

The (Un)managed Self: Paradoxical Forms of Agency in Self-Management of Bipolar Disorder

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Abstract Self-management of mental illness is a therapeutic paradigm that draws on a distinctly biomedical conceptualization of the isolability of personhood from pathology. This discourse posits a stable and rational patient/consumer who can observe, anticipate, and preside over his disease through a set of learned practices. But in the case of bipolar disorder, where the rationality of the patient is called into question, the managing self is elusive, and the disease that is managed coincides with the self. While humanist critiques of the biomedical model as applied to mental illness have argued that its logic fatalistically denies patients intentionality and effectiveness (Luhmann, *Of Two Minds: The Growing Disorder in American Psychiatry*, 2000), biomedical proponents claim that psychiatry's way of envisioning the body as under the control of the intentional mind actually returns agency to the patient/consumer. Rose (*The Psychiatric Gaze*, 1999) remarks that biomedical models have the potential to "[open] that which was considered natural to a form of choice" (p. 37), and that techniques of medical self-control help constitute the free embodied liberal subject who is obliged to calculate and choose. Through an examination of clinical literature as well as the practices and narratives of members of a bipolar support group, this paper explores ethnographically the possibilities for subjectivity and agency that are conditioned or foreclosed by the self-management paradigm, which seems to simultaneously confer and deny rational selfhood to bipolar patients. To express their expertise as rational self-managers, patients/consumers must, paradoxically, articulate constant suspicion toward their present thoughts and emotions, and distrust of an imagined future self. I argue that through their self-management practices, bipolar support group members model provisional and distributed forms of agency based on an elusive, discontinuous, and only

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partially knowable or controllable self—revealing, perhaps, the limits of the contemporary reification and medicalization of both selfhood and disease.

Keywords Self-management · Bipolar disorder · Agency · Subjectivity

I neither willed with my whole will nor was I wholly unwilling. And so I was at war with myself and torn apart by myself. And this strife was against my will; yet it did not show the presence of another mind, but the punishment of my own.

—Augustine, *Confessions and Enchiridion*¹

Introduction

In a donated basement of a private psychotherapy center, members of DBSA²—a national organization for people living with mood disorders—are talking casually before the official start of their weekly support group meeting. Predominantly in

¹ I am indebted to one of my anonymous peer reviewers for directing my attention to this passage.

² DBSA, or the Depression and Bipolar Support Alliance, is a patient-directed national not-for-profit organization that was founded in 1985. According to its mission statement, DBSA provides “hope, help, and support” to people living with bipolar disorder through “peer-based, recovery-oriented, empowering services and resources *when* people want them, *where* they want them, and *how* they want them” (http://www.dbsalliance.org/site/PageServer?pagename=dbsa_aboutdbsa, emphasis in original). Between May of 2009 and January of 2010, I attended nearly every weekly 90-min support group meeting of a DBSA chapter. I often arrived early and socialized with my informants in a local coffee shop or in the meeting room, and usually stayed after the meetings, when people would hang out and smoke outside of the center. During the meetings, I participated in weekly introductions and closing “games” (each week, a different person was responsible for coming up with a question—which ranged from “What is your favorite food?” to “You have a bulldozer and can bulldoze one person or thing; what do you pick?”—for everyone to answer). I did not generally speak during the meetings, although on a few occasions I was asked personal questions and answered those honestly. I received permission from the group’s clinical leader to take notes during the meeting, but not to use a recording device. I also confirmed each week that those present were comfortable with my attendance and observation. Apart from attending support group meetings, I conducted semi-structured interviews with five members: Warren, James, Christine, Kurt, and Tricia. These interviews ranged from 1.5 to 4 h in length, and were recorded and transcribed.

The individuals described in this paper are those with a diagnosis of Bipolar Disorder 1 or 2 who regularly attended meetings and considered the support group to be an important component of their therapeutic regimen. I chose to focus on their narratives partly for pragmatic reasons—I had more of an opportunity to become well acquainted with regular support group attendees than with those who come only once or infrequently—but also theoretical ones: I wanted to study the cultivated subjectivities of people who not only accept and believe in their mood disorder diagnosis, but also make a constant, vigilant effort to self-manage. Insofar as the biomedical paradigm of self-management, and the broader notions of rational personhood and choice from which it draws, are the concerns of this paper, I do not claim that the issues I describe are representative of all or even most people with bipolar disorder. Instead, if any generalizations can be drawn, they are at the level of theoretical questions about selfhood, rationality, and agency and not specific to those classified as mentally ill. Because of their putative irrationality juxtaposed with the incitement to highly rational enactment contained in the therapeutic paradigm, however, bipolar self-managers render particularly visible certain paradoxes and contradictions of governmentality through their practices.

their twenties and thirties, they commute from all over the city, and although as usual there are a few new faces in the room, the group “regulars” look forward to this time to catch up with what for many have become their closest or only friends. Several people arrive in work clothes; others may mention later during the meeting that this is the first time all day, or all week, that they have gotten dressed and left home. Nonetheless, with few exceptions the presentation of members and the tone of discussion in the space of the support group room are notably “normal”; the diagnosed conditions of major depression and bipolar disorder that unite the members of the group and occasion their presence in this basement are referenced and rationally analyzed, but seldom enacted. The irony of the situation doesn’t escape the group. On this holiday season evening, when a bipolar woman³ arrives from a crowded store late and flustered, announcing that “people are *crazy* this time of year,” another member doesn’t miss a beat in delivering the response: “Yeah, kind of makes *us* less special!”

As the meeting gets underway, people raise and discuss issues ranging from the everyday to the existential. The only criterion, invoked weekly by the clinical leader who recites a list of support group rules, is that the discussion relates in some way to depression or bipolar disorder. Members are encouraged to manage the discussion among themselves, and to intervene if they feel that their peers are veering too far off topic.

On this particular evening, the group lands on the subject of psychiatric hospitalization, an experience familiar to many, but not all, of those present. Jessie,⁴ a bipolar woman in her mid-twenties wearing a tee shirt that reads “I wish my lawn was emo so it would cut itself,” poses a question in her usual bored-yet-slightly amused tone:

So, how come some of you are always getting hospitalized, and I’ve never been? I mean, my aunt tried to make me go once because I was cutting myself, but I was cutting *responsibly*. It’s my coping strategy, and I knew I wasn’t trying to *kill* myself, and I told them that at the hospital, so they didn’t admit me. I told them “I’m not going to kill myself, I just want to lay in bed for a week,” and that’s what I did. So how do you *decide* if you need to be hospitalized? How do I know if *I* need to go to the hospital?

Tricia, a bipolar woman in her late thirties, responds with an anecdote:

Well for me, getting hospitalized is the way I reset myself. I think of it like my two-year tune-up; that’s about how often I need to go, and I can usually tell when I start showing signs that it’s time for a tune-up. The most recent time, I knew for a couple of weeks that I needed to go, and I kept telling my boyfriend

³ Throughout this paper, I generally choose to use the phrase “bipolar person” as opposed to “person with bipolar disorder” in order to avoid reinscribing the notions of the discreteness and separability of rational selfhood and disease that I seek to interrogate. To further explore the ramifications of this choice, I take up debates about “I am” versus “I have” language ethnographically and within anthropological literature later in the paper.

⁴ In accordance with federal privacy regulations, support group members’ names have been replaced with pseudonyms.

to take me, but he'd say "oh, I don't feel like it tonight," or "next week; we have plans this weekend." I got so frustrated that while I was shaving my legs, I took the razor—I don't cut often anymore, but when I cut I *know* it's time for me to go to the hospital—and I did, and then I showed my boyfriend and was like "look—I'm *cutting—I need to be hospitalized.*" So he finally took me. I could have just driven myself, but I wanted to *be hospitalized*, you know?

Jessie's question and Tricia's story illustrate a complex and often contradictory model of selfhood, mental illness, rationality, and agency that is the larger focus of this study. Jessie does not simply wonder why she has never been hospitalized. Instead, she asks how one *knows* and *decides* whether one needs to be. Her very questions disrupt the logic of psychiatric hospitalization for bipolar disorder as it is popularly imagined, whereby a floridly manic or suicidally depressed patient, decidedly out of control, is brought to an institution by someone more capable of rational judgment. Likewise, Tricia's response reveals some surprising spaces of negotiation and indeterminacy between self-knowledge, self-control, and rational decision-making. In the following, I argue that Jessie, Tricia, and other bipolar members of the support group model a form of discontinuous selfhood and distributed⁵ agency produced at the intersection of their experiences living with a condition that calls their rationality into question, and their engagement with a therapeutic modality known as self-management that entails extremely rational practices of calculation, prediction, and self-surveillance. In so doing, they render particularly visible more universal contradictions and dilemmas contained within the premises of neoliberal selfhood.

As Emily Martin (2007) has eloquently described, "being known as a manic-depressive [or bipolar] person throws one's rationality into question" (p. 5). Such a designation carries high stakes for the diagnosed, both in terms of its practical implications and its foreclosure of claims to foundational aspects of personhood in Western society. While the ontological and legal status of the mentally ill has shifted, through various disciplining practices and technologies, from little more than beasts in the seventeenth and eighteenth centuries to potentially recuperable citizens by the nineteenth (Scull 1989; Foucault 1967), Martin argues that a vastly overdrawn yet powerful divide still demarcates and degrades those classified as irrational:

[A] diagnosis of major mental illness, in practice, if not in law, often disqualifies a person from high-security clearance, from employment of various kinds, from political office, from insurance coverage, and from college enrollment. Some kind of terrible abyss is still thought to divide "normal people" from the "mentally ill" (Martin 2007, p. 87).

Martin's seminal ethnographic research on mania shows that within this imagined abyss, there exists a wide range of complex social experiences that blur the boundaries between rational and irrational. Deliberate enactments of mania that Martin observes, for example, effectively index the diagnosed person's volition and

⁵ I am grateful to Emily Martin for discussing this vignette with me at an early stage of my writing process and suggesting the term 'distributed' for the style of agency that I was describing.

awareness of his or her putative irrationality, thus illustrating that he in fact possesses key attributes of rationality. Likewise, clinicians and rational bureaucratic organizations can be viewed as acting irrationally when they elect to place a mentally ill person in a managerial role (*ibid.*, p. 95).

