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Research Paper

Self, Identity and Conflict Within: Who am I? Unveiling the Mask of Identity in Disorders of the Self

Tanvi Trivedi[1]*

ABSTRACT

The present paper offers an understanding of disorders of self —whether manifesting through delusions, misidentifications, or dissociation— offer profound insights into the fragility and complexity of human identity. Traumatic events or prolonged exposure to high-stress situations are believed to be a common factor leading to dissociative identity disorder, as individuals may cope by creating alternate selves or personas to handle the overwhelming emotional burden. These identities can manifest in vastly different ways, ranging from subtle personality changes to distinct and fully separate alters, each with their own memories, behaviors, and ways of interacting with the world. From a therapeutic standpoint, exploring the concept of "self" becomes a critical part of treatment. This involves piecing together the fragmented aspects of identity and helping the individual develop a coherent narrative that acknowledges their trauma, emotional experiences, and the impact on their sense of self. Cognitive-behavioral therapy, trauma-focused interventions, and other psychotherapeutic approaches can aid in re-integrating these dissociated parts of the self, leading to a more stable sense of identity and improved functioning in daily life. The intricate dance between our internal experiences and external social environments underscores the vulnerability of self-perception and the delicate balance required to maintain a cohesive, functioning sense of who we are. By understanding these disorders, we can begin to comprehend the broader human experience of identity, agency, and reality itself.

Keywords: *Self, Identity, Delusional disorders, Dissociation, Trauma*

The greatest hazard of all, losing one's self, can occur very quietly in the world, as if it was nothing at all. No other loss can occur so quietly; any other loss—an arm, a leg, five dollars, a wife etc.; is sure to be noticed.—Søren Kierkegaard

What happens when the self starts to disintegrate? What happens when you lose touch with oneself? Lose touch with others, the environment and reality itself. Let's take it a step further. Is it just limited to losing one's identity? What happens when there is more than one identity? Within oneself, in others or your environment? How then, do we answer the age-old question of who am I?

[1]Department of Psychology, Christ (Deemed to be) University
*Corresponding Author

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The following article discusses the interplay of disorders of the self, the inception of identity and the conflict within. Disorders of the self explored in the articles are namely, Delusional disorders, Delusional misidentification syndromes, dissociative identity disorders, depersonalisation/derealisation disorders. The article puts emphasis on the history of conceptualisation and aetiology of the disorders, how identities are shaped, how the self is viewed in the social perspective with respect to the disorders and hence ends with the understanding of how society defines delusions and "madness" in contemporary times.

According to Jaspers (1997) there are four aspects of the experience of the self, one being the awareness of existence and activity of the self (reflective consciousness), being in unity at a given point of time, a continuous stream of identity over a period of time and being aware of the ego boundaries. Understanding delusions and dissociation often comes with an understanding of the constituent symptoms that make up the disorder, i.e., understanding prodromal phase that led to full-blown, well-crystallised psychotic symptoms. This understanding dates back in earlier times by French psychiatrists. Eugene Bleuler (1911) described various symptoms of schizophrenia always involve an affliction ("*Spaltung*") of the self, that the self is not intact. The self is often soon as fragments which have a coherence, much like a jigsaw puzzle, whose pieces are put together to form one pattern or a picture. In dissociation identity disorder, the self is thus unable to form a coherent picture of the jigsaw pieces are distorted among themselves. If a self is seen as an agent, people with disorders of the self often suffer with impairments of agency and a disunity of their consciousness (Kraepelin, 1913). The disunity of the consciousness is intertwined with "a destruction of psychic personality's inner integrity, whereby emotions and volition in particular are impaired." Kurt Schneider talks about the first-rank symptoms and addressed them as a reflective loss of ego boundaries. Scharfetter goes beyond Jaspers' understanding of the self-experience which is compromised in a hierarchal order of increasing experiential complexity, vitality, activity, continuity, demarcation, and identity. He considered delusions to be compensatory reaction to self-disorder.

