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SELF-MANAGEMENT IN PSYCHIATRY AS REDUCING SELF- ILLNESS AMBIGUITY

ROY DINGS & GERRIT GLAS

ABSTRACT: In this article, we argue that a crucial component of “self-management” as management *of the self* consists of reducing what John Sadler has called “self-illness ambiguity” (Sadler, 2007). The article seeks to supplement Sadler’s view on self-illness ambiguity in two ways. First, we *zoom out* of self-illness ambiguity and provide a philosophical analysis of self-ambiguity more generally. We will argue that ambiguity may arise both on the level of (unreflective) self-experience as well as on the level of (reflective) self-understanding. Acknowledging these levels and their interplay enables us to see how self-ambiguity might arise and how it might be reduced or even resolved. Second, we *zoom in* on self-illness ambiguity and elucidate some of the contextual, conceptual and epistemological obstacles that may arise when trying to reduce self-ambiguities in a psychiatric context (such as self-*illness* ambiguity).

KEYWORDS: Self-management, self-illness, ambiguity, psychiatry

IN RECENT YEARS, researchers, clinicians and policymakers in the field of mental health care have shown an increased interest in the “self” (Kyrios et al., 2016; Sadler, 2007; Tekin, 2019; Glas, 2019). That is, there is an emerging awareness that, to understand and investigate psychopathology but also to treat it or, from the patient perspective, to actually *live* with it, we

need to acknowledge and elucidate the role of the *person* who is diagnosed.

For instance, one of the key components of recovery (from a user-based perspective) is to re-conceptualize the self, to define who one is in the context of a psychiatric diagnosis (Schrang & Slade, 2007). Related to this are worries of authenticity in psychiatry (Erler & Hope, 2014). Indeed psychiatry, like other medical disciplines, is increasingly becoming “person-centered” (Glas, 2019). Others have argued that the idea of self-management in the context of psychiatry amounts to a management *of the self*—rather than management *by* the self (Franssen & Van Geelen, 2017; Miklowitz, 2012; Van Geelen, 2014; Weiner, 2011; Wisdom, Bruce, Auzeen Saeedi, Weis, & Green, 2008).

However, despite an increasing agreement that such issues are important, they remain rather vague. What does it mean to “manage oneself”?¹ How does one “define who one is in the context of a psychiatric disorder”? Answering these questions requires philosophical elucidation, which this article aims to provide.

Specifically, we argue that to “manage oneself” in the context of a psychiatric illness consists, in addition to, for example, symptom-management and emotion-regulation, in reducing what John

Sadler (2007) has called “self-illness ambiguity.” Self-illness ambiguity pertains to the difficulty in distinguishing one’s self, or “who one is,” from a mental disorder or diagnosis. Such ambiguity might be expressed in statements such as “Is it me or my mental disorder?” and “I don’t know who I am anymore.” In terms of recovery, a necessary (but not sufficient) step towards successful self-management consists in “having defined oneself properly,” understood here as having resolved self-illness ambiguity.²

The article is set up to supplement John Sadler’s view on self-illness ambiguity in two ways. We will start by *zooming out* from self-illness ambiguity and offer a philosophical analysis of self-ambiguity more generally. We will argue that self-ambiguity is something that can also occur outside of clinical contexts, and we will show how philosophical views on internality and externality, such as Harry Frankfurt’s, offer a starting point for thinking about such self-ambiguity. We will also add some revisions to the Frankfurtian picture, and argue that it is crucial that self-ambiguity may occur on two levels: the level of self-*experience* and the level of self-*reflection* or self-*narrative*. Acknowledging these levels and their interplay also enables us to see how self-ambiguity might arise and what strategies might be deployed to reduce or even resolve self-ambiguity.

After that, we will *zoom in* on self-illness ambiguity. After introducing the phenomenon more elaborately, we will show how the two levels (of self-experience and self-narrative) play a role. We then will elucidate some of the contextual, conceptual and epistemological *obstacles* that may occur when trying to reduce *psychiatric* self-ambiguities in particular (such as self-illness ambiguity). We end with a summary of the key points.

A PHILOSOPHICAL ANALYSIS OF SELF-AMBIGUITY

In this section we offer a brief analysis of what self-ambiguity entails and how an agent might try to reduce such self-ambiguity. For a more extensive analysis, including a discussion and overview of relevant literature, see Dings (2020).

INTERNALITY, EXTERNALITY AND AMBIGUITY

A good starting point for getting a grip on the phenomenon of self-ambiguity is to look at existing research on *internality* and *externality*. To understand these terms, consider that some of our desires or actions truly feel like *ours*. Not so much in the sense that it is our body that is carrying out the action -because in that sense every action is by definition ours—but more in the sense that the action *reflects who we are*. While performing such actions, or even when one is drawn to act in a certain way, one clearly experiences oneself as the “source” or “origin” of the particular action. In Frankfurt’s (1988) terms, the “moving principle” of our actions is experienced as *internal* to the self. There is a sense of freedom, of doing what one wants to be doing. The action feels as “mine” because it is *in line with* one’s reflectively endorsed values, one’s self-narrative and one’s development and history. In this sense, the action is “self-referential” (for a more elaborate discussion of “mineness,” including its phenomenology and self-referentiality, see, e.g., Dings, 2018; 2019; 2020).

For most people, such feelings of an act being “mine” form the default mode of being engaged with the world. In fact, one might only notice the *lack* of such feelings: one only notices when an act does *not* feel like yours, when it is not in line with who you are or how you see yourself.

In contrast to actions that feel like ours, are experiences where the “moving principle” of is experienced as *external*. Think here of spasms, bad habits, or Harry Frankfurt’s example of the unwilling addict who “may meaningfully make the analytically puzzling statements that the force moving him to take the drug is a force other than his own, and that it is not of his own free will but rather against his will that this force moves him to take it” (Frankfurt, 1998, p. 18). Or imagine having an ignorant referee who will reject your article unless you implement a point of feedback that you yourself feel is misguided. If you were to implement this feedback anyway, there is an important sense in which this does not feel as “your” action. Surely you may be carrying it out but it does not *reflect* you or your ideas—rather

it reflects someone else's ideas. In this case the "source" of the action, its moving principle, is experienced as being external.