This paper examines a related but distinct dimension of the relationship between bipolar disorder and rational selfhood: the injunction that certain types of people who have been designated as chronically mentally ill, particularly those diagnosed with bipolar disorder, undertake a project of vigilant self-management as the pivotal component of their treatment regime. Rooted in a biomedical distinction between person and disease, the very term “self-management,” when applied to bipolar disorder, contains an unintended dual meaning which foregrounds the difficulty that people with this diagnosis face in locating themselves in the space between rationality and irrationality: While meant to emphasize the diagnosed person’s central role in taking responsibility for the everyday management of his *disease*—management of bipolar disorder *by* the self—the term is suggestive of a slippage; the management *of* a self. This ambiguity is borne out in the experiences and practices of bipolar individuals such as many of the members of DBSA, for whom participation in a weekly mood disorder support group discussion is a component of their conscious self-management efforts. Whereas Martin draws our attention to the forms of rationality that are obscured by psychiatric classification, I ask what possibilities for subjectivity and agency are conditioned or foreclosed by a biomedical paradigm that seems to simultaneously confer and deny rational selfhood to bipolar patients.

Self-management approaches to the treatment of bipolar disorder have been widely lauded in the clinical literature as empowering the patient, who is more often in this context referred to as a “client” or “consumer,”⁶ to regain control of his or her life (Depp et al. 2009). But the practices and modes of thinking envisioned within this therapeutic modality would hardly include or predict those described by Jessie and Tricia above. I suggest that this is because the paradigm of self-management engages in two forms of reification⁷ that are unsustainable in ways that become particularly apparent in the case of bipolar disorder. First, the paradigm posits a stable and rational managing self who can observe, measure, anticipate, and preside over a disease separable from the self. Such an imagined subject draws upon broader notions of a kind of compulsorily free *homo economicus* who satisfies the demand of neoliberal government for “active individuals seeking to ‘enterprise themselves,’ to maximize their quality of life through acts of choice” (Rose 1996, p. 57). Never fully realizable, this choosing self is experienced as especially elusive for people diagnosed with bipolar disorder, who on the one hand are enjoined to

⁶ A brief genealogy of the notion of the patient as consumer is provided below. For a more detailed account, see McLean (1995, 2000).

⁷ While the objective of this paper is not to make an explicitly Marxist argument, I employ the term “reification” following Taussig (1980). Drawing on his conversations with a terminally ill patient about the patient’s search for meaning in her symptoms, Taussig illustrates that “medical practice is a singularly important way of maintaining the denial as to the social facticity of facts” (p. 5). Here, I wish to emphasize that the delineation of rational self and bipolar symptom in the self-management literature similarly mystifies a set of social, intersubjective, and embodied relations.

take on a hypervigilant form of rational self-surveillance, but on the other hand in order to do so must constantly second-guess the rationality of their every thought and feeling. Contrary to the discourse's implicit promise, it seems, the more that bipolar patients/consumers take on a project of self-management, the greater the ambiguity generated around delimiting a rational, agentive self. Second, the reification of bipolar disorder as an isolable "disease" to be managed fails to adequately describe the ways in which it is experienced as neither a fixed object nor apart from the self, but rather as a temporal formation that expresses or realizes the self in a particular, if pathological, way.

In the sections that follow, I first elaborate several divergent perspectives in the medical anthropological literature on the relationship between biomedical subjectivity and agency. Then, I briefly review the history and biomedical characterization of bipolar disorder, as well as the emergence of self-management—a paradigm borrowed from chronic physiological conditions such as diabetes and heart disease—as a therapeutic modality thought to be especially effective and appropriate for the treatment of certain mental illnesses. Next, I look at self-management materials such as clinical workbooks and the bipolar lifestyle magazine *bp*, both of which were frequently cited and circulated among members of the support group, in order to show how the reified, rational choosing self and the controllable disease are imagined within this discourse. Then, I turn to the experiences and practices of members of the DBSA support group as they attempt to enact and locate the managing self and object to be managed. Finally, I return to Tricia's hospitalization narrative to consider the ways in which, through their interactions with the self-management paradigm, bipolar people model provisional and distributed forms of agency based on an elusive, discontinuous, and only partially knowable or controllable self—revealing, more broadly, the limits of contemporary reification and medicalization of both disease and selfhood.

Agency, Responsibility, and Biomedical Subjectivity

Contemporary psychiatric taxonomies and treatment modalities in the United States are increasingly driven by a biomedical model that presumes the isolability of personhood from pathology and focuses on the latter as the object of intervention. Such a model, humanist anthropologists have long argued, carries consequences for "the way doctors perceive patients, the way society perceives patients, and the way patients perceive themselves" (Luhmann 2000, p. 23), often doing violence to the patient's complex psychological experiences and identity. Anthropologist Tanya Luhmann, in her foundational ethnography of the ways in which two competing conceptions (psychoanalytic and biomedical) of personhood and mental illness play out in American psychiatric education and practice, claims that the biomedical model results in the sacrifice of "a respect for the difficulty of human life" (p. 290). The "popularized, vulgarized medical model," she claims, invites a moral instinct of viewing the mentally ill as "not as human, not quite as alive, as we are" because it figures them as having been "struck by something that came in from the outside. It was not under control in the first place, and it remains no more under control than a

doctor can control it” (pp. 284–285). Furthermore, in rendering patients blameless for their psychiatric diseases, this model simultaneously denies patients the capacity for intentionality and effectiveness. Ultimately, Luhrmann worries, the danger of biomedically derived epistemologies is that they preclude the maintenance of a desperately needed “culture of responsibility”—in which, despite constraints of illness and suffering, individuals are compelled to “choose to live good and productive lives”—and instead encourage fatalism and unaccountability (pp. 290–291).

More recently, however, medical anthropologists and science studies scholars have begun to interrogate and re-envision the possibilities for subjectivity, responsibility, and agency conditioned by the biomedical paradigm (Schüll 2006; Sunder Rajan 2005; Lakoff 2005; Rose 1996, 1999, 2003, 2007). Examining modes of selfhood that are emerging out of new medical technologies, these researchers have proposed we are entering an age of such actors and models of being as the genomic “sovereign consumer”/“patient-in-waiting” (Sunder Rajan 2005), the modulating “homo-addictus” (Schüll 2006), and psychiatric taxonomies based not on broad disease categories but on specific medication response profiles (Lakoff 2005, p. 174).

Nikolas Rose in particular has written extensively on the implications of what he views as a contemporary shift to somatic or molecular (as opposed to psychological) selfhood, motivated by the biomedical psychiatric gaze and its related technologies for intervention upon madness. Conversely to Luhrmann, Rose argues that through this gaze, varieties of normality “[become] open not to fatalism but to choice,” individuation, explanation, and manipulation (Rose 1999, pp. 11–12). To be a somatic individual, Rose claims, “is to code one’s hopes and fears in terms of [the] biomedical body, and to try to reform, cure or improve oneself by acting on that body” (Rose 2003, p. 54). For Rose, the somatic subject is afforded a new type of agency and responsibility by means of “the application of what one might term techniques of the molecular self” (1999, p. 37).

According to Rose, the technologies of the psychological sciences in general, and especially those of the emergent somatic individual, are deeply tied to and appear to constitute the free embodied subject of liberal democracy:

The modern liberal self is ‘obliged to be free,’ to construe all aspects of its life as the outcome of choices made among a number of options...The technologies of psychology gain their social power in liberal democracies because they share this ethic of competent autonomous selfhood, and because they promise to sustain, respect, and restore selfhood to citizens of such polities. They constitute technologies of individuality for the production and regulation of the individual who is ‘free to choose’ (Rose 1996, p. 100).

The restoration/subjectification that Rose envisions these technologies as potentiating is distinctly liberal in its linkage of “the notion of self-realization with individual autonomy, wherein the process of realizing oneself is equated with the ability to realize the desires of one’s ‘true will’” (Mahmood 2005, p. 11). Applied to the neurochemical self-management of mental illness, Rose’s perspective would seem to suggest, as does the clinical literature for bipolar

patients/consumers, that learning and engaging in this set of practices will instantiate the ideal neoliberal subject: “an entrepreneur managing his or her own life...that calculates rationally and acts responsibly” (Maasen and Sutter 2007, p. 7).

Bipolar Disorder and the Self-Management Paradigm

Bipolar disorder, formerly termed manic depression, is “an especially intriguing category of illness” because while it is classified as an Axis I major mental disorder in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM), it “seems to exist on both sides of certain key boundaries of mental disorder—in DSM, the boundary between affective and thought disorder, and in psychoanalytic epistemology, between neurosis and psychosis” (Lakoff 2005, p. 33). The liminal status of bipolar disorder in contemporary psychiatry can be situated, in part, by examining a series of theoretical turns over the course of the nineteenth century. These turns ultimately differentiated kinds of madness according to the degree to which they seemed to impair the intellect. This ontology helped to establish the psychosis of mania as qualitatively distinct from that of schizophrenia—a discursive boundary always at risk of dissolution given the often-indistinguishable presentations of the madness states. With the rise of psychopharmaceutical treatments in the mid-twentieth century, manic depression was further set apart from other forms of chronic madness, which had until then all been thought to require lifelong institutionalization: when, in the 1960s, lithium was found to be an effective mood stabilizing treatment for bipolar patients, “bipolar disorder became a rare success story within psychiatry, able to be managed if not cured” (ibid.).

Until the nineteenth century, “mania” was a broad term for madness in general, and “melancholia,” a subtype of mania. In the early 1800s, French psychiatrist Jean-Étienne Dominique Esquirol, a student of Philippe Pinel, introduced the concept of “partial insanity” as a kind of mania that resulted from a dysfunction in affect or volition rather than intellect (ibid.). He further specified melancholia as a distinct state characterized by *sad* affect. The two extremes of mania and melancholia were then brought together in the mid-nineteenth century under one concept of alternating, periodic, or “circular madness” (ibid. ; Martin 2007, p. 18). The emergence of this category of cyclic affective disturbance culminated in German psychiatrist Emil Kraepelin’s radical and famous reorganization of all known mental illnesses in 1899 into two groups. Under Kraepelin’s ontological scheme, *dementia praecox* (the forerunner of schizophrenia), designated diseases of the intellect marked by progressive mental deterioration and bearing an especially poor prognosis, while *manic depressive insanity* was a malady of the emotions and the will that could leave intelligence intact. Kraepelin’s system “continues to operate with force in contemporary psychiatric taxonomies, shaping the division between cognitive and affective disorders” (Martin 2007, p. 18).

With Kraepelin’s system and the closely related “DSM-III revolution” (Young 1995) in 1980, manic depression was re-termed “bipolar disorder,” and subsequently broken down into several different subtypes. The most recent edition of the

diagnostic manual includes two broad categories of the disorder—Bipolar 1 and Bipolar 2—and six separate criteria sets for Bipolar 1. A diagnosis of any subtype of Bipolar I Disorder requires a history of at least a single manic or “mixed”⁸ episode. Symptoms of manic episodes include “a distinct period of abnormally and persistently elevated, expansive, or irritable mood,” “inflated self-esteem or grandiosity,” “flight of ideas or subjective experience that thoughts are racing,” “increase in goal-directed activity,” and “excessive involvement in pleasurable activities that have a high potential for painful consequences” (American Psychiatric Association 2000). Bipolar 2 is defined by a history of at least one major depressive and one “hypomanic” episode, and the absence of a history of a manic or mixed episode. Both Bipolar 1 and 2, then, are characterized in psychiatry by the notion of discrete mood episodes that in turn have effects on the rationality of the diagnosed person’s thoughts and actions.

