climate of opinion*'. However, contemporary psychiatrists of the day in Europe were by no means convinced by Freud's theories, which had far greater success in the USA. Although psychoanalytic theories were influential in psychiatry for two or three decades, they have been superseded and to some extent disproved by later study of the development of psychological development in childhood, based on empirical study of children. Some of his hypotheses have been proven to be correct; for example, our early childhood experiences do have a significant influence on how we interpret the world; especially our closest relationships.

### **The twentieth century and later...**

The experience of mass warfare in the USA and Europe had a significant effect on understanding of mental health and psychology. For the first time, it became clear that healthy, fit people, with no history of emotional weakness or vulnerability, could be emotionally damaged and disabled by exposure to high and persistent levels of threat and fear. During the first world war, early descriptions of 'shellshock' in England or 'shrekneuroses' in Germany raised the question of possible brain damage as an explanation for symptoms; but it was also accepted that the experience of war was a psychological issue that had different meaning and implications for different personnel. Army psychiatry quietly developed as a speciality; not only to treat military personnel and get them back to active service but also to study how psychology might be used to improve the function of groups of people working together for a common purpose.

A key development in the twentieth century has been an understanding of the mind as not purely individual but relational: so that a disturbance of one person's mind causes social and relational problems. After WW1, the problems of populations of traumatised and bereaved people led to the development of marriage and child guidance clinics. The combination of psychoanalytic methods of treatment and the psychological needs of people traumatised by war and loss was perhaps an important driver for the concept of the Self-in-pain that needed to be relieved of distress. People began to see the Self as an object of therapeutic care, to be relieved of pain and distress: or as Freud famously put it, neurotic unhappiness would become ordinary unhappiness.

Since the Second World War, there have been radical challenges to hierarchical and traditional accounts of identity; a reaction against the evidence of what happens when a state (such as the Nazi regime) defines individual identity. The civil liberties movement was not just a demand for civil and legal rights; it was also a claim to the right to the individual to define themselves in terms of their experience. The legal and political struggle was also a personal one, which saw more people seeking therapy as Self-knowledge, a response to inner conflict and development of personal consciousness of experience. In the 1960s, psychiatric treatments included prescribing powerful sedatives and psychotropics; courses of individual and group therapy; use of hallucinogenic drugs; and theoretical attacks on psychiatry itself as a concept.

- The contemporary 'medical' model of the Self still equates Self with mind. One result of this model of mind-as-object in Western culture is a vast industry of how the self or mind becomes 'sick' and how expert interventions can help the self becomes 'well'. Sick selves lack agency and may lack responsibility; so that people will say, 'I am not myself' or of someone else, 'That's not really him'. Psychological therapies are now usually offered to people who seek therapeutic help ; who define themselves as "unwell", and seek to have 'normal' function restored or dysfunction improved.

The latter part of the twentieth century has often been called the 'age of the brain', as psychiatry has focussed again on neuroscience, using new technologies that offer exciting images: a different and ultimately materialist kind of self -portrait. Psychiatry and psychology have become divorced, so that clinical psychologists now offer a wide variety of therapies. To change your mind and your self, you need not see a doctor, but rather someone with expertise in changing thoughts. Sadly, this approach to changing your mind is still generally only available to those *without* severe mental illnesses, who are generally only offered psychoactive medications that can be effective but have high risk side-effects.

### **Conclusion**

The increasingly secular nature of society and the limited links between philosophy and psychiatry have meant that it is to psychology that people turn to understand themselves. What began as a search for pain relief in therapy has now been replaced with a search for self-improvement in therapy, and there are many techniques from which to choose.

Although there have been strong claims that changing your self is a therapeutic and not a moral venture, moral discourse is still very present in the process of psychological change. When therapists make people 'better', there are still moral debates to be had about what this means in practice. One example is the spread of short-term manualised therapies for anxiety and sadness that are designed to get people back to work (Scanlon & Adlam, 2013); and which discourage therapists from talking about anything with clients but '*goals*' and '*achievements*'. The psychoanalytic concept of therapies in which people take time out to reflect on their

experiences of fear or anger, their conflicts and their sadness, seem only to be available to those who can pay.

The lack of psychological therapies for those with complex and severe mental conditions is due to two worrying trends in mental health services in the UK. First, the internal market in the NHS and the commodification of healthcare more generally, has had an especially damaging effect on mental health services (Ballat & Campling, 2011). Only in mental health services is it permissible to say 'We don't offer that treatment' or 'we do not care for that condition'. Such an approach would be unthinkable in general medicine or surgery: one may imagine the outcry if a local general hospital baldly stated that 'We don't offer treatment for bone fractures or heart valve replacement here'.

The second trend is the gradual erasure of medicine from mental health, usually on the basis of cost. While it is true that one does not have to have a medical degree to deliver psychological therapies, it is also true that for severe and complex conditions, it may be helpful to train therapists who also understand the biochemical sciences of how brain and body interact. The cost reduction agenda has generated a claim that changing minds is really a rather simple process that anyone can do, with a bit of training; and physicians can be excluded from this process. However, as I have suggested above, changing minds is not a simple process because it involves moral and social aspects of the person. Further, we do not usually exclude highly trained people from important domains of human endeavour. Really complex human structures and activities are thought to need the best minds with extensive and expensive training: one thinks here of scientists or work at Cern or economic experts that work in banking and finance.

Psychoanalysis has virtually disappeared from NHS mental health practice. However, where Freud's legacy is still influential today is in the value of using human relationships to change minds; and the practice of close attention to what is said by people in psychological distress. Modified forms of psychoanalysis are still seen as the basis for psychological change, even though (as one might have expected) the techniques and theories have changed in the last 100 years. The language of psychological experience remains a crucial area of study for psychology and psychiatry; especially the question of *how* people use language to describe experience, and how they tell their story. How psychological change takes place in this process will be the focus of my second talk.

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