Crucially, this dichotomous view on internality and externality that has dominated the philosophical debate, overlooks the possibility of self-*ambiguity*. The alternative view, despite considerable overlap with that of, for example, Harry Frankfurt, is different in its emphasis on the fact that we might experience *degrees* of whether an action feels as ours, and that within such a spectrum of "mineness," there might be ambiguous cases where we are not sure whether something feels as internal or external. In addition, whereas most existing research on internality and externality focuses on motivations and desires as states that can be experienced as internal or external, this alternative view emphasizes that also beliefs, values, actions, invitations to act and actual possessions can be experienced as internal, external and ambiguous. Let us briefly elucidate these different suggestions.

To start, consider that actions can be experienced as "more or less" *mine*: there is a spectrum between externality and internality. To illustrate, contrast the previous example of the ignorant referee with being told to do something by your spouse or a well-respected colleague. As you are still carrying out an action for the sake of somebody else telling you to, there might still be a sense of externality, but it is probably felt as "more internal" than in the case of the ignorant referee. Although the action might still not reflect your own values or self-narrative, it does reflect your spouse's, with whom you have identified to some degree, or to whom you have committed yourself.

The idea of self-*ambiguity* then pertains to the fact that we might be unclear about where on the spectrum an action is located, and this ambiguity is reflected in our phenomenology. So understanding cases of self-ambiguity starts by acknowledging that, from a phenomenological point of view, the source of an action (i.e., its moving principle) need not be experienced as *either* internal *or* external. Rather, it may be felt as somehow "in-between," as ambiguous. One might experience uncertainty as to whether or to what degree the source is internal or external; whether or to what degree the action

reflects who you are. In such cases one does not feel like being completely in control or being the source of the action, *nor* does one clearly feel that one is "forced" by some external source. These are the sort of cases that form the target of this article.

To clarify, imagine that you are once again told to carry out a certain action by your colleague or spouse, but this time you are actually in the process of thinking about quitting your job or filing for a divorce. Does the action still feel as yours? Has it become more of an external factor forcing you to act? Its moving principle might still feel, overall, to be more external or more internal, yet there is also a sense in which one is unclear about the "degree" of internality or externality. A similar ambiguous phenomenology might arise when you have to carry out an action that conflicts with another desire or value. So, on the one hand, you value X and want to do Y, but at the same time you value P and want to do Q, yet XY and PQ are irreconcilable (compare Frankfurt, 1988 on a lack of "wholeheartedness").

Importantly, we are not denying that there may be experiences of "pure" internality or externality, where it is immediately clear to the agent, on a phenomenological level, whether a source is felt as external or internal. Rather the point we are making is that there are various contexts where there are experiences of ambiguity. These contexts might range from everyday contexts to life-events to clinical contexts. That is, one might not feel like oneself or have difficulty on getting clear "who one is" after being fired from one's job, after becoming a parent, after losing a loved one, when one has fallen in love—or when one's partner has asked for a divorce. In such contexts, what was previously uncontroversial (e.g., "I know who I am; I know why I do what I do") might now become worrisome. Such self-ambiguities appear to be more common in a psychiatric context. Not only because receiving a mental health diagnosis can itself be seen as a life-event, and because psychiatric illnesses may in various ways affect our self-experience, but also because there might be additionally complicating factors in psychiatry. For instance, a patient might get the sense that she is no longer in control of her actions or wonder whether her actions are in fact due to her diag-

nosed disorder—or to the prescribed medication, psychotherapy, or deep brain stimulation she receives as treatment (Dings & De Bruin, 2016).

MANAGING SELF-AMBIGUITY

Before turning to self-*illness* ambiguity, which is a common self-ambiguity in a psychiatric context, let us first discuss how self-ambiguity might be reduced or even resolved. Recall the example of carrying out a task to satisfy one's spouse or colleague's request, whilst being in the process of quitting one's job or filing for divorce. Or think of someone who recently received a mental health diagnosis or was implanted with a deep brain stimulation device. Initially, some of these people experience self-ambiguity, yet over time it seems likely that they manage, to some extent at least, to resolve this ambiguity. How might people do that—how to *manage oneself*?

To understand the mechanism underlying such acts, it has to be acknowledged that we can distinguish between two “levels” of self-ambiguity, related to two main forms of self-experience. That is, we might experience ourselves in an *unreflective* manner, for instance when we are engaged with the world around us and our attention is directed towards the world or the action we are carrying out. But we might also experience ourselves in a more *reflective* manner, where we turn the attention towards ourselves. Importantly, self-ambiguity may arise on both levels. On the first, *phenomenological level*, we might get a sense that a particular action that we carry out does not feel like “ours.” There might be a small hesitation in our previously smooth and flexible interactions with our environment, accompanied by a sense of “not me” or alienation.

If such phenomenological ambiguity is persistent, it is likely that the agent will switch to what we will call the *conceptual level*, that is, the level of reflective self-understanding where one deliberates about one's self-concept or self-narrative. On this level as well there might be a form of ambiguity, to the extent that one is unclear about “who one is.” There might be some inconsistencies in one's self-concept, or some flaws in one's self-narrative. Indeed following major life events (such as filing for divorce or receiving a mental health diagnosis),

one might have to re-evaluate one's values or self-concept. During that process, the ambiguity on a conceptual level may impact one's self-experience. So actions that were previously experienced as clearly “mine” might now be felt as ambiguous.

The proposed solution then is to re-negotiate oneself (or “one's self”); to reflect on one's self-concept or deliberate on one's self-narrative. When this self-concept or self-narrative is made coherent, the phenomenological ambiguity is resolved in that one has either accommodated or endorsed the ambiguous factor (i.e., internalized) or discarded it (i.e., externalized).