Today, according to research conducted at the National Institute for Mental Health (NIMH), bipolar disorder is said to affect more than 2.3 million United States residents (Bipolar disorder research at the National Institute of Mental Health, 2000). Resources for patients/consumers such as the NIMH website describe bipolar disorder as a disease caused by “abnormalities in brain biochemistry and in the structure and/or activity of certain brain circuits,” that fortunately can—and *must*—be vigilantly managed “to achieve and maintain a balanced state.” (ibid.). At the same time, the website reminds patients of the peculiar nature of the disorder, and of the ways in which the disease may entice the insufficiently vigilant with productivity and euphoria into irrational and deadly behaviors. This warning is conveyed through a quotation by Kay Jamison, the influential author of *An Unquiet Mind*⁹:

Manic-depression distorts moods and thoughts, incites dreadful behaviors, destroys the basis of rational thought, and too often erodes the desire and will to live. It is an illness that is biological in its origins, yet one that feels psychological in the experience of it; an illness that is unique in conferring advantage and pleasure, yet one that brings in its wake almost unendurable suffering and, not infrequently, suicide (Jamison 1995, in Bipolar disorder research at the National Institute of Mental Health 2000).

The discourse of bipolar disorder as a disease in particular need of active management also grew out of the increasingly complex pharmaceutical “cocktails” with which clinicians began to treat it. Although lithium is still used in the treatment of bipolar disorder, recent decades have seen a flooding of the market with dozens of new psychopharmaceuticals that purport to provide increased control of the

⁸ “Mixed episodes” include symptoms of both mania and major depression.

⁹ Jamison is a clinical psychologist and professor whose published work for lay audiences includes *Touched with Fire* (1993) and *An Unquiet Mind: A Memoir of Moods and Madness* (1995). In *Touched with Fire*, Jamison marshaled historical evidence to assert that manic depression is associated with creativity and artistic ability, and that the diagnostic category can be retroactively applied to figures such as Virginia Woolf, Lord Byron, and Vincent van Gogh. Jamison subsequently revealed her own struggles with manic depressive illness in her memoir, *An Unquiet Mind*. As Emily Martin notes, “it would be hard to exaggerate the impact of Jamison’s work, which has been featured in major newspapers, magazines, and documentary films” (Martin 2007, p. 23).

disease through specificity of neurochemical effect. As such, drug treatment regimes for bipolar disorder today are often elaborate and consuming projects. This aspect of living with the disorder, together with the psychiatric notion of the bipolar patient as intellectually intact, has given rise to a conception of bipolar disorder as a mental illness extraordinarily well suited to the self-management modality.

One of the earliest appearances of the term “self-management” was in a book by Thomas Creer about the rehabilitation of chronically ill children written in the 1970s (Lorig and Holman 2003). The book drew on the early writing of Canadian psychologist Albert Bandura, who proposed the construct of *self-efficacy*—the belief in one’s “capacity to exercise control over one’s own thought processes, motivation, and action”—as central to human agency (Bandura 1989, p. 1175). Creer referred to “self-management” in his research to indicate that the patient was self-efficacious, and an active participant in his own treatment. Subsequently, Professor of Health Education and clinician Kate Lorig elaborated upon the term and it grew to be widely used, particularly in the literature on patient education programs for chronic physiological diseases such as diabetes, hypertension, asthma, and arthritis management. Lorig and others cite medical management, emotional management, and the development of skills in problem solving, informed decision-making, and action planning as among the components pivotal to successful disease self-management (Lorig and Holman 2003; Bodenheimer et al. 2002).

In the 1980s, the concept of self-management was picked up by the recovery movement in mental health, a grassroots self-help initiative originated by mentally ill “ex-patients”/“ex-inmates” and emphasizing the restoration of their identities and meaningful roles in society (Depp et al. 2009; Mueser et al. 2002; U.S. Department of Health and Human Services, 1999). Founded in the early 1970s by a small group of antipsychiatry political activists who came from middle- and upper-class backgrounds, the recovery movement in its earliest years took an ardently anti-medical position, opposing involuntary commitment as well as the acceptance of government funds for mental health services (McLean 2000). But after a decade of uneasy alliance with an association of self-proclaimed “radical therapists,” and sharp declines in attendance at the group’s Conference on Human Rights and Against Psychiatric Oppression, some ex-patients began to feel that the recovery movement had become disorganized and ineffectual, and thus advocated for reform from within. These reformers started attending annual meetings of the American Psychiatric Association, and engaging in dialogue with the mental health professionals with whom the movement had formerly eschewed all interaction. Citing the growing problem of homelessness and poverty among the discharged ex-patient community, they pushed for a strategy that accepted the medical model of mental illness and empowered patients to optimize their lives by exercising consumer choice in the treatment marketplace.¹⁰ Debates that ensued following this reformist turn exposed

¹⁰ It is ironic, of course, that “empowering” ex-patients who had little social or economic capital to exercise consumer choice in many ways only served to “[exaggerate] preexisting differences in a two-tiered treatment system” (McLean 2000, p. 830). McLean notes that while being a patient/consumer in the private sector meant already having the power to “shop for” the therapeutic services that one actively chose, the same empowerment in the public sector “produced consumers who ‘consumed’ treatment without exercising any choice in clinician or control over treatment” (ibid.).

“the anarchistic, radical reformist, and conservative ideological differences and the class differences in the [recovery] movement” (ibid., p. 825). Ultimately, these differences led to the creation of two separate national organizations: the more conservative National Mental Health Consumers’ Association, and the staunchly anti-medical National Alliance of Mental Patients (later renamed the National Association of Psychiatric Survivors). As a result, “the ex-inmate/ex-patient movement became transformed into a more organized, though politically more divergent, ‘consumer/ex-patient’ movement..., whose ideologically diverse members were willing to work with the mental health system and government agencies” (ibid., p. 826).

By 2004, “recovery” was cited by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) as the “single most important goal” for the country’s mental health service delivery system (National consensus statement on mental health recovery 2004). As defined in a consensus statement developed by a panel of 110 mental health consumers, providers, and government officials, “recovery” centered around notions of self-governance, consumer choice, and responsibility:

Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self determined life. By definition, the recovery process must be self- directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness (ibid.).

As such, the discourse of psychiatric self-management, in parallel with the evolving recovery movement, expanded from being about a belief in one’s own efficacy and ability to participate in disease treatment to describing a fundamental component of citizenship that entails both rights and responsibilities. The bipolar patient came to be envisioned as an ideal neoliberal subject in potentia who, though suffering from a disease that threatens to destroy the basis of rational thought, has the capacity to fully manage the disease and determine his or her own destiny through rational choice.¹¹

Envisioning Self, Disease, and Agency in Clinical Discourse

This section develops an account of the ways in which self and disease are imagined, and the kinds of relationships posited as instantiable, within the literature on bipolar

¹¹ While my focus in this section and in the study at large is limited to the self-management modality and experiences of its enactment in the contemporary United States, it bears mention that recent cross-cultural literature on bipolar disorder—particularly in sites that are undergoing processes of neoliberalization or transitioning toward a market economy—speaks to the findings and arguments in this paper. Emily Ng (2009), for example, describes how in the city of Shenzhen, China, “narratives of individual responsibility and self-blame for illness control were prominent among patients of the post-Mao generation (those who grew up in the post-1980s economic reform era in China), while such narratives were almost absent in patients who reached their adolescence during the Maoist era” (p. 430).

disorder self-management. In the practices and technologies advocated in these texts, 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.

The Reified Managing Self

The Bipolar Disorder Survival Guide (Miklowitz 2002), a resource that was regularly referenced during conversations between members of the DBSA group, speaks directly in the second person to the presumed diagnosed reader. Written by a clinical psychologist who was inspired by the coping strategies he witnessed in a bipolar support group as a predoctoral intern, the *Guide* is a particularly insightful and sensitive example of the self-management workbook genre. But while the text lends credence to the distinct set of questions and difficulties faced by those managing a mood disorder, and takes seriously the role of social support as a component of self-management, it nonetheless draws upon and reifies the notion of a true and autonomous choosing self who can learn to control his disease through rational practices. The language of governance is present from the beginning of the *Guide*: “It is my sincere hope,” the preface reads, “that after reading [this book] you will feel less alone in your struggles, realize that there are effective treatments available, and *have at your fingertips strategies to prevent mood swings from ruling your life*” (ibid., p. ix, my emphasis).

A chapter of *The Bipolar Disorder Survival Guide* titled “Is It an Illness or Is It Me?” begins to demonstrate how the self-management paradigm, when applied to mental illness, imagines and seeks to instantiate a separable, stable, and transparent self. Likening the experience of adjusting to a chronic mood disorder diagnosis in some ways to that of patients who live with physiological conditions such as diabetes or hypertension, the text proceeds to acknowledge that “bipolar disorder has its own particularities” (p. 55). These “particularities” are encapsulated by two questions to the reader which, while rhetorical-sounding, are meant to be read literally and answered through strategies offered in the *Guide*:

How do you know what is really your illness and what is your “self” or your personality (your habits, attitudes, and styles of relating to others; the way you are most of the time)? How do you train yourself to know the difference between you when you’re well and you when you’re ill, and not fool yourself into thinking that changes in mood, energy, or activity are just “how I’ve always been”? (ibid.).

According to the model developed in the *Guide*, the distinction between self and illness is real, complete, and always already existent. The task of the diagnosed reader is to cultivate “the ability to *recognize* these differences” (ibid., my emphasis). This recognition is important not only for effective disease management, but also because it “can contribute to a more stable sense of who you are” (ibid.). An example of the type of unproblematic self-management work that can ostensibly be accomplished through appropriate differentiation of person and disease is provided through the case of the hypothetical patient “Maureen,” who is able to see

and act upon her pathology while leaving her real self intact: “Maureen...knew she had always been extraverted but realized she needed to visit her doctor when she began staying up late to call people—all over the country—to whom she hadn’t spoken in years. The requirement of an increased dosage of lithium did not interfere with her appreciation of others” (ibid.). In contrast, those who do not fully and correctly delineate the stable and true self run the risk of not realizing their full potential or letting the disease take control as alluded to in the book’s preface:

[S]ome people begin thinking of themselves as if they were nothing more than a diagnostic label or a set of dysfunctional molecules... They usually accept the need for medications but unnecessarily limit themselves and avoid taking advantage of opportunities that they actually could handle (p. 56).