Understanding Delusions from a Socio-Epistemological Perspective

A delusion is, roughly, a belief that is held despite obvious counterevidence and that is not explained by the person's social, cultural or religious background. The presentation of delusions is in multiple ways: the delusions of patients can be circumscribed that is they are isolated in their system of beliefs and monothematic, they focus on a particular topic and beliefs are quite normal concerning other topics. Second, the delusions of patients can be elaborated forming an intricate delusional system of beliefs and polythematic involving multiple topics.

The theories explaining the etiology of delusions are individualistic. The social epistemological conception of delusions in schizophrenia are partially explained by testimonial (evidence based) abnormalities, including (1) the loss of testimonial interaction with others, known as "testimonial isolation" and (2) the discounting of testimonial evidence, called as "testimonial discount" (Miyazono et al., 2021).

What are the origins of testimonial isolation in schizophrenia? The possible genesis of delusions includes a social skill deficit wherein people with schizophrenia lack appropriate skills and competence in social and communication exchange (Mueser et al., 1991) necessary for testimonial interaction or social anhedonia which is the reduced ability to experience pleasure from social relationships (Blanchard et al., 2001) which deprive them of the motivation for testimonial interaction. Social cognition contributes to testimonial

isolation, such as deficits in emotional perception, i.e., being unable to identify emotions or express them, theory of mind deficits, i.e., failure to take in different perspectives, beliefs, intentions, irony, metaphors and attribution biases, for example, the tendency blame others/oneself rather than situations for negative events (Miyazono et al., 2021).

What causes testimonial discount? The crucial constituents of epistemic trustworthiness in testimony are underestimation of competence and sincerity (Fricker, 2007) from others which accounts for testimonial neglect. That depends on the kind of delusions, paranoid delusions and thoughts can cause people to underestimate the sincerity of testifiers. Grandiose delusions may also cause people to underestimate the competence of testifiers.

The failure of group identification is a cause of the underestimation of competence and sincerity. What is group identification? Social psychology (Brewer, 1991), and the ideas of collective intentionality (Pacherie, 2013) intersect on the idea that understanding self as agents is one of the motives for humans' ultra-cooperative nature (Tomasello, 2019). The process of group identification follows that, when agents do things together, they perceive themselves as group members. An agent in a group identifies various "group cues" in the environment (Pacherie, 2014) such as having sharing a common fate, common interests, using we-language, facing a competing group, etc. (Bacharach, 2006). An awareness and saliency of these cues triggers two interrelated results: self-categorization and de-individuation. Self-categorization means to be able to identify similarities within a group and de-individuation refers to separation of oneself within the group. The last step of group identification is the formation of the social self (Brewer, 1991) which enables the individual to be a collaborative member of the group.

People with schizophrenia are unable to trust the competency and sincerity due to reduced group identification with others (Miyazono et al., 2021). A reduced group identification is due to non-psychotic, anomalous self-experiences in people with schizophrenia which are considered as trait-like features of the disorder, which precede psychosis and persist after remission. Why does this happen?

According to Salice and Henriksen (2015) there are four self-experiences which lead to fragility of group identification. The process of self-categorisation and de-individuation is disrupted. The ontological dissimilarity meaning pervasive feelings of being different from others. For example, people often report that they are someone else inside a human body. People with schizophrenia might often neglect similarities among group members (such as having similar tastes) or might not believe in such similarities and consider them superficial, or insignificant. Thus, one is unable to self-categorise themselves within a group. Patients are unable to make a distinction among things which are obvious and trivial to other individuals. Thus, self-categorization faces friction due to loss of common sense and unrecognition of salient group cues. Hyper-reflectivity is the tendency to place aspects of the environment and the self at the center of intense reflection (Sass, 1992). It leads to excessive self-monitoring in group interactions which makes it difficult to lose sight of their own personal and unique traits and hinders immersion of themselves in the social world. Thus, counteracting the process of de-individuation. Lastly, the phenomenon of transitivity, that is being able to have permeable self-other boundaries and demarcations. Patients with schizophrenia tend to avoid any circumstances that have the capacity to blur their identity due to disturbing nature of the experience of separating oneself, others and the world.