In other words, resolving self-ambiguity, according to the current proposal, entails achieving a form of congruence between one's reflective self-understanding (e.g., one's self-concept) and the bodily and affective feedback one receives while unreflectively acting on the world. In the case of such congruence, there is a sense of “me-ness” or “mineness” (Køster, 2017; Dings, 2018; 2019), of authentic self-experience (Bortolan, 2017) and wholeheartedness (Frankfurt, 1998). As we have noted, achieving that congruence requires determining whether an ambiguous factor, as the moving principle of your action, is either internal or external to the self. There are various ways to do this, which have been highlighted by other researchers as well. We believe that, as a matter of fact, people often employ narrative self-understanding and may try to alter one's self-narrative to incorporate possibly disrupting life-events (Schechtman, 2007). With regard to resolving phenomenological ambiguity, such “narrative self-appropriation” consists of “bringing what is alien in experience to a meaningful *order*, a sense of familiarity, thereby dissolving its very character of being alien” (Køster, 2017, p. 472). This process may also occur in non-narrative forms, where the agent revises her self-concept or more generally how she sees herself, by endorsing a certain value, by committing herself to a particular course of action, and through acts of identification (Frankfurt, 1998).

Crucially, however, we should not *overemphasize* the importance of reflection for our self-understanding. That is, reducing self-ambiguity, and potentially resolving it, is more likely to be a

diachronic process, consisting of a constant back and forth between narrative self-understanding and unreflective engagement with the world (cf., Dings, 2019). Throughout this process, our unreflective engagement with the world provides bodily and affective feedback that feeds into our reflective self-understanding, which in turn leads to attempts to “program” oneself to act in a particular manner. So to fully understand how people attempt to resolve self-ambiguities, we need, in addition to a picture of how reflective endorsement works, a better understanding of the role of the agents unreflective engagement with their environment and how this contributes to, or provides an obstacle for said endorsement. In particular, the phenomenology of agency is something that needs to be taken into account: the bodily and affective feedback of someone who experiences self-ambiguity is a crucial source of information that needs to feed into the reflective self-deliberation. In addition, we should keep in mind the social and material “niche” that we inhabit, which may provide a scaffold for our attempts to reduce self-ambiguities (Dings, 2019).

There is certainly more to be said about self-ambiguities in general, and the proposed analysis can be fleshed out in numerous ways (see Dings, 2020). Yet it suffices for present purposes as it provides a starting point for thinking about self-management in psychiatry as an attempt to reduce self-illness ambiguity. Let us therefore turn to the phenomenon of self-*illness* ambiguity.

INTRODUCING SELF-ILLNESS AMBIGUITY

Here we will introduce self-illness ambiguity more elaborately, and then, in the following sections, see how self-illness ambiguity also arises on both the phenomenological and conceptual level, and show that what makes phenomenological ambiguity in the context of psychiatric illness particularly complex and problematic are the additional conceptual, contextual and epistemological complications that arise when dealing with mental disorders.

The term self-illness ambiguity was coined by psychiatrist and philosopher John Sadler, who used it to refer to the difficulty of distinguishing

the “self” or “who one is” from a mental disorder or diagnosis (Sadler, 2007). Although the phrase self-illness ambiguity is not widely adopted, the elusiveness of the self-illness relation has been addressed by various researchers from a range of disciplines (Bröer & Besseling, 2017; Cruwys & Gunaseelan, 2016; Davidson & Strauss, 1992; Epstein, Wiesner, & Duda, 2013; Erler & Hope, 2014; Estroff, 1989; Estroff, Lachicotte, Illingworth, & Johnston, 1991; Graham, 2004; Griffith, Totsika, Nash, & Hastings, 2012; Hickey et al., 2018; Howard, 2006, 2008; Inder et al., 2008; Karp, 1992; 1994; Kenny et al., 2016; Mathur, Bhola, Khanam, & Thirthalli, 2014; Miklowitz, 2012; Pedley, Bee, P., Berry, & Wearden, 2017; Rego, 2004; Sadler, 2007; Sass, 2007; Shea, 2009; Singh, 2013; Weiner, 2011; Wisdom et al., 2008).³ It goes beyond the scope of the present article to provide an in-depth review of all of this research, but we do want to point out some findings or considerations in this literature that are relevant for our purpose of conceptualizing self-management in psychiatry as a management of the self.

As a starting point, it is important to note that various researchers have emphasized that clarifying the self-illness relation is a diachronic process, consisting of different phases, each of which “assumes and requires redefinitions of self” (Karp, 1994, p. 13; see also Estroff et al., 1991; Howard, 2006, 2008; Shea, 2009; Kokanovic, Bendelow & Philip, 2013; Mathur et al., 2014; Glas, 2019).⁴ Moreover, this diachronic process of clarifying the self-illness relation typically starts with ambiguities on the level of phenomenology.

That is, patients are initially confronted with experiences of their self being “lost.” As Shea (2009, p. 46) put it: “Not all participants recognized them [the symptoms] as part of a mental illness, but most clearly recalled a feeling of being uncomfortable and something just not right.” Indeed many patients struggle with such “inchoate feelings” (Karp, 1994). As a result their daily lives are filled with experiences of *confusion* and *self-doubt* (Inder et al., 2008), leading some patients to say they are not feeling like themselves, and that things do not or no longer make sense (Wisdom et al., 2006). The world is experienced as “not right.” Kokanovic et al. (2013, p.382)

remark that the participants in their study (who were diagnosed with depression):

described not being their “usual self” ... or feeling that “something wasn’t right.” ... Often, they were uncertain about whether what they were experiencing was simply a problem in everyday life, or a problem requiring medical attention.

When patients are unclear about whether it is really them who is in control of their actions, thoughts and feelings, this may over time lead to a sense of *distrust* in their own feelings, as illustrated by the 25-year-old patient with bipolar disorder that Miklowitz (2012, p. 61) reports on:

I feel like everything I do is now somehow connected to my being sick. If I’m happy, it’s because I’m manic; if I’m sad, it’s because I’m depressed. I don’t want to think that every time I have an emotion, every time I get angry at somebody, it’s because I’m ill. Some of my feelings are justified. People say I’m a different person every day, but that’s me! I’ve never been a stable person.