You may start to think that you can accomplish little with your life, believing “All I am is bipolar, and I can’t change. It’s all biochemical and I can’t take responsibility for myself.” This way of thinking may lead you to avoid going back to work, withdraw from social relationships, and rely more and more on the caretaking of your family members...I disagree with this way of characterizing bipolar disorder. Many—in fact, most—of my patients are productive people who have successful interpersonal relationships. They have adjusted to the necessity of taking medications, but *they don’t feel controlled by their illness* or its treatments (p. 66, my emphasis).

In boldface type, the *Guide* succinctly lays out the relationship that drives the self-management model: “**Bipolar disorder is something that you have, but it is not who you are**” (p. 56, emphasis in original).

To help readers identify who they really are, the text provides a “Self-Administered Checklist” tool called “What’s Me and What’s My Illness?” consisting of two columns: “your personality traits” on the left and “your manic or depressive symptoms” on the right. “Spirited,” “boisterous,” and “talkative” are among the left column options; “full of energy” and “overly goal-driven” among the right. “Erratic” and “indecisive” are personality traits; “wired” and “highly distractible,” illness symptoms. “What’s me” or the real personality, the book explains, “hang[s] together” coherently and stably across time; it is “the cluster of traits that describe you throughout your life” (Miklowitz 2002, p. 63).

This notion of the real, isolable, and enduring self is also pervasive in *bp*, a bipolar disorder lifestyle magazine heavily sponsored by full-page psychopharmaceutical advertisements. Although a recurrent narrative in the magazine articles is that of the celebrity who bravely fights stigma by telling the public about his or her personal experiences with mental illness, *bp* does *not* endorse a view of bipolar disorder as a culture or identity to be embraced.¹² Instead, it generally retains the biomedically derived distinctions described above: bipolar disorder is a brain disease to be treated and self-managed without shame, in the service of liberating the “real” person to the

¹² Neurodiversity movements, characterized by this type of rhetoric and patient self-advocacy, have emerged in recent years among persons diagnosed with autism and schizophrenia, among other diseases/disorders. To my knowledge, no such movement exists for bipolar disorder, although there are certainly arguments such as Martin’s (2007) demonstrating a cultural affinity for mania in the contemporary United States, as well as a popular association of manic depression with artistic talent and creativity.

fullest extent possible. An article about author and mental health advocate Ross Szabo, for example, concludes with the following quotation by the celebrity: “For me, I’ve wanted to find out what is bipolar disorder and what is me...I try never to use the disorder to get out of anything or as an excuse, but to use it as a challenge to understand who I really am, how my brain works” (Roberts 2010, p. 40).

Similarly, an exchange between readers in the “Letters” section of the magazine reveals the apparent stakes of terminological decisions in the representation of the separable self. The Spring 2007 issue of *bp* published a letter with the following criticism:

As a psychiatrist who receives your magazine, I am appalled by a phrase that recurs throughout your magazine: “he/she has bipolar.” In many years of practice, I have never heard a mental health professional use this terminology. Someone is bipolar, or has bipolar disorder. To use your terminology makes the writer (and by extension, the magazine) sound uneducated. Patients who imitate this usage will sound uneducated too—surely not your intention. (Psychiatrist Criticizes Magazine Phrasing, Spring 2007).

The subsequent issue of the magazine featured three letters, all written by mental health professionals (one of whom was also herself diagnosed), in response to the psychiatrist’s criticism. All three took offense at the suggestion that it would ever be preferable to say that someone *is*, rather than *has*, bipolar, with or without the word ‘disorder’ attached:

To call someone bipolar is dehumanizing. I am not bipolar. I do not identify with my disorder. I am a woman who has bipolar disorder. I am also a mental health professional who has bipolar disorder.

[The phrase “I am bipolar”] is tantamount to saying, “I embody the illness”—not unlike someone saying “I am cancer” or “I am diabetes.” It is not healthy for one’s self-esteem, coming to terms with yourself, or making forward progress. (“A Person Can’t ‘Be’ an Illness,” 2007, p. 13).

As these examples from the clinical literature illustrate, the managing self of biomedical discourse is predicated on a distinct notion of authentic selfhood as something that is and must be delineated and distanced from the disease. According to this logic, there exists a subtle but actual boundary between the real person—who is characterized by coherence and stability, or continuity across time—and disease manifestations that may take the appearance of personhood and “fool” the untrained patient. Thus, when the *Guide* describes learning to know “the difference between you when you’re well and you when you’re ill,” as in the example of Maureen, the implication is that in fact even when ill, the real self retains the ability to rationally assess and act upon the disease. Proper self-management, then, as a “technology of the self”¹³ (Foucault et al. 1988), entails a transparent self that is fully knowable and recognizable to itself.

¹³ Foucault writes that technologies of the self privilege self-knowledge over self-care, and “permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault et al. 1988, p. 18).

The self as envisioned in this model not only is autonomous from bipolar disorder, but also must characterize and locate the disease in a particular way. Conceptualizing bipolar disorder as a biological imbalance is necessary but not sufficient; one also must avoid conflating the managing self with this “set of dysfunctional molecules,” and instead position the rational self in a relationship of direct control over the neurochemical. For this reason, the possessive phrasing of “I have bipolar (disorder)” is viewed as more accurate and favorable than “I am bipolar.” Although medical anthropologists have noted that persistent and severe psychiatric disorders are often—and sometimes to better effect—subjectively experienced as “*I am illnesses*” (Estroff 1989; see also Strauss 1989), the discursive insistence upon the “*I have*” formulation seen above firmly divides and structures the relationship between manager and object managed.¹⁴

Disciplining the Disease

The preceding section described the manner in which the self-management paradigm imagines and characterizes a true, coherent, and enduring self that is fully distinguishable from the disease—in this case a mood disorder—to be managed. I move now to a closer examination of the relationality between disease and management as envisioned within this model. I argue that the discourse of bipolar self-management treats the disease to be managed as though it were a stable object whose internal logic is discoverable by a calculating subject through rational processes. As such, the paradigm reifies both disease and rational manager. I focus my analysis on a number of charting technologies that comprise a major component of self-management therapy as reflected in the clinical literature. The section concludes with a consideration of several additional forms of rational self-surveillance, prediction, and choice that are considered unproblematically enactable by—and are indeed demanded of—the bipolar self-manager.

The self-management literature strongly encourages bipolar patients/consumers to “take control” of their disorders through various forms of recordkeeping, with units of surveillance and scrutiny ranging from hour-to-hour fluctuations to one’s entire life history. The simplest versions of such tools suggest that the patient rate his or her mood, on paper or on the Internet, one or several times per day using an ordinal scale (–3 to +3, –5 to +5, 1 to 20, etc.) with full-blown mania at one extreme and major depression at the other. Most mood-charting tools, such as one provided on the DBSA website, are quite a bit more extensive; in addition to mood levels, medication types and dosages, hours of sleep, symptoms of anxiety, physical activity, and menstrual cycle are among the variables recorded. *The Bipolar*

¹⁴ In his article on “‘Schizophrenic Person’ or ‘Person with Schizophrenia’?” Louis Sass (2007) offers a compelling argument that in bracketing out the schizophrenia “disease” and only listening to “what can be understood to emanate from [the patient’s] supposed ‘personhood’” (p. 414), the biomedical model is, in unintended ways, inherently stigmatizing. Specifically, Sass shows, the “person with schizophrenia” formulation systematically obscures or dismisses important “schizophrenic modes of being”—including forms of intentionality, insight, and irony—by considering them to come from something wholly distinct from the self. Thus, the failure of biomedical models to listen to “the specifically *schizophrenic* qualities of the person” forecloses the possibility of encountering “points of view that can most deeply challenge as well as enrich our own” (p. 415, emphasis in original).

Disorder Survival Guide explains that mood charting is critical to maintaining wellness because “becoming aware of even subtle changes in your mood and activity levels will help you recognize if you are having a mood disorder relapse and determine whether you should contact your doctor to see if a change in medication would be helpful” (Miklowitz 2002, p. 154). Moreover, coordinating all of the other information on the chart with the mood level is said to help the patient identify “environmental triggers” that cause mood cycling. This combination of recognition and causal identification promises to instantiate the proper relationship between rational actor and neurochemical object of management: “Identifying mood triggers is an important step in gaining control over your moods” (p. 155).

The Bipolar Workbook (Basco 2006), following a technique developed by a clinician at the National Institute of Mental Health (NIMH), advises bipolar self-managers to also create a “life chart” plotting time, labeled with ages and major life events, along one axis and corresponding episodes of mania or depression along the other. Once this history is charted, patients/consumers can fill in additional information about times in which they drank alcohol excessively or used street drugs, periods of hospitalization (and medications taken there), and other psychological problems. Life charting, the *Workbook* explains, reveals to the manager “your common patterns” which in turn enables “you [to be] in a better place to predict when the next episode is likely to occur so that you can take precautions to keep it from happening” (p. 41). Besides this predictive and preemptive function, discerning patterns also serves to impart clarity and order to the disease:

If you’re like many other people who have bipolar disorder, you may struggle with so many daily ups and downs that you find it hard to see discrete periods of depression and mania. When your life of ups and downs seems like a blur, you can get the sense that you have no control over it. Looking more closely at the patterns can give you ideas for how you might take control over this illness rather than feeling out of control (ibid.).

Rational management techniques such as mood and life charting are “borrowed directly from the neoliberal arsenal of tools with which consumers/clients can plan their own futures and govern their lives, their consumption, their health, and their risks” (Valverde 1998, p. 175; see also Schüll 2006, p. 230). Based on what Weber (1978) described as a “specifically modern calculating attitude” (p. 86), they imagine and seek to constitute a self-surveilling accountable subject who can measure and control these risks through rational processes. Thus, the self as posited by self-management discourse is not only coherent, continuous over time, and separable from the disease, but is also taken to be a fully rational actor—a “calculating individual” (Miller 2001, p. 380) whose conduct is governed through “technologies of the self” (Foucault 1988; Foucault et al. 1988; see also Strathern 2000), and who is the subject “simultaneously of liberty and of responsibility” (Rose 1996, p. 12).

As the rationales for charting in the clinical literature illustrate, self-management discourse also imagines and reifies the bipolar disorder “disease” as a fixed object that can be isolated, ordered, predicted, and disciplined. By engaging in rational

practices, the manager is envisioned as capable of uncovering the true hidden logic or patterns of the disorder, partitioning what only appears to be random into discrete and controllable rationally organized entities.