Phenomenology Integrates with Understanding Etiology of Delusions

Another conception can be seen from the lens of phenomenology. For Husserl, "consciousness" refers to the stream of lived experiences that make up an individual's subjective life. These include experiences which exude diversity in content and kind, include perceiving, sensing, imagining, willing, etc. cover the entire range of "mental processes" of which the self becomes aware in their daily life. Husserl suggests, these are "intentional" acts no matter how varied their quality or content is. Thus, the consciousness, has the characteristic of intentionality (1913). The two aspects of intentionality are awareness of something and a subjective experience directed towards something outside of itself. Thus, it is a bidirectional interaction between the subject and the object. The experience of perception is directed toward an object which is seen as an active process. The receptive or passive process is when the object sends "counter rays" that the subject takes in. Here, the receptive or passive dimension is thus an essential element of the lived experience of individuals (Davidson, 2021). The objects constitute, not just natural objects but layers, institutions, cultural objects, the environment that shape socio-cultural worlds (Davidson, 2021). The second aspect is known as the act of doing. The process of willing, making plans and acting on them which being able to take various positions on the aspects of the world. Individuals typically develop their sense of self and personal identity through introspection, past experiences, and an openness to the meanings inherent in their lives (Davidson, 2021). However, in schizophrenia, there is a notable dominance of passivity and helplessness in one's sense of self, leading to a marked impoverishment concerning active and volitional aspects. Those affected seem to lack an appreciation of their own agency, constructing their identity more around experiences of being influenced and moved by the world rather than actively engaging with it (Davidson, 2021). People with schizophrenia often express a perception of being controlled by external forces (such as radio waves) and frequently discuss the many things in their lives that exert control over them. Paradoxically, they seldom discuss aspects of their lives that they believe they can control. This outlook leads them to view external entities (such as the CIA or other influential figures) as powerful and influential, while seeing themselves as fundamentally powerless and lacking in control (Davidson, 2021).

Understanding other Delusional disorders

The idea of shared delusions, *folie à deux* is a rare disorder characterized by sharing a specific delusion among two or more people in a close relationship might involve a different kind of testimonial abnormality. A tempting idea would be that *folie à deux* involves testimonial isolation and/or testimonial discount at a collective level. For example, a *folie à deux* between a mother and son, it can be conjectured that they form a particularly cohesive group and, as groups can engage (Tollefsen, 2007), as a group, they fail to engage in in testimonial interactions with non-members ("collective testimonial isolation"). Or, as a group, the son and the mother discount testimonial evidence from non-members ("collective testimonial discount").

Another way to look at it is, the *folie à deux* might involve the abnormal overrating rather than discounting of testimonial evidence from the mother which is caused by the overestimation rather than underestimation of the competence and sincerity of the particular individuals, which in turn might be due to excessive rather than fragile group identification with the individuals. The idea of excessive group identification in *folie à deux* is coherent with the observation that *folie à deux* is often seen in families and that families are characterized by particularly intense group identification among their members (Sani, 2012).