Importantly, nearly all patients are prompted by these alterations in experience to “make sense” of them. This brings us to the *conceptual level* of reflective self-understanding and thereby to the unique complexities of *self-illness* ambiguity. When patients reflect on their phenomenological alterations, or when discussing these experiences with others, they are inevitably confronted with another set of ambiguities at the conceptual level. Specifically, they are confronted with the vagueness and uncertainty associated with the issue of “what is a psychiatric disorder” as well as “how does a psychiatric disorder relate to the individual?” For instance, “is schizophrenia best conceptualized as a disease entity that comes, as it were, from the outside, and with which the sufferer must contend, as with a burden or an enemy? Or is it better seen as a more intimate factor: something that emerges from within, permeates the very core of one’s being, and must, perhaps, be understood as an aspect of the sufferer’s very soul?” (Sass, 2007, p. 395).

SELF-ILLNESS AMBIGUITY AND THE INTERACTION BETWEEN UNREFLECTIVE SELF-EXPERIENCE AND REFLECTIVE SELF-UNDERSTANDING

How these conceptual ambiguities interact with ambiguities on a phenomenological level is nicely illustrated in Ruth Henry’s (2000) personal account of dealing with self-illness ambiguity:

For more than a decade I’ve been trying to understand what’s wrong with me. I know I’m insecure. I hate confrontation, I lack discipline, and I have ugly legs. I’m also terribly out of shape, and I ought to do something about my hair. What I don’t understand, though, is why what I thought was a sensitive disposition became in, 1989 a diagnosis of depression. ... When the doctor first told me I was depressed, I was puzzled. Of course I was depressed. I was often depressed, loads of times, ever since I first learned the word. But I certainly wasn’t *depressed*. It would have been nice to blame all my problems on an authentic mental condition, but I didn’t have one. [italics in original text]

As to why she thought she didn’t have a mental disorder, she discusses both her phenomenology and her conceptual understanding of mental disorder:

The depression I experience never feels like an illness. To me, it’s a bad attitude, a deficiency of willpower, and something I brought upon myself. It is a weakness that I’m ashamed of. When I’m “depressed,” this is how I reason: “I am not nauseated. I don’t have a fever. I can walk and talk and eat and read and shout hallelujah if I have to—I just don’t want to. Which means I’m the one who’s uncooperative. It’s obviously my fault—don’t go blaming it on some disease. Maybe other people have this disease, but not me.” It never occurred to me that maybe all of my objections about having depression were being fueled by it. *Real depression*, in my mind, was validated by tragedy, heartache, financial woes, abusive parents, a family death—the powerful blows life can deliver, not a few slaps on the wrist. It seemed to me one had to earn the right to call herself depressed. My loneliness and despair came from character flaws within me, not from tragic circumstances surrounding me. [italics added]

Although the process of clarifying who she is in the context of her disorder has continued for over a decade, it remains troublesome and, indeed, riddled with ambiguity:

I think I was born with the tendency to think pessimistically and be overly sensitive and anxious. At what point did my temperament metamorphose into symptoms of a disease? Are they distinct, or are they one and the same?

What we see in this personal account are attempts to make sense of the self-illness relation. But these attempts are hindered by the fact that various conceptualizations of “self” and “disorder” are at play.

In a nutshell, what makes self-*illness* ambiguity so complex, is that in addition to phenomenological ambiguity, where one is uncertain about whether one’s feelings are really theirs or part of something external, there is also ambiguity on the conceptual level. Henry (2000) clearly struggles with what depression *is*, and switches between various conceptualizations. In other forms of self-ambiguity, one can try to reduce the phenomenological ambiguity by reducing the conceptual ambiguity, for instance by re-evaluating one’s self-concept or revising one’s self-narrative, such as to get clear on whether the ambiguating factor is internal or external to who one is. The problem in self-illness ambiguity is that this ambiguating factor (i.e., the illness) itself is ambiguous. In the next paragraph we will investigate this suggestion, that is, that in psychiatric cases it is often unclear whether the illness belongs to the self or to something external.

CONCEPTUAL, CONTEXTUAL AND EPISTEMOLOGICAL COMPLICATIONS IN RESOLVING SELF-ILLNESS AMBIGUITY

Let us look more closely at several conceptual, contextual and epistemological issues that are strongly intertwined and overlapping, and which thereby make self-illness ambiguity so difficult to resolve (in comparison to other instances of self-ambiguity). In other words, if we imagine a person who is diagnosed with a mental disorder,

then what kind of (conceptual, epistemological and contextual) obstacles might this person encounter that make reducing self-illness ambiguity additionally complex? We discuss several of these obstacles and illustrate them by referring to case studies based on empirical research.

REIFICATION

The first problem in dealing with self-illness ambiguity is the fact that, as elsewhere in psychiatric contexts, there is a tendency of *reification*. Through reification, people might come to think of mental disorders as “entities” or “things” that *cause* their symptoms (as opposed to the term mental disorder referring to the collection of symptoms itself). If one, conversely, also conceives of the “self” as a thing, then one ends up with various conceptual questions of how these two “things” relate to each other.⁵ Reification thereby adds an unnecessary level of complexity to the already difficult process of self-illness ambiguity. For instance, if selves and mental disorders are two “things,” a diagnosed person might wonder to what extent their “self” and their “disorder” overlap or are distinct (Sadler, 2007; Sass, 2007; Pedley et al., 2017). Or they might wonder whether their “self,” or who they are, is the *cause* of their depression, or whether it is better understood as an *effect* of their illness (Westerbeek & Mutsaers, 2004, p.27). Or they might feel the need to, when diagnosed with a disorder on a later age, re-evaluate their lives in terms of actions or events explained in terms of either selfhood or disorder (Hickey et al., 2018). Or they might question whether it is their “self” or their “disorder” that is “in charge.” In this regard, consider the findings by sociologist David Karp, who investigated self-help groups for affective disorders and regarding what he called “illness ambiguity” noticed that