Sociologists and philosophers of science have noted that quantification practices such as charting and accounting “[accord] a specific type of visibility to events and processes, and in so doing [help] transform them” (Miller 2001, p. 382; see also Dean 1999; Poovey 1998). This idea, along with the concept of *inscriptions*, is helpful in understanding the way in which bipolar disorder appears to become a governable object in the self-management literature. Inscriptions, as invoked by Latour (1987), are the readable output produced by scientific instruments and technologies, which subsequently become the basis for scientific texts. Moreover, as Rose elaborates, inscriptions differ from *phenomena* in that

inscriptions must render ephemeral phenomena into stable forms, which can be repeatedly examined and accumulated over time. Phenomena are frequently stuck in time and space, and inconvenient for the application of the scientist’s labor; inscriptions should be easily transportable so that they can be concentrated and utilized in laboratories, clinics, and other centers of accounting, calculation, and administration (Rose 1996, p. 108).

In purporting to convert seemingly “blurry” or chaotic mood phenomena into true discrete and quantifiable inscriptions or “episodes” to be read and acted upon, self-management discursively figures the biomedical divide between agentic rational person and static disease.

In the remainder of the paper, I turn to the practices and paradoxes that emerge as people diagnosed with bipolar disorder attempt to take on projects of vigilant self-management. Specifically, I show that many of the very acts that self-management entails paradoxically constitute the patient/consumer as a subject disparate from the kind that the paradigm seems to envision and promise. I then look at the forms of agency that bipolar self-managers themselves claim and model.

Unfolding Diseases, Elusive Selves: (Dis)locating the Agent and Disease in Self-Management Practices

“Do you want me to tell my war story?”

Kevin, a bright and attractive young DBSA member, asked me this facetiously at the start of an interview. Yet in a way, his phrasing is perfectly apt. While there are many, often long and circuitous, paths by which a person might ultimately wind up with a diagnosis of bipolar disorder, the diagnostic criterion for the disease’s classic form (Bipolar I) is a history of a single manic episode (DSM-IV-TR 2000). Moreover, regardless of their particular clinical subtype classification, every member of the support group seemed to have a “war story” that began with a psychiatric incident and marked a turn in the way that the person talked about and experienced his or her present and future self. In Kevin’s case, his first and only

manic episode had occurred during college 6 years ago. He recounted writing a letter to President Bush detailing a plan to end all religious wars, hearing auditory hallucinations, and eventually spending 9 days in a psych ward. Since then, Kevin had moved back closer to his parents, changed his career plans, and reoriented his life around managing his mental illness. He was on a cocktail of 20 mg of Abilify (an antipsychotic), 1,200 mg of Trileptal (an anticonvulsant used as a mood stabilizer), and 40 mg per day of Adderall (an amphetamine), and was diligent about medication adherence. Although Kevin had never before or since experienced anything similar to his “war story” episode, when I asked whether he thought he could ever become manic again, the response was unhesitant: “oh yeah, if I stop taking my medicine I’ll become manic within like a week.” Moments later, he frowned and added: “I’ve been doing really well, but the medication can just stop working... At my job [working with severely mentally ill people] I often think ‘this is me, I can relate.’ But sometimes it’s ‘this will be me again,’ like I’m just waiting for the shit storm to come. That makes me anxious.”

For Kevin and other group members discussed in this section,¹⁵ having a diagnosis of bipolar disorder and choosing to try to manage it entails the inculcation of a particular identity and anticipated life trajectory; a shift in ways of talking about, acting upon, and experiencing the self. As I will show, this subjectivity emerges out of—but is, paradoxically, contrary to the self envisioned by—the biomedical self-management paradigm. As seen in the preceding sections, self-management imagines a fully rational, continuous, and recognizable self who can calculate and act upon a fixed and isolable disease. Here, however, we see that acting on the “disease” generates ambiguities regarding its location and boundaries, and that enacting expertise in self-management constitutes and indexes the self as discontinuous and uncertain.

¹⁵ Not every story or experience in the support group was one of self-management. A particularly striking and disturbing counterexample emerged one evening early in my fieldwork, when the wife of a bipolar man with whom several group members were acquainted showed up at the meeting on her own. Alternately tearing up and laughing in bitter disbelief, she described her husband’s current manic state: he’d stopped going to his real job in favor of staying up all night working on a “new business plan,” was lying and using illegal drugs, had left their two-year-old daughter alone to play with an X-ACTO knife, and had drained the couple’s savings by \$20,000 at a casino. What upset her the most was the fact that her husband had seen the manic episode coming and was presently aware of his state, but was unbothered by it and felt no obligation to intervene and self-manage. “He *knows* he’s manic but doesn’t care,” she had complained. “He’s doing these things on purpose.”

The discussion that ensued was a complex one for the group, but I believe that the direction it took is illustrative of the distinct and paradoxical form of self-managing bipolar subjectivity that many of the group members inhabit, and that this woman’s husband was rejecting. Using their own personal histories as examples, group members found themselves in the strange position of explaining to the woman that it might not be worthwhile to try to reestablish trust with her bipolar husband. As James put it:

I imagine down the line he may feel remorse, but that may not matter. Lots of people feel remorse. Abusive people even feel remorse. But even if he is medicated, what happens the next time around? And there *will* be a next time around.

The group’s consensus was that an awareness of one’s mania implies a capacity and responsibility to distance oneself from and attempt to act upon it, explaining: “Once you have any awareness you should be trying to take some responsibility”.

Specificities and Ambiguities in Neurochemical Self-Management

As is common practice in many types of support groups, the official start of each DBSA meeting was marked by the ritual of introductions (Cain 1991; Martin 2007). The group's peer leader, a friendly and rather giddy man in his mid-thirties who often described his personal "baseline mood" as slightly hypomanic, enjoyed startling everyone at the appointed time by loudly and abruptly interrupting casual conversation. A typical pass around the room might begin:

Hi! I'm Warren! I have bipolar disorder, OCD, and anxiety, which are all kind of the same thing! I was thinking this week about how it's funny never to know what you're going to be like the next day. Like, what's it gonna be? Will I be depressed or manic?

I'm Tricia, I have bipolar 2, anxiety, and ADHD which is probably caused by the other two. I've had an okay week, but I'm concerned today because apparently Abilify is causing me neurological damage, according to some test results. I can't feel it, but my psychiatrist noticed some subtle differences in my movements and behaviors.

James. Bipolar, um, PTSD, and a bunch of other shit. We just raised my dosage of Trileptal today and I'm feeling totally drugged out. It's causing dizziness, drowsiness, blurred vision—but it's doing what it's supposed to do. I can read and concentrate now for the first time in years.

As these introductory statements indicate, gaining direct access to and control of the disease via drugs, or even delineating the psychiatric disease categories that are being treated, is far from unproblematic for bipolar self-managers. Indeed, in many cases the effort to do so only makes more apparent the elusiveness of the managing self and the impossibility of isolating pathology from experience in time or space.

Rose (2003) argues that one of the principal processes by which individuals in the contemporary United States have become "neurochemical selves" is the spread of the biomedical presupposition of specificity, which has become central to the research and campaigns of the pharmaceutical industry. Tracing this way of thinking to the development of selective serotonin reuptake inhibitors (SSRIs) in the 1960s, Rose claims that the presupposition was initially made up of three parts:

First, it was premised on the neuroscientific belief that these drugs could, and ideally should have a specificity of target. Second, it was premised on the clinical belief that doctors or patients could specifically diagnose each array of changes in mood, will, desire, affect as a discrete condition. Third, it was based on the neuroscientific belief that specific configurations in neurotransmitter systems underlay specific moods, desires, and affect (p. 55).

When subsequent research proved incorrect the theory that there was one kind of receptor for each neurotransmitter, the presupposition was not abandoned, but rather elaborated with *further* specificity:

It was now argued that each of these subtypes of receptors had a specific function, that anomalies in each type were related to specific psychiatric

symptoms, and that they could be ameliorated by drugs designed specifically to affect them (ibid.).

This logic of increasing specificity and accuracy of target has been influential in the treatment of bipolar disorder. Whereas the disorder was once treated only with lithium, bipolar patients/consumers today work closely with their psychiatrists to develop and constantly tweak a “cocktail” of sophisticated psychotropic medications, each chosen to act on a specific aspect of the disease. At meetings, it was not uncommon for group members to bring up issues related to their sometimes very elaborate cocktails. Many carried a chart or list at all times, detailing their prescriptions and dosages in case of an emergency. Most considered lithium to be too crude and dangerous, and would only think about using it as a last resort.

But while these pharmaceutical cocktails seem, as Rose argues, to “offer the promise of the calculated modification and augmentation of specific aspects of self-hood through acts of choice” (2003, p. 59), their specificity often produced an experience of diminished agency or even randomness for members of the support group. This occurred for a variety of reasons. Lapses in health insurance coverage, changes in provider policies, periods of hospitalization, or simply clinician turnover at the community mental health centers where some members received services led to switches in doctors, prescriptions, and sometimes diagnoses. Even those who were treated by the same psychiatrist for a long period of time became familiar with endless medication adjustments or overhauls, which came to feel, members reported, more like arbitrary guesswork than systematically calculated modulations or informed acts of choice. New drugs often brought with them new side effects, followed by more drugs to treat those side effects, and so forth. Over the years, members lost track of why particular changes in their treatment regimes had been made, and sometimes questioned during group discussions whether their current cocktails were redundant or suboptimal. Furthermore, at times the drugs seemed to have agencies of their own that defied a relationship of rational management by the somatic individual. Like Kevin, many of the group members had experienced or worried that a medication they relied upon might suddenly lose its effects. Others, like Tricia and James, had to weigh the benefits of a medication against risky or debilitating side effects, either all too perceptible or dangerously invisible to them.

Not only did neurospecificity fail to produce an experience of rational disease management, the process of determining which moods and thoughts needed to be pharmaceutically acted upon also proved to be less than straightforward for group members. One week during introductions, for example, Christine wondered aloud whether she needed to make an appointment for a medication adjustment. “I think I’m a little hypomanic today,” she described, “but maybe I’m just excited because I got a call about a job interview. It’s hard to tell.” More confusingly, Kevin explained that *not* being in the mood to go see his therapist was often a sign that he was becoming symptomatic (and therefore that he *needed* the therapy). Faced with the task of having to constantly export the experiential to the neurochemical, and the suspicion that nearly anything could be a symptom, group members struggled in their attempts to locate the managing self and an ordinary, asymptomatic position from which to manage.