Since the first case of Capgras syndrome was described in 1923, various other syndromes have been identified, including Fregoli syndrome, intermetamorphosis, subjective doubles, reduplicative paramnesia, mirrored self, delusional companions, and clonal pluralization of the self (Klien et al., 2014). They all carry a common classic theme of one person being an exact likeness of another: the sosie or double. There are difficulties in the self-reflexive property of the human mental functioning and the first-person linguistic expression of human experience, with an aberrant semantic processing of identity (Klien et al., 2014). The Capgras delusion, where the sufferer forms the belief that a loved one has been replaced by a duplicate, is thought to arise in part because brain damage removes the affective component from recognition. The loved one looks the same, but seeing them does not produce the usual affective response in the subject due to misidentification of the other. Perhaps in Capgras this is not simply the experience of a lack of normal emotional response to someone familiar, it is more precisely the experience as of someone looking like an imposter (Klien et al., 2014). The unsettling experience in some way produces the delusional beliefs. Ellis and Young (1990), in their account of the Capgras delusion, propose a two-factor account: as well as an abnormality of emotional experience with others, the subject somehow comes to accept a highly improbable explanation of the experience. Davies and Coltheart (2000) adopt a similar account of this delusion in general. They begin from an anomalous experience and propose three further factors: a bizarre hypothesis about the cause of the experience that is "my wife is an imposter"; the adoption and maintenance of the hypothesis as a belief despite counterevidence that the wife infact is real; and last, the circumscription/elaboration of the belief which is adopted and maintained without a major upheaval in the subject's belief system. The experience of introspecting a series of thoughts as someone else's, or worse yet, as the thoughts of someone sharing this body, must be had in addition to some different features of belief formation (Klien et al., 2014). Thus, how beliefs shape identity is also an important aspect of the formation of identity especially in people with delusional misidentification syndromes.

"No-one can join you in your self-consciousness. You cannot join others in theirs. However, when self-consciousness breaks down or becomes disturbed, it appears to the self-conscious person as if other selves or agents are involved in his or her stream of consciousness. Within introspective awareness, other persons seem to speak or think." The quality of "my-ness" vanishes from the thought," writes Stephens and Graham (2000).

Dissociation and Trauma

Delusions and dissociations are quite close and similar in their characteristics. Dissociation identity disorder (DID) is characters by distinct alters, meaning having more than one alters within self, looking-on phenomenon or co-consciousness also called depersonalization/ derealization and gaps in memory (Kennett et al., 2003). The reality testing is intact in people with dissociative disorders. Alterations in the experience of autobiographical memory often coincide with disruptions in comprehending one's own identity (Kennett et al., 2003). Additionally, a loss of agency and heightened reflexivity and self-observation may accompany these changes. Guralnik et al (2000) note that dissociation "involves a splitting off of whole chunks of experiences or self-states, which leads to an altered state of being, whereas repression is a more selective riddance of information". Dissociation, as outlined by Guralnik et al, differs from repression in that it involves the separation of entire segments of experiences or self-states, resulting in a modified state of being. In Dissociative Identity Disorder (DID), autobiographical memories are not repressed; rather, there's a distinct mechanism or set of mechanisms causing a lack of access to these memories. Unlike the typical process where individuals reconstruct their past through memory, in dissociation,

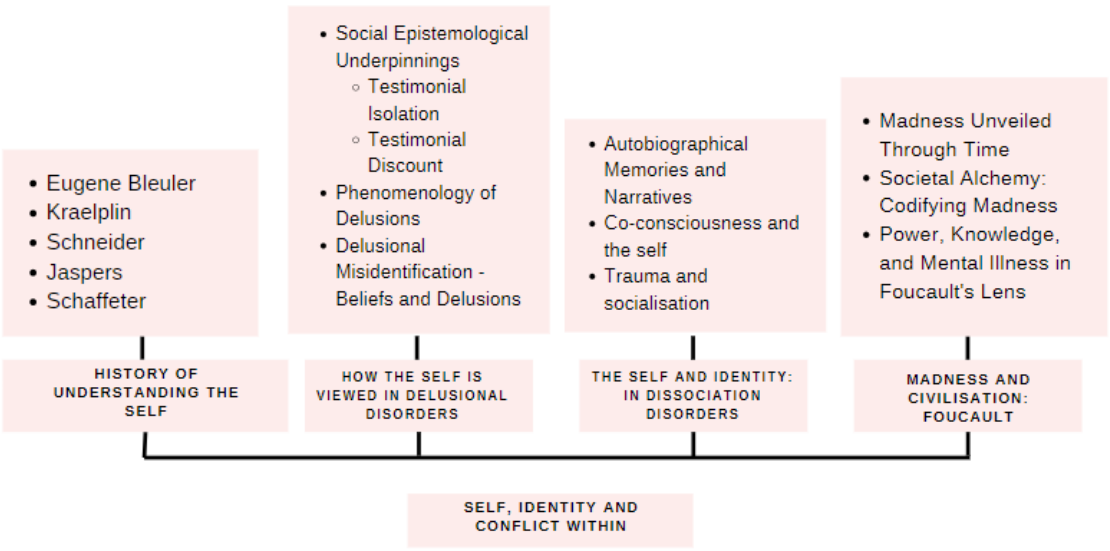
it might be more accurate to say that the past reconstructs the individual. These memories may remain available in certain consciousness states or periods. DID's psychosocial causes encompass developmental trauma and sociocognitive effects, while biological factors involve neurobiological responses to trauma (Kennett et al., 2003). Depersonalization, a common experience in dissociative disorders, can impair the ability to form new memories as part of one's life story. Hence, unusual experiences may contribute to misidentifying one's thoughts and activities in DID, with depersonalization being a shared aspect across dissociative disorders.