It was quite common to hear people talk about the fact that when they were overly aggressive, acting out, irritable, and so on, “it was the illness talking,” not them. One woman whose husband was a manic depressive said that sometimes “it is unclear whether the illness is talking or whether [he] is talking.” In a different meeting, a woman, who described a history of beginning to take college courses only to drop out, offered

the following analysis of her behavior: “I would always start courses and then drop out. I used to think I was easily bored. Now I don’t blame myself or the class. It’s not me or the class, it’s the illness.” Yet another woman who was undecided about returning to work as a preschool teacher wondered out loud: “Do I not want to go back to it, or is it because of the illness that I don’t want to return? .” [Another participant added:] “I’m trying to discover my basic personality aside from the disease. That’s why I’m at these meetings, to discover which is which.” (Karp, 1992, p. 105)

Weiner (2011) also elaborately discusses the problem of reification in resolving self-illness ambiguity or trying to “manage oneself.” She notes that the paradigm of “self-management” seems to presuppose a detached and rational manager (‘the self’) which is able to manage an isolated mental disorder. In literature on self-management, “the self is established as separable from disease and recognizable through its properties of coherence and continuity. The managed disease, in turn, is figured as calculable, visualizable, and thus able to be ordered predicted and tamed by the rational manager” (Weiner, 2011, p. 459).

Yet in practice, things could not be further off. As an anthropologist, Weiner attended dozens of support-group meetings for people with bipolar disorder, and held semi-structured interviews with several of its participants. She finds that “group members struggled in their attempts to locate the managing self and an ordinary, asymptomatic position from which to manage” (ibid., p. 467). Thus, Weiner concludes that

the relationship between selfhood and disease entity envisioned as enactable in the self-management literature for bipolar patients/consumers ... is unsustainable in a way that draws particular attention to the limitations of medicalized/somatic selfhood. As bipolar patients/consumers cultivate and perform what is taken as expertise and responsible behavior within the self-management paradigm, they must, paradoxically, index and increasingly recognize themselves as uncertain, discontinuous, unreliable and never fully knowable. Furthermore, their efforts to predict, calculate and discipline the bipolar “disease,” while valuable, ultimately foreground the absence of a singular agentive subject and the inextricability of bipolar phenomena from the expression of the managing self. (Weiner, 2011, p. 478)

So the problem is that the idea of “managing oneself” presupposes two reified “things,” one managing and the other managed, but in practice “[managing] the “disease” generates ambiguities regarding its location and boundaries” and “enacting expertise in self-management constitutes and indexes the self as discontinuous and uncertain” (ibid., p. 465).

THE HYPONARRATIVITY AND CONTEXT-INSENSITIVITY OF THE DSM

The influence of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) on how people think about mental disorders is difficult to overstate. In this regard some have argued that the DSM has a “monopoly” on how we think and talk about mental disorders (Epstein et al., 2013), and that we live in a “DSM culture” (Tekin, 2015a).

Although the DSM started out as a manual for clinicians and/or researchers, it now serves many other functions as well. It is used by insurance companies to determine reimbursements; by welfare institutions to determine compensation; by lawyers to determine competence; by schools to determine allocation of special educational provisions, and many more. Now the point here is that because it was devised for researchers and clinicians, it might be ill-suited for other parties or for other goals. One goal for which the DSM is not well equipped is for *self-understanding*. As philosopher of science Şerife Tekin has argued for in a series of articles, the DSM is not suitable as a source for (narrative) self-understanding because it is both hyponarrative and context-insensitive, due to its focus on the biomedical model (which construes disease as something isolatable and manageable) and its symptom-based approach (cf., Tekin, 2015a, 2015b, 2019). The point here is not to deny that the DSM might contribute to self-understanding, which in some cases it definitely does, if only by providing a word or label for that which people have suffered from (see e.g., Howard, 2006). Rather, the point is that for many people who receive a mental health diagnosis, or who wonder whether they suffer from a mental disorder, the DSM provides a skewed framework for self-understanding.

On the one hand, because it is thoroughly context insensitive. The primary and most often discussed example of this is how the DSM fails to adequately distinguish between depression and grief (Horwitz & Wakefield, 2007; Tekin, 2015a). That is, there are instances of prolonged states of sadness, which fit the DSM criteria for depression, but which are not adequately characterized as a “mental disorder.” Instead, they are proper reactions to a change in one’s life/context. And we do not want people who have “normal” responses to life events to think that there is something wrong with them.

On the other hand, the DSM is ill-suited for self-understanding because it is *hyponarrative* (Sadler, 2005; see also Glas, 2019). Tekin (2015a, p. 186) describes this hyponarrativity as follows:

Even though mental disorders are sensitive to an individual’s life story, including developmental history, biological and environmental risk factors, interpersonal relationships, race, gender, and other important aspects of personal identity, these elements of the story are not included in [DSM’s] mental disorder categories. In other words, the DSM categories abstract (or bracket) the self-related and context-specific aspects of the encounter with mental disorders.

The problem that this hyponarrativity and context-insensitivity of the DSM poses for adequate self-understanding is clarified by Tekin (2015b, pp. 146-147) by showing how it enables the so called “Barnum effect” (also called the subjective validation effect), which is “the tendency of subjects to identify their personal features with broad or vague characterizations of their personality, even when such characterization is not veridical.” Taking mood disorders as an example, she writes:

The influence of the DSM-led psychiatric knowledge that prioritizes symptoms at the expense of eliminating subjectivity in mood disorder descriptions might trigger [the Barnum effect]. Because these descriptions are general, lack detail, and provide no room for particular contingencies, patients, when exposed to such information via various media of the DSM culture, might overidentify their experiences with the suggested symptoms, undermining other, more personal aspects of their lives. Some patients, upon being informed of the symptoms of mood disorders, might start making

sense of their lived experience with a skewed focus on the symptoms. By attending to their symptoms and ignoring other essential components of their lives, such as personal identity and interpersonal relationships, they might attribute the sources of their interpersonal problems to their symptoms, not to other fundamental ingredients of their lives.

In other words, when trying to get clear on self-illness ambiguity, that is, when trying to make sense of who one is in the context of a mental disorder, or when determining whether a particular symptomatic behavior or feeling is “internal” or “external” to one’s self, drawing on the DSM and its categories provides a skewed framework that prioritizes symptoms rather than say personal characteristics or changes in their context.

This is precisely what happens when patients try to “manage their selves.” Weiner (2011, p. 467) reports about a person saying “I’m a little hypomanic today ... but maybe I’m just excited because I got a call about a job interview. It’s hard to tell.” Another participant in Weiner’s study remarked: “‘Other people might get upset if that happened too, though. I’m gonna give myself a couple days leeway to see if this is depression or a normal emotion.’” Another time, a bipolar man received a parking ticket that everyone in the room agreed was unfair. “I’m feeling really angry about it,” he said calmly, “‘which makes me wonder if maybe I’m hypomanic.’” (Weiner, 2011, p. 470).

Epistemological Complications: Access, Trust, Expertise and Authority

Another set of complicating factors when trying to resolve self-illness ambiguity pertains to epistemology. More specifically the access to and trustworthiness or reliability of experiences of selfhood and mental disorder. In addition, the questionable status of expertise and authority in the context of self-illness ambiguity.

As indicated elsewhere in this article, the phenomenology of self-illness ambiguity often leads to a sense of distrust in one’s experiences. This may over time result in a state of “hypervigilance” where one constantly monitors and interrogates one’s thoughts and feelings because these might be symptoms (Weiner, 2011, p. 470). Or it may lead to what Weiner calls *tentativeness*, that is, “the

literal practice of avoiding commitment to future plans that would require a reliable, continuous self, and to a cultivated stance of uncertainty and suspicion towards one's own thoughts and emotions at any given moment" (ibid., p. 472).

So how to make sense of your experiences, if those experiences themselves may be unreliable or cannot be trusted? How to proceed when a strong feeling of not being in the mood to go see your therapist might actually be an indication that you need to go see your therapist (ibid., p. 467)? One commonly used strategy is to use "alternative selves" as a contrast class. For instance, patients might wonder what they would have been like or how they would have acted if they had not had the disorder (cf., Inder et al., 2008, p. 128). They might compare their selves prior to the diagnosis to their selves after the diagnosis (Miklowitz, 2002, p. 55). Or they might compare their selves prior to the onset of the illness versus their selves after the onset of the illness. But there are epistemological problems here as well. Most obviously that one's self itself might change following a diagnosis or following the onset of an illness (Estroff, 1989; Sass, 2007). But also because the contrast-class one creates (e.g., "who I was before the illness") might similarly be unreliable or difficult to access. In the case of chronic illnesses, many people might feel like they do not have a "baseline" for judging whether something is wrong. One participant in Karp's study noted that "I could not think in terms of "something isn't right" because I had nothing to judge it against" (Karp, 1994, pp. 13–14).

If one cannot reliably draw on one's own experiences or self-knowledge, then an alternative is to rely on other people's knowledge or expertise. (In the next subsection we will address friends or families; in this subsection we focus on "experts," that is, clinicians and researchers). Again, there are various obstacles. The first is that it is extremely difficult to put one's experiences into words (Karp, 1994, p. 18). Indeed many people inevitably resort to the use of metaphors to communicate their experiences of self-illness ambiguity (Westerbeek & Mutsaers, 2004). But even if one manages to adequately put into words one's experiences to, say, a clinician, there is still the moral-epistemological issue of whether and to what extent one can trust

the clinician's judgment. In other words, who is authoritative on the self-illness relation—the patient him—or herself or their psychiatrist? It is easy to imagine a scenario where a patient and their therapist disagree on the matter of self-illness ambiguity—such as when a therapist interprets a patient's report of self-illness ambiguity as a "lack of illness insight." Or think of those who *experience* their disorder as a part of who they are versus a clinician who *judges* that this is not the case. For instance, a patient saying he "is autistic" and a clinician responding that, instead, "he has autism" (cf., Kenny et al., 2016). Now with regard to medical issues, the psychiatrist gains his authority from his medical training. But on the basis of what do we attribute authority when it comes to existential or personal issues such as "self-management" as management of the self?⁶

Aside of consulting their clinicians, people also turn to science as a source for sense-making of mental disorder. Yet scientists have not adequately addressed the self-illness relation. Illustrative for this, we believe, is the fact that there is a lot of research on lay concepts of mental disorders (see e.g., Ahn, Flanagan, Marsh, & Sanislow, 2006), as well as research into lay conceptions of selfhood (see e.g., Strohming, Knobe & Newman, 2017), but there is close to no research on lay conceptions of how selfhood and mental disorders interrelate. That is, many researchers acknowledge that clarifying the self-illness relation is something that patients and laypeople struggle with, yet this self-illness relation itself is seldom the main target of scientific investigations. As a result, clinicians and patients who make use of and apply scientific knowledge speak about illness as a "condition," a state of affairs in the afflicted person, thereby increasing the tendency to reify terms that refer to psychiatric illness.

Social and Societal Complications

Another set of complicating factors for when people try to deal with self-illness ambiguity consists of the various *social* and *societal* forces that motivate individuals in a particular way. That is, patients might find that there is no "neutral" or "value-free" point from which they can determine how they see themselves in relation to their

disorder. The perhaps most often investigated social pressure with regard to self-understanding is stigma and self-stigma, which can have substantial effects on patients' self-esteem and self-image and is connected in several ways to self-illness ambiguity (see e.g., Cruwys & Gunaseelan, 2016). The literature on stigma and self-stigma is massive, and it goes beyond the scope of this article to properly review it. Instead, what we want to do in the remainder of this subsection is to take a philosophical perspective at some other, and perhaps less obvious, social and societal forces.

As a starting point, it has to be acknowledged that dealing with self-illness ambiguity is, at its core, a social endeavor (Broër & Besseling, 2018; Epstein et al., 2013; Inder et al., 2008; Pedley et al., 2017). On the one hand, other people might help or facilitate one's self-management (Weiner, 2011). They might "co-regulate" our self-ambiguity. In this regard, Shea (2009) describes how people, when revising their self-concept in the context of a mental disorder, use social contexts to "test" whether their new self "fits." On the other hand, other people may also provide an obstacle by either unduly moralizing about the patient's behavior (as if the illness is an expression of who one is) or by strengthening the reification of the illness. Furthermore, there is another layer of self-understanding and of identity-formation that is thoroughly social. For instance, identifying as someone with an affective disorder, or incorporating an affective disorder into one's self-narrative can lead one to become a "member" of the social group of "people with an affective disorder." Importantly, members of such identity-related groups tend to "scaffold" each other's identities. As a consequence, if who one is or how one sees oneself is tightly interwoven with a group identity, or even derived from a group identity, then changes in that group identity can be felt as a personal threat. Groups may, in a sense, "defend" their shared identity. In this respect, it is interesting to see how Karp (1992, p. 146), when trying to study self-help groups for affective disorders, was initially approached with skepticism until it became clear that he was "one of them" because he had also suffered from depression. Such a social dynamic may similarly help to explain why one

of the main obstacles for "disidentifying" with a mental disorder label is social pressure from the group that one is trying to distance oneself from (Howard, 2008). All these processes—testing of one's new self-image, dealing with the comments of others, and learning to cope and make use of the group dynamics that go along with being an identified patient, help the patient to come to terms with the illness, but also may lead to problems in self-management.

The complexity and layeredness of these social factors in the formation of self-illness ambiguity becomes eminently clear in the use of *language*. It has often been argued that language plays a pivotal role in patient's processes of clarifying the self-illness relation (Estroff et al., 1991). Indeed, how we talk about mental disorders matters for how we understand them and how we see ourselves in relation to them. With regard to self-illness ambiguity, the most prominent question then is: does one *have* a mental disorder, or *is* someone disordered (e.g., does one have autism or is someone autistic?). There is an ongoing debate targeting this question, and we will briefly summarize it here (primarily to indicate the complexity and various motivations that play a role, not to do justice to all of the details).

The American Psychiatric Association, by means of the DSM, and in an effort to fight stigma has, for some time now, advocated a "person-first language": the proper way to speak is of "a person with schizophrenia" rather than "a schizophrenic person" (American Psychiatric Association, 2000, p. xxxi). By using this formulation, an analogy is made with—much less stigmatized—somatic illnesses. Now there are various reasons for why adopting such person-first language need *not always* be preferable. First, language can be used with different goals in mind, such as accuracy or self-understanding and it is not clear whether person-first language is always beneficial for achieving those goals (Sass, 2007; Tekin, 2015b). Second, there has been some discussion as to whether person-first language reduces stigma, or perhaps even increases—some parts of—stigma (Deacon & Baird, 2009; Thibodeau, Fein, Goodbody, & Flusberg, 2015). Third, and perhaps most importantly, some argue that person-first language

is itself stigmatizing. For instance, neurodiversity activists argue that the proposed linguistic convention of “not reducing an individual to their mental disorder label” implies that such a label is something not worth identifying with. However, some people with for instance autism, do not see their condition as a disorder or illness but as a distinct way of being—as something that is not negatively valenced but neutral or even positive (Bagatell, 2010).

The point here is that these various motivations and social forces at play complicate the process of reducing self-illness ambiguity. Let’s again take autism as an example. Recent research indicates that various parties (e.g., patients themselves; parents and family members; professionals) have different linguistic preferences on how to talk about autism, based on whether they see the person as something that can be isolated from the disorder or not (Kenny et al., 2016). So whereas many people who are diagnosed with autism are fine with calling themselves “autistic,” their clinicians might strongly oppose this phrasing. This brings us back to the above-mentioned dilemma of authority: do I assign authority to the clinician and revise my self-understanding such that I see myself as separate from the disorder? Or do I reject the clinician’s phrasing and instead stay close to what my personal experience tells me? This is an unattractive either/or. We would suggest at this point to see self-management in cases such as these—cases in which ambiguity belongs to the illness and its story—as a form of self-regulation. Instead of plain denial or acceptance there are, after all, other ways of coming to terms with one’s illness, ways in which parts of the illness, though undeniably present, need to be circumvented or diligently ignored as far as possible and desirable; and other parts are integrated into the story about oneself.

This is not at all an easy process. The balance to which self-regulation ideally leads, may remain utopian. If one’s self-understanding hinges too much on one’s identification with a particular disorder, or when it is the key structure of a self-narrative, then the process of recovery can feel as a threat to the self (Kokanovic et al., 2013, p.368). To help see why, some researchers make use of

the psychological construct of “self-complexity.” According to research on this construct, having a diverse or complex self-understanding (in which one see oneself as not only an academic, but also as the son of my parents, as the coach of a junior league team, as a fanatic gardener, etc.) provides a buffer for experiences of adversity. In this respect, Wisdom et al. (2008, p. 493) emphasize that for people in the process of understanding themselves in the context of a mental disorder, it is crucial to have multiple fixed social roles that are clearly distinct from their mental disorder (such as “being a parent”), as these roles provide comfort and stability during the sense-making process.

CONCLUSION: SELF-MANAGEMENT AS MANAGEMENT OF THE SELF

The current article has tried to elucidate the idea of self-management in psychiatry amounting to a management *of* the self (as suggested by e.g., Wisdom et al., 2008; Weiner, 2011; Miklowitz, 2012; Van Geelen, 2014; Franssen & Van Geelen, 2017). Specifically, it has argued that such self-management consists, in addition to symptom-management and emotional management, in reducing self-illness ambiguity (Sadler, 2007). To do this, we have started by clarifying instances of “self-ambiguity” more general. On the one hand, such self-ambiguity may occur on a phenomenological level, where the source of intentional action might be experienced as neither internal nor external but as ambiguous. On the other hand, self-ambiguity may also pertain to the conceptual level, where agents reflect on who they are, and form a self-concept or self-narrative, but are confronted with conceptual difficulties such as “who am I,” “what is a mental disorder” and “how do mental disorders relate to who I am?” We argued that, to reduce or even resolve self-ambiguity, the dynamic interplay of these two levels is crucial: the aim is to achieve congruence between one’s reflective self-narrative and one’s unreflective bodily and affective experiences. In addition, we have emphasized that the individual’s social and material niche plays a modulating role in achieving this congruence.