As the rational manager became more elusive and indeterminate, so did the disease. The quotations in the beginning of this section demonstrate that support group members did not necessarily experience themselves as targeting or modifying specific psychiatric disorders, let alone particular symptoms or neurotransmitters, through their self-management practices. Instead, they casually conflated categories that psychiatry would hold to be distinct, such as Warren's equation of bipolar and obsessive–compulsive disorders. This conflation was especially notable on several occasions when the subject of schizophrenia would arise in the support group discussion. Although schizophrenia and bipolar disorder are among what clinicians in the U.S. consider to be the “big three” severe mental illnesses (Luhmann 2000, p. 13), the diseases are classified as ontologically discrete, and a diagnosis of bipolar disorder is generally associated with a superior prognosis¹⁶ (Lakoff 2005; Benabarre et al. 2001). Nonetheless, given the overlaps in symptom presentation and treatments, bipolar group members at times experienced the diseases as continuous, and themselves as at risk of slipping into the schizophrenia category. Tricia, for example, described an incident in which she'd found a man urinating on her lawn during a dinner party she was hosting. Explaining to the group that she had felt more empathy toward the man than did her friends, Tricia said: “He was probably schizophrenic and off his meds, which could be me. There but for the grace of medicine I'm not schizophrenic.”

Occasionally, a member of the support group would attempt to invoke the comparison between bipolar disorder and diabetes¹⁷ or hypertension in a manner that was aligned with the clinical self-management discourse; that is, as a metaphor for unproblematic disease management in which the locations of rational self and disease are ostensibly fixed and nonoverlapping. However, such attempts usually gave way to commentary on the inadequacy or unsustainability of the envisioned biomedical relationship. These emergent critiques foregrounded members' experiences of bipolar disorder as an unfolding temporal formation that moves with and through the self, rather than a measurable or targetable object. For James, these intangible and dynamic qualities of the “disease” produced an inability to ever know with certainty that one was sick or well:

I've heard a lot of people in the group compare depression and bipolar to diabetes, and I don't find that very helpful. I mean it's useful for sort of justifying it to quote unquote normal people but in a lot of ways it's not useful. Diabetes is fairly controlled. You know, you take your blood test and you take

¹⁶ Huxley and Baldessarini (2007), however, report that the “prognosis for BPD was once considered relatively favorable, but contemporary findings suggest that disability and poor outcomes are prevalent, despite major therapeutic advances” (p. 183).

¹⁷ The management of diabetes is itself far from unproblematic, and in fact often implicates aspects of selfhood and mood. Indeed, the struggles faced by patients managing supposedly straightforward physiological conditions are a testament to the broader unsustainability of the biomedical distinction between managing self and disease. Yet, the *notion* that there exist diseases that can be fully divided from and managed by the self (among which diabetes and hypertension are thought to be paradigmatic) is a powerful imaginary that is constantly invoked by bipolar patients and in the mental health self-management literature. For examples of excellent ethnographic work that take up the difficulties experienced in diabetes management, see Borovoy and Hine (2008) and Mol (2008).

your insulin and you have a special diet and you're gonna be fine for a fairly long period of time. And if you don't you're gonna die. And mood disorders aren't like that. For one thing, there's no blood test. There's no way of absolutely knowing how sick you are at any given point. And there's no way of regulating your diet and regulating your meds to the point where you're gonna be fine.

For Tricia, the problem was also a communicative one: In the absence of a visible sign, she had difficulty expressing her experience of bipolar as “shifting back and forth” to others as a disease:

Now James has a shake, so they're gonna notice that right away. But particularly [with] bipolar – I mean depression you *look* depressed, real mania you're acting kinda crazy, you really are. But bipolar, when you're not high, like completely suicidal or completely manic, when you're just shifting back and forth – it's very hard to explain to people. You know, [they say] “I don't understand why you can't brush your teeth or get out of bed.” Or “you look fine, why can't you get out of the house?” It's very hard to explain to 'em. Part of me wishes I had a little brand on my head that said you know “don't ask me anymore. This is what I am.”

Thus, the experience of bipolar disorder as temporally unfolding phenomena intertwined with selfhood defied attempts to neatly extricate manager from disease, or to fix the disease in space and time. Moreover, management practices designed to effect a relationship of governance through neurochemical specificities had the unintended consequence of producing new ambiguities. The next section further develops the paradoxes that emerge in the enactment of good and responsible self-management.

The Paradox of Enacting Self-Management Expertise

Of all the support group members, James' story was the one that hit me closest to home. Once a Ph.D. student like myself, he had dropped out of graduate school in the middle of writing his dissertation after a frightening psychotic break. Now, James mostly stays at home, living a circumscribed life of simple routines and supporting himself on the tight budget of his monthly disability check. Our interview ran nearly twice as long as any of the others I had conducted, and when I apologized for taking up so much of his time, James replied wryly: “I'm on disability; I have nowhere else to be. And hey, we're talking about me—there could not be a better subject!”

When he is not too debilitated by the neurological damage his medications cause, James is eloquent, articulate, and unusually scholarly. He immediately intuits some of the theoretical implications of my research, and seems to enjoy having the opportunity to converse in academic jargon; upon learning that I am an anthropologist, James nods knowingly and asks whether I am studying the ways in which bipolar disorder is both socially constructed and real. Group members joke that James is the “anger expert” because of his sarcastic humor and the homicidal

fantasies that he admits to having. But according to James, he is far less angry and more responsible now than he ever was in the past. “Seven years ago,” he tells me, “when I chose to go on medication, I chose to live. And I take that very seriously. I want to live.” At the support group, James conveys his commitment to a lifelong project of vigilant self-management by calling himself “a professional bipolar” whose “job is to do a good job being alive and getting up every day.” But choosing to act responsibly and rationally in spite of the disorder is complicated because, as James puts it, “bipolar alone is not sufficient to explain every behavior that you do—but neither is it *not* the explanation for everything that you do.”

For DBSA members such as James who make a choice to engage in self-management, the act of consistently attending support group meetings is both a management practice in itself and an occasion in which self-management expertise—a type of “second order indexicality”—can be discursively enacted (Silverstein 2003; see also Carr 2010a, b; Agha 2007; Wortham 2001). However, this expression of expertise entails a paradox, which is explored in this section: Whereas self-management discourse imagines a rational, transparent, coherent, and continuous self, the types of statements that one must make to index oneself as a responsible self-manager constitute a model and experience of selfhood as unreliable, fragmented, and discontinuous.

One of the principal ways that support group members could discursively practice expert self-management was by interrogating their own thoughts and emotions for possible errors in rationality (which in turn would ostensibly allow them to determine whether they were symptomatic and modify their symptoms with medication). Thus, during meetings it was common for someone to discuss his or her current mood with detachment and suspicion, even if the mood seemed to have a reasonable antecedent: “I’ve been kind of in a funk because someone broke into my apartment and my computer was stolen,” Kevin remarked one day. “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.”

These practices of hyper-rational self-interrogation did not instantiate the isolable, “real,” agentive, and enduring self envisioned in the clinical self-management literature. Instead, they blurred self and disease, and divided the managing subject into fragmented selves marked by uncertainty. James described to me how his self-management practice of scrutinizing in therapy—and often modifying with medication—any out of the ordinary thoughts, left him unable to recognize or find himself:

A few weeks ago, it occurred to me that I could do a project: I could write a paper. On my own. You know just—I had an idea and it seemed interesting and it would give me something to do. And as I, you know, as I’ve gotten more medicated, that idea has kind of slipped away from me. So is that me losing a thread of mania? Or is that the drugs completely, you know, just sort of squashing me flat? And I don’t know: Would another person in my

situation—I'm on disability—would another person *want* to do some work? Or would they be okay with basically doing nothing? Which is mostly what I do with my day, is nothing. And I don't know.

What is striking about James' narrative is the multiplicity of "I"s and "me"s that emerge as true choosing self and disease elude definition or delimitation. These personal pronouns, or shifters (Jakobson 1971; Benveniste 1971), index and simultaneously iconically constitute James as a collection of disjointed speaking subjects. Self-management as articulated here leaves James uncertain as to whether he is the person who is interested in work and "could do a project"—in which case, management leaves him flattened—or the person who remains after extricating himself from a harmful and irrational inclination. Neither can James determine whether a piece of himself has "slipped away," or he has agentively facilitated the removal of "a thread of mania." By expressing his distrust of his desire to engage in a possibly irrational activity that "other people" might not choose, James aligns himself with the type of proper manager envisioned in the clinical workbooks, and interactionally attempts to persuade his interlocutor of his competence as a self-manager. In the end, however, this enactment of rational self-management does not free James to act and choose; it perpetuates his life of "doing nothing."

Not only did engaging in self-management produce an experience of uncertainty and fragmentation within the present managing self, it also led group members to narrate and view themselves as unreliable and discontinuous over time. In contrast to the knowable self—who uses rational calculation and prediction to delineate a continuous person separate from his pathology—presupposed by the discourse, support group members were compelled to imagine an unpredictable and irrational future self through their self-management practices. As Tricia described it, a future unmanaged state of depression or mania was something that she anticipated but could not predict or control, regardless of medication compliance:

One of the most frustrating things about bipolarity—I think anybody would say this—is you don't know—you can't be depended on. That's the thing that bothers me the most. Um I can be, like right now I feel pretty normal, and meet you here we'll have lunch; it will be fine. But then one day, or one moment, I will just suddenly shut down. Brushing my teeth is just *too much* for me to manage. It doesn't matter how much medicine I take. There's gonna be days—I've accepted it now—that my pink nightgown is going to be my friend (laughs) for the next few days!

Scrutinizing herself and her disease in the manner required of proper self-managers leads Tricia to accept as certain *not* that she will remain a true, continuous, choosing self over time, but that she will become a different kind of self regardless of her efforts.

In response to this type of experience of the self, many group members took on a conscious self-management practice of not committing to any future plans. Christine, for example, explained her rationale and strategy for managing her social life as: "I might be fine or manic today, but tomorrow I may be suicidal. My friends will call and ask me 'are we still on for Wednesday?' and I'll say 'ask me

tomorrow.’” Similarly, some of the group members who had once held full-time jobs now felt that they could not resume employment on the basis of their imagined future irrationality. James hoped that he would someday work again, but made a habit of talking to his therapist any time he “got these feelings like I could actually start working.” Nor did he envision a time in the future where he would ever become a fully self-controlled employee. In spite of his intelligence and over-qualification for many jobs, James claimed, it was difficult to apply for work knowing that “you’ll occasionally [have] paranoid delusions that coworkers will poison you. I’ll have months when I don’t feel like getting out of bed. And I’ll occasionally go to work and feel slightly homicidal.”