Madness and Civilisation: Foucault's Analysis

In the end, the author would like to highlight the ideas of madness in civilisation.

Foucault (1960) examines the shifting attitudes toward madness, tracing the evolution of asylums, confinement, and the treatment of the mentally ill. He argues that the understanding of madness is closely linked to broader societal changes, including shifts in power, knowledge, and governance. The ways in which madness was perceived, categorized, and institutionalized, revealing the social and cultural mechanisms that led to the exclusion and marginalization of individuals deemed "mad" or "insane." Foucault critiques the development of psychiatric institutions, highlighting how they often served as tools of social control and normalization rather than spaces for genuine care and healing. He challenges conventional notions of reason, sanity, and madness, to critically examine the social constructs that define and regulate mental illness. He sheds light on the historical context that shaped our understanding of madness, inviting reflection on the complex relationship between power, knowledge, and the treatment of those deemed mentally ill.

Figure 1. Summary of the Article



Identity, and the self are complex to understand especially in the context of mental illnesses such as disorders of the self. In a civilisation, the conceptualisation of mental illness thus becomes integral for us to look forward to. An all-encompassing, coexistence in the world thus, seems like the need of the hour. People with schizophrenia, and dissociation identity disorders have had difficult lives, and generational trauma. The understanding of mental health disorders teaches us more than the normal ever could. Lastly, even though there have been years of work in the field of academia, we still don't know the answer to the age-old question of who am I? Yet, we still keep searching.

REFERENCES

Bacharach, M. (2006). Beyond individual choice: Teams and frames in game theory. Princeton: Princeton University Press.

Blanchard, J. L., Horan, W. P., & Brown, S. A. (2001). Diagnostic differences in social anhedonia: A longitudinal study of schizophrenia and major depressive disorder. Journal of Abnormal Psychology, 110(3), 363.

Brewer, M. B. (1991). The social self: On being the same and different at the same time. Personality and Social Psychology Bulletin, 17(5), 475–482.

Bleuler, E. 1911. Dementia Praecox oder Gruppe der Schizophrenien. *In Handbuch der Psychiatrie*, ed. G. Aschaffenburg. Leipzig: Franz Deuticke.

Davies, M., Coltheart, M., Langdon, R., & Breen, N. (2001). Monothematic delusions: Towards a two-factor account. Philosophy, Psychiatry, & Psychology, 8(2), 133–158.

Davidson, L. (2002). Intentionality, identity, and delusions of control in schizophrenia: A Husserlian perspective. Journal of Phenomenological Psychology, 33(1), 39-58.

Ellis, H. D., Young, A. W., Quayle, A. H., & De Pauw, K. W. (1997). Reduced autonomic responses to faces in Capgras delusion. Proceedings of the Royal Society of London. Series B: Biological Sciences, 264(1384), 1085–1092.