In the remainder of the article, we zoomed in on self-*illness* ambiguity. We discussed the various contextual, conceptual and epistemological obstacles that complicate the process of reducing self-illness ambiguity, thereby bringing into focus the various difficulties of “self-management” in psychiatry. Specifically, these problems pertain to reification, the hyponarrativity and context-insensitivity of the DSM categories, epistemological issues concerning trust, reliability and authority, social forces and the problematic role of language and the limitations it poses.

Our approach has a number of clinical implications. One of them is that psychoeducation should entail much more than telling the patient which psychiatric condition he or she is suffering from. Psychoeducation involves a reconstruction of the impact of one’s illness on how one relates to oneself; of how others react to one’s condition; and how these two influence one’s self-image, trust, hopes, and desires. Later on, self-management would ideally lead to a form of managing of (instead of by) the self, namely, to new ideas about how to identify oneself and to acceptance of the changes of this self-definition, in the light of the vulnerability-patterns that come along with the illness. Self-management is then interpreted as a form of self-regulation. This self-regulation is not an individual, isolated activity. It occurs in the context of co-regulating attention, interpretation and intervention of others, among whom the clinician. Clinicians should be open for considerable variability in how this process gets shape. There are after all many ways to regain one’s “self.” Mourning about what is lost and finding new meaning and purpose in life are at the heart of this process of re-finding oneself. It is the patient who determines how fast and in what way this process of mourning, re-identification and regaining of trust and hope will unfold. Self-management is a flat term for this process, even when taken as indicating the managing of (instead of by) the self. The process of recovery involves dealing with ambiguity, pain, and loss; and regaining one’s openness for new opportunities. Support and recognition by others are crucial for its success.

NOTES

1. For instance, Weiner (2011) and Brijnath & Antoniadis (2016) have shown that there is a disconnect between the policy rhetoric of self-management and the ultimate practices of patients who manage themselves.

2. In this article, we focus on what we think is the most common experience of self(-illness) ambiguity, namely as frustrating and alienating and thus something one aims to resolve. However, in earlier work we acknowledge that there are many ways in which patients might relate to their self-ambiguity (cf., Glas, 2019). For instance, one might experience self-ambiguity as opening up new worlds and as enriching one’s self-experience. In such cases, resolving self-ambiguity is clearly not a necessary step towards personal recovery.

3. Somewhat surprisingly, the elusiveness of the self-illness relation and its possible configurations (e.g., in terms of internality, externality and ambiguity) has not received that much philosophical attention (although, to be fair, it is sometimes discussed with regard to authenticity, see, e.g., Erler & Hope, 2014).

A notable exception is Rego (2004), who discusses Frankfurt-style externality in relation to mental disorders, and notes a “paradox of agency,” namely, that disownership of the mental disorder (i.e., the disorder being construed as external) seems to increase agency with regard to that disorder. Interestingly, Rego comes close to advocating a sort of “management of the self” when he notes that through externality and strategic acts of identification, “the patient can now treat him- or herself in a manner of speaking” (ibid., p.316).

There is a lot to be said about Rego’s discussion on externality (see e.g., Graham, 2004), but we will limit ourselves to three remarks that most clearly indicate how our view differs from his. First, Rego suggests that externality might be beneficial for therapeutic purposes, yet he does not pay attention to its effect on what Tekin (2015b) calls the “reflective impact” of a psychiatric diagnosis, that is, “how the diagnosis informs the patient’s reflection on the states of affairs in her life, including who she is, how her mental disorder is expressed, how her interpersonal relationships proceed, and how these interact” (p.140). Second, although Rego seems to acknowledge that there are cases that are too complex, where self and illness are too much intertwined, he does not elaborate on these cases. Consequently, he does not elucidate the particular complexities that arise when one actually tries to identify with a disorder (or, conversely, to see it as separate from who one is). A third point, related to the previous remark, is that Rego does not discuss cases of self-ambiguity, but instead adopts—following Frankfurt—a dichotomous view of internality and externality.

4. “Defining oneself” in the context of a psychiatric illness is an intricate and complex process, which requires a lot more work to fully elucidate. To indicate the complexity at stake, consider that this process is fundamentally diachronic and in some sense never-ending. On the one hand, because the process has a “feedback quality” to it, and “a new episode of depression casts doubt on all of the previous interpretive work and requires persons to once again move through a process of sense-making and identity construction” (Karp, 1994, p.26). On the other hand because it might just be the case that one receives a –different–diagnosis at a later age (Hickey et al., 2018). Moreover, many patients might initially embrace the disorder label because it enables them, to paraphrase Howard (2006), to “name the present, reinterpret the past and anticipate the future.” But over time, identifying with the disorder may give rise to a feeling of being too passive: patients felt like they could no longer grow, like they were being held down by their disorder, and that their self-perception became narrow. This may lead to a new phase of disorder disidentification (Howard, 2008), in which patients try to define themselves apart from their disorder. Importantly, this process of disidentification appears to depend in part on the initial conceptualization of the disorder as, for example, a medical condition, an emotional disturbance or a social circumstance (cf., Estroff et al., 1991).

5. In terms of self-ambiguity, the issue is whether “a disorder” such as autism or depression, is experienced or conceptualized as internal or external, or whether a particular (set of) symptom(s) is internal or external, such as “pervasive sadness” or “difficulties in sensory processing.” Thus, reification may lead to a different set of questions: compare “How does who I am relate to my autism?” to “How does who I am relate to the difficulties I may experience in sensory processing?”, or “How do I relate to my depression” versus “How do I relate to the fact that I am often very sad?”

6. In this context, an important recent development is the use of ‘experts by experience’ in mental health care, who might play a mediating role between the patient and the clinician.

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