To describe the way in which being a responsible self-manager meant never fully trusting the rationality of the present self, and anticipating the appearance of an unmanaged irrational self at some unknown time in the future, support group members developed a term that I did not encounter in any of the clinical literature: *tentativeness*. As invoked by the group on several occasions, tentativeness referred to both 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 toward one’s own thoughts and emotions at any given moment. Tentativeness thus described a distinct disposition in relation to risk—one that required an acknowledgment of the management of *future* uncertainty by an uncertain *present* self. Discursively enacting tentativeness by expressing awareness of one’s own uncontrollability and skepticism toward the legitimacy of one’s own emotional experiences indexed members’ expertise at self-management by demonstrating a kind of vigilance. It also bespoke a rational regimentation of the bipolar disease/self through members’ voicing of a scientific register, using the language of hypothesis testing, comparison with a norm, and deductive reasoning to scrutinize themselves for bipolar symptoms. But at the same time, as seen above, “doing” recognizable expert self-management by embodying tentativeness undermined the implicit promise of the therapeutic paradigm by foregrounding the unlocatability of an isolable, stable, and continuous managing self.

In his exegesis of Wittgenstein’s philosophical works on solipsism through an analysis of the phenomenological reality described by a patient, Louis Sass provides an account of schizophrenic “double bookkeeping,” or ability to “live in two parallel but separate worlds: consensual reality and the realm of their hallucinations and delusions” (Sass 1994, p. 21; cited in Martin 2007, p. 55). These two worlds, Sass shows, are differentiable to persons with schizophrenia “according to their felt ontological status” (Sass 1994, p. 43), enabling patients who are “profoundly preoccupied with their delusions” to “nevertheless treat these same beliefs with what seems a certain distance or irony” (p. 21). Sass argues that this extreme self-awareness is a widely overlooked but in fact fundamental characteristic of mental illness:

Madness, on my reading, is neither the psyche’s return to its primordial condition, nor the malfunctioning of reason, nor even some inspired alternative to human reason. It is, to be sure, a self-deceiving condition, but *one that is generated from within rationality itself rather than by the loss of*

rationality. The parallels between Wittgenstein and Schreber reveal not a primitive or Dionysian condition but something akin to Wittgenstein's notion of a disease of the intellect, born at the highest pitches of self-consciousness and alienation. Madness, in this view, is the endpoint of the trajectory consciousness follows when it separates from the body and the passions, and from the social and practical world, and turns in upon itself (p. 12, my emphasis).

To the extent that successful self-management, as described in this section, requires that patients/consumers enact constant rational self-surveillance, it similarly helped to constitute bipolar group members as elusive subjects *through*—rather than in spite of—their rational practices. As James described, the kind of self-awareness that managing his “disease” demanded produced an experience of heightened fear and lack of control:

They always say that as long as you know that you're crazy, that you're not *actually* crazy, but that's not true. Sometimes the more you know that you're crazy the more fucking scary it is because you *know* the things you're thinking are not *real*. You know the things that you're thinking aren't true. And that's a lot scarier than just sort of living your way through the delusions. I mean because [for example:] you're scared of things. You're scared of going out in public, but whatever. But who cares? But if you *know* that your fear of going out in public is irrational, then that's how much you know you're out of control. That's how much you know that your disability is ruining your life. Or running your life.

“What Goes Down, Comes Back Up”: Distributed Agency and the (Un)manageable Self

Having considered the ways in which the choosing self and disease are envisioned and reified within self-management discourse, and the paradoxical subjectivities that emerge as bipolar patients/consumers attempt to locate themselves within and properly enact this paradigm, I return in this section to Tricia's hospitalization narrative. How are we to conceptualize a managing self who agentively “knows” and “decides” that she needs to visit the hospital, yet desires—and then orchestrates—the passive experience of “being hospitalized”? What kind of relationship between self-control and unmanageability is constituted, as “hospitalization” becomes a drawn-out process of negotiation and scheduling, while its necessity remains a foregone conclusion? And what are the implications of Tricia's final act, if the distinction between readable disease sign and self-management practice collapses, and cutting becomes a form of calculated—albeit not clinically sanctioned—rational choice? I suggest that bipolar self-managers are able to claim certain kinds of *provisional* and *distributed* agency, exemplified by unexpected and contradictory practices such as Tricia's. These forms of agency bear consideration because although they are produced through the very technologies of self-surveillance and rational calculation that characterize ideal neoliberal personhood,

they are constitutive of a model of selfhood and choice that poses challenges to the presumed self-knowledge and integrity of choosing subjects.

One genre of self-management narrative that support group members sometimes told was that of a particularly difficult day or moment which the member was able to overcome *not* by acting upon himself or the disease, but by waiting. Reflecting on such incidents, group members would remark that even when, for example, they felt suicidal, they knew that “the good thing about bipolar is—what goes down, comes back up” and could, therefore, count on bipolar disorder itself to bring about the change in mood that they desired but could not willfully produce. This sort of wisdom did a great deal of work to carve out a space of partial agency for the bipolar patient/consumer, and shift the paradigm from one in which the disease could only either control or be controlled to a more fluid and distributed conceptualization of agentive management. In claiming such knowledge about the nature of bipolar disorder, members could thus recuperate a form of choice—though one unlike that of the envisioned somatic self—via the very quality of temporally unfolding vicissitudes that rendered the disease and the manager inextricable.

Confronted phenomenologically with the limitations of the myth of direct and complete self-governance, support group members elaborated complex alternative models of self and agency. Tricia, for instance, took pains to parse her own repertoire of possible behaviors and actions into those that were predictable and under her full control, and those that were not. Recounting a time in which she had defaulted on her credit card payments because of hypomanic compulsive shopping, relied on her parents’ financial support to rescue her from debt, and then immediately made the same mistake again, Tricia theorized her excessive spending as made up of both unmanageable and deliberate, reasonable, or even therapeutic components:

I guess it’s a release. It’s something you can’t control and yet in some ways it makes me feel normal, cuz normal people go and spend money. I don’t spend it on like...a whole bar. I go and buy a shower curtain. And you know what? You probably need the things to go with the shower curtain. And you know? The toilet paper’s piled up in the corner; we probably need the thing to hold the toilet paper so let’s spend fifty dollars on it. So they’re *sensible* things, which is kind of weird. But they’re—they add up, you know?

Choosing/succumbing to this kind of lapse in self-management, however, did not completely place Tricia outside of the project of vigilance and awareness. Instead, Tricia positioned herself in a provisionally agentive relationship with her bipolarity, through which she could coordinate with or work around those disordered behaviors that eluded full managerial regimentation. When asked whether she ever stopped herself from compulsively buying something, Tricia replied that she typically did not attempt to do so,

but I’m pretty good about saving the receipts. That’s usually my way of curing it...You know, I’ll keep one thing and then I’ll take the rest back. I’ve gotten pretty good about that; probably drive Target and Joanne’s crazy but—I really

don't do it every week—but it is a constant in my life that I have to be aware of.

Tricia's "cure" thus draws upon technologies of the self that are central to clinical self-management discourse, such as the cultivation of attentiveness in order to recognize regularities and modify imbalances. In so doing, however, she is able to articulate a claim to rational choice and responsibility as a self who can only ever be *incompletely* managed.

Another way in which bipolar group members modeled a distributed form of agency was through a discourse of "faking it" and the consequences therein. Faking it—or performing mood stability in spite of one's "actual" state of hypomania or depression—was a powerful self-disciplining technique with real and often far-reaching effects for the patient/consumer. Described at times as a painful mask that one could put on for the sake of "holding it together" for a particularly significant event, faking it could also refer to a more sustained strategy for functioning that was nonetheless experienced as less authentic than something felt to underlie it. One woman in the support group, for example, recounted how after a month-long psychiatric hospitalization, she had summoned the strength to return to work and "fake" her way to success in her corporate career:

I told myself, "they're all expecting me to fail. I'm not going to. I'm smarter than these people and I'm going to prove them wrong by showing them just how well I can do here." Whenever I am feeling bad or disconnected from my coworkers, I tell myself that the joke is on them; they have *no idea* what I'm really thinking or feeling.

When discussed in these terms, faking it indeed began to sound not unlike a realizable instantiation of the clinical self-management ideal, in which the sovereign self transcends the isolable disease through constant micro-acts of self-surveillance and rational choice. Yet most of the time, such narratives were immediately followed by an acknowledgment that faking it was a tenuous and risky endeavor because the "disease," never truly or permanently contained, would ultimately exert its own agency with a force proportional to that with which the manager had suppressed it. Thus, those who were able to perform stability at a given time or place reported experiences of uncontrollable rage or immobilizing sadness, often redirected toward family members or spouses, which they attributed to a sort of calculus of managerial rebalancing. Tricia, for example, recounted an incident in which she returned home after controlling herself for several days during a family emergency:

I walked in the back door and [my boyfriend] hadn't cleaned out the litter box, and I completely went berserk. Like he could have been sleeping with someone else, you know what I mean? Like, in the bed! So it's like I sometimes can steel myself but then it's gonna be a nightmare. Then it's cutting and it might be hospitalization.

In this more distributed model of agency, self-management and choice came to refer not only to the kinds of technologies of the self imagined to be enactable in the

biomedical paradigm, but also to the cultivation of an intuition about when and to what degree to defer management. This intuition was based on a reflexive understanding of self-governance as fundamentally multifaceted, partial, and distributed temporally as well as across various human and non-human actors.

In addition to taking up rational choice and self-surveillance so as to model a form of agency other than that of the reified choosing subject, bipolar self-managers also articulated a model of responsibility based on a non-transparent self. As discussed earlier, engaging in expert self-management discourse paradoxically required that group members index and become acutely aware of their unreliability as predictable or continuous selves. As such, their claims to agentic action (or non-action) emerged neither from what Foucault et al. (1988) described as the modern moral imperative to know oneself entirely, nor from an unproblematic notion of somatic individuality, but instead out of a recognition of self-knowledge as inherently limited. In this manner, Tricia explained that while she experienced many of her own behaviors as *reactions*—outside of the purview of her ability to choose or even anticipate them—suicide was something that she could subject to rational choice and control with certainty:

I have always said: I'm not suicidal. I'm not. I said at this point, as much money and time as I've spent on this, I'd kick my own ass if I fail. It's pointless. It's not something [my parents] should worry about. But they do. I may have ideation, but I'm not gonna do it. And I know I won't... I can't predict how I'm gonna *react*—you know be it panic attacks or hiding or (laughs) you know, not bathing for several days—but I *know* I'm not gonna die. *That* I know.

In place of the absolutely locatable and knowable self envisioned in clinical discourse, then, Tricia's formulation enables her to possess a piece of expert self-knowledge and intentionality while simultaneously denying the possibility or necessity of full transparency.