Ellis and Young (1990). "Accounting for Delusional Misidentification", British Journal of Psychiatry, 157, 239-48.

Guralnik, Orna, Schmeidler, James, and Simeon, Daphne (2000). "Feeling Unreal: Cognitive Processes in Depersonalization", The American Journal of Psychiatry 157, 103-109.

Henriksen, M. G., & Nordgaard, J. (2014). Schizophrenia as a disorder of the self. Journal of Psychopathology, 20, 435–441.

Husserl, E. (1983). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy*. First book: General introduction to a pure phenomenology (F. Kersten, Trans.). The Hague: Martinus Nijhoff. (Original work published 1913)

Fricker, M. (2007). Epistemic injustice: Power and the ethics of knowing. Oxford: Oxford University Press.

Foucault, M. (2003). Madness and civilization. Routledge.

Jaspers, K. (1963). General psychopathology. Manchester: Manchester University Press.

Jaspers, K. 1923. Allgemeine Psychopathologie, 3ded. Berlin: Springer.

Kraepelin, E. 1896. Psychiatrie. 4th ed. Leipzig: J. A. Barth. 1913. Psychiatrie, III Band: Klinische Psychiatrie, 2. Teil. Leipzig: J. A. Barth.

Klein, C. A., & Hirachan, S. (2014). The masks of identities: who's who? Delusional misidentification syndromes. Journal of the American Academy of Psychiatry and the Law Online, 42(3), 369-378.

Kennett, J., & Matthews, S. (2003). Delusion, dissociation and identity. Philosophical Explorations, 6(1), 31-49.

Maher, B. A. (1974). Delusional thinking and perceptual disorder. Journal of Individual Psychology, 30(1), 98.

Miyazono, K., Salice, A. Social epistemological conception of delusion. Synthese 199, 1831–1851 (2021). https://doi.org/10.1007/s11229-020-02863-1

Mueser, K. T., Bellack, A. S., Douglas, M. S., & Morrison, R. L. (1991). Prevalence and stability of social skill deficits in schizophrenia. Schizophrenia Research, 5(2), 167–176.

Pacherie, E. (2013). Intentional joint agency: Shared intention lite. Synthese, 190(10), 1817–1839.

Parnas, J., & Sass, L. A. (2001). Self, solipsism, and schizophrenic delusions. Philosophy, Psychiatry, & Psychology, 8(2), 101-120.

Salice, A., & Henriksen, M. G. (2015). The disrupted 'we': Schizophrenia and collective intentionality. Journal of Consciousness Studies, 22(7–8), 145–171.

Sani, F. (2012). Group identification, social relationships, and health. In J. Jetten, C. Haslam, & S. A. Haslam (Eds.), The social cure: Identity, health and well-being (pp. 21–37). London: Psychology Press.

Sass, L. A. (1992). Madness and modernism: Insanity in the light of modern art, literature, and thought. Harvard: Harvard University Press.

Scharfetter, C. 1980. General psychopathology: An introduction, trans. H. Marshall. Cambridge: Cambridge University Press. (orig. publ. as *Allgemeine Psychopathologie.* Stuttgart: Georg Thieme, 1976). 1981. Ego-Psychopathology: The concept and its empirical evaluation. *Psychological Medicine* 11:273–80.

Schneider, K. 1959. *Clinical psychopathology,* trans. M. W. Hamilton. New York: Grune and Stratton.

Stephens, G Lynn and Graham, George (2000). When Self-Consciousness Breaks: Alien Voices and Inserted Thoughts. Cambridge Mass: MIT Bradford.

Tajfel, H. (1970). Experiments in intergroup discrimination. Scientific American, 223(5), 96–103.

Tollefsen, D. (2007). Group Testimony. Social Epistemology, 21(3), 299–311.

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Conflict of Interest

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