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Jan Bransen & Gerrit Glas

When we first anticipated the research project concluded with this special issue, about 8 years ago, it seemed timely and appropriate to investigate the opportunities and the challenges of self-management in mental health care. At the time self-management was well on the rise in general health care, offering both empowerment to patients and efficiency and cost-effectiveness to the health care system. It seemed a most promising approach in an era that celebrates individualistic self-reliance. And we were sure about our insight that self-management in *mental* health care would deserve comprehensive investigation because "the self" that was supposed to do the management would itself be the core problem in psychiatric and psychosomatic conditions.

Now that the project is over and done with some changes seemed to have happened in the general appreciation of individualism and of the dominant kind of management. As we are writing this during the coronavirus disease-19 crisis—locked up at home obeying the instruction to keep physical distance—these changes seem to accelerate. We cannot do it alone. And we should not think of self-regulation in terms of decisive control. Solidarity and entrustment markedly strike home.

It may be that we have picked up the *Zeitgeist* in our research or have played a role ourselves in bringing about these changes. Either way, the results discussed in this issue certainly resonate with a transformation that might be in progress. In this concluding article we want to highlight two novel features of our understanding of self-management as it turned out to find articulation in our investigations. One feature concerns a shift in our understanding of management, a shift away from decisive control towards an embedded facilitation. We can follow this shift along three lines of analysis, which concern different scaffolding resources: environmental cues, language and caregivers. The other feature concerns the acknowledgement of a potentially persistent ambiguity of the self as an element of self-management. The preceding articles display the conceptualization of this ambiguity along five different dimensions of "the self": responsible agency, experiential subjectivity, personal integrity, narrative authority and existential concern.

The Shift Toward Embedded Facilitation

Strijbos and Slors (2020) make an interesting distinction between management-as-control and management-as-facilitation. They use the etymology of the verb "to manage"—derived from the Italian verb "maneggiare," which means the capacity to direct or exercise a horse—to point out an interesting difference between driving a

car and driving a herd of cattle. The behavior of a herd is, as they emphasize, "dynamically complex, responsive to several external and internal factors … , and therefore heavily context-dependent." (Strijbos & Slors, 2020, p. **361**). To manage a herd, to drive it through a terrain is therefore not simply a matter of directly and explicitly controlling the herd's behavior. It is rather a matter of using one's knowledge of the terrain and one's knowledge of how the herd responds to salient features of the terrain to drive the herd by manipulating the saliency of those features. This is much more indirect than driving a car. To drive a car you need to be in the driver's seat from where you can push and pull the wheel and the pedals which will mechanically bring it about that the car will go wherever you want it to go. The design of the car will allow you to use the linear causality of the car's mechanism to control its movements. But such straightforward causal control of the herd's behavior is not available. To manage a herd, Strijbos and Slors argue, requires a different kind of management. They call it management-by-facilitation, because the kind of activity you can undertake to manage a herd, to drive it in the direction you want it to go, is a matter of facilitating the herd to respond appropriately to the environmental cues you manipulate.

Self-management can take both forms. It can be a matter of control, a matter of being in the driver's seat, as in the case of a patient with diabetes who monitors her blood sugar level and injects insulin in her own body when needed. But it can also adopt the form of shaping a niche in which the patient can live, as might be the case in patients with autism who benefit from regularity in daily rhythms and occupational activities and from absence of distractions in their physical environment.

One of the main results of our research is that in psychiatry and psychosomatic medicine self-management can much better be conceptualized as a matter of facilitation. For many people with a psychiatric or psychosomatic condition, self-management mainly is a matter of helping oneself by manipulating one's environment such that it becomes easier, more obvious, more *manageable*, to respond appropriately to the challenges you face because of your condition.

The articles collected in this issue discuss three kinds of scaffolding resources that people with a psychiatric or psychosomatic condition can use to facilitate their self-management: environmental cues, language and caregivers. We will first discuss these three kinds of scaffolding and then focus on the ambiguities of the self that complicate the efforts that aim at facilitation.