Under the experienced conditions of shifting “disease” and elusive managerial selfhood, even the charting technologies emblematic of the self-management paradigm for mental illness could be repurposed in ways that foregrounded the fragmentation and distribution of the imagined singular and agentic self. For example, Tricia found it helpful to follow a self-management protocol of assessing her mood four times per day on a scale of one to twenty. But with such finely gradated intervals, she often claimed that it was difficult to discern for herself whether “I am a fourteen or a seventeen right now,” or even at times to know “with a mixed episode if I'm really bad or sorta bad or just a little less than normal.” These ambiguities did not lead Tricia to abandon the management technique altogether, but rather facilitated a shift in the practice, rendering calculation of self and disease an intersubjective and distributive project. Specifically, Tricia stated that within moments of hearing her voice on the telephone, her mother could provide a read of her true mood level: “I can say ‘hello’ and she can tell me with an amazing amount of accuracy where I am on a scale of one to twenty.” By diligently tracking her mother's instantaneous impressions of her depression or mania each day, Tricia in some ways instantiated the biomedical relationship of responsible

choosing subject disciplining isolable “disease,” yet did so through a displacement of the boundaries of the free embodied individual.

Tricia similarly talked about a list of “how to let your boyfriend know what he should look for” that she had half-jokingly developed with her therapist. Functioning as a sort of algorithm for quantifying and interpreting her observable and presumably symptomatic behaviors, Tricia’s list, she felt, was her method of imparting her own self-management expertise to her nonperceptive boyfriend: “I’ve deliberately set that up. My boyfriend’s got, you know, ‘here are your visible steps, cuz you obviously can’t spot it otherwise.’” While thus maintaining a form of authority, Tricia simultaneously models, through the list, a gradual expansion of the boundaries of agentic self-management from within the single actor to between the couple:

“How to let your boyfriend know what he should look for”

If you stay in your pajamas one day, it’s nothing to worry about; you’re having a bad day.

If you stay in your pajamas two days, it’s time to ask “honey, are you okay?”

If you stay in your pajamas for three days, then you ask “maybe you should call your therapist?”

Four days, you call the therapist for her.

Even Tricia’s language in her narration (above) of the how-to list itself reflects the shifting and multi-layered aspects of agentic action emergent through her self-management practice. What begins as a set of instructions by, to, and about herself (“how to let *your* boyfriend know; *you’re* having a bad day”) gives way to a blurring of the positions of manager, actor, and observed (If *you* stay in your pajamas for three days, then *you* ask “maybe *you* should call your therapist?”), and finally produces a full relocation of agency and self-control (“*you* call the therapist for her”).

Thus, a close examination of the kinds of subjectivity enacted by bipolar self-managers foregrounds a significant destabilization of—but not complete departure from—the reified notion of agentic selfhood upon which the therapeutic modality is based. It suggests, more broadly, that the choosing subject of liberal democracies may be less of a contained and transparent self-modulating or maximizing rational actor, and more of a never-fully knowable or controllable self whose agency resides in the negotiated spaces between action and inaction, and is distributed beyond the body of the individual. Framed as such, the exchange between Jessie and Tricia about knowing and deciding that one must “be hospitalized” begins to gain intelligibility: it points to the elusive and paradoxical aspects of self-surveillance and control, and foregrounds the ways in which conscious self-management makes visible its own limits. By cutting, Tricia acts agentively, in collaboration with her boyfriend, to the end of *being hospitalized* passively. “Hospitalization” thus stands in for an act of self-management, a form of intersubjective agency, and a refusal to inhabit the position of choosing subject. That Tricia’s act of cutting herself serves, in her narrative, both as an index of her *unmanageability* and as a recuperation of a form of agency, compels us to consider a model of self-management in which the

patient does not act *upon* an isolable and static disease, but rather around and through shifting phenomena that overlap with personhood.

Conclusion

I have argued that the relationship between selfhood and disease entity envisioned as enactable in the self-management literature for bipolar patients/consumers—which relies more broadly on contemporary notions of the transparent choosing subject—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. As a result, bipolar self-management is productive of what we might consider to be a more nuanced and realistic model of agency as distributed across multiple actors and technologies, yet as always provisional and incomplete.

A variant of what philosopher of science Ian Hacking has termed “looping effects” of human classification—in which a clinical or scientific discourse “becomes known to the people classified, changes the way these individuals behave, and loops back to force changes in the classifications and knowledge about them” (1999, p. 105)—the story of bipolar self-management is one in which the limitations of the clinical modality—and, more broadly, of neurochemical selfhood—are brought out *through* its practice. In other words, rather than focusing on the ways in which self-management practices resist, undermine, or contradict the clinical discourse, I wish to draw attention to the unexpected forms of agency that are embedded within, and emerge directly out of, its embodiment.

In *The Birth of the Clinic* (1973), Foucault traces the origins of the contemporary biomedical model, in which “disease” is reconfigured as discrete bodily lesion, to the work of Bichat and other French anatomists in the late eighteenth century. For Foucault, this ontological shift is closely related to the emergence of a mode of inquiry that he terms the “anatomy-clinical gaze,” the basis of which lies not in the experiences and symptoms of living patients, but in the dissection of the corpse. This medical gaze is multi-sensorial but ultimately guided by the “figure of the visible invisible” (p. 170): “multi-sensory perception is merely a way of anticipating the triumph of the gaze that is represented by the autopsy; the ear and hand [of the clinician] are merely temporary, substitute organs until such time as death brings to truth the luminous presence of the visible” (p. 165).

On the other hand, Nikolas Rose, inverting Foucault’s title to describe a turn that he calls “the death of the clinic,” asserts that in our contemporary age of the brain, “[t]he clinical gaze has been supplemented, if not supplanted, by [a] molecular gaze, which is itself enmeshed in a ‘molecular’ style of thought about life itself” (Rose 2007, p. 12). In this new style of thought, Rose argues, bodies are no longer

envisioned and acted upon primarily at the “molar” level of organs, tissues, and lesions. Rather, they are molecularized; technologies of visualization are overshadowed by technologies of mobilization and optimization, and “our somatic, corporeal neurochemical individuality has become opened up to choice, prudence, and responsibility” (ibid., p. 8).

Contrary to Rose’s claims, however, my findings suggest that the paradigm of self-management does not escape, and indeed relies upon, the notion of the culprit object or lesion¹⁸ in its formulations of the managing self and that which is managed.¹⁹ Bipolar self-managers are promised in the clinical literature that by inhabiting the anatomico-clinical gaze and turning it in upon themselves, they too will render the invisible visible, locating, bringing to light, and cutting apart the bipolar “disease” from the true rational self. It is the failure of bipolar phenomena to conform, through self-management enactments, to a figuration as fixed structural condition that brings about provisional styles of agentic selfhood.

The condition of being putatively irrational by virtue of a psychiatric diagnosis, but simultaneously compelled to constant rational self-surveillance, positions bipolar self-managers to render visible the unexpected forms of agency that are possible within this paradoxical space. However, these contradictions of governmentality, and the ways that its technologies both presume and elude rationality and transparency, extend beyond mentally ill subjects. This research thus contributes to a growing recognition within anthropology of the ways in which mental illnesses and treatment modalities do not exist outside of, but rather co-constitute and articulate with, conditions of modernity (Carr 2010b; Martin 2007; Schüll 2006). The dilemma of self-control—of, as Saint Augustine confessed, being a self that is torn apart by itself—is not a new one; yet, it is a dilemma that seems somehow particularly relevant at a moment in which we are both pressed by social and political economic forces to manage our selves to an intense, unprecedented degree,

¹⁸ I borrow the phrase “culprit lesion” from Barry Saunders’ (2008) fascinating ethnography of the historically genred reading, writing, and diagnosing practices that occur in a university hospital CT suite. Saunders demonstrates that even in the post-modern era of so-called “non-invasive” diagnostic modalities, “CT technology...is *haunted* by nineteenth-century projects of comparing, interpreting, classifying morphological specimens and residues—including, ultimately, the residue of the cadaver” (p. 12). Furthermore, he asserts that even though the lesion, “once fixed, macroscopic, and retrieved from the cadaver” is now “microscopic, molecular, fluid,” it nonetheless persists, particularly as the object of diagnostic aesthetics of detection and intrigue: “even if very small, the fixable, visible lesion remains important” (pp. 2–3).

¹⁹ In fact, contemporary psychiatry is often acutely aware that the success of its project will depend upon its ability to apply something analogous to the anatomico-clinical gaze to mental illnesses. As such, psychiatry explicitly describes its disease objects as, if not lesions per se, at least isolable neurochemical events that can (now or someday) be visualized. In an influential commentary on “Psychiatry as a Clinical Neuroscience Discipline” published in the *Journal of the American Medical Association (JAMA)*, for example, NIMH Director Thomas Insel argued that

psychiatry’s impact on public health will require that mental disorders be understood and treated as brain disorders. In the past, mental disorders were defined by the absence of a so-called organic lesion. Mental disorders became neurological disorders at the moment a lesion was found. With the advent of functional neuroimaging, patterns of regional brain activity associated with normal and pathological mental experience can be visualized, including detection of abnormal activity in brain circuits in the absence of an identifiable structural lesion (Insel and Quirion 2005, p. 2221).

and simultaneously (or perhaps, therefore) potentially more aware than ever of the impossibility of this management. Indeed, the widespread use of psychoactive medication epitomizes this concurrent dilemma and possibility: we now have a technical means by which we can manage our selves, but those very means also communicate the fact of our necessarily incomplete autonomy.²⁰

The model of agency and selfhood that ultimately gets elaborated under the paradoxical conditions of bipolar self-management invites consideration of modes of responsibility and choice that are available to the discontinuous and never-entirely knowable subject. Judith Butler (2001, 2005) writes extensively on these possibilities, arguing that the inherent nonsingularity of the self accounts for the unattainability of full transparency and is simultaneously the precondition for questions of responsibility:

I want to suggest that the very meaning of responsibility...cannot be tied to the conceit of transparency. Indeed, to take responsibility for oneself is to avow the limits of any self-understanding and to establish this limit not only as a condition for the subject, but as the predicament of the human community itself...I cannot think the question of responsibility alone, in isolation from the Other, or if I do, I have taken myself out of the mode of address that frames the problem of responsibility from the start (Butler 2001, pp. 37–38).

In a different manner, philosopher Annemarie Mol proposes a related shift in considering issues of responsible and good action from a “politics of who” to a “politics of what” (2002), or from a “logic of choice” to a “logic of care” (2008). The ideal of choice, Mol argues, “carries a whole world with it: a specific mode of organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies” (2008, p. 7). Viewing action through the lens of choice, encoded in the language of market rationality and rights of citizenship, then, obscures as many possibilities for enactment as it liberates for patients. According to Mol, “in care practices patients are not passive at all. They are active. However, they do not primarily figure as subjects of choice, but as the subjects of all kinds of activities” (ibid.). A characterization of bipolar self-management as agentive action that complicates and exceeds the relationships presupposed by the figures of the somatic patient/consumer and reified disease offers a productive site for an interrogation of the modern subject of choice.

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²⁰ Eugene Raikhel, personal correspondence.

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