Environmental Cues

There is a wide variety of environmental features that can be used to facilitate self-management, the absence of which might be used to explain what hinders people with psychiatric or psychosomatic conditions to manage themselves. Dings and Glas (2020), for instance, discuss a wide range of complicating factors such as social pressure and stigma, but also something quite specific such as the context-insensitivity of the *Diagnostic and Statistical Manual of Mental Disorder*. An environment, they argue, that is professionally organized on the basis of a context-insensitive disease model like the *Diagnostic and Statistical Manual of Mental Disorders*, is short of environmental cues that are useful for self-management; nor does it provide guidance for personalized treatment. Something similar is discussed by Franssen (2020), who shows how the medical interpretation of chronic fatigue syndrome (CFS) impedes patients with CFS to manage themselves. Interestingly, Franssen makes a case for the significance of popular autopathographical memoirs as environmental cues for fellow patients and non-diagnosed lay readers to facilitate their self-management.

Language

Both Dings and Glas and Franssen emphasize in their discussions the role of language as a powerful and significant environmental tool for the facilitation of self-management. How we talk about mental disorders, or about an "invisible illness" such as CFS, matters a lot for how the patient's attitude to the illness is shaped. Part of the job in self-management strategies is to unravel these, often implicit, influences of lingual cues on patient attitudes. It is precisely with respect to this role of language, that we developed our humani-

ties approach to self-management in psychiatry and psychosomatic medicine. Distinguishing as Strijbos and Slors argue between management-as-control and management-as-facilitation is not only a practical but also a conceptual and interpretative strategy. It helps to see how language can be used to build the "house" in which the patient can live. Metaphors, stories and interpretations will be shared with peers and professionals. They help shape the verbal niche in which patients are able to grasp what is going on. This is even more needed in conditions in which it is the patient's "self" that is the core problem.

Caregivers

A crucial part of people's environment are the social practices in which they participate. Those practices receive special attention in the article by Brandenburg and Strijbos (2020), especially our moral practice of holding one another responsible. Advocating self-management might seem to involve a shift of responsibility from the health care system to the patient. If successful, such a shift would contribute to the efficiency and cost-effectiveness of the health care system and it might empower patients. But it is risky for patients with a psychiatric or psychosomatic condition, as it would deprive them from appropriate cues for self-management provided by dedicated caregivers. Brandenburg and Strijbos explore two stances caregivers can take towards people struggling with self-ambiguities in their responsible agency: the clinical stance and the nurturing stance. Both provide service users in health care contexts with useful cues to facilitate their self-management. The clinical stance may offer service users effective cues for guided "self-management" when they are for some reason unwilling to engage in a therapeutic process. But when service users are committed to recovery and when they trust and accept the therapeutic relation between them and their caregivers, the nurturing stance offers the most appropriate cues for the advancement of self-management.

Self-management-as-control may have been, and probably may still be, the dominant kind of management in the general health care system. But in mental health care we need a different kind of management: self-management-as-facilitation. This kind of management, as Strijbos and Slors argue, crucially involves person specific, context sensitive interventions that depend for their success on scaffolding resources. These resources do exist, but in important ways their contribution requires us to accept that self-management in mental health care does not involve an individualistic kind of self-reliance. It is instead, as Dings and Glas emphasize, at its core, a social endeavor, especially, as pointed out by Strijbos and Slors, when the patient's managerial capacities are at stake.

Acknowledging Self-Ambiguity

One of the reasons why we should favor socially supported self-management-as-facilitation in mental health care is because people with a psychiatric or psychosomatic condition characteristically suffer from a potentially persistent "self-ambiguity" (Dings, 2019; Sadler, 2007). This ambiguity is much better accounted for in the self-management-as-facilitation than in the self-management-as-control approach. This predicament of psychiatric patients is the focal point of the article of Dings and Glas, but it also figures prominently in the other articles brought together in this issue. Self-ambiguity takes many different forms, depending on which dimension of the self we are talking about. The articles in this issue display at least five different dimensions, which we shall briefly recapitulate here: self-illness ambiguity in responsible agency, in experiential subjectivity, as threat to personal integrity, as a challenge for narrative authority, and as existential concern.

Responsible Agency

A dominant way in which a person's self appears on stage is in terms of the person's agential capacities. People perform actions. They do things in the world, display activity, bring about certain changes. We tend to keep people responsible for what they do, tend to think that we can know them by virtue of what they do, that is, that their selves are expressed in their actions. Analyzing the responsible agency of a person can take many forms and one of the targets of Strijbos and Slors's distinction between management-as-control

and management-as-facilitation is to get rid of a dominant but inappropriate conception of this agency in terms of consciously controlling one's behavior. Agency is not best understood, they argue, if we try to conceptualize it as a matter of consciously bringing about changes in the world by initiating bodily movements. If this is right, responsibility is not best understood in terms of causal accountability. This has repercussions for how to understand the "self-illness ambiguity" introduced in the discussion by John Sadler (2007). The distinction between self and illness, especially when reified, as critically discussed by Dings and Glas, might suggest a simple picture, as if my behavior is either consciously brought about by my *self*, or by the illness that inhabits me as an alien daemon. Whether the patient sees the illness as a thing inhabiting her or as an expression of who she is, will in real life depend on the nature of the problem, the stage in the illness history and the context. Simplicity will not give us a satisfactory understanding of the agential ambiguities that trouble people with a psychiatric or psychosomatic condition. What is needed is careful, phenomenological and contextual sensitive analysis of what patients experience and tell in real life.

We learn more about self-ambiguity by Brandenburg and Strijbos' analysis of the practice of ascribing responsibility. In this practice there is a certain shift from the attempt to analyze in detail what is going on in an agent who *knowingly and willingly* displays harmful conduct to an analysis of the sense of entitlement to feelings of resentment of those who have to withstand the harm. In mental healthcare contexts service users sometimes display harmful conduct. The attempt to settle in such cases the ambiguity about whether or not these service users responsibly acted harmfully might be futile if we would focus on the question whether they consciously controlled their behavior. But we might, or so Brandenburg and Strijbos argue, cope with the ambiguity by taking one of the stances they discuss, Pickard's clinical stance (Pickard, 2013) or Brandenburg's nurturing stance (Brandenburg, 2017). Those stances do not dissolve the ambiguity of the responsible agency of people with a psychiatric or psychosomatic condition, but resonate with this ambiguity either by applying responsibility without blame or by engaging in nurturing reproach, thus facilitating the service user to manage their own responsible agency as a fragile feature of a shared practice.

Experiential Subjectivity

A second dimension of self-ambiguity is discussed particularly in Franssen's article as well as in Dings and Glas. Franssen astutely elaborates on the phenomenological character of the indeterminacy of autopathographies. Patients who suffer from CFS deeply experience the indeterminacy of their illness, as if, in Rehmeyer's image "the illness felt a bit like Schrödinger's cat: neither dead nor alive" (quoted via Franssen, 2020). Even if the "sick self" clearly experiences being sick, it is—precisely in this clarity—phenomenologically obvious that having FSC is an ambiguous, inherently indeterminate experiential state. In a similar vein Dings and Glas describe strong experiences of phenomenological ambiguities, as if actions, thoughts and feelings that occur to psychiatric patients in some sense feel external, as if it is inappropriate for these patients to identify those actions, thoughts and feelings as their own. Managing this subjectively experienced ambiguity is, according to Dings and Glas, a matter of reducing the ambiguity. Reading autopathographies, or so Franssen argues, might be a way to facilitate such a reduction.

Personal Integrity

Importantly, self-ambiguity often involves a kind of inner, motivational or experiential split, as if one is not an integrated person. This dimension of the self, this lack of wholeheartedness in Frankfurt's well-known phrase, is discussed in most of the articles (Frankfurt, 1988, chapter 12). Accepting one's illness as a chronic condition that is here to stay even though it might seem a strange, alien, external, and unwelcome feature that interferes with one's life is a dominant theme in psychiatric or psychosomatic self-management. Dings and Glas discuss self-management as the challenge to achieve a form of congruence, to somehow create a meaningful order in which there is room for what appears to be alien but what might nevertheless acquire a sense of familiarity. Reducing self-ambiguity becomes a way of building personal integrity.

Franssen discusses this dimension of self-management diachronically, as a dynamic history reported in the autopathographies he studied. These narratives show a characteristic development, moving from loss to recovery, involving a mental transformation. The narratives, Franssen argues, typically follow a path that entails a sequence of plots, first a restitution plot suggesting a straightforward, medical recovery from illness, then a chaos plot in which bewilderment takes place and in which the patient's personal integrity is lost, and finally a quest plot in which a kind of self-shaping has to take place, a mental transformation or personal growth. The dynamic typically involves the loss of one's old self and the eventual acceptance and appreciation of a new self.

Brandenburg and Strijbos discuss this dimension of managing the self as a relevant feature of the practice of holding one another responsible. Personal integrity plays a role in this practice in the recognition of oneself as an equal and valuable community member. The nurturing stance of a caregiver conveys the message that the service user is taken seriously as a person. Even though the service user is not to be blamed for their harmful conduct, they are recognized and treated as a member of a shared norm-guided practice. In this way the caregiver facilitates the service user to manage themselves and to foster the service user to act as an integrated person.

Narrative Authority

Narratives play a profound role in people's self-understanding. Both as narrators and as protagonists people receive support by the narrative schemes that enable them to make sense of their lives. It is therefore no surprise that narrative authority plays a role in accounts of self-management. This is specifically true of Franssen's article that explores this role in detail by analyzing three illness memoirs that have offered both their writers and their readers meaningful insights into the dynamics of coping with a medically unexplained and undiagnosable illness: CFS. Franssen discusses the question of the epistemological reliability of these autopathographies, focusing on the rhetoric of telling a good story, the subjective phenomenology of the illness and the background of medical science that have long tended to suggest that the illness is "all in the mind." Even though there are epistemological limitations, Franssen shows that it is precisely the inherent indeterminacy of the illness and the challenge of the writer to capture in words the ambiguities and uncertainties that dominate a life with CFS, that grant these autopathographies with a specific narrative authority. It is a fragile authority that comes with acknowledging and accepting that the story to be told about oneself is an ambiguous story, a story that displays the self-ambiguity of both the author and the protagonist of their story.

A similar theme is discussed by Dings and Glas who explore the possibilities of reducing self-ambiguity by what they call "narrative self-appropriation." Somehow, of course, acknowledging self-ambiguity seems itself to be a rather ambiguous endeavor and a real challenge for facilitating self-management. This brings us to the final dimension of the self to be managed.

Existential Concern

When we first started to think of the research project concluded with this special issue, we were quite convinced that self-management in *mental* health care needed serious investigation because "the self" that does the management is itself the core problem in psychiatric and psychosomatic conditions. Being philosophers, mostly, we also were quite convinced that our investigations would not result in a neat and practical guide that would help psychiatric and psychosomatic patients to manage themselves successfully. We hoped that we would contribute to an improvement of the questions to be asked about self-management in psychiatry and psychosomatic medicine. But we were not so naïve to believe that we would be able to resolve the existential concern that comes with the need to live one's own life when this life is a painful muddle and one's capacity to live it seriously damaged. Philosophical theorizing definitely has its limits.

Yet, there may be some practical results to be wrapped up from our investigations. Management-as-facilitation seems to deserve special attention in psychiatric self-management strategies. That is, self-management is a socially embedded endeavor.

It needs a social (and emotional) environment that provides ample scaffolding resources. This scaffolding aims at resolving or, at least, diminishing the self-illness ambiguity, by making the existence of the illness in one's life bearable and easier to adapt to. Facilitating change in this sense is not a straightforward manageable activity. Facilitation may, initially or ultimately, deepen the existential concern, i.e., the ambiguity between who one is and who one imagines or desires to be; between oneself with and oneself without the illness; between oneself with the illness in a facilitating and in a non-facilitating environment. Context and personal stance towards one's illness are deeply intertwined.

Theoretically speaking, that is a further result of our investigations, a result that might have practical consequences, or so we believe. Self-management in mental health care seems to require that we acknowledge a potentially persistent and many-faceted ambiguity of the self. Such an ambiguity may haunt all of us, some of the time. Self-knowledge, self-love, self-acceptance and self-management can be deeply puzzling challenges, especially whenever, in the words of Dings and Glas, there are serious disruptions between one's unreflective self-experience and one's reflective self-understanding. People suffering from psychiatric or psychosomatic conditions face this existential concern with much more profundity. It is their predicament to develop a mode of self-management that opens up the mental space to appropriate their enduring self-ambiguity. It is our predicament to facilitate them by taking up a nurturing stance